

National Divisions Diabetes Program



Diabetes and CVD Division Profiles

National Divisions Diabetes Program
Divisions Diabetes and CVD
Quality Improvement Project

*Divisions improving quality of care &
health outcomes in chronic disease*

November 2003

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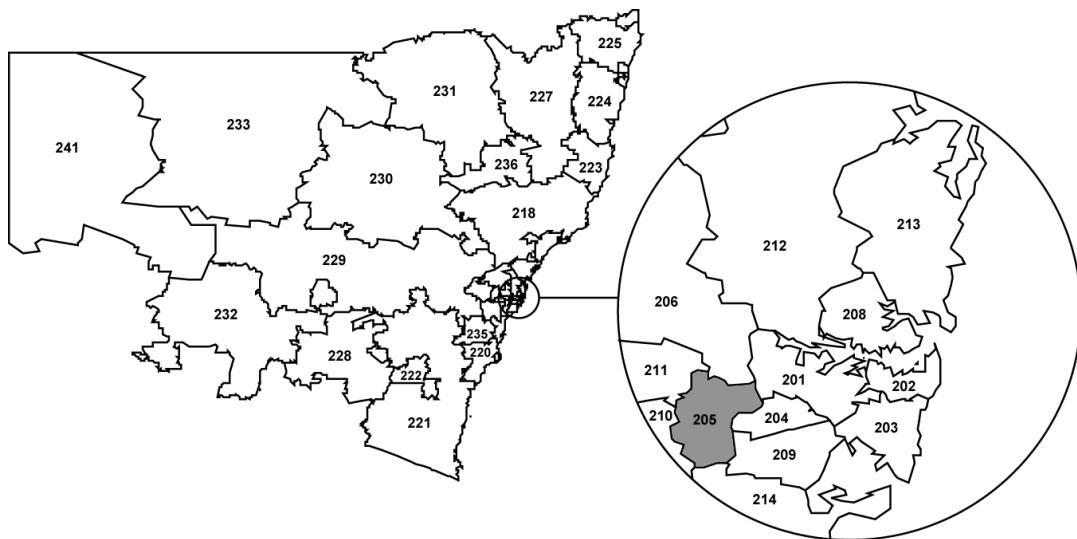
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Northern Territory Divisions	Division Number
Top End	801

Bankstown DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	157,850	
■ Aboriginal or Torres Strait Islander	1256	0.8%
■ Speaks language other than English at home	71,006	45.0%
■ RRMA classification ¹		
1: Capital city	157,850	100.0%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	8383	8.2%
■ High blood pressure ⁴	31,689	31.2%
■ High blood cholesterol ⁵	52,265	51.4%
■ Obese or overweight ⁶	61,123	60.1%
■ Physical inactivity ⁷	42,278	41.6%
■ Smoking ⁸	18,934	18.6%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

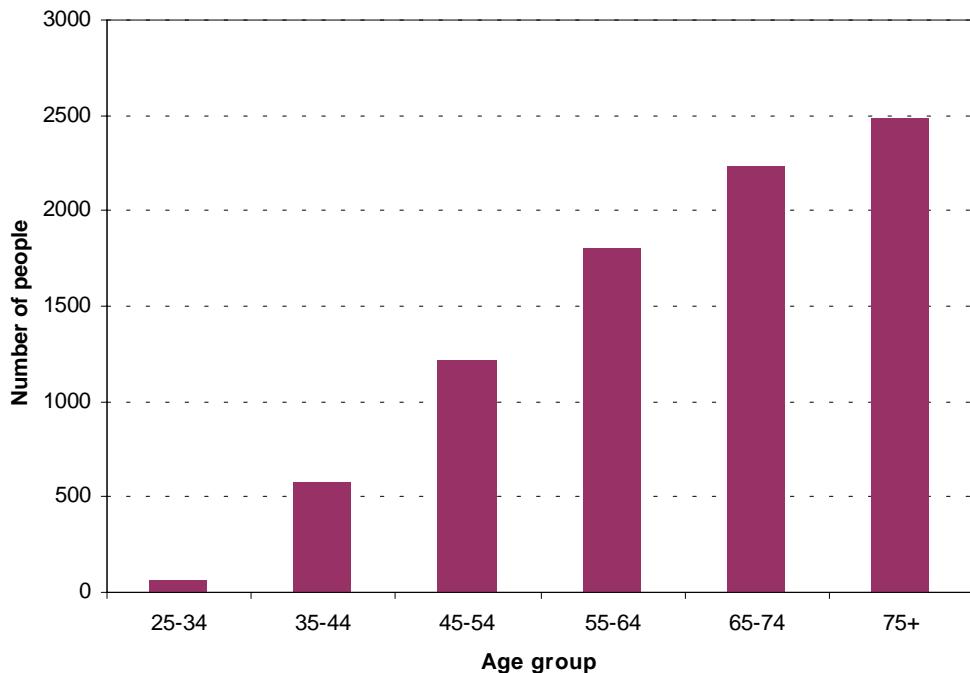
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

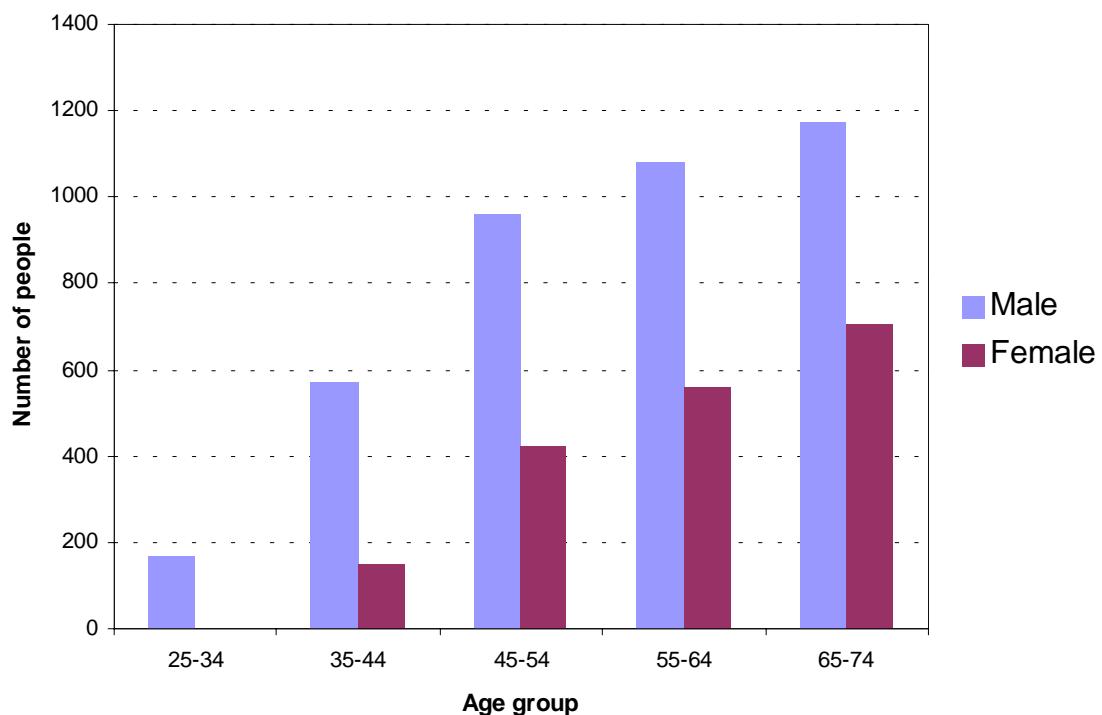
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



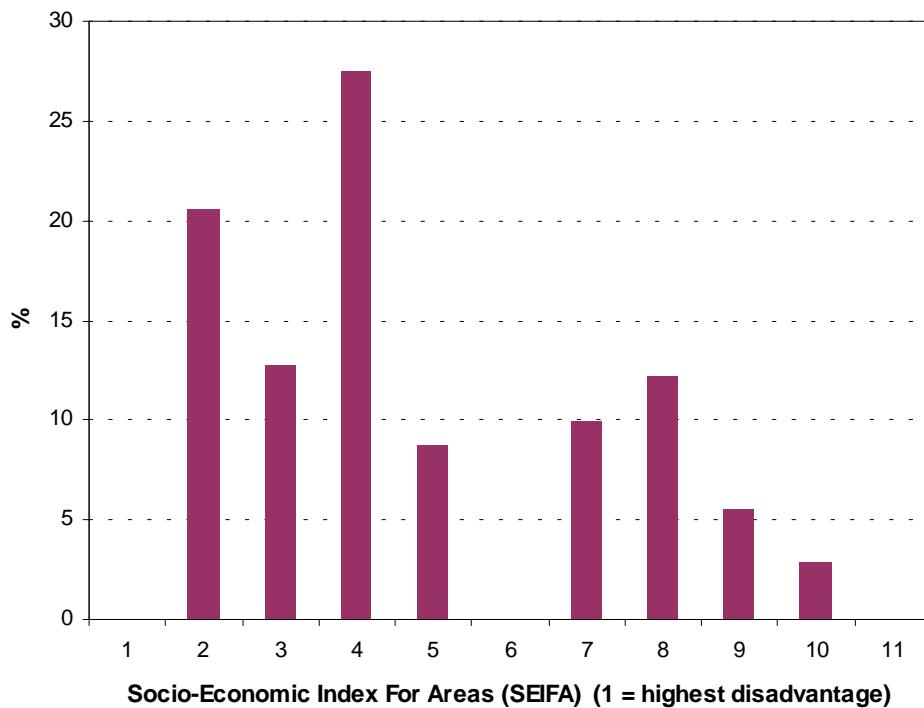
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

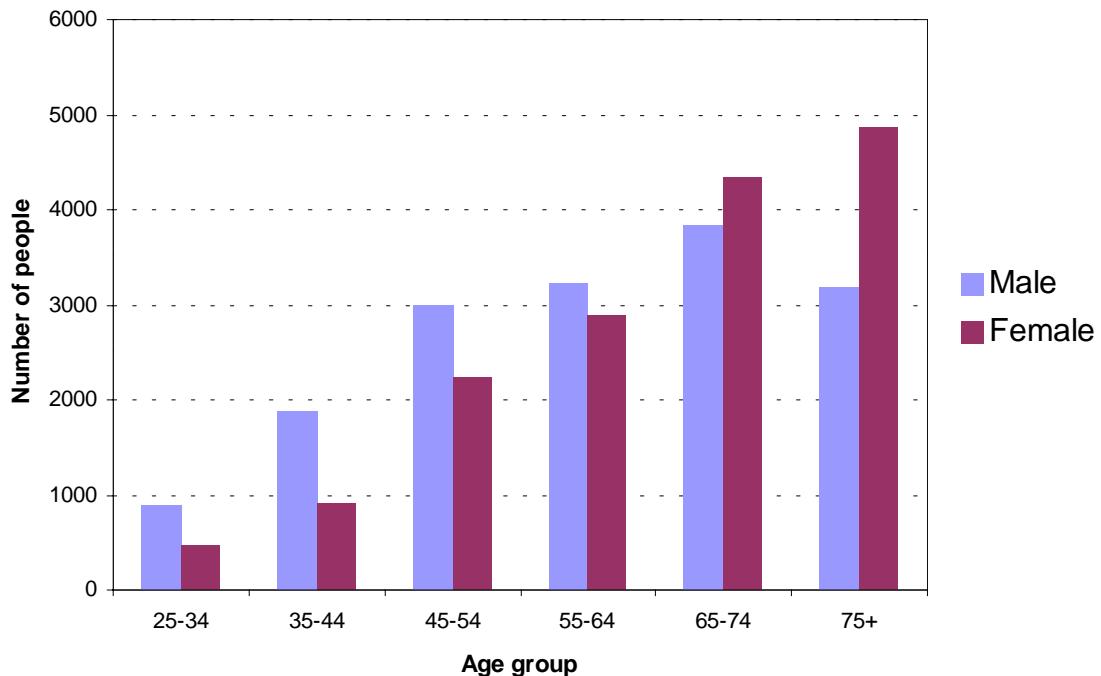
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

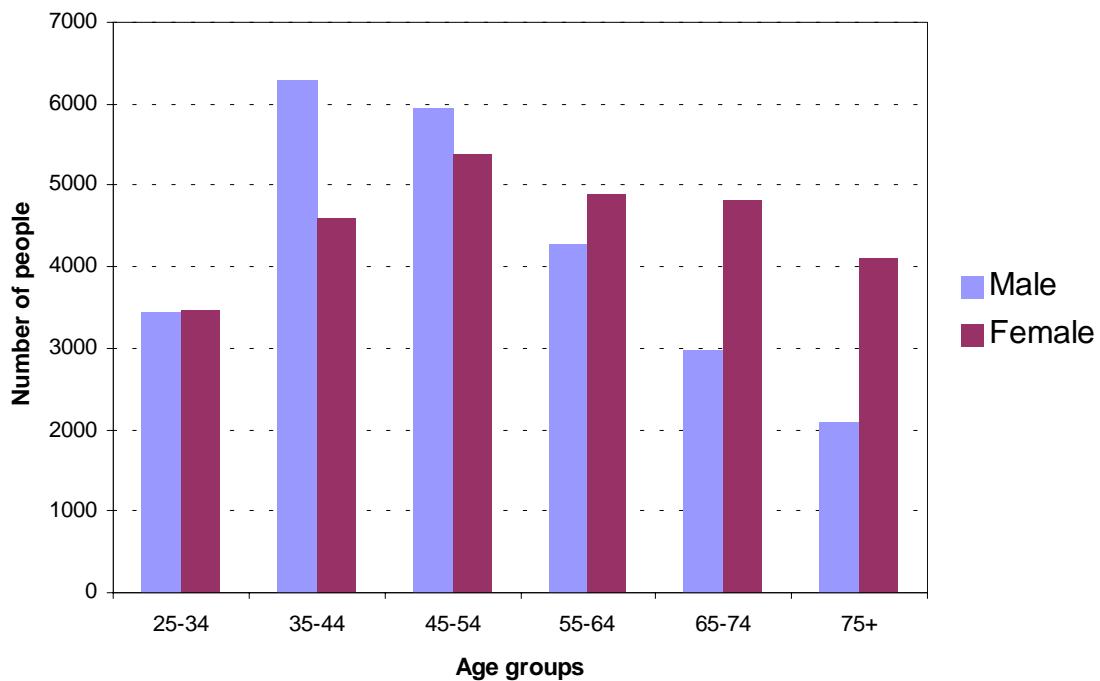
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



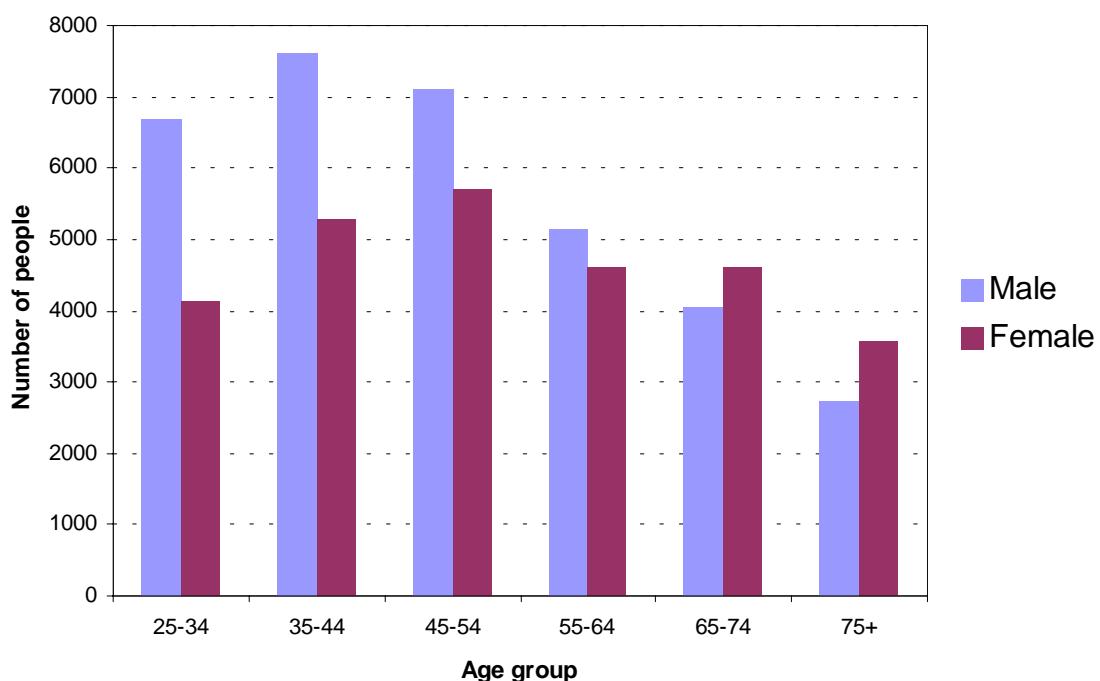
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



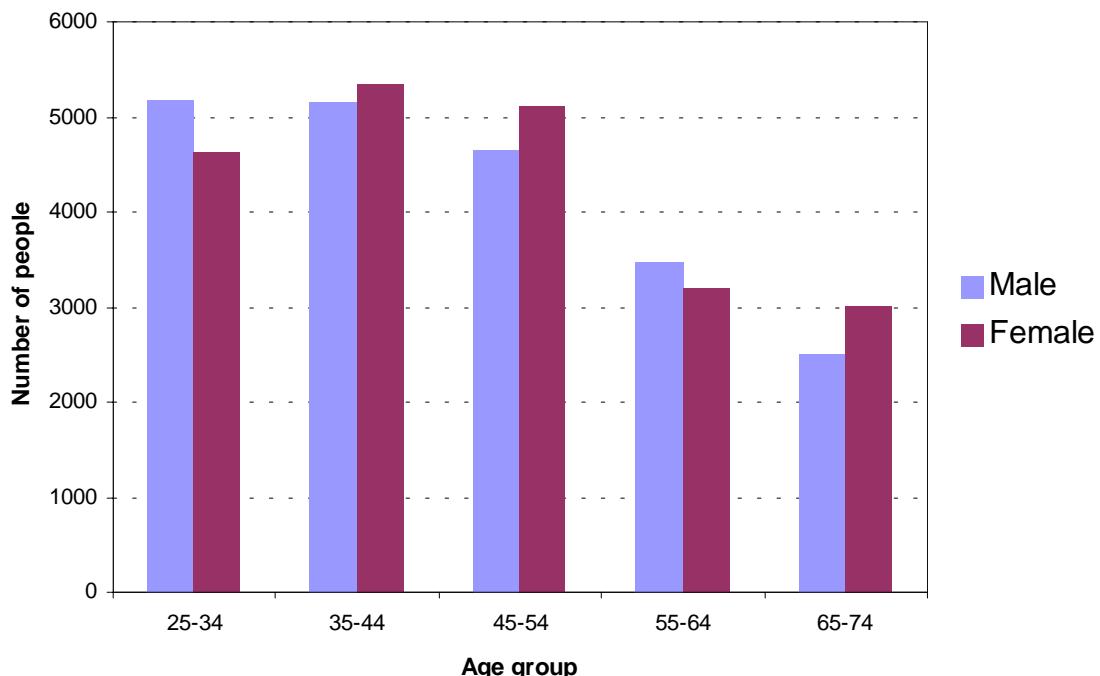
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



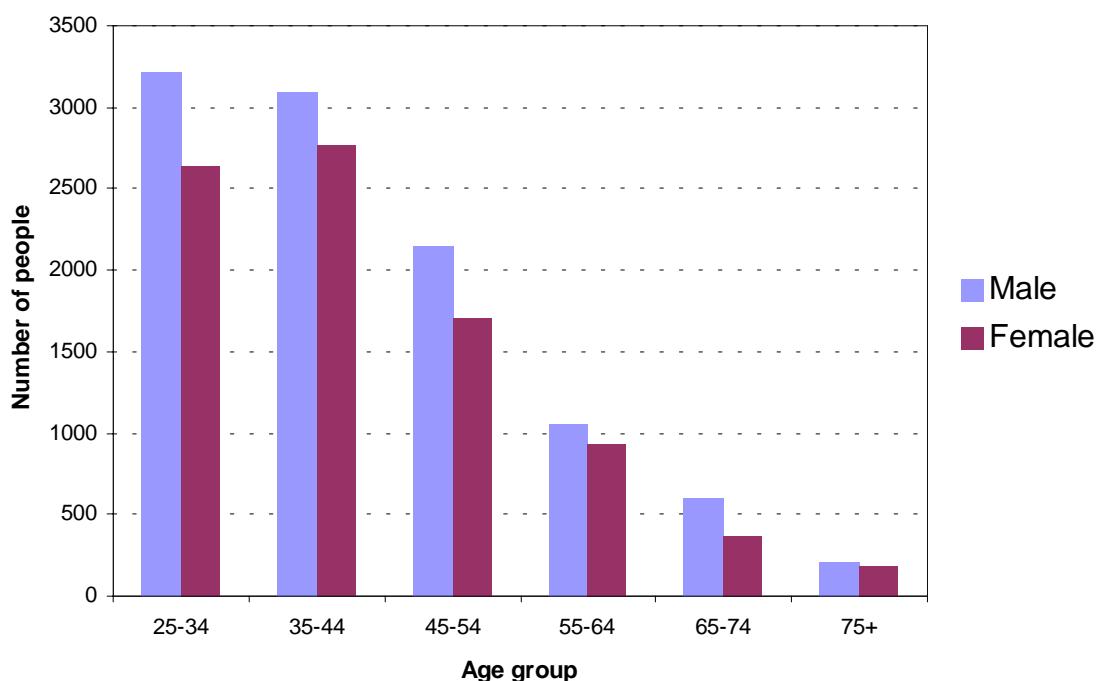
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 170 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - The Division runs a patient education and recall Diabetes program. Through this program patients have access to discounted podiatry and dietitian services,
 - Bankstown-Lidcombe Hospital runs a Diabetes Centre,
 - There are also podiatry and dietetic services available through the public system.

- What services are needed but are not available in your Division area?

While there is access to public podiatry, dietitian and Diabetes Educators, these services are overloaded at the current staffing levels.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The current program is based on providing patients with information in one of eight languages and a recall service. Previously, the Division has employed a Diabetes Nurse Educator (DNE) who ran miniclinics in doctors practices. The program was changed due to the limited number of patients able to be seen by one DNE.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Development of patient education kit in eight languages,
 - Liaison with local Diabetes Centre for “difficult to manage patients”,
 - Links with local services including private dietitians, podiatrists and fitness centres.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

The uptake of the podiatry and dietetic services through the program has been disappointing. It appears that people are prepared to wait for the public system and/or may not be able to afford the services.

- What future plans do you have for diabetes management in your Division?

The Division is looking to improve the current recall system through improved communication between the Division and GPs. Aiming for increased uptake of discount offers of the private podiatry, dietetic and fitness services offered through the Divisions program.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

- An understanding of the initiatives and the benefits to both patient and practices,
- A willingness to try.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Division has established links with local, private podiatrists, fitness centres and dietitians to provide patients registered with the program with discount services.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

The Division has used:

- Diabetes Australia resources,
- EPC guidelines,
- PIP/SIP guidelines,
- Clinical management guidelines.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Interested Divisions are welcome to inspect the material that the Division has collated for the patient education kits.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No.

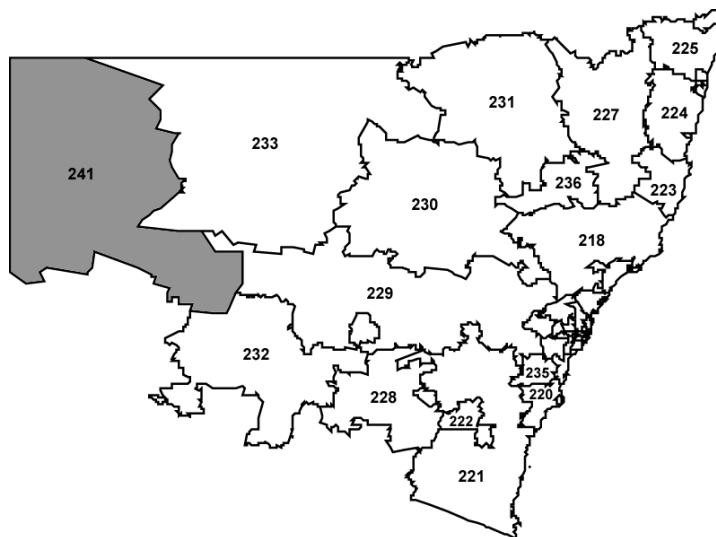
- What resource materials do you provide to practices?

As relevant information becomes available this is distributed by GPs.

Division Contact Person/
Program Co-ordinator

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Barrier DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	23,928	
■ Aboriginal or Torres Strait Islander	1866	7.8%
■ Speaks language other than English at home	460	1.9%
■ RRMA classification ¹		
4: Small rural	21,630	90.4%
7: Other remote	2297	9.6%
■ SEIFA category containing population median: ²	2	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1466	8.9%
■ High blood pressure ⁴	5502	33.5%
■ High blood cholesterol ⁵	8719	53.1%
■ Obese or overweight ⁶	10,091	61.4%
■ Physical inactivity ⁷	6884	41.9%
■ Smoking ⁸	2996	18.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

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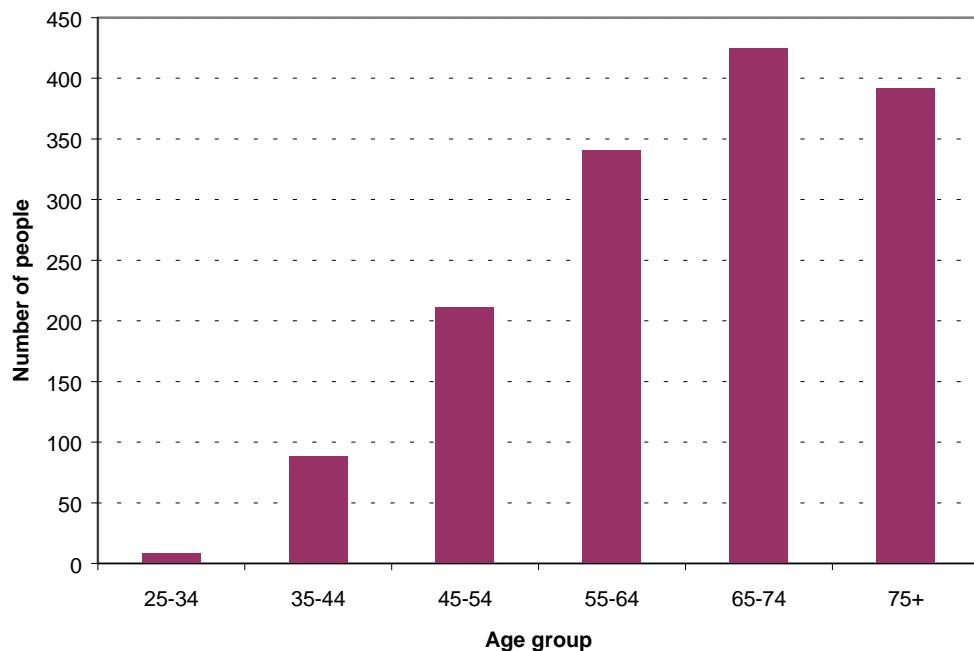
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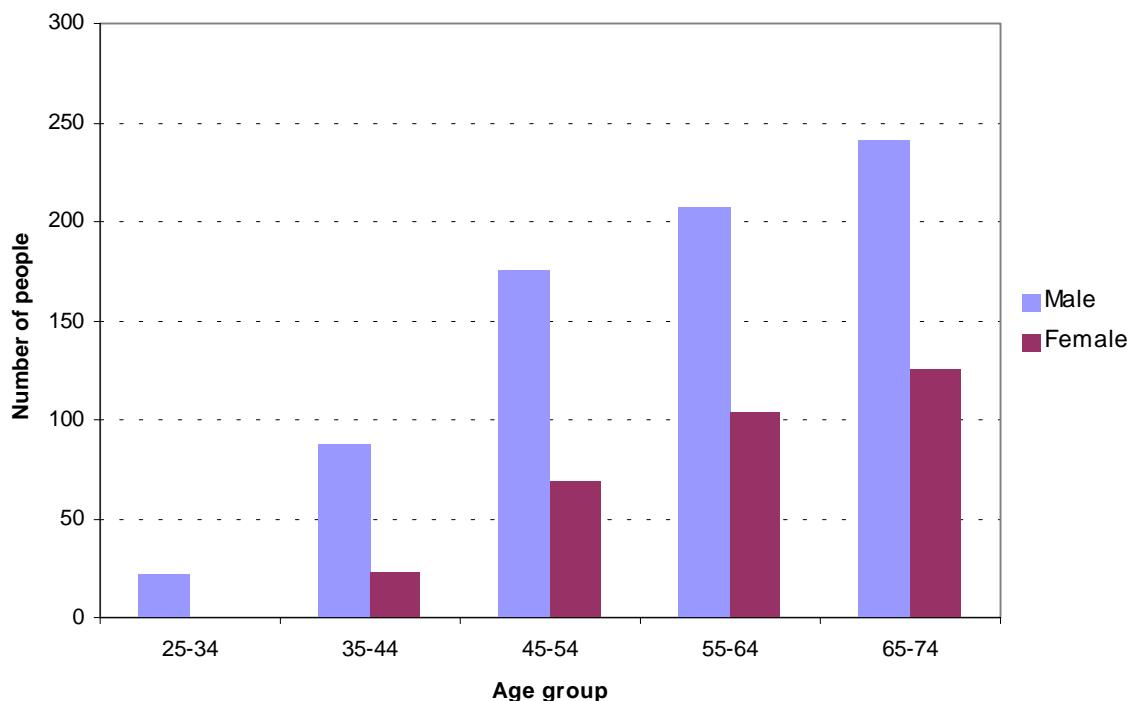
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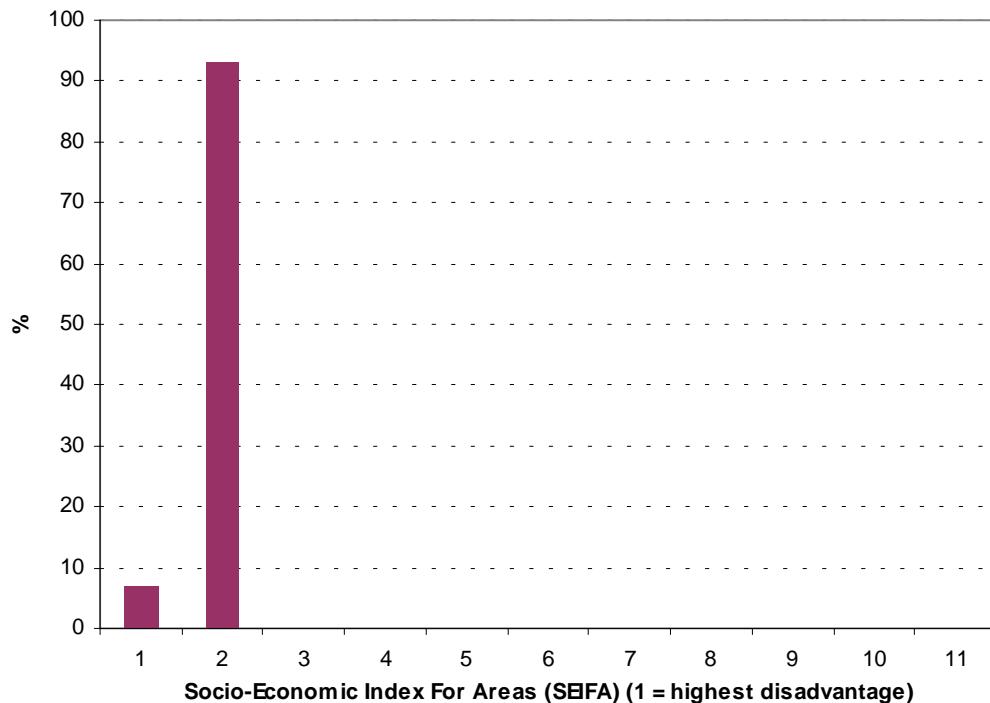
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Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

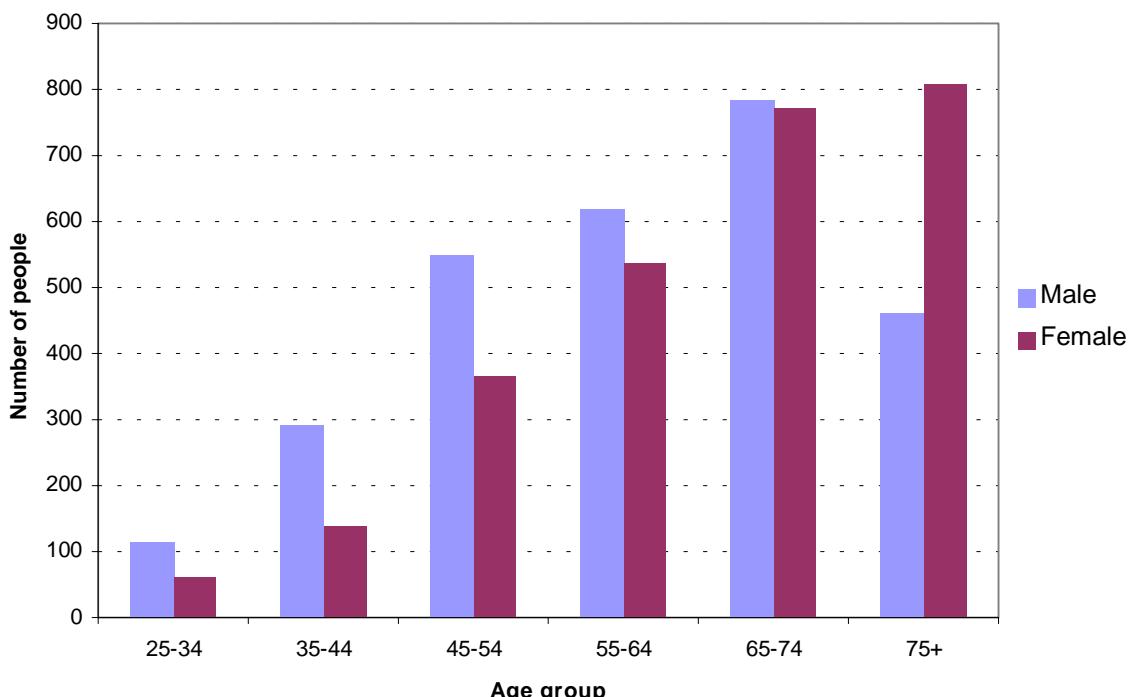
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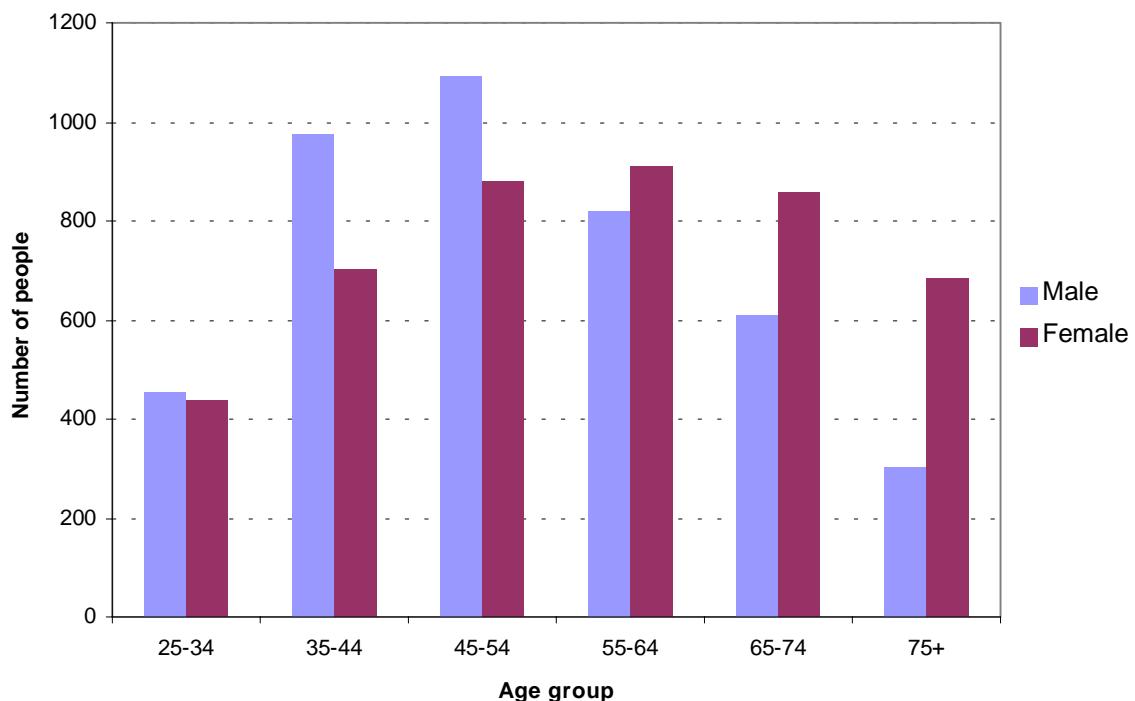
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



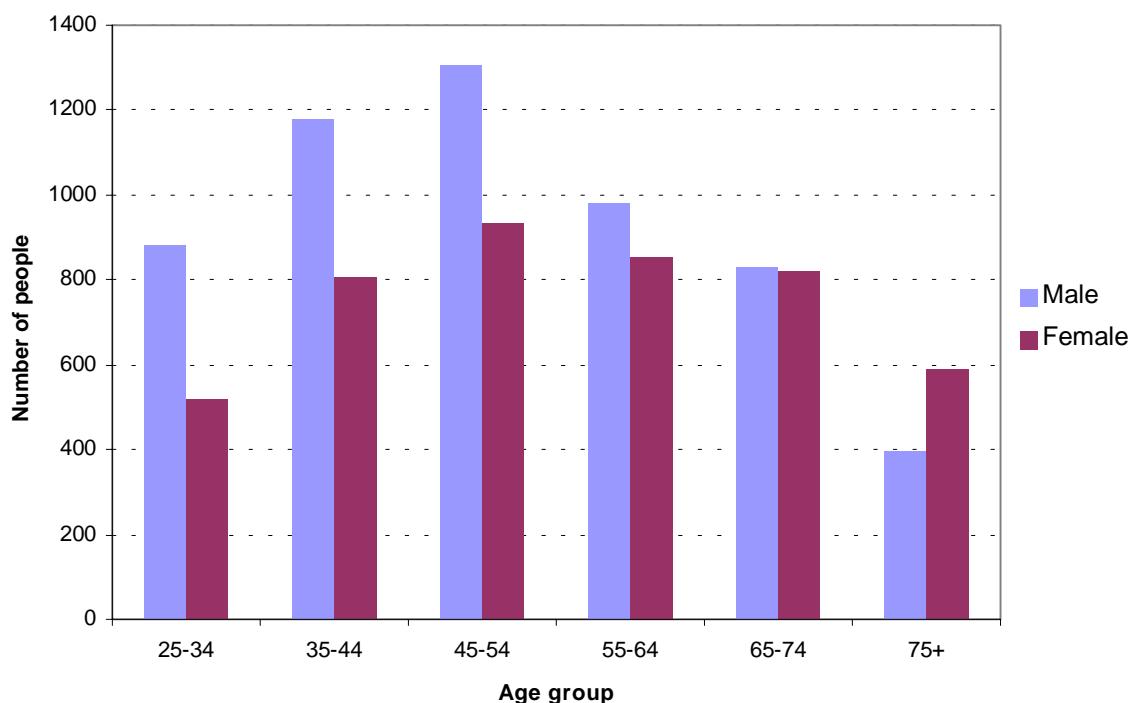
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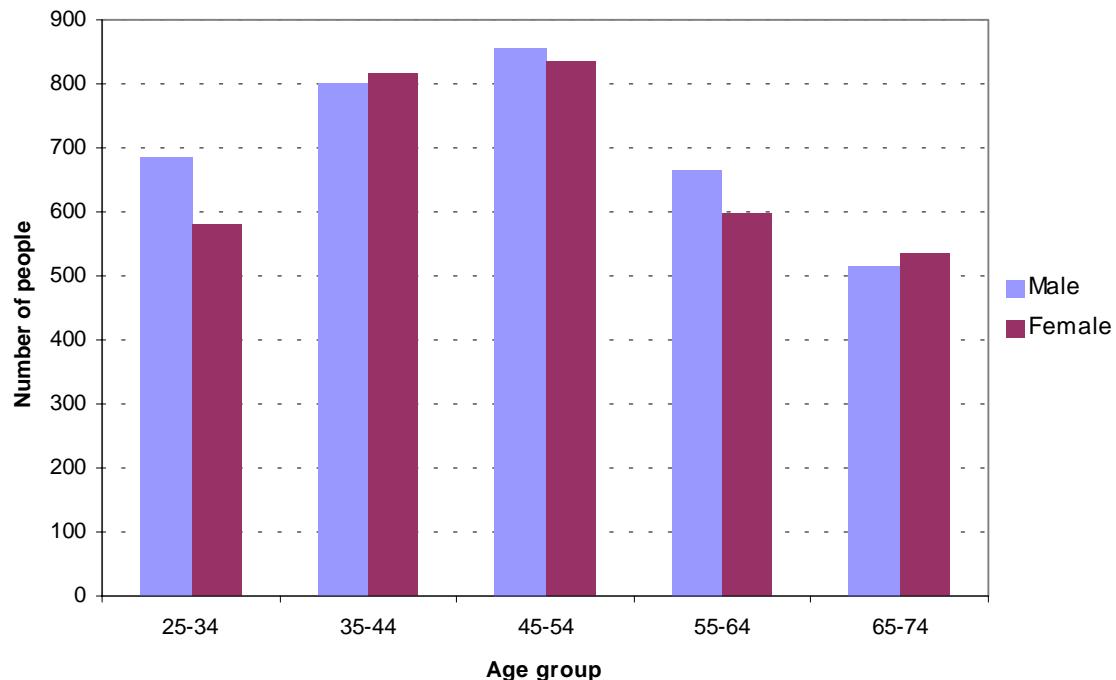
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Figure 6: Estimated prevalence of overweight and obese people by age and sex



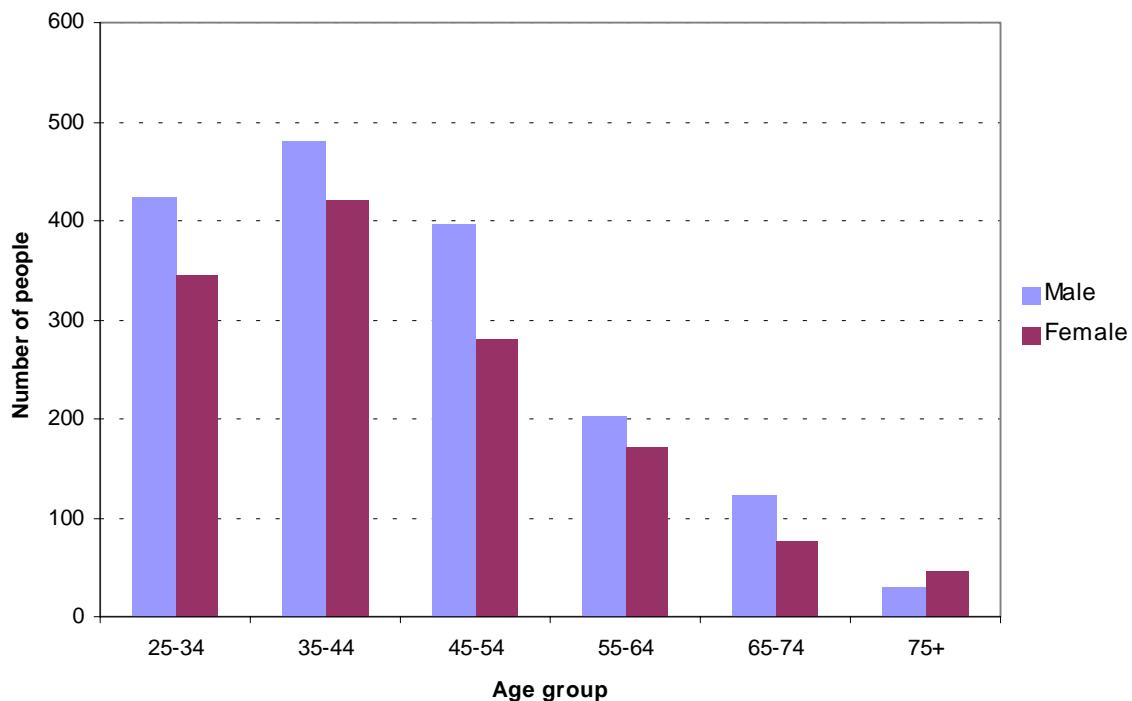
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Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

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Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

▪ Number of GPs working in the Division area:	Total	20
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Division Comments

- Do you have any comments about the nature of the population in your area?

