

Strengthening risk assessment and referral pathways for diabetes and CVD prevention in the community

Executive Summary



Executive Summary Report, July 2017 Prepared by:

Philip Flanagan
Primary Care Engagement Officer
National Heart Foundation of Australia

Harry Patsamanis
Clinical Strategic Adviser
National Heart Foundation of Australia
harry.patsamanis@heartfoundation.org.au
Ph: +61 3 9321 1509



The Strengthening risk assessment and referral pathways for diabetes and CVD prevention in the community project is supported by the Victorian Government.

1. Contents

1.	Contents.....	3
2.	Glossary of terms	4
3.	Executive summary	6
4.	Case study	19

2. Glossary of terms

Glossary of terms

The following terms are used throughout this report:

Absolute CVD risk – Absolute CVD risk refers to the likelihood of a person experiencing a cardiovascular event within the next five years. The *Guidelines for the Assessment of Absolute Cardiovascular Disease Risk* (National Vascular Disease Prevention Alliance 2012) provide guidance on the management of CVD risk in a primary prevention setting for adults over 45 years of age (35 years for people of Aboriginal or Torres Strait Islander descent).

AUSDRISK – Australian type 2 diabetes risk assessment tool (AUSDRISK). The Australian type 2 diabetes risk assessment tool (AUSDRISK) is a short list of questions to help both health professionals and consumers to assess the risk of developing type 2 diabetes over the next five years.

CVD – Cardio Vascular Disease - generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke.

Type 2 diabetes/diabetes – Is a progressive condition in which the body becomes resistant to the normal effects of insulin and/or gradually loses the capacity to produce enough insulin in the pancreas. Type 2 diabetes is associated with modifiable lifestyle risk factors. Type 2 diabetes also has strong genetic and family related risk factors.

Risk screening (risk detection and awareness) – In this context screening is defined in line with the World Health Organisation definition which refers to the use of simple tests across an apparently healthy population in order to identify individuals who have risk factors or early stages of disease, but do not yet have symptoms. Screening is used to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.

Risk assessment – In this context assessment is defined as an evaluation that will often require more testing and questioning by a health professional (using validated tools and questionnaires) to better understand the combined effect of multiple risk factors for an individual with regard to developing a chronic condition, in particular diabetes, stroke, heart disease.

Risk stratification – Through screening and assessment the level of risk for an individual developing a chronic condition can be determined and stratified often as low, moderate or high risk. Risk stratification enables a more directed approach to risk reduction with interventions better tailored to address the level of risk that is identified.

GP – The Royal Australian College of General Practitioners (RACGP) defines General Practitioner/s as a health professional providing a person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities.

General Practice/General Practice Sites - the location that is most likely to be the first point of contact in matters of personal health. At a general practice patients receive the following services:

- Coordinated care and referrals to other specialists
- Cares in a whole of person approach and in the context of their work, family and community
- Cares for patients of all ages, both sexes, children and adults across all disease categories
- Cares for patients over a period of their lifetime
- Advice and education on health care.

Primary Care Partnership - Victoria's Primary Care Partnership (PCP) strategy brings together local health and human service providers who work together within voluntary alliances to improve access to services and provide continuity of care for people in their community. PCP partner organisations focus on better coordination among services, management of chronic disease management, integrated prevention and health promotion, and strong partnerships. Victoria's 28 PCPs involve approximately 600 organisations, including hospitals, community health services, Primary Health Networks, local governments, mental health services, drug treatment services and disability services.

Primary Health Networks - On 1 July 2015, 31 PHNs were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.

Peak bodies – Refers to the Heart Foundation, National Stroke Foundation and Diabetes Victoria.

PENCAT (PEN Clinical Audit Tool) – A clinical audit tool that allows practices to analyse data, devise the necessary strategies to improve patient care and report on quality improvement activities undertaken by the practice. Ultimately, optimises patient health outcomes while enhancing business capabilities for the general practice.

Referral – For the purposes of this report a referral is defined as follows:
A *referral* is where a GP/Pharmacist has determined that a patient is eligible to participate in the *Life!* program and a referral form has been completed and sent to Diabetes Victoria. *Life!* program referrals are collected and reported by Diabetes Victoria.

Recommendation – For this report a *recommendation* is where a patient following a discussion with their health professional receives a recommendation to attend the *Life!* program, with or without a formal referral being made directly to the *Life!* program. Data related to recommendations were collected and reported at the general practice and pharmacy level. Due to the different definitions, the referral numbers reported by Diabetes Victoria may not match the number of recommendations reported by the general practices/pharmacies.

Stakeholders acronyms

- Heart Foundation – (HF)
- National Stroke Foundation – (NSF)
- Diabetes Victoria – (D-VIC)
- Department of Health and Human Services – (DHHS)
- South Eastern Health Providers Association – (SEHPA)
- Western Victoria Primary Health Network – (WVPHN)
- Ballarat Community Health – (BCH)
- Central Highlands Primary Care Partnership – (CHPCP).

CALD - Culturally and Linguistically Diverse Communities.

3. Executive summary

Background

The Heart Foundation and Stroke Foundation completed the *Application of Absolute CVD risk into the Life! program* project in March 2015 and reported on the projects findings in July 2015. This pilot project showed that engagement with key local stakeholders working closely with community based partners and services can positively influence the uptake of Absolute risk Assessment and Management with their respective agencies and networks, and aid with the development of locally appropriate service pathways.

