Nurse led prevention model of care for chronic conditions

Initiative Type

Model of Care

Status

Deliver

Added

21 May 2024

Last updated

01 July 2024

URL

https://test.clinicalexcellence.qld.gov.au/improvement-exchange/nurse-led-prevention-model-care-chronic-conditions

Summary

This project was initiated as a trial in Mackay Hospital and Health Service (HHS) to co-design a model of care that assist Aboriginal and Torres Strait Islander and other vulnerable populations in the management and prevention of chronic conditions with a specific focus on Type 2 Diabetes. The model of care was targeted toward those who are pre-diabetic, newly diagnosed or living with Type 2

Diabetes, with the aim to reduce Emergency Department presentations and hospitalisations related to the associated complications of Type 2 Diabetes. Designed as a secondary prevention model of care, a key priority of this trial was to deliver a program that focuses on promoting healthy behaviour and better lifestyle choices in the management of Type 2 Diabetes. Centred around a Multi-Disciplinary Team approach, the model of care incorporated a team consisting of a Nurse Practitioner, Credentialled Diabetes Educator, Dietitian, Physiotherapist and First Nations Community Liaison Officers to provide a culturally supportive environment for clients and to guide the clinicians in providing culturally appropriate care. Delivery of care was via individual or group interventions that are client centred and as determined by the client themselves. Additionally, to ensure easy access to clinical care, clients were able to access the program directly via self-referral, thereby removing the associated costs and burden in obtaining a General Practitioner (GP) referral, and also via other healthcare services or community organisations.Co-design played an integral part in the establishment and development of a localised, holistic client centred model of care, with substantial engagement with community organisations, health services and consumer members. The expectation of the model of care is to establish a program that will provide more timely and appropriate access to Type 2 Diabetes care that is more culturally appropriate and as close to home as possible.

Key dates

Mar 2023

Jun 2024

Implementation sites

Macay Hospital and Health Service

Partnerships

Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Mackay, Girudala Community Co-Operative Society Ltd, Northern Queensland Primary Health Network, Health and Wellbeing Queensland, Logan Healthy Living program

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Aim

- for clients to achieve a greater understanding of the risks and complications of Type 2 Diabetes
- optimise the support and care for clients at risk of, or, diagnosed with Type 2 Diabetes to prevent hospitalisation
- encourage clients to self-manage their Type 2 Diabetes by incorporating healthy lifestyle choices
- enhance health pathways between healthcare providers

Benefits

All appropriate consultations, processes and structures outlined in the Model of Care have been established, allowing for full implementation and transitioning into the Together Strong Connected Care program. From the 5th of June 2023 the trial has received over 130 referrals and by April 2024 was delivering care to 70 active clients. Over a seven-month period the TSCC clinicians have conducted over 255 face-to-face consultations (predominantly within the client's home), 11 telehealth appointments and 53 phone consults. The program has also delivered five outreach clinics to communities that have limited or no access to T2DM services.

Background

The model of care strived to reduce the unique barriers and challenges faced by Aboriginal and Torres Strait Islander and Australian South Sea Islander people seeking healthcare. Aligned with national and state health priorities such as Closing the Gap and Making Tracks, this trial aimed to improve health outcomes for Indigenous Queenslanders by 2033.

Solutions Implemented

By supporting each client dependent on their stage of change or readiness, management of clients will occur across two platforms, including:

1. One-on-one individual comprehensive clinical management and one-on-one comprehensive clinical management, including the development of a self-management plan based and tailored to each individual, dependent on their health care needs. Clients referred into the program could also be involved with other health services such as endocrinologist and renal services, which was considered throughout their clinical management.
2. Group based interventions - the program complimented and worked with existing community and healthcare services. Group based programs focused on healthy eating/lifestyle, physical activity to support behaviour change and to improve self-management of clients' Type 2 Diabetes.

Evaluation and Results

In order to monitor and evaluate the success of the TSCC program, a number of localised measures and baseline data were collected:
Behavioural Impacts: Physical activity assessment, Dietary intake assessment, Digital Health technologies utilisation.
Client Experience: Community Liaison Officer surveys, Mackay Hospital and Health Service compliments and complaints.
Cultural Safety: Community Liaison Officer attendance at appointments, Community Liaison Officer attendance at community events, Culturally appropriate educational resources, attendance of program staff at Cultural capability training.
Program Processes: Number of occasions of service, Program completion rates, Fail to attends, Appointment types face to face, telehealth, Referral to intake assessment timeframe, Number of outreach clinics.
Health Workforce Capability: In-services, Workshops, Supporting other Health Programs, Student Supervision.
Partnerships: Number of Partnerships with key internal and external stakeholders and applicable State and National organisations.
Health System Impact: Potentially preventable hospitalisations from Type 2 Diabetes, Emergency department presentations for the management of Type 2 Diabetes, More timely and appropriate access to care that is as close to home as possible where clinically appropriate.Early data has suggested a demonstrated improvement for referred clients in weight loss, blood glucose within range and HbA1C levels. Group sessions were also a key aspect of the program, which led to the inclusion of a weekly hydro group. Participants of the hydro group indicated that before the being referred into the program, they did little or no physical activity, however, after the program they

actively seeked to incorporate these weekly sessions into their lives.
Whilst early data was limited, promising observational and anecdotal indicators were identified by clinicians including, improvement in personal care and hygiene, changes in health behaviour and beliefs, increased engagement in own healthcare and improved Type 2 Diabetes self-management.

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