The figures for the Aboriginal population in this area seem low. Local Aboriginal Health Services estimate a population of between 2500 and 3000, so we would estimate that the Aboriginal population is close to 10% of the total Division, but 50% or so higher in some of the outlying communities within it.

With the estimated number of adults with diabetes at 1466 in Broken Hill, then at 1300 active registrations (we've just cleaned the database, so it's 1282), we think we are getting fairly close. However, unfortunately, we suspect there are at least several hundred more that don't use our service.

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Regional Diabetes Centre – a three-way partnership between Barrier Division, Far West Area Health Service (FWAHS) and Maari Ma Health Service.

Services include diabetes education, (individual and group sessions), dietitian, complication screening, visiting endocrinology and podiatry, health promotion, and diabetes support group.

- What services are needed but are not available in your Division area?

Area needs additional GPs if all people with diabetes are to be able to access appropriate medical care.

Psychologist or social worker to address complex psycho-social needs. High number of clients present with anxiety and depression and behavioural issues. Apart from hospital-based mental health team, nil other professional counselling services available.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The Regional Diabetes Centre was set up as a pilot project in 1997 between Barrier Division of General Practice and Far West Area Health Service. Initially a GP worked from the centre one day a week, but this was discontinued after approximately 12 months. Maari Ma Aboriginal Health later joined the partnership, through provision of an Aboriginal Health Worker (AHW)/Eye Health Coordinator. Diabetes education and complication screening is provided at the centre by two diabetes educators, as well as through outreach at the Aboriginal Health Centre, pre-admissions clinic at the hospital and clinics in five outlying communities. A fundus camera enables eye screening and bypasses waiting lists for direct ophthalmology, and a visiting podiatry service over the past two years has greatly enhanced patient care. The centre also operates a glucometer loan lending service for newly diagnosed and GDMs, and has a support group.

(coordinated by a volunteer). Staff at the centre provide regular in-services and training to other health workers, and are active in community health promotion and disease prevention activities, (eg media campaigns, well persons checks).

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - 1300 active registrations,
 - Demonstrable reductions in HbA1c and microalbumin levels,
 - Appointment of Regional Eye Health Coordinator to Centre by Maari Ma, increasing accessibility to Aboriginal people,
 - Outlying communities serviced,
 - Securing podiatry clinics.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Initially having GP on site seemed to result in limited number of referrals by other GPs,
 - Recruitment and retention issues in remote areas at times impede smooth service delivery/continuity from allied health staff,
 - Border issues – towns outside Division's area but inside key partners areas, limits service provision.

- What future plans do you have for diabetes management in your Division?
 - Barrier Division of General Practice (BDGP) Chronic Disease Nurse will encourage case conferencing and care planning with GPs,
 - Update to CARDIAB V3,
 - Expand Diabetes Support Group and consumer involvement in self-management programs,
 - Conduct ongoing community education and strategies for increasing access by Aboriginal community.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Spend time consulting with all stakeholders,
 - Have regular interviews,
 - Ensure data collected is useful data,
 - Work in partnerships.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Partnership with FWAHS and Maari Ma Aboriginal Health Service, plus Royal Flying Doctor Service for transporting podiatrist. Developed through formal and informal communication.

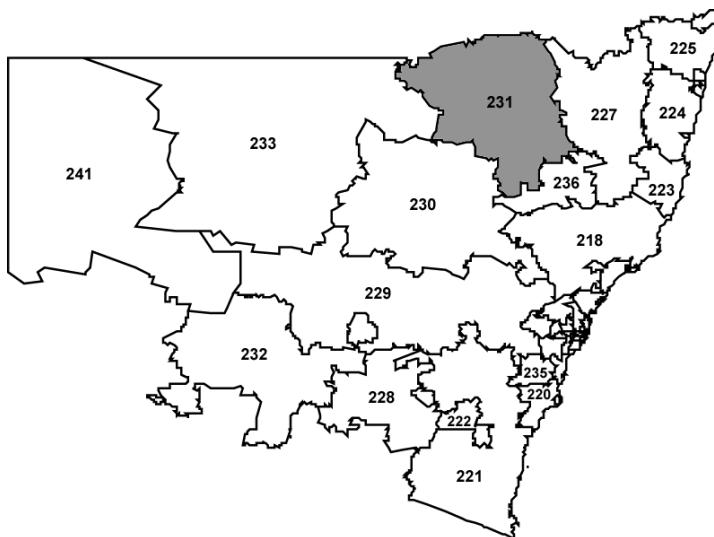
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice,
 - Diabetes Australia educational packages and brochures,
 - Pamphlets from Queen Adelaide Hospital – Access Scheme.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
N/A.
- What resource materials do you provide to practices?
Currently being developed.

Division Contact Person/
Program Co-ordinator

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Barwon DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	52,788	
■ Aboriginal or Torres Strait Islander	5522	10.5%
■ Speaks language other than English at home	849	1.6%
■ RRMA classification ¹		
4: Small rural	15,730	29.8%
5: Other rural	35,579	67.4%
7: Other remote	1478	2.8%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2830	8.2%
■ High blood pressure ⁴	10,768	31.0%
■ High blood cholesterol ⁵	18,067	52.1%
■ Obese or overweight ⁶	21,168	61.0%
■ Physical inactivity ⁷	14,850	42.8%
■ Smoking ⁸	6595	19.0%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

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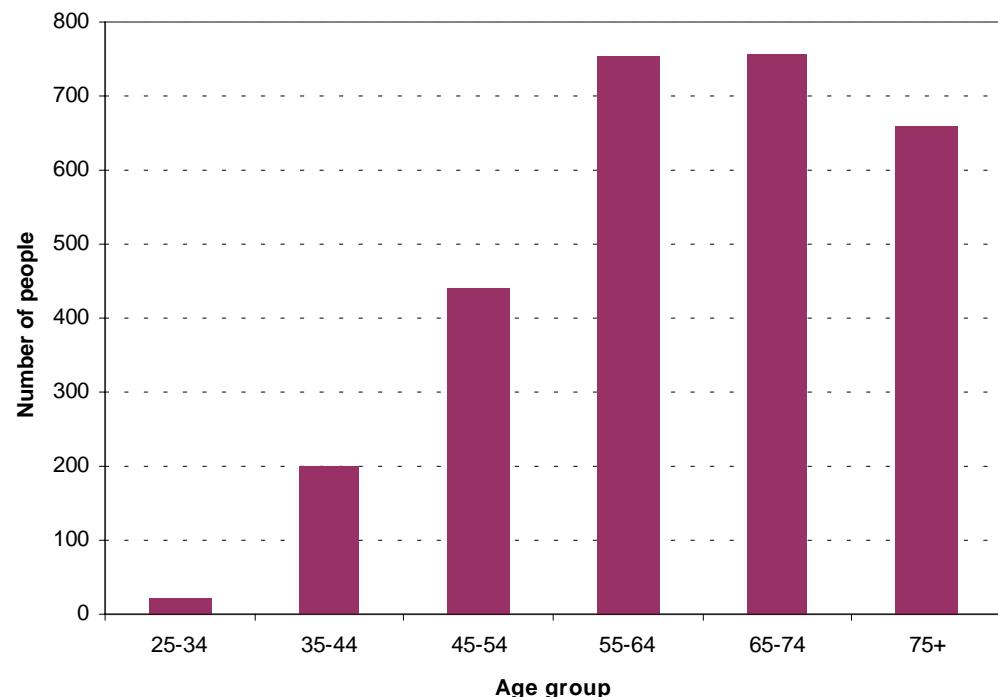
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⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

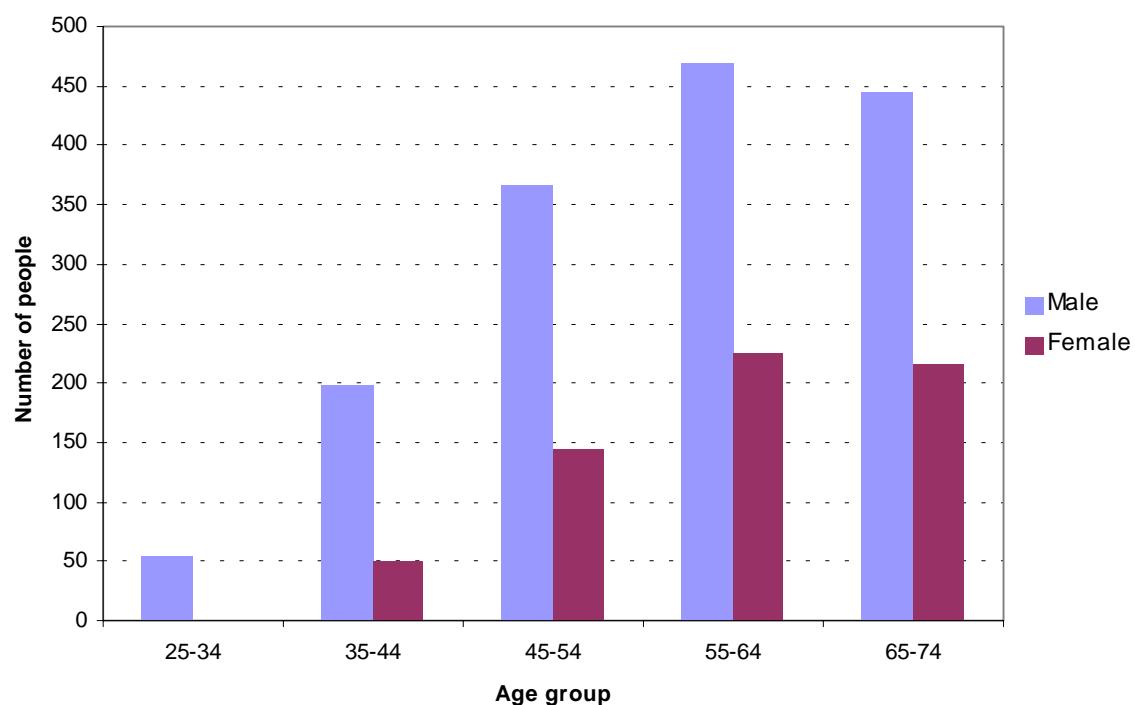
Key Descriptors of Division Population

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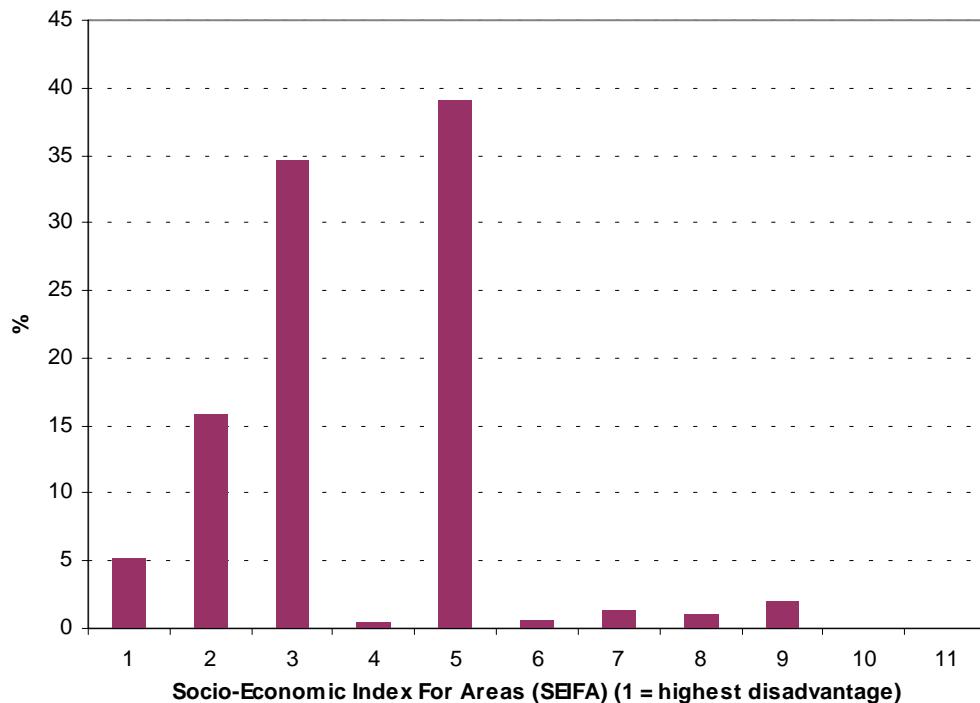
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Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

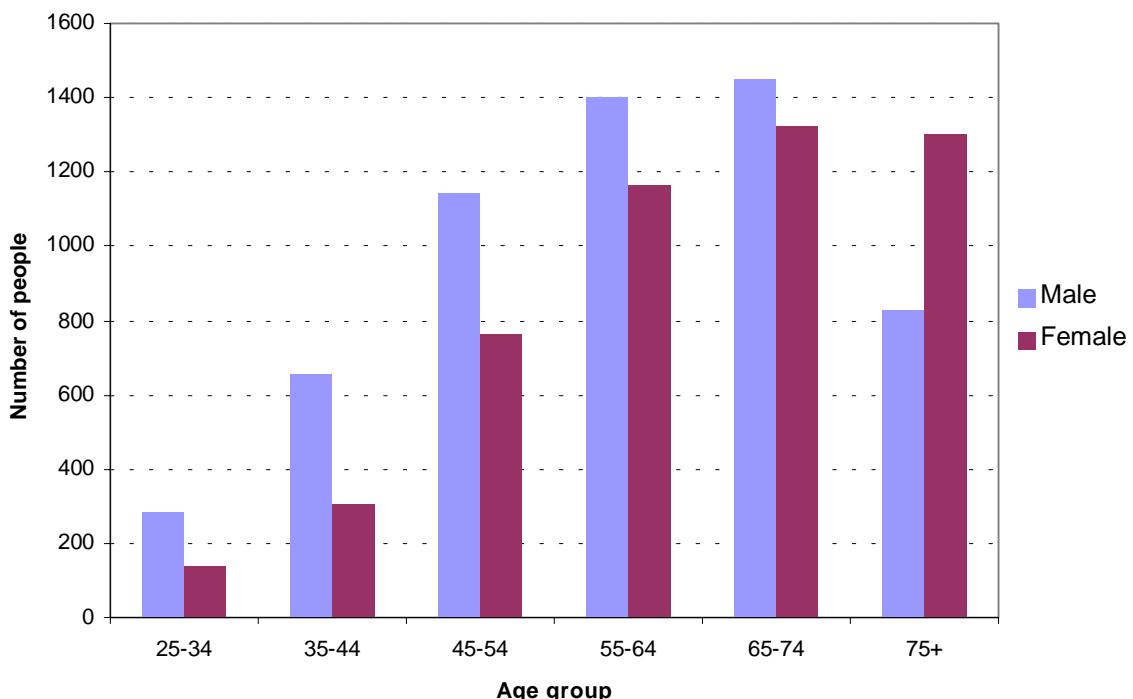
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

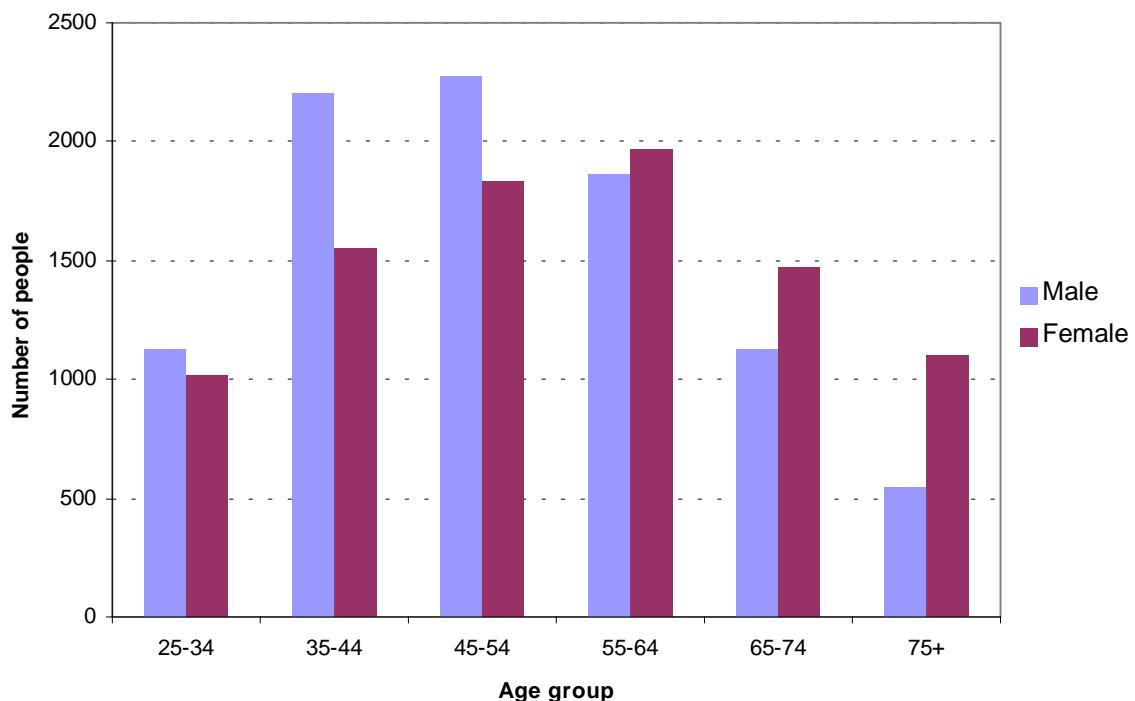
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



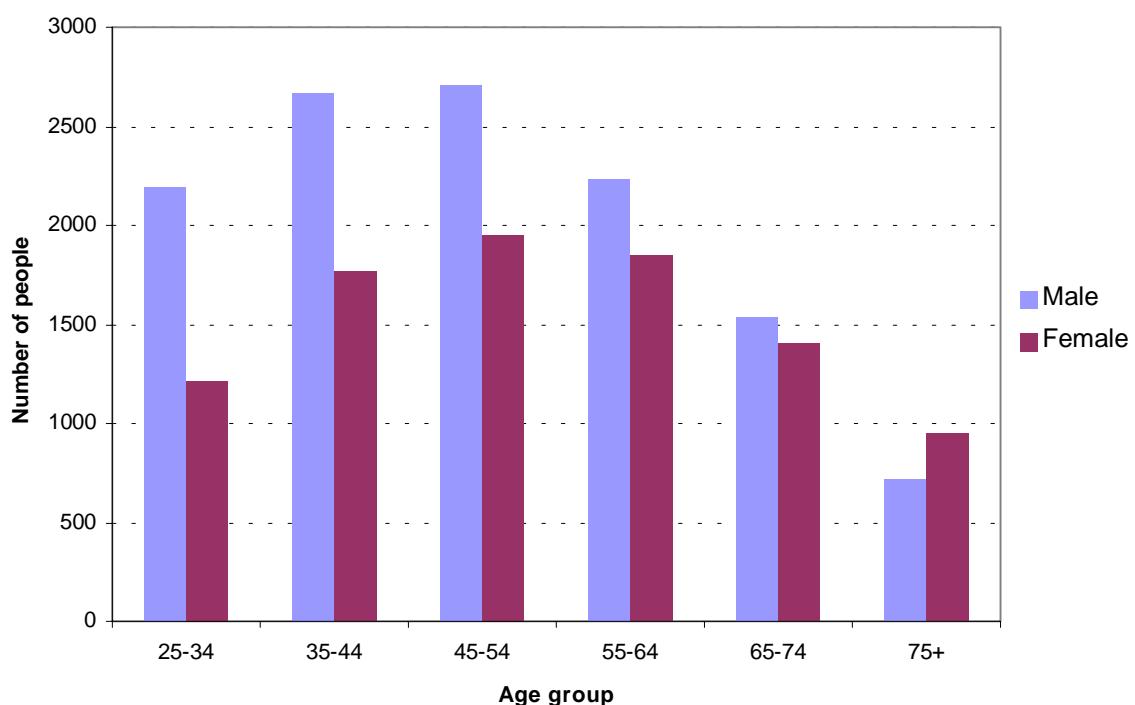
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



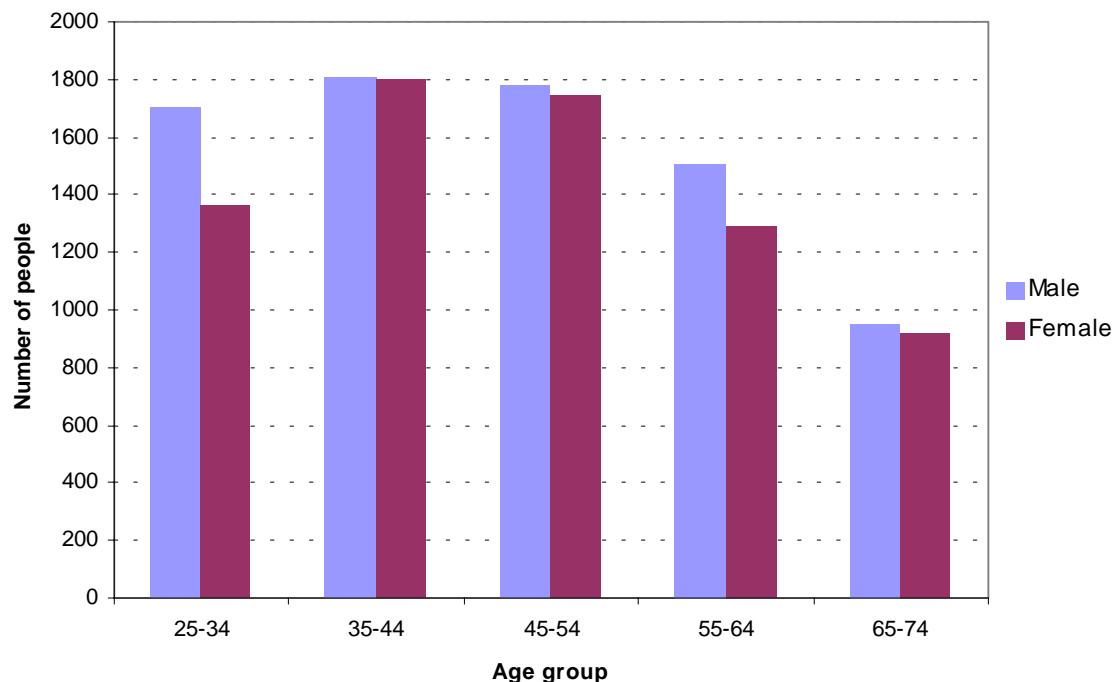
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



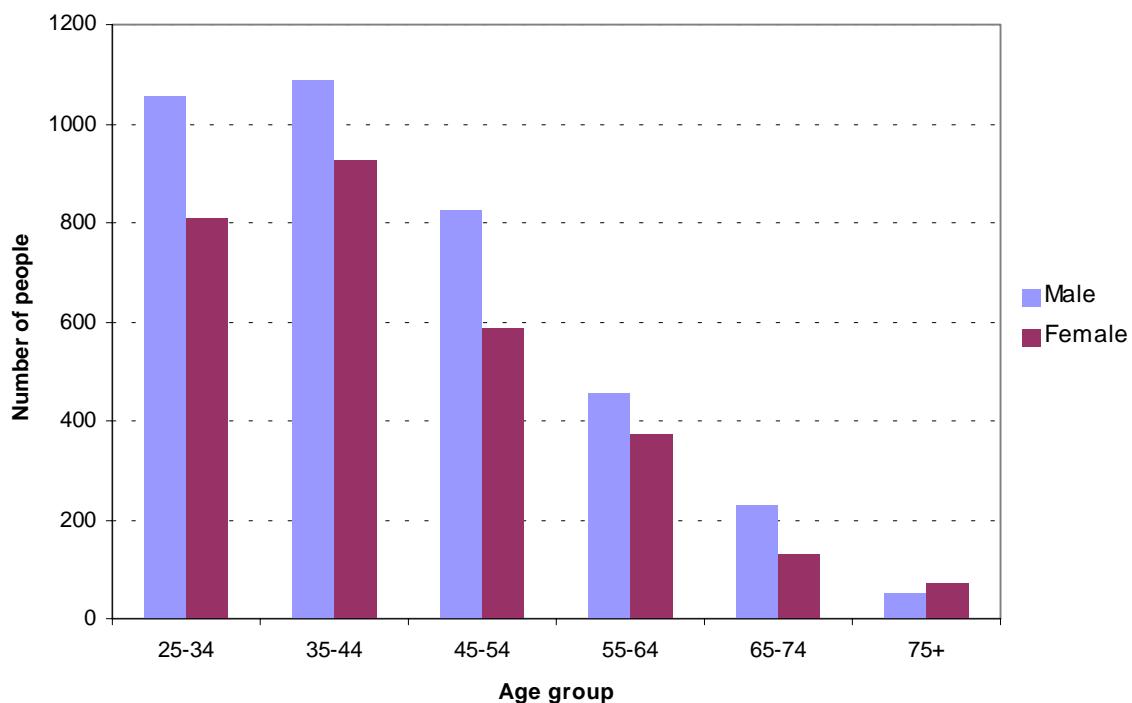
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 35 |
|--------------------------------------------------|-------|----|
-

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Public – diabetes educator, dietitian services (non specialist), Aboriginal health education, generalist nurses,
 - Division – podiatry and dietitian services,
 - Private – podiatry.

- What services are needed but are not available in your Division area?

Public podiatry services are required in all areas, and more diabetes educator and dietitian hours. Specialist services are also required. A private podiatry service is required in Moree and Narrabri.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Barwon Division has a Diabetes Integrated Care program consisting of a register and recall system based on the NSW clinical guidelines for diabetes management and is centralised at the Division. The program is coordinated by a committee of local representatives from local diabetes services. The program commenced in 1998 and data is maintained on a custom built Access database. Patients are recalled every 6 months per the guidelines and the Division has a template for data collection that has been amended over time and now can be used, where appropriate, as a Care Plan – MBS item 720.

The Division has been able to offer participating GPs a clinical audit on diabetes management.

Division Perspective

- What have been the major achievements or highlights of your program so far?

- Increasing support from Division GPs (83% participation),
- Increased registrations; 900 patients, of which 15% are ATSI,
- Establishment of regular diabetes clinics at a local Aboriginal Medical Service,
- Development of a data template that can be utilised, where appropriate, as a Care Plan.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

The major barrier to our program is the fact that it is paper based. We are waiting to incorporate HL7 messaging to overcome this issue.
- What future plans do you have for diabetes management in your Division?

Future plans are centred around the expansion and refinement of the program and continued community promotion of the need for regular, timely diabetes management reviews. We will also be targeting our indigenous population within the Division area.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

A coordinated approach to care of these patients is essential through collaboration and effective two-way communication between the GP, allied health professionals, community health staff as well as the practice nurse and practice staff. Appropriate IM/IT support is also a contributing internal factor.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Strategic alliances have been developed with staff at local community health centres and Aboriginal Medical Service (AMS). We see these alliances as vital to the ongoing success of the program and appropriate collaborative diabetes care for patients. Linkages have been developed over time by means of meetings and discussions focusing on community needs.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

We utilise a Division-developed data collection template (Diabetes Care Plan) and the NSW Guidelines for Management of Diabetes Mellitus as well as the RACGP Guidelines for Diabetes Management.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

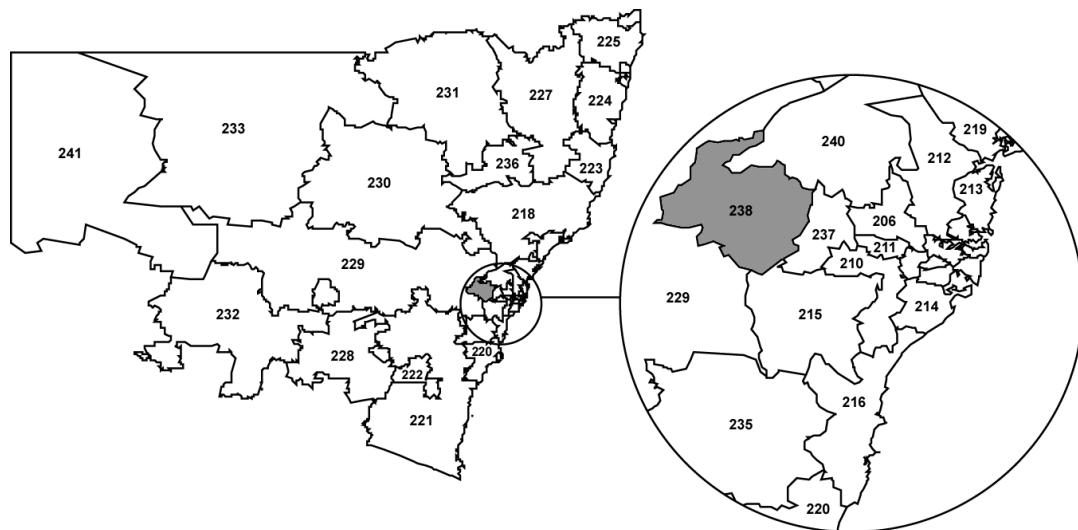
Diabetes Care Plan template.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? No.
- What resource materials do you provide to practices? We provide practices with posters promoting the Division program, a program manual, printed program consents and Diabetes Care Plans. We also provide one-to-one support from program staff to GPs.

Division Contact Person/
Program Co-ordinator

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Blue Mountains DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	73,675	
■ Aboriginal or Torres Strait Islander	866	1.2%
■ Speaks language other than English at home	3417	4.6%
■ RRMA classification ¹		
1: Capital City	73,675	100.0%
■ SEIFA category containing population median: ²	11	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	3889	8.1%
■ High blood pressure ⁴	14,715	30.5%
■ High blood cholesterol ⁵	25,221	52.3%
■ Obese or overweight ⁶	29,138	60.5%
■ Physical inactivity ⁷	20,477	42.5%
■ Smoking ⁸	9123	18.9%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

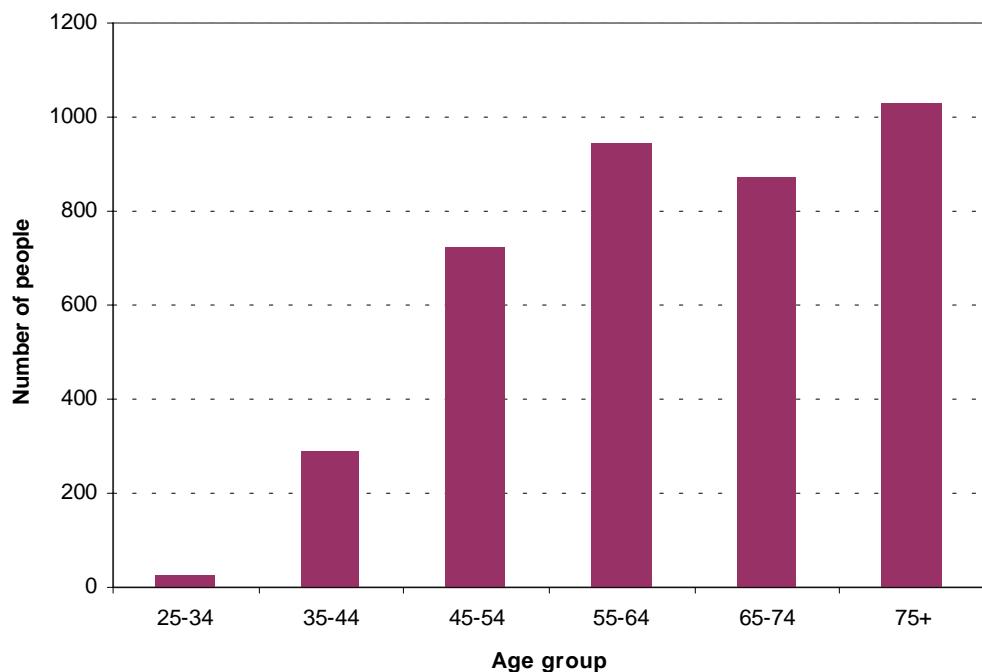
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

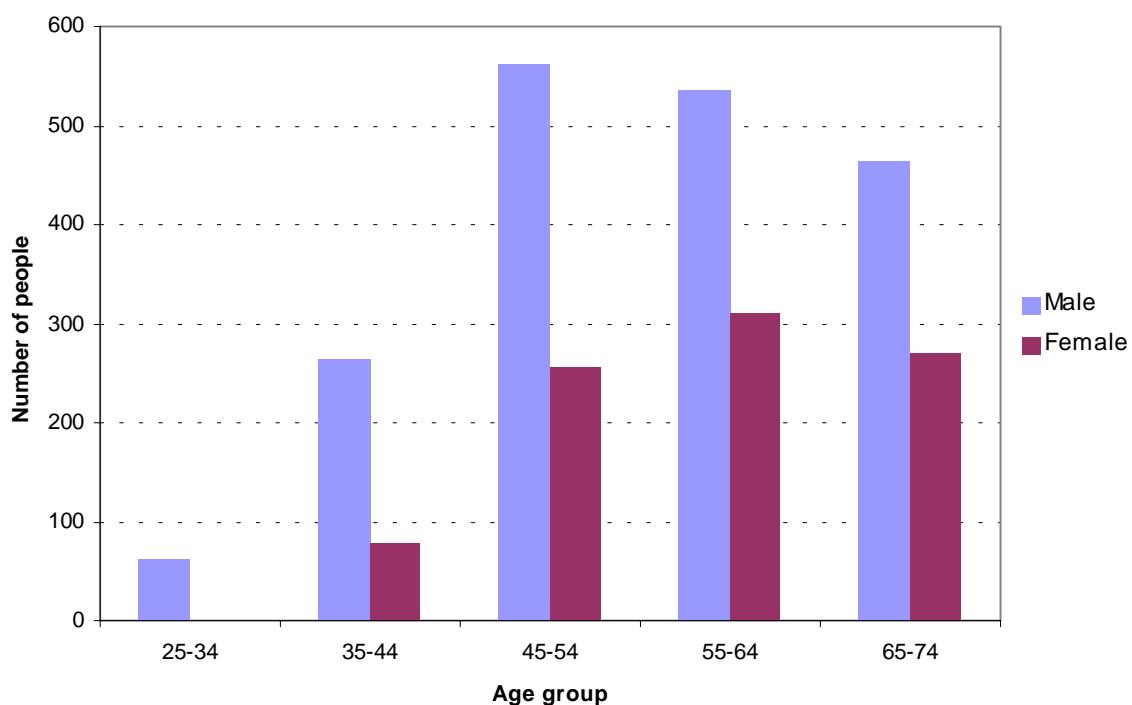
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



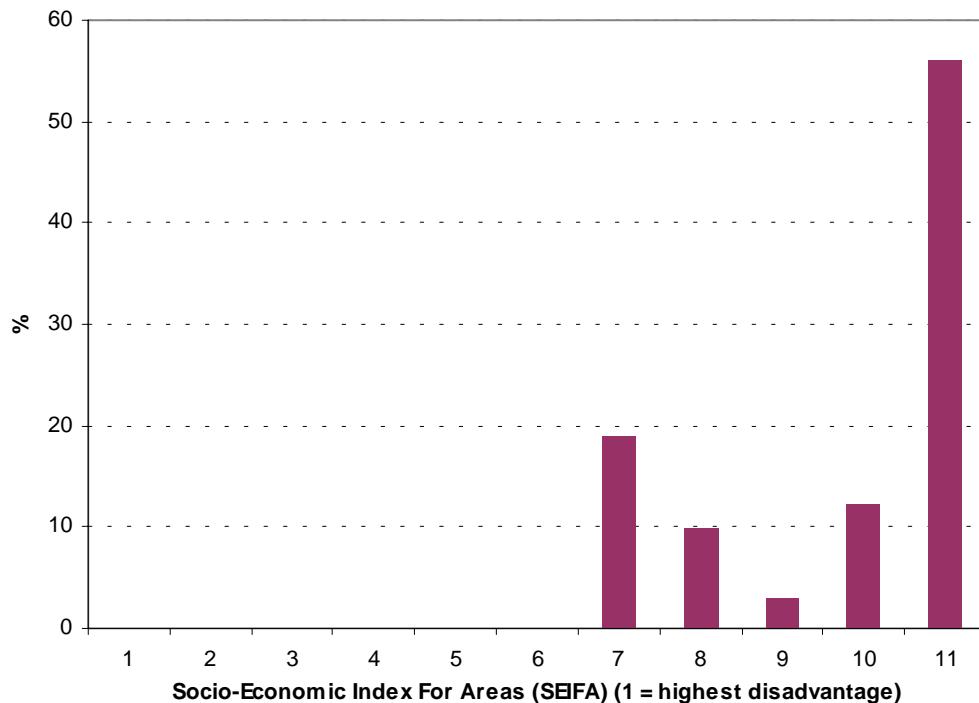
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

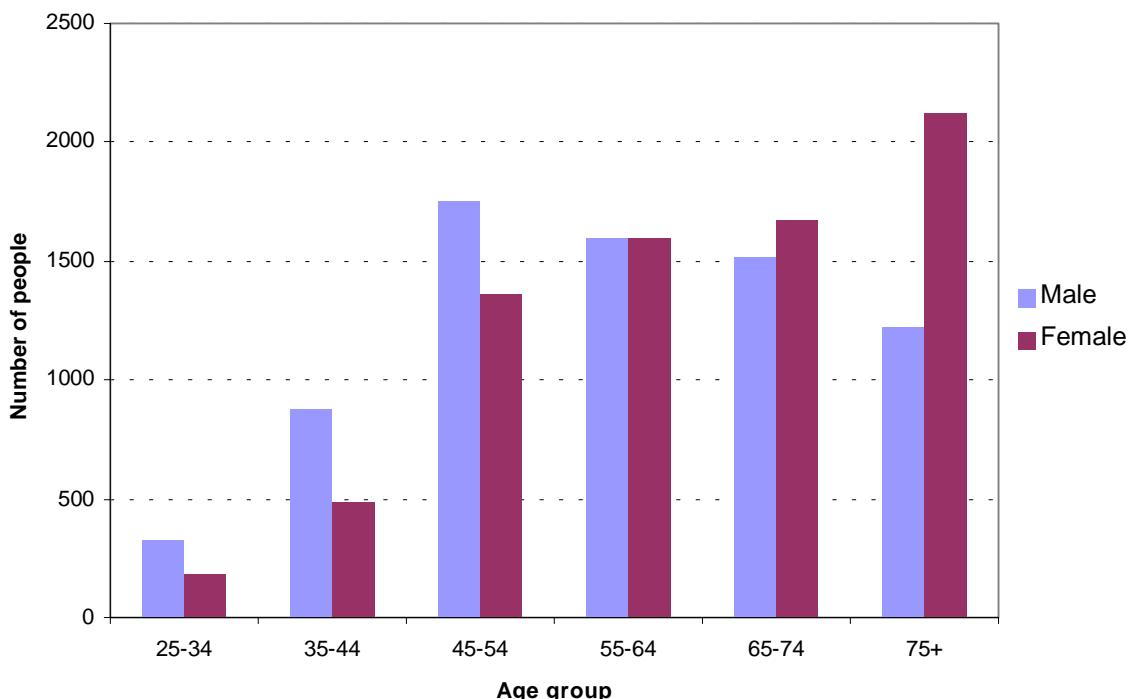
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

