The project involved redesigning the existing Chronic Disease Diabetes Model of Care to align with the MSH Service Plan. The project objectives were:

- To embed a connected and enhanced model of care to improve the patient journey and to build capacity through improved system efficiencies to appropriately manage diabetes across the spectrum of the disease.
- To decrease clinical variation – everyone working towards the same goal.
- To develop a clear understanding of the current service provision, identify changes required and opportunities to improve.

Aims & Goals:

- To improve the capacity of primary care services to prevent and manage diabetes and its complications
- Develop an efficient interface between general practice (GP), community-based diabetes prevention and management services and acute services
- Improve efficiencies within the acute care setting, by identifying current gaps in service
- Improve work flow process – scope of practice, defined work roles
- Create clear referral pathways for inpatient/outpatient services and improve patient flow
- Reduce avoidable hospital admissions/presentation.

Evaluation/outcomes:

This project met the planned objectives:

1. DESMOND and SMARTS Program collaboration with Diabetes Queensland
   - Develop referral pathway for Cat 3 and 4 low risk services to primary care and community based prevention programs to the Diabetes Queensland DESMOND and SMARTS program
   - Transitioned Cat 3 and 4 low risk services from the MSHHS What Now group programs to primary care and community based prevention programs

1. MSHHS – QAS Diabetes Service Referral Pathway
   - Implementation of the QAS-MSHHS Diabetes Service referral pathway to identify diabetic patients who frequently use the QAS service and present to the hospital for non-acute care
   - Provide a direct referral from QAS to the MSHHS Diabetes Service for clinically appropriate patients to decrease the number of hospital presentations and non-acute service episodes for QAS
   - Provision of MSHHS Diabetes Service to support patient access to knowledge and self-management of their chronic condition

1. Mater Young Adults Program
   - Improve adolescence/paediatric services Logan contract in place with Mater Young Adults Outpatient Clinics for patients to access services

1. Workflow Process
   - Improvements to workflow, patient journey and SOPD waitlist – process change to ARMS for direct options for Beacon Clinic and Nurse Practitioner clinics
   - Development of Nurse Practitioner discharge criteria to decrease duplication and service variation
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Medicine and Chronic Disease
Keywords:
Diabetes, Chronic Disease, Model of Care
Last updated 12 December 2018