diabetes tasmania

A submission by Diabetes Tasmania
to the

Enquiry into Rural Health Services

March 2021

Our values

Integrity | Compassion | Quality

Transparency | Respect | Professionalism

1. The health of rural and remote Tasmanians

Tasmanians are older, poorer, sicker, less educated and experience greater socioeconomic disadvantage than Australians on average.[1,2,3]. While most of Tasmania's population live in urban areas (Hobart, Launceston, Devonport and Burnie), the remainder live in some of the 21 out of 29 Local Government Areas (LGAs) classified as rural, remote or very remote. These rural and remote areas are some of the most socioeconomically disadvantaged parts of the state[4] and generally have a higher proportion of residents over the age of 65 years.[5]

Over half (53.0%) of Tasmanians who saw a GP in 2019 had a chronic condition and nearly one third (29.3%) had two or more chronic diseases.[3] The most common chronic conditions seen by GPs were chronic musculoskeletal problems, mental health problems, asthma, diabetes and cardiovascular disease.[3] Coronary heart disease is the leading cause of death across Tasmanian rural LGAs.[5]

Risk factors common to several chronic diseases include smoking, obesity, poor eating habits and lack of physical activity. Risk factors such as these are higher in lower socioeconomic rural and remote areas of Tasmania[6] including the North-West coast, Derwent Valley and Southern Midlands. Many Tasmanians, including those in rural and remote areas, are concerned about the lack of access to a variety of affordable, fresh food.[6]

About 20% of Tasmanians have a mental health condition, mostly depression and anxiety, compounded by the burden of having to manage multiple chronic diseases such as diabetes and heart disease[3] as well as factors including social isolation, access to primary health care services and socioeconomic disadvantage.

The poor health of Tasmanians results in potentially preventable hospital admissions and deaths every year.[6] Tasmanians on average experience low health literacy and many struggle to participate in or navigate the health system.[7]

2. A health system over-reliant on GPs and hospitals

Comprehensive teamwork between primary care providers including GPs, nurses, allied health and pharmacies is integral to both the *prevention* and management of chronic disease. Access to primary health services, including greater collaboration with allied health services, can help to reduce risk factors and improve management of chronic disease, resulting in improved population health outcomes and reduced preventable hospital admissions.[3]

The management of Tasmanians with chronic disease in the community, particularly diabetes and heart disease, is largely performed by GPs.[3] Many Tasmanians, including those in rural and remote areas, find it difficult to visit a GP due to physical limitations (osteoarthritis, obesity or chronic pain), lack of transport or cost. Many GPs no longer bulk-bill, making GP visits less affordable for lower socioeconomic people who need them most.[10] On the flip side, many GPs do not charge or undercharge for their services, thereby placing the viability of their clinics in doubt. Some communities struggle to recruit and retain GPs.[3]

The future looks dire, with an increasing proportion of Tasmanians, including those living in rural and remote areas, in the more vulnerable 65+ age group over the next 10-15 years likely to experience one or more chronic diseases.[6,8] Referral pathways between available primary health services are often poorly defined or coordinated and many Tasmanians report not knowing how to navigate the health system to receive the care they need.[9]

The THS hospitals are swamped and waiting lists are long. A limited number of Tasmanians are responsible for 6% of preventable hospital admissions.[6,10] The top 10 reasons for admissions included pulmonary conditions, heart disease and diabetes.[6,10] Many of these admissions could be prevented through comprehensive team-based management with greater collaboration with allied health care.[10,11] These patients take up beds and time resulting in greater demand and pressure on limited THS emergency and hospital services.

3. Diabetes Tasmania - our experience

Diabetes is a condition that exposes very clearly the challenges to the state's health system outlined above. Diabetes disproportionally affects rural/remote, socioeconomically disadvantaged and minority populations in Australia. Tasmania has a higher rate of diabetes than the national average, and when combined with an older and more rapidly ageing population, the future is not only one of increasing numbers but increasing complexity as well.

GPs and primary care services in the state, as well as aged and disability care providers, are not sufficiently resourced in their current models to effectively manage adults with diabetes in our communities to maintain health and reduce reliance on acute and emergency services. Specialised, multi-disciplinary teams are required to support GPs and other primary care services in the state.

