

InterHealth wins Major Health Prevention Award

Congratulations to local medical clinics Interhealth and Cheltenham who were announced as the recipients of the inaugural Victorian Prevention in General Practice Awards. In thanking all award entrants and congratulating this year's winners as excellent examples of the important role that general practice can play in primary prevention, the Victorian General Practice Prevention Alliance praised the Interhealth submission as a stand out in implementing primary care prevention. Well done PN Marlene Ferrie who put the submission together . VGPPA comprised of Cancer Council Victoria, Diabetes Australia – Vic, General Practice Victoria, Heart Foundation (Victoria) and The National Stroke Foundation aims for the awards to inspire practices to become more proactive in primary prevention, encourage divisions of general practice to assist implementation of primary prevention activities and recognise commitment to systematic prevention activities.

For further information about the VGPPA, including profiles of the winning entries, and examples and resources to integrate more prevention activities into everyday practice, please visit: www.gpv.org.au/vgppa/VGPPA_Prevention.htm

Here is InterHealth's submission :

DINGLEY & CHELTENHAM

Taking Action on Diabetes!

About Us and Our Practices

Locations:

Interhealth Medical Clinic, 110 Centre Dandenong Road, Dingley Village (see photos attached)

Cheltenham Medical Centre, 145 Centre Dandenong Road, Cheltenham (see photos attached)

Sportscare Physiotherapy, 110 Centre Dandenong Road, Dingley Village

The Practice Team:

14 GP's (8.1 FTE), 1 Practice Manager, 16 Receptionists, 4 Practice Nurses, 6 Physiotherapists, 1 Podiatrist, 1 Dietician.

Demographic Trends:

- Outer suburban areas of need; based on income, education and occupation (2001 Census Survey)
- Low Socio economic demographic (Socio-Economic Indexes for Areas 2001, Australian Bureau of Statistics)
- Highly industrialized area

Age/Sex Profile:

The patient population seen in last 15 months at Interhealth:

- Males: 5,308 (45.72%) Females: 6,099 (52.54%)
- 74.25% of patients are from Dingley/Cheltenham and adjoining suburbs.
- Our highest percent of patient population is in the 35 – 49 years (30%)

Program Implemented: Life! Taking Action on Diabetes Program

Date: April 2009

Life! Taking Action on Diabetes is evidence based, behavior change program, which was implemented by our combined clinics in April 2009. Detailed studies in America, Finland and China have consistently shown that programs which actively support behavioral change (improved nutrition and physical activity) in people with pre-diabetes, can prevent more than half the expected progression to type 2 diabetes. A key component of the program is the ability of the General Practitioner to refer eligible patients and therefore its success is dependant on their full support.

Diabetes Australia is doing a three year study on the effectiveness of this program and there are now over 50 Providers statewide. Diabetes Australia - Victoria pays the health care provider on an attendance basis once the participant's details and proof of attendance has been provided.

How we got started:

- Information was received at the clinics on the **Life! Taking Action on Diabetes Program** in April this year from Bayside General Practice Network.
- Carmel, our Physiotherapist, organized a practice meeting to discuss implementing the program.
- Practice meeting was positive and it was unanimously agreed to offer this program to our eligible patients – those 50 years and over.
- Carmel was appointed Coordinator and Bridie (Physiotherapist) would be the Facilitator of the program.
- Campaign brochures and the Australian Type2 Risk Assessment Tool (Ausdrisk) displayed on the counters of the clinics. Posters advertising the program displayed around the clinics. We are also on the Diabetes Australia website as being one of the Providers of the course.
- Using Practice 2000, reception staff at both clinics would print off the list of patients booked in for the following day. The target group – 50 years and over – would be highlighted on the list. When these patients presented they would be offered the Ausdrisk to complete whilst waiting to see their Doctor.
- The form would be handed to the Doctor by the patient and if they had a score of 15 or more a Life referral form would be completed. The patient would also be given a Pathology form requesting a Fasting Blood Glucose; this is to ensure that the patient does not already have Type 2 Diabetes.
- The Practice Nurse is responsible for printing the results of the blood test from Medical Director. She takes the results and the referral form to the Coordinator who contacts the patient and books them into a group for the program.
- The Practice Nurse would do the patient's weight, height, waist circumference and blood pressure and repeated measures are done at the ten week and then six month mark.

About the Program

The lifestyle behavior change program runs over six sessions in groups of between 8 and 15 participants over the age of 50 and is facilitated by Bridie. The first group started in April 2009 and we hold the sessions on a Tuesday evening and a Saturday morning.

Sessions one to five run each fortnight over a ten week period. Participants are given the confidence to make small, achievable changes to improve their lifestyle. They are encouraged to reach a weight loss goal through healthy eating and moderate daily exercise. Session six takes place eight months after session one and our first group going through will complete the course in December 2009.

The sessions are unexpectedly turning into a support group and it is also encouraging to see partners attend, especially the males in the group who do not do the cooking at home, their wives attending can implement the necessary dietary changes required.

We now have the sixth group going through and retention rates are high. The GP is provided with feedback on their patient's progression and success through Medical Director as they make their way through the program. Upon completion of the program, group members are linked into local support networks (such as walking groups) to allow them to maintain their improved lifestyle.

The program is gaining momentum because of word of mouth in the community and improved marketing by Diabetes Australia.

Our Diabetes Clinics

Interhealth Medical Clinic and **Cheltenham Medical Centre** attended the National Primary Care Collaborative three years ago and now have successfully established Diabetes Clinics as a result. The clinics are run by the patient's GP and the Practice Nurse.