Following successful project delivery, the Heart Foundation, in collaboration with the Stroke Foundation, proposed in December 2015 that a second phase of this project be funded to build on experiences and lessons learned, and to aid with further strengthening risk assessment and referral processes for type 2 diabetes and cardio vascular disease (CVD) prevention in general practice and pharmacy settings. The new project would engage with stakeholders who had previously been involved with the *Application of Absolute CVD risk into the Life! program* in the South East of Melbourne (SE Melbourne) and be expanded to include the local government area of Ballarat to add a rural/regional area to the project. It was also proposed that selected agencies working in the Knox City Council (as identified by the Department of Health and Human Services) under the previous *Healthy Together Victoria* Framework be included in the collaboration as an opportunity for them to learn from existing partners and the previous project work, and to adapt and adopt the service pathway and referral models for their service networks.

The aims and objectives of the project would build upon those in the pilot project and included:

Project aims:

- To strengthen and expand on the screening, risk assessment and referral pathways developed in the pilot project to identify individuals at risk of cardiovascular disease (CVD) and Type 2 diabetes (hereafter referred to as diabetes) and appropriately connect them into primary care using Absolute CVD risk and the Australian Diabetes Risk Assessment (AUSDRISK) as a best practice approach
- To extend the reach of this project into rural/regional Victoria to assess whether the implementation model applied in metro Melbourne will be able to translate to rural/regional communities
- To promote the *Life!* program as a key referral point for people at moderate and high risk of CVD and/or high risk of diabetes, and
- To increase awareness and engagement of Aboriginal and Torres Strait Islanders Peoples and Culturally and Linguistically Diverse community groups in relation to Absolute CVD risk and diabetes and to connect them with culturally appropriate service providers.

In addition, the project had the following objectives:

- To facilitate the identification of people at increased risk of CVD and or diabetes in general practice and other primary care settings
- To establish this model in a rural setting (Ballarat)
- To promote adaption and adoption of the existing model developed in the pilot project with Healthy Together Knox amongst service providers
- To increase referrals into the *Life!* program for individuals with moderate and high risk of CVD and/or high risk of diabetes
- To increase referrals into appropriate programs and services for people identified as moderate and high risk and those with diabetes who are not eligible for the *Life!* program
- To include pharmacies (who are part of the regional services network) in the

pathway to assist in identifying people who would benefit from *Life!* program participation

- To monitor enrolment in the *Life!* program to include participants with moderate and high CVD or diabetes risks
- To identify information and resources that promote Absolute cardiovascular disease risk and AUSDRISK to consumers to better understand their risk profile for CVD and diabetes.

Project partners

The following partners were engaged to implement the project:

- Heart Foundation – (HF)
- National Stroke Foundation – (NSF)
- Diabetes Victoria – (D-VIC)
- Healthy Together Knox (Participated in initial phase of the Project up to 30th June 2016)
- South Eastern Health Providers Association – (SEHPA)
- enliven (PCP)
- Western Victoria Primary Health Network – (WVPHN)
- Ballarat Community Health – (BCH)
- Central Highlands Primary Care Partnership – (CHPCP)
- *Life!* program providers.

The project recruited fifteen pharmacies across SE Melbourne and Ballarat. Pharmacies were supported to provide health checks to customers comprising a blood pressure check and completion of the AUSDRISK tool. Depending on the outcome of the screening, customers were provided with advice and further referral and/or recommendation either to their GP or the *Life!* program.

In addition, ten general practices were recruited in SE Melbourne and six in Ballarat. General Practices were supported to introduce systems of care that support diabetes and CVD risk assessment. They were encouraged to use the online Absolute CVD risk calculator in accordance with the Guidelines for the management of Absolute Cardiovascular disease risk (National Vascular Disease Prevention Alliance 2012) and AUSDRISK tool to risk stratify their patients and to implement appropriate management pathways based on the level of risk identified.

The Implementation timelines and major project phases are outlined on the following pages.

Implementation Timeline

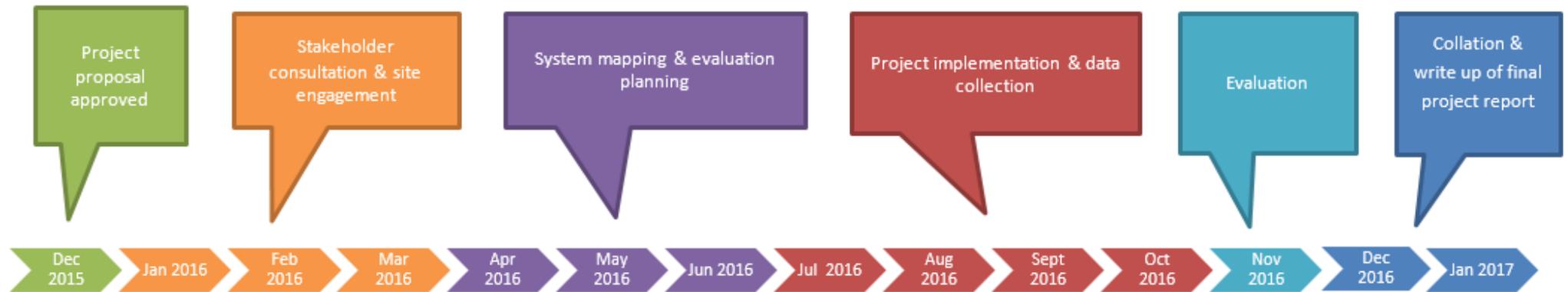


Figure 1.