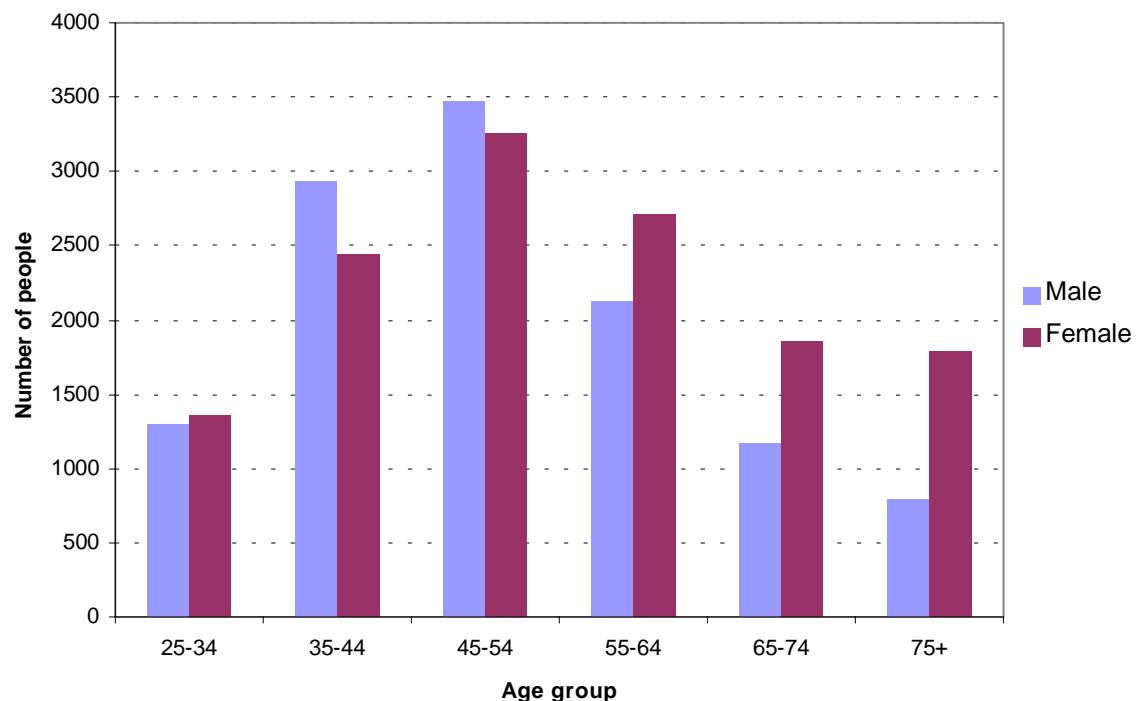
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



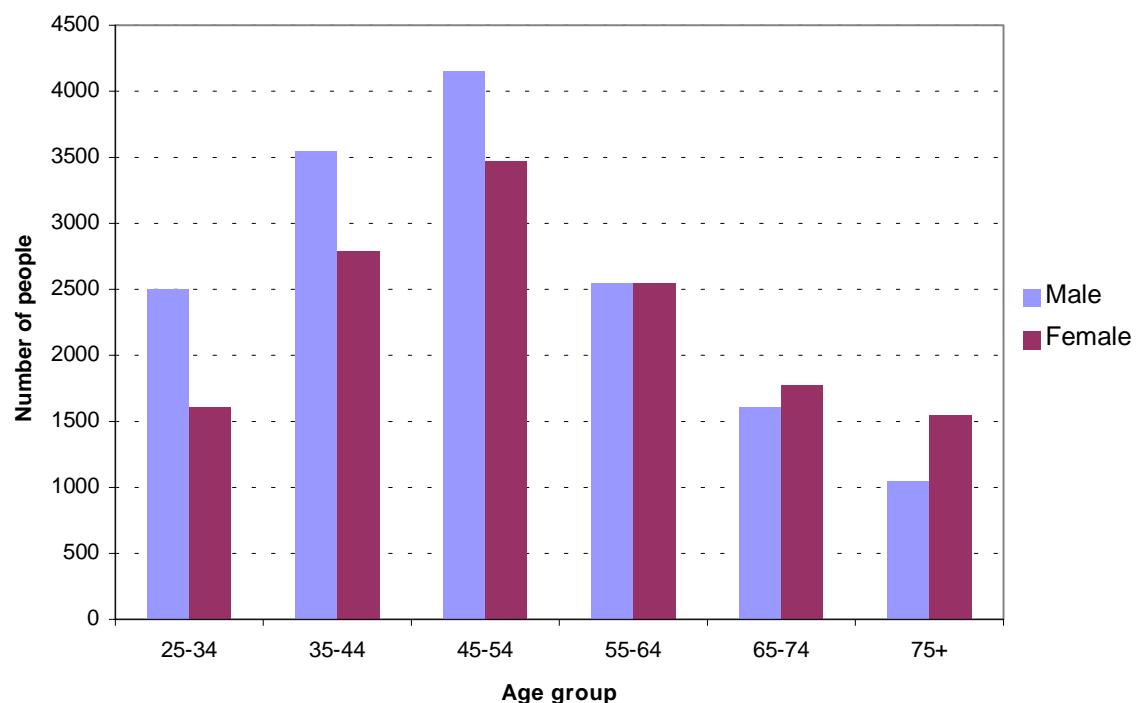
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



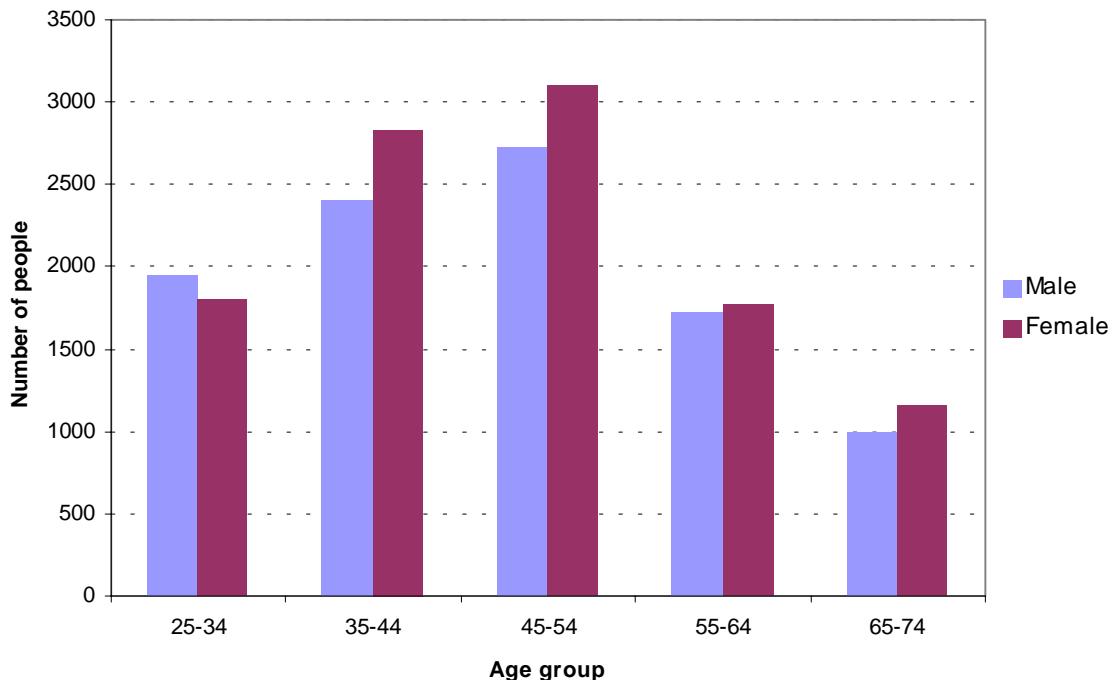
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



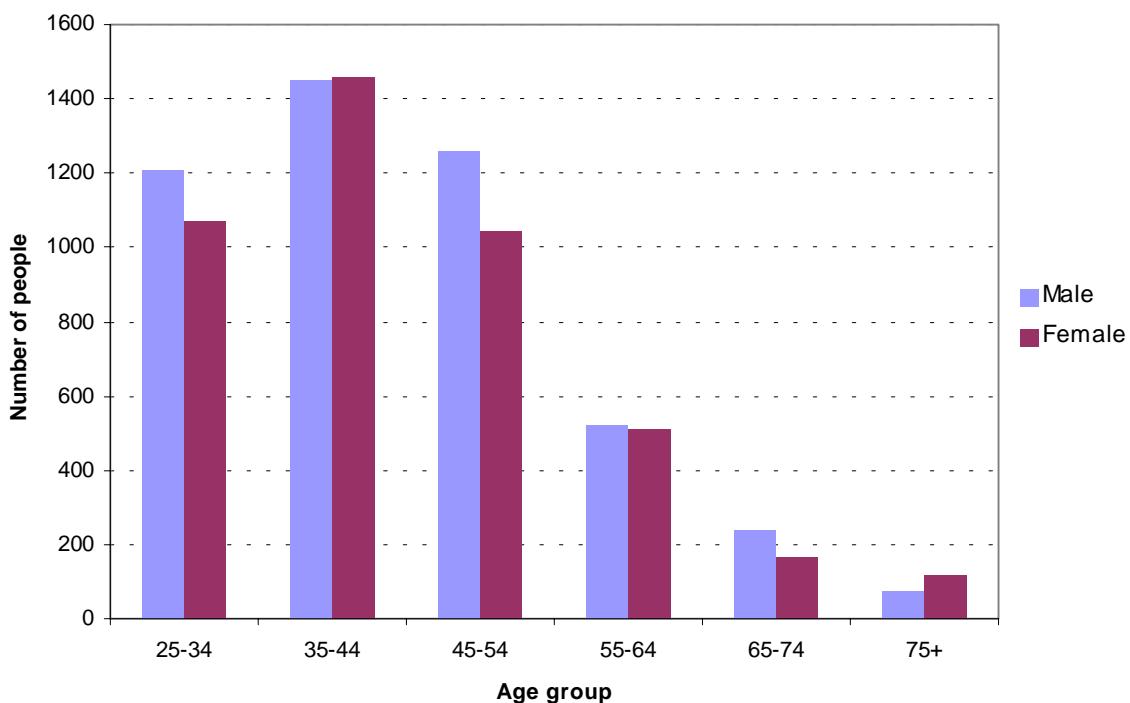
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 64 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

- What services are needed but are not available in your Division area?

The Division provides the services of a diabetes nurse educator and the Area Health Service conducts a diabetes service with dietitians, podiatrists and other professionals.

It would be helpful if there were more nutritional educational services and resources for promotion of healthy lifestyle and the prevention of diabetes.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

- Please describe your diabetes program including any changes that occurred over time?

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

The Diabetes Project conducted by our Division has been active since 1996. The Division maintains a CARDIAB database and GPs register their diabetic patients with the project. GPs advise the Division when the various complications screening tests are conducted. The database generates reports and audits, which flag patients who are overdue for a screening test. The Division then advises the GP, and the patient can be recalled for the test. The Division also provides a Nurse Educator Service to registered patients. Our Nurse Educator is available to see patients at their local GP surgery or Community Health Centre. Complication screening rates as measured in CARDIAB are variable and we believe that this is due to the lack of an electronic data transfer system. If GPs had a system to directly transfer information in Medical Director software to the Division, we believe the screening rate data would be more accurate and positive.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Two-thirds of the estimated diabetic population in our area are registered with our Diabetes Project. Glycaemic control of registered patients continues to improve over the course of the project with proportion of the “good” category improving from 32% pre-project to 55% in June 2002.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

The lack of an electronic data transfer system from Medical Director software to CARDIAB.
- What future plans do you have for diabetes management in your Division?

To implement an electronic data transfer system which will encourage more GPs to participate in the project by eliminating excessive paperwork.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

 - Commitment,
 - Empowered practice staff,
 - An interest in diabetes, and
 - An appreciation of the value of the diabetes project.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

We have developed links with our Area Health Service, the other two Divisions in our area, the University of New South Wales and the CARDIAB Alliance.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

 - CARDIAB,
 - The University of New South Wales, and
 - The Wentworth Area Diabetes Service.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Process and systems, templates and advice.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

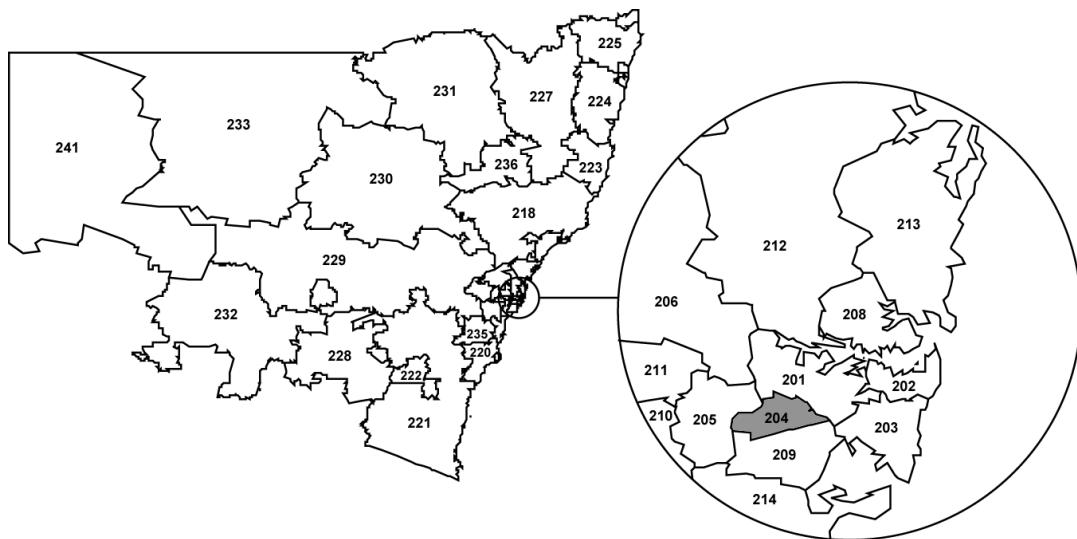
An electronic data transfer system from Medical Director software to CARDIAB.

- What resource materials do you provide to practices?
 - Registration forms,
 - Review forms,
 - Clinical audits,
 - Recall lists,
 - Feedback from education sessions,
 - Patient information cards,
 - Brochures and leaflets.

Division Contact Person/
Program Co-ordinator

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Email: Leila@bmdgp.com.au

Canterbury DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	136,822	
■ Aboriginal or Torres Strait Islander	653	0.5%
■ Speaks language other than English at home	85,664	62.6%
■ RRMA classification ¹		
1: Capital city	136,822	100.0%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6901	7.7%
■ High blood pressure ⁴	26,406	29.4%
■ High blood cholesterol ⁵	45,464	50.6%
■ Obese or overweight ⁶	53,641	59.7%
■ Physical inactivity ⁷	37,944	42.3%
■ Smoking ⁸	17,443	19.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

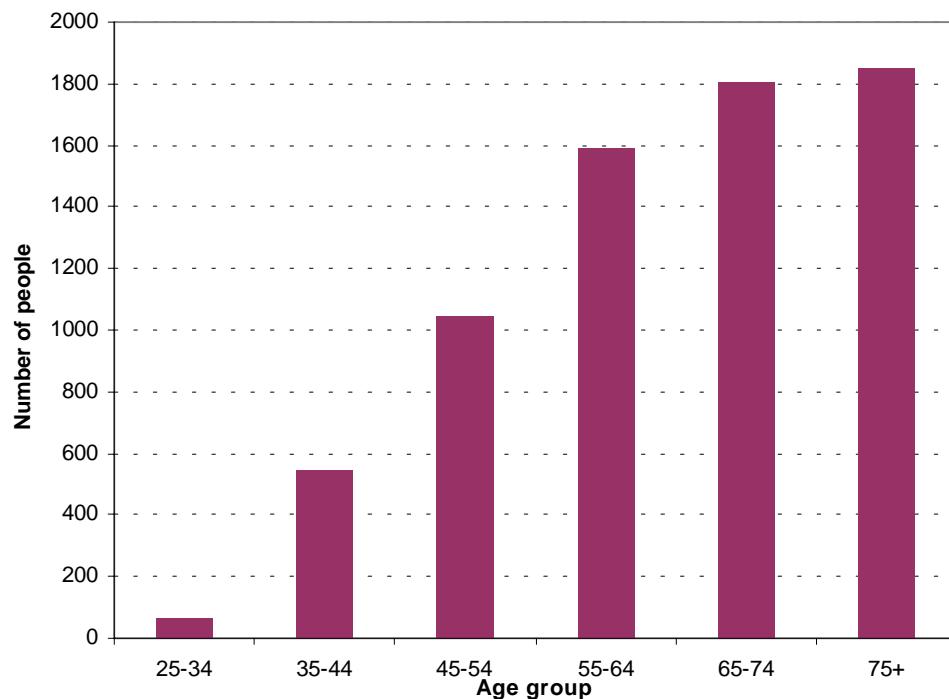
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

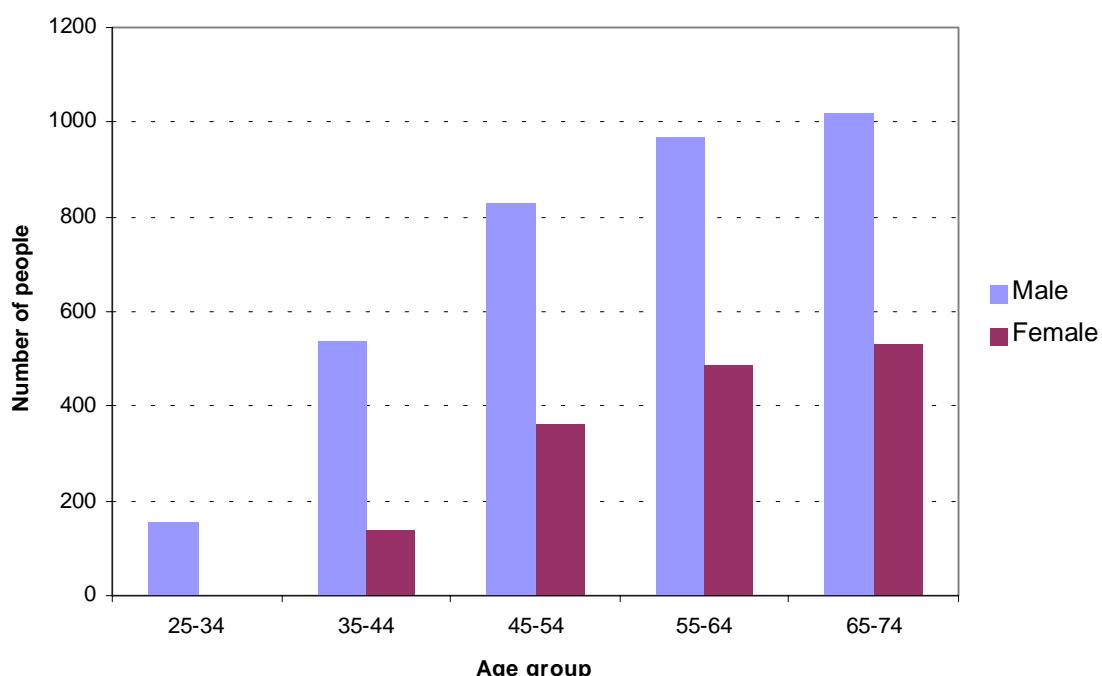
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



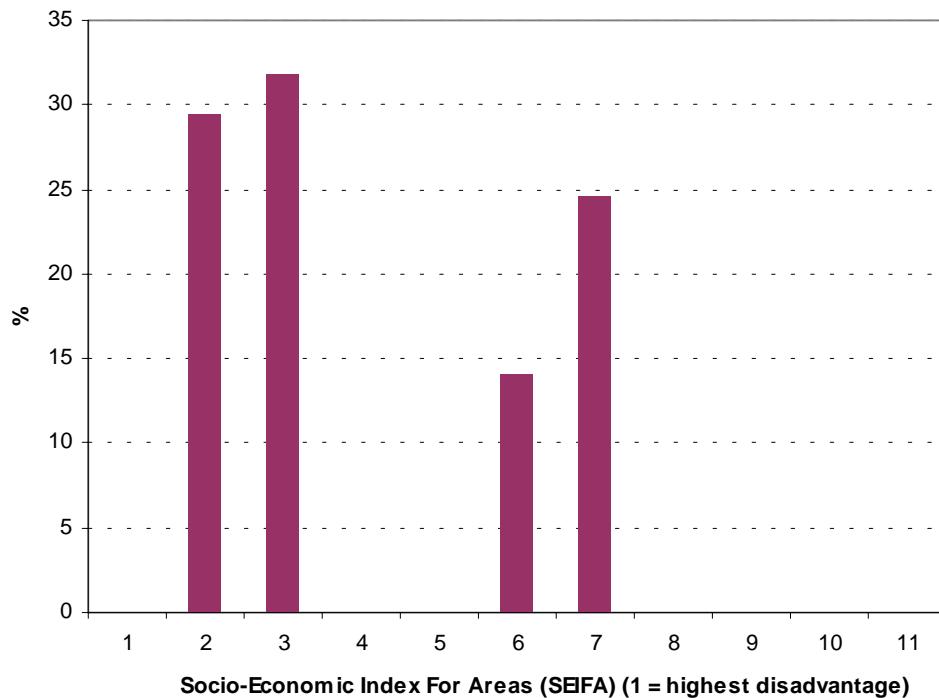
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

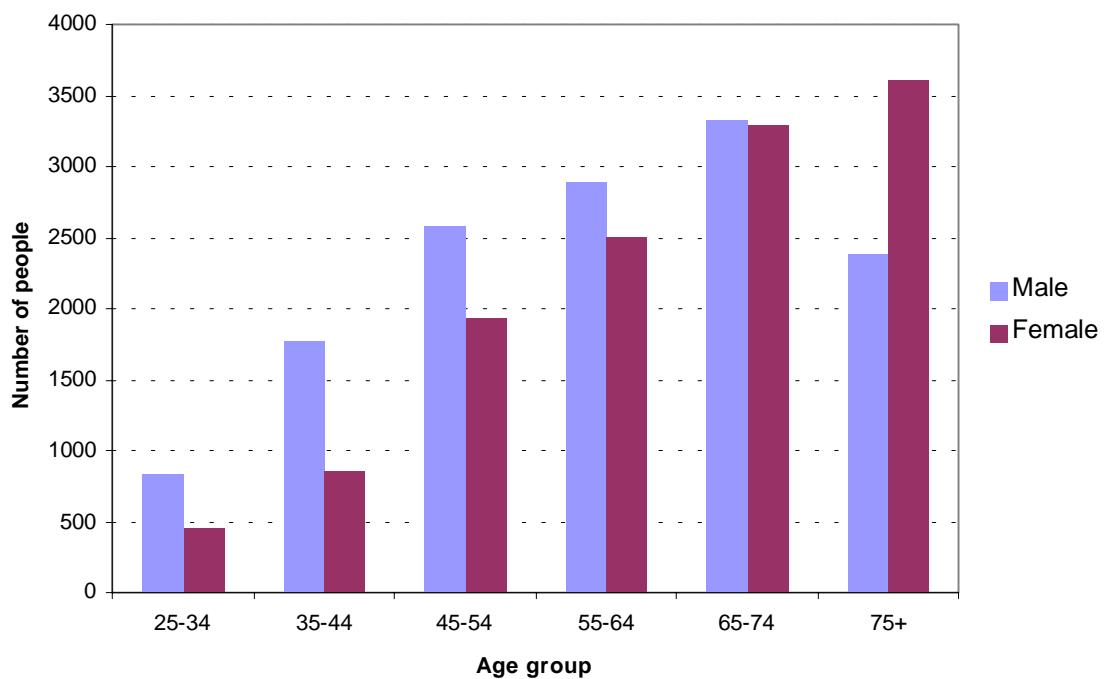
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

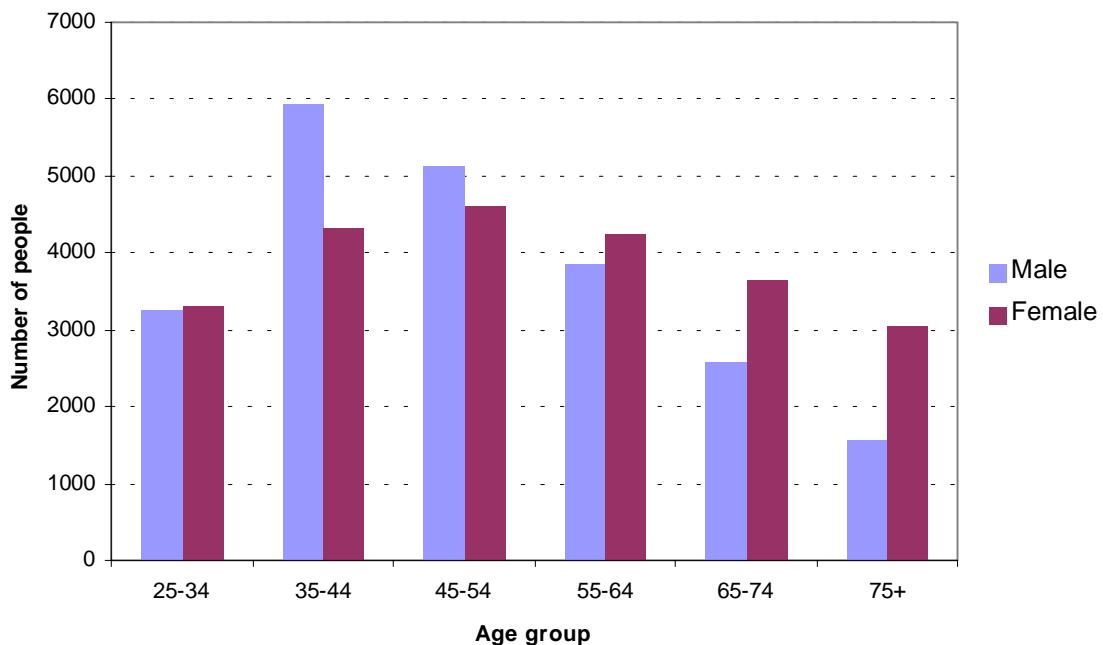
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



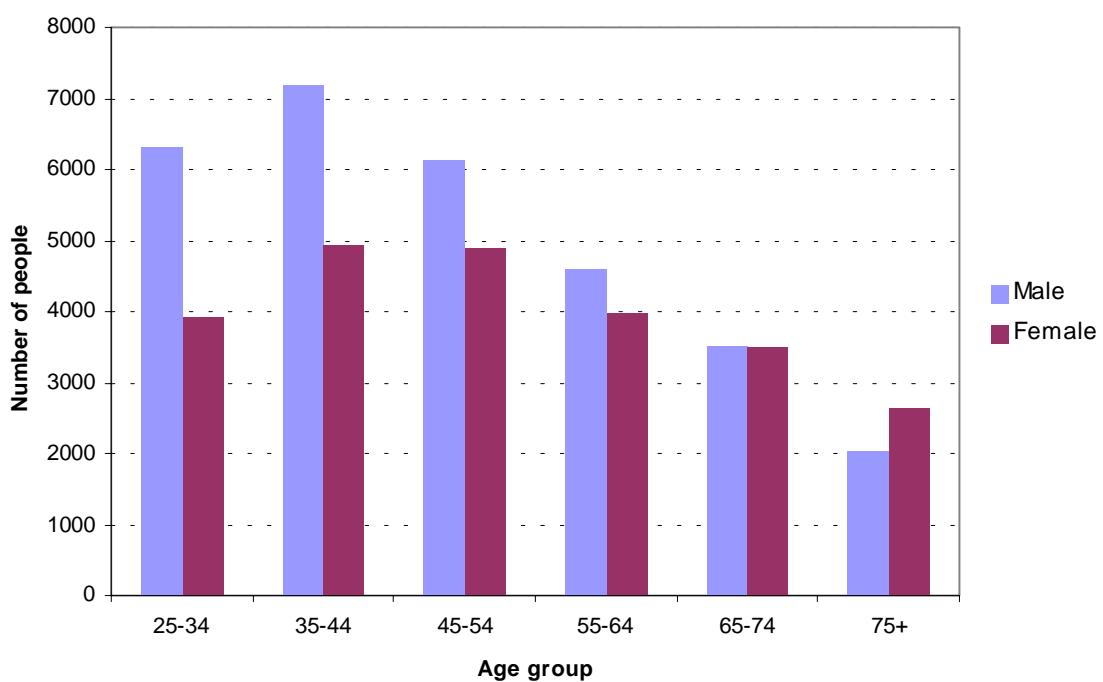
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



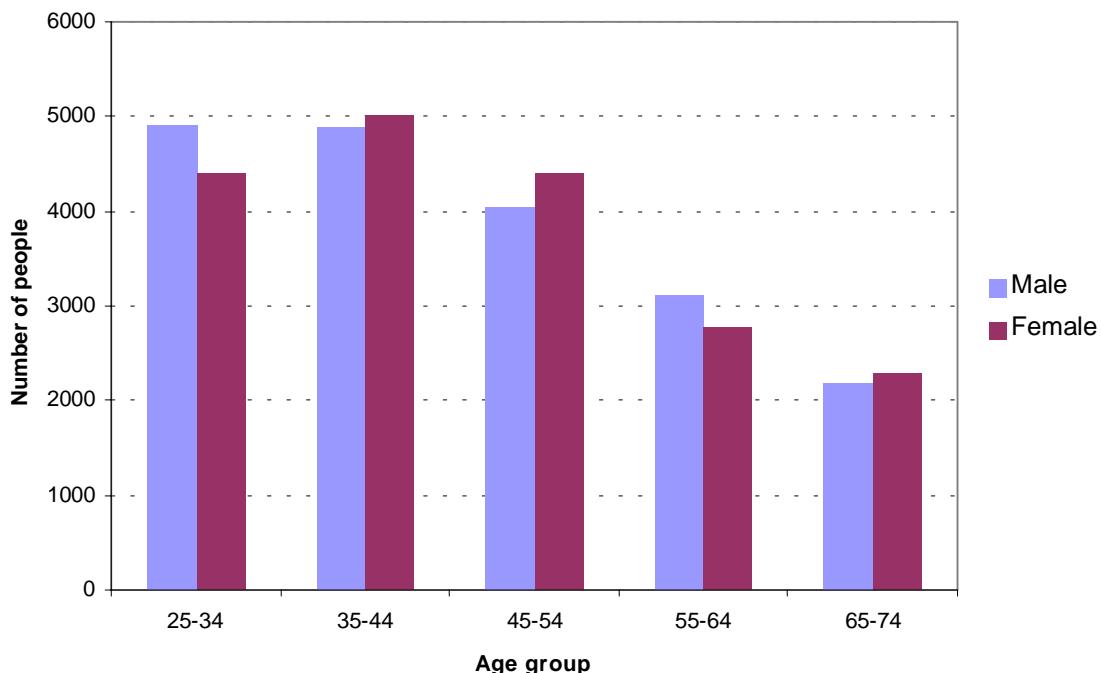
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



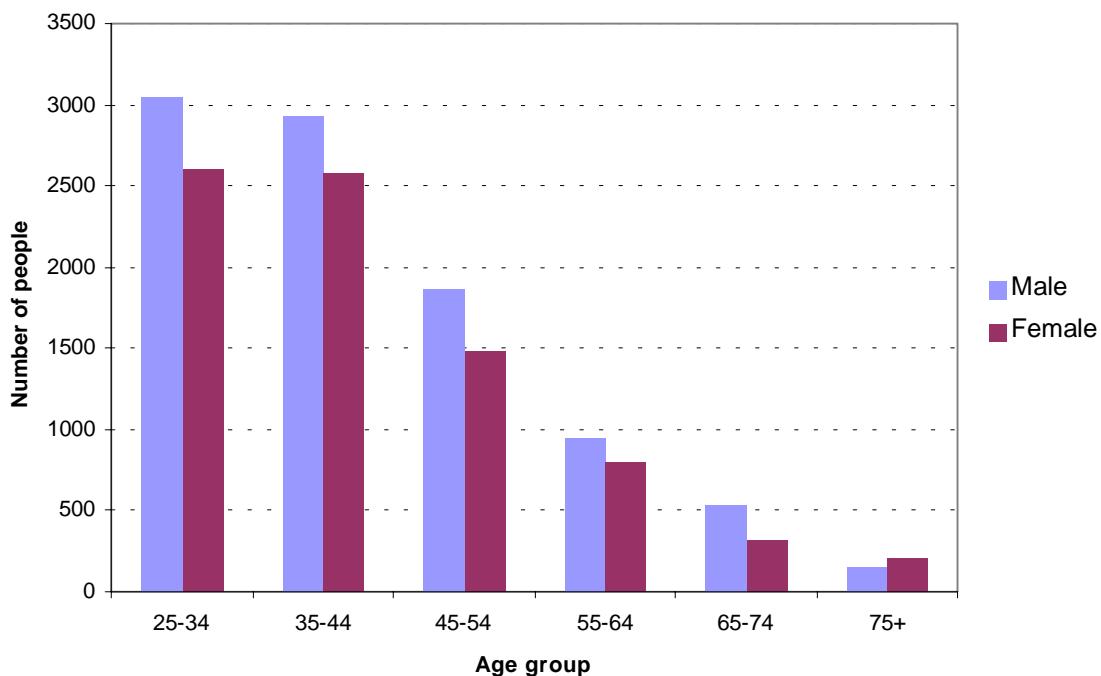
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 194 |
|-----------------------------------------------|-------|-----|

Division Comments

- | | |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| ▪ Do you have any comments about the nature of the population in your area? | The Canterbury area is situated in the inner west of Sydney and is an area of high cultural and linguistic diversity. |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|

In the 2001 census 44% of people stated they were overseas born, the three main countries of birth were:

- | | |
|--------------------------------------------------|------|
| • China | 6.4% |
| • Lebanon | 5.8% |
| • Greece | 4.8% |
| • 0.51% of people identified as being Indigenous | |

English was stated as the language spoken at home by 30%. The three most common languages spoken at home were:

- | | |
|-------------------------------|-----|
| • Arabic (including Lebanese) | 14% |
| • Greek | 11% |
| • Chinese languages | 11% |

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Acute Intervention Clinic (endocrinologist, diabetes educator, dietitian, podiatrist), two half-day clinics (Wednesday mornings and Friday afternoons),
 - High-risk foot clinic,
 - Diabetes Australia branch (shared with Bankstown).

- What services are needed but are not available in your Division area?
 - Fitness classes designed for diabetics from certain cultural groups,
 - Expansion of the already available services at Canterbury Hospital, ie endocrinology, podiatry, dietetics, and diabetes educators.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The program employs multiple strategies, including:

- Collaboration: Collaboration with local service providers whenever possible, eg local diabetes clinic to deliver Continuing Professional Development (CPD) activities, to have joint research quality improvement activities,
- Integration: Planning and delivery of program activities with other programs, eg with Enhanced Primary Care (EPC) to develop sample care plan for diabetics, and with Domiciliary Medication Management Review (DMMR) to deliver CPD (to local pharmacists),
- Education: The use of clinical attachments, as well as usual CPD to improve knowledge and provide current information,
- Networking: Facilitate networking between local service providers and GPs. Use functions such as End-of-the-Year party, CPD, clinical attachment, etc,
- Resources Development: Develop and distribute resources that encourage best practice, reduce GP workload and improve patient health outcomes, eg clinical

management checklist, step-by-step guide to the establishment of a diabetes register and recall/reminder system using “Medical Director”.

These strategies have been used since January 2000.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Plan and implement a clinical attachment program with the diabetes clinic,
 - Joint program activities with EPC.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Limited GP engagement as a result of GP time restraints,
 - Limited Divisional resources impact on program delivery.
- What future plans do you have for diabetes management in your Division?
 - Expand the recall/reminder service to other clinical areas such as gestational diabetes (GDM) and impaired glucose tolerance (IGT),
 - Promote the use of desktop prescribing software,
 - Establish ethno-specific fitness classes to cater for diabetes groups (Arabic ladies, Chinese, etc).
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Access to the initiatives may be influenced by accreditation and the PIP,
 - Practice population breakdown,
 - GP motivation,
 - Time constraints,
 - GP engagement with the Division and access to guidelines, CPD etc.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Local diabetes clinic – to collaborate service planning and provision, joint research projects.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP diabetes management in general practice,
 - Alliance of NSW Divisions web site,
 - State and Commonwealth Department initiatives on web sites.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Sample care plan for patients with diabetes,
 - Step-by-step guide to the establishment of a diabetes register and recall/reminder system using “Medical Director”,
 - Diabetic foot assessment protocol.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Weight management guidelines (for diabetics and non-diabetics).
- What resource materials do you provide to practices?
 - Clinical decision flowchart,
 - Sample care plans, step-by-step guide to the establishment of a diabetes register and recall/reminder system using “Medical Director”,
 - Assessment tools for patient record,
 - List of local services relevant to the management of diabetes.

Division Contact Person/
Program Co-ordinator

Name: Christine Mak
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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Cardiologist (physician) in The Canterbury Hospital (TCH) and private sector.
- What services are needed but are not available in your Division area?
 - Cardiac Rehab Program (including patient education),
 - Lipids Clinic (high prevalence of overweight/obesity and dyslipidaemia).

CVD Program Description

- In which years did you have a CVD project or program operating:

 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?

The CVD and diabetes program have been merged.

Division Perspective

- What have been the major achievements or highlights of your program so far?

N/A.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Limited Divisional resources impact on program delivery.
- What future plans do you have for CVD management in your Division?

N/A.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Consider local needs (GP and community) and available local services,
 - Assess available Divisional resources.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them? N/A.

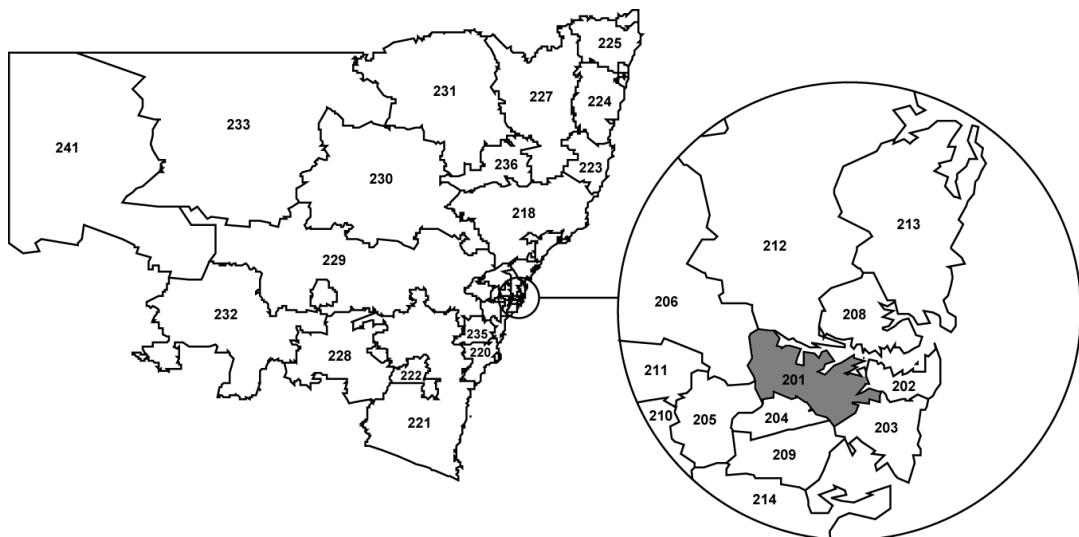
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - NHF Guidelines and web sites,
 - RACGP Guidelines.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? N/A.

