Diabetes Street Hub:

A novel integrated, community-based service to improve care for people with diabetes who experience housing instability including homelessness

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Introduction

- People experiencing housing instability including homelessness suffer from a high burden of chronic disease and often have poor health outcomes
- Combination of homelessness and diabetes mellitus (DM) is particularly disadvantageous
- Homelessness is associated with poor glycaemic control, increased complications and more frequent hospital presentations
- An important contributor to poor outcomes are significant barriers to accessing care. This includes financial constraints, lack of transport and communication, psychiatric co-morbidities, fragmented care, stigma and care avoidance
- Traditional health care models are ineffective to meet the needs of this community leading to suboptimal care and outcomes

Take home messages

- The Diabetes Street Hub offers a more accessible community-based health care model for people with DM who experience homelessness
- The service is designed to offer a more holistic, agile and patient-centred approach compared to traditional models of care
- Collaboration and co-location with other relevant services, programs and community partners is key
- A dedicated diabetes service for homeless does not alleviate all access problems and missed opportunity to treat rates are high but improving
- Future work will focus on better understanding patients' care needs and barriers to care to further improve service delivery

Learn more about the ***Diabetes Street Hub:***

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The Diabetes Street Hub

- The Diabetes Street Hub is a community-based, patient-centred, solution-focused and accessible service to improve care access and outcomes for people with DM experiencing homelessness
- Established in 2023 as a partnership between MSH and Micah Projects with funding from Queensland Health

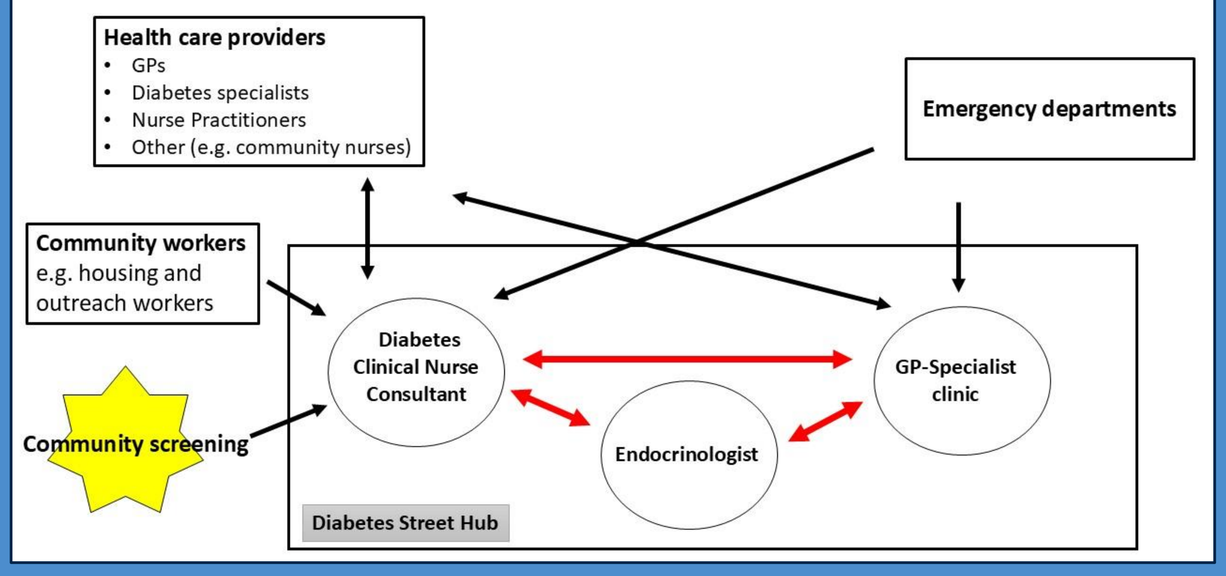
Core features of the Diabetes Street Hub

- *Community-based diabetes Clinical Nurse Consultant co-located with Micah Projects and its Inclusive Health clinic*
- *Collaborative GP and Endocrinologist co-led diabetes clinic*
- *Active integration and care coordination with Micah Project's nursing, support and advocacy workers and their GP service*
- *Proactive community outreach, engagement, education, screening and advocacy*

Key statistics

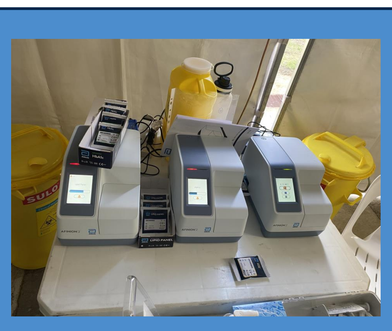
- 200 clinical nursing encounters over 6-month period (Sept 2025-Feb 2026) servicing 49 individual patients
- Since 2023, 84 individual patients booked in the GP-Specialist clinic (239 scheduled encounters)
- Missed-opportunity-to-treat rate 20.9% and 41% for nurse and specialist appointments, respectively
- Main recorded living circumstances were: crisis / transitional accommodation (25%), Supported Independent Living (25%), Rehabilitation Facility (8%), Public Housing (6%) and No Fixed Address (65)
- High proportion of people with T1DM: 19% vs 77% T2DM and 2.4% other forms of DM
- Mortality rate in this population is exceedingly high: at the time of review of service data, 16.7% had deceased

Referral pathways and workflow



Community Outreach and Engagement

- Outreach services to supported accommodation, short- and long-term housing facilities, drop-in centres
- Attendance at community events such as Homeless Connect
- Community Diabetes Screening Program
- Participation in street patrols (Brisbane City Council– BCC)
- Community service meetings (BCC)
- Stakeholder meetings with broad inclusion of relevant community organisations



Community Diabetes Screening at Homeless Connect (November 2025)

MICAH PROJECTS

Metro South Health | Princess Alexandra Hospital

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