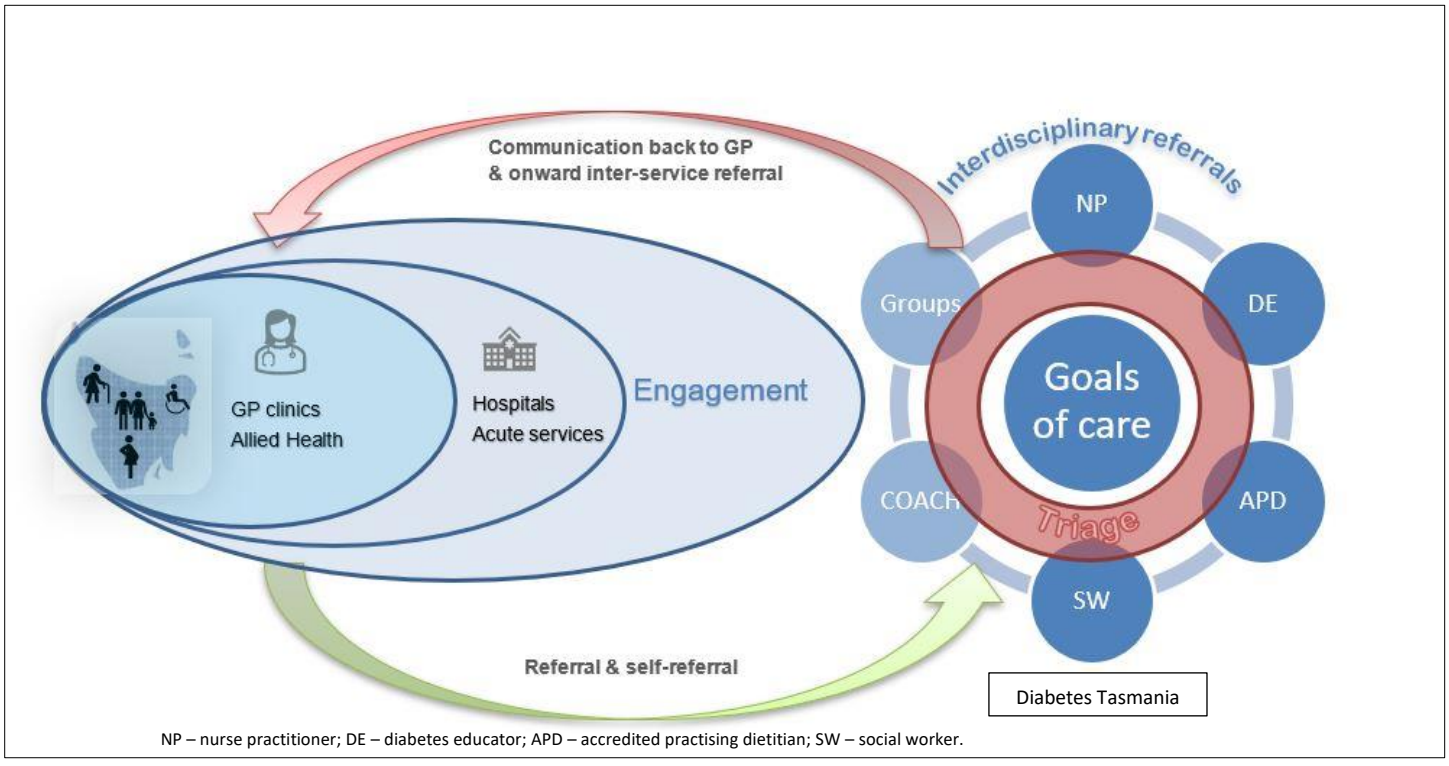
4. Supporting diabetes self-management through a multi-disciplinary team approach

Diabetes care is predicated on self-management. The aim is to support the person with diabetes to adapt healthy behaviours, learn new skills and understand their condition while overcoming common myths and ongoing stigma. Diabetes management in primary care is plagued by what has been described as 'clinic inertia'.[12] Essentially, there is often a delay in treatment intensification to achieve guideline-recommended targets of glycaemia for people with diabetes, especially when it comes to starting insulin.[12] Furthermore, the goal of diabetes self-management is more difficult to achieve where psychosocial barriers exist for individuals.[13] International guidance recommends providing collaborative psychosocial care to people with diabetes as part of their ongoing management.[14]
Diabetes Tasmania, with the support of Primary Health Tasmania (PHT), are currently piloting an expanded model of clinical service to regional and rural communities which responds to these two broad challenges of inertia and psychosocial barriers to care.

A **nurse practitioner** (NP) has been engaged to improve access to treatment intensification and support GPs with this process. A **social worker** (SW) has joined the clinical team to provide psychosocial support for patients in the form of counselling, advocacy, and linkages to other services across the state.

Both roles compliment the diabetes educator (DE) and dietetics (APD) clinics, and with the growth in telehealth and video consultations, the service is potentially more equitable, adaptable and responsive to the individual needs of people with diabetes across the state. When combined with our telephone health coaching program - The COACH Program - and our suite of group education and health professional education programs, we believe this will enhance our capacity to care for people with diabetes or at risk of diabetes in Tasmania.

The diagram below represents the model of care Diabetes Tasmania is currently developing. Central to the clinical services is the work of an engagement team who actively communicate with primary care and allied health services as well as hospitals to understand and ultimately facilitate improved inter-service referral pathways. Finally, our triage process allows the team to assess and direct people to appropriate clinics or programs, keeping their GP at the centre of their ongoing care.



NP – nurse practitioner; DE – diabetes educator; APD – accredited practising dietitian; SW – social worker.

5. Summary: how can we support better integrated primary health care for Tasmanians with, or at risk of chronic disease?

A. Diabetes Tasmania - Supporting General Practice

Diabetes Tasmania works closely with general practice throughout the state, predominantly in rural areas, to both support people living in rural areas and as well as those working in general practice.

- All patients referred to Diabetes Tasmania, including self-referrals, are triaged by a health professional to ensure the patient receives the right care at the right time and that their GP remains at the centre of their ongoing care.