Division Contact Person/
Program Co-ordinator

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Central Sydney DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	331,697	
■ Aboriginal or Torres Strait Islander	3163	1.0%
■ Speaks language other than English at home	112,820	34.0%
■ RRMA classification ¹		
1: Capital city	331,697	100.0%
■ SEIFA category containing population median: ²	9	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	15,734	6.9%
■ High blood pressure ⁴	61,348	26.8%
■ High blood cholesterol ⁵	111,919	48.9%
■ Obese or overweight ⁶	134,066	58.6%
■ Physical inactivity ⁷	97,075	42.4%
■ Smoking ⁸	46,168	20.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

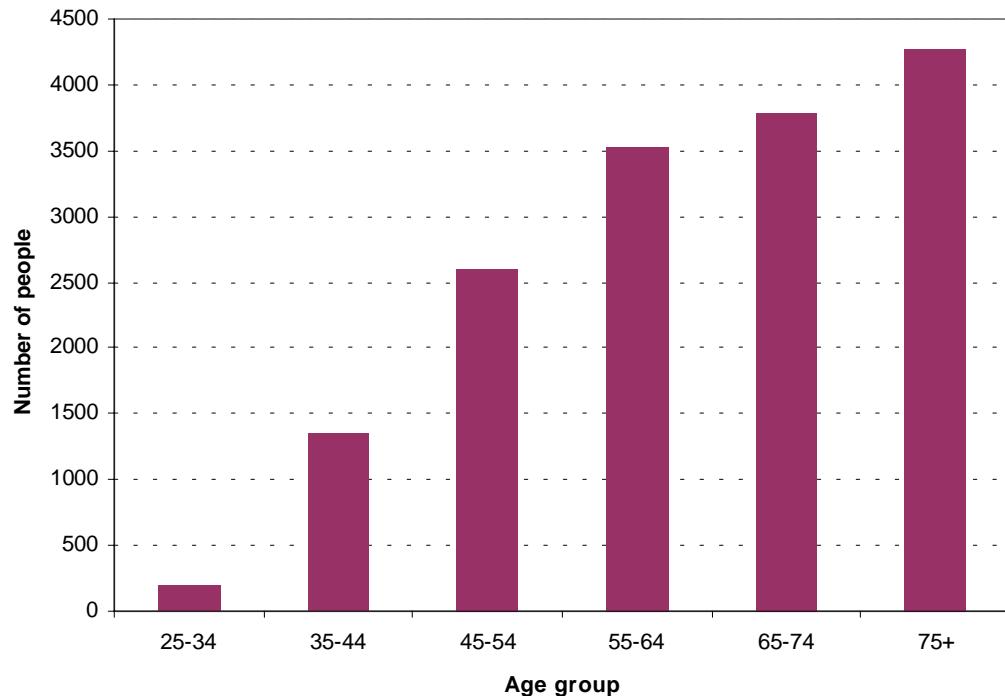
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

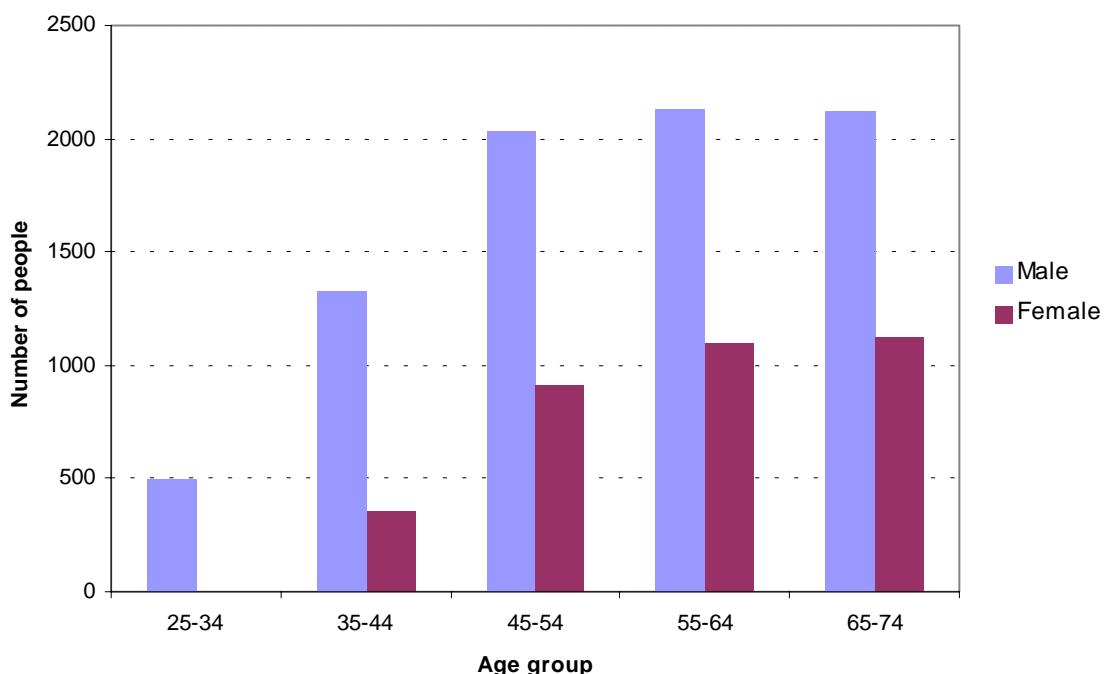
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



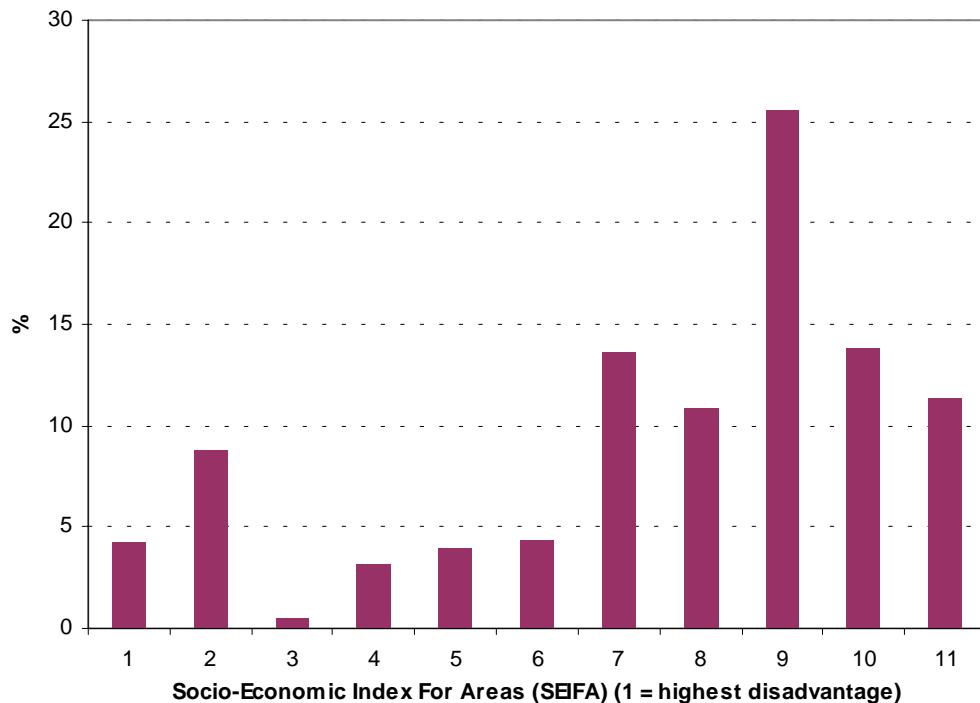
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

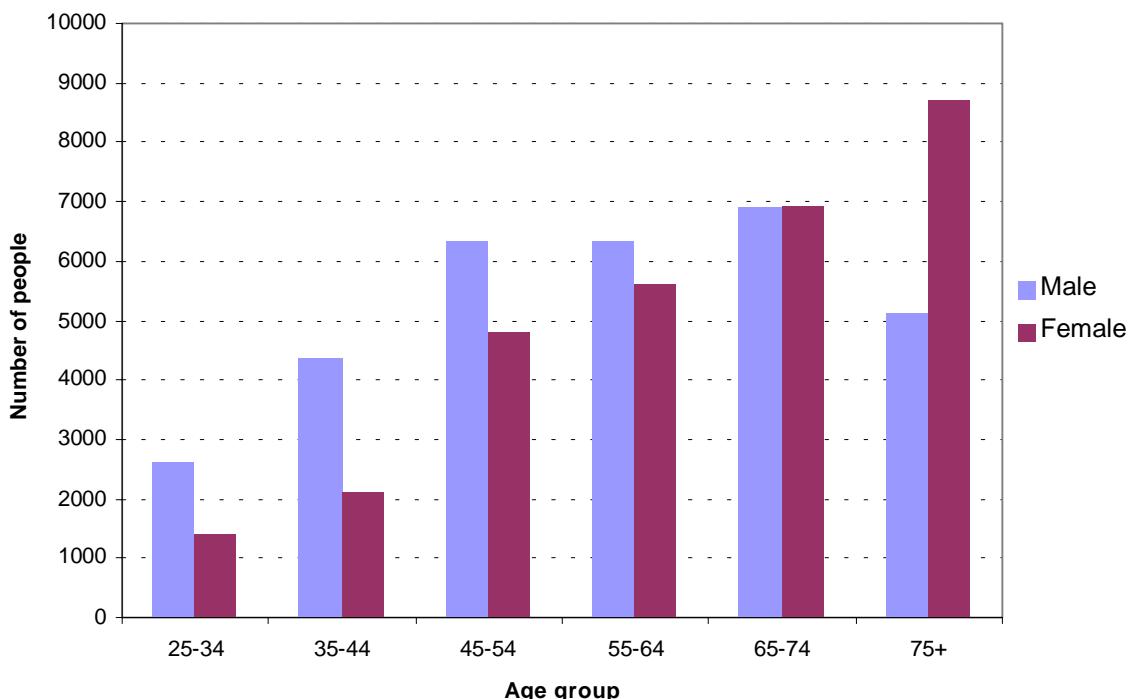
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

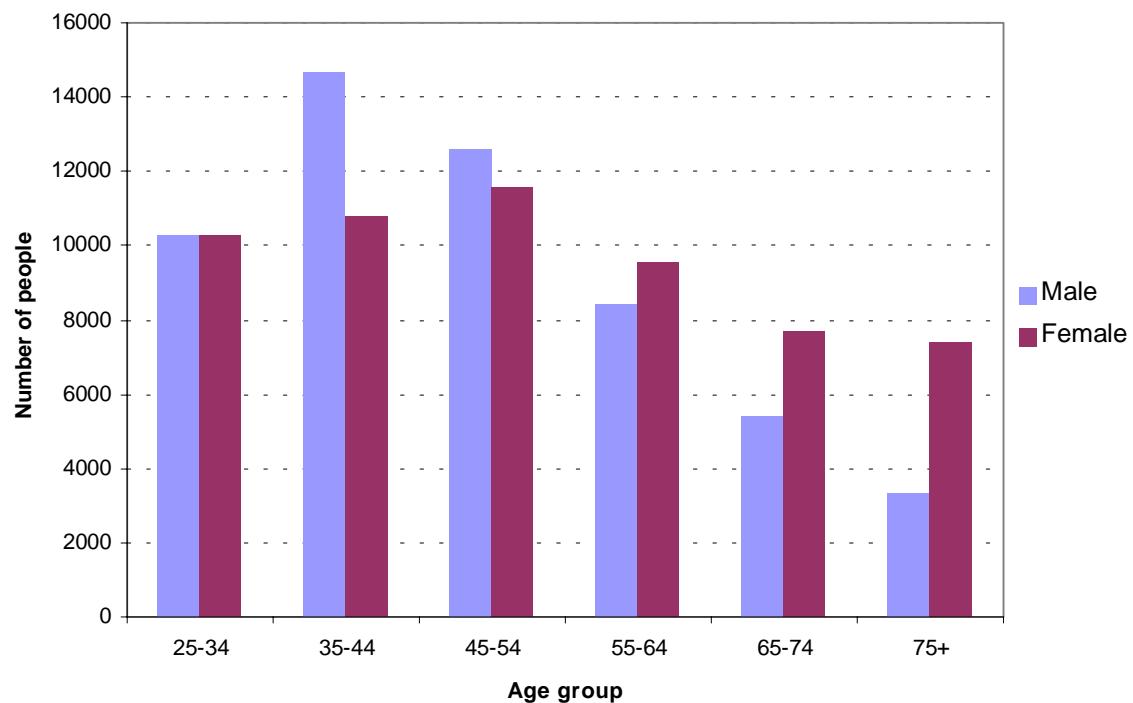
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



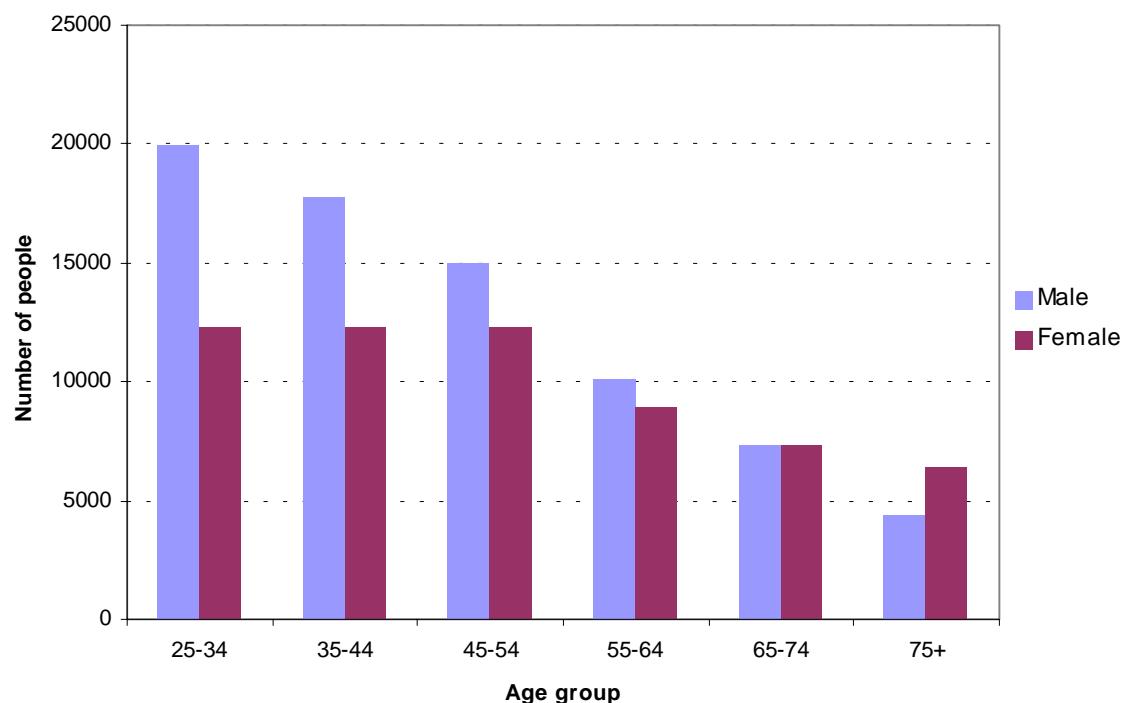
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



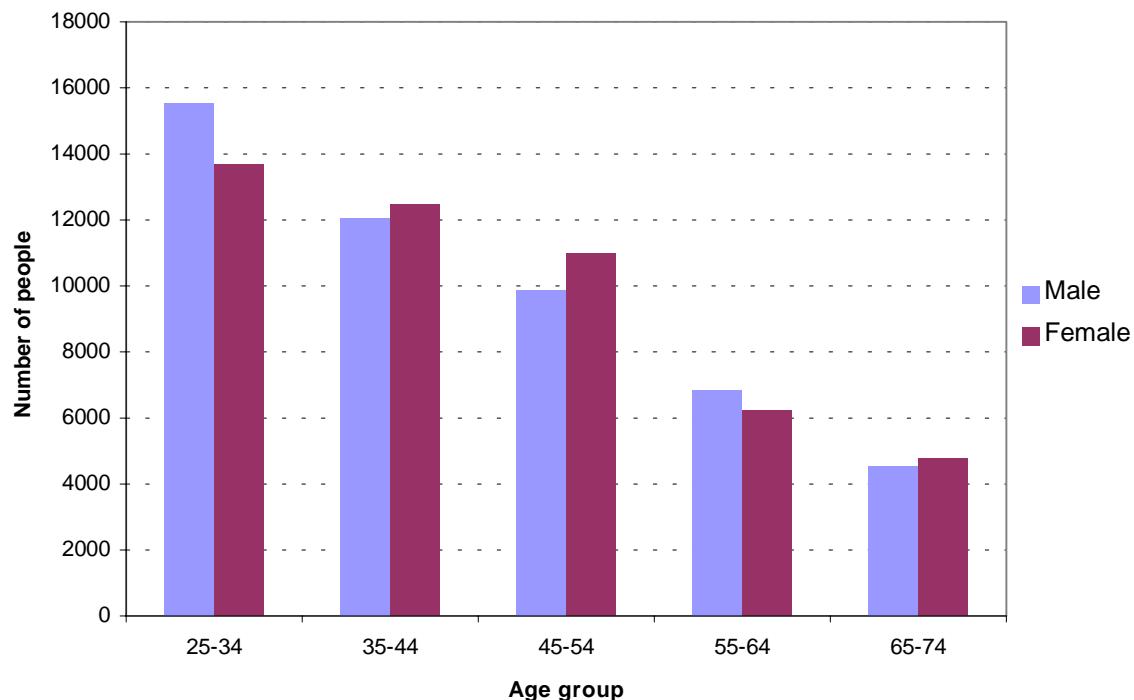
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



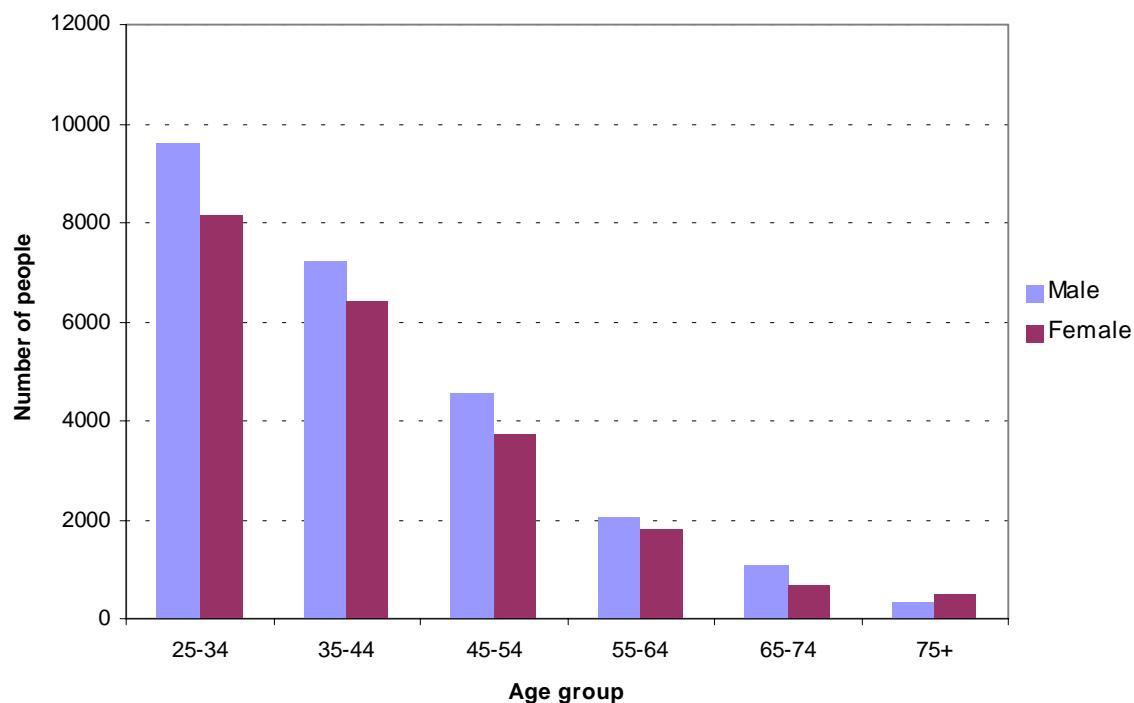
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 625 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Royal Prince Alfred (RPA) and Concord Hospital Diabetes Centres,
 - ReMinD – Diabetes/Vascular Recall and Management Program,
 - Diabetes Australia – including local support groups,
 - Outpatient podiatry services at RPA,
 - High risk podiatry clinic,
 - Streamlined access to dietetics department at RPA,
 - Central Sydney Area Health Service (CSAHS) is well serviced by ophthalmologists and optometrists,
 - Directory to private podiatrists with interest in diabetes,
 - Complications Assessment Clinic,
 - Ambulatory stabilisation,
 - High risk foot education and treatment clinics,
 - Consultations for complicated cases including gestational diabetes mellitus (GDMs).

- What services are needed but are not available in your Division area?
 - More access to public podiatry services,
 - Multilingual education classes for diabetes and diets,
 - Facilities for exercise in patients who are obese with lower limb osteoarthritis.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

ReMinD is a recall system aimed at:

- Developing sustainable recall of patients with diabetes or vascular risk factors using a six month recall, or in the case of insulin dependant diabetes, a three month recall. The system has a partnership with local pathology companies (who send recall letters and collect data) and the RPA diabetes centre,
- Facilitating regular surveillance and optimal treatment of patients with diabetes based on

the latest NSW Health guidelines,

- To collect outcome data for people with diabetes and vascular risk factors living in Central Sydney Area Health Service (CSAHS). Additional data is collected by the GP and is entered with the pathology results into a database and sent annually to RPA Diabetes Centre.
- GPs are given annual feedback on their patient outcome data.
- Changes in the ReMinD program now include people with vascular risk factors,
- Ensuring that GPs using the program are Service Incentive Payment (SIP) compliant,
- Developing small group workshops in an attempt to raise the level of care and actively attempting to access specialist clinic services in a more appropriate and efficient manner,
- We have people on this program who have had up to twelve visits,
- There is a return rate in ReMinD of:
 - 52% between the initial and second visit,
 - 70% between the second and third visit,
 - 73% between the third and fourth visit.

Division Perspective

- What have been the major achievements or highlights of your program so far?
- We now have over 140 GPs participating in the program as of December 2001, with over 1,400 people enrolled, some having returned for 11 cycles of care,
- All major pathology companies within the CSAHS are involved,
- Reformatting data collection forms and protocols to ensure best practice and SIP compliant. Obtaining clinical audit points for participating GPs,
- The body of data collected is really quite useful for research evaluation purposes. Self-sustaining compared to other existing models being used. We are in the process of giving other Divisions full and free access to ReMinD in an effort to establish ReMinD as a major tool in the management of diabetes by GPs in all Divisions,
- Unique evaluative software, which is self-sustaining, independent of data entry.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Change of staff and divisional infrastructure has limited the dissemination and promotion amongst GPs,
 - Other Divisions attempting to duplicate ReMinD are confusing pathology companies by setting up different protocols, thus the need to stamp ReMinD as the major program.
- What future plans do you have for diabetes management in your Division?
 - Get more GPs and their patients involved in ReMinD,
 - Workshops to really lift the standards of care in the basic management of diabetes and secondary failure (currently working with RPA Diabetes Centre),
 - Continuing to embrace the management of all macro vascular risk factors including diabetes in an integrated approach,
 - Disseminating ReMinD to all Divisions in Australia.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GPs wanting to provide best care for their patients,
 - Communication – GPs informed about patient admission, impending discharge, being involved in some basic discharge management,
 - A clear idea of GPs role in program (flowcharts, contact numbers),
 - GPs knowing the contact person running the program,
 - Ensure that the program which is set up has sufficient input initially to ensure that it is GP friendly and useful,
 - The program should leave behind some permanent changes in the infrastructure that will allow the program to continue when funding has ceased,
 - Short-term projects that vanish have poor GP uptake.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - We have good relationships with local pathology companies,
 - Diabetes Centre – working closely with them to develop diabetes workshops and regular Continuing Professional Development (CPD) presentations,

- National Heart Foundation (NHF) – by promoting their programs,
- Diabetes Australia – by inviting them to CPD events, using GPs to present at their conferences (Living with Diabetes).

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - State-based resources,
 - National criteria Practice Incentive Payments (PIP),
 - NHF guidelines for management of hypertension, dislipidemia, and physical activity,
 - Local expert advice from the major specialist clinics.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices?
 - Data collection forms,
 - Patient information sheets,
 - Patient consent forms.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Extensive and comprehensive investigative services available, ranging from stress tests, ambulatory monitoring, blood pressure (BP) monitoring, full range of echo facilities, coronary angiograms, all levels of interventional procedures and electro-physiological studies, Hypertrophic Obstructive Cardio Myopathy (HOCM) clinics, and cardiac rehabilitation,
 - All these are available both publicly and privately with Strathfield Private Hospital showing itself as being a private facility of excellence to complement the public system.

- What services are needed but are not available in your Division area?
 - More smoking cessation clinics,
 - Multilingual education services,
 - Improve patient admission/discharge communication between hospitals and GPs,
 - More cardiac rehab facilities – public and private.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your CVD program including any changes that occurred over time?

It is an integral part of ReMinD (Diabetes/Vascular Recall and Management Program) and cannot be seen as a separate entity.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Dissemination and implementation of National Heart Foundation (NHF) hypertension, dyslipidaemia and physical activity guidelines,
 - Improving access to specialist clinics,
 - Increased liaison with key personnel in the CVD specialty,
 - Bringing new advances and changes in management to GPs,
 - Giving them access to a recall system through ReMinD to assist GPs in managing patients with any CVD risk factor.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Because the CVD and diabetes components are integrated within ReMinD the same barrier exists.
- What future plans do you have for CVD management in your Division?
 - We are currently developing a patient pedometer study in an effort to increase physical activity within the Central Sydney Area Health Service (CSAHS),
 - The two priority areas we see are obesity and cigarette smoking and we will attempt to address these areas.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Be realistic, be useful, be sustainable and integrated,
 - All risk factors ought to be under the umbrella of one program.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

National Heart Foundation – undertaking the pedometer study.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

National Heart Foundation.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Whole program.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

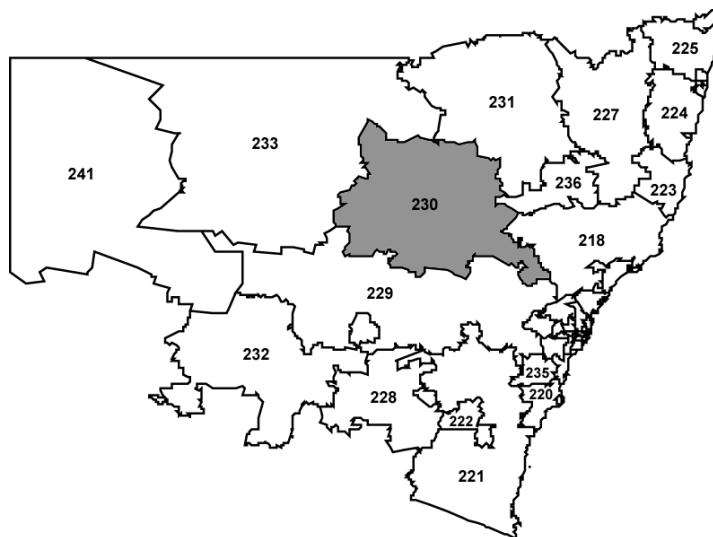
N/A.

- What resource materials do you provide to practices? All the latest updates.

Division Contact Person/
Program Co-ordinator

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Dubbo/Plains DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	91,607	
■ Aboriginal or Torres Strait Islander	8917	9.7%
■ Speaks language other than English at home	1595	1.7%
■ RRMA classification ¹		
3: Large rural	37,101	40.5%
5: Other rural	50,109	54.7%
7: Other rural	4397	4.8%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	4,930	8.4%
■ High blood pressure ⁴	18,601	31.7%
■ High blood cholesterol ⁵	30,706	52.4%
■ Obese or overweight ⁶	35,663	60.9%
■ Physical inactivity ⁷	24,877	42.5%
■ Smoking ⁸	10,950	18.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

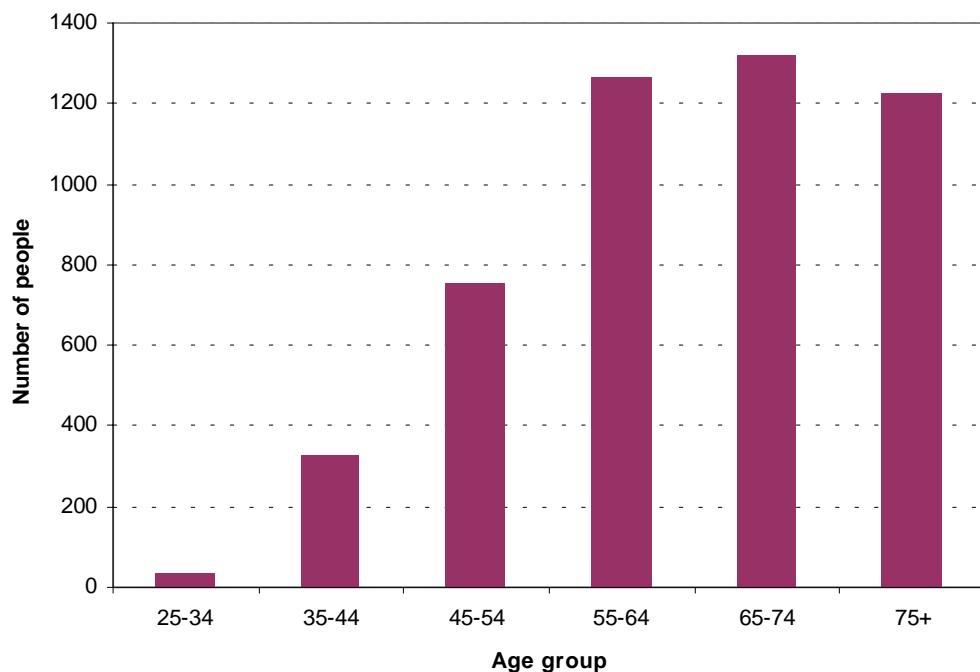
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

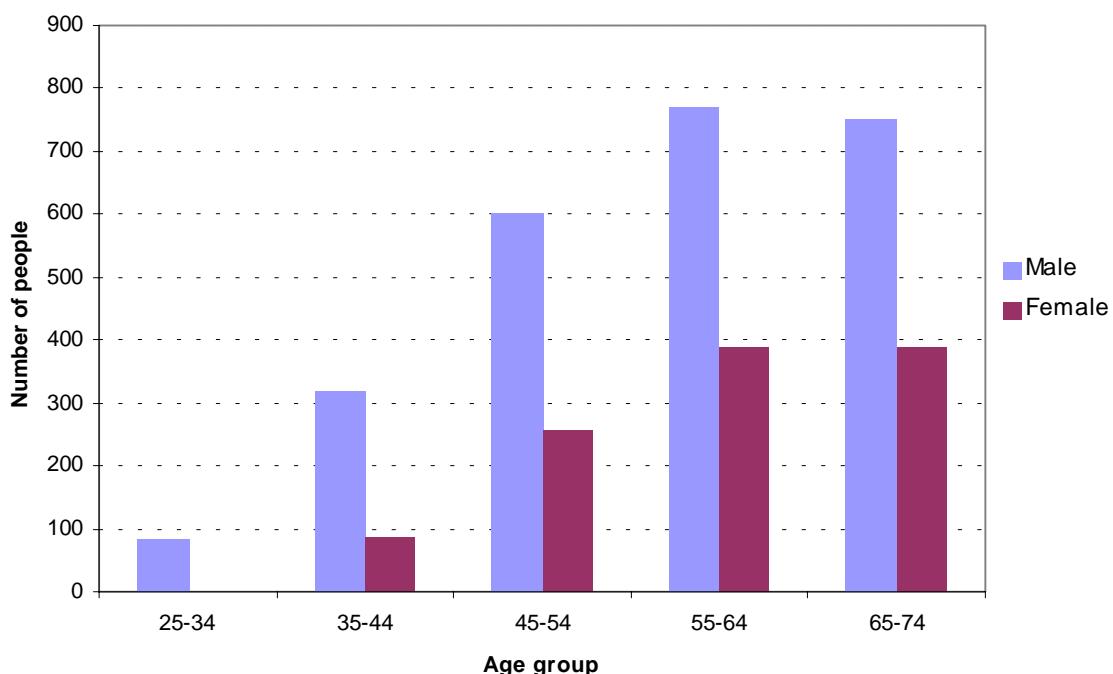
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



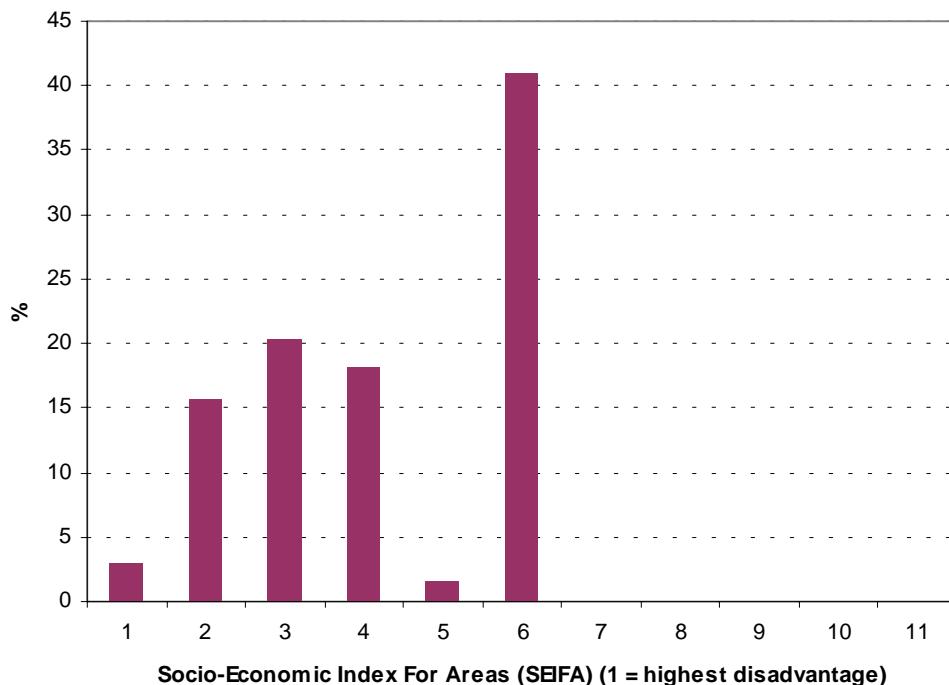
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

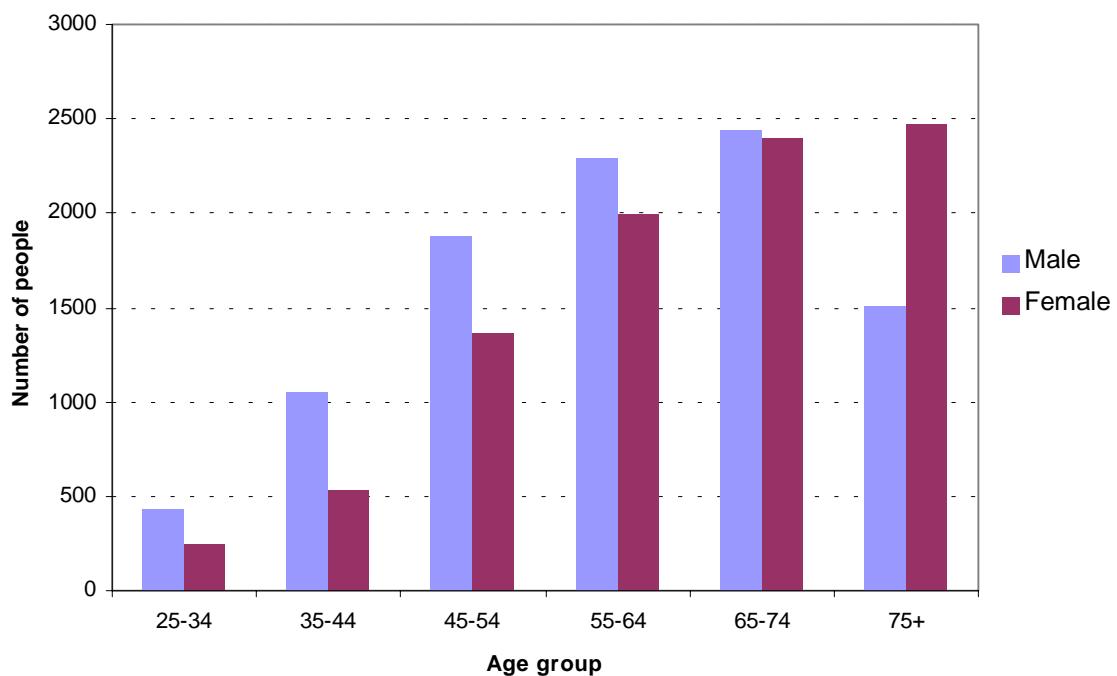
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

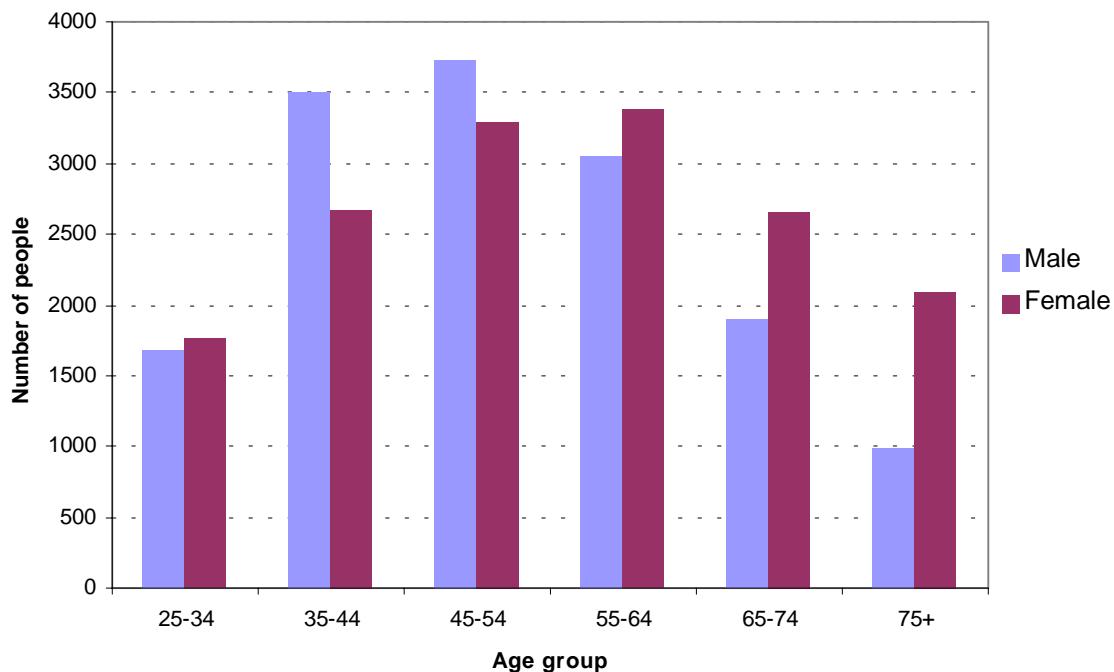
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



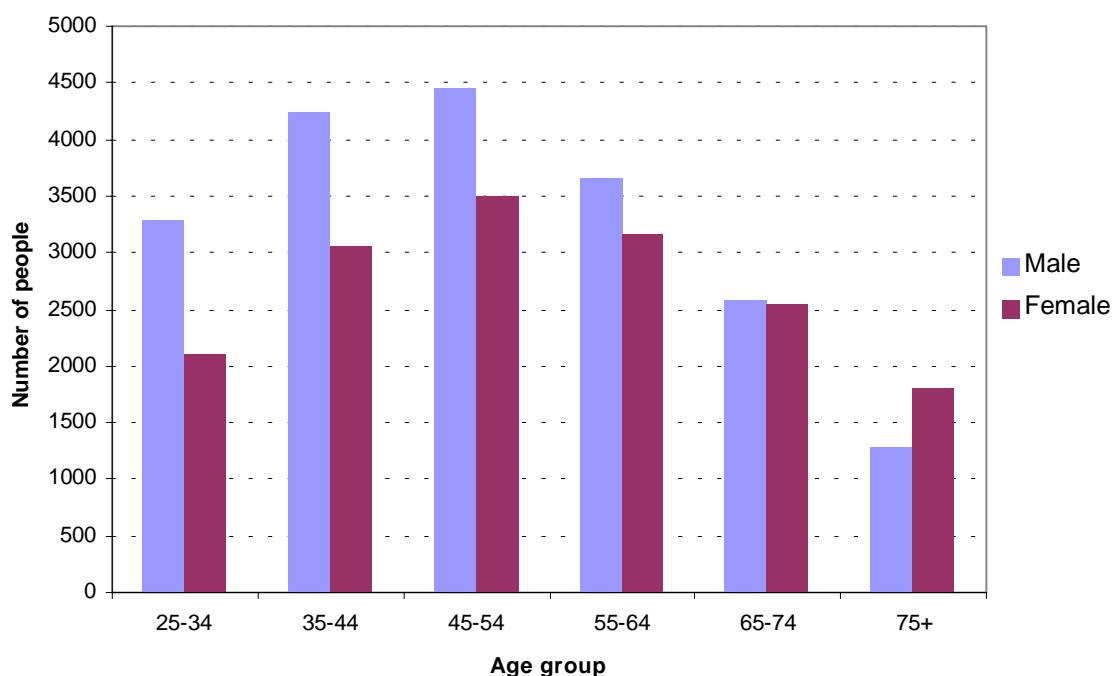
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



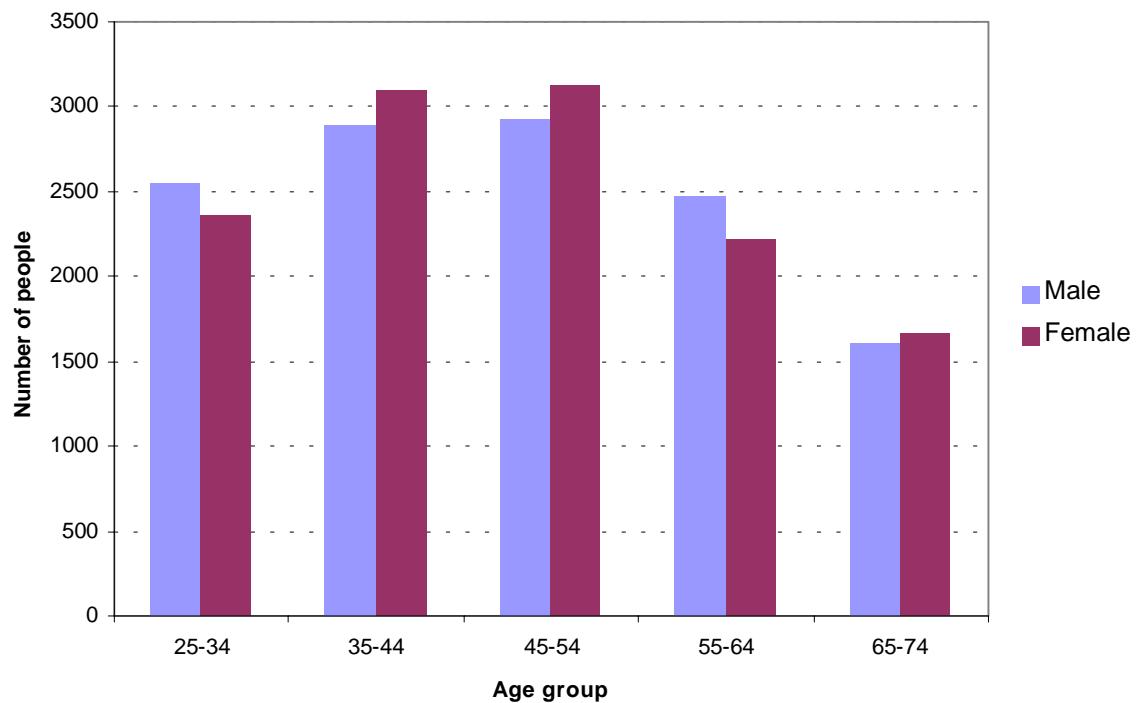
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



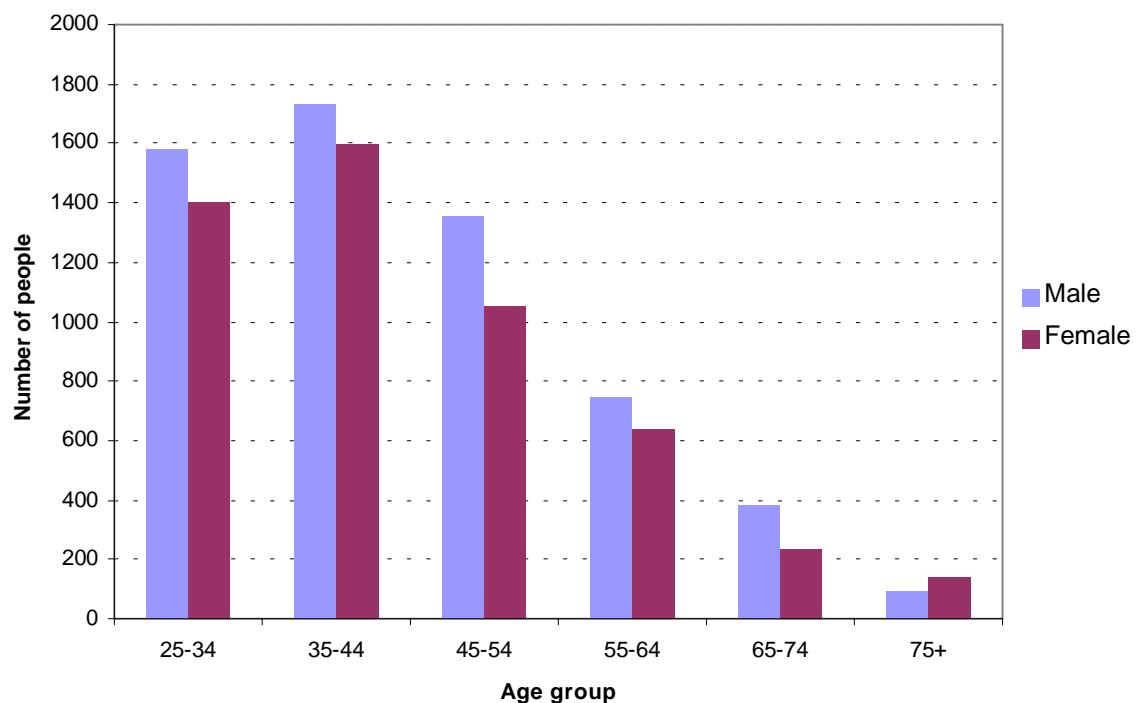
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 71 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Public diabetes education program run by Area Health Service (AHS) public dietitians (optometry public and private),
 - CARDIAB register/recall Division,
 - Individual GP practices register/recall,
 - Visiting endocrinology clinic,
 - Staff specialist endocrinologist at base hospital,
 - High risk foot clinic/public and private podiatry,
 - Aboriginal vascular health clinic – public,
 - Diabetes educator attends GP practice once a month.