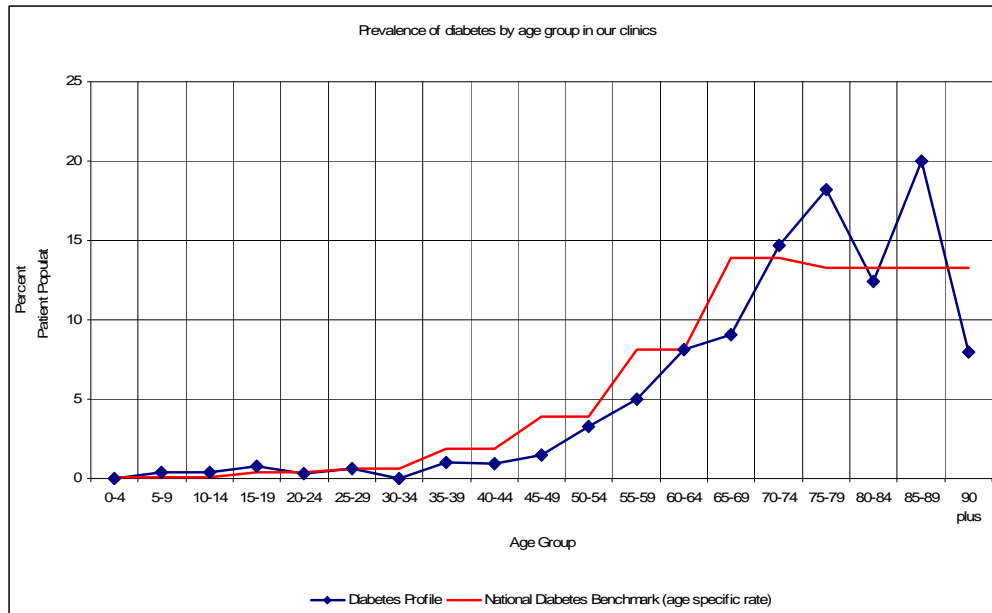
To assist us to set up the clinics we used the NPCC change principles 1 & 2.

- 1) Establish a system for creating, validating and updating a register of people with diabetes.
- 2) Be systematic and proactive in managing the care of people with diabetes.

We wanted to use these principles when setting up the **Life! Taking Action on Diabetes** program due to success in setting up the Diabetes Clinics.

Patients who have been diagnosed with Impaired Glucose Tolerance and Impaired Fasting Glucose are on the increase as are the risk factors associated with these conditions, which include obesity, hypertension, physical inactivity and poor nutrition. Patients with these conditions are invited to attend our Diabetes Clinics for education. Patients are able to build a relationship with the Practice Nurse and feedback is positive and encouraging.

The following chart shows the prevalence of diabetes profile by age group and the **Life! Taking Action on Diabetes** program is aimed at this group most at risk of developing diabetes – the 50 years and over patients.



What else is happening in Dingley?

At the same time as we implemented the **Life! Taking Action on Diabetes** program we also announced our **“Great Health; Great Life”** program (see attached flyer).

We also have an established and successful local walking group. The walking group is an integral part of our community program as increasing physical activity has the following benefits:

- Improves energy levels
- Increases energy expenditure resulting in weight loss
- Increased feeling of wellbeing
- Improved blood pressure and lipid profiles.

We have taken a community approach to addressing the issues of lifestyle management and programs we have introduced are targeting different groups in our community.

Making these programs community events has:

- Increased socialization, less isolation
- Increased motivation when friends involved.
- To promote our programs we have letter dropped flyers, advertised in the Dingley Dossier, the local Pharmacy is displaying flyers and Central Bayside Community Health Centre is displaying flyers and promoting our programs.

Our education series begins in October 2009 and the Practice Manager has arranged for the Dingley Eye Centre and Absolute Hearing to give talks to the community; this will be advertised in the Dingley Dossier. Before the end of the year the community will be invited to hear from our Podiatrist and Dietician.

Our Challenges:

Plan, Do, Study, Action (PDSA’s)

Patient compliance - Participants are now given reminder SMS's to attend each session.

Keeping the practice team enthusiastic, particularly the doctors

- Regular practice meetings updating staff on the progress of the program.
- Reception staff involvement is crucial to the programs success – they are the first person potential participants speak to about the program
- Communication book introduced with updates and reminders
- Receptionists are assisting the Physiotherapist with the walking group each Tuesday.

Time consuming process – Facilitator and Coordinator require time each week for completion of paperwork

What have we learned?

Success of our programs will be marked by the change of patient's measurements – weight, waist circumference, blood pressure. We hope that at the end of the six month mark, positive changes in weight and health statistics will increase doctor and new patient interest and help us to take even more action on diabetes and other chronic diseases affecting our community.

Commencing the program mid season had its challenges. Weather was becoming cold and wet and more difficult to persuade participants to join in the walking group. We have also found that different walking areas are needed so that we can cater to a variety of different ages and fitness level of participants.

To make this program sustainable we need to ensure that all practice team members continue to be well informed about our programs and their benefits to our community.

One of our Success Stories:

A patient who attended the Practice Nurse for her measurements half way through the program, lost 10cm from her waist, it was a satisfying moment for all concerned, the patient was absolutely thrilled. She is feeling energized, happier, and fitter, has gained confidence and feels inspired. She has now introduced friends to the program.