- Diabetes Tasmania's clinical services (diabetes educator and dietitian clinics; group education sessions and telephone health coaching through The COACH Program) support patients to better understand and prevent or manage their diabetes;

- Diabetes Tasmania's **nurse practitioner** provides timely clinical interventions for patients such as insulin treatment intensification as well as support to GPs with this process. Ongoing funding beyond the funding of this pilot project would enable this position to be expanded and embedded into a model of multi-disciplinary integrated patient care;

- Diabetes Tasmania's **social worker** is available to support patients to work through psychosocial issues which may be barriers to better prevention or management of diabetes;

- **Multi-disciplinary video-link and telephone consults** for patients and GPs/ nurse practitioners are available with Diabetes Tasmania's diabetes educators and nurse practitioner to support better integrated care for the patient;

- **Telephone-based clinical support for GPs and practice nurses with a diabetes educator or nurse practitioner** is available to support clinical decision making around treatment options for patients;

- **Diabetes Tasmania's resources** – printed and online resources are available to support GPs and their patients to explain and understand diabetes and its management, and identify triggers for referral to Diabetes Tasmania's health professionals;

- **Our education events for the public and health professionals** working in general practice provide up to date information on the latest technologies and services available to support people with diabetes.

B. Telephone health coaching (The COACH Program) to reduce biochemical and lifestyle risk factors for chronic disease

The COACH Program, an evidence-based cardiovascular disease prevention program delivered by telephone, has been shown to be an effective and equitable means of helping Tasmanians to prevent and better manage their risk of chronic disease.

Coaches - trained health professionals - call patients by phone once a month for up to 6 months to improve three key biochemical risk factors for chronic disease including high blood glucose, high blood pressure and high cholesterol. In addition, coaches work with patients to reduce the key lifestyle risk factors for chronic disease including poor eating habits, inadequate physical activity, quitting smoking and reducing alcohol intake.

Coaches also encourage patients to discuss with their GP appropriate blood tests and medications in accordance with evidence-based guidelines for the management of their particular chronic disease(s). Coaches support multi-disciplinary integrated care by promoting referrals to diabetes educators, nurse practitioner, social worker, optometrists, podiatrists and psychologists as/if required, as well as other health services such as exercise physiologists, physiotherapists and local exercise classes.

Diabetes Tasmania has been delivering **The COACH Program** to people with, and at risk of type 2 diabetes for more than 11 years. In an additional 18-month pilot project from 1 Nov 2018 to 30 June 2020, Diabetes Tasmania delivered **The COACH Program for heart health** as an alternative cardiac rehabilitation option for patients with, or at risk of heart disease who were discharged from the THS who were unable to attend face to face cardiac rehabilitation.

In the most recent 6 monthly outcome reports for **The COACH Program for type 2 diabetes and those at risk**, and **The COACH program for heart health**, participants graduated from the program with significant improvements in the three main biochemical risk factors common to several chronic diseases:

- a 17-21% increase in the number of patients with diabetes who achieved the recommended 2-3 month average blood glucose level (HbA1c);
- a 10-32% increase in the number of participants who achieved the recommended LDL-cholesterol level;
- a 14-21% increase in the number of participants who achieved the recommended blood pressure level.

These results are consistent with interstate findings that show that participation in The COACH Program reduces risk factors for cardiovascular disease and/or diabetes[15-20]; in the long-term[18-19] and across a range of socio-economic demographics[17], resulting in reduced hospital admissions[21] and increased life-span.[22]

The COACH Program in Tasmania enables state-wide, equitable, cost-effective[23] and evidence-based prevention and management health support for people with, or at risk of chronic diseases including type 2 diabetes and heart disease. Delivered by phone including after-hours, it allows people to access health care who might otherwise struggle due to geographical isolation; transport or mobility issues or working hours.

For more information about Diabetes Tasmania's proposal to expand the program to become Tasmania's state-wide chronic disease prevention and management program, please see Diabetes Tasmania's submission in response to the Our Healthcare Future consultation paper (attached).

C. Automatic referral to Diabetes Tasmania for patients with type 2 diabetes discharged from the Tasmanian Health Service.

Diabetes Tasmania has been in discussion with the Royal Hobart Hospital (RHH) Diabetes Centre to encourage automatic referral of patients who are discharged from the RHH with either a primary or secondary diagnosis of diabetes. There is also discussion that this referral pathway should extend to include the High-Risk Foot Clinic.

An automatic referral to Diabetes Tasmania would provide the patient with the opportunity to receive support to treat the underlying cause or contributing reason for their hospital admission. For example, patients currently admitted to the High-Risk Foot Clinic for a foot ulcer will see the necessary health professionals in hospital to treat the ulcer, but may not be referred to a Diabetes Educator for support to manage the diabetes which caused the foot ulcer in the first place.

Automatic referral to Diabetes Tasmania post-discharge for all patients with a primary or secondary diagnosis of diabetes ensures more consistent, equitable, streamlined and integrated diabetes care. Referring patients to Diabetes Tasmania will raise awareness of diabetes as a cause of preventable hospital admissions; provide support to the patient to better manage their diabetes and help to reduce preventable hospital admissions related to diabetes.

Conclusion

Tasmanians living in rural and remote areas of the state experience worse health outcomes and face greater health care challenges than their urban counterparts. Better integration of primary health care services and referral pathways between GPs and allied health, nurses and pharmacists would improve health outcomes and reduce potentially preventable hospital admissions for chronic disease.

