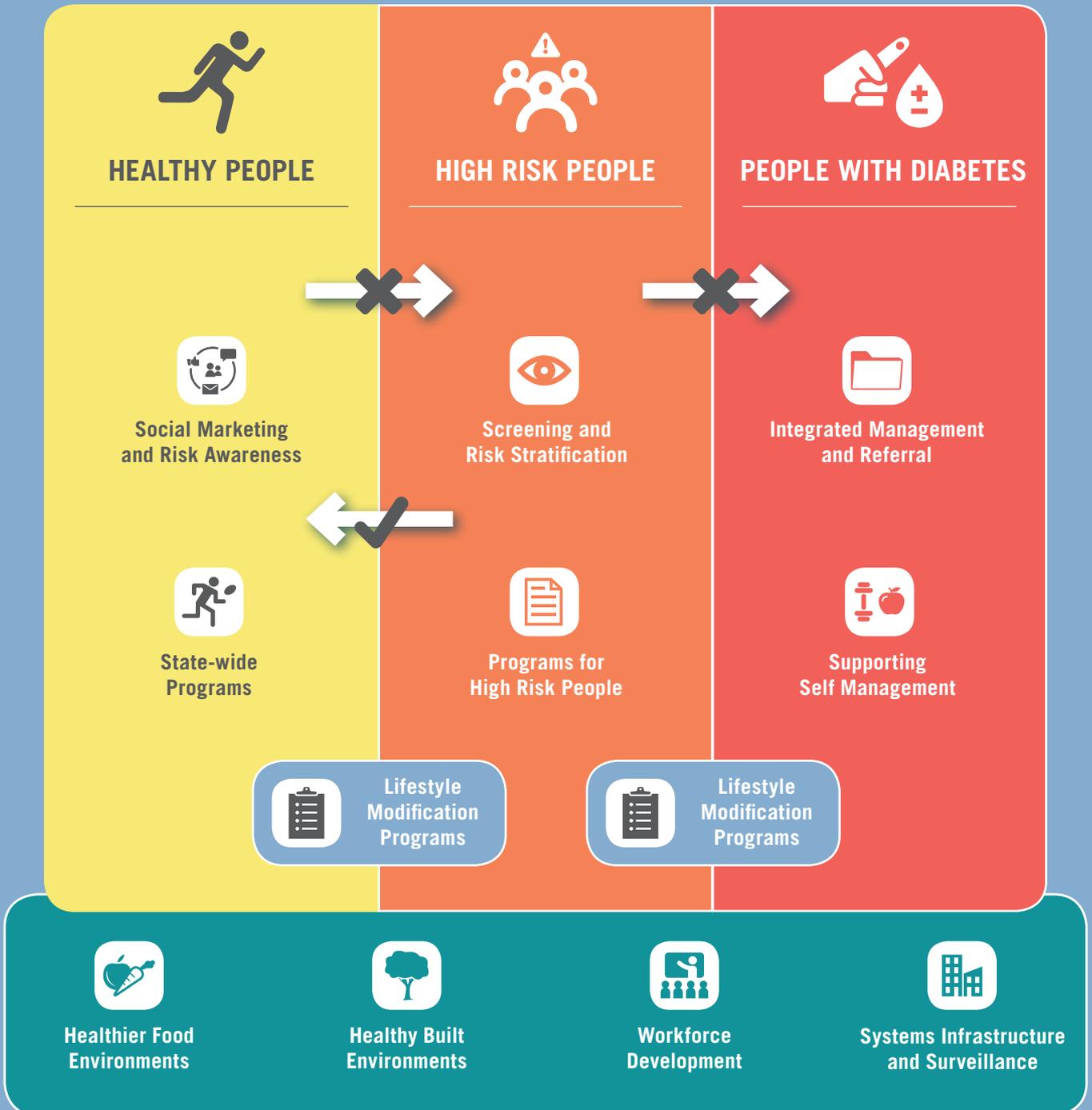


**NSW ACTION FOR DIABETES PREVENTION:
WHAT HEALTH PROFESSIONALS AND
HEALTH SERVICES CAN DO**

CONTENTS

FRAMEWORK AT A GLANCE	4	INTEGRATED CARE STRATEGY	34
NSW DIABETES PREVENTION FRAMEWORK		JUSTICE HEALTH FORENSIC MENTAL HEALTH NETWORK ABORIGINAL CHRONIC CARE PROGRAM	37
FRAMEWORK EXPLAINED	5		
SCOPE OF ACTION	5		
PURPOSE OF ACTION	6		
HEALTHY PEOPLE: STATE-WIDE PROGRAMS FOR TYPE 2 DIABETES PREVENTION	7	PEOPLE WITH DIABETES: SUPPORTING SELF MANAGEMENT	39
GET HEALTHY INFORMATION AND COACHING SERVICE	7	BROKEN HILL CHRONIC DISEASE PREVENTION GROUP	39
GET HEALTHY AT WORK	15	DIABETES NSW	41
HEALTHY PEOPLE: SOCIAL MARKETING AND RISK AWARENESS	18	ENABLERS: HEALTHIER FOOD ENVIRONMENTS	44
MAKE HEALTHY NORMAL CAMPAIGN	18	KILOJOULE LABELLING AND THE <i>8700.COM.AU</i> CAMPAIGN	44
HIGH RISK PEOPLE: SCREENING AND RISK STRATIFICATION	21	ADDRESSING FOOD SECURITY IN SOUTH WESTERN SYDNEY	47
WESTERN SYDNEY DIABETES PREVENTION AND MANAGEMENT INITIATIVE	21	ENABLERS: HEALTHY BUILT ENVIRONMENTS	49
PREVENTIVE CARE IN HUNTER NEW ENGLAND COMMUNITY HEALTH SERVICES	25	HEALTHY URBAN DEVELOPMENT CHECKLIST	49
HIGH RISK PEOPLE: PROGRAMS		HEALTHY BUILT ENVIRONMENTS IN NORTHERN SYDNEY	52
THE NSW ABORIGINAL KNOCKOUT HEALTH CHALLENGE	27	ENABLERS: WORKFORCE DEVELOPMENT	54
TARGETED FAMILY HEALTHY EATING AND PHYSICAL ACTIVITY PROGRAM – <i>GO4FUN</i>	29	TRAINING PROGRAMS FOR TYPE 2 DIABETES PREVENTION AND MANAGEMENT	54
PEOPLE WITH DIABETES: INTEGRATED MANAGEMENT AND REFERRAL	32	SYSTEMS INFRASTRUCTURE AND SURVEILLANCE	56
AGENCY FOR CLINICAL INNOVATION'S ENDOCRINE NETWORK	32	PREVENTION OF TYPE 2 DIABETES ENABLING RESOURCES	58

FRAMEWORK AT A GLANCE



NSW DIABETES PREVENTION FRAMEWORK

FRAMEWORK EXPLAINED



Prevent or Delay Healthy People from Becoming High Risk People

Programs and campaigns implemented by NSW Health to educate the public about the modifiable risk factors for, and the lifestyle modification programs available to reduce the risk of developing or delaying the onset of Type 2 diabetes.



Prevent or Delay High Risk People from Developing Type 2 diabetes

Early detection of Type 2 diabetes and holistic risk assessment for chronic conditions to prevent or delay onset, and steps to screen and refer high risk people to tailored programs.



Prevent People With Diabetes Experiencing Complications

Optimise treatment and referral. Empower the self management of people with Type 2 diabetes.



Utilise System Enablers

Workforce development opportunities, population level data collection on Type 2 diabetes risk and prevalence, food and built environment initiatives that aim to address the underlying modifiable drivers of Type 2 diabetes within the community.

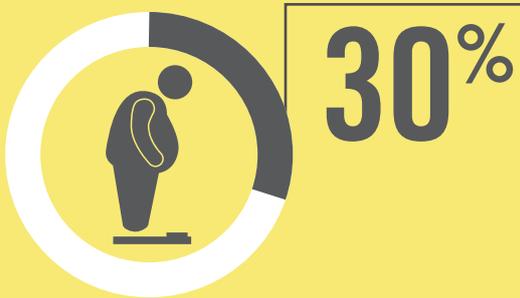
SCOPE OF ACTION

The *NSW Diabetes Prevention Framework* brings together diabetes-related work across the state, identifies enhancements to evidence-based practice, and sets a range of strategic directions for NSW Health for decreasing the risk of developing diabetes or diabetes complications in local populations.

This document, *NSW Action for Diabetes Prevention: What Health Professionals and Health Services Can Do* is a companion document to the framework that sets out a sample of case studies collected from Local Health Districts and partner organisations across the state.

These case studies are a sample of the activity taking place across the health system to respond to the increasing prevalence of Type 2 diabetes in our community.

An average weight loss of 2 kgs reduces the risk of developing Type 2 diabetes by



Reduce Type 2 diabetes by **SCREENING** for chronic disease risk factors, providing **BRIEF INTERVENTIONS** and **REFERRING** to tailored programs



Controlling HbA1c levels in people with diabetes to

≤7%

reduces diabetes-related complications

PURPOSE OF ACTION

The *NSW Diabetes Prevention Framework* and *NSW Action for Diabetes Prevention* documents are resources to support Local Health Districts reduce Type 2 diabetes risk factors and Type 2 diabetes in the NSW population, and enhance health outcomes for people with Type 2 diabetes.

NSW Health will work in partnership with communities, people with Type 2 diabetes and their families and carers, health professionals, Primary Health Care Organisations, the Commonwealth Government and non-government organisations, to:

- increase awareness of Type 2 diabetes risk factors in the NSW population
- increase the use of prevention services by people at high risk of developing Type 2 diabetes
- increase the use of complication prevention services for those people with Type 2 diabetes
- better integrate referral and management pathways to support self-management for people with Type 2 diabetes.

HEALTHY PEOPLE

STATE-WIDE PROGRAMS FOR TYPE 2 DIABETES PREVENTION

GET HEALTHY INFORMATION AND COACHING SERVICE



WHAT HEALTH SERVICES CAN DO

Health Services can:

- Refer adults who are overweight or obese to the Get Healthy Service using the Health Professional Referral Form
- Refer children aged 7-13 years who are overweight or obese to the local Go4Fun program through the website (www.go4fun.com.au)
- Refer smokers to the NSW Quitline and the Aboriginal Quitline (www.icanquit.com.au)
- Implement the Munch and Move and Live Life Well @ School healthy eating and physical activity programs to achieve high levels of adoption in children's settings such as primary schools and centre-based early childhood services (www.healthykids.nsw.gov.au)
- Recruit local businesses to the Get Healthy @ Work program (www.getthehealthyatwork.com.au)

The *NSW Get Healthy Information and Coaching Service* targets Type 2 diabetes prevention by providing free, confidential, telephone-based coaching for NSW adults in relation to healthy eating, physical activity and maintaining a healthy weight – some of the key risk factors for Type 2 diabetes.

Participants receive 10 coaching calls over 6 months with a university-qualified health coach, or elect to receive a one-off coaching call and printed resources to help them on their journey to better health.

The Get Healthy Service offers:

- 6 months support to set personal health goals and achieve them, through confidential, one-on-one phone sessions with a free health coach
- Advice on breaking through barriers that stop people from achieving their health goals
- Online tools and trackers to help people stay on track
- Expert advice on nutrition, exercise and achieving a healthy weight.



Systematic reviews have confirmed that telephone-based interventions are effective in increasing physical activity, improving nutrition and reducing weight. Interventions have been effective in the short to medium term (3 – 6 months), across different populations, in a range of settings, and using different modalities.

Participants who have completed the 6-month program have reported significant improvements, helping them achieve great results. These include:

- An average weight loss of 4kg
- An average loss of 5cm off their waist
- An increase in the amount of fruit and vegetables consumed daily
- A decrease in the amount of take away meals consumed per week
- A decrease in the amount of sweetened drinks consumed daily, such as soft drinks, cordials and fruit juices
- An increase in physical activity levels.

“The Get Healthy Service offers free access to professionals who can set realistic goals and help my patients achieve them without a substantial financial or time burden. People are often reluctant to commit but when they do the feedback is almost always very positive. So for me it’s part of normal practice.”