- What services are needed but are not available in your Division area?

More treatment options for eye surgery are required. Most residents need to travel for laser surgery, etc.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The program continues to change to meet the changing needs of general practice and to include a more multidisciplinary approach. The Division now contracts a diabetes educator clinical nurse consultant to work more closely with GPs to provide more comprehensive care planning for diabetics.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Visiting endocrinologists,
 - The AHS program working more closely with Division input,
 - Incentives for diabetes reminder/recall.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

In relation to CARDIAB database utilisation – GPs still reluctant due to time involved. Yet to see direct benefit to them.

- What future plans do you have for diabetes management in your Division?

Currently reviewing together with AHS. Developing five-year plan for diabetes management. Intend to offer CARDIAB so that GP data can be uploaded/extracted for area use.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

Good support from Division staff. Practice nurses and staff that have a good understanding of the initiatives and how to implement within their practice and support their GP in doing so. The GPs on their own cannot and will not take up.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

We work very closely with AHS programs and personnel so that links to them are streamlined. AHS are contracted and/or sit on our advisory committees and vice versa. I regularly provide talks to local Diabetes Australia groups.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Royal Australasian College of General Practitioners (RACGP) diabetes management,
 - AHS protocols.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

CARDIAB template for data collection.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No – can get or develop most things ourselves together with AHS.
- What resource materials do you provide to practices?
 - CARDIAB – template,
 - CARDIAB – guidelines for management,
 - Access to Diabetes Australia resources for education.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiology consultants – visiting,
 - General physicians,
 - Echos, thallium persantins, exercise stress test (EST), etc,
 - Comprehensive cardiac rehabilitation programs in each town.

- What services are needed but are not available in your Division area?
 - Cardiologists – Visiting Medical Officer (VMO),
 - Patients have to travel to Sydney for angiography, etc.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input type="checkbox"/>	2002		

- Please describe your CVD program including any changes that occurred over time?

We do not collect CVD info alone – only if patient is a diabetic, therefore, info on CARDIAB not reliable.

Division Perspective

- What have been the major achievements or highlights of your program so far?

N/A.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for CVD management in your Division?
 - Ongoing Continuing Medical Education (CME) as requested by GPs,
 - Continued facilitation of referrals to cardiac rehab programs.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Talk regularly and work with AHS programs. No use commencing alternative programs. Have a look around at what is working in other areas and see if it is applicable to your GP needs.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Division staff sit on AHS chronic and complex care steering committee. One Division staff member sits on NSW National Heart Foundation advisory committee for cardiac rehab and secondary prevention.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

N/A.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

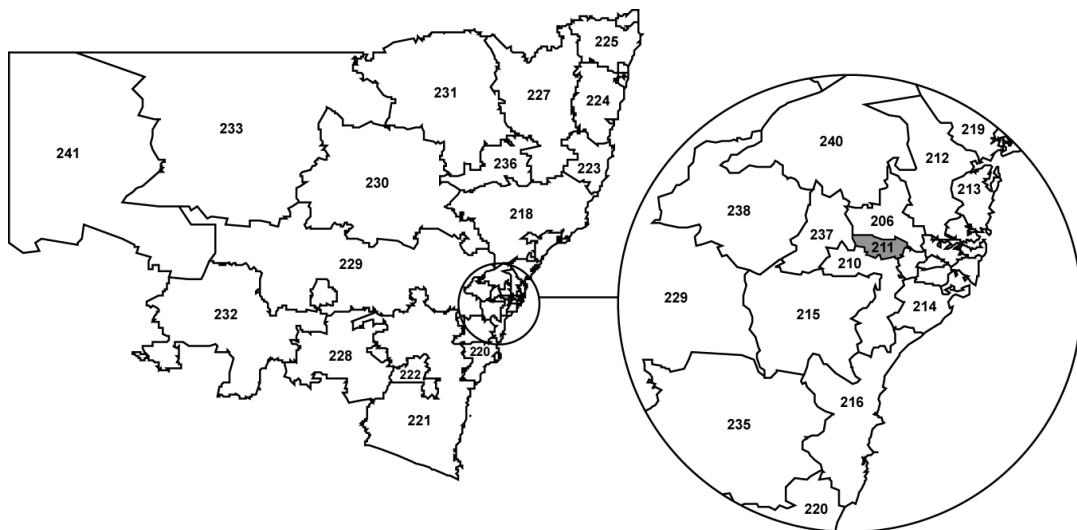
No.
- What resource materials do you provide to practices?

Access to AHS programs.

Division Contact Person/
Program Co-ordinator

Name: Maureen Thornhill/Erica Gilbert
Phone: 02 6884 0197
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Fairfield DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	210,671	
■ Aboriginal or Torres Strait Islander	1379	0.7%
■ Speaks language other than English at home	133,570	63.4%
■ RRMA classification ¹		
1: Capital city	210,671	100.0%
■ SEIFA category containing population median: ²	1	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9360	7.1%
■ High blood pressure ⁴	36,380	27.8%
■ High blood cholesterol ⁵	66,099	50.4%
■ Obese or overweight ⁶	78,192	59.7%
■ Physical inactivity ⁷	56,683	43.3%
■ Smoking ⁸	26,093	19.9%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

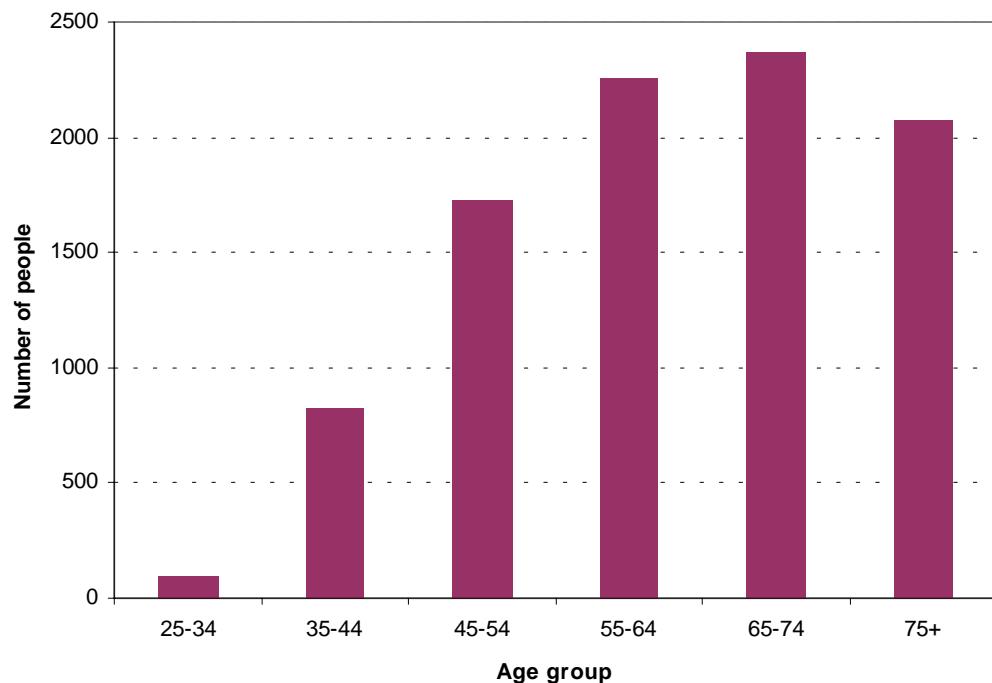
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

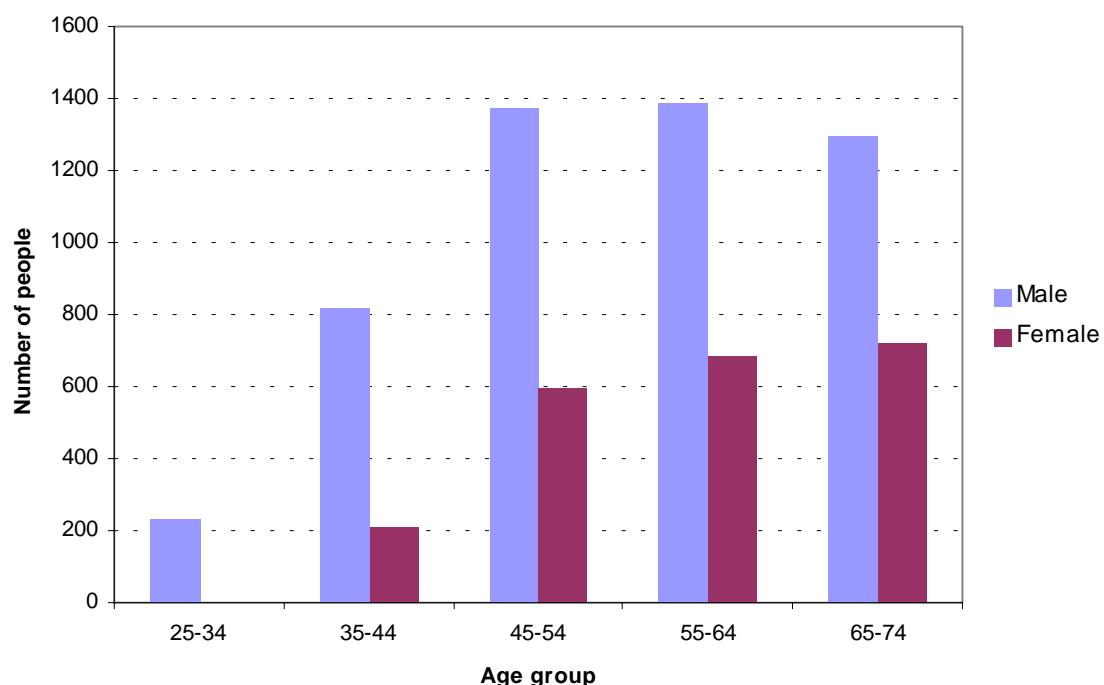
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



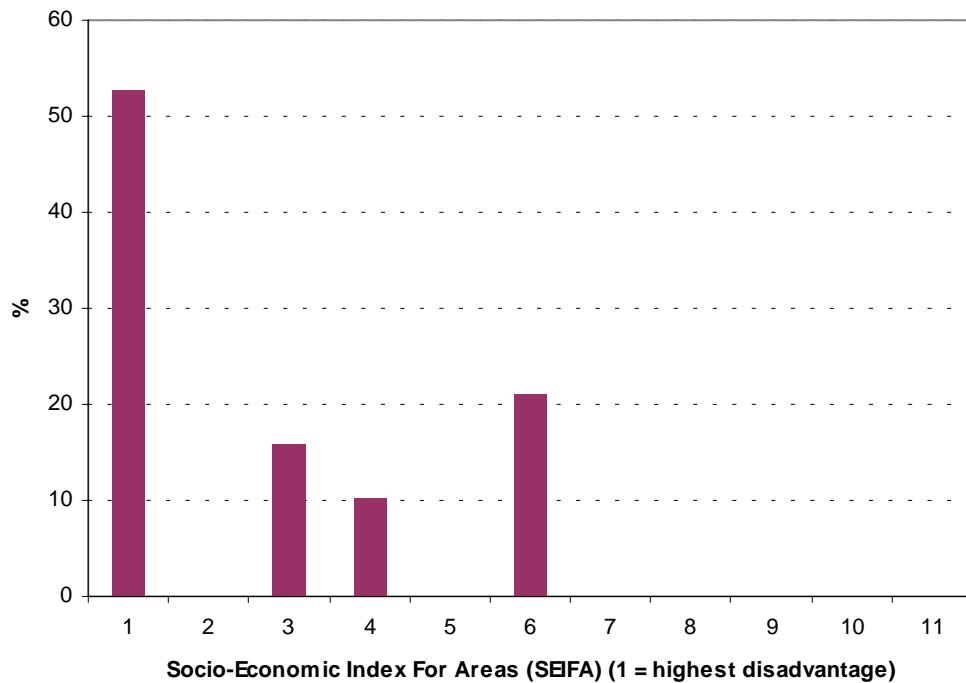
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

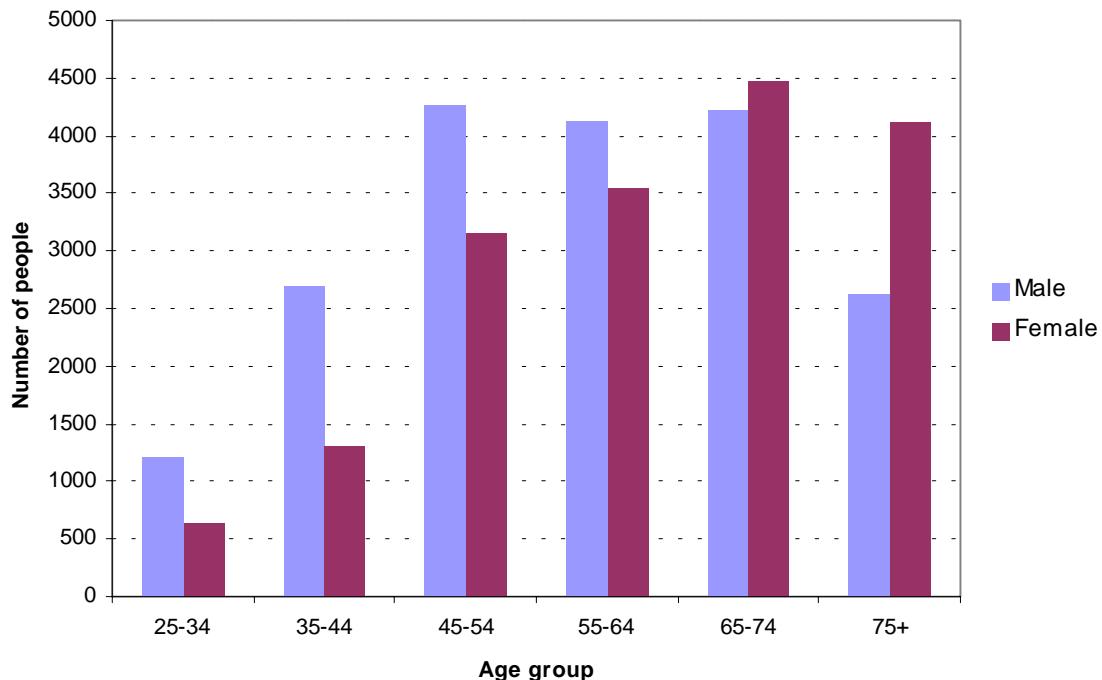
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

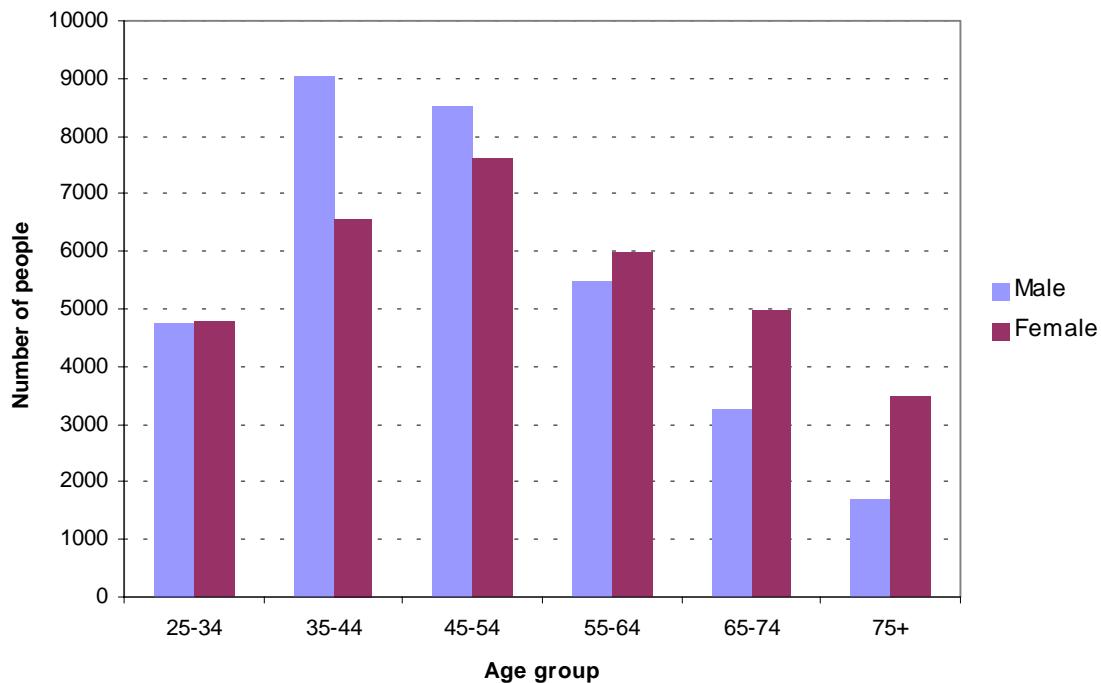
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



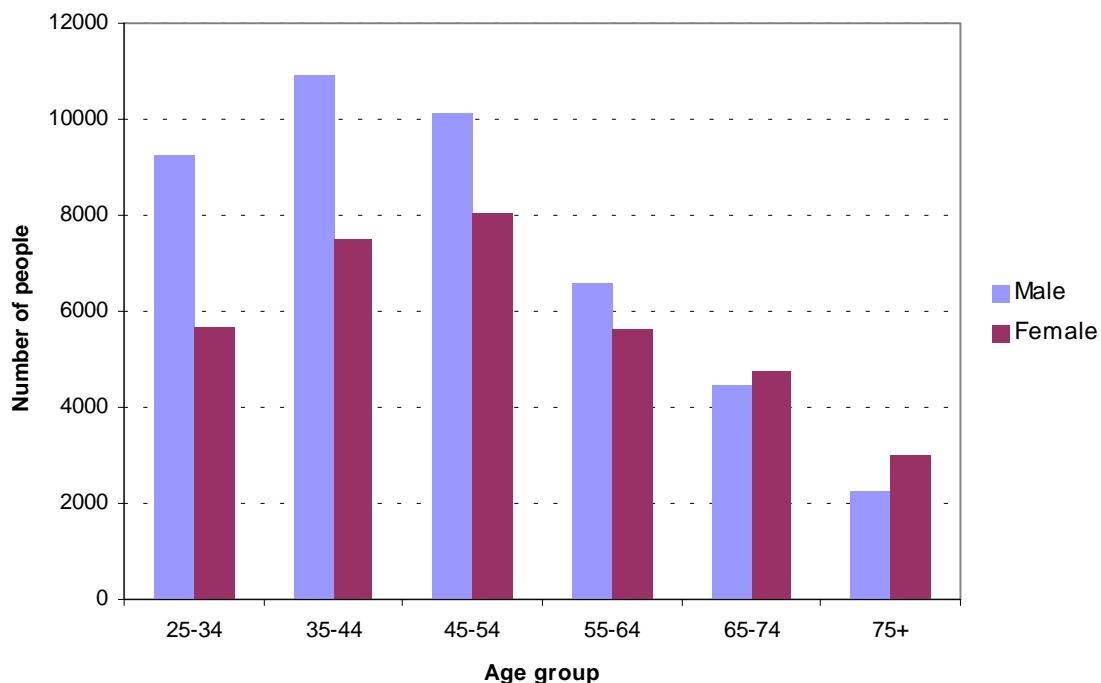
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



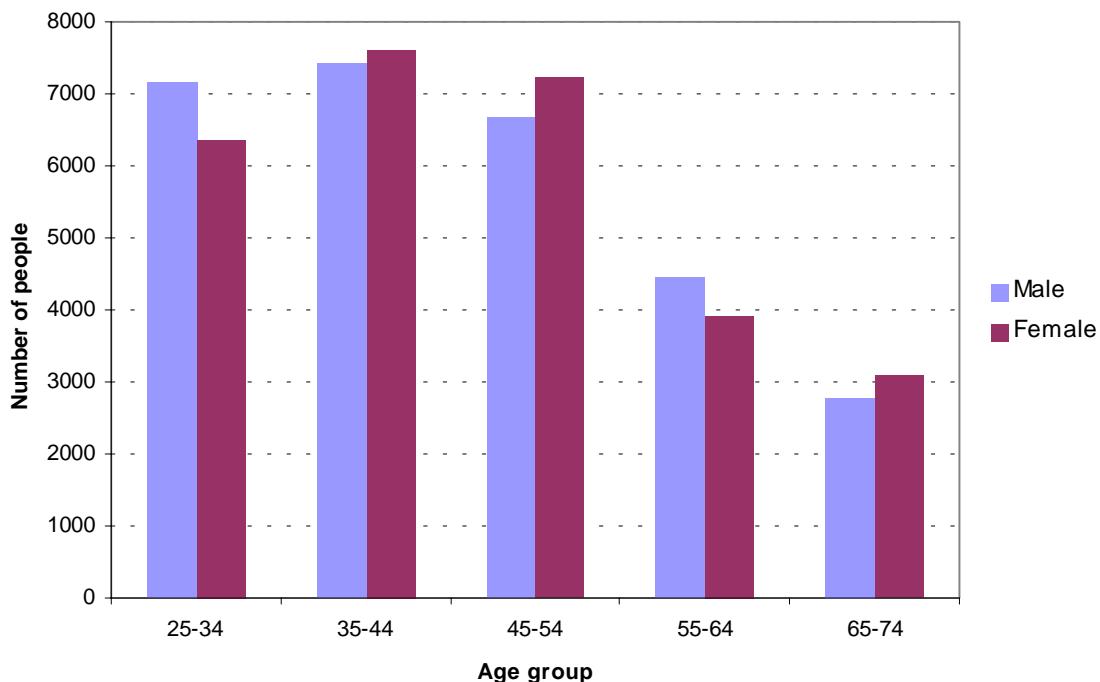
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



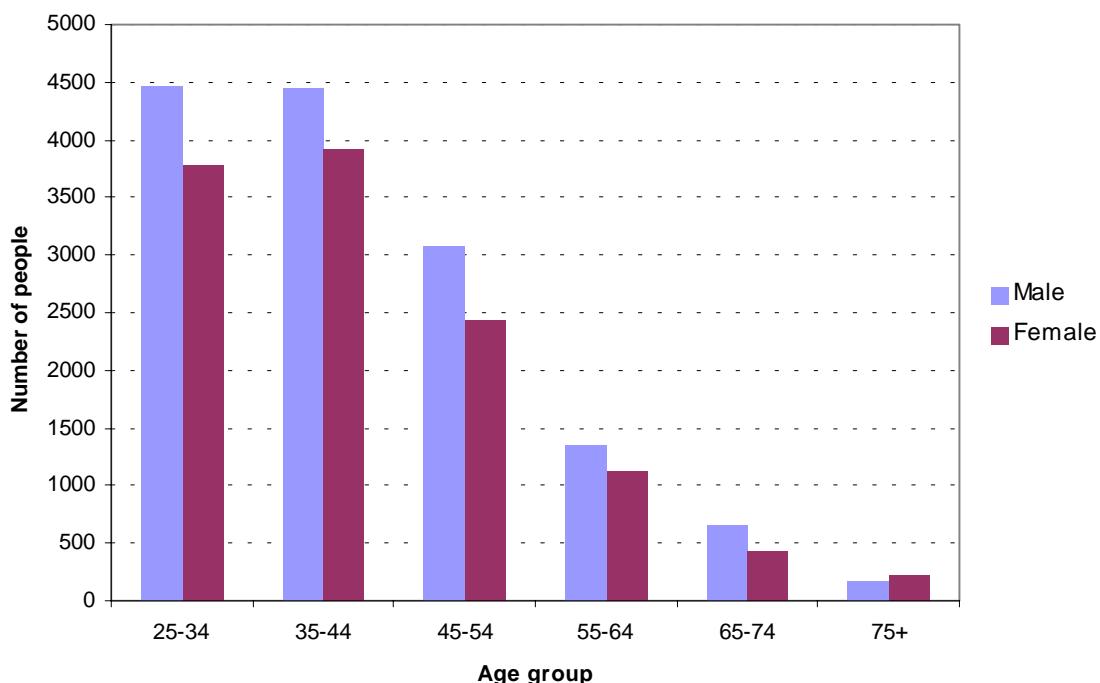
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 217 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Shared Care Register Program – Fairfield Division of General Practice,
 - Diabetes Centre – Fairfield Hospital,
 - Pharmacies involved with diabetes programs. Our Diabetes sub-committee has a pharmacist representative amongst its core members,
 - Fairfield City Council – Health Forum. Provide support to leaders in the community, on different issues related to aged care including diabetes,
 - Diabetes is one of Fairfield Division of General Practice's pioneer programs supporting GPs through patient registrations and monitoring and by the provision of diabetes workshops and educational materials for both GPs and patients. Communications with GPs include monthly diabetes article in the Division's newsletter, posting articles and other information on the Division's website, phone contact and practice visits to GPs.

- What services are needed but are not available in your Division area?
 - Podiatrist services (podiatrists position in the Fairfield Health Service are continuously vacant),
 - Dietitian's services availability are limited. compared to demand,
 - Physical activity venues. The Prairiewood Centre is difficult to access, as the transport is limited to bus service only,
 - Dental services. Many patients cannot manage their diabetes properly because they don't have dentures or ones that they don't fit. Waiting time for an appointment at the hospital is excessive. When the manager spoke to one of the dentists, he suggested they go to a private practice, which is unaffordable for many of our registered patients in this area.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The Fairfield Division of General Practice Diabetes Shared Care Program started in 1994 as one of the pioneers in Australia, soon after the creation of the Divisions of General Practice.

It started with the manual registration of diabetic patients, which later was improved with the introduction of the CARDIAB database system. This enabled the definition, design and implementation of projects with the big advantage of targeting the right group of patients, (eg patients at the highest risk for complications), and the specific needs of GPs (professional development, accreditation, etc).

This program had a very good start, which lasted for almost 4 years, but due to a number of changes in personnel this was not maintained. In the last two years, the program has recovered to a great extent. The program is very well supported by the CEO, and with his input a number of diabetes research projects have been undertaken together with incentive programs for GPs, Continuing Professional Development, and IT support for GPs. I am optimistic that with his ongoing support, and with the support of the Fairfield GP Unit and the CARDIAB database program, the Diabetes Shared Care Program will enhance its services to its members.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Implementation and monitoring of the NSW Diabetes Management Guidelines by the GP members of the Diabetes Shared Care Register, utilising the CARDIAB database program,
 - Improvement of the management of diabetes in patients registered with the Diabetes Shared Care Register Program (DSCP) of the Division,
 - Increased participation of the GPs in activities organised by the DSCP by way of: increase in number of patient registrations and reviews, increase attendance at the diabetes workshops, more consultation with the DSCP manager (phone, requests for visits, incentive programs, etc),
 - Production of a new design for the diabetes registration card, which is being very well received by GPs, and which facilitates the effective functioning of CARDIAB,
 - Statistics produced and regularly extracted from CARDIAB.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Need for commonly agreed protocol or set of guidelines that clearly specify areas of responsibility and decision making across the local health spectrum, and that build upon mutual respect and collaboration,
 - Need to ensure that there is a well-established community understanding about the importance and value of general practice in the management and care of diabetes patients,
 - Lack of culturally appropriate diabetes educational material in other languages for those of Non English Speaking Background.

- What future plans do you have for diabetes management in your Division?

Conditional on approval by the Diabetes Sub-Committee and CEO, I would like to develop the following programs/activities:

 - To target Aboriginal communities and NESB populations,
 - To produce educational material relevant to those communities. I have material to develop resources for the Assyrian population,
 - To introduce nutrition education sessions for GPs and their patients, as an initiative from the Division, following the NSW Diabetes Management Guidelines,
 - To fully utilise CARDIAB database as a tool for the development and support of programs for patients and GPs.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Economic incentives,
 - Logistic support,
 - Allied Health Professional support rather than only nursing support, eg. Podiatrists, occupational therapists, dietitians, psychologists, etc,
 - RACGP accreditation,
 - Support with surgery accreditation.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Diabetes Australia contacted as the leading organisation for diabetes in this country,
 - National Heart Foundation because heart disease is one of the major diabetes complications. I use their resources for GPs resource kits,

- Fairfield Meals-on-Wheels, for special requests,
- Provide full support to the Diabetes Centre at Fairfield Hospital,
- Excellent alliance with the Fairfield GP Unit Academic members: Support for research projects and activities.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice booklets,
 - Diabetes Australia (DA) and National Heart Foundation educational material. Free cost from DA, paid from the NHF,
 - Health Department Just Walk It Program specific material for Physical Activity,
 - CARDIAB Database Register instructions and incentive description material,
 - Nutrition and diabetes educational material,
 - CARDIAB Database statistics help to develop different projects not only in the Fairfield area but also in the SWSAHS.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes research projects reports, CARDIAB statistics, and any educational material, which can be developed in the future.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Demographic statistics on the Fairfield diabetes incidence and prevalence by English and multicultural groups,
 - Physical activity statistics,
 - Guidelines for working collaboration between Divisions and area health service.
- What resource materials do you provide to practices?
 - Patient registration/review cards,
 - Resources kits for every member of the DSCP.

Division Contact Person/
Program Co-ordinator

Name: Gladys Hitchen
Phone: 02 9726 1663
Fax: 02 9726 1698
Email: gladys-hitchen@fairdiv.org.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiac Assessment Rehabilitation Education Program – Fairfield Health Service,
 - Fairfield City Leisure Centre – Phase III & Heart Move,
 - Fairfield Health Service CCF (Heart Failure Program) - chronic and complex care,
 - Short programs run by multicultural health workers, eg. diet, physical activity.

- What services are needed but are not available in your Division area?
 - Aboriginal Health,
 - More culturally specific programs.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The Cardiac Shared Care Program (CSC) is a cooperative program between the Fairfield Health Service Cardiac Assessment Rehabilitation and Education program (CARE), Fairfield Division of General Practice, local GPs and their patients.

People attending the CARE program at Fairfield Hospital elect to participate/join the CSC program.

There are two components of the CSC program;

Program A – 18 month intensive program

This is an individual twelve-month program for patients requiring cardiac rehabilitation. Patients attend the cardiac rehabilitation program either at Fairfield Hospital or are visited in the community by the CARE team. The program involves the following:

- Six – eight week intensive program (individualised, can be longer or shorter if required),
- Six month risk factor review by GP and EST/lifestyle review by CARE staff,

- Twelve month risk factor review by GP and EST/lifestyle review by CARE staff.

An agreement exists between the multidisciplinary team at CARE and the patients nominated general practitioner (GP) to work together towards the rehabilitation and optimal management of the patient. Staff at CARE provide the GP with regular correspondence regarding the progress of their patient.

GPs participating in the program are required to complete 3 physical assessments on their patient during this program;

- Prior to the participant finishing the 6 - 8 week rehabilitation program at Fairfield Hospital (CARE),
- Six months after completion,
- Again 6 months later.

The attending GP records this assessment onto the “Cardiac Shared Care Patient Review Form”. This is then forwarded to CARE or the Fairfield Division of General Practice (FDGP). Patients registered on this program receive reminder notices to visit their GP when their six (6) month risk factor review is due.

Program B – Maintenance Program (ongoing)

This program aims to assist GPs with monitoring their patients cardiovascular risk factors.

Participants of this program are sent recall/reminders by the Division, to visit their GP every six (6) months. The attending GP records an assessment of their patients’ current Coronary Artery Disease risk factors and medication management onto the “Cardiac Shared Care Patient Review Form”. The completed Patient Review Form is then faxed to the Division where the data is entered onto a database.

Support for GPs in the Program

- GPs commencing on the Program are visited by the program manager and provided with an updated resource folder outlining details of the program/cardiac rehab/education resources available.
- A Cardiac Rehab/Shared Care Clinical Nurse

Specialist is employed by the Division to support GPs with;

- Providing cardiac education and rehabilitation to patients enrolled on the Cardiac Shared Care Program,
- Patient reviews/patient management strategies particularly with regard to lifestyle changes and risk factor modification,
- Planning and coordinating care planning/case conferences with participants, families/carers and their nominated GP.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Improvement in process in program,
 - Development of a new database,
 - 250 patients registered on Cardiac Shared Care program,
 - Model of Care – has been developed and endorsed by Fairfield Health Service & FDGP Cardiac Shared Care sub-committee,
 - Formal agreement between FHS & FDGP for employment of Cardiac Shared Care nurse.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Availability of resources at Health Service level.
- What future plans do you have for CVD management in your Division?
 - Expanding program to include all cardiac diagnostic groups.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Ensure a formal document/agreement (process) exists for your program,
 - Employment of program staff with CVD experience (specialty),
 - Employment of program manager in joint position between both services.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Fairfield Health Service Cardiac Assessment Rehab & Education Program (CARE),
 - Prairiewood/Fairfield Leisure Centre.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation information,
 - Hospital based information (program information),
 - Local community/council information (physical activity),
 - Fairfield Division of General Practice newsletter.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

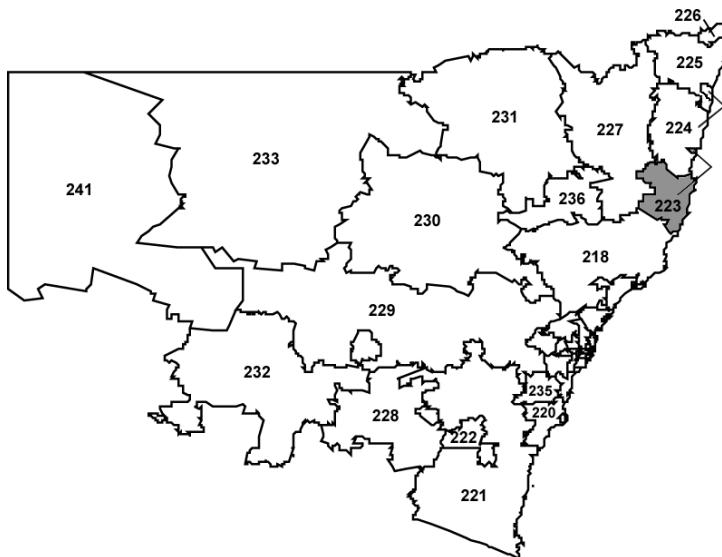
We have not developed any – use existing organisations.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.
- What resource materials do you provide to practices?
 - Diet,
 - Physical activity,
 - Cardiac Rehabilitation Guidelines,
 - Smoking cessation,
 - Cardiac Shared Care program information service directory for FHS.