Multi-disciplinary integrated care is essential and can be delivered via video and telehealth consults with Diabetes Tasmania's dietitians, diabetes educators, nurse practitioner and social worker. Consistent, embedded and streamlined referral pathways between the THS hospitals, GPs and other community primary health care providers such as Diabetes Tasmania will improve equity of care, reduce risk factors, improve health outcomes and reduce potentially preventable hospital admissions.

Diabetes Tasmania's telephone health coaching program – The COACH Program – offers an accessible, equitable, cost-effective means of helping Tasmanians to reduce their risk of chronic disease. The COACH Program helps patients to understand how to prevent and/or manage their condition and encourages referral to other primary health services such as optometry, podiatry and exercise physiology.

References:

1. *Our Healthcare Future – Immediate Actions and Community Consultation Paper*, Tasmanian Government, Dec 2020.
2. Ahmed S., Shaw K., Tye I., Ho V., Edwards L., Kneebone J. *Primary Health Tasmania Needs Assessment: Health Intelligence Report, September 2017*. Primary Health Tasmania, Hobart, Tasmania; 2017.
3. Howes, F, Ahmed S, Lin L, Kitsos A, Shaw K. *General Practice in Tasmania 2019*. Primary Health Tasmania, Hobart, Tasmania; 2020.
4. Australian Bureau of Statistics, 2016, 2033.0.055.001 – Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA) Australia 2016, State Suburb (SCC) Index of Relative Socio-economic Advantage and Disadvantage.
5. Primary Health Tasmania, *Primary Health Tasmania Needs Assessment Report 1 July 2019 – 30 June 2022,* Hobart, Tasmania.
6. Department of Health, Tasmania 2020, *Report on the Tasmanian Population Health Survey 2019*, Hobart
7. Department of Health, Tasmania 2020, *Health Literacy Action Plan 2019 – 2024*, Hobart.
8. Department of Treasury and Finance, Tasmania, *2019 Population Projections – Tasmania and Local Government Areas*, Hobart.
9. Health Consumers Tasmania – *Our Healthcare Future Discussion Paper,* 2020
10. Primary Health Tasmania personal communications.
11. Primary Health Tasmania, *Stakeholder Consultation Summary – Cardiopulmonary rehabilitation provision in NW Tasmania,* Sept 2020.
12. Khunti, K et al. Clinical inertia in people with type 2 diabetes. Diabetes Care. 2013. 36.11.
13. Hill-Briggs, F, et al. Social determinants of health and diabetes: a scientific review. Diabetes Care. 2020, November. Published online, accessed 10 Mar 2021, care.diabetesjournals.org /content/early/2020/10/31/dci20-0053.
14. Young-Hyman, D et al. Psychosocial care for people with diabetes: A position statement of the American Diabetes Association. Diabetes Care. 2016. 39, 2126-2140.
15. Vale MJ, Jelinek MV, Best JD, Santamaria JD. Coaching patients with coronary heart disease to achieve the target cholesterol: a method to bridge the gap between evidence-based medicine and the 'real world'. Randomized controlled trial. J Clin Epidemiol 2002; 55: 245-252.
16. Vale MJ, Jelinek MV, Best JD, Dart AM, Grigg LE, Hare DL, Ho BP, Newman RW, McNeil JJ. Coaching Patients On Achieving Cardiovascular Health (COACH); A Multicenter Randomized Trial in Patients with Coronary Heart Disease. Arch Intern Med 2003; 163: 2775-83.
17. Ski CF, Vale MJ, Bennett GR, Chalmers VL, McFarlane K, Jelinek MV, Scott IA, Thompson DR. Improving access and equity in reducing cardiovascular risk: the Queensland Health model. MJA 202 (3) · 16 February 2015; doi: 10.5694/mja14.00575.
18. Jelinek MV, Santamaria JD, Thompson DR, Vale MJ. 'Fit for purpose'. The COACH Program improves lifestyle and biomedical risk factors. Heart 2012; 98:1608.

19. Jelinek MJ, Vale MJ, Liew D, Grigg LE, Dart AM, Hare DL, Best JD. The COACH Program produces sustained improvements in cardiovascular risk factors and adherence to recommended medications - 2 year follow-up. Heart, Lung and Circulation, 2009;18(6): 388-92.
20. Jelinek MV, Santamaria JD, Best JD, Thompson DR, Tonkin AM, Vale MJ. Reversing social disadvantage in secondary prevention of coronary heart disease. International Journal of Cardiology. Int J Cardiol 2014 Feb 15; 171(3): 346-50.
21. Vale MJ, Sundararajan V, Jelinek MV, et al. 4-year follow-up of the COACH study multicentre RCT. Circulation 2004; 110: Suppl: III-801
22. Byrnes J, Elliott T, Vale MJ, Jelinek MV, Scuffham P. Coaching Patients Saves Lives and Money. Am J Med. 2018 Apr;131(4):415-421.e1. doi: 10.1016/j.amjmed.2017.10.019. Epub 2017 Dec 11.
23. Tasmanian Department of Health (Public Health Services): Department of Planning, Purchasing and Performance, Monitoring, Reporting and Analysis. Cost-effectiveness Analysis: Summary of Fundings. Community sector preventative health interventions funded by Public Health Services, Tasmania, May 2017.