**DR LYNDON BAUER,
CENTRAL COAST NSW**

ABORIGINAL PROGRAM

The *Get Healthy Service Aboriginal Program* was developed to ensure that Aboriginal people in NSW have access to a culturally appropriate service. It offers coaching and materials that are specific to Aboriginal or Torres Strait Islander communities. Three additional coaching sessions are provided, with an information book and journal containing information specific to Aboriginal and Torres Strait Islander communities.

Get healthier for your mob
Start A Better Health Journey Now!

FREE
NSW Health Service

- Eat Healthier
- Exercise More
- Feel Better

And we'll help you along the way.

So call the Get Healthy Service on **1300 806 258**. It's **Free!** Or ask your GP, local Aboriginal Medical Service or Health Clinic to refer you today.

Call **1300 806 258**
www.gethealthynsw.com.au

NSW GOVERNMENT Health

get healthy
Information & Coaching Service
1300 806 258

Denise Barwick is currently an Aboriginal Youth Health Worker working at the Aboriginal Corporation Health Service in Wellington NSW and a referrer to the Get Healthy Service. Currently she runs Aboriginal Fitness groups for clients aged between 18-65 years old and regularly takes the groups for daily walks, gym and aqua. Denise is aware of many clients that have lost a lot of weight by participating in the Get Healthy Service. She also enjoys trying to help clients maintain the effort and changes they made by participating in Get Healthy.

“The Get Healthy Service gives clients the opportunity to set goals and track their achievements. A lot of the participants have said it’s great to have the same coach all the time, the person isn’t changing every time you ring. Sometimes you can go to the doctor and get someone different but with Get Healthy you have the same coach so you don’t always have to repeat everything.”

“I find the process of referring is easy – you just fill a form out. Some clients may need a medical clearance – and we arrange for them to visit the doctor to get checked out.”

“I have clients who are really benefiting from the program and getting good advice. They have given high ratings of the program.”

“I like that there is a mentor coaching clients on the phone and also providing support.”

**DENISE BARWICK,
ABORIGINAL YOUTH
HEALTH WORKER,
WELLINGTON NSW**



JOIN THE GET HEALTHY SERVICE

INDIVIDUALS CAN CONTACT THE GET HEALTHY SERVICE DIRECTLY

by calling 1300 806 258 between Monday – Friday 8am – 8pm, for the cost of a local call or register online at www.gethealthynsw.com.au. A number of screening and assessment questions are asked to assess health status and the health coach helps to set personalised health goals. Medical clearance from a GP may be required prior to taking part in the program.

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Refer adults who are overweight or obese to the Get Healthy Service using the Health Professional Referral Form



REFERRALS BY HEALTH PROFESSIONALS

General Practitioners and other Health professionals can refer patients to the Get Healthy Service.

GPs can provide medical clearance when referring patients to the Service. Health professionals can also order or print resources including posters, brochures and materials in community languages from the Get Healthy Service website at www.gethealthynsw.com.au.

General Practitioners and Health Professionals can earn points toward their ongoing professional development by participating in an online ThinkGP educational activity that supports doctors and professionals to encourage healthy lifestyle changes in their patients. The ThinkGP module, “Managing a Patient’s Lifestyle - Get Healthy Information and Coaching” looks at what the Get Healthy Service is, as well as the General Practitioner and Health Professional’s role in the program, the process of assessing patients for their sign-up suitability, and the patient referral process.



Independent evaluation of the Get Healthy Service has found that participants referred by a health professional are more likely to complete the 6 month coaching program and achieve better health outcomes.

TYPE 2 DIABETES PREVENTION PROGRAM

In response to the growing rates of Type 2 diabetes in NSW, the Get Healthy Service introduced the *Type 2 diabetes Prevention Program* in 2013.

This program focuses on empowering participants with the knowledge and skills to prevent Type 2 diabetes. Get Healthy Service callers who are over 40 years of age or Aboriginal, are assessed for Type 2 diabetes risk using the AUSDRISK tool. If the caller receives an AUSDRISK score of 12 or more they are enrolled in this tailored program, which provides 3 additional coaching sessions focusing on Type 2 diabetes awareness and personal risk factors.

The AUSDRISK tool can be found here:
<http://www.health.gov.au/internet/main/publishing.nsf/Content/diabetesRiskAssessmentTool>

All people with an AUSDRISK score greater than 12 are recommended to go and see their doctor for further advice.



40% of Get Healthy Service participants are currently enrolled in the *Type 2 diabetes Prevention Program*.

GET HEALTHY IN PREGNANCY

The *Get Healthy in Pregnancy Program* provides free, confidential and telephone-based information and coaching to support pregnant women aged 16 years and over to achieve healthy gestational weight gain. Up to 10 coaching calls are available for pregnant women, over a 6 month period. Women can join the service during pregnancy and/or post-birth.

The service provides pregnancy-specific factsheets on healthy weight, physical activity and gestational weight gain, coaching through the pregnancy and post-birth period, and complements the antenatal care provided by health professionals. The program incorporates the latest guidelines on gestational weight gain, ensuring that women receive evidence-based information and advice on healthy lifestyles during pregnancy and in the early months with baby. Referring health professionals receive updates on the women's progress in the program.

A phased state-wide rollout of the *Get Healthy in Pregnancy Program* is planned. The Program has been tested through a randomised control trial to assess its effectiveness. Preliminary results from the trial point to its helpfulness in supporting women to make healthier lifestyle choices. Women who participated in the trial reported that coaching sessions were helpful as they were motivational, interactive, personalised, tailored and regular. Women are recruited to the *Get Healthy in Pregnancy Program* at their first hospital booking visit.

GET HEALTHY ALCOHOL PROGRAM

The NSW Population Health Survey for 2013 reported that 26.5% of people aged 16 and over were drinking at levels that put them at a lifetime risk of harm.

In response to such high rates of drinking, the Get Healthy Service is introducing an enhancement to the Get Healthy Service, an Alcohol Program, which will aim to empower participants with the knowledge and skills to reduce their alcohol consumption. The Alcohol Program will be a standalone coaching program with a focus on current NSW Health recommendations for evidence-based brief alcohol interventions.

All Get Healthy Service callers will be asked about their rates of alcohol consumption. Participants whose drinking is classed as risky or harmful can nominate to enroll in the Alcohol Program of the Get Healthy Service. They then receive alcohol-sensitive coaching over 10 coaching sessions and alcohol related resources.

People classed as high-risk drinkers will be referred to their General Practitioner or to an alcohol intervention service for further support.

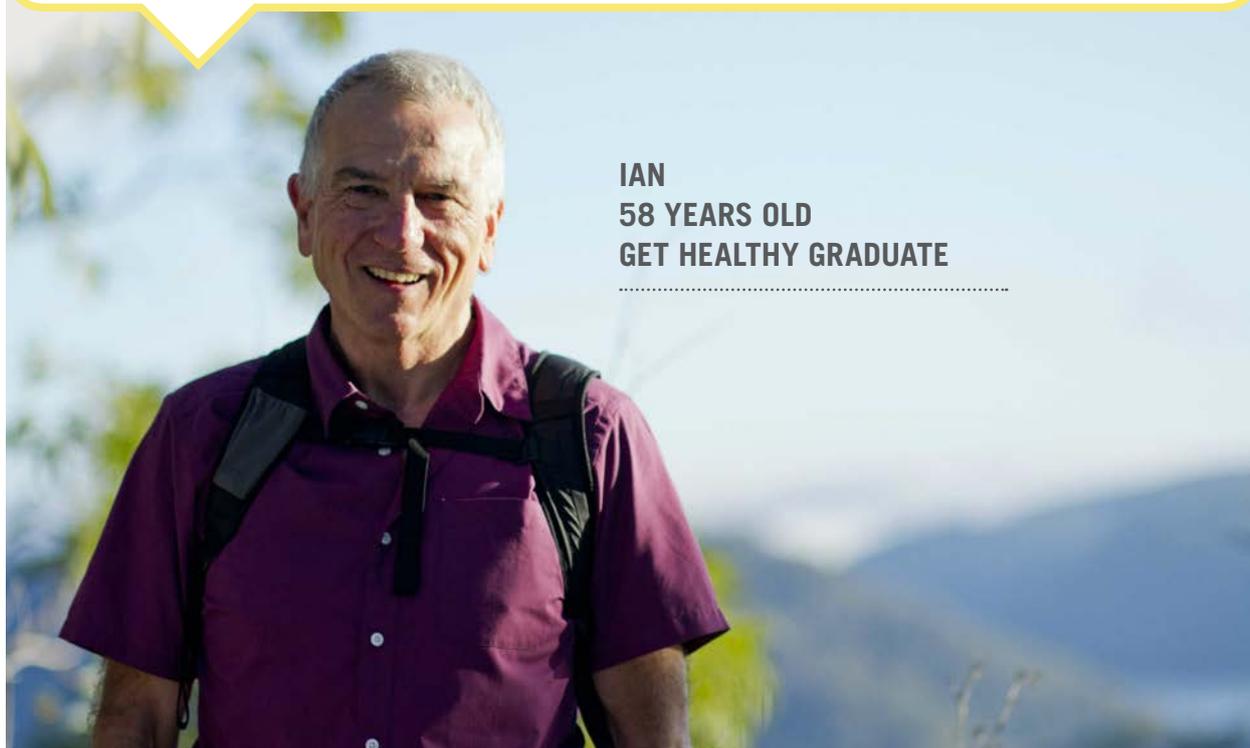
After watching a Get Healthy Service advertisement on TV it clicked with Ian that he was leading an unhealthy lifestyle and that he needed to do something about it. Indulging in take-away foods, constant snacking and not enough exercise was leaving him unhappy *“I had no energy and consumed too much alcohol. I knew it was bad, I just had never taken that first step.”*

After signing up to the Get Healthy Service Ian completely changed his way of life and since joining the program has lost 23 kilograms.

“Every time I talked to my coach I would come away with something really helpful. They never criticised, always encouraged.”

Even though Ian knew all along that he needed to exercise and eat healthier foods, having that backup to reinforce the positive actions was the key. Now he does a 45-minute walk every morning with friends and has gotten back into the sports he enjoyed as a kid.

When asked whether Ian could see himself going back to his previous lifestyle, he said *“I don’t see this as a diet that I have been on; I see this as a lifestyle change, as I have changed how I go about my life. It is not a diet, it is my life.”*



**IAN
58 YEARS OLD
GET HEALTHY GRADUATE**

LOCALISATION BY LOCAL HEALTH DISTRICTS

SOUTH WESTERN SYDNEY LOCAL HEALTH DISTRICT

South Western Sydney LHD supports clinicians to make referrals to the Get Healthy Service. For example, Clinical Nurse Consultants and Physiotherapists at the Whitlam Joint Replacement Centre in Fairfield Hospital have embedded referral to the Get Healthy Service for individuals who are on the surgical list for a joint replacement. The LHD has provided Get Healthy Service resources for the Centre to give to clients and a number of referrals have resulted.

The LHD also undertook a promotion activity with University of Western Sydney Campbelltown and Bankstown campuses as part of their Mental Health & Wellbeing Events. Students were engaged in an interactive game involving sugar sweetened drinks and were informed of the Get Healthy Service. Across the two events approximately 150 students were engaged in the discussion and there were 37 active referrals on the day.

NORTHERN SYDNEY LOCAL HEALTH DISTRICT

The Get Healthy Service was promoted to low income community groups, residents and services. With the help of local councils and services, the service was promoted over 12 months to:

- 3,900 residents at Ivanhoe Estate and Link Housing via in-house newsletters
- 310 community service organisations in the Ryde, Hornsby and Ku-ring-gai areas
- 14 Link Housing Managers, managing 1,200 properties in Northern Sydney
- Clients and customers of 19 organisations in the Ryde area.



The Western Sydney LHD took the Get Healthy Service to the Paramasala festival in Parramatta. Engaging with CALD communities is a key strategy to the prevention and reduction of Type 2 diabetes in NSW.

GET HEALTHY AT WORK

With growing rates of Type 2 diabetes in the community affecting productivity as well as causing illness in the community and stress on health services, Get Healthy at Work is an important and innovative Type 2 diabetes prevention initiative in the workplace setting. LHDs can support workplace preventive health strategies by promoting and recruiting local businesses (including public sector agencies like local councils and their own LHD workforces) to Get Healthy at Work.

