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ABSTRACT SUBMISSION FORM

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TITLE Centralized resourcing versus distribution service models: a comparative exploration of implementing hybrid inter-disciplinary in-reach acute foot disease services in rural/remote Queensland.

AUTHORS Nevin, M., Ryan, L, Leech, C., Walker, A. and Ward., B.

EMAIL meegan.nevin@health.qld.gov.au **INSTITUTION** Queensland Health (Podiatry- Metro Souh He

ABSTRACT (maximum 450 words. Please use the following or similar headings: Background/Methods/Results/Conclusions)

Background:
The Queensland Diabetes Clinical Network identified a need for sustainable, streamlined service models ensuring stronger connection between regional patients with acute foot disease and tertiary-level interdisciplinary teams. Four metropolitan “Foot Care Hubs” and their corresponding regional “spoke” services were established, aligning with existing vascular surgery service regions. The Hubs aimed to improve access to specialist care, reduce unnecessary hospital transfers, major amputations and hospital length of stay, as well as enhancing primary care clinician recognition, interim management and escalation capabilities through education and clinical upskilling. The implementation strategies and developmental trajectories to achieve these goals have varied across the hubs significantly. This variation presents opportunity to compare implementation success and its relationship to clinical outcomes across the community foot care hub models.

Methods:
Four Foot Care Hubs were established, aligning with existing tertiary referral pathways to vascular surgery centres:

• Far Northern FCH: Cairns & Hinterland HHS- Torres & Cape HHS
• Northern FCH: Townsville HHS- North West HHS, Mackay HHS
• Central FCH: Metro North HHS-Central West HHS, Central Queensland HHS, Wide Bay HHS
• Southern FCH: Metro South HHS-South West HHS, Darling Downs HHS, West Moreton HHS

All four hubs consist of standard interdisciplinary teams: advanced clinical coordinator (podiatrist), senior podiatrist, Endocrinology, Infectious Diseases, and Vascular Surgery specialists (SMOs), dietitian/diabetes educator, Indigenous liaison officer, and psychologist. Team composition variations were determined by respective health service landscape and identified service gaps.
Over a 12-month establishment phase, clinical coordinators established interdisciplinary teams, engaged stakeholders across Queensland Health and primary care, and co-designed service models informed by gap analysis reflective of the local context. The team delivered upskilling to local clinicians, established escalation pathways and initiated telehealth services. A subsequent 6-month refinement phase focused on improving service accessibility, strengthening stakeholder engagement, evaluating performance, integrating emerging health technologies at spoke sites, and commencing face-to-face outreach services.

Results:
• Total Occasions of Service (OoS): 3940
•Service Model: Far Northern used centralised resourcing; Northern and Central combined centralised resourcing with distribution; Southern used distributed resourcing.
•Virtual Non-QH Service Use: Far Northern 14%, Northern 72%, Central 10%, Southern 71%.
•Patient Travel Saved: Far Northern 78,990 km; Northern 981,771 km; Central 235,904 km; Southern 1,809,509 km.
•Avoided Travel Subsidy Spend: Far Northern $26,857; Northern $1,044,104; Central $80,207; Southern $679,126.
•Common Interception Point: Far Northern and Central via QH podiatry escalation; Northern via GP post-nursing; Southern via primary care provider.
•Time to MDT Escalation: Far Northern 3-days; Northern 4-days; Central 2-days; Southern 4-days.
•Time in Service: Far Northern 16-weeks; Northern 14-weeks; Central 10-weeks; Southern 14-weeks.
•Avoided Tertiary Admissions: Far Northern 0; Northern 87; Central 7; Southern 42.
•Time to Surgery: Far Northern 5-days; Northern 4-days; Central 10-days; Southern 14-days.4

Conclusion:
All service models demonstrated efficacy in reducing unnecessary patient travel and subsidy scheme use, offering transferable value to other services. Models combining centralised and distributed resourcing, or employing distribution alone, showed greater engagement with non-Queensland Health providers, reduced interhospital transfers, and facilitated earlier patient interception and escalation. Conversely, centralised models achieved faster surgical intervention. While all three models prove beneficial, further investigation is needed to extrapolate distinct advantages of each approach in managing acute foot disease in rural and remote Queensland.