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Our Healthcare Future

consultation paper

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1. The health of Tasmanians

Tasmanians are older, poorer, sicker, less educated and experience greater socioeconomic disadvantage than Australians on average.[1,2] Over half (53.0%) of Tasmanians who saw a GP in 2019 had a chronic condition and nearly one third (29.3%) had two or more chronic diseases.[3] The most common chronic conditions seen by GPs were chronic musculoskeletal problems, mental health problems, asthma, diabetes and cardiovascular disease.[3]

More Tasmanians report unhealthy risk factors including smoking, obesity and excess alcohol intake than their mainland counterparts and experience additional risk factors including poor eating habits and lack of physical activity, which are common to several chronic conditions.[4]

About 20% of Tasmanians have a mental health condition, mostly depression and anxiety, significantly compounded by the burden of having to manage multiple chronic diseases such as diabetes and heart disease.[3]

The poor health of Tasmanians results in potentially preventable hospital admissions and deaths every year.[4] Tasmanians on average experience low health literacy and many do not have the skills to manage the tasks of everyday life, let alone navigate and optimise their participation in the health system.[5]

2. The health of the Tasmanian health system

The management of Tasmanians with chronic disease in the community, particularly diabetes and heart disease, is largely performed by GPs.[3] Unfortunately, too many Tasmanians do not seek preventative care and only engage with their GP or local hospital in an emergency.[1] Only when they have a heart attack due to undiagnosed or poorly managed type 2 diabetes do they seek help. Why? In part because there are inadequate state-wide, affordable and accessible primary health services to help Tasmanians understand, prevent and self-manage chronic disease.[1,6]

The same patient - once discharged from the Tasmanian Health Service (THS) after their heart attack - may be referred to and able to participate in the THS Cardiac Rehabilitation Program. However, many patients unfortunately cannot, due to living out of town, return to work or waiting lists for their local cardiac rehabilitation service.[7,8] Discharged back to their GP for ongoing care and management, many patients with chronic disease will continue living their lives without any lifestyle improvements until the next heart attack or hospital admission.

A growing cohort of Tasmanians at high risk of type 2 diabetes and heart disease are women with gestational diabetes (GDM). In the last 12 months, almost 700 Tasmanian women were diagnosed with GDM and the number is increasing.[9] Although this type of diabetes usually goes away once the baby is born, 50% of women with GDM develop type 2 diabetes within

10-20 years.[10] In addition, women with a history of GDM have an increased risk of heart disease[11] and their children are at increased risk of obesity and type 2 diabetes later in life.[12]

The future looks dire, with an increasing proportion of Tasmanians in the more vulnerable 65+ age group over the next 10-15 years experiencing chronic disease such as heart attack or diabetes.[4,13] Many of these people are functionally disabled – that is, unable to easily access their GP or other health services in person due to arthritis, obesity or chronic pain.

The THS hospitals are swamped and waiting lists are long. A limited number of Tasmanians are responsible for 6% of preventable hospital admissions.[4,14] The top 10 reasons for admissions included pulmonary conditions, heart disease and diabetes.[4,14] Many of these admissions could be prevented through comprehensive team-based management with greater collaboration with allied health care.[15] These patients take up beds and time which is then not available for other patients, resulting in increased admissions to the THS emergency department and poorer health outcomes.

Out in the community, many Tasmanians find it difficult to visit a GP due to physical limitations (osteoarthritis, obesity or chronic pain), lack of transport or cost. Many GPs no longer bulk-bill, making GP visits less affordable for lower socioeconomic people who need them most.[14] A proportion of chronic disease prevention and management care could be delivered by primary health services other than GPs, such as through accessible, proactive, phone-based, allied-health staffed programs.[15]

3. One part of the solution

The COACH Program, an evidence-based cardiovascular disease prevention program delivered by telephone, has been shown to be an effective and equitable means of helping Tasmanians to prevent and better manage their risk of chronic disease.

Coaches - trained health professionals - call patients by phone once a month for up to 6 months to improve primary biochemical risk factors for chronic disease including high blood glucose, high blood pressure and high cholesterol. In addition, coaches work with patients to reduce the key lifestyle risk factors for chronic disease including poor eating habits, inadequate physical activity, quitting smoking and reducing alcohol intake. Coaches also encourage patients to discuss with their GP appropriate blood tests and medications in accordance with evidence-based guidelines for the management of chronic disease.

Diabetes Tasmania has been delivering **The COACH Program** to people with, and at risk of type 2 diabetes for more than 11 years. In an additional 18-month pilot project from 1 Nov 2018 to 30 June 2020, Diabetes Tasmania delivered **The COACH Program for heart health** as an alternative cardiac rehabilitation option for patients with, or at risk of heart disease who were discharged from the THS who were unable to attend face to face cardiac rehabilitation.

A second pilot project currently underway – **The COACH Program for women after gestational diabetes**, funded by the Tasmanian Community Fund – has recruited more than 350 participants in 20 months. Participants have graduated from the program with improved eating habits and increased physical activity, as well as a greater awareness of future diabetes risk and increased participation in diabetes screening as per national guidelines. **The COACH Program for women after gestational diabetes** is currently the program available in Tasmania to help these women reduce their risk of future chronic disease.