Get Healthy at Work is a *free* workplace health service that aims to help improve the health of working adults by giving workplaces tools and support to address Type 2 diabetes risk factors including:

- Healthy eating
- Healthy weight
- Physical activity
- Active travel
(i.e. walking, cycling, public transport to work)
- Smoking
- Harmful alcohol consumption.

No matter what industry or size of the workplace, Get Healthy at Work makes it easy to identify the biggest health issues in a particular business and to institute changes at an organisation and individual level.

The free service consists of support for workplace health programs and brief health checks.



WORKPLACE HEALTH PROGRAM SUPPORT

All the tools, templates and resources needed to develop a simple action plan to address a priority health issue at a workplace are provided. The program is available online or at your business with the support of a service provider.

BRIEF HEALTH CHECKS

A free and confidential service for workers, completed either online or by a health practitioner at a workplace. It takes just 15 minutes and offers immediate feedback about an individual's health and risk of developing Type 2 diabetes and heart disease. It also provides advice on how to make changes for better health, with referrals to lifestyle coaching programs and general practitioners.

A successful workplace health program may influence the performance of a workplace through:

- Gains in staff attraction and retention,
- Improved productivity,
- Enhanced corporate image,
- Reductions in absenteeism.

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Recruit local businesses to the Get Healthy @ Work program (www.gethealthyatwork.com.au)

LOCALISATION OF GET HEALTHY AT WORK

SYDNEY LOCAL HEALTH DISTRICT

commenced rolling out Get Healthy at Work across six LHD facilities in June 2015. Events and information stalls have been held to raise awareness of the program. To date over 450 staff members have completed the online Brief Health Check and over 600 staff have completed a survey as part of the planning process.

In Sydney LHD Get Healthy at Work brings together current health and wellbeing initiatives. Promoting Get Healthy at Work has been part of National Safety Month at most facilities and has included stalls, competitions and healthy food. Stalls in facility foyers have enabled the Get Healthy at Work healthy lifestyle messages to be shared with patients and community members.

“Health and wellbeing should be included in every workplace. It improves morale and productivity and a UK study found a healthy workforce can improve patient outcomes.”

**CATHERINE MACKAY, WHS MANAGER,
SLHD**



Sydney LHD launch Get Healthy at Work at Royal Prince Alfred Hospital

NORTHERN SYDNEY LOCAL HEALTH DISTRICT

launched Get Healthy at Work in October 2014. To support the rollout of the program a communications plan was developed, a Get Healthy at Work intranet banner advertising the link to the Brief Health Checks was created along with promotional stalls.

High level support was provided by the Director, Workforce and Culture in an email broadcast to all staff across the LHD. Promotional items including stickers, posters and flyers, Get Healthy at Work tape measures and drink bottles were used to help drive uptake of the Brief Health Check at the registered facilities. Posters and flyers had a QR code for each facility so that staff could complete the Brief Health Checks on their smart phone.

Northern Sydney Local Health District has had great success with nearly 15% of all staff members participating in the Brief Health Check to date. Promotion of the program will continue as planned.



Northern Sydney LHD

HEALTHY PEOPLE

SOCIAL MARKETING AND RISK AWARENESS

MAKE HEALTHY NORMAL CAMPAIGN

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Use Make Healthy Normal social marketing resources to promote healthy eating, active living and smoking cessation programs in workplaces, public places and children's settings such as primary schools and centre-based early childhood
- Share posts from the Make Healthy Normal Facebook page to LHD Facebook pages (<https://www.facebook.com/makehealthynormal>)
- Use signature blocks, web banners and a link from the LHDs intranet site to the Make Healthy Normal website (www.makehealthynormal.nsw.gov.au)
- Work with local councils to amplify campaign messages by placement of campaign signage on council infrastructure e.g. park benches
- Adopt key campaign messages in preventive health activities
- Encourage staff to register for the Make Healthy Normal 10 week Challenge or the Get Healthy Service.

At a population level, social marketing is a proven strategy for enhancing risk awareness and increasing the readiness of individuals and communities to make behaviour changes. Social marketing has been utilised effectively and efficiently to reduce tobacco smoking and prevent the adoption of smoking among young people. Now, NSW Health is leading a social marketing strategy targeting Type 2 diabetes risk factors including overweight and obesity, poor nutrition and inadequate physical activity.

With this new campaign, NSW Health is aiming to generate a community-wide conversation about the increasing rates of Type 2 diabetes and increases in the risk factors driving this trend. By implementing the simple, easy and effective measures laid out in the Make Healthy Normal campaign, we can all take charge of reducing the risk of developing Type 2 diabetes.

With over half the adults in NSW overweight or obese, being unhealthy has become normal. Just a handful of belly fat increases risk of heart disease, cancer, stroke and Type 2 diabetes. The campaign contains the good news – that it's never too late to make healthy normal.

Television, digital, outdoor and press advertisements as well as outdoor advertising will promote 5 key messages to the NSW community:



1. Choose smaller portions and less kilojoules



2. Eat more fruit and vegetables



3. Be active every day



4. Make water your drink



5. Sit less and move more.

www.makehealthynormal.nsw.gov.au
www.facebook.com/MakeHealthyNormal



SMALL STEPS CAN MAKE A BIG DIFFERENCE.



1 CHOOSE SMALLER PORTIONS
AND LESS KILOJOULES



2 EAT MORE
FRUIT AND VEG



3 BE ACTIVE
EVERY DAY



4 MAKE WATER
YOUR DRINK



5 SIT LESS AND
MOVE MORE

When it comes to losing weight and getting healthy, it is the healthy choices you make every day that truly make all the difference. Choose smaller portions, eat more fruit and vegetables, make water your drink, be active every day and sit less and move more.

You will feel better, look better and help protect yourself against chronic diseases such as heart disease, type 2 diabetes and some cancers. Every healthy choice you make counts.

Now is the time to get healthy.

FIND OUT IF YOU ARE A HEALTHY WEIGHT Search 'BMI NSW Health' for BMI calculator

HIGH RISK PEOPLE

SCREENING AND RISK STRATIFICATION

WESTERN SYDNEY DIABETES PREVENTION AND MANAGEMENT INITIATIVE

WHAT HEALTH SERVICES CAN DO

Health Services can:

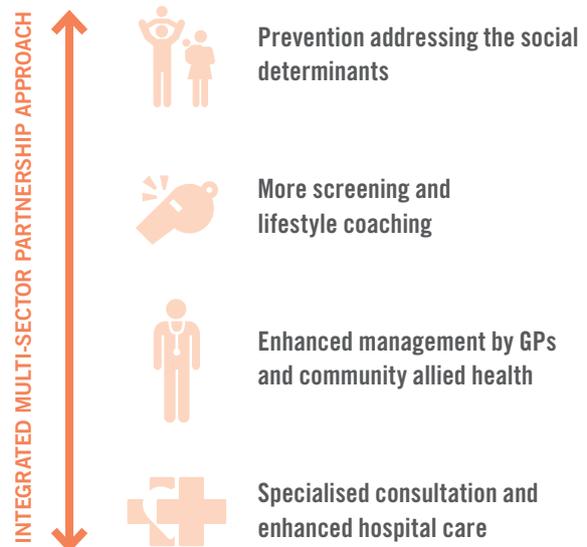
- Initiate and evaluate screening and risk stratification measures as part of the Integrated Care Strategy or other local chronic disease initiatives
- Screen for diabetes in acute care settings.



Western Sydney Local Health District (LHD) is leading the way for other health services across NSW in making a local investment to prevent and manage Type 2 diabetes. Western Sydney LHD is a Type 2 diabetes 'hot spot' with 4 of the 5 Local Government Areas experiencing rates of diabetes above the NSW and national rates.

In response to this growing concern, Western Sydney LHD and Western Sydney PHN (WentWest) have developed a multi-sector, multi-intervention approach reaching across the whole district. Strong leadership from both organisations has been key to developing the relationships, funding and infrastructure needed to implement the Western Sydney Diabetes Initiative.

The LHD is preventing and improving Type 2 diabetes care by better integrating General Practice and acute care through 4 key strategies¹:



1. Western Sydney Diabetes Prevention and Management Initiative brochure. Western Sydney Local Health District and Western Sydney Medicare Local, 2013

Three components of the Western Sydney Diabetes Initiative are described below.

BUILDING GENERAL PRACTICE CAPACITY TO ENHANCE DIABETES CARE IN THE COMMUNITY VIA CASE CONFERENCING

The Blacktown Hospital Outpatient Diabetes medical team, comprising an endocrinology consultant, community advanced trainee in endocrinology, resident medical officer and credentialed diabetes nurse educator, visited 90 General Practices and conducted 500 case conferences to build GP capacity to better manage diabetes².

Five to ten patients were reviewed in each General Practice to ensure patients received best practice Type 2 diabetes care, including medication management and referral to lifestyle modification programs such as the Get Healthy Information and Coaching Service.

By 2025, it has been estimated that within Western Sydney the prevalence of diabetes within the population will be



[ref WS Diabetes Prevention and Management Initiative 2013-2018].



2. Building general practice capacity to enhance diabetes care in the community via case conferencing: early findings from Western Sydney Local Health District. 2015 Poster presentation at the Australian Diabetes Society Scientific Meeting. Mani Manoharan, Sian Bramwell, Amanda Hor, Vidura De Silva, Sumathy Ravi, Xiaoqi Feng, Thomas Astell-Burt, Marina Fulcher, Mark McLean, Glen Maberly.

Following the case conferencing program, improvements were reported in patients with Type 2 diabetes, and the integration between hospital services and primary care:

- 85% of GPs reported they would be less likely to refer less complicated cases to specialist services in future, saving resources in specialist services for the most complex cases and allowing more people to be treated in General Practice where they are comfortable
- The mean concentration of HbA1c (a measure of glucose in the blood) was reduced by 0.85% 3-6 months after the case conference. This is a highly clinically significant result
- Reduction of systolic blood pressure, diastolic blood pressure and cholesterol was observed.

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Assess individuals for Type 2 diabetes risk factors e.g. by using the AUSDRISK tool. www.health.gov.au/preventionoftype2diabetes
- Engage with primary care including local Primary Health Networks and Aboriginal Community Controlled Health Services (ACCHSs) to enhance Type 2 diabetes screening in general practice and community based care.

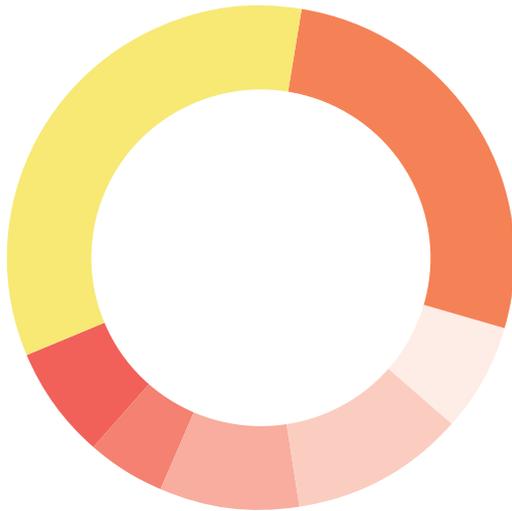


TYPE 2 DIABETES TESTING IN THE EMERGENCY DEPARTMENT

Western Sydney LHD identified the Blacktown Hospital Emergency Department as a potential point for identifying individuals for Type 2 diabetes (through an HbA1c blood test), and providing an opportunity for better Type 2 diabetes prevention and care. If a non-pregnant person presenting to the Emergency Department had a blood test for any clinical indication, the pilot study measured glucose levels for that patient. HbA1c was then automatically measured if the random glucose was ≥ 5.5 mmol/L. Admitted patients with a high glucose reading were referred to the Inpatient Diabetes Management Service. For admitted and non-admitted patients the results were communicated to the patient and to their GP by mail. Western Sydney LHD has shown that opportunistic testing for Type 2 diabetes is highly effective. The recent testing trial of 1,267 individuals detected pre-diabetes in 27% and diabetes in 39%. One in three people detected with diabetes (157 individuals) were unaware of their condition until the results of the HbA1c test were brought to their attention. In addition, almost one quarter of individuals were at risk of developing diabetes. In preventing Type 2 diabetes emerging in these patients, and providing the opportunity for management of those with newly diagnosed Type 2 diabetes, Western Sydney LHD is making a difference to the present and future health of its community³.

