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| Diabetes Connect28074 |
| Outcome objective: Victorians are healthy and wellOutput group: Primary, Community and Dental HealthOutput: Community Health Care |

**OFFICIAL**

**1. Service objective**

Diabetes Connect is a community health-led integrated care pathway for people with type 2 diabetes. Diabetes Connect seeks to improve health and wellbeing outcomes for people with type 2 diabetes, reduce avoidable disease progression and hospitalisation, and improve integration and coordination between primary, community and acute care services.

**2. Description of the service**

Funding provided through this activity is for the delivery of services as part of the Diabetes Connect program. This includes funding to provide care coordination, health coaching and monitoring activities, as well as allied health and nursing services delivered to enrolled clients. Funding may also be used by community health service providers to broker services through other service providers, or to purchase material supports where these are essential to the client’s participation in the Diabetes Connect program. This activity also provides implementation support funding as part of the Diabetes Connect program pilot.

**3. Client group**

• Client Facing

The client group this activity is targeted at is people with type 2 diabetes, who are at risk of avoidable diabetes complications and hospitalisation, due to clinical and/or social risk factors.

**4. Obligations specific to this activity**

In addition to the obligations listed in the Service Agreement, organisations funded to deliver this activity must comply with the following:

**4a. Registration and Accreditation**

N/A

**4b. Program requirements and other policy guidelines**

* [Policy and Funding Guidelines](https://www.dhhs.vic.gov.au/policy-and-funding-guidelines-health-services)

<https://www.dhhs.vic.gov.au/policy-and-funding-guidelines-health-services>

* [Diabetes Connect pilot service framework](file:///F%3A/Oracle/Middleware/Oracle_Home/user_projects/domains/bi2/Partnerships.Primary%40health.vic.gov.au)

<Partnerships.Primary@health.vic.gov.au>

* [Community Health Program access policy](https://www.health.vic.gov.au/community-health/community-health-program-access-policy)

<https://www.health.vic.gov.au/community-health/community-health-program-access-policy>

* [Incident reporting for Community health services](https://www.health.vic.gov.au/incident-reporting-community-health-services)

<https://www.health.vic.gov.au/incident-reporting-community-health-services>

* [Registration, accreditation and governance of community health centres](https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres)

<https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres>

**5. Performance**

Funding is subject to achieving the performance targets specified in Schedule 2 of the Service Agreement.

Performance is measured as follows:

**Performance measure 1: Submission of quarterly report**

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| **Aim/objective** | The aim of this performance measure is to ensure that agencies meet all reporting requirements for the Diabetes Connect program |
| **Target** | Quarterly reporting as per reporting requirements outlined in Diabetes Connect pilot service framework |
| **Type of count** |  Non-cumulative |
| **Counting rule** | Manual |
| **Data source(s) collection** | * Diabetes Connect program reporting
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| **Definition of terms** | N/A |

**6. Data collection**

The reporting requirements for this service are:

| **Data collection name** | **Data system**  | **Data set**  | **Reporting cycle** |
| --- | --- | --- | --- |
| Community Health Minimum Data Set (CHMDS) | CHMDS  | CHMDS  | Quarterly |
| Diabetes Connect program reporting | Manual Data Collection  | As per reporting requirements outlined in Diabetes Connect pilot service framework  | Quarterly |

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