A submission by Diabetes Tasmania

in response to the

Our Healthcare Future

consultation paper

Our values

Integrity | Compassion | Quality

Transparency | Respect | Professionalism

1. The health of Tasmanians

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

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

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

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

2. The health of the Tasmanian health system

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

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

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

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

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

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

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

3. One part of the solution

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Clinical health outcomes:

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

B. Equitable access to preventative health care:

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

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

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

D. Already established and recognised program with opportunities for expansion

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

E. Cost-effective

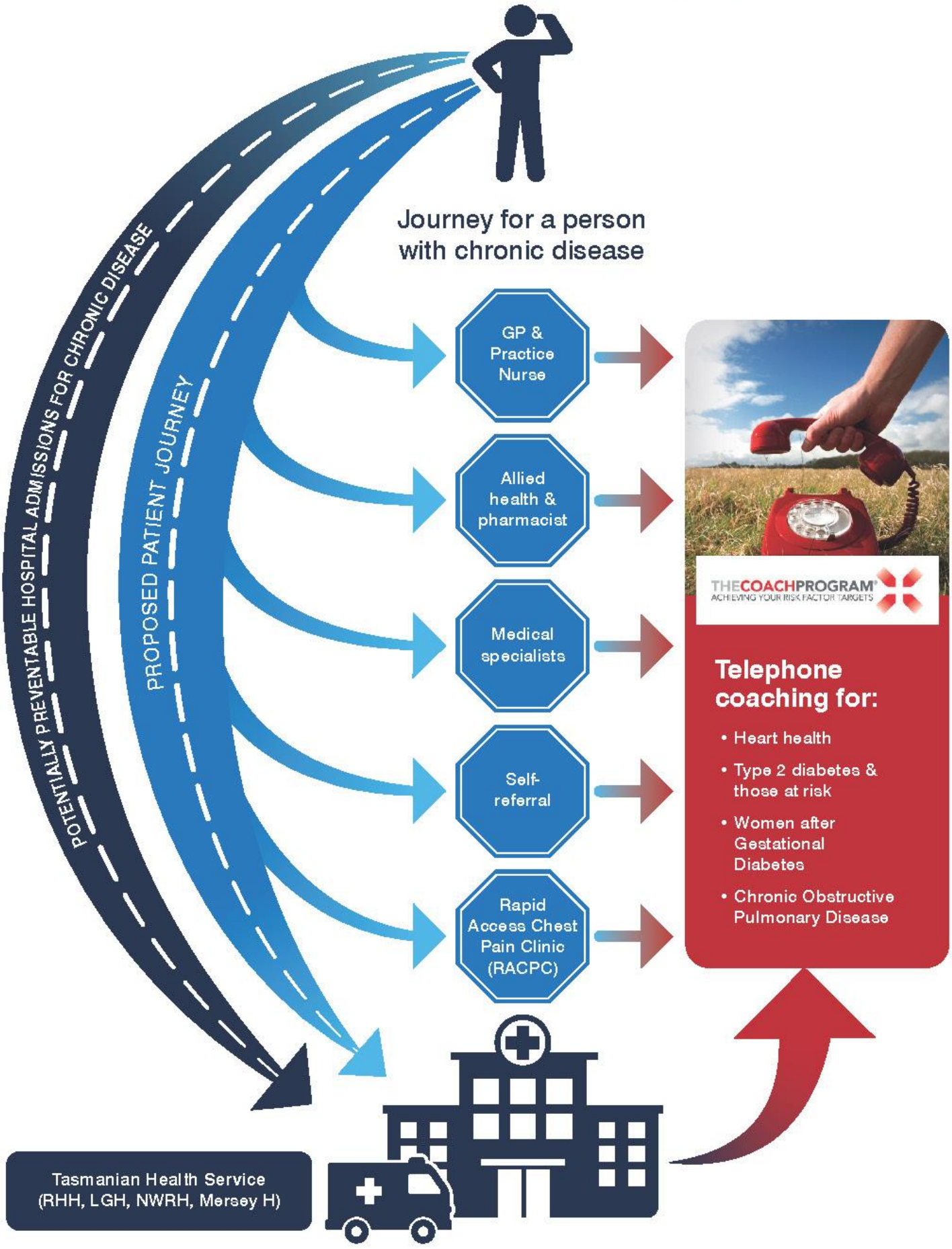
- **The COACH Program** was independently assessed as being a cost-effective program for type 2 diabetes patients in Tasmania[33]
- Recognised by Public Health Services (Tasmania) as a cost-effective program[24]
- Shown to be cost-effective for cardiovascular disease[23]

Summary

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

Potentially preventable hospital admissions through THECOACHPROGRAM®

ACHIEVING YOUR RISK FACTOR TARGETS



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