The Western Sydney Diabetes Initiative is funded by the Local Health District, in partnership with the Western Sydney PHN (WentWest) and with some funding support for the advanced trainees from the Ministry of Health.

3. REF: HbA1c screening in the Emergency Department: Opportunity for better Diabetes detection, prevention and care. 2015 Poster presentation at the Australian Diabetes Society Scientific Meeting. Amanda Hor, Tien-Ming Hng, Sumathy Ravi, Xiaoqi Feng, Jaime Lin, Thomas Astell-Burt, David Chipps, Mark Mclean, Glen Maberly.



No known diabetes	34%
Prediabetes	27%
HbA1c >= 9.0%	7%
HbA1c < 8.0%-8.9%	5%
HbA1c 7.0%-7.9%	9%
HbA1c 6.5%-6.9%	11%
HbA1c < 6.5%	7%
n=1,267	

THE PREVENTION ALLIANCE

The Prevention Alliance is a partnership involving the Western Sydney LHD, the Western Sydney PHN (WentWest), the local councils, non-government organisations, local universities and developers.

The LHD convenes the Prevention Alliance to grow strategic alliances for better health in Western Sydney. This is a model which can be replicated across the State by other LHDs in collaboration with local partners.

The Prevention Alliance considers a range of social determinants which impact on good health in the community and the prevalence of Type 2 diabetes. By increasing the healthiness of the community setting, Type 2 diabetes in individuals can be prevented.

The Prevention Alliance considers issues such as food availability, accessibility and affordability, the availability of drinking water in public places, active travel, and increasing physical activity through enhancing community infrastructure.

One project involves geo-mapping the availability of healthy and energy-dense, nutrient-poor foods within walking distance of residences within the LHD.

A key feature of the Prevention Alliance is engagement with a range of organisations at a sufficiently senior level to facilitate leadership in partner organisations.

PREVENTIVE CARE IN HUNTER NEW ENGLAND COMMUNITY HEALTH SERVICES

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Assess individuals for lifestyle risk factors including overweight and obesity, smoking and alcohol use
- Refer people at high risk of developing Type 2 diabetes to the Get Healthy Service and local Go4Fun programs for lifestyle modification support.

Community health services represent a key primary health care setting for the provision of preventive health care and provide a diverse range of care types, including: community nursing, allied health, community child and family health, diabetes services, aged care, post-acute care, mental health, and drug and alcohol care. Community health services are delivered by a variety of providers, most commonly nurses and allied health professionals.

Hunter New England LHD recognised that despite the potential for community health services to deliver the preventive care that reduces the risk factors for Type 2 diabetes, the limited evidence available suggested that this is usually provided at suboptimal levels. A multi-strategic approach to clinical practice change is most likely to increase clinician care provision. Practice change strategies that have been shown to be effective in changing clinical practice are those that address: local consensus processes and organisational leadership; access to enabling organisational systems; training and ongoing support for clinicians; audit and feedback; and distribution of training materials and patient resources.

Hunter New England LHD's Preventive Care Initiative aimed to increase community health clinician's routine provision of preventive care across a network of community health services.

In circumstances where clinician - client contact is too brief to provide intervention according to the '5A's' of the behavioural counselling framework, it has been recommended that the 5A's model be shortened to 2As and an R (ask, advise and refer), to provide clients with preventive care and advice.

PRACTICE CHANGE STRATEGIES

- **A Health District policy:** required the routine assessment of all clients regarding their smoking, fruit and vegetable consumption, alcohol use, and physical activity status, and for clients identified as being “at risk,” the provision of brief advice and referral/follow-up.
- **Local leadership and consensus processes:** Oversight of the intervention was via a Preventive Care Taskforce involving clinicians and Health District executives. A key performance indicator was incorporated in the operational plans of the services.
- **Enabling systems:** the electronic medical record was modified to: prompt, facilitate, and record preventive care delivery; produce tailored client and GP/Aboriginal Medical Service provider information letters based on the preventive care provided; and generate automated preventive care delivery performance reports for managers.
- **Performance monitoring and feedback:** monthly performance reports regarding care delivery were provided to and discussed with facility managers.
- **Manager/clinician educational meetings:** face-to-face training was provided to managers (two 1-hour sessions). All existing and new clinicians were provided online competency-based training in preventive care delivery and recording (approximately 2 hours).
- **Educational outreach:** Practice change support officers were allocated to each intervention facility to support clinicians and managers through monthly face-to-face visits and fortnightly telephone support to facilitate delivery of preventive care.
- **Clinician practice change resources:** managers/clinicians were provided with; an e-mail helpline, training/resource website, clinician resource pack, list of referral resources, newsletters, tip sheets, and a workstation reminder to prompt care delivery.
- **Community promotion:** GP newsletter articles and three newspaper articles were published, and a poster and brochure for Aboriginal clients were provided to health facilities.

The preventive care initiative supports the provision of the following elements of care: assessment of all risks, and for all relevant risks, the provision of brief advice and offering a referral to general practitioners/Aboriginal Medical Service providers, telephone helplines or other care providers.

OUTCOMES

Number of clients who have received preventive care

	Assessed	Number clients at risk	Brief advice for all risks	Offered all recommended referrals	Accepted all recommended referrals
Oct 10 -Aug 15	157,254	99,665	89,821	48,975	12,428

Get Healthy Information and Coaching Service data



Between January 2015 and June 2015, 532 residents of Hunter New England LHD engaged in the Get Healthy Service, making up 18.9% of the total NSW Get Healthy Service population. This was a 118% increase in participation from the previous six month period (01 July 2014-31 December 2014).



In 2015, 41.5% of referrals from Health Professional referrals came from the Hunter New England LHD (n=217)

HIGH RISK PEOPLE

PROGRAMS

THE NSW ABORIGINAL KNOCKOUT HEALTH CHALLENGE

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Refer adults who are overweight or obese to existing high quality, proven programs including the Get Healthy Service, Knockout Health Challenge and local primary care programs
- Refer adults over 40 years with an AUSDRISK score of more than 12 to the Get Healthy Service, and the tailored Type 2 diabetes prevention module
- Offer all pregnant women referral to the Get Healthy Service to support healthy gestational weight gain and increase the likelihood of preventing gestational diabetes
- Refer people with high risk alcohol intake to the Get Healthy Service Alcohol Program.

NSW Health and the NSW Rugby League partnered to deliver the first NSW Aboriginal Knockout Health Challenge in 2012 – a primary prevention program which engages Aboriginal communities to make healthy lifestyle changes. The Knockout Health Challenge is run by NSW Health in partnership with NSW Rugby League and the NSW Agency for Clinical Innovation.

Local communities nominate teams of Aboriginal people to participate in different elements of the health challenge. Teams commit to a physical activity and nutrition schedule, with each team structuring their schedule to losing unhealthy weight in line with their local resources and services. Team results are based on the largest weight loss percentages. Winners are awarded community grants to support further local healthy lifestyle initiatives. NSW Rugby League players support challenge teams and act as ambassadors and mentors to participating teams.

In 2015, there were 4 events:

- George Rose Challenge – 12 week weight loss challenge from March to May
- Kyle Saunders Challenge – a challenge where teams create a fitness video
- Julie Young Challenge – 12 week weight loss challenge from June to September
- Ronny Gibbs Challenge – for those teams who achieved a team weight loss of 3% or greater.

In the George Rose Challenge in 2015, 48% of participants lost weight, and the average weight loss across all teams was 2.7%.

Participants are referred to the Get Healthy Service, if they provide consent, when registering for the challenge.

Health services can support the Knockout Health Challenge by connecting with local Team Managers, and providing healthy eating and physical activity support through educational sessions.

What Challenge participants say:

“The Challenge has been a great way to meet new people in the community and better my lifestyle. We come together, have a laugh and a yarn and exercise, encouraging one another. It’s been a great way to motivate me to lose weight after having my kids and try and get control of my blood pressure. The Challenge has encouraged me to be active and eat healthy for my jarjums. The more you move around, the better you feel, even mentally. My fitness is definitely improving and I’m watching what I eat, which is hard work as I love my sweets. I’m now able to complete exercises that I couldn’t do at the start.”

BULLINAH BURNERS FROM BALLINA

“Since starting on the Challenge my health has improved a lot. I exercise every day, mainly walking and eat healthier. I feel so much stronger in myself. I’ve lost some weight but many inches from my waist. It’s been great meeting people and I really look forward to the group sessions. I’ll continue doing what I’m doing now after the Challenge has finished as I need to do it for myself.”

TWEED GOORIE GO GETTERS



TARGETED FAMILY HEALTHY EATING AND PHYSICAL ACTIVITY PROGRAM – *GO4FUN*



WHAT HEALTH SERVICES CAN DO

Health Services can:

- Refer children aged 7-13 years who are overweight and obese to the local Go4Fun programs for lifestyle modification support.

Go4Fun is a free healthy living program for kids above a healthy weight and has been implemented across NSW since 2009. This fun and family-focussed program helps children aged between 7 and 13 years adopt a long-lasting healthy lifestyle. The program focuses on improving:

- Eating habits
- Fitness and participation in physical activity
- Health and wellbeing.

Go4Fun programs are led by trained health professionals and take place after school for 10 weeks, running parallel with school terms. Children and their families become fitter, healthier and happier as they have fun, meet new friends and learn new skills.

The program aims to improve the health of the child through the development of healthy lifestyle behaviours at a family level, as well as educating and positively affecting childrens' attitude to food and exercise. The program includes:

- Nutritional information, food serving sizes, reading food labels, menu planning and recipes, guidelines for eating out and parties
- Support and advice for children and parents/carers talking about weight, setting goals and rewards, role modelling healthy behaviours, and problem solving
- Personal improvement through physical activity and self-esteem
- Fun games enhancing fitness, movement skills and team-building.

WHAT PARENTS HAVE TO SAY

“My daughter loves going to the group and has made new friends with the other children and they are accepting of each other. She makes a conscious effort with the foods she chooses, checks packets at the supermarket and is more willing to do exercise and suggests it more.”

– Debbie Smith, Southern NSW

“As a parent it was nice to meet others who were in the same situation as me. We have now started to make changes in the family as simple as going for a walk every day together, even if it’s not for too long. I am even using healthier alternatives in my cooking.”

– Antoinette Kassis, South Eastern NSW

WHAT LEADERS HAVE TO SAY

“The best part of the Go4Fun program is the confidence kids get from it. We see kids with very low self-esteem who desperately want to participate in community sports but don’t feel like they fit in. Go4Fun brings kids together in a way where they can participate in activities that allow their skill to develop and shine.”

– Sandra Landrigan, Go4Fun Exercise Leader, South Western Sydney LHD



RESULTS

Go4Fun is proven to deliver significant results. On average children achieve:

- A significant decrease in body mass index (0.6kg/m²)
- A drop in waist circumference of 1.54cm
- An increase of 3.7 hours per week in time spent being physically active
- A decrease of 3.2 inactive hours per week
- Increase in fitness and self esteem
- Improved dietary habits including increased fruit and vegetable serves per day.



JOINING THE PROGRAM

Referral from a health professional is not required if the child is generally healthy. Families can self-refer via online registration at www.go4fun.com.au, a toll-free phone call to 1800 780 900 or SMS 0409 745 645 for a call back. If a child has any medical conditions that may affect their ability to participate in the program, parents/carers may need to seek guidance from their child's general practitioner (GP). Parents/carers are required to complete a medical questionnaire at the start of the program to inform the program leaders of any existing medical conditions of the child.

REFERRALS BY HEALTH PROFESSIONALS

Referrals are accepted from health professionals, organisations, friends and family members. Some parents may seek advice from a health professional about whether their child is appropriate for the program, including understanding whether their child is at an unhealthy weight. A BMI calculator is available on the *Go4Fun* website <https://go4fun.com.au/why/bmi-calculator>.