Division Contact Person/
Program Co-ordinator

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Phone: 02 9726 1663
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Email: kerrie@fairdiv.org.au

Hastings Macleay DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	92,835	
■ Aboriginal or Torres Strait Islander	3595	3.9%
■ Speaks language other than English at home	1660	1.8%
■ RRMA classification ¹		
3: Large rural	61,828	66.6%
5: Other rural	30,635	33.0%
7: Other remote	371	0.4%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6585	10.2%
■ High blood pressure ⁴	24,087	37.3%
■ High blood cholesterol ⁵	35,244	54.6%
■ Obese or overweight ⁶	40,086	62.1%
■ Physical inactivity ⁷	26,211	40.6%
■ Smoking ⁸	10,929	16.9%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

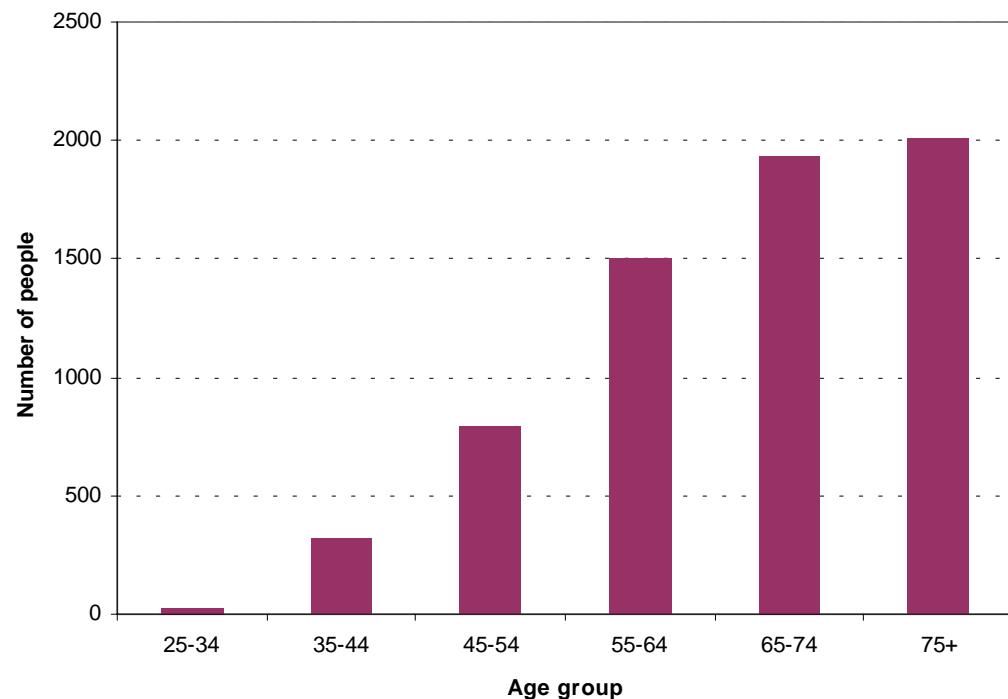
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

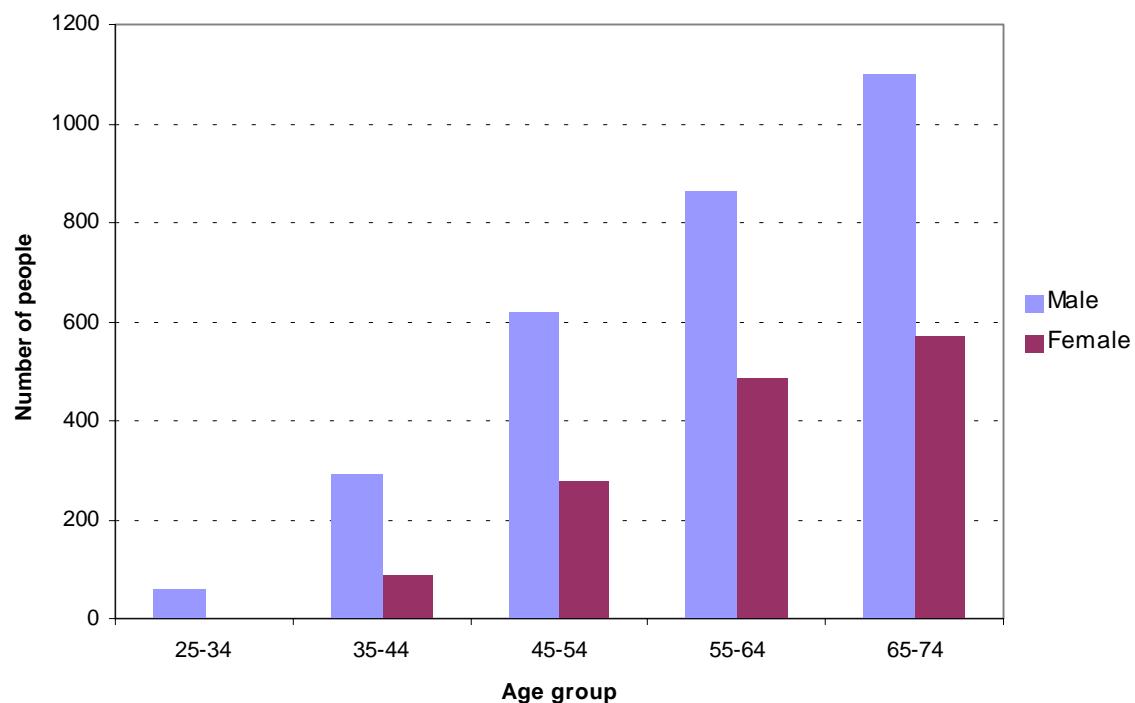
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



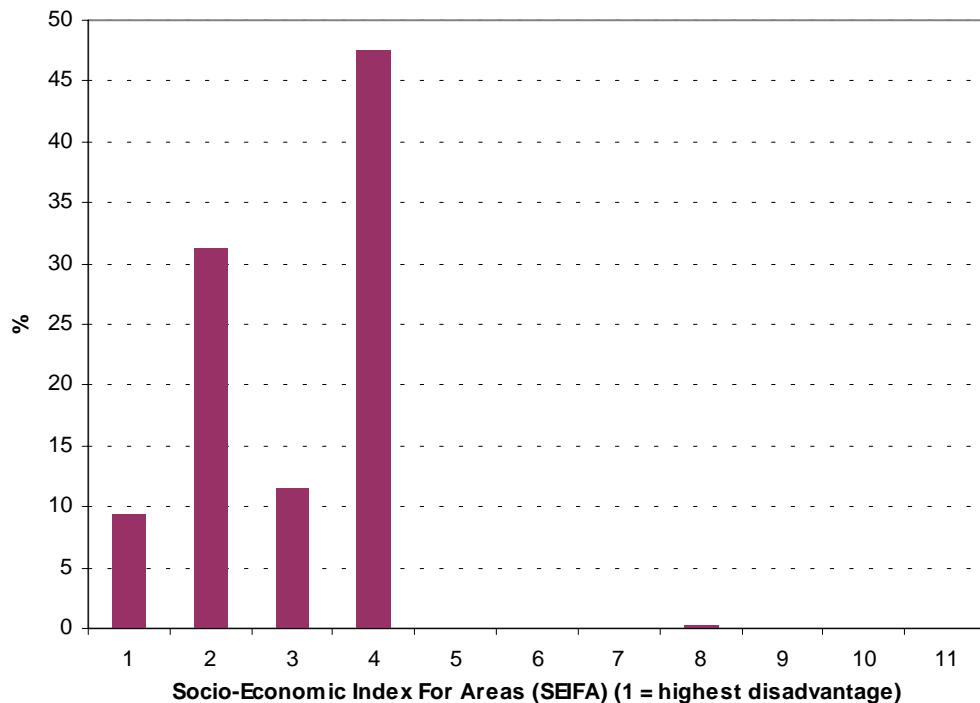
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

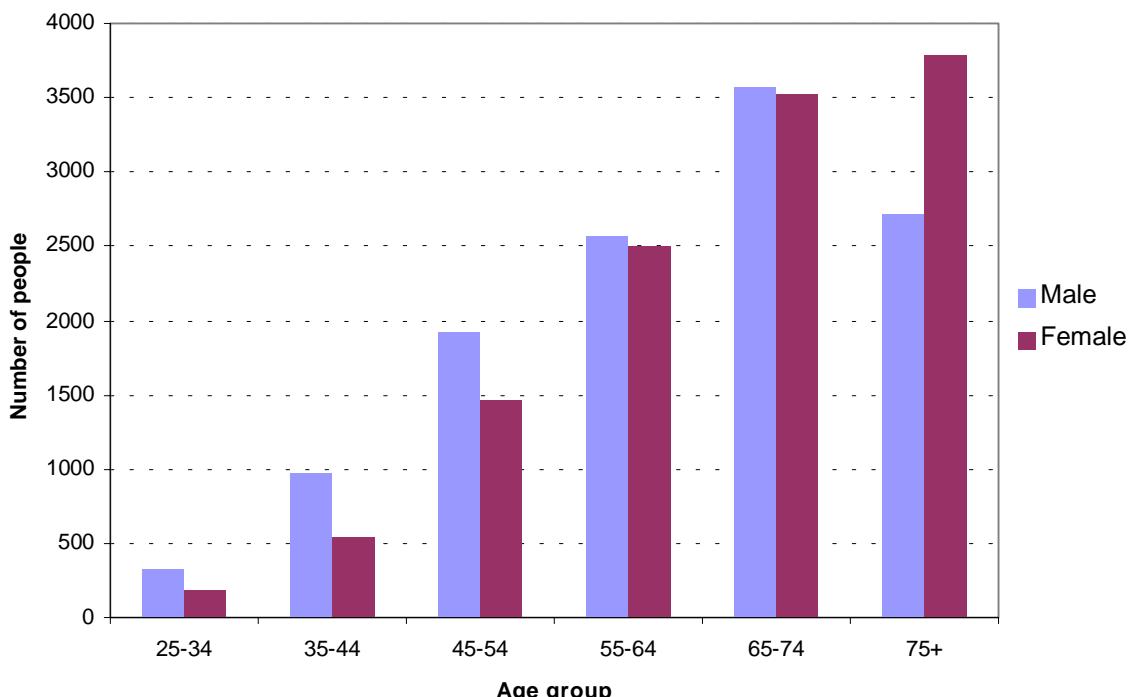
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

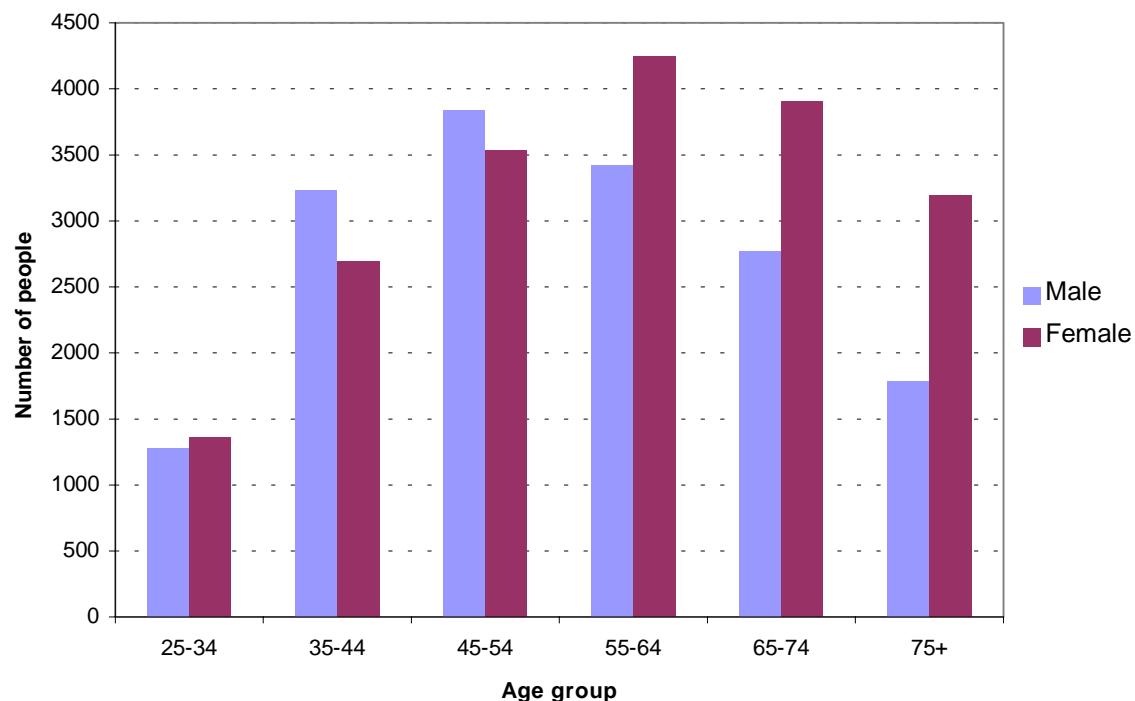
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



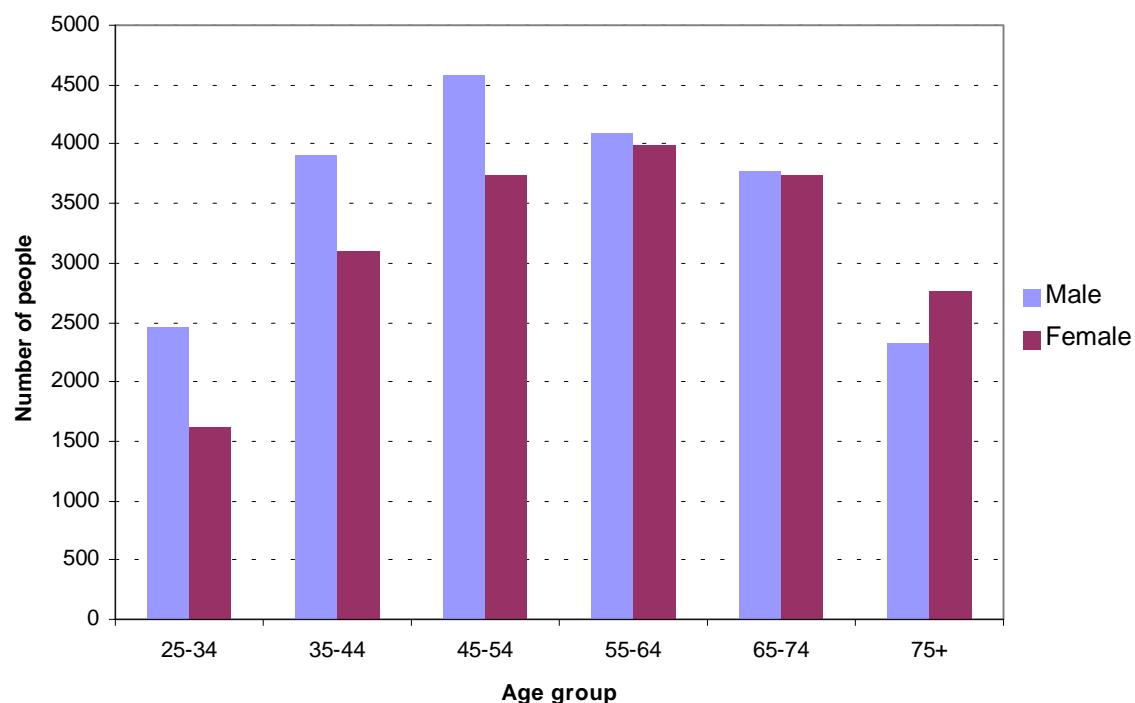
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



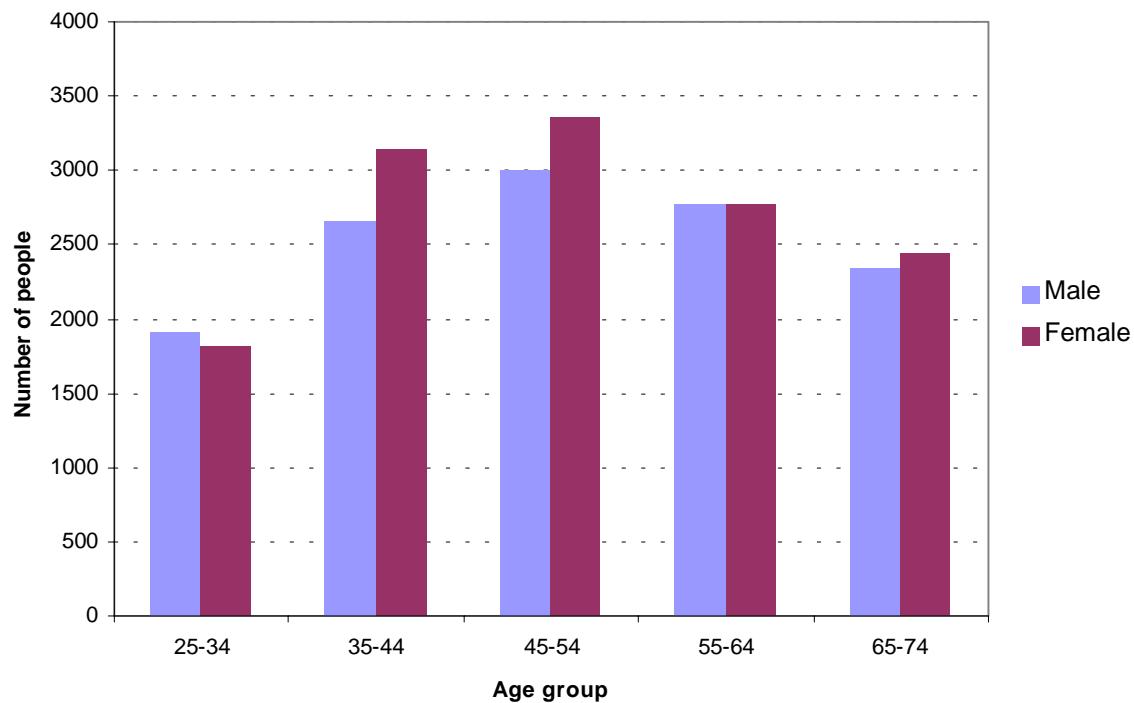
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



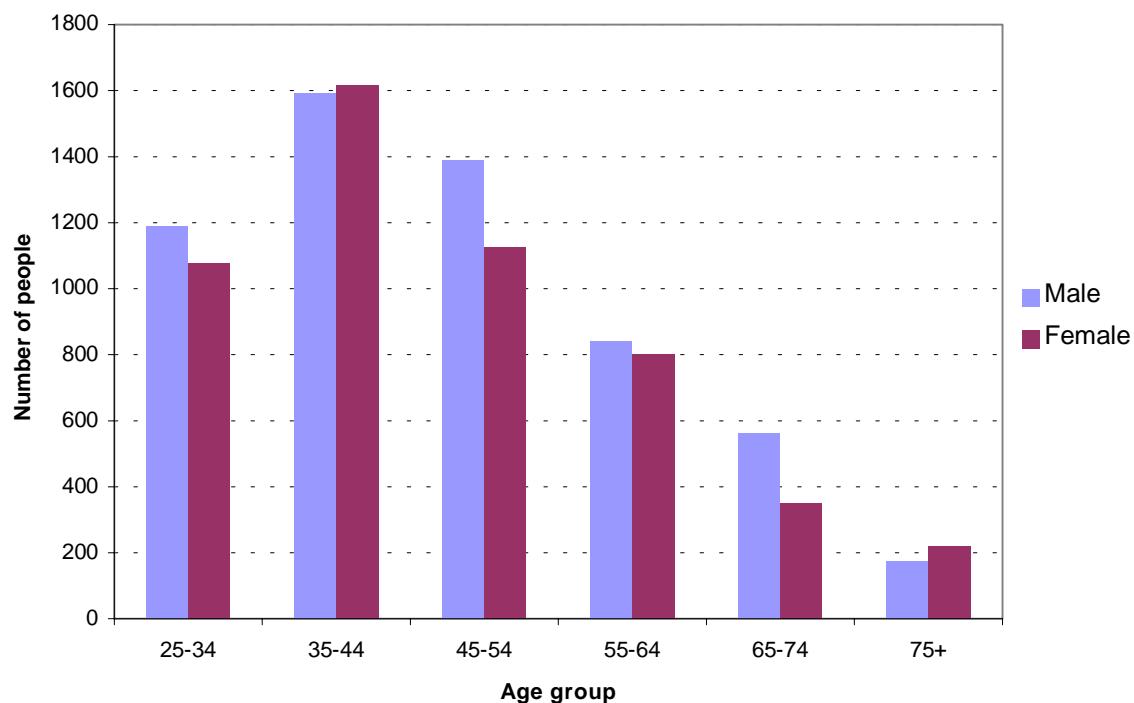
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 106 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Area Health Service has one full time and two part time (one shared with Division) educators. One educator employed by Port Macquarie Base Hospital.

Division has one educator in shared position with Area Health Service.

- What services are needed but are not available in your Division area?

Endocrinologist – will be starting one day a month later this year. Currently people with diabetes have to travel to Newcastle, which is three hours away.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Diabetes pilot September 1996 – 1998 had project officer and four educators doing mini-clinics.

September 1999 – June 2002: One educator who is Diabetes Project Officer doing mini-clinics since February 2002. Educator utilised as care plan service provider during clinics. GPs' rooms now make appointments for clients, whereas previously, educator made appointments.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Improved management of clients with diabetes. At completion of pilot project, 29.4% of participants had HbA1c < 7%. This has improved to 60% of participants. Similarly, at the end of the pilot, 22.3% of participants had microalbumin levels < 30mg/L. This has improved to 76% of participants.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Time constraints with educator working two days a week for Division. Some GPs stating they have no room or time.

- What future plans do you have for diabetes management in your Division?
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Continuation of the Shared Care Project with endocrinologist visiting one day per month.
- Practices being pro-active and wanting to be involved,
 - EPC, SIP & PIP incentives,
 - Support from the Division of GPs regarding education and helping organise clinics, etc.

Divisions and Mid North Coast Area Health Service interaction is continually improving with both sharing funding on a number of occasions as well as continuing collaborative programs, eg. Diabetes Program. Have GP and staff representation on a number of Mid North Coast Area Health Service (MNCAHS) committees and this Division has implemented the three Divisions (MNCAHS, Port Macquarie DGP and Hunter Rural DGP), Area Health Service liaison committee this year. We have successfully linked with other stakeholders, eg Carelink, Port Macquarie Base Hospital, Durri Area Health Service, and in doing so, have brought issues that affect general practice to the forefront.

Division Resources

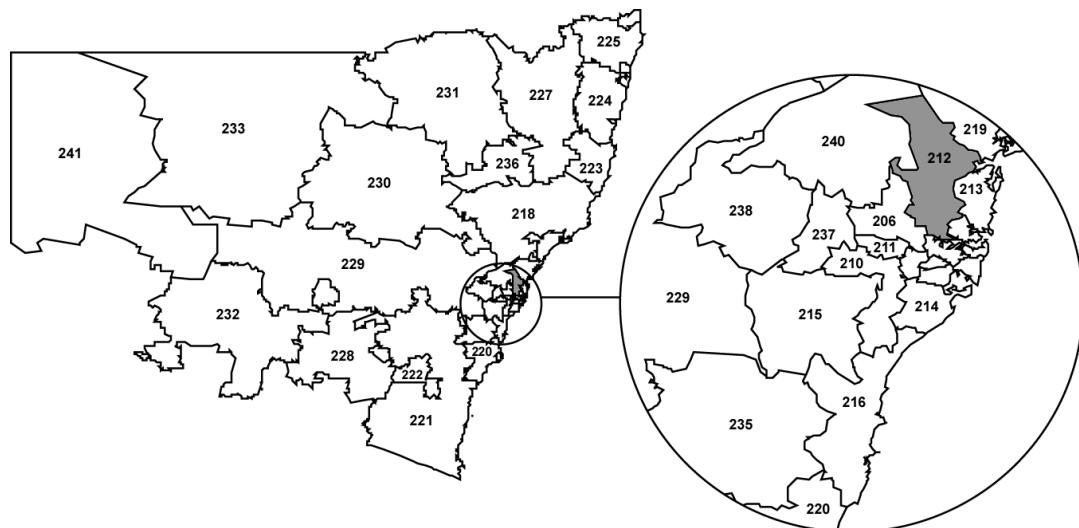
- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- RACGP Diabetes Management in General Practice, CD-ROM from Diabetes Australia, Insulin Guidelines from Novo Nordisk, Eli-Lilly.
- Practice nurse folder “Guidelines for Diabetes Management” developed in conjunction with Mid North Coast Area Health Service.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? Practice Nurse folder “Guidelines for Diabetes Management”. This folder is also utilised by GPs.

Division Contact Person/
Program Co-ordinator

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Email: diabetes@pmdgp.org.au

Hornsby Ku-ring-gai Ryde DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	386,032	
■ Aboriginal or Torres Strait Islander	915	0.2%
■ Speaks language other than English at home	89,646	23.2%
■ RRMA classification ¹		
1: Capital city	386,032	100.0%
■ SEIFA category containing population median: ²	11	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	20,993	8.3%
■ High blood pressure ⁴	79,010	31.2%
■ High blood cholesterol ⁵	132,356	52.3%
■ Obese or overweight ⁶	152,991	60.4%
■ Physical inactivity ⁷	106,252	42.0%
■ Smoking ⁸	47,461	18.7%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

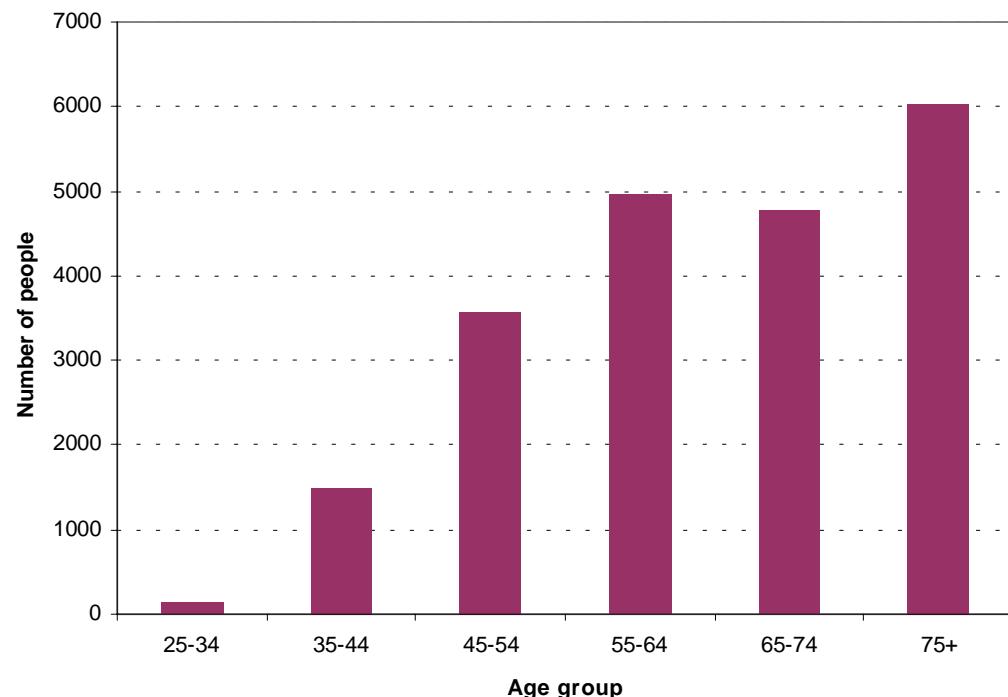
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

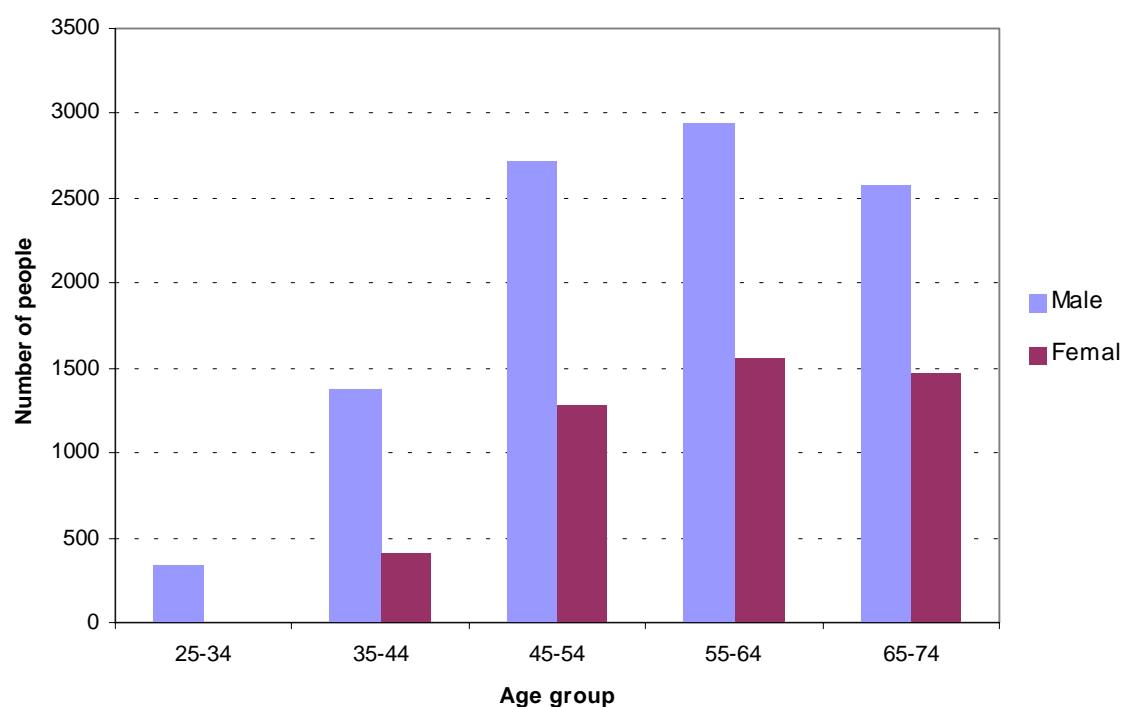
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



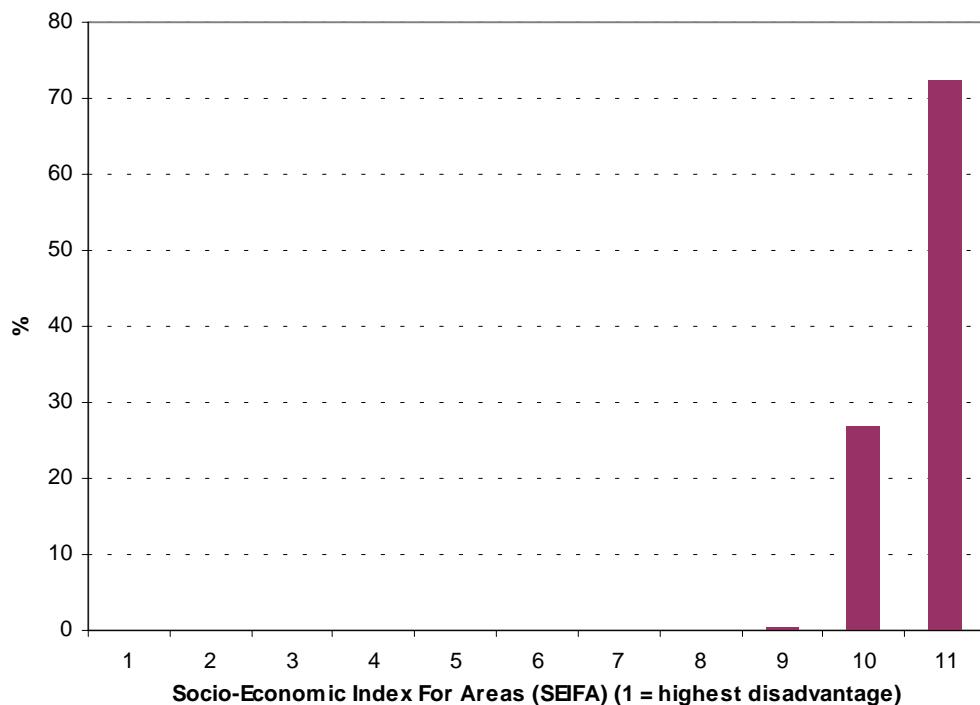
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

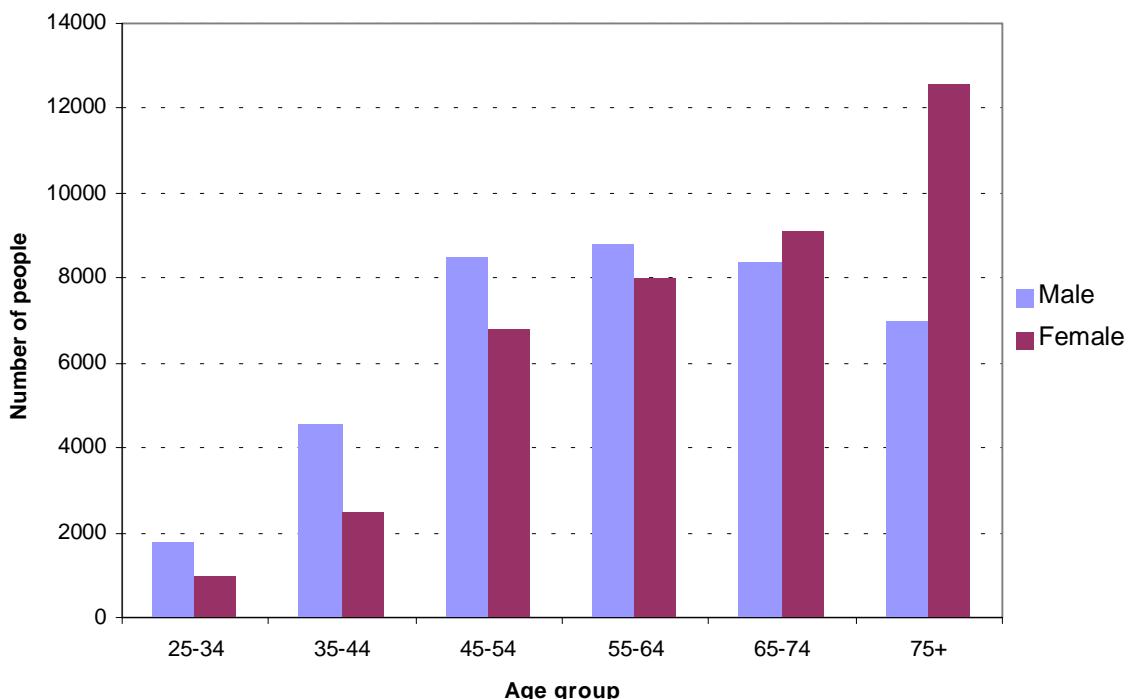
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

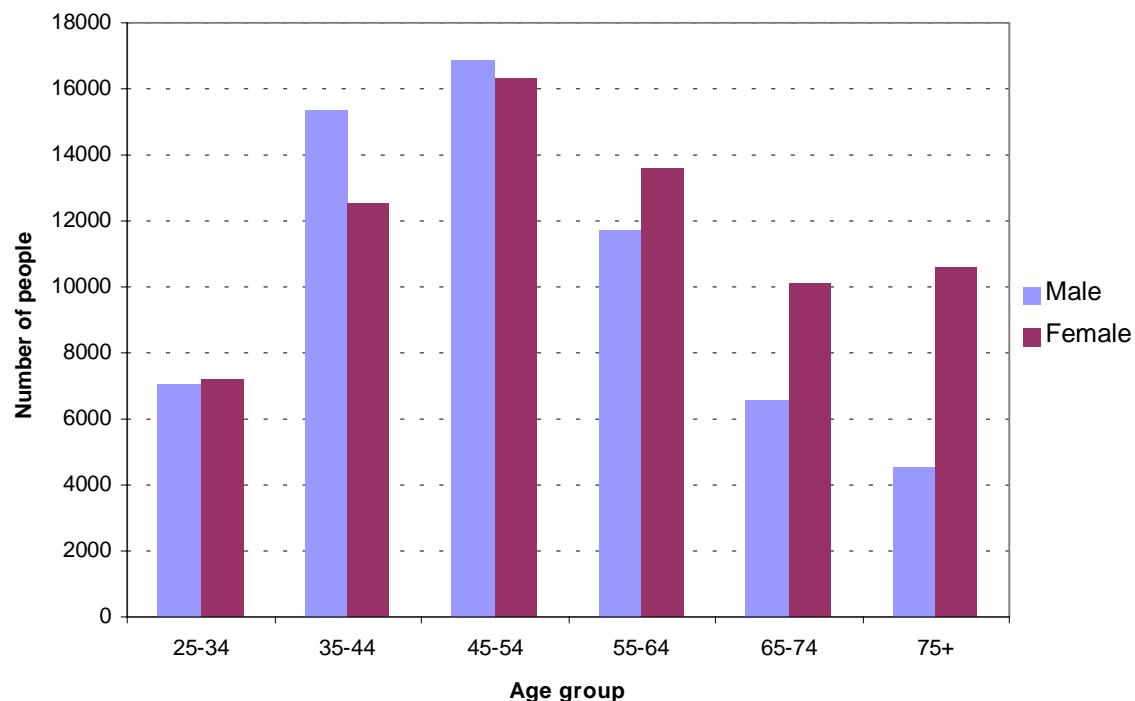
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



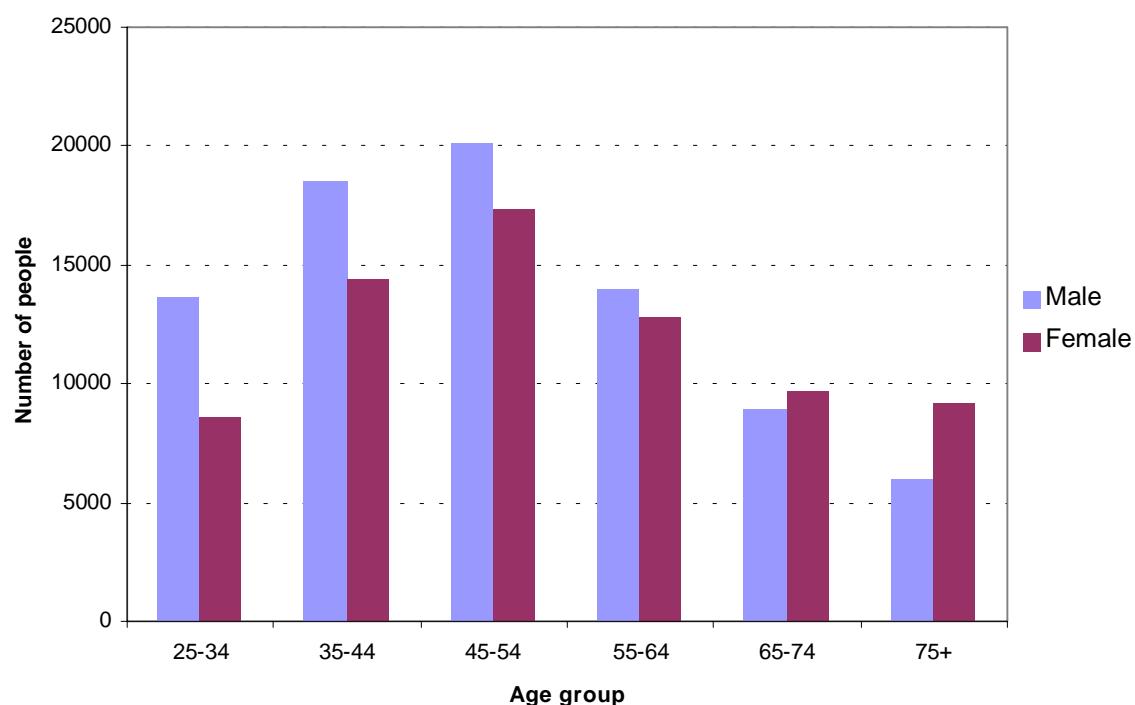
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



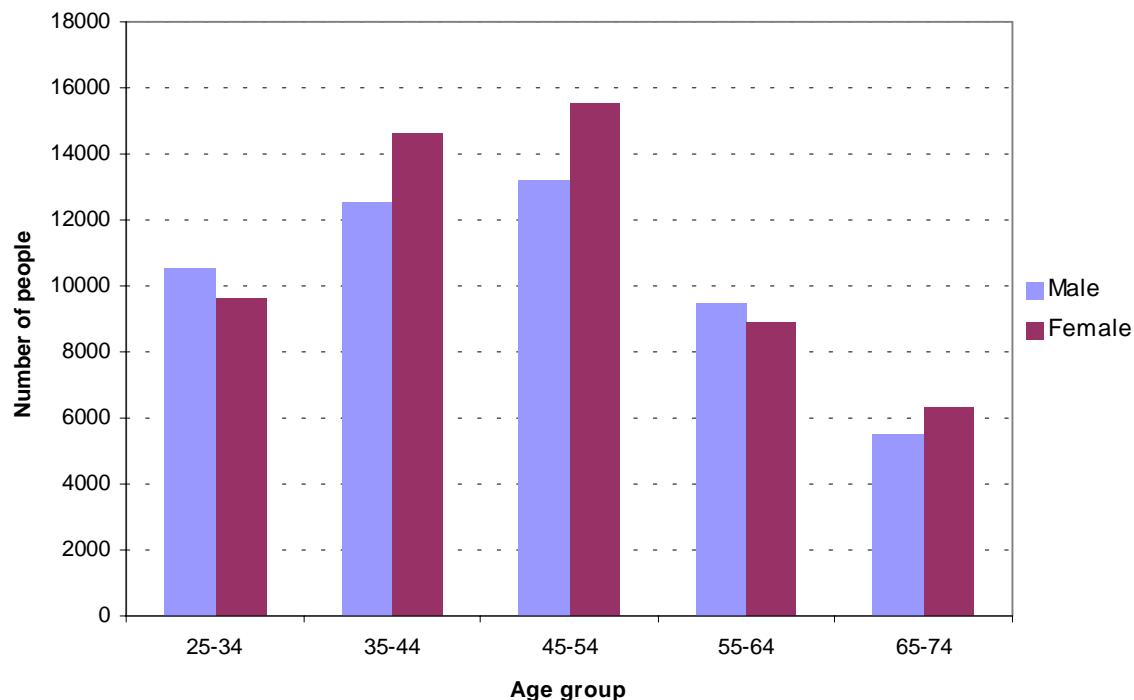
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



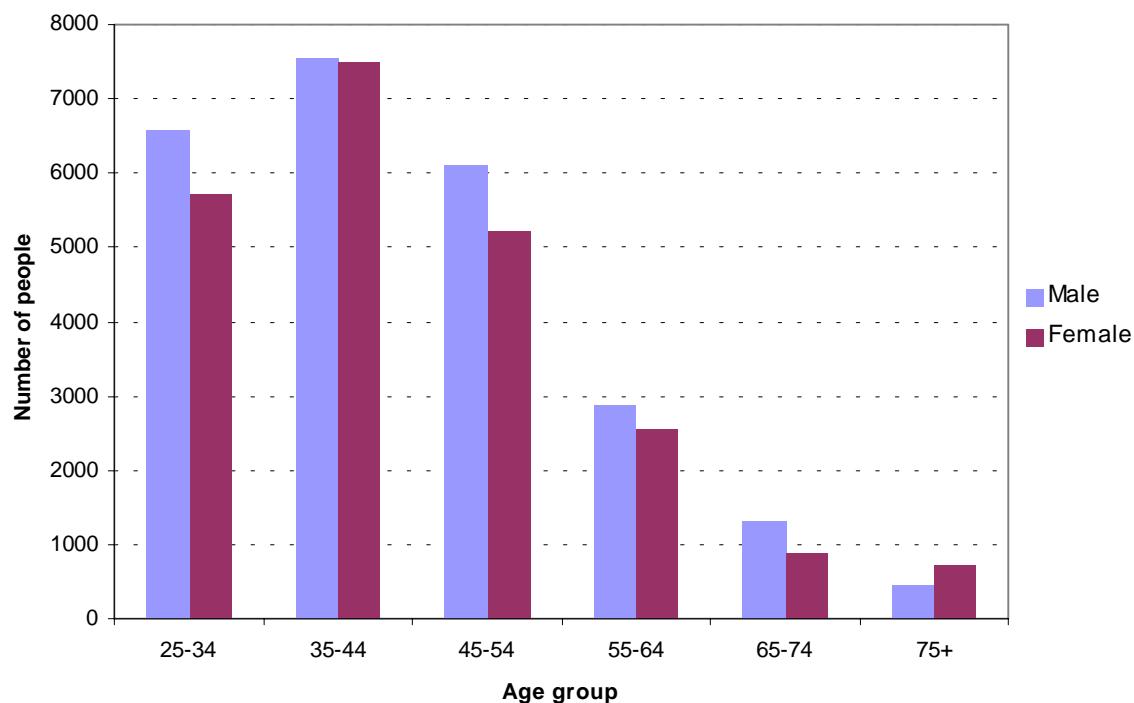
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 543 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes educators at both Hornsby and Ryde Hospitals,
 - Diabetes high risk clinic (Royal North Shore Hospital),
 - Podiatry services at Hornsby and Ryde,
 - Dietitian services at Hornsby and Ryde.

- What services are needed but are not available in your Division area?
 - GPs consistently report long waiting times for allied health, particularly podiatry,
 - A coordinated Diabetes Centre at Hornsby Hospital.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?
 - 1995 – 1998: Diabetes Project conducted management of patients over 12 month period. Clinical audit component,
 - 1998 – present: Development and updating of diabetes management resources,
 - GP education,
 - Integrating Enhanced Primary Care (EPC),
 - Education regarding budget initiative.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Expansion of working group to incorporate allied health professionals,
 - Development of diabetes management kit,
 - Success of GP education.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

No – currently Division and Working Group happy with content of program.

- What future plans do you have for diabetes management in your Division?
 - Continuing with provision of resources for GPs,
 - Program staff conducting practice visits and academic detailing,
 - GP education and practice staff education.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Internal: Computerisation
 - Delegated authority to practice staff to ensure data submission,
 - External: Divisional support in both resources and program staff.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Diabetes Working Group has a representative of the local Diabetes Australia branch, two consumer representatives, diabetes educator, dietitian, and podiatrist (Area Health representatives).

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Management of Diabetic Retinopathy,
 - RACGP Diabetes Management Guidelines,
 - Locally produced Allied Health Directory,
 - Locally produced Specialist Directory,
 - Dietetic advice sheets,
 - Diabetes Australia faxback pads,
 - NSW guide to lower limb ulcers.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes history and management record,
 - Twelve month diabetes management record.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

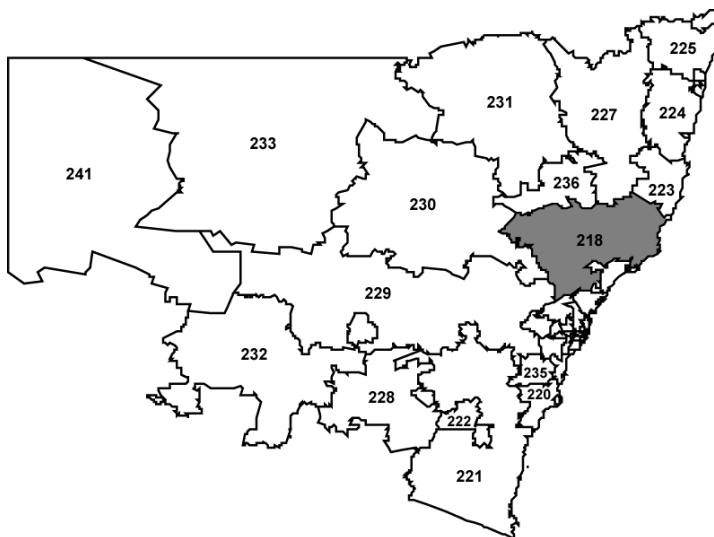
N/A.
- What resource materials do you provide to practices?

As above, also information on current diabetes incentive.

