Model of Care for People with Diabetes

Initiative Type

Model of Care

Status

Deliver

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12 September 2017

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08 August 2024

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https://cnxp3cuvtvrn68yjaibaht5ywrxspj7m.clinicalexcellence.qld.gov.au/improvement-exchange/people-diabetes

Summary

The intent of this initiative is to establish a system in the Darling Downs Hospital and Health Service (HHS) whereby patients with diabetes are able to access appropriate, evidence based clinical care in, or as close as possible to, their own communities and to ensure health care providers feel competent and capable of providing the best care to patients with diabetes with cost effective use of resources.

Key dates

Jan 2016

Jan 2019

Implementation sites

Darling Downs Hospital and Health Service

Partnerships

Healthcare Improvement Unit, Goondir Medical Services, General Practitioners (GPs), Queensland Ambulance Service, Tunstall Healthcare, AH Diabetes and Darling Downs and West Moreton PHN

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Aim

- Reduce the demand on specialist and emergency services.
- Up-skill primary health care to manage their patients within the community.
- Improve patient health literacy and self-management.

Benefits

- Reduction of potentially avoidable diabetes-related hospital admissions.
- Reduction of Queensland Ambulance Services (QAS) utilisation for non emergency diabetes-related care.
- Increase access treatment for patients from high-risk groups.
- Improved GP-reported capacity to manage diabetic patients.
- Improved quality of life for diabetic patients through self-management.

Background

In some areas of the Darling Downs, diabetes rates are up to 15 per cent higher than National rates. The Diabetes Queensland prevalence maps show that in 2011, the Darling Downs Hospital and Health Service (HHS) region had much higher rates of type 2 diabetes and diabetes requiring insulin compared to State and National rates. In 2015, the Heart Foundation rated Darling Downs – Maranoa as the most obese and inactive place in Australia – Toowoomba region was the 10th worst. Diabetes complication make up over one-quarter of Darling Downs HHS' chronic, potentially preventable, hospitalisations and patients with type 2 diabetes, particularly those in rural areas, have difficulty accessing specialist care when they experience complications. The Integrated Care Innovation Fund provides financial support to innovative projects that deliver better integration of care, address fragmentation in services and provide high-value healthcare. Funded projects also demonstrate a willingness to embrace and encourage the uptake of new technology alongside the benefits of integrating care and improving communication between health care sectors.

Solutions Implemented

The project has four key components:

1. Aboriginal and Torres Strait Islander care coordination virtual team.

2. GP-led diabetes care.
3. Queensland Ambulance Service (QAS) referral pathway.
4. Home monitoring.

Evaluation and Results

The project has yielded the following results:

- 337 referrals to the project.
- 34 out of the 71 discharged patients have provided a pre and post HbA1C test with a trend toward reduction in HbA1C.
- AH diabetes has conducted 926 patient visits.
- 25 patients have been referred to the home monitoring service.
- GP collaboration and education has been supported by the project’s endocrinologist and diabetes educator.

Further Reading

Hospital staff work hard to reduce the impact of diabetes

PDF saved 02/04/2025