PEOPLE WITH DIABETES

INTEGRATED MANAGEMENT AND REFERRAL

AGENCY FOR CLINICAL INNOVATION'S ENDOCRINE NETWORK

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Encourage managers, clinicians and consumers to get involved by joining the ACI Endocrine Network at the following link: <http://www.aci.health.nsw.gov.au/networks/endocrine>
- Promote ACI initiatives and models of care for patients with endocrine disorders such as diabetes within their LHDs.



The Agency for Clinical Innovation's Endocrine Network includes representatives of Local Health Districts (LHDs) and Speciality Health Networks, endocrinologists, dietitians, diabetes specialist nurses and diabetes educators, consumers and non-government organisations with an interest in diabetes. The Endocrine Network works closely with the NSW Ministry of Health and other agencies within NSW Health, such as the Clinical Excellence Commission.

The Endocrine Network works with clinicians, consumers and managers to improve outcomes and services for patients with endocrine disorders, such as diabetes, by developing best practice guidelines and Models of Care for the treatment and management of these patients. A Model of Care provides an evidence-based, comprehensive and consistent approach to delivering services to people who need them.

The Endocrine Network has a number of Working Groups primarily advancing issues related to diabetes.

IMPROVING DIABETES MANAGEMENT IN NSW

Recent work of the Endocrine Network includes:

- standards for establishing and operating high risk foot services for people with Diabetes Mellitus in NSW. The standards aim to improve patient outcomes, and reduce emergency department presentations, inpatient admissions, amputations and clinical variation and promote equity of access to appropriate foot care throughout NSW.
- implementing and evaluating the Adult Subcutaneous Insulin Prescribing Chart, with user guides, training resources and audit tool.

Members of the Endocrine Network are also working on:

- a resource to support the provision of care for people with Diabetes Mellitus which covers identification, treatment and management of people with Type 1 and 2 diabetes, and gestational diabetes.
- a paper to provide guidance to the NSW Health system with regards to the diagnostic criteria for gestational diabetes mellitus. This will support LHDs to utilise consistent and evidence-based criteria to ensure women in NSW receive the same high level of service.

JOINING THE NETWORK

The Agency for Clinical Innovation works with clinicians, consumers and managers to design and promote better health care for NSW.

Our Networks, Taskforces and Institutes are open to clinicians, consumers and managers with experience, interest and a passion to improve health care.

For resources, more information about the Network, and to join the Network, see:

www.aci.health.nsw.gov.au/networks/endocrine

www.aci.health.nsw.gov.au/networks/join-a-network

INTEGRATED CARE STRATEGY

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Ensure people with diabetes who have other chronic disease risk factors receive appropriate intervention and referral e.g. brief intervention for smokers and referral to Quitline
- Ensure any inpatient with diabetes has their medication reviewed and where relevant, receives support from a specialist diabetes team
- Support health professionals to routinely check that people with diabetes are receiving regular assessment and management of secondary complications.
- Use resources developed as part of the Integrated Care Strategy (www.health.nsw.gov.au/integratedcare) to better connect and coordinate care for people with Type 2 diabetes, including identification and risk stratification tools and chronic disease management.

The Integrated Care Strategy is a \$180 million investment over 6 years into the development of integrated care models to transform the NSW health care system.

The investment will help to achieve the delivery of more connected and coordinated care across primary, acute and community settings and focus on individual patient needs, including for people at risk of Type 2 diabetes or with established Type 2 diabetes and other chronic illnesses.

Local integration is focused on improving health outcomes and meeting the needs of patients by working with carers and their families to deliver the care they need while empowering patients to be more active participants in their health management.

Key pieces of state-wide infrastructure are also being developed to support and enable better connectivity and integration across all levels of the health care system, including HealtheNet which will enable patient records to be shared with their health care team, risk stratification tools to identify early intervention opportunities for people likely to need health care services frequently, and systems that will allow patients to provide direct feedback on their care to drive improvement in services.

Three 'demonstrator' sites have been established in Western NSW, Central Coast and Western Sydney Local Health Districts. Other innovative approaches to integrating care across the state are being funded through the Planning and Innovation Fund.

For more information see the NSW Health website: <http://www.health.nsw.gov.au/integratedcare/Pages/Integrated-Care-Strategy.aspx>

OBJECTIVES OF INTEGRATED CARE

The objectives of the NSW Integrated Care strategy are to transform how we deliver care to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services by:

- focusing on organising care to meet the needs of targeted patients and their carers, rather than organising services around provider structures
- designing better connected models of health care to leverage available service providers to meet the needs of our smaller rural communities
- improving the flow of information between hospitals, specialists, community and primary care health care providers
- developing new ways of working across State government agencies and with Commonwealth funded programs to deliver better outcomes for identified communities
- providing greater access to out-of-hospital community-based care, to ensure patients receive care in the right place for them.

EXPECTED BENEFITS OF INTEGRATED CARE

- Patients reporting they can more easily navigate their journey through the health system
- An improved patient experience, better health outcomes and quality of life
- Reduced waiting times for patients as they navigate the system
- More people being cared for in the community, with a reduction in avoidable hospitalisations and Emergency Department presentations
- Less duplication of pathology and radiology tests through better sharing of information
- Better use of health resources.

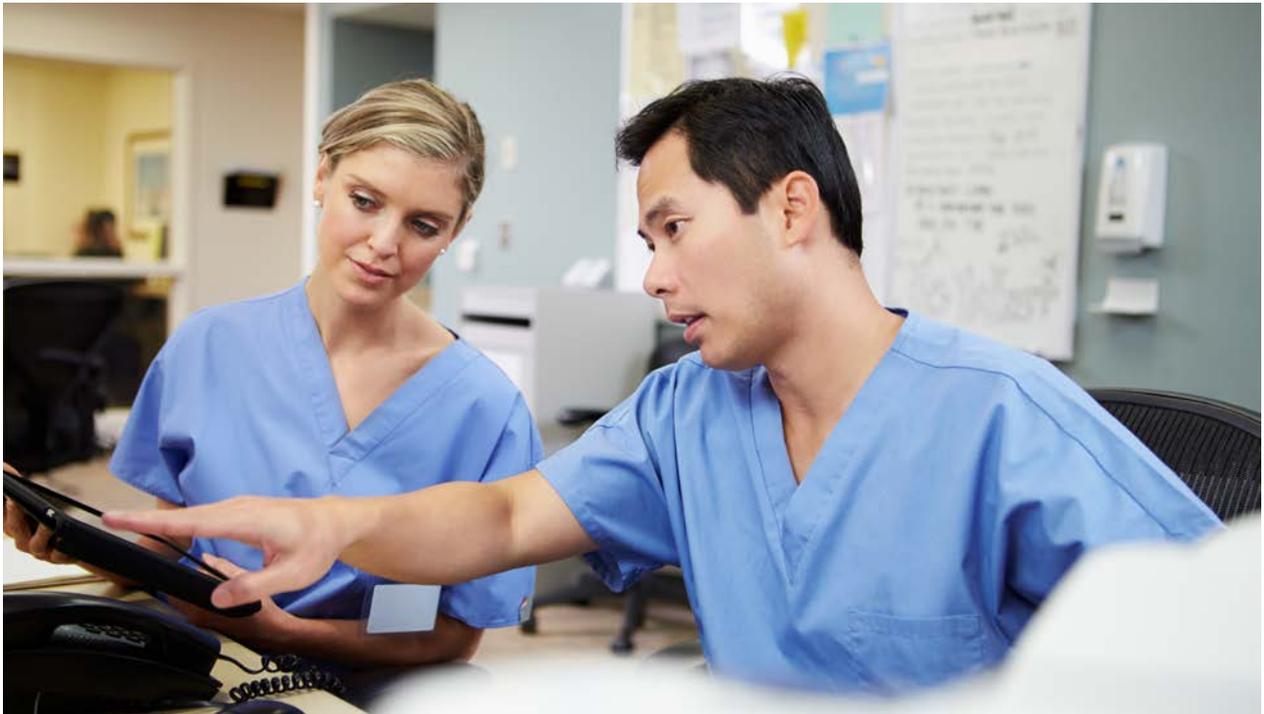
INTEGRATED CARE DEMONSTRATORS

As part of the Integrated Care Strategy, three demonstrator sites have been established in Western Sydney LHD, Central Coast LHD and Western NSW LHD.

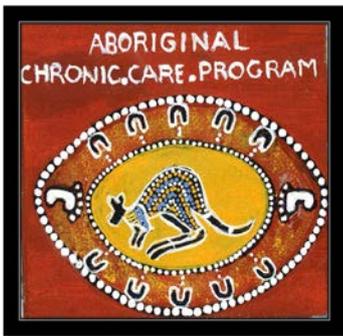
Western Sydney LHD and Western Sydney PHN (WentWest) are delivering a joint program in chronic disease management and integrated care. Targeted patients are being enrolled into a Patient-Centred Medical Home in general practice which provides patients with referral to health coaching, self-management strategies, and specialist and other health care services.

Central Coast Local Health District is taking a 10-year view to integrated care which incorporates social determinants of health and social care, such as education and housing, for three key population groups: people with complex and chronic conditions, vulnerable older people, and vulnerable young people. A key partner in this work is the Hunter New England Central Coast Primary Health Network alongside a range of service providers and agencies including non-government providers, education, police and Family and Community Services.

Western NSW LHD is strengthening partnerships with general practice, NGOs, pharmacy, Aboriginal Community Controlled Services and private providers. Care navigators are assisting enrolled patients to manage their illness in the community, avoiding unnecessary hospital presentations.



JUSTICE HEALTH FORENSIC MENTAL HEALTH NETWORK ABORIGINAL CHRONIC CARE PROGRAM



The South Coast Correctional Health Centre is part of the Justice Health and Forensic Mental Health Network, providing health care to people in custody. The South Coast Correctional Health Centre participates in the Aboriginal Chronic Care Program (ACCP), and has a dedicated Aboriginal Chronic Care Nurse and an Aboriginal Health Worker who support patients with Type 2 diabetes, as well as other chronic conditions. This case study demonstrates how the ACCP works in custodial settings.

The patient is an Aboriginal man (Mr M) who has been in custody for around 10 years. Before entering custody he was homeless and engaging in opportunistic drug use, and had a diagnosis of schizophrenia. Mr M smoked approximately 30 cigarettes a day, was obese and had poor nutrition. He presented with high blood pressure and high levels of glucose in his blood, (HbA1c- 7.5%).

Mr M has a strong passion for his culture which includes playing the didgeridoo, bead making and cultural art.

ABORIGINAL CHRONIC CARE PLAN

The Aboriginal Chronic Care Program screen uses the latest evidence based point of care diagnostic testing including the instant HbA1c results from a single finger prick. As a result, Mr M was highlighted as having an elevated HbA1c reading and follow up care with the Aboriginal Chronic Care Nurse was commenced. An Aboriginal Chronic Care Plan was developed involving a multi-disciplinary team of health care services and clinicians.

Mr M was subsequently referred to a General Practitioner and a mental health referral was also made. The Aboriginal Health Worker was engaged to communicate with and support the patient. The General Practitioner diagnosed Type 2 diabetes and recommended exercise along with counselling in relation to diet and lifestyle. Appropriate medication was commenced in combination with lifestyle modifications which included:

- Smoking cessation education and support was offered, including 4 weeks of Nicotine Replacement Therapy
- Nutritional advice, education and a diet program were commenced with support from the Aboriginal Health Worker, Aboriginal Chronic Care Program Nurse and General Practitioner
- The Aboriginal Health Worker supported Mr M with a physical activity regime to increase physical aptitude over time
- Alcohol relapse was identified as an issue on release from custody therefore plans were introduced to support the patient through a high assistance residential program.

CHANGING LIVES FOR ABORIGINAL PEOPLE WITH CHRONIC DISEASE

Mr M has been compliant with his medication for approximately 4 months with a marked decrease in blood sugar levels, (HbA1c- 5.5%). He has lost 10kgs and stopped smoking. Mr M has noted that his breathing has improved.

Mr M is actively participating in post-release residential drug treatment program solutions. He has stated that his general mental health and quality of life has improved and is now looking forward to being released and working intensively with community corrections. He is committed to enrolling in a post drug and alcohol rehabilitation program. Programs including “Close the Gap” through the local Primary Health Network and the Men’s Shed’s Group, are also part of Mr M’s post release plan.