Division Contact Person/
Program Co-ordinator

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Hunter Rural DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	191,733	
■ Aboriginal or Torres Strait Islander	5384	2.8%
■ Speaks language other than English at home	3287	1.7%
■ RRMA classification ¹		
2: Other metro	62,313	32.5%
4: Small rural	103,344	53.9%
5: Other rural	26,267	13.7%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,788	9.2%
■ High blood pressure ⁴	43,877	34.2%
■ High blood cholesterol ⁵	68,467	53.3%
■ Obese or overweight ⁶	78,952	61.5%
■ Physical inactivity ⁷	53,346	41.5%
■ Smoking ⁸	23,077	18.0%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

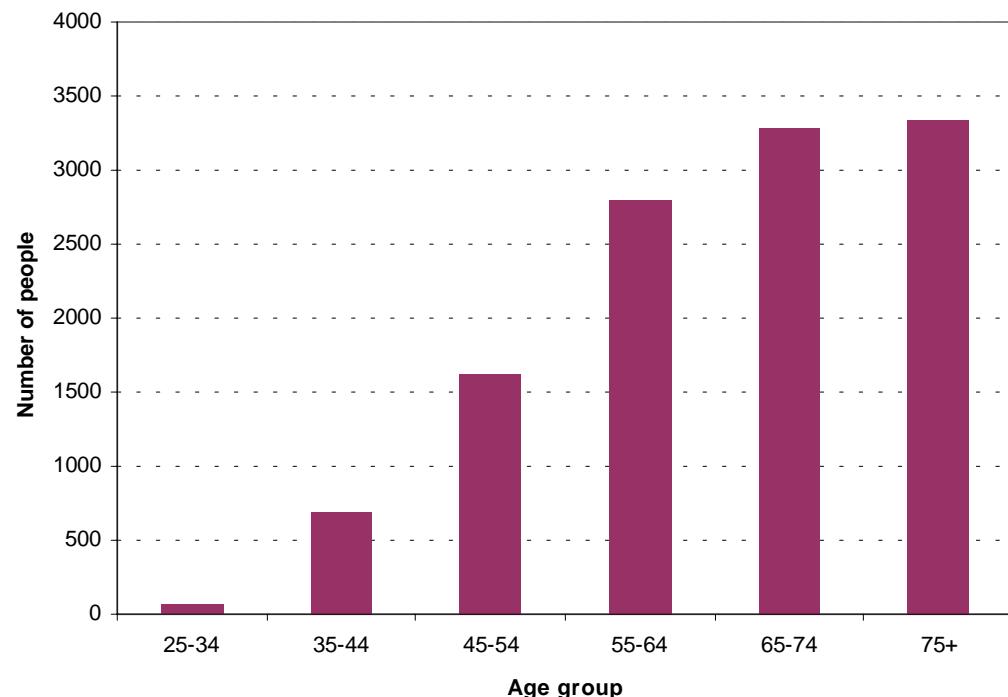
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

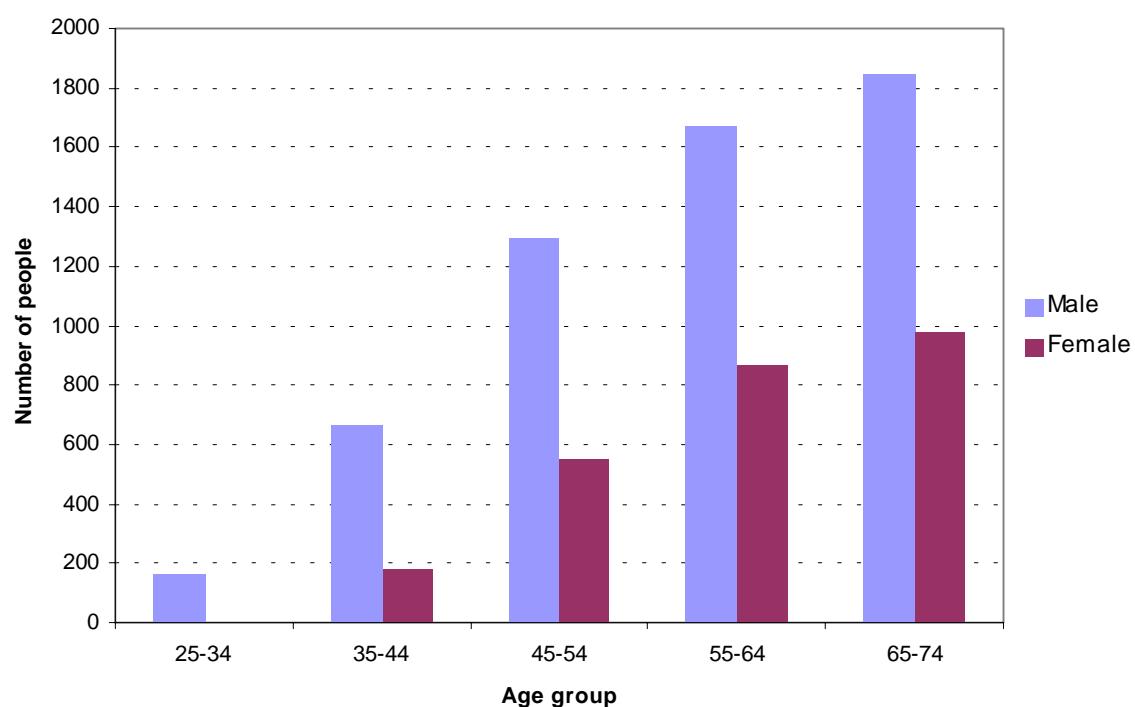
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



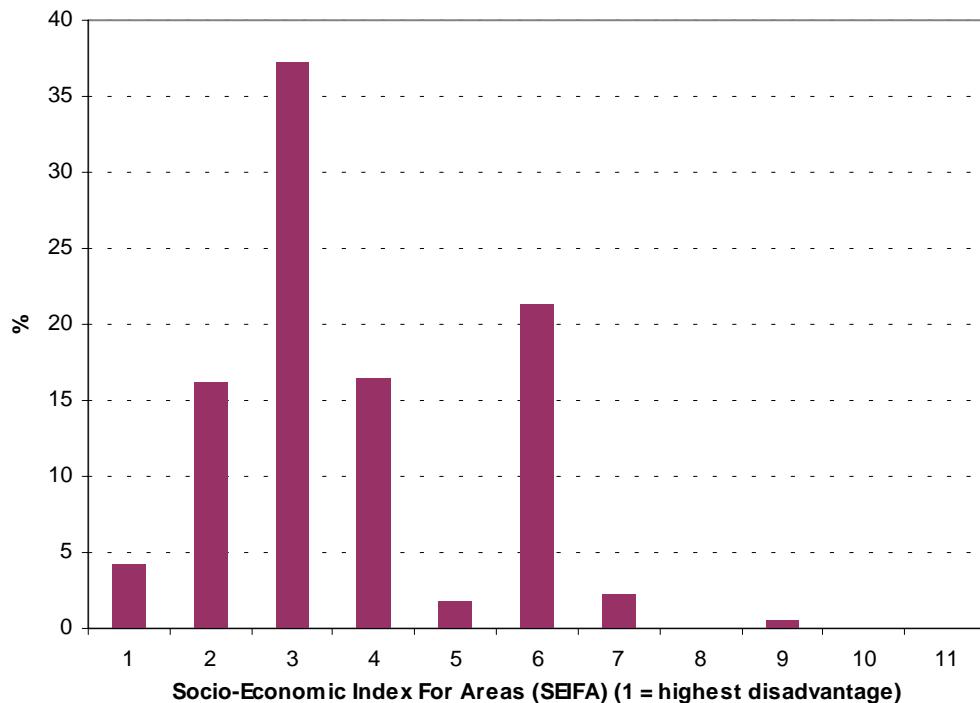
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

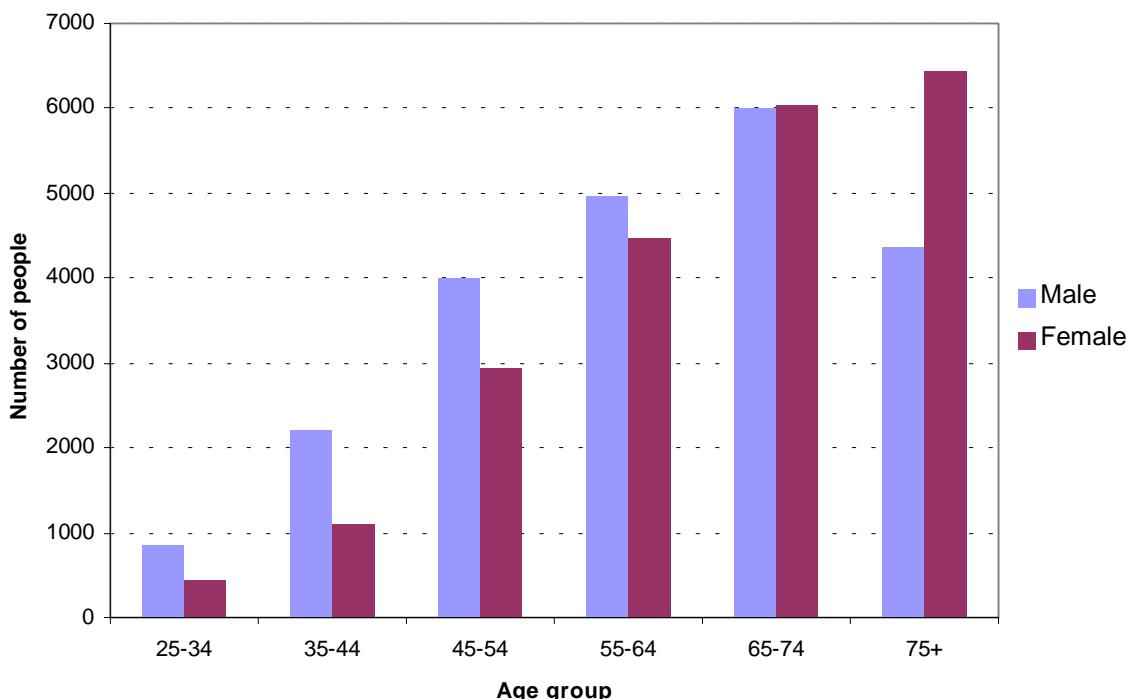
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

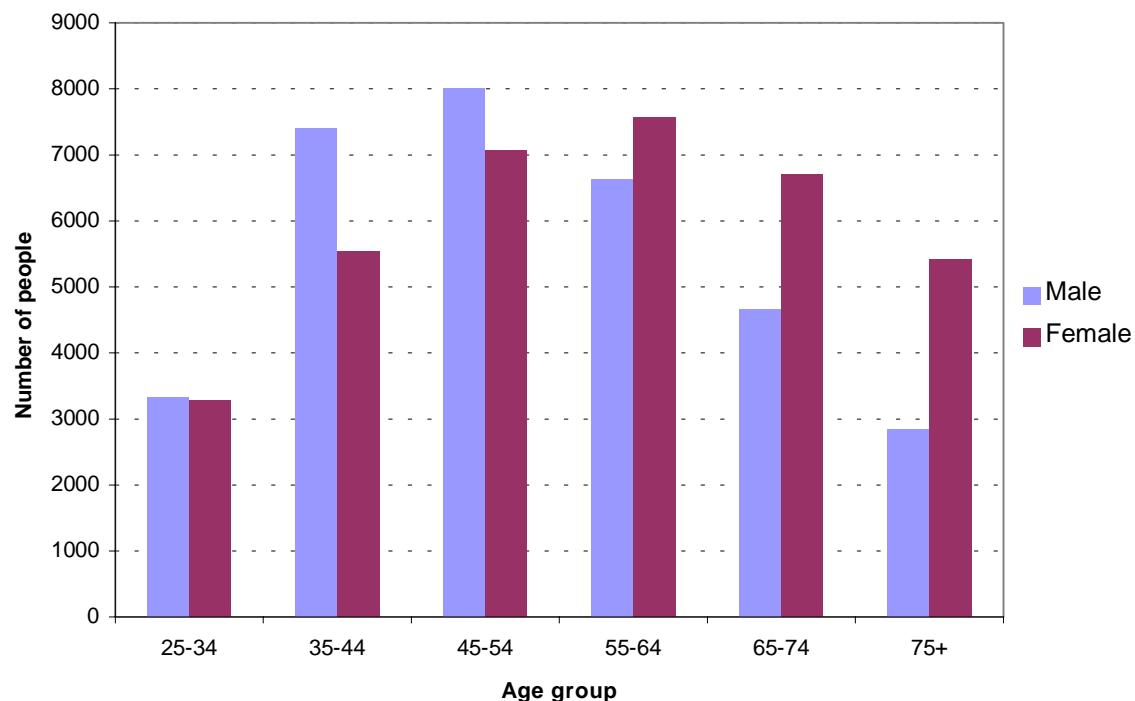
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



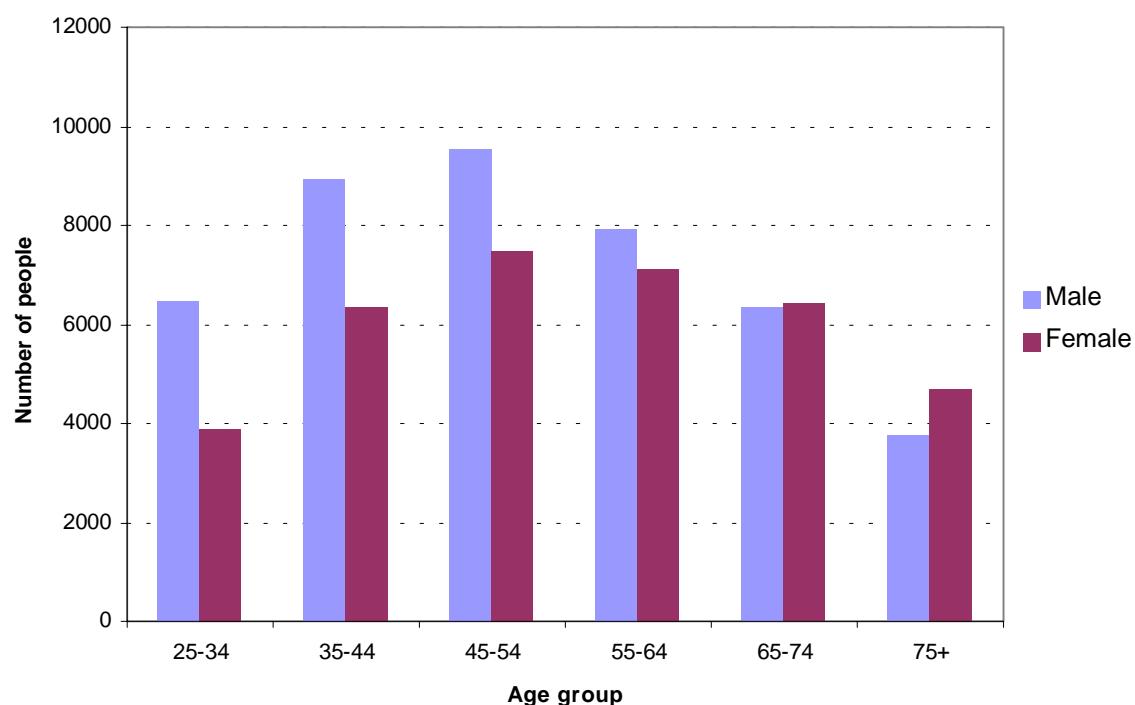
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



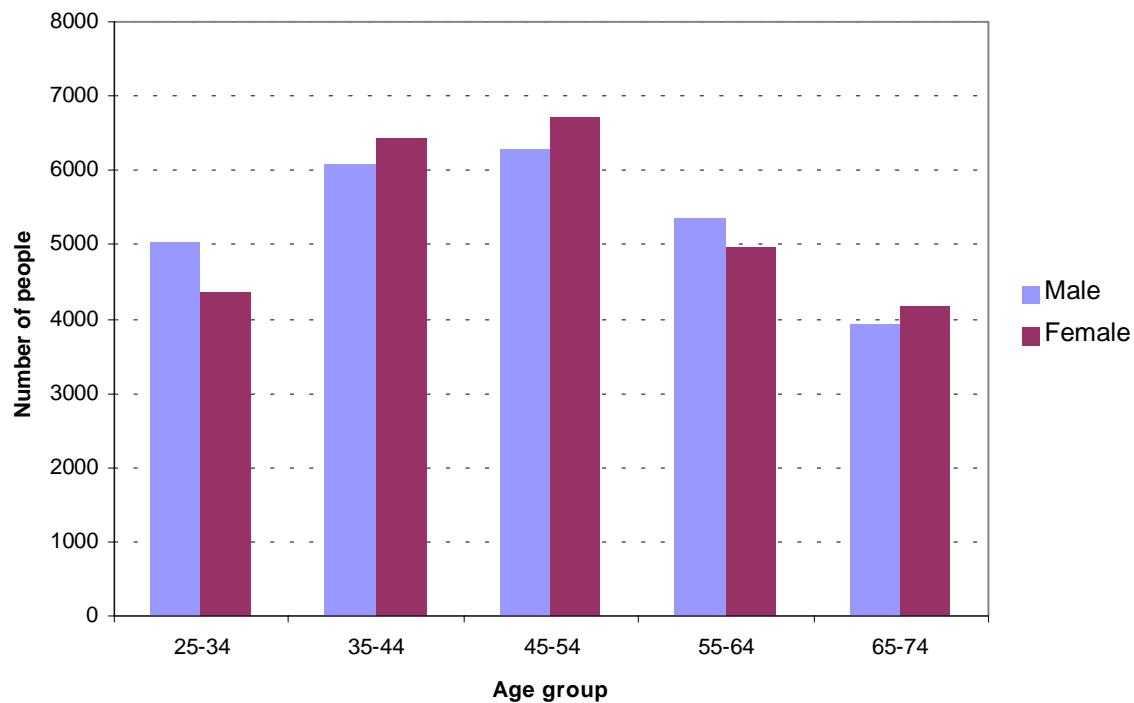
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



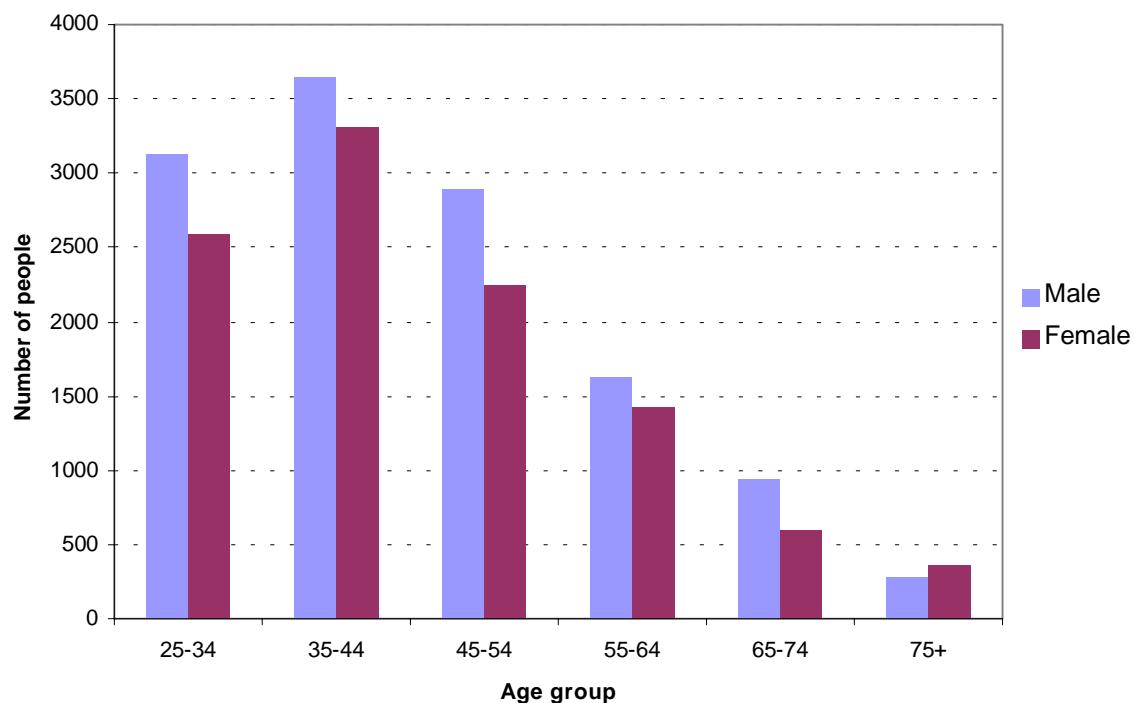
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 171 |
|--------------------------------------------------|-------|-----|
-

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Upper Hunter Diabetes Program:

- Diabetes Educator employed by Hunter Area Health Service (HAHS) – 24 hours per week,
- Dietitian employed by HAHS – 40 hours per week,
- Two dietitians (private) available on a part time basis,
- Three podiatrists (private) available on a part time basis and one podiatrist available through community health on a part time basis,
- Ophthalmologist (private) available one day every second month, also ophthalmologist available on a part time basis to see privately referred patients.

- What services are needed but are not available in your Division area?

Based on needs assessment completed 2001, podiatry and dietetic services, although available in the Division, are not provided at a sufficient level.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

- 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Upper Hunter Diabetes Program began in May 1999 and has focused mainly on the Upper Hunter with some parts of the program offered to other network areas in the Division. The Program aimed to provide multidisciplinary shared care diabetes management through the establishment of GP based diabetes clinics and to collaborate with Hunter Area Health Service (HAHS) to increase the diabetes educators hours in the Upper Hunter and therefore decrease the need for patients to travel outside their local area for diabetes education and services.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Development of an educational program by the Diabetes Education Centre, Royal Newcastle Hospital and funded by the Division has provided practice nurses with the knowledge and skills to

assess patients with known diabetes prior to their consultation with the GP.

The Upper Hunter Diabetes Educator's hours have been increased from one day to three days per week. The increase in hours was initially funded through the HAHS by the Diabetes Program, within the last twelve-months funding has been provided through More Allied Health Services (MAHS) funding. Due to the increase in hours, diabetes education is now offered on site in local clinics thus allowing greater access to diabetes education.

Improved GP knowledge through education has increased the use of current guidelines in diabetes management and care planning for persons with diabetes with multidisciplinary care needs. The establishment of the CARDIAB database to coordinate diabetes clinical records has increased the exchange of clinical information between various health professionals and has successfully been used as a tool to facilitate recall at a Division level.

Increased community knowledge through a Diabetes Consumer Seminar held in the Upper Hunter. The response to this was positive with large proportion of people attending registered with the diabetes program. As a result of the positive response from those attending these seminars will be a regular event.

-
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Some of the barriers initially experienced that limited implementation of the program were the constraints on GP and practice staff time and the problem of accommodating planned care into existing practice models.

There was a low participation rate in the uptake of the program until financial remuneration was available possibly due to a lack of understanding of the need for data collection and relevance of best practice models.

-
- What future plans do you have for diabetes management in your Division?

The Diabetes Program in its current form has finished but through the new Chronic Disease Management Initiatives, GPs will be encouraged to continue to assess their diabetes patients on the indicators and at the intervals recommended within the current guidelines and diabetes education will

continue for practice nurses and GPs.

The CARDIAB database will be utilised by the Upper Hunter Diabetes Educator as an ongoing tool for patient management.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

The financial incentives provided by the Enhanced Primary Care (EPC) MBS item numbers were the largest external influence in the success of the uptake of the program. Internally the utilisation of the practice nurse to assess patients prior to their consultation with the GP, and to coordinate the diabetes register and recall system at practice level has been very successful.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- Diabetes Education Centre, Royal Newcastle Hospital to provide ongoing education to practice nurses,
- Upper Hunter sector of HAHS to increase the Upper Hunter Diabetes Educator's hours.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- NSW Health Principles of Care and Guidelines for the Management of Diabetes Mellitus (1996),
- Royal Australian College of General Practitioners (RACGP) and Diabetes Australia, Diabetes Management in General Practice (2000).

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

- Diabetes Care Plan based on the RACGP and Diabetes Australia Diabetes Management in General Practice (2000):
 - Paper-based form,
 - Electronic form suitable for Medical Spectrum,
 - Electronic form suitable for Medical Director.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

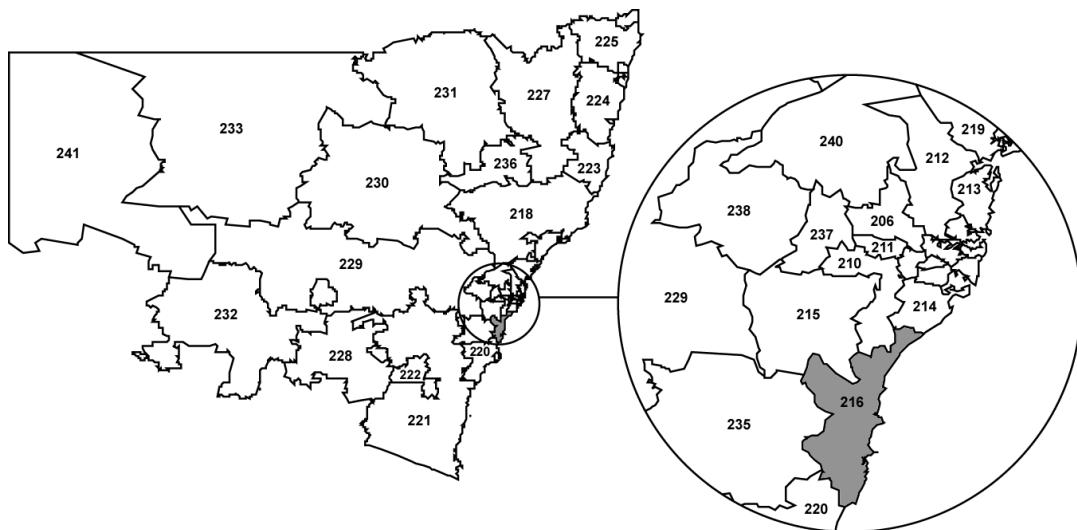
User-friendly diabetes specific software, compatible with the different medical software available.

- What resource materials do you provide to practices?
 - Diabetes Care Plan based on the RACGP and Diabetes Australia Diabetes Management in General Practice (2000):
 - Paper-based form,
 - Electronic form suitable for Medical Spectrum,
 - Electronic form suitable for Medical Director,
 - Diabetes Resource Manual,
 - Recall letter,
 - Copy of Royal Australian College of General Practitioners (RACGP) and Diabetes Australia, Diabetes Management in General Practice (2000),
 - Consent form.

Division Contact Person/
Program Co-ordinator

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Email: cheryl@hrdgp.org.au

Illawarra DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	256,095	
■ Aboriginal or Torres Strait Islander	4085	1.6%
■ Speaks language other than English at home	38,471	15.0%
■ RRMA classification ¹		
2: Other metro	256,095	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	13,571	8.2%
■ High blood pressure ⁴	51,396	31.0%
■ High blood cholesterol ⁵	85,805	51.7%
■ Obese or overweight ⁶	100,196	60.4%
■ Physical inactivity ⁷	69,971	42.2%
■ Smoking ⁸	31,387	18.9%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

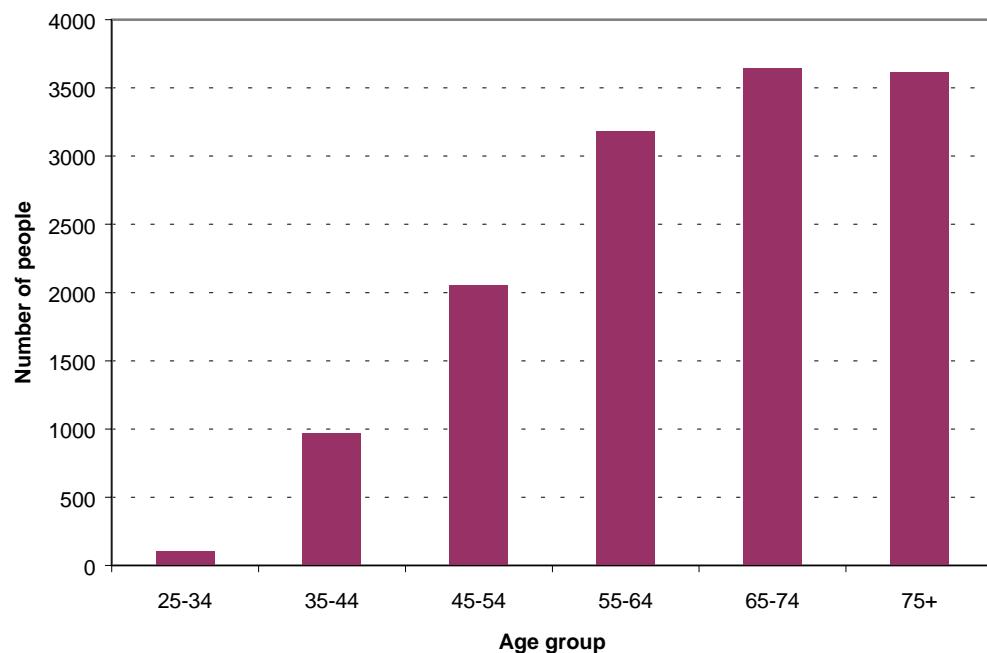
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

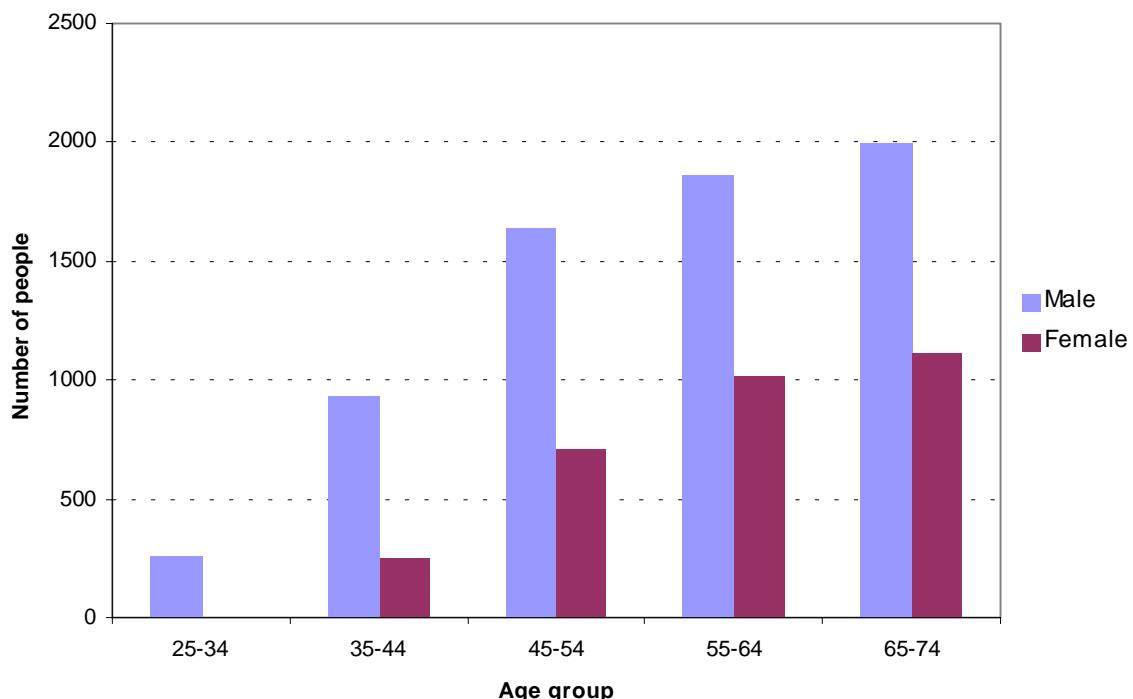
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



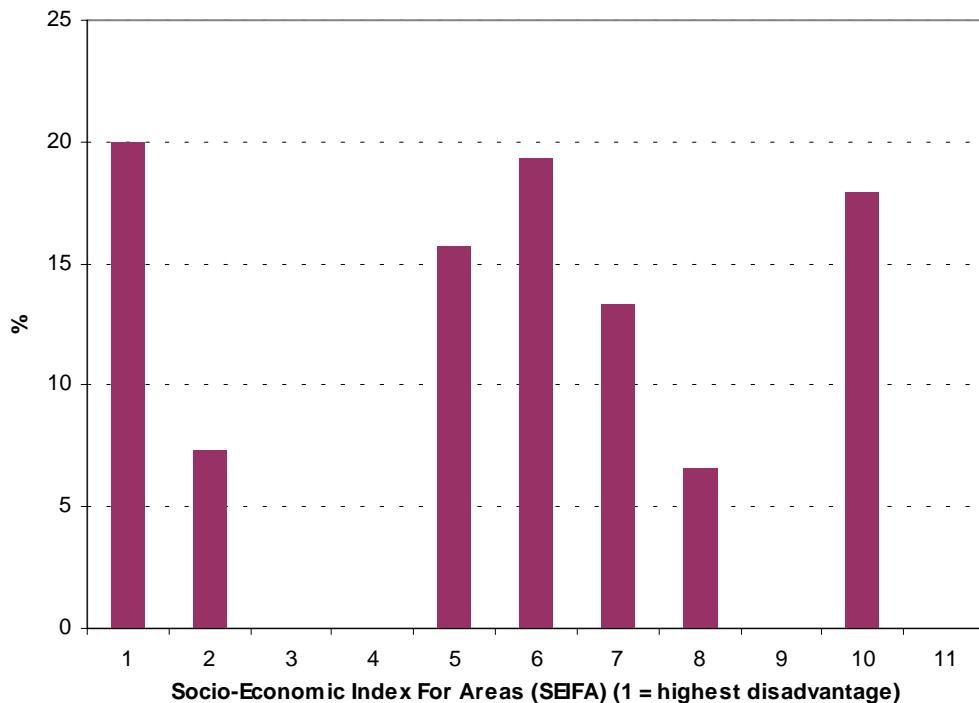
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

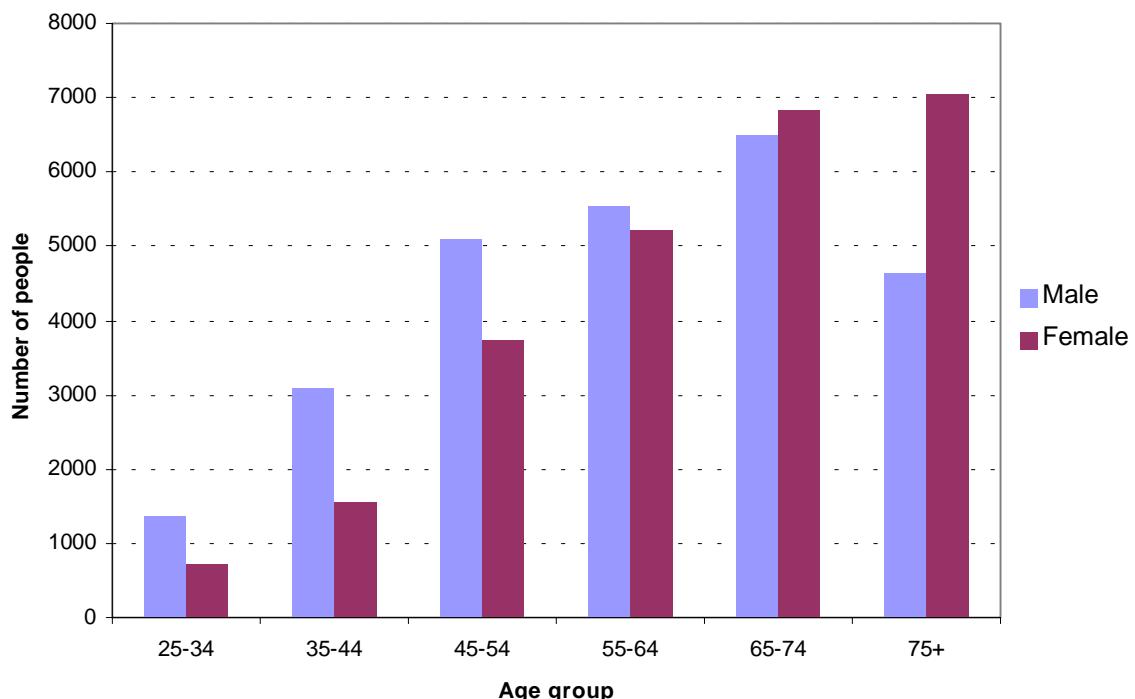
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

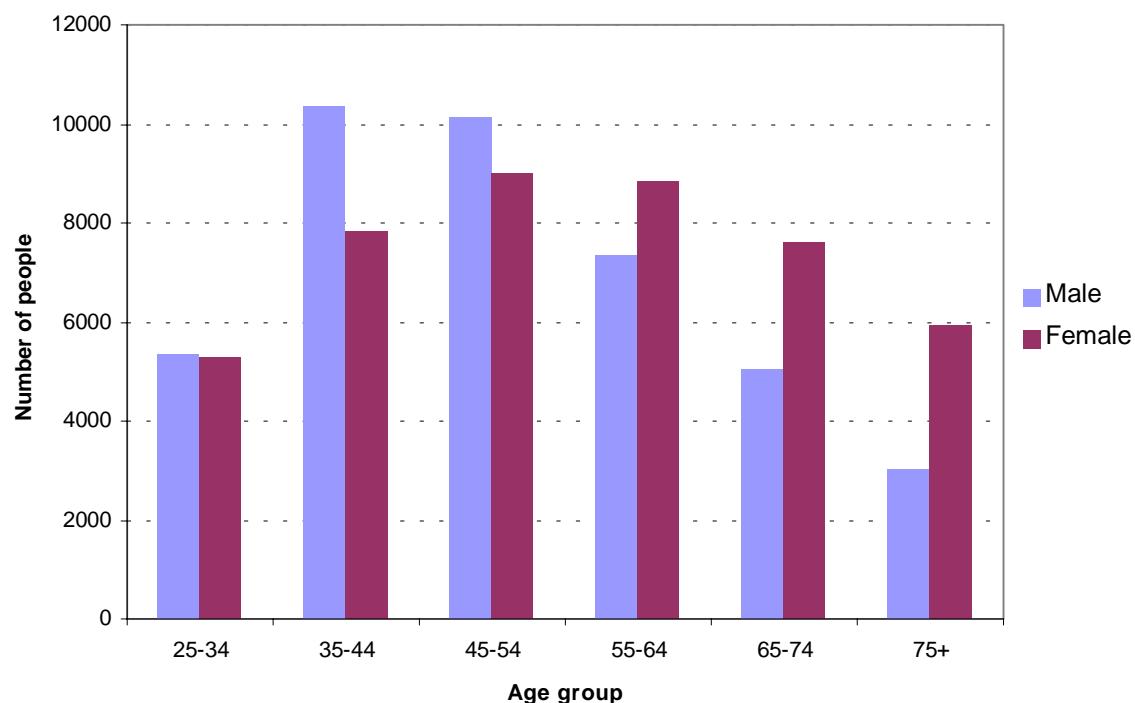
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



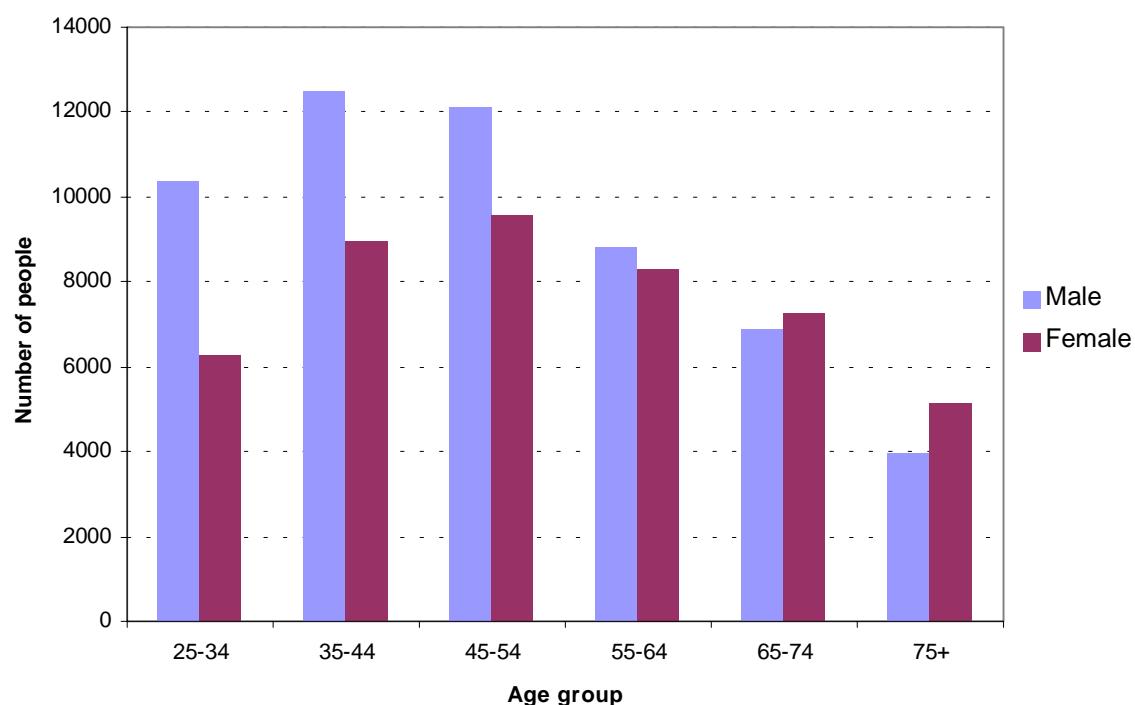
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



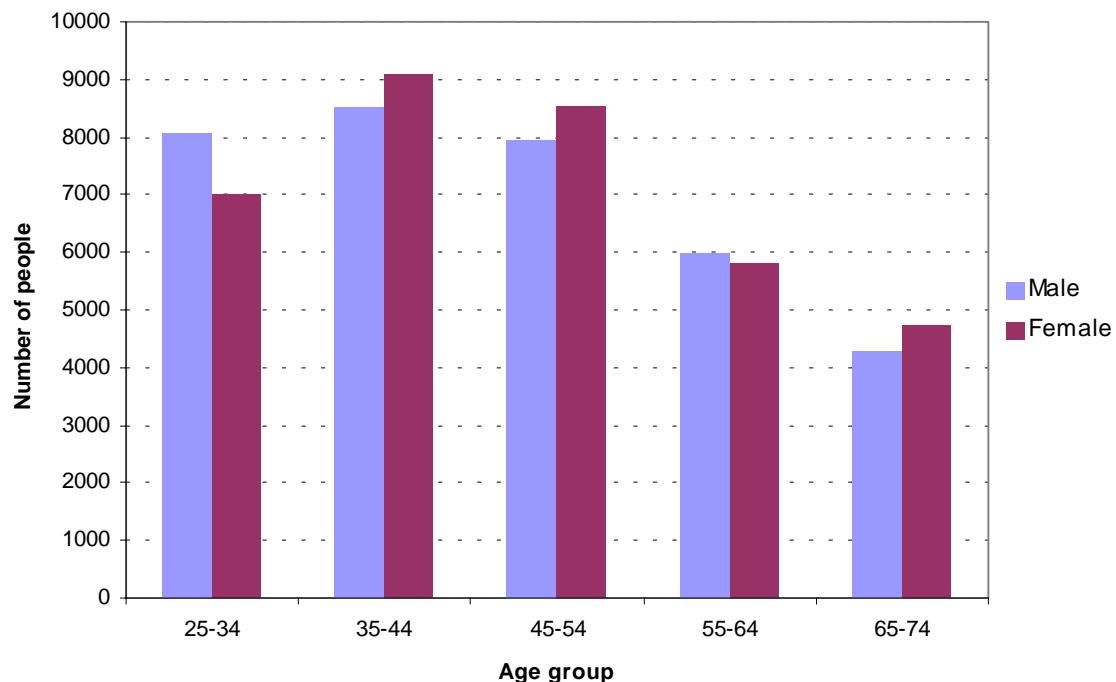
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



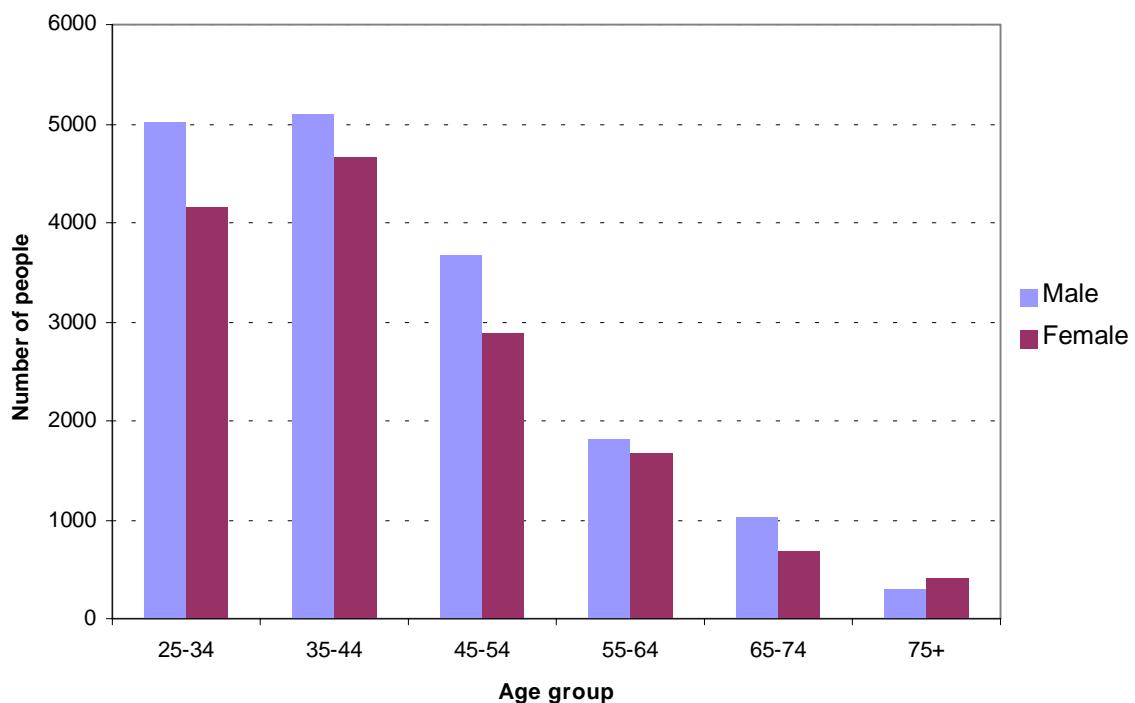
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 213 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Centre-based individual appointments for people with diabetes provided by dietitians and diabetes educators. Group education also provided for people with type 2 diabetes and impaired glucose tolerance (IGT). Dietitians also provide supermarket tours and cooking instruction,
 - Paediatric in-patient admission and education,
 - High risk foot ulcer clinic,
 - Hospital dietetics services,
 - Private endocrinologists,
 - Private dietitians and podiatrists,
 - Amputee service,
 - National Diabetes Services Scheme (NDSS) pharmacists.

