Stakeholder Forum - First WHO Global Meeting of National NCD Programme Managers and Directors organised by WHO GCM (Global Coordination Mechanism) on NCDs—16-17 February 2016: APNA input

15 February 2016

The Australian Primary Health Care Nurses Association welcomes the opportunity to add to the contribution by Dr Frances Hughes to the first WHO Global Meeting of National NCD Programme Managers and Directors—APNA was asked to provide examples of collaborative primary health care models, best practices and tools for supporting national noncommunicable disease (NCD) efforts in Australia.

We are providing this submission on behalf of our membership, Australian primary health care nurses.

APNA Submission

Australian examples are as follows:

1. Life! Program, Victoria, Australia

Summary of the program

The Life! program is a lifestyle modification program coordinated by Diabetes Victoria where people assessed as high-risk of developing Type 2 Diabetes complete education sessions related to diet, exercise and goal setting related to:

- Reducing total fat consumption
- Reducing saturated fat consumption
- Increasing fibre consumption
- Increasing physical activity
- Reducing waist circumference.[1]

Indicators of success

[1] http://www.lifeprogram.org.au/

- Since the program began in 2008 over 40,000 Victorians have completed the program.
- Preliminary studies found a similar program to reduce the risk of Type 2 Diabetes by up to 58%.[2]
- The program was expanded in 2013 to include heart disease and stroke prevention. At this point, an additional program goal was added related to the reduction of salt consumption.
- Program eligibility criteria are based on a simple validated tool – the AUSDRISK – a 10-item assessment.
- The program has been expanded to include either a group education program, or individual telephone health coaching (especially for people in rural and regional areas).

Primary health care model

- General Practice 'case finding' agreements have been offered to clinics by Diabetes Victoria in the past, offering financial incentives for general practice clinics to establish systems for identifying patients at high-risk for type 2 diabetes and referring to the program.
- Life! program facilitators are trained by Diabetes Victoria, but are qualified health professionals with some experience in the provision of health education. Nurses working in primary health care comprise a large component of facilitators.
- Referral to the Life! program must be from a GP, a health professional, or a specific Life! program provider. All program referrals are accompanied by pathology results to ensure that diabetes diagnosis is excluded, and to ensure that primary health care remains at the centre of the referral process.
- After completion of the Life! program, program providers also send follow up patient measurements (before and after weight and waist measurements) to the General Practice clinic, for appropriate advice and follow up.
- In many general practice clinics the AUSDRISK tool now forms part of their standard 45+ and 75+ health assessments, and paper-based versions of the tool can be completed in the waiting room.
- The Life! program is the program used in Victoria, but similar programs exist in other states. In NSW, the 'Beat It' program, in WA the 'Walking Away' program, in Tasmania the 'COACH' program. All have important components of screening and referral via primary health care professionals.
- The Finnish authorities that developed the Life! program model[3] and their Australian counterparts[4] have identified primary health care as an essential part of the success of the program, and acknowledged that nurses in primary health care settings are invaluable resources to perform diabetes risk screenings, to give patients information about the program and appropriately refer patients to the program.
- In a 2003 report from the WHO and International Diabetes Federation (IDF) regarding diabetes screenings considerations of relevance to primary health care were:
    - The cost to primary health care provider (e.g. Nurse/GP time, materials) of conducting the screenings.
    - The cost to the primary health care system of managing newly diagnosed cases of diabetes.

[2] Tuomilehto J, Lindström J, Eriksson JG, et al. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Engl J Med 2001;344:1343–1350

[3] Schwarz PE, Reddy P, Greaves C, Dunbar J, Schwarz J (Eds.). Diabetes Prevention in Practice Dresden, Germany, TUMAINI Institute for Prevention Management, 2010

[4] Saaristo T, Moilanen L, Korpi-Hyövälti E, et al. Lifestyle intervention for prevention of type 2 diabetes in primary health care: one-year follow-up of the Finnish National Diabetes Prevention Program (FIN-D2D). Diabetes Care 2010;33:2146–2151

- Competing priorities in primary health care (i.e. is it more valuable to manage existing diabetes cases or screen for impaired glucose tolerance etc.)
- The importance of shifting diabetes prevention and management out of hospitals and into primary care.[5]

2. The Australian Primary Care Collaboratives (APCC) Program, Australia

The objective of the Australian Primary Care Collaboratives Program[6] was to encourage and support general practices and health services throughout Australia in delivering rapid, measurable, systematic and sustainable improvements in the care they provide to patients. This was achieved through the sound understanding and effective application of quality improvement methods and skills.

Health services that joined the APCC Program participated in what was known as a 'wave'. A GP and a staff member from each health service would come together with other health services in their wave to participate in the Program. A wave was made up of an orientation session followed by a series of learning workshops. There were four types of 'waves' in the APCC Program; national, hybrid, virtual and local.

More than 1,800 Australian general practices and health services participated in the Program since its inception in 2005. Collectively these participants have improved patient outcomes and practice/health service systems for better management and prevention of coronary heart disease, diabetes, chronic obstructive pulmonary disease, and improvements in patient access to timely and effective care.

Collaboration between neighbouring health services has enhanced the spread of ideas to make 'the possible' become 'the usual'. The Practice Nurse Lead Wave, one of the waves referred to above, was a coordinated and integrated approach to improving health outcomes for people with, or at risk of, coronary heart disease and cardiovascular disease. This wave recognised that primary health care nurses working in general practice have a pivotal role in the implementation of quality improvement in general practice. The collaborative process was immeasurably enhanced by the enthusiasm of participating GPs, primary health care nurses working in general practice, practice managers, Aboriginal health workers and reception staff.

3. ComDiab (community based diabetes education program), New South Wales, Australia

ComDiab is a free patient focused and interactive type 2 diabetes introductory group education program led by Community Health Registered Nurses (accredited with Diabetes NSW).[7] Trained Community Health Registered Nurses deliver quality group introductory diabetes education to enable individuals to better understand diabetes and self-manage diabetes.

The program is delivered in 2 x 2 hour sessions at Community Health Centres across the Central and Eastern Sydney Primary Health Network.

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[5] http://www.who.int/diabetes/publications/en/screening_mnc03.pdf
[6] http://www.apcc.org.au/about_the_APCC/the_collaborative_program/
[7] https://www.cesphn.org.au/programs/chronic-disease-management/diabetes-management/comdiab

About APNA

Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

Nurses in primary health care contribute to a healthy Australia through innovative, informed and dynamic care.

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