Once released, Mr M has plans to continue painting and creating whilst networking, and to introduce a local art gallery that will commission his paintings.

The Aboriginal Chronic Care Program has been instrumental in improving the quality of life for this man. This was facilitated by implementing a holistic approach and incorporating health, cultural and social aspects of his life which enabled him to achieve good health outcomes; successful post incarceration rehabilitation and a healthier, happier future.

PEOPLE WITH DIABETES

SUPPORTING SELF MANAGEMENT

BROKEN HILL CHRONIC DISEASE PREVENTION GROUP

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Ensure effective communication with primary care to ensure continuity of care and care coordination
- Use Diabetes Educators and Diabetes Clinics to support effective self-management of Type 2 diabetes e.g. case conferencing within General Practice
- Refer people with diabetes to the Get Healthy Service
- Promote and refer patients with Type 2 diabetes to self-management services offered by Diabetes NSW through the National Diabetes Services Scheme (NDSS)
- Promote and support the safe management of used sharps waste



The Far West Local Health District has established the Broken Hill Chronic Disease Prevention Group to support prevention of Type 2 diabetes and other chronic conditions in its population. The Chronic Disease Prevention Group (CDPG) is a free, monthly drop-in clinic for anyone concerned about their chronic disease risk factors. It is staffed by a Dietitian, Diabetes Educator and Renal Nurse, who provide checks of blood pressure, blood glucose, weight and Body Mass Index. An education topic is presented to the group either by LHD staff members or by visiting students and guest speakers. These sessions cover topics relevant to chronic disease self-management and have so far included: explaining blood pressure, understanding food label reading, easy home exercises and medication management.

Previously in Far West LHD, chronic disease clinicians carried out ad-hoc community testing of risk factors, usually associated with promotional days. These events were well-attended by both LHD staff and community members and participants found these days useful.

However, this model lacked capacity for formal follow-up of abnormal results or tracking of progress of disease risk factors. To help provide a more continuous service to the community a regular group was established.

“The strong rapport we can build with clients by seeing them so regularly helps us to gain their trust which means they respect what we tell them, this leads to them following that advice more readily.” **HEIDI DRENKAHN, COMMUNITY DIETITIAN**

HOW THE GROUP WAS ESTABLISHED

- Relevant chronic disease management clinicians were consulted to find days and times that would suit for a monthly drop-in clinic
- Templates for required documentation were created, such as participant information cards, GP feedback forms, and participant results trackers
- The first group was promoted through local media, as well as through chronic disease management clinicians
- Ongoing promotion of, and referrals to, the group were done via the Emergency Department, chronic disease management clinicians and Facebook.

OUTCOMES

Letters are sent to the participants' General Practitioners after each group to provide results and identify any trends or issues of concern.

Data has been analysed of participants attending at least 3 clinics, with the following improvements shown:

- Average weight loss of 2.7kg
- Average Body Mass Index reduction of 0.81 kg/m²
- Systolic blood pressure down 4.6mm Hg
- Diastolic blood pressure down 6.2mm Hg.

All of these outcomes are important results for those at risk of or with established chronic diseases. Whilst some changes may be small they represent a positive step for disease prevention and management.

LESSONS LEARNT

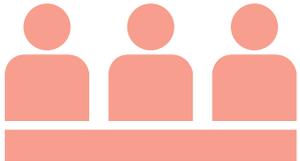
The importance of pre-planning: Prior to starting the clinic all of the required documents were set-up and ready to use which made implementation a smooth process.

Ongoing, regular promotion is important: after the initial wave of recruitment there was a lag in new numbers and the group required further promotion. Recruitment is heavily associated with promotional activities and the LHD is currently investigating avenues for regular promotion in local media, to coincide with the monthly clinic.

The 'big-picture' learning from this clinic has been:

- Rapport builds trust
- Trust improves confidence
- Confidence promotes compliance.

Results of a feedback survey showed that

100% 

of attendees agreed/strongly agreed with the statement:
Attending Chronic Disease Group has helped me manage my own health.

The survey feedback demonstrates that this group was successful in up-skilling clients to feel capable of controlling and managing their own health.

DIABETES NSW

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Promote and refer patients with Type 2 diabetes to self-management services offered by Diabetes NSW through the National Diabetes Services Scheme (NDSS).

Diabetes NSW provides advice and support services to people with diabetes, through membership and for people with diabetes under the National Diabetes Services Scheme (NDSS). Local Health Districts can access www.diabetesnsw.com.au and see the Enabling Resources section of this guide for the full range of education and self-management resources offered by Diabetes NSW.

Diabetes NSW supports people to learn about diabetes and how to manage it, create a support network and set self-management goals. For example:

- Forums and seminars are offered across NSW to assist people diagnosed with Type 2 diabetes to understand their condition and manage their risk factors
- Free Annual Cycle of Care screenings are designed to help keep diabetes care on track in the community and to encourage engagement with the local diabetes health care team. Screenings include HbA1c, total cholesterol, HDL cholesterol, blood pressure, BMI, and kidney health checks, and a foot assessment. These sessions include consultations with a team of Diabetes NSW experts including a diabetes educator, exercise physiologist and dietitian, to highlight the need for ongoing care and escalate issues of concern to primary care practitioners where needed
- Diabetes Educators are available to discuss self-management and support patients with their clinical interactions by answering questions over the phone and providing resources. Patients can access this service by calling 1300 136 588
- A key seminar offered by Diabetes NSW supports patient empowerment and self-management by guiding patients on how to get the most out of their visit to general practice.

DESMOND

About the program

DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) is an evidence-based self-management education program targeted at people diagnosed with Type 2 diabetes. The DESMOND program was designed to support the participant to become an expert. Each module has been designed to be effective and evidence based, is supported by a strong person-centred philosophy and adult learning theories, and uses an interactive non-didactic style of delivery.

Facilitated by two Diabetes NSW health professionals, the program is delivered to small groups of up to 10 participants who are encouraged to bring a partner/friend for support. They are guided through a range of activities designed to increase their knowledge and understanding of diabetes, while learning practical self-management skills. Participants are encouraged to share their experiences and beliefs about Type 2 diabetes. Topics include food choices, physical activity, medications, complication risk, and goal setting. The structured 6 hours program can be delivered flexibly on one day or two half days.

Potential outcomes that may be achieved from attending a DESMOND program?

- Improved understanding of Type 2 diabetes
- Increased practical self-management skills
- Improved HbA1c and biomedical outcomes
- Weight reduction
- Improved levels of physical activity
- Increased awareness of the need for smoking cessation
- Increased awareness for seeking support and treatment for anxiety and depression

Evaluation results in Australia have shown:

- A significant decrease in systolic blood pressure
- A significant decrease in 'Diabetes Distress'
- A significant increase in physical activity
- A trend towards reduction in cholesterol and HbA1c

Contact Diabetes NSW on the Infoline
1300 136 588.

BEAT IT GYM

Regular exercise and healthy eating are key components in helping to better manage Type 2 diabetes. Diabetes NSW offers Beat It Gym – an 8-week program for people with diabetes and an overweight/obesity co-morbidity, involving moderate intensity aerobic, strength and balance based exercises as well as education sessions on healthy living topics. The sessions are fun, safe and supportive, with exercises specifically tailored to suit individual health and fitness levels. Beat It Gym supports people with established Type 2 diabetes to gain confidence and capacity for physical activity. Activity is modified for the individual, such as using weights while sitting, and teaches physical activity which can be done in a gym setting or in the home or outdoors. Beat It Gym is free to people registered under the NDSS.

Diabetes NSW offers train the trainer education in the Beat It Plus program for exercise physiologists in hard-to-reach locations and private gyms, to support better knowledge in the workforce about physical activity for people with Type 2 diabetes, who are often older, and who may have other co-morbidities including obesity.



“Since starting the Beat It Gym program I have already noticed a slight weight reduction and a significant reduction in my blood glucose levels. My morning blood glucose levels have halved from 16+ to 8 on average, which I am so happy about! I am enjoying the workouts as they are not too hard but still challenging.”

**PROGRAM PARTICIPANT
PETER SHUTTLEWORTH**

ENABLERS

HEALTHIER FOOD ENVIRONMENTS

KILOJOULE LABELLING AND THE 8700.COM.AU CAMPAIGN

8700 FIND YOUR IDEAL FIGURE

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Support healthy eating in their communities by promoting the Make Healthy Normal campaign, the 8700.com.au mobile app and the Health Star Rating System
- Establish healthier eating environments in their facilities by providing healthier choices for staff and visitors.

KILOJOULE LABELLING IN FOOD OUTLETS

Fast food chains, café and coffee chains and major supermarkets are required by law to display kilojoule information and the average adult daily kilojoule intake (8700kJ) on their menu boards. The kilojoule labelling initiative is part of the NSW Government's broad set of responses to help tackle high rates of overweight and obesity in the community. The legislation and supporting 8700kJ campaign have shown a significant increase in consumer awareness of the average daily kilojoule intake (8700) and a 15% (519kJ) median reduction in fast food kilojoules purchased.

8700.COM.AU

The kilojoule labelling legislation is supported by a range of tools (www.8700.com.au website; 8700kJ Facebook page <https://www.facebook.com/8700kj> and app) that explain kilojoules and provide calculators for the number of kilojoules required for healthy living by both adults and children, 'your ideal figure'. These tools also provide tips for making changes to enhance nutrition and increase physical activity, which are major risk factors for Type 2 diabetes. Achieving and maintaining a healthy weight is good for your overall well-being and is important for a healthy lifestyle.

The 8700kJ mobile app is a free iPhone and Android-enabled app that provides tools, calculators and converters, tips and the information to help consumers make informed food choices when eating at larger 'fast' and snack food chains. The app is available for download from the iTunes store and the Android Marketplace.



HEALTH STAR RATING SYSTEM

The voluntary national Health Star Rating front-of-pack labelling system, introduced in 2014, provides a nutritional rating of packaged food products from ½ to 5 Stars with the more Stars indicating a healthier choice within the product category. This initiative supports people to make healthier packaged food and beverage choices in the supermarket (www.healthstarrating.gov.au).



LIVE LIFE WELL @ HEALTH POLICY DIRECTIVE (LLW@H)

Providing a healthy eating environment in NSW Health facilities is an important way to model healthier behaviours to communities, as well as making it easier for visitors and staff to make healthier food and drink choices. The LLW@H policy directive requires health facilities to meet nutritional and marketing criteria to build healthy food environments for visitors and staff, where making a healthy choice is not only possible, but easy and accessible.

The policy and its underlying criteria are currently under review, with updated materials due for release in 2016. In the interim, the nutrition and marketing standards are available at <http://www.health.nsw.gov.au/heal/Pages/policies-and-guidelines.aspx>

ADDRESSING FOOD SECURITY IN SOUTH WESTERN SYDNEY

South Western Sydney Local Health District has included a food security approach to addressing Type 2 diabetes risk factors in its communities. Evidence shows that areas of disadvantage in metropolitan, regional and rural NSW have higher prevalence of Type 2 diabetes risk factors including poorer nutrition. Often energy-dense nutrient-poor foods are perceived to be cheaper than healthier options and are more accessible locally. South Western Sydney LHD has implemented community supermarkets and school breakfast programs to support healthy eating in low-income communities.

WARWICK FARM 'Food 4 Life' COMMUNITY SUPERMARKET

In partnership with The Salvation Army, the LHD established a community supermarket near community housing in Warwick Farm. The LHD along with Community Builders invested funds in capital works to bring the site to standard and ensure accessibility, and worked to establish and make the supermarket sustainable.

Bags of healthy food can be bought for \$15, with a value of \$80-\$95, with products from Food Bank and local businesses. Food 4 Life allows low income people to go shopping and make food choices, and be less dependent on emergency food vouchers. Food choices include pasta, rice, tinned meat and fish, bread, some dairy products, frozen foods such as chicken, fish and mince, fresh fruit and vegetables, and some household items such as low-cost nappies and soaps.

Community volunteers are provided with training in customer service, food handling, stocktaking, first aid and safe food handling. Training ensures that customers of Food 4 Life are provided with a good shopping experience, as well as building skills for employment in the volunteers.