In the most recent 6 monthly outcome reports for **The COACH Program for type 2 diabetes and those at risk**, and **The COACH program for heart health**, participants graduated from the program with significant improvements in the three main biochemical risk factors for chronic disease:

- a 17-21% increase in the number of patients with diabetes who achieved the recommended 2-3 month average blood glucose level (HbA1c);
- a 10-32% increase in the number of participants who achieved the recommended LDL-cholesterol level;
- a 14-21% increase in the number of participants who achieved the recommended blood pressure level.

These results are consistent with interstate findings that show that participation in The COACH Program reduces risk factors for cardiovascular disease and/or diabetes[16-21]; in the long-term[19-20] and across a range of socio-economic demographics[18], resulting in reduced hospital admissions[22] and increased life-span.[23]

Participation in **The COACH Program** helps patients to reduce their risk factors for chronic disease through healthy lifestyle changes and adherence to prescribed medication, hereby helping to reduce the likelihood of another heart event and re-admission to hospital.

The COACH Program in Tasmania enables state-wide, equitable, cost-effective[24] and evidence-based prevention and management health support for people with, or at risk of chronic disease including type 2 diabetes and heart disease. Delivered by phone including after-hours, it allows people to access care who might otherwise struggle due to geographical isolation; transport or mobility issues or working hours. Internationally, The COACH Program has been rated the most evidence-based cardiovascular disease (CVD) prevention program in the world on clinical and cost effectiveness by the British Heart Foundation and Public Health England's *International cardiovascular disease prevention case studies report – October 2018;* selected from 118 programs across the globe.[25, 26]

4. A more effective and efficient Tasmanian Health System with:

The COACH Program: Tasmania's State-wide Chronic Disease Prevention and Management Program

The COACH Program is well-placed to become Tasmania's state-wide chronic disease prevention and management program.

Specialising in the prevention and management of type 2 diabetes, cardiovascular and respiratory diseases (chronic obstructive disease) which share many of the same biomedical and lifestyle risk factors, **The COACH Program** would continue to achieve:

A. Clinical health outcomes:

- Reduced key biochemical risk factors for chronic disease (high blood glucose, high blood pressure and high cholesterol)[27,28]
- Reduced lifestyle risk factors for chronic disease (improved eating habits, increased physical activity, reduced smoking and reduced alcohol intake)[27,28]
- Reduced diabetes distress, which in turn reduces overall mental health burden[29]
- Promotion of cross-referral with other health services including diabetes educators, dietitians, social worker, GPs, specialists, podiatrists, optometrists, psychologists and pharmacists
- Improved health literacy, self-management of chronic disease and engagement with preventative health services
- Improved awareness of, and engagement with local community services such as gyms and community centres for group-based physical activity and social programs.

B. Equitable access to preventative health care:

- Delivered by phone, it eliminates the need to travel and is accessible to most Tasmanians
- Available after-hours on weekdays to accommodate full-time workers
- Available to regional/ rural Tasmanians as well as low-income and older clients[30]

C. Improved chronic disease prevention and self-management for Tasmanians:

- Improved prevention and management of chronic disease in the community
- Reduced potentially preventable hospital admissions for chronic disease
- More THS bed-days available for other patients
- One-stop shop for GPs and primary/ community health care providers to refer patients to who are at risk of chronic disease or need support to manage chronic disease
- Multiple referral pathways including THS referral, GP/ allied health referrals and self-referral
- Shown to be complimentary to existing primary health care services such as THS cardiac rehabilitation programs[31]

D. Already established and recognised program with opportunities for expansion

- **The COACH Program** has been delivered by Diabetes Tasmania for more than 11 years
- **The COACH Program** is already included in the Tasmanian Health Pathways for Type 2 Diabetes and Pre-diabetes[32]
- Pilot program funded by PHT (Jan – June 2021) is underway to promote **The COACH Program** to older Tasmanians receiving Home Care Packages
- A discussion was had with Primary Health Tasmania on 4 December 2020 to consider **The COACH Program** for inclusion in the Tasmanian Health Pathways for Cardiorespiratory Conditions