Service mapping and referral pathways

A key component of the project was the development of service maps and referral pathways. The PCPs led the work to survey agencies in their respective regions to identify programs that were available in the community that could assist people to improve their lifestyle risk factors, thus reducing their risk of developing diabetes and CVD. The service maps developed during the project identified structured lifestyle modification programs (likely to be evidence-based) and general healthy lifestyle programs, that were already available in the community setting that patients could be referred to. The *Life!* program was showcased as an evidence based program that was available to people (without existing diabetes) at high risk of diabetes and/or moderate/high risk of CVD. In all sites, the service maps identified that a wide range of lifestyle modification programs are available, with options for structured intensive programs and more casual healthy lifestyle activities, however many of these services are under subscribed and have variable (often low) referral rates into them by health professionals. The service maps were promoted to agencies across the sector to encourage greater uptake and referrals.

Findings

The project demonstrated the importance of engaging, supporting, and resourcing existing stakeholders already working in the community to champion system improvements. These stakeholders have effective networks and relationships that they are able to engage and mobilise to introduce change.

In Ballarat the PCP and the community health service pooled their resources to combine efforts to implement health check models and to develop comprehensive referral pathways. In SE Melbourne SEHPA was able to provide practical support to general practices to better utilise their data, proactively identify patients who would benefit from risk assessment and to promote the range of programs that are available to support patients to modify their lifestyle risk factors.

The project highlights the ability of both pharmacy and general practice to implement risk screening and assessment models to identify patients at risk of chronic disease. Through this process patients were engaged in a conversation about prevention which is an important first step in the prevention pathway. The use of risk assessment tools was valuable in identifying the level of risk and therefore the level of intervention that was required. Patients at highest risk were more likely to be referred into prevention programs such as *Life!* The variation in practice that was seen between practices and between pharmacies highlights the diversity of approaches that were used to implement the risk assessment and referral models. This is never going to be a 'one size fits all' exercise; allowances need to be made for a local practice approach to implementation but guidance needs to be provided to ensure that general practices and pharmacies have a good grasp of the evidence, the tools and the best practice approach that is fundamental to achieving best practice.

Although the project was twelve months in duration the implementation phase at the pharmacy and general practice level was essentially between June and October (five months). The planned six-month implementation timeline was not achieved primarily because of the time it took to establish project partnerships and to get the pharmacies and general practices engaged and ready to implement change. In addition, new eligibility criteria for the *Life!* program commenced from 1 July 2016 and a decision was made to delay implementation so that practices were commencing the implementation with the new criteria and referral processes in place. Even with the reduced timeframe general practices and pharmacies achieved 714 patients receiving a risk assessment in general practice and 695 in pharmacy.

The key findings of the evaluation are summarised below for each of the project objectives.

Objective 1. To facilitate the identification of people at increased risk of CVD and or diabetes in general practice and other primary care settings. To establish this model in a rural setting (Ballarat), and to promote adaptation and adoption of the existing model developed in phase 1 within the Knox LGA amongst service providers.

One of the key enablers to introducing risk screening and assessment into practices was the use of existing evidence based tools such as the AUSDRISK and the Absolute CVD risk calculator. The WVPHN and SEHPA worked with practices to familiarise them with the tools and to encourage the use of the Absolute CVD risk calculator in the GP software. The evaluation showed a positive shift in the use of these tools. The biggest change was seen in the number of general practice sites who began to use the software. Three general practice sites used the calculator prior to participation, and this rose to 12 by the end of the project. Similarly, only five general practice sites used the AUSDRISK tool at commencement with 12 general practice sites using the tool at the end of the project. Three general practice sites indicated that they had changed their way of conducting diabetes risk assessments by trialing new strategies to increase screening via an opportunistic approach. This included AUSDRISK form completion by patients in the waiting room.

Overall general practice sites calculating patient Absolute CVD risk increased from 64.3% at project commencement (baseline survey) to 100% at the end of the project (follow up survey) and similarly assessing diabetes risk increased from 79% (baseline survey) to 100% (follow up survey).

The use of existing patient data to better understand the practice population was very useful in allowing practices to better target patients who would benefit from risk screening. The PENCAT tool was implemented in all general practices (except one who used a different software) to enable data mining and risk profiling of patients. It should be noted that practices participating in the project did not use PENCAT to do AUSDRISK assessments. Patients who were identified through the PENCAT tool as being potentially at moderate to high CVD risk could be proactively managed. One site noted that during the project PENCAT was used to identify patients at moderate to high risk of CVD who were flagged for follow up at their next practice visit.

At the end of the project all general practice sites indicated that they were highly likely to continue CVD and diabetes risk assessments.

Objective 2. To increase referrals into the Life! program for individuals with moderate and high risk of CVD and/or high risk of diabetes and to increase referrals into appropriate programs and services for people identified as moderate and high CVD risk with diabetes who are not eligible for the Life! program.