Food 4 Life has now been operating for six years. A steering committee developed policies and procedures for its operation; it is now sustainable, and is wholly operated by The Salvation Army, ensuring LHD resources can be deployed in other areas of need. A community garden has been established at the rear of the community supermarket, and The Salvation Army established another community supermarket in Miller in 2013.

Food 4 Life provides an important community hub, a place for engagement with some of the most socially isolated members of the community. Hundreds of people registered over the first year of operation, and the supermarket has around 80 regular customers.

An evaluation of the program demonstrated that the supermarket was servicing its intended low income population. Respondents to the qualitative part of the evaluation reported their food security had increased, and half reported that they relied on the Food 4 Life for at least half of their total food.

SCHOOL BREAKFAST PROGRAM

Knowing that food security issues in a household can be difficult to identify, because of fear of the stigmatising effect of poverty or income instability, South Western Sydney LHD determined that it would take a settings-based approach to increasing food security among its population.

The LHD has built partnerships with two schools in the Fairfield LGA, with very high levels of disadvantage and in particular, high refugee and refugee-background populations, to deliver healthy and culturally relevant breakfasts to primary school children. Breakfast recipes include lentil soup, pumpkin soup, noodles, congee (Chinese rice soup) and healthy pancakes. 31% of students in one school, and 80% in the other attend the program twice a week, with 800 breakfasts provided each week.

The program provides food which is readily available in the community, including seasonal fruit and vegetables, to introduce children who are newly arrived to Australia to fruit and vegetables which may not be familiar but which are locally available. The program also provides information about where to access traditional foods locally.

Over time the program has become self-sustaining, with a strong local parent cohort who plan the menu and collect and prepare the food, and receive training in safe food handling. Parent groups are now considering the feasibility of introducing other food security measures such as a food co-operative, community kitchen and a school garden.

The LHD team has worked in a number of schools, negotiating use of school canteens before school, investing staff time and expertise in planning and partnership building, and providing limited funding towards capital equipment, such as fridges, toasters and a grill plate for a school kitchen.

The school breakfast program is currently being evaluated. Research questions include the impacts on students regularly eating breakfast, student diets including more fruit and vegetables, and the impact on student attendance and participation in education.

ENABLERS

HEALTHY BUILT ENVIRONMENTS

HEALTHY URBAN DEVELOPMENT CHECKLIST

WHAT HEALTH SERVICES CAN DO

Health Services can:

- Use the Healthy Urban Development Checklist in consultations with local councils
- Develop active travel plans for health facilities to encourage the use of public transport and increase incidental physical activity
- Work with local councils to integrate Healthy Eating, Active Living measures into their Community Strategic Plan using the Integrated Planning and Reporting Framework.



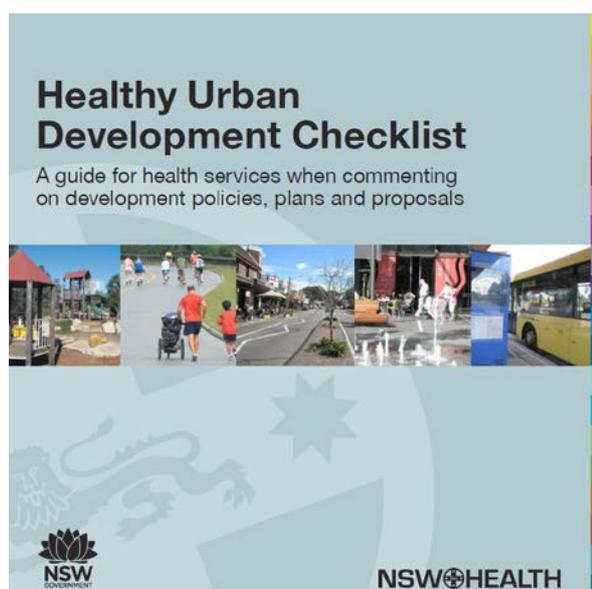
There is growing evidence of the link between the built environment and lifestyle diseases such as Type 2 diabetes. It is imperative that health services, local councils, planning and transport agencies work together to ensure that planning and health objectives are aligned.

Influencing specific characteristics of the built environment can have a direct impact on improving population health and preventing chronic disease. For instance the kinds of roads and houses that are built, where they are located, the proximity of schools and workplaces to green open spaces, and the availability of 'active' transport such as walking and bike pathways are increasingly being viewed as influencing the health of the population.

NSW Health has published the *Healthy Urban Development Checklist*, which is available here: <http://www.health.nsw.gov.au/urbanhealth/Pages/healthy-urban-dev-check.aspx>.

This Checklist was developed and tested by the South West Sydney Area Health Service (now South West Sydney LHD).

The purpose of the Checklist is to help build the capacity of Local Health Districts to provide feedback to local councils and other organisations, on health issues in relation to urban development plans and proposals. The use of the checklist is facilitating strengthened partnerships and collaboration between LHDs and urban planners and developers as part of NSW Health's initiatives to promote healthy communities in NSW.



Whilst there is an increasing dialogue between the planning and health sectors, there is more that NSW Health can do to ensure that engagement in urban development is effective, such as:

- Building the capacity of NSW Health Staff to influence policies and plans
- Building the evidence base and making it more accessible
- Strengthening capacity across the State in the contribution that LHDs make to urban development proposals.

This can be done by, for example:

- Training in and conducting Health Impact Assessments on urban policies, plans or projects
- Participation in consultations regarding health impacts, including service effects of policies, plans and projects such as rezoning, renewal and greenfield developments
- The provision of advice on regional, sub-regional and local government plans
- Making submissions in relation to specific local development applications.

QUICK GUIDE QUESTIONS TO HEALTHY URBAN DEVELOPMENT

Are there likely to be significant issues related to...

Healthy Food

- Access to fresh, nutritious and affordable food?
- Preservation of agricultural lands?
- Support for local food production?

Physical Activity

- Encouragement of incidental physical activity?
- Opportunities and infrastructure for walking, cycling and other forms of active transport?
- Access to usable and quality outdoor spaces and recreational facilities?

Housing

- Dwelling diversity?
- Affordable housing?
- Adaptability and accessibility of housing?

Transport and Physical Connectivity

- Availability of public transport services?
- Reduction of car dependency and encouragement of active transport?
- Encouragement of infill development and/or integration of new development with existing development?

Public Open Space

- Access to green space and natural areas?
- Public spaces that are safe, healthy, accessible, attractive and easy to maintain?
- Sense of cultural identity, sense of place and public art?

Social Cohesion and Social Connectivity

- Environments that will encourage social interaction and connection among people?
- Promotion of a sense of community and attachment to place?
- Social disadvantage and equitable access to resources?

(an extract from the *Checklist Quick Guide* – for full details see the Checklist).



HEALTHY BUILT ENVIRONMENTS IN NORTHERN SYDNEY

Northern Sydney Local Health District has had a long investment in healthy built environment activity, to help promote and maintain the health of its local population and to prevent chronic disease such as Type 2 diabetes. Northern Sydney LHD has undertaken healthy built environment work to support its health priority areas of healthy eating and active living, tobacco smoking, social wellbeing and reduction of harm from alcohol consumption.

“Good planning is planning that is good for people’s health”.

The local investment by the LHD includes Health Promotion team members at the Royal North Shore Hospital, Manly Hospital and Macquarie Hospital sites who focus on engagement with local councils to influence better health in the community. An Urban Planning for Health program group (UP4Health) meets regularly to share information and to provide a structure for engagement across the LHD. The UP4Health program is embedded in the Population Health Improvement Plan for the LHD.

The Pittwater Local Environmental Plan now has two ‘health’ objectives:



1. TO PROTECT AND PROMOTE THE HEALTH AND WELL-BEING OF CURRENT AND FUTURE RESIDENTS OF PITTWATER



2. TO IMPROVE ACCESS THROUGHOUT PITTWATER, FACILITATE THE USE OF PUBLIC TRANSPORT AND ENCOURAGE WALKING AND CYCLING.

BUILDING CAPACITY IN HEALTH SERVICES

Capacity within the LHD has been developed through:

- Undertaking formal training in healthy built environments and sharing knowledge and practice across health promotion and public health units
- Use of the *Healthy Urban Development Checklist*
- Use of Healthy Built Environment Program: A review of the literature: <https://www.be.unsw.edu.au/city-futures/city-wellbeing/literature-review>
- Seeking out engagement opportunities with key partners in local government, such as participating in council community consultations and committee structures (such as committees and reference groups with a focus on community safety, sustainable transport, playgrounds and public open space)
- Engaging with local and state-wide organisations such as the Heart Foundation, the Department of Planning, and Transport for NSW.

The Northern Sydney LHD has developed templates and key recommendations for making submissions on development matters, and made them available for other LHDs and community members to use and share: http://www.nslhd.health.nsw.gov.au/HealthInformation/HealthPromotion/Pages/Projects/Other_Projects/UP4Health/UP4Health.aspx

KEY ACHIEVEMENTS

The LHD monitors the submissions which it makes on behalf of the community, and tracks outcomes arising from its submissions. The estimated population-reach of those outcomes is also recorded. The types of recommendations made by the NSLHD which have been adopted by local governments range from the provision of connected cycleways and bike parking to baby-changing rooms at shopping centres and drinking water fountains in public open spaces.

A notable achievement of the UP4Health program has been NSLHD's influence and engagement with Pittwater Council, which culminated in the inclusion of two specific health and wellbeing objectives in Pittwater Council's Local Environmental Plan. These objectives will ensure that all development applications are assessed with health and wellbeing impacts in mind.

The emphasis on population health in the Local Environment Plan (LEP) was the result of longer term investment in engaging with Pittwater Council on planning issues. Some of the contributing actions were:

- Systematically identifying and responding to Council policies and Development Applications that had the potential to impact on health-supporting environments, which built trust between the Council and the NSLHD
- Developing and maintaining productive working relationships with council through working groups, inter-agency committees and alliances, including the contribution of expertise and evidence at community forums and workshops.

Focusing on key areas of action in council's Community Strategic Plan where council priorities and targets overlap with population health priorities and targets, and collaborating on mutually beneficial solutions and interventions.

ENABLERS

WORKFORCE DEVELOPMENT

TRAINING PROGRAMS FOR TYPE 2 DIABETES PREVENTION AND MANAGEMENT

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Support health care workers including midwives, nurses, dietitians and Aboriginal Health Workers to undertake clinical training in the identification and management of lifestyle-related risk factors for Type 2 diabetes
- Support staff to undertake relevant online training
- Use the array of tools and resources available on the NSW Health website to support staff to provide smoking cessation brief intervention to clients.

The Health Education and Training Institute (HETI) supports education and training for excellent health care across the NSW Health system. HETI's mission is to improve the health of NSW and the working lives of NSW Health staff through education and training. To do this, it works closely with Local Health Districts, Specialty Health Networks, other public health organisations and health education and training providers.

HETI ensures that education and training for NSW health professionals:

- support safe, high quality, multi-disciplinary, team based, patient centred care
- meet service delivery needs and operational requirements, and
- enhance workforce skills, flexibility and productivity.

CULTURALLY APPROPRIATE CARE

The Australian Government Aboriginal and Torres Strait Islander Health Performance Framework (2014 report) reveals a preference by Aboriginal people to seek medical care in primary care settings rather than hospitals. Despite this, Aboriginal people with Type 2 diabetes experience higher levels of hospitalisation as a result of complications, and more serious levels of morbidity from the disease.

These facts make it essential that primary care settings implement best practice, culturally appropriate management and complication prevention strategies for Aboriginal patients with Type 2 diabetes.

The Ministry of Health module on HETI online *Aboriginal Culture – Respecting the Difference* specifically features a case study of an Aboriginal man with Type 2 diabetes, which provides health care staff with invaluable insights into best practice models of culturally appropriate care.

OTHER HETI COURSES RELATED TO TYPE 2 DIABETES RISK FACTORS AND PRIORITY POPULATIONS

A range of courses provided by HETI will support Type 2 diabetes risk factor awareness and reduction, and prevention and management of Type 2 diabetes among priority populations. These are:

- Activity Based Funding
- Care Coordination
- Care of the Bariatric Patient
- Continuity in Medication Management
- Health and Wellbeing during Pregnancy
- Managing Diabetes in Primary Care (developed for Custodial settings)
- Mental Health Basics
- Nutrition Screening
- Partnering with Carers
- Screening for Smoking, Alcohol and other Substances
- Smoking Cessation: Brief Intervention at Chairside
- Working in Culturally Diverse Contexts
- Yarning about Quitting.