E. Cost-effective

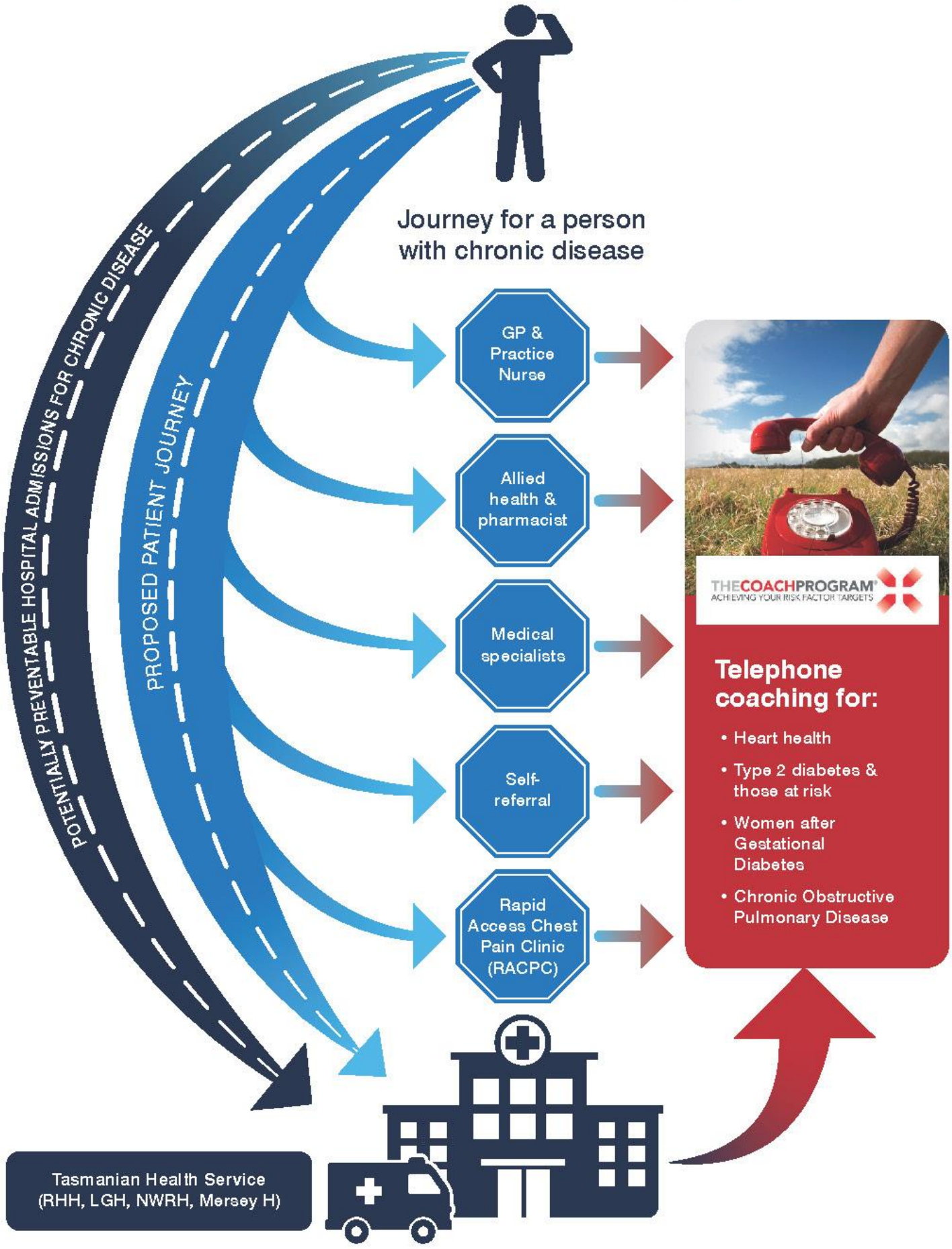
- **The COACH Program** was independently assessed as being a cost-effective program for type 2 diabetes patients in Tasmania[33]
- Recognised by Public Health Services (Tasmania) as a cost-effective program[24]
- Shown to be cost-effective for cardiovascular disease[23]

Summary

The COACH Program is well-placed to become Tasmania's state-wide chronic disease prevention and management program. Providing cost-effective, evidence-based and accessible telephone health coaching for Tasmanians with, or at risk of cardiovascular disease, type 2 diabetes and/or chronic obstructive pulmonary disease with multiple referral points including self-referral, it would improve the health of Tasmanians, reduce potentially preventable hospital admissions and make our healthcare system more efficient and effective. A brighter healthcare future for Tasmanians.

Potentially preventable hospital admissions through THECOACHPROGRAM®

ACHIEVING YOUR RISK FACTOR TARGETS



References:

1. Our Healthcare Future – Immediate Actions and Community Consultation Paper, Tasmanian Government, Dec 2020.
2. Ahmed S., Shaw K., Tye I., Ho V., Edwards L., Kneebone J. Primary Health Tasmania Needs Assessment: Health Intelligence Report, September 2017. Primary Health Tasmania, Hobart, Tasmania; 2017.
3. Howes, F, Ahmed S, Lin L, Kitsos A, Shaw K. General Practice in Tasmania 2019. Primary Health Tasmania, Hobart, Tasmania; 2020.
4. Primary Health Tasmania Needs Assessment Report 1 July 2019 – 30 June 2022. Primary Health Tasmania, Hobart, Tasmania.
5. Health Literacy Action Plan 2019 – 2024, Department of Health, Tasmania.
6. Morley, C. Emergency department presentations in Tasmania, Australia: a sequential explanatory investigation. PhD Thesis, University of Tasmania, 2019.
7. Redfern J, Hyun K, Chew DP, Astley C, Chow C, Aliprandi-Costa B, et al. Prescription of secondary prevention medications, lifestyle advice, and referral to rehabilitation among acute coronary syndrome inpatients: results from a large prospective audit in Australia and New Zealand. Heart 2014;100(16):1281-8.
8. Australian Cardiac Rehabilitation Association and Heart Foundation Position Statement on Cardiac Rehabilitation: Face-to-face and telehealth delivery options, 16 December 2020 https://www.heartfoundation.org.au/getmedia/3d4ea61a-9a61-4d44-8041-510071fade61/Heart-Foundation_ACRA-Position-Statement-on-cardiac-rehabilitation_telehealth_1.pdf
9. National Diabetes Services Scheme (NDSS) National Snapshot & Detailed State / Territory Data Reports for Quarter 2 2020-2021 (available upon request). Recent reports available at: https://www.ndss.com.au/about-the-ndss/diabetes-facts-and-figures/diabetes-data-snapshots/
10. Australian Government: National Diabetes Services Scheme (NDSS). Life After Gestational Diabetes booklet, 2020. https://www.ndss.com.au/wp-content/uploads/resources/booklet-gestational-diabetes-life-after.pdf
11. Gunderson, EP, et al. Gestational diabetes history and glucose tolerance after pregnancy associated with coronary artery calcium in women during midlife – The CARTIA Study. Circulation. 2021; 142:00-00. https://doi.org/10.1161/CIRCULATIONAHA.120.047320
12. Damn, P. Future risk of diabetes in mother and child after gestational diabetes mellitus. Int. J. Gynecol. Obstet. 2009. 104, S25-S26.
13. 2019 Population Projections – Tasmania and Local Government Areas. Department of Treasure and Finance, Tasmanian Government.
14. Primary Health Tasmania personal communications.
15. Stakeholder Consultation Summary – Cardiopulmonary rehabilitation provision in NW Tasmania, Primary Health Tasmania, Sept 2020.
16. Vale MJ, Jelinek MV, Best JD, Santamaria JD. Coaching patients with coronary heart disease to achieve the target cholesterol: a method to bridge the gap between evidence-based medicine and the 'real world'. Randomized controlled trial. J Clin Epidemiol 2002; 55: 245-252.

17. Vale MJ, Jelinek MV, Best JD, Dart AM, Grigg LE, Hare DL, Ho BP, Newman RW, McNeil JJ. Coaching Patients On Achieving Cardiovascular Health (COACH); A Multicenter Randomized Trial in Patients with Coronary Heart Disease. Arch Intern Med 2003; 163: 2775-83.
18. Ski CF, Vale MJ, Bennett GR, Chalmers VL, McFarlane K, Jelinek MV, Scott IA, Thompson DR. Improving access and equity in reducing cardiovascular risk: the Queensland Health model. MJA 202 (3) · 16 February 2015; doi: 10.5694/mja14.00575.
19. Jelinek MV, Santamaria JD, Thompson DR, Vale MJ. 'Fit for purpose'. The COACH Program improves lifestyle and biomedical risk factors. Heart 2012; 98:1608.
20. Jelinek MJ, Vale MJ, Liew D, Grigg LE, Dart AM, Hare DL, Best JD. The COACH Program produces sustained improvements in cardiovascular risk factors and adherence to recommended medications - 2 year follow-up. Heart, Lung and Circulation, 2009;18(6): 388-92.
21. Jelinek MV, Santamaria JD, Best JD, Thompson DR, Tonkin AM, Vale MJ. Reversing social disadvantage in secondary prevention of coronary heart disease. International Journal of Cardiology. Int J Cardiol 2014 Feb 15; 171(3): 346-50.
22. Vale MJ, Sundararajan V, Jelinek MV, et al. 4-year follow-up of the COACH study multicentre RCT. Circulation 2004; 110: Suppl: III-801
23. Byrnes J, Elliott T, Vale MJ, Jelinek MV, Scuffham P. Coaching Patients Saves Lives and Money. Am J Med. 2018 Apr;131(4):415-421.e1. doi: 10.1016/j.amjmed.2017.10.019. Epub 2017 Dec 11.
24. Tasmanian Department of Health (Public Health Services): Department of Planning, Purchasing and Performance, Monitoring, Reporting and Analysis. Cost-effectiveness Analysis: Summary of Fundings. Community sector preventative health interventions funded by Public Health Services, Tasmania, May 2017.
25. Solutions for Public Health, British Heart Foundation and Public Health England. International cardiovascular disease prevention case studies report – October 2018. https://www.bhf.org.uk/for-professionals/healthcare-professionals/commissioning-and-services/service-innovation/international-cardiovascular-disease-prevention-case-studies
26. COACH: Australian chronic disease management program leads world - MJA InSight 7, 25 February 2019 Issue 7 / 25 February 2019 (https://insightplus.mja.com.au/2019/7)
27. Diabetes TAS-Evaluation#23_TCP_01 Jul 2020 31 Dec 2020 report (available upon request)
28. Diabetes TAS-CR Evaluation_TCP_1 Nov 2018 1 Nov 2020 report (available upon request)
29. Diabetes Tasmania COACH 6-month Service Delivery Report 1 Jan to 30 June 2020 (available upon request)
30. Diabetes Tasmania COACH 6-month service delivery report July - Dec 2020 (available upon request)
31. The COACH Program for heart health - graduation results to 1 Nov 2020 (available upon request)
32. https://tasmania.communityhealthpathways.org/23168.htm
33. Palmer, AJ, and Vale, MJ, et al. The long-term cost effectiveness of the "Coaching Patients On Achieving Cardiovascular Health" (COACH) Program in type 2 diabetes in Tasmania. Value in Health, vol.19, no.7, 2016; A899-A899. https://doi.org/10.1016/j.jval.2016.08.746