Throughout this project the *Life!* program was promoted to both pharmacies and general practice as a comprehensive evidence based behavior change program that could help patients reduce their risk of developing diabetes and CVD. A finding of this project is that general practices are more inclined to refer patients to services that they are familiar with and trust. It is therefore important that GPs have an understanding of who is providing the programs and where they are provided. The central intake model used by *Life!* to manage referrals into programs that are running meant that GPs could not refer directly into a program that was in a specific location and delivered by a particular facilitator or agency, this caused some initial resistance. To manage these concerns Diabetes Victoria provided education materials and practice visits to better inform practices of the central intake model and to reassure GPs that patients would be allocated a program that best suited their needs; this meant patients were less likely to be on waiting lists.

One practice noted that it would be easier if GPs could refer all patients that they felt were at risk and could therefore benefit from lifestyle changes. This creates a significant challenge for the *Life!* program that developed the criteria to ensure that people being referred to the program are more able to benefit from it i.e. those that are at moderate to high CVD risk or high risk of diabetes with modifiable risk factors rather than just any person who may benefit from a lifestyle modification program.

Even with the challenges mentioned above, the evaluation showed that the project was successful in facilitating referrals to the *Life!* program in both pharmacies and general practice.

During the project the number of general practice sites which indicated that they recommended or referred to the *Life!* program increased from six to eleven general practice sites. During the project, GPs reported 78 recommendations or referrals to the *Life!* program and Diabetes Victoria received 73 referrals from participating general practice sites with 51 of these converted to enrollment into the program (including 16 that enrolled into a Group Course, 31 into Telephone Health Coaching (THC) and 4 into a CALD group course). The GP Follow Up Survey asked, "Has participating in this project made a difference to where your practice refers patients who are at risk of CVD or diabetes?" eight general practice sites (57%) reported that participation had made a difference due to an increased awareness within the practice about the *Life!* program and a general improvement in referral practices. It was also apparent that participating general practice sites may have decreased referrals to other lifestyle management programs during the project in favor of referrals to *Life!* For example, weight management was a referral option for 50% of general practice sites at baseline whereas this decreased to 36% at follow up.

Only 29% of pharmacies reported that they recommended or referred to the *Life!* program prior to the start of the project, however throughout the project period 71% of pharmacies reported that they referred a customer directly or gave them a brochure and recommended self-referral.

The follow up survey for pharmacies showed that during the project there was an increase in the number of pharmacies who reported information to customers about GPs, The *Life!* program and exercise and internal pharmacy programs, and a decrease in the number of pharmacies providing information on weight management and Quit programs.

Objective 3. To include pharmacies (who are part of the regional services network) in the pathway to assist in identifying people who would benefit from Life! program Participation.

Pharmacies are showing an increasing interest in providing health information and screening services to patients that are also able to generate income (business models). There are models emerging in pharmacy that look to introduce these approaches and this project looked to capitalise on this interest to support pharmacies to introduce a screening and referral approach for diabetes and CVD prevention. Of the 14 pharmacies participating six noted that they did not undertake health checks prior to project commencement. A total of 695 health checks were undertaken during the project. At the end of the project 71% of pharmacies had either referred a customer directly to the *Life!* program or had given them a brochure and encouraged self-referral, representing a 42% increase of pharmacies referring to the *Life!* program. Overall 155 recommendations were made to the *Life!* program, with 47 referrals directly to Diabetes Victoria. By November 25, 2016, 35 had enrolled into one of the *Life!* program interventions (including 2 into a Group Course, 11 into THC, and 22 into a CALD group course).

The benefits of participation were highlighted in the follow up survey when pharmacies were asked 'what was the biggest change or improvement to the way they screened high risk customers'. Three pharmacies indicated that they had improved processes around screening and referrals and three reported that they were more proactive in terms of their questioning of customers. Almost half of the pharmacies also reported that the project had been positive for their relationships with their customers.

Objective 4. To monitor enrolment in the Life! program to include participants with moderate and high Absolute CVD risk and/or high risk of diabetes.

Prior to project participation all general practice sites were aware of the *Life!* program with six general practice sites (43%) recommending or referring to the *Life!* program at baseline (Baseline survey) and 11 general practice sites (77%) recommending or referring by project conclusion (Follow up survey). At baseline, only one practice indicated that they refer patients (with a score greater than 10%) to the *Life!* program even though 57% responded that they were aware that these patients were eligible.

General practice sites reported 78 recommendations to the *Life!* program, including 73 referrals directly to Diabetes Victoria. Of those, 42 were eligible according to the criterion of AUSDRISK and BMI, 31 were eligible according to pre-existing conditions or clinically determined CVD risk, and 0 were eligible according to Absolute CVD risk.

Prior to the project only 29% of pharmacies recommended or referred to the *Life!* program. Throughout the project 71% of pharmacies either referred a customer directly to the *Life!* program or gave them a brochure and encouraged self-referral.

Pharmacies made 155 recommendations to the *Life!* program, including 47 referrals directly to Diabetes Victoria.

Health check results were available for 152 referrals into the *Life!* program and 120 (79%) had an AUSDRISK score of 12 or greater and BMI > 25 with 56% having high or moderate blood pressure.

Objective 5. To identify information and resources that promote Absolute Cardiovascular disease risk and AUSDRISK to consumers to better understand their risk profile for CVD and diabetes.