SYSTEMS INFRASTRUCTURE AND SURVEILLANCE

HEALTH STATS NSW

www.healthstats.nsw.gov.au

Surveillance (including collection, analysis and interpretation of data on Type 2 diabetes incidence and complications) facilitates health service planning and the allocation of appropriate resources within the health care system.

Health Stats NSW is an interactive, web-based application that provides high quality, tailored data and analytical capacity for Local Health Districts across NSW. Using the NSW Adult Population Health Survey and admitted patient data, Health Stats NSW reports on the following Type 2 diabetes related indicators.

WHAT HEALTH SERVICES CAN DO



Health Services can:

- Use local and state-wide data to monitor the prevalence of Type 2 diabetes risk factors and the incidence of Type 2 diabetes in their communities
- Compare local data to state-wide data and use the LHD level data reported at Health Stats NSW to drive local priorities (www.healthstats.nsw.gov.au)
- Partner with local councils and Primary Health Networks to share data for planning purposes
- Undertake evaluation of local Type 2 diabetes initiatives.

RISK FACTORS

- Smoking rates in adults, students and during pregnancy
- Overweight and obesity rates in adults
- Type 2 diabetes or high glucose prevalence in adults (self reported)

These risk factors can be analysed by:

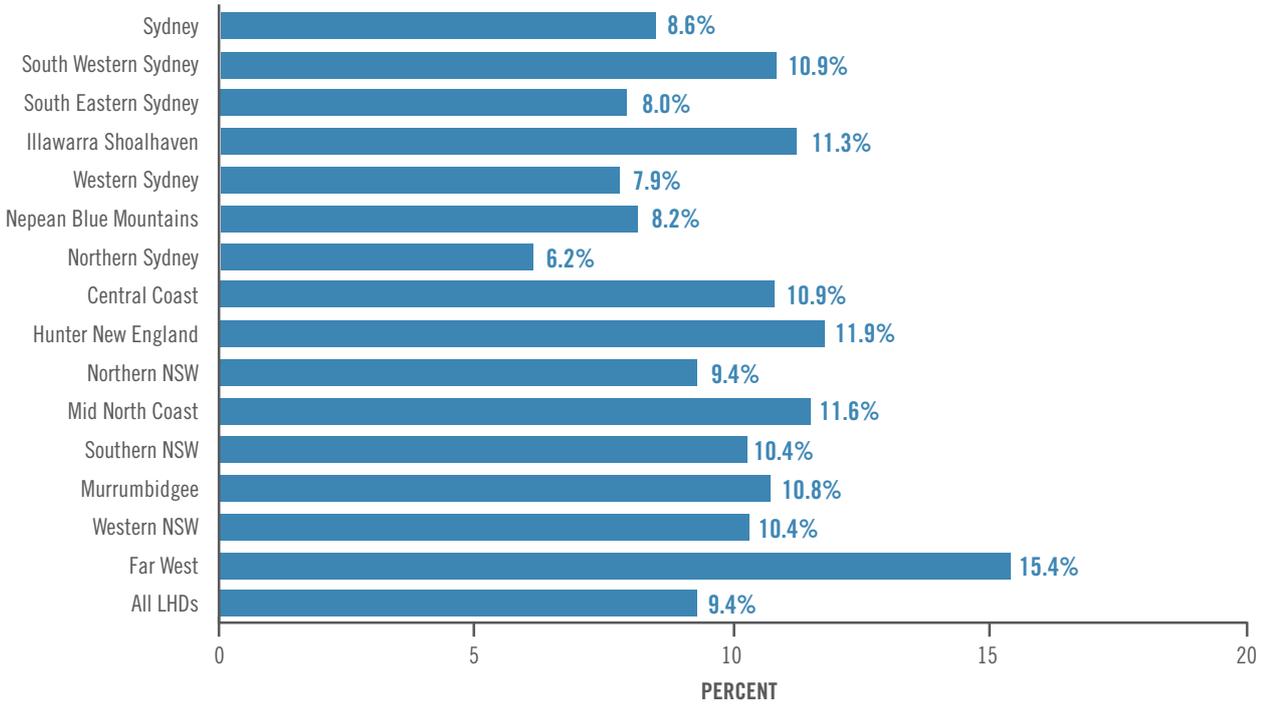
- LHD
- age
- remoteness
- Aboriginality
- country of birth, and
- socio-economic status.

HOSPITALISATION DATA

- Type 2 diabetes hospitalisations by age, Aboriginality, LHD, remoteness and socio-economic status
- Amputations due to diabetes, by site of amputation and sex
- Diabetes-related deaths by age, Aboriginality, LHD, remoteness and socio-economic status.

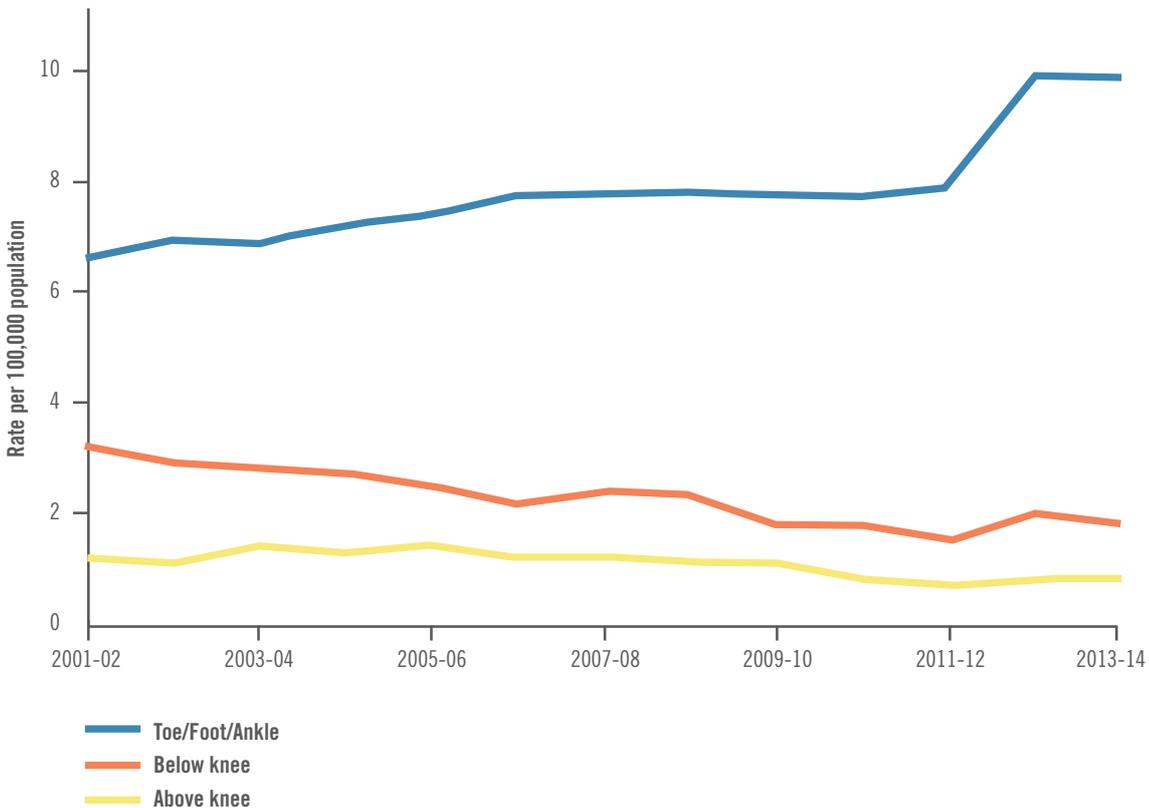
Diabetes or high blood glucose by Local Health District, persons aged 16 years and over, NSW 2014

Source: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, Ministry of Health.



Amputations due to diabetes: hospitalisations by site of amputation, NSW 2001-02 to 2013-14

Source: NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.



PREVENTION OF TYPE 2 DIABETES ENABLING RESOURCES

Enabling resources	What currently exists?	Who is responsible?
An organisational structure for comprehensive diabetes prevention and care	<ul style="list-style-type: none"> • Diabetes NSW • Diabetes Centres (members of the National Association of Diabetes Centres) • Royal Australasian College of General Practitioners • National Diabetes Services Scheme • Local Health Districts • Aboriginal Health Workers/ACCHSs 	<ul style="list-style-type: none"> • NGO consumer led organisations • NGO peak scientific and medical bodies • Agency for Clinical Innovation • NSW Ministry of Health • Commonwealth Department of Health • ACCHSs
Guidelines and plans	<ul style="list-style-type: none"> • Australian National Diabetes Strategy • Australia's Physical Activity Guidelines • Australian Dietary Guidelines • NSW Tobacco Strategy • NSW Healthy Eating and Active Living Strategy • NSW Integrated Care Strategy • NHMRC Clinical Care Guidelines in Diabetes • National Evidence Based Guidelines for the Primary Prevention of Type 2 diabetes • RACGP/Diabetes Australia Clinical Care Guidelines • ACI Model of Diabetes Care (in development) 	<ul style="list-style-type: none"> • RACGP/Diabetes Australia • Commonwealth Department of Health • NHMRC • NSW Ministry of Health
Workforce training and capacity	<ul style="list-style-type: none"> • Online courses in diabetes management • Training at medical undergraduate, postgraduate, and public hospital employee level • Education of primary care physicians and allied health in diabetes management • Diabetes essentials, Nurses study day 	<ul style="list-style-type: none"> • Australian Practice Nurse Association • LHDs • The Australian Diabetes Educators Association • Relevant Universities • Primary Health Networks • Diabetes NSW • HETI
Information systems including a patient registry	<ul style="list-style-type: none"> • EHealth records • The National Gestational Diabetes Register • NDSS • AIHW • Primary care collaborative • ANDIAB 	<ul style="list-style-type: none"> • Commonwealth Department of Health • The NDSS is administered by Diabetes Australia
Healthy Built Environment	<ul style="list-style-type: none"> • Healthy Urban Development Checklist • Healthy Built Environment Literature Review 	<ul style="list-style-type: none"> • NSW Ministry of Health

Enabling resources	What currently exists?	Who is responsible?
Prevention resources	<ul style="list-style-type: none"> • Health Star Rating System • 8700 campaign and legislation • Get Healthy Service • NSW Quitline • Make Healthy Normal campaign • Healthy Children Initiative • NSW Health Live Life Well Policy Directive 	<ul style="list-style-type: none"> • NSW Ministry of Health • Australian Government • NSW Ministry of Health • NSW Office of Preventive Health • Cancer Institute NSW
Patient information resources and programs	<ul style="list-style-type: none"> • Diabetes NSW includes: <ul style="list-style-type: none"> – Supermarket tours – Living with insulin program – Annual cycle of care screening – Connecting your diabetes seminar – Individual health information sessions – Beat It Gym program – DESMOND program – Moving for Health physical activity session – Building healthy meals workshop 	<ul style="list-style-type: none"> • Diabetes NSW
Primary care reimbursement incentives for improving diabetes care	<ul style="list-style-type: none"> • Chronic care plans • Annual cycle of care plan • Federal Chronic Disease Management (formerly Enhanced Primary Care) • PIP Diabetes Incentive • Pharmacy Practice Incentives for providing diabetes screening/risk assessments and/or management 	<ul style="list-style-type: none"> • Commonwealth Department of Health • Relevant pharmacies
Shared care plans	<ul style="list-style-type: none"> • NSW Integrated Care Strategy • LHD level diabetes prevention and management initiatives 	<ul style="list-style-type: none"> • Agency for Clinical Innovation • NSW Ministry of Health • eHealth • LHDs
Utilisation of MBS funding mechanisms	<ul style="list-style-type: none"> • MBS item numbers – individual and group consultation • MBS item numbers – Telehealth • EPC programs • Activity based funding in development including multidisciplinary care 	<ul style="list-style-type: none"> • Commonwealth Department of Health