- What services are needed but are not available in your Division area? N/A

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input checked="" type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	
- Please describe your diabetes program including any changes that occurred over time?

The Division operated dietary clinics for patients with diabetes at GP surgeries between 1993 and 1996. This was accompanied by Continuing Medical Education (CME) activities for participating GPs. Patient data was collected by GPs and faxed to the Division where it was entered on the database, a time-consuming and resource intensive process.

In 1999 a new system was piloted which allowed patient data to be downloaded from the GPs' clinical software program to the Division's diabetes database. This program continues and today the diabetes program relies heavily on information technology. Clinical data on blood pressure, HbA1c, lipids and BMI is downloaded from participating GPs' desktops. Patients' results are aggregated at the GP and Division level and the

timeliness of the intervention is plotted against clinical management guidelines. Reports are provided to GPs. GPs can monitor their patients' diabetes program data via the Division's website. The program evaluates adherence to clinical guidelines and ultimately whether improvements to patient health outcomes have been achieved.

This initiative is supported by provision of clinical management guidelines to GPs, quarterly Continuing Professional Development (CPD) program for GPs, a clinical audit activity and mail outs of patient education materials consistent with CPD topics to participating patients.

A further development occurred in 2002 with the implementation of a trial of the "Smart ID" technology, involving collaboration with the University of Wollongong. This innovative web-based technology provides secure, shared access to patient diabetes records. GPs and patients are provided with i-keys, which are used during consultations. These enable both GPs and patients to have access to patient records. Patients can also access their records at any location via the internet, using their password.

Work is currently underway to expand the IT capabilities of the diabetes program to enable secure, shared access to patient records by Illawarra Health Diabetes Service and local endocrinologists.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Thirty eight GPs and 550 patients are participating in the program,
 - Successful downloads of patient data from GP clinical software to the Division's diabetes database,
 - Analysis of results from the diabetes database to date indicate improvements in HDL, HbA1c, BMI and blood pressure,
 - Successful development and trial of the innovative, web-based "Smart-ID" technology,
 - The active involvement of patients on the "Smart ID" trial in monitoring their health,
 - Collaborative partnerships formed with Area Health, University of Wollongong and local consumers,
 - Consumer empowerment consistent with a primary care model.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Changes to pathology company reporting have necessitated modifications to the diabetes database program,
 - Early technical problems occurred during implementation of “Smart ID” trial,
 - Internet access.
- What future plans do you have for diabetes management in your Division?
 - Expansion of web-based access to patient records to include the diabetes service and endocrinologists,
 - Expansion of web-based access for diabetes patients,
 - Introduction of Division-based diabetes recall system.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GP interest in/commitment to chronic disease management,
 - Financial incentives,
 - Requirements of the incentives, eg. The diabetes Service Incentive Payment (SIP) table is easy for GPs to follow.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - University of Wollongong. Linkages developed through collaboration on development of IT/IM projects,
 - Diabetes Service: Service input into program planning via Division diabetes program committee and IT/IM working parties; collaboration/input regarding education for GPs and practice nurses,
 - Local endocrinologists involved in program committee and provision of GP education,
 - Area Diabetes task force: Attendance by members of diabetes program committee,
 - Diabetes Australia – Wollongong branch: attendance by Division staff, provision of professional support and resources, consumer input into program decision-making.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state
 - National Health and Medical Research Council (NHMRC) guidelines for management of type 2 diabetes,
 - Royal Australian College of General Practitioners (RACGP) diabetes management guidelines booklet,

based resources)?

- NSW Health diabetes clinical management guidelines,
- Reports from Commonwealth Department of Health and Ageing and NSW Health,
- Australian Institute of Health and Welfare (AIHW) reports, eg Bettering the Evaluation and Care of Health (BEACH),
- Ausdiab report,
- National Divisions Diabetes Program (NDDP) data collation project reports,
- Diabetes Australia publications,
- National Heart Foundation publications.

▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

- Diabetes patient booklet,
- Service Incentive Payment (SIP) checklist.

▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

NHMRC guidelines developed into a GP resource.

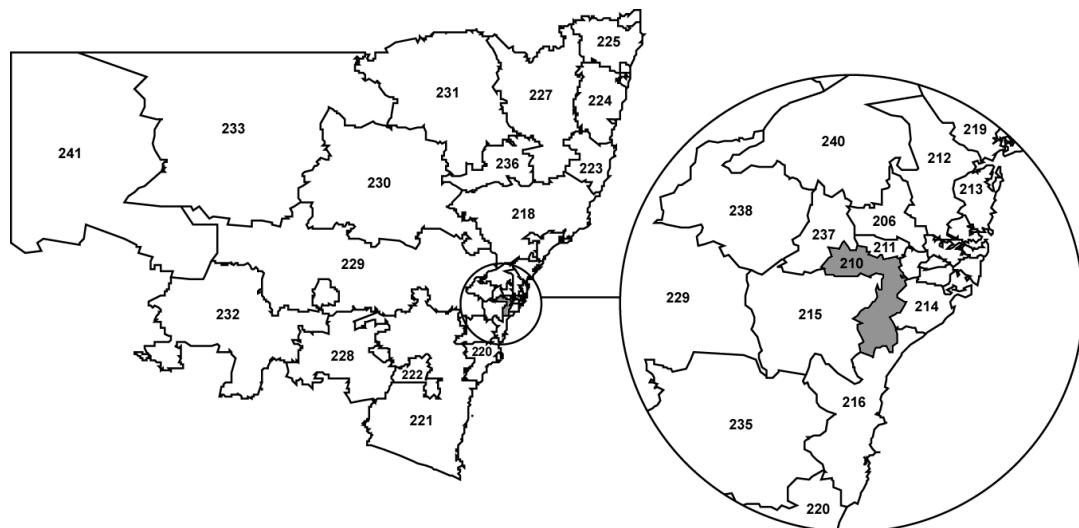
▪ What resource materials do you provide to practices?

- Diabetes patient booklets,
- Diabetes program manual – includes instructions for clinical software programs, a diabetes service directory and patient education resources,
- Practice Incentive Program (PIP)/SIP information.

Division Contact Person/
Program Co-ordinator

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Liverpool DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	159,832	
■ Aboriginal or Torres Strait Islander	2120	1.3%
■ Speaks language other than English at home	69,874	43.7%
■ RRMA classification ¹		
1: Capital city	159,832	100.0%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6015	6.2%
■ High blood pressure ⁴	23,969	24.9%
■ High blood cholesterol ⁵	47,171	48.9%
■ Obese or overweight ⁶	56,589	58.7%
■ Physical inactivity ⁷	42,343	43.9%
■ Smoking ⁸	20,054	20.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

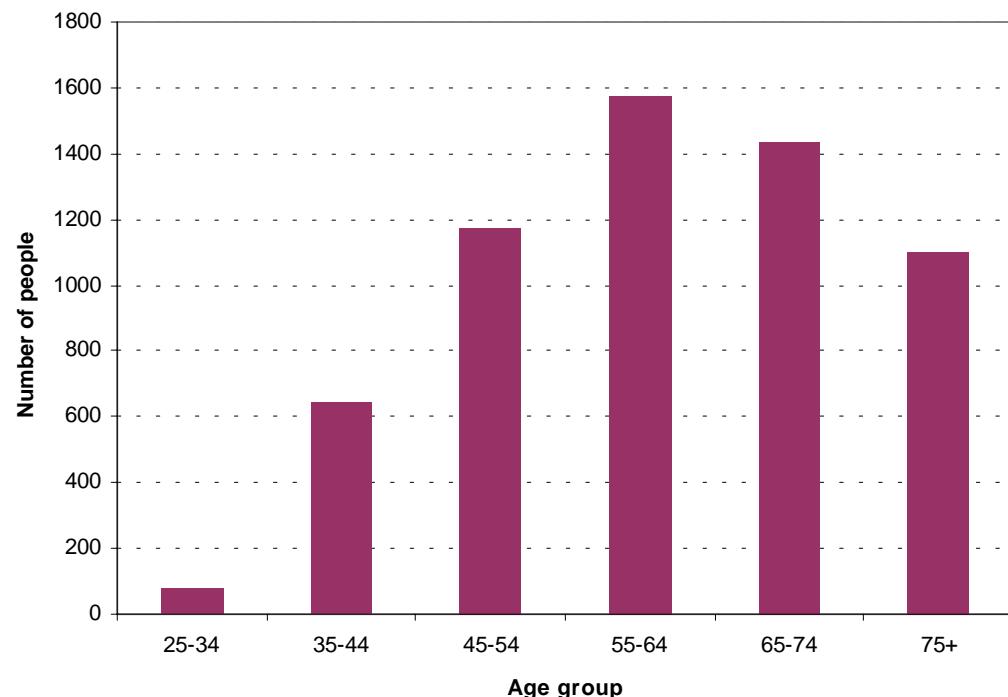
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

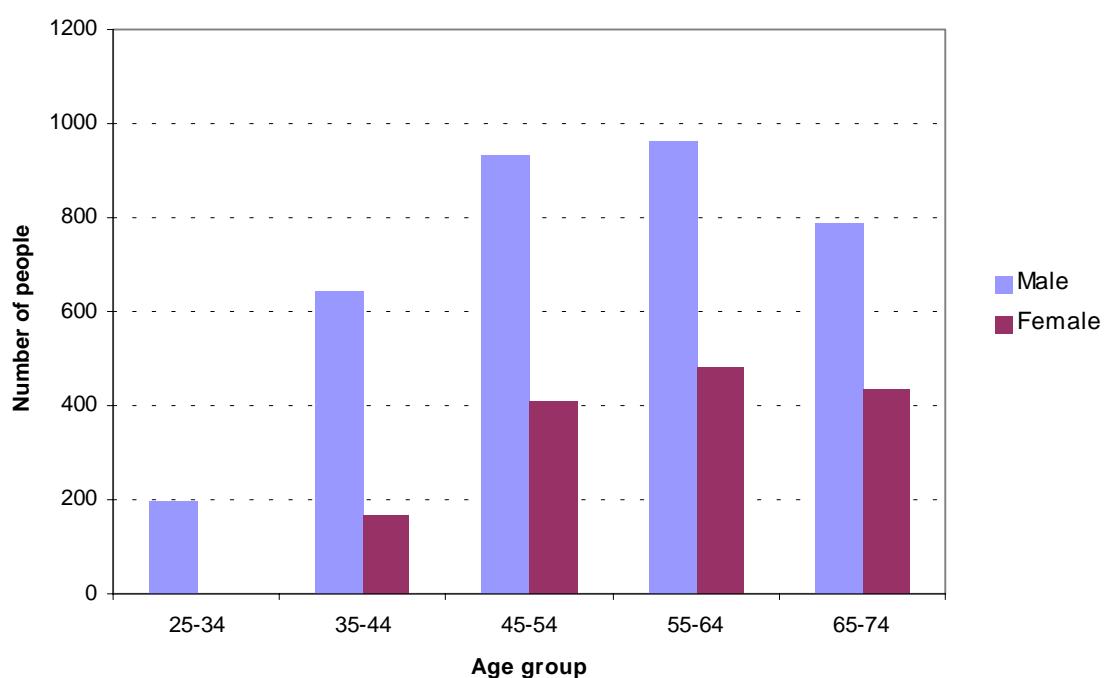
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



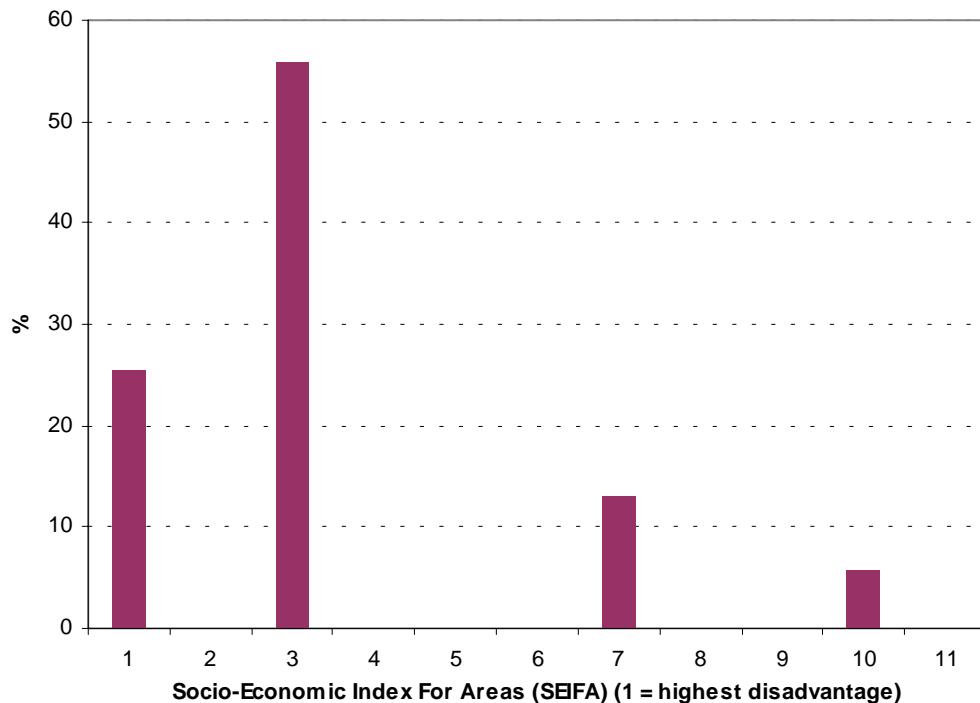
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

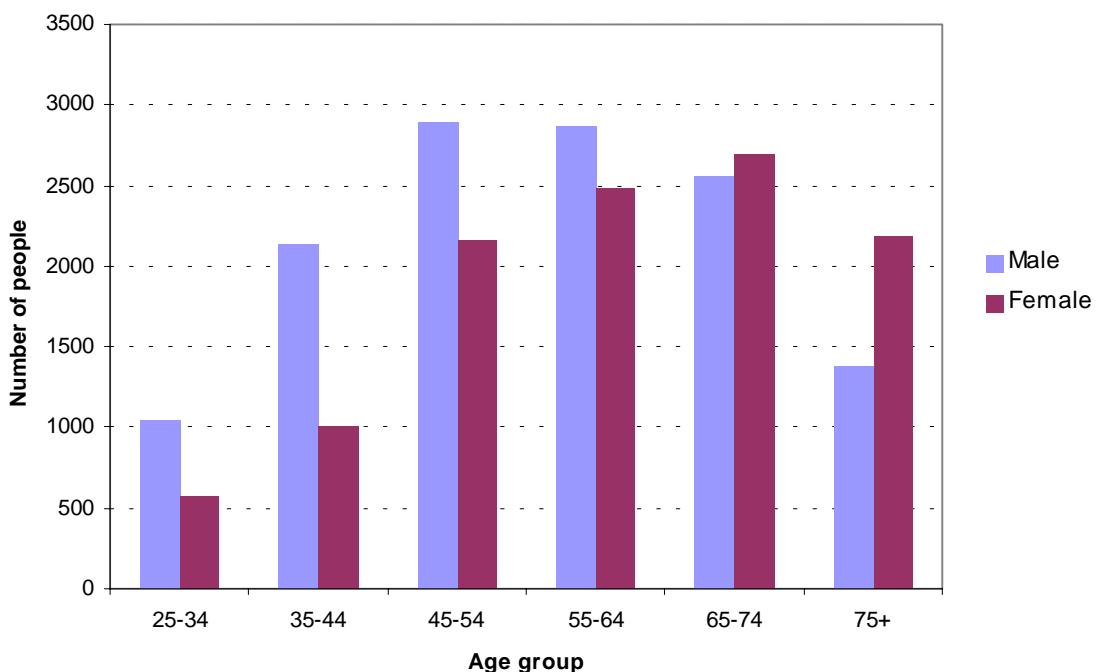
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

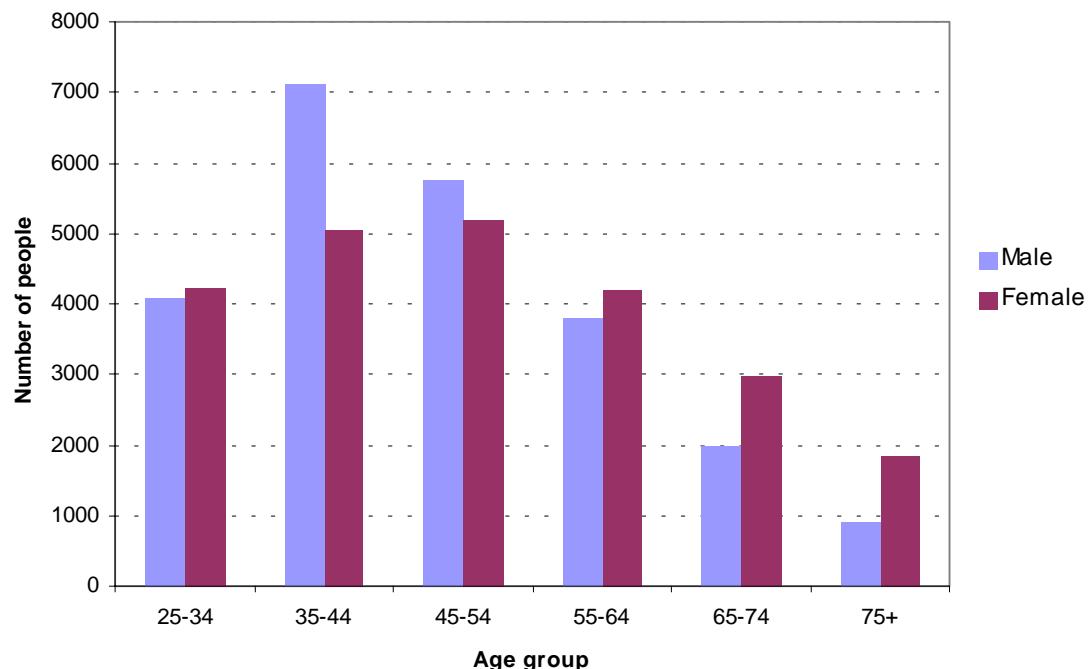
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



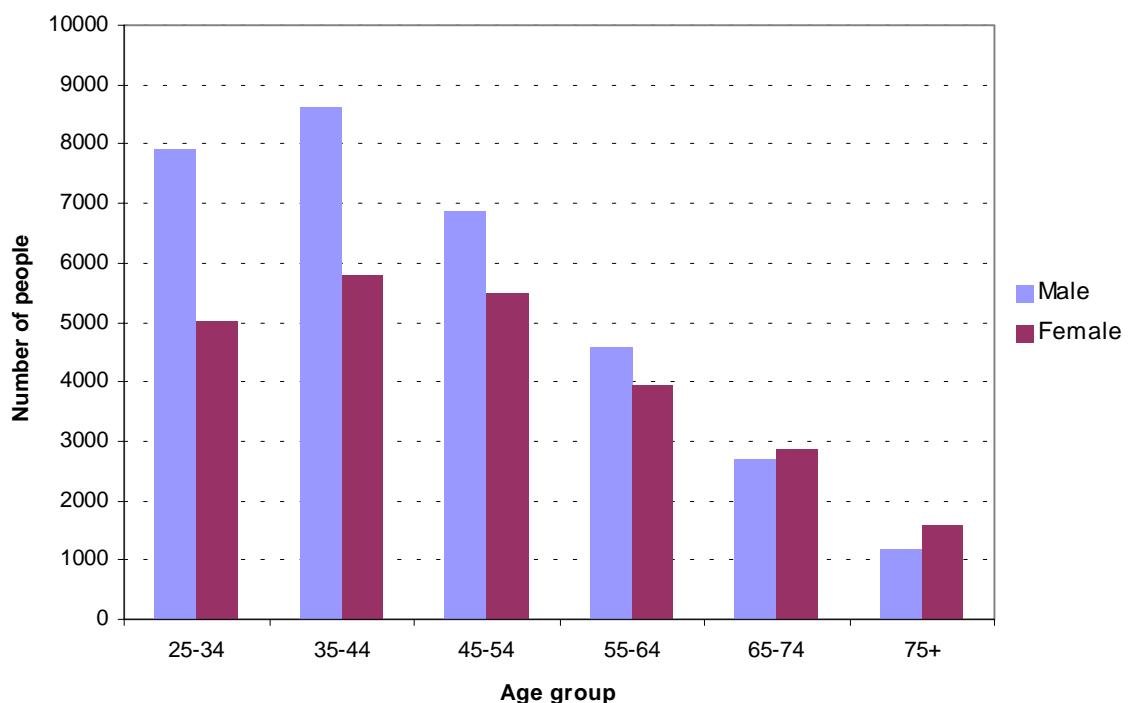
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



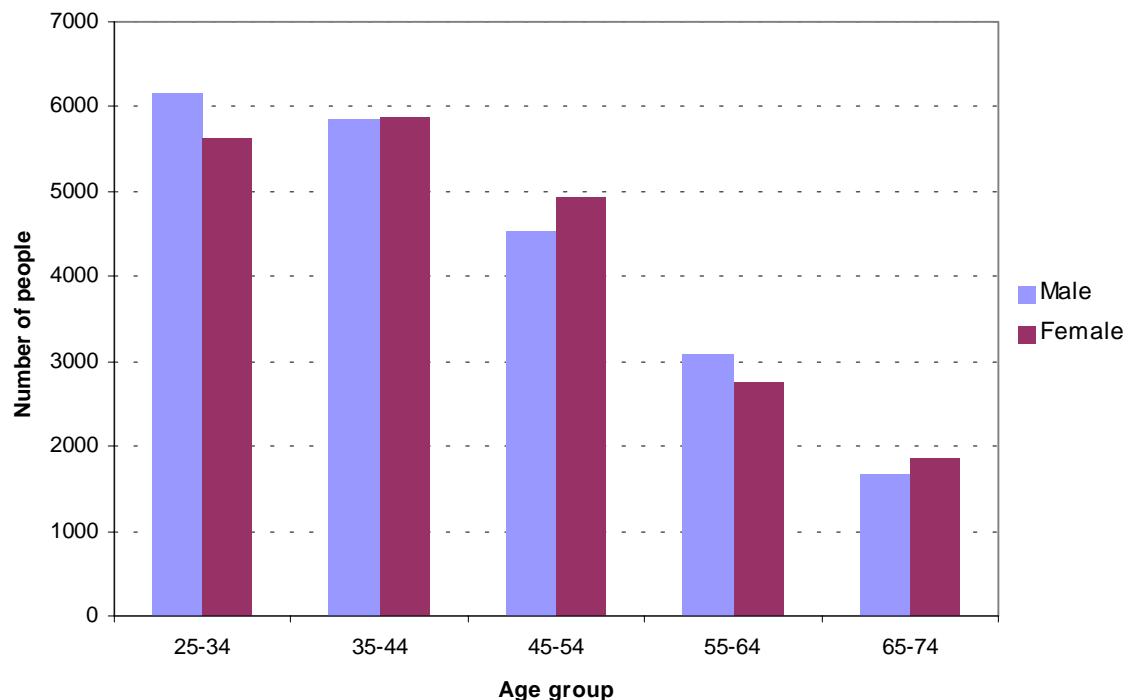
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



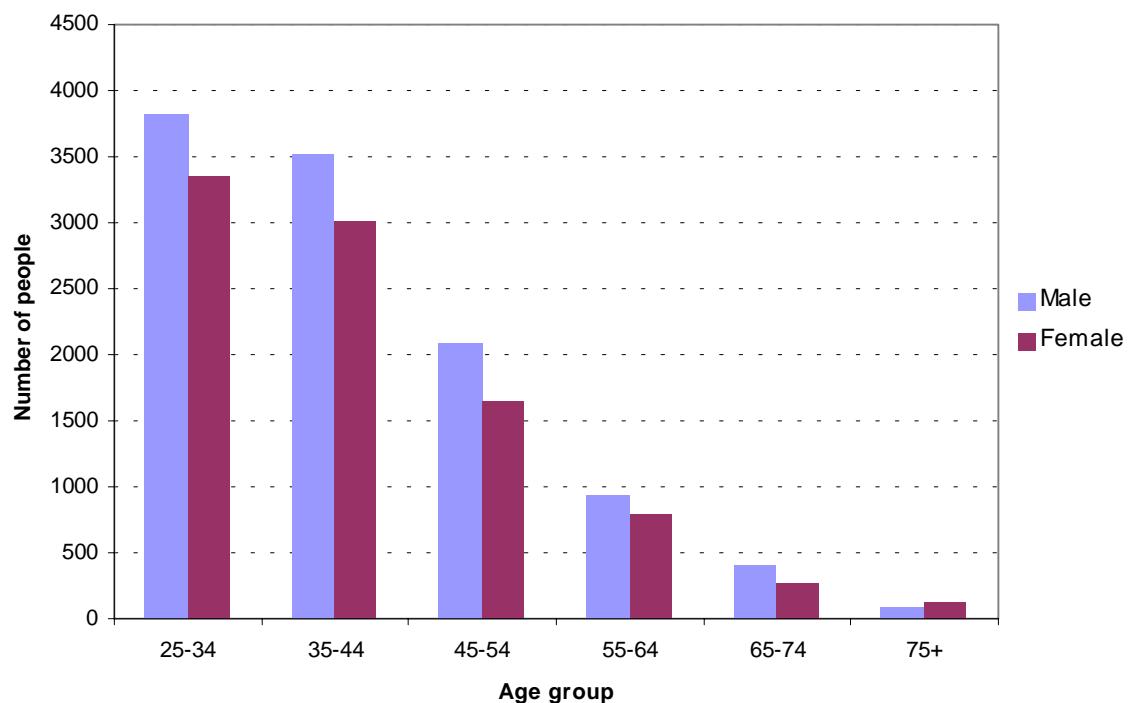
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 142 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Public and private diabetes centres,
 - Dietitian clinic,
 - Eye clinic,
 - Podiatrists,
 - Diabetes Australia Liverpool Branch.

- What services are needed but are not available in your Division area? N/A.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

With aims of providing optimal quality of care to diabetes patients and thus improving health outcomes in Liverpool area. More and more GPs regard the program as key to helping them in management of their diabetes patients and upskilling their knowledge.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Over eighty GPs accredited to the program and forty GPs were actively participating in the program. Over 700 diabetes patients have been recruited (not including those lost in follow-up).

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

- Time,
- Low rate of computerisation,
- GPs desk-top is not compatible with the Divisional database,
- Funding.

- What future plans do you have for diabetes management in your Division?

Electronic data transfer.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Time,
 - Low rate of computerisation,
 - No motivation.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Program committee,
 - Committee meeting regularly.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Divisional brochure,
 - Booklets from Diabetes Centre, South Western Sydney Area Health Service (SWSAHS),
 - RACGP,
 - Diabetes Australia.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Patient brochures,
 - Basic Guide to Diabetes,
 - Healthy Eating with Type 2 Diabetes.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Need patient brochures in other languages.

- What resource materials do you provide to practices?
 - Patient brochures for patient,
 - Basic Guide to Diabetes for patient,
 - Healthy Eating with Type 2 Diabetes for patient,
 - Diabetes Management Guidelines for GP.

Division Contact Person/
Program Co-ordinator

Name: Jun Lian
Phone: 02 9828 6523
Fax: 02 9602 0162
Email: junlian@liverpoolgp.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Liverpool public hospital & private hospital,
 - Liverpool cardiac rehabilitation and health lifestyle program,
 - Upbeat exercise program,
 - Social support group.

- What services are needed but are not available in your Division area?
N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
The CVD program focuses on people who are at risk of CVD disease initially. The Division encourages GPs to play an essential role in the primary and secondary prevention, and in collaborating in shared initiatives with South Western Sydney Area Health Services (SWSAHS) and local government.

Division Perspective

- What have been the major achievements or highlights of your program so far?
A program manual has been developed, which includes clinical guidelines. The manual will be updated as needed to reflect the latest available information and progress in the area of CVD progress.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of time,
 - Funding,
 - Low computerisation rate.

- What future plans do you have for CVD management in your Division?
 - Electronic data transfer,
 - Working together with Area Health Service,
 - Increase public awareness.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - To make it easier for GP to participate in the program,
 - To have practice incentives payment available.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The program has a committee, which included cardiologists, dietitians, the local council, the National Heart Foundation and consumers.

Division Resources

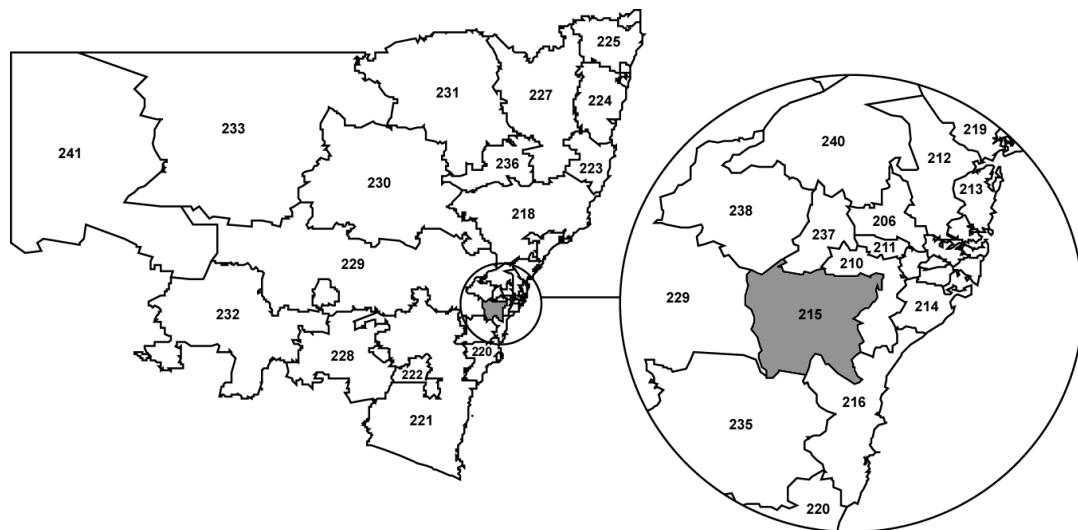
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation,
 - State-based resources.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Program manual,
 - Patients brochures,
 - Healthy eating with a healthy heart.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Patient's brochures (especially in multi languages).
- What resource materials do you provide to practices?
 - Program manual for GP,
 - Patients' brochures,
 - Healthy eating with a healthy heart,
 - Materials from National Heart Foundation.

Division Contact Person/
Program Co-ordinator

Name: Jun Lian
Phone: 02 9828 6523
Fax: 02 9602 0162
Email: junlian@liverpoolgp.com.au

Macarthur DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	220,482	
■ Aboriginal or Torres Strait Islander	4610	2.1%
■ Speaks language other than English at home	34,759	15.8%
■ RRMA classification ¹		
1: Capital city	220,482	100.0%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	8057	6.3%
■ High blood pressure ⁴	32,014	24.8%
■ High blood cholesterol ⁵	63,779	49.5%
■ Obese or overweight ⁶	75,861	58.9%
■ Physical inactivity ⁷	56,821	44.1%
■ Smoking ⁸	26,685	20.7%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

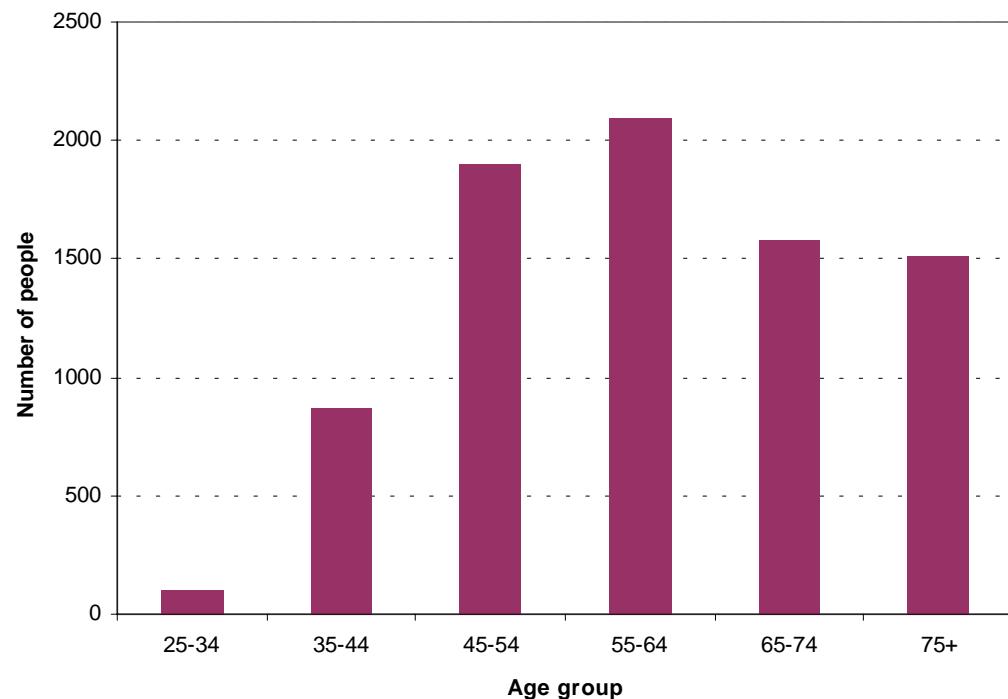
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

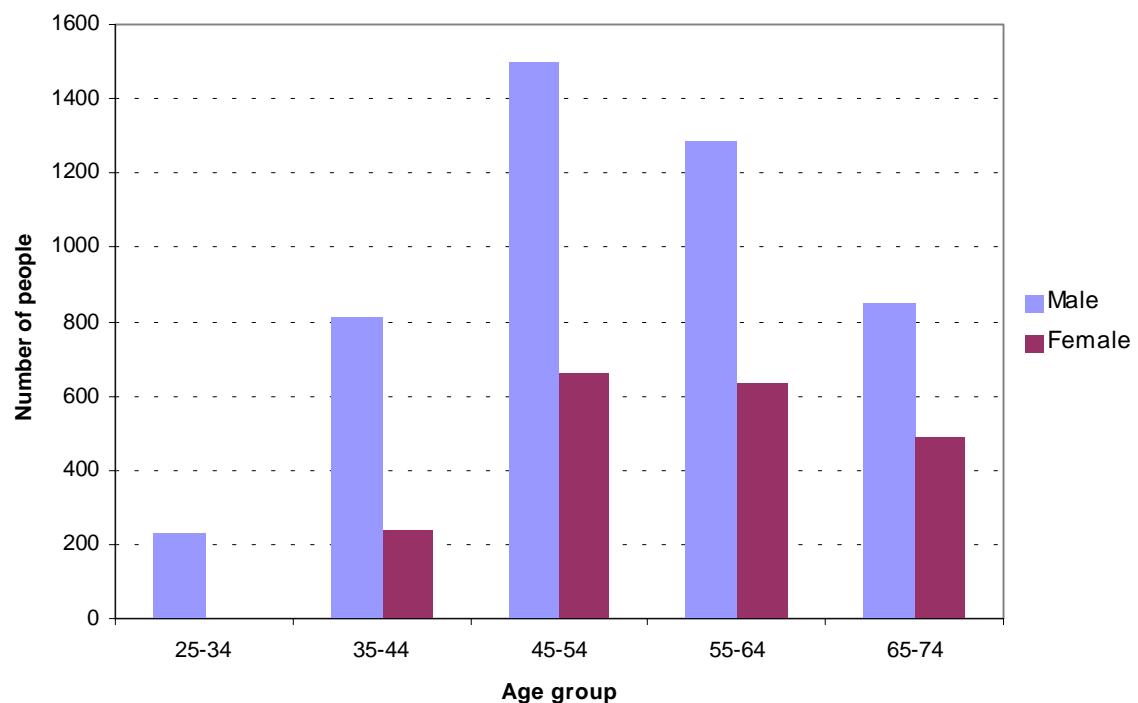
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



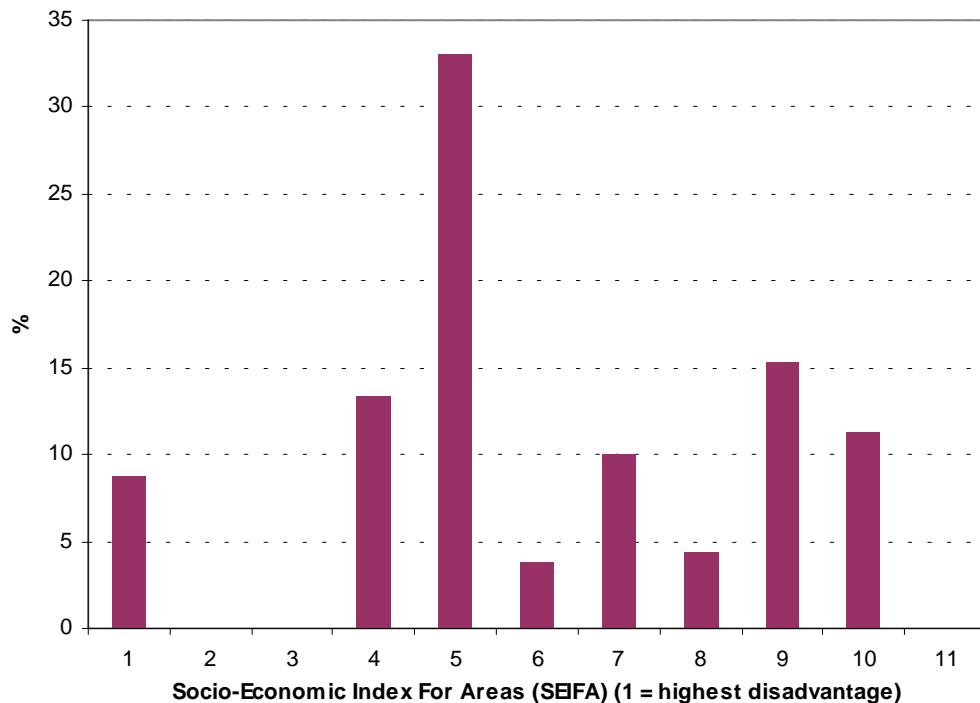
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