In addition to working with pharmacies and general practice the project looked to undertake a multipronged engagement approach with the community to improve their understanding and interest in prevention. Having a community that is better informed and proactive in seeking information to improve their health reinforces the importance of this for health professionals. Rather than passive participation it is far more effective to have patients seeking out and looking for prevention programs that will reduce their risk of developing diabetes and CVD. As part of this project a community awareness and engagement strategy was developed to assist with the development of appropriate resources to aid with community awareness of the risks associated with CVD and diabetes. The strategy also included community engagement events in each project locality, delivered with local stakeholders.

Community engagement events were delivered in Ballarat as part of Heart Health Week 1-7 May 2016, which included free heart and stroke health checks (Absolute risk screening) conducted by the Heart Foundation in conjunction with Ballarat Community Health. These events were targeted at the general community and did not specifically focus on Aboriginal and Torres Strait Islander Peoples or Culturally and Linguistically Diverse community groups.

A Healthy Hearts community engagement forum was also held on 5th July, organised by Ballarat Health Services, Ballarat Community Health, The Heart Foundation and Heartbeat Community Inc. to provide information about diabetes, CVD risks, and lifestyle management.

Three community events were also delivered in October in SE Melbourne in partnership with enliven, the Southern Migrant Refugee Centre, The Heart Foundation and Diabetes Victoria. The events included presentations by the Heart Foundation and Diabetes Victoria to the Berwick Tamil Group, Dandenong Polish Group, and Springvale Vietnamese Group. It was initially expected that the events would be held earlier in August, the delay highlights the challenges associated in working through the logistics of organizing these types of events. All the presentation's included messaging around:

- Risks for CVD/Stroke/Diabetes
- Lifestyle factors, i.e. smoking, physical activity, healthy eating
- Visiting your GP for a diabetes and Heart Health Check
- Information on the *Life!* program.

Interpreters facilitated the presentations and discussions, and the sessions engaged with 150 people.

A general information brochure was also developed jointly by the Heart Foundation and Stroke Foundation during the project entitled *Have you had a Heart and Stroke Check?* The brochure included information about risk factors associated with heart attack and stroke to provide consumers with information on the importance of having a health check. The brochure has been developed being mindful of the low health literacy that exists in many of the communities that this project was looking to engage. The brochure uses simple language and pictures to highlight key messages associated with reducing risk factors and to encourage people to seek out a 'heart and stroke' check from their doctor or nurse. The clear language used made it more amendable to translation.

These brochures will be distributed in a variety of community languages in key areas identified by local project stakeholders.

Enablers

One of the key components of the project, mirrored from the pilot project, was the support provided at a local level by SEPHA, WVPHN and BCH/CHPCP to several general practices, which aided with ensuring their participation in the project. This support included regular contact with the practices both prior to commencement and during the project implementation, via site visits, phone conversations and e-mail communications to ensure the practices were appropriately preparing for participation in the project and to help with problem solving any issues that may be required around familiarising practice staff with the project and its aims and objectives. Support was also provided around data management and reporting, and this included assistance for some practices in areas such as data clean up and mining. Patient resources, PENCAT and the online risk calculator were also seen as important enablers in facilitating project implementation.

Project champions were also integral to the participation of practices. The engagement of key respected team members like the practice manager and practice nurse to facilitate a whole of practice approach to the implementation of the risk assessment for CVD and diabetes and the subsequent referrals made to *Life!* or other programs was essential.

The inclusion of Ballarat in the project, where both BCH and CHPCP collaborated to pool resources and appoint a consultant to project manage delivery of key components of their involvement, such as the service mapping exercise, showed that two organisation's

working closely together in their locality could effectively combine their knowledge and resources and increase access to a range of networks and service providers to aid with promotion of the project.

Challenges

One hurdle experienced in the project was not having the appropriate clinical audit tools (PENCAT) readily available in all of the practices. During the initial implementation stage of the project this became a specific risk to the engagement of many practices in SE Melbourne that resulted in the Heart Foundation and SEHPA requesting an amendment of the project funding structure to aid with the purchasing of eight PENCAT licenses for the practices engaged by SEHPA. The lack of licenses for the practices became a potential “deal breaker” at a crucial stage of the project and ensured the recruitment and participation of all the SEHPA GP practice cohort to the project.

A potential challenge to long term sustainability in terms of the systems and practice change that the project aims to influence was highlighted by the fact that five of the general practice sites engaged in this project had participated in the “Application of Absolute CVD risk into the *Life!* program” conducted in 2015, and all the five general practice sites at commencement of this phase indicated that they were either currently conducting ‘very few’ or ‘no’ CVD risk assessments. In addition, none had reviewed their patient population records to identify at risk patients.

As with the pilot project general practices liked using their internal lifestyle management programs for patients at risk of CVD and diabetes for a number of reasons including the location of the program, and the cost to the patients. These factors were reported by thirteen of fourteen respondents. Alternatively, practices tended to refer to other service providers with which they had existing relationships supporting the view that GPs tend to refer to those service providers that “they know” and are familiar with.

Another challenge related to engagement with Pharmacies. Fifteen pharmacies were recruited to participate but only fourteen returned data on health checks. Challenges with pharmacies were varied and included the relatively low incentive payment of \$1000 used to recruit pharmacies to undertake (a minimum) 50 health checks which was not seen as financially significant by pharmacies. In addition, some pharmacies recruited were part of larger corporate chains who did not always prioritise engagement in the project, in the same way that smaller/independent pharmacies may have due to competing operational management challenges and conflicts with running numerous simultaneous health promotion campaigns.

Some pharmacies recruited also concentrated their activity for health checks at specific times, such as National Stroke Week (12th – 18th September) which may have reflected intermittent data returns over the course of the project and potentially impacted on the longer - term systems and practice change within the pharmacies in relation to undertaking CVD and diabetes health checks.

Other factors such as the increasing focus on retail activities within the pharmacy sector, which now compete with the more traditional aspects of the pharmacist’s role such as dispensing and the provision of healthcare advice, may have also impacted on the pharmacies engagement in the project.

Finally, the relatively short project implementation time frame (five months) may have reduced the possibility of identifying any additional project outcomes. For example, the establishment of systems within general practice, such as the use of PENCAT to identify and recall patients at risk can take time and may not have been fully implemented within the project timeframe.

Conclusion

All the key players involved with primary care services were represented in the project:

- General Practice
- Pharmacy
- A Primary Health Network
- Community Health
- Primary Care Partnerships
- Peak bodies (Heart Foundation, Stroke Foundation, Diabetes Victoria)
- and for a limited time, Local Government via the inclusion of Healthy Together Knox.

The project model has shown that it is adaptable and has the capacity to be delivered to other regions across Victoria, via collaborative implementation with key local primary care stakeholders.

The model framework was discussed with project participants in order to allow them to guide systems level implementation and to apply the model to their local context. For example, in Ballarat the systems level change was implemented by BCH and the CHPCP. At an agency level, general practices and pharmacies were engaged to work with change champions, such as practice nurses and practice managers, to drive change within their practice or pharmacy.

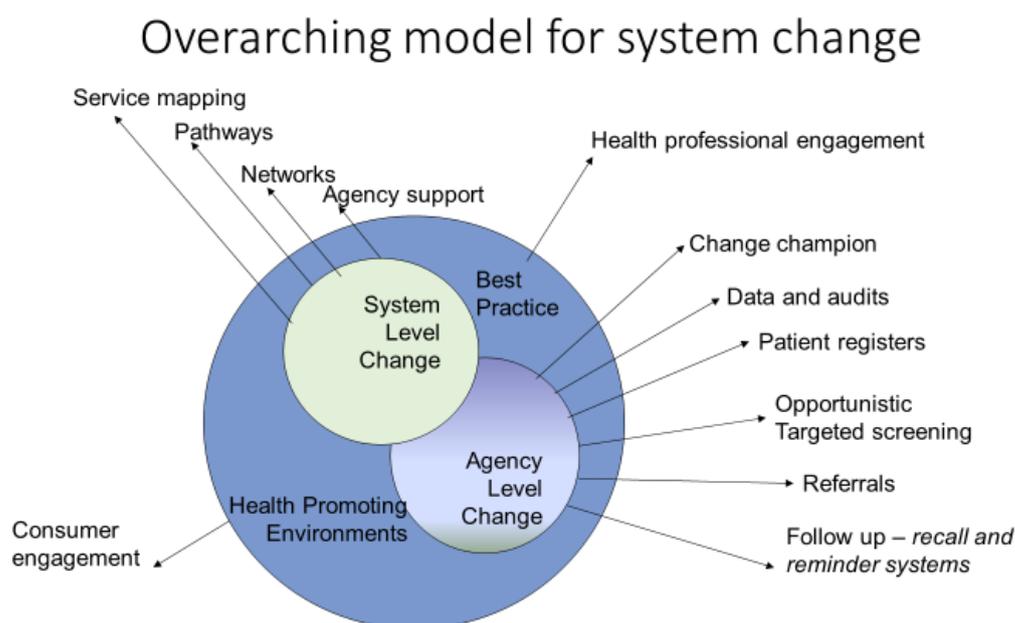


Figure 2.

The model is flexible enough to be implemented to ensure local context is taken into account and we feel that this framework could be adapted and adopted within other locations throughout the state for future projects/initiatives.

The overall approach also ensures that the chances of duplication and fragmentation of services and referral pathways can be reduced with organisations working together to provide easy points of access and information for members of the community at risk of CVD and diabetes.

Several key themes emerged in this project which need to be considered for any future implementation. These include:

- Support provided by local primary care stakeholder organisations, such as PHNs, PCPs and Community Health, to participating general practices and pharmacies is essential to project engagement
- The availability of practice resources, such as the PENCAT tool and online Absolute risk CVD risk calculator are critical elements to project implementation
- Project champions, such as practice nurses, practice managers and pharmacists, and the role that they can play as trusted and respected members of the practice or pharmacy team, helps to drive change and practice and promote the positive messages around taking a targeted risk assessment approach
- Making the *Life!* program more accessible, for CALD communities, by running groups in other languages, other than the English, Chinese and Vietnamese currently available, as well as providing appropriate resources would aid with take up and referrals
- Practice-based services are often a preferred option for referrals as they are on site and more accessible for patients.

Recommendations

There is a need to change our thinking to recognise that prevention is not a *single intervention that happens in a single setting with a single health professional*. As things evolve we need to recognise that prevention is a pathway that is a joint effort – most important to any prevention pathway is the conversation that we have with patients that sets them on the right pathway. All health professionals have a role to play and patients need to be at the centre of care.

The diagram, *Prevention Pathway Approach*, proposes an approach that may help to evolve our thinking further. It starts to define the elements that are required to achieve an integrated health check approach to managing CVD and diabetes risk/s in the community. In particular, the diagram identifies what the patient experience should be of an effective prevention model. Including: the provision of information that builds knowledge and awareness of the risk factors and their impact on health; a conversation that builds a better understanding of the risks that are relevant to that patient and what they can do to reduce their risk; facilitated referrals that link patients to appropriate support services and programs; and review and monitoring that follows up with patients to see how they are progressing and what might need to be changed or enhanced to achieve better health outcomes.

The elements of the pathway are defined as:

- Risk Detection and Awareness – to improve awareness of relevant risk factors
- Risk Assessment – to better understand the combined effect of multiple risk factors and the level of risk for an individual developing a chronic condition, in particular diabetes, stroke, kidney and heart disease
- Risk Management - reducing risks via medications, lifestyle programs and behavior change.

The pathway supports the notion that prevention is not something that happens in a single interaction or at a single point in time. The Referral Pathway that was developed during this project by the stakeholders in Ballarat (see section 8) demonstrates how the elements of the pathway can be adapted for a local context. The Ballarat Referral Pathway has contextualised the broader elements as; discuss risk, assess risk, plan for risk reduction and review. This provides guidance to both the health professional and the individual to the elements required for ongoing management of their risk and the important role of referrals to lifestyle modification programs (such as *Life!*).

Further work will need to be undertaken to refine this approach; it requires input from a broad range of stakeholders and professional groups (as identified in this project) to develop a model that is able to be adapted and adopted into the health care system. The lessons and learnings from this project will inform future work and opportunities; recognising the importance of local engagement and building on existing capacity to support practice change and innovation.

Prevention Pathway Approach

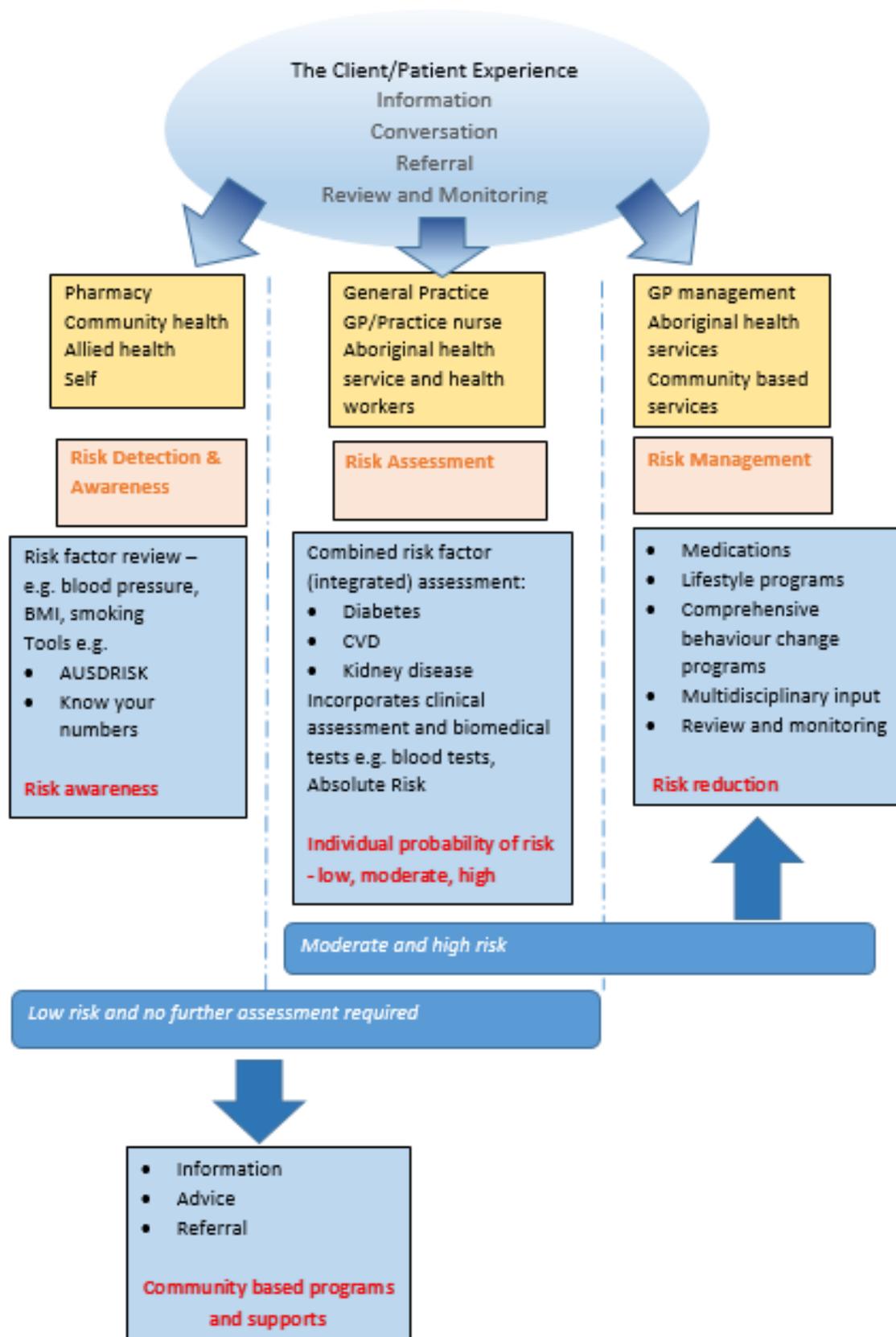


Figure 3.

4. Case study

South Eastern Health Providers Association – Practice Case Study: GPG GP Clinic

Summary of outcomes

- The project built upon work the practice was already doing. Through the project there was an increased focus on diabetes risk assessment, CVD risk assessment activities were introduced and referrals to the *Life!* program increased
- Diabetes and CVD risk assessment were particularly relevant to the practice as it has a large number of Culturally and Linguistically Diverse (CALD) patients and a population group at high risk of diabetes
- All members of the practice team have been involved in the diabetes and CVD risk assessment and referral activities including the GPs and practice nurse
- Medical students and a registrar on placement at the practice have been actively involved and have gained experience of risk assessment and lifestyle support as well as an understanding of referral options including the *Life!* program
- The practice's focus on ensuring patient data is collected and recorded in correct fields in clinical software has been important in facilitating risk assessment
- The practice has linked risk assessment activities with Medicare items for health assessments
- The number of referrals to the *Life!* program has increased although some limitations have been identified in relation to services for CALD patients
- Work on diabetes and CVD risk assessment and referral is continuing at the practice.

GPG GP clinic in Dandenong is one of ten practices in the South-Eastern Health Providers Association (SEHPA) catchment that participated in the *Strengthening the Risk Assessment and Referrals for Diabetes and CVD Prevention Project* in 2016.

GPG GP Clinic is a fully accredited practice established by Dr Gowrie Ratnavelar in 2003 and has undergone major renovations in recent years. The practice has a large Culturally and Linguistically Diverse (CALD) patient population, particularly from India and Sri Lanka. For many of the patient's Tamil is their first language and GPs at the practice speak a range of languages including Tamil, Hindi and Urdu. The practice is a teaching practice and is actively involved in GP training with ongoing medical students and registrars completing placements at the practice.

Diabetes is a major health concern with high rates of diabetes and gestational diabetes within the practice population. Dr Ratnavelar was very keen to be involved in a project that would benefit her patients by focusing on promoting risk assessment and lifestyle support for those at risk. She also saw it as an opportunity for involving other members of the practice team including medical students and the registrar during their time at the practice.

The practice had been working on diabetes risk assessment prior to the project, but through the project there has been an increased focus on risk assessment and referral with more proactive screening of patients. In addition to diabetes risk the practice is also now looking at patients' CVD risk and has found the online risk calculator a useful tool in calculating and recording patients' CVD risk. Early identification of patients at risk and provision of lifestyle support is important to the practice and patients benefit from the support they receive in reducing their risk.

All members of the practice team have been involved in the risk assessment and referral process. The project provided a great opportunity for engaging medical students in the risk assessment process and increasing their understanding of referral options including the *Life!* program. For the registrar, it has also provided an opportunity to look at population health issues. The practice nurse at GPG GP Clinic had been previously involved in the 2014 Absolute cardiovascular risk project at

another practice and was a strong advocate for the *Life!* program. The practice nurse completes risk assessment for patients booked in to see her and the GPs follow up after patients have seen the nurse. Where appropriate the practice has included the risk assessment activities in health assessment Medicare items.

The practice has PENCAT and has used the CV Event Risk tool in PENCAT to identify patients at moderate to high risk of CVD. Risk assessment has also been done opportunistically within the practice. For example, the AUSDRISK tool has been handed out to patients in the waiting room. This has been found to be a useful process with patients completing the AUSDRISK before they see the nurse or GP, and then discussing the results during the consultation. Dr Ratnavelar has suggested it would be useful to have other paper based resources on CVD risk that could be handed out to patients in the waiting room such as posters and pamphlets in English and other languages including Tamil.

A key to risk assessment and the use of risk assessment tools is ensuring that all relevant patient data is collected and entered in the correct field in the patients' record in the practice's clinical software (Genie). Dr Ratnavelar has worked hard to encourage all clinical staff and students to collect and record data. This makes the use of the risk assessment tools much simpler when the data is readily accessible. Through this process the practice has also identified where further pathology tests are required for individual patients.

Patients identified as being at risk are provided advice and support within the practice by the GPs and nurse. Where appropriate patients are also referred to other services including the Quit program, dietitian, exercise programs and the *Life!* program.

The practice has referred 25 patients to the *Life!* program during the project period and is continuing to do so. The practice has registered for case finding funding and found a visit from one of the *Life!* program staff during the project provided some useful tips. The practice has identified some limitations of the *Life!* program for its practice population. For example, the phone health coaching service is only available in English and the *Life!* groups are not available locally in Tamil.* The practice would be interested in having the *Life!* group run at the practice and has space available to do this in the newly renovated facility, if this was an option *Life!* would consider. The strict eligibility criteria for *Life!* program referral has also meant that at times the practice has had patients who would be keen to do *Life!* and would benefit from it but are excluded because of the eligibility criteria. For example, a patient under 25 years of age with a strong family history of diabetes who cannot be referred because his BMI is not over 25.

The practice has welcomed the opportunity to be involved in the risk assessment and referral project and feedback from patients has been positive. The work that has been undertaken by the practice during the project is continuing at GPG GP Clinic.

Written by Mary Saunders
Quality and Member Services Management, SEHPA
December 2016

* These were available during implementation through SMRC in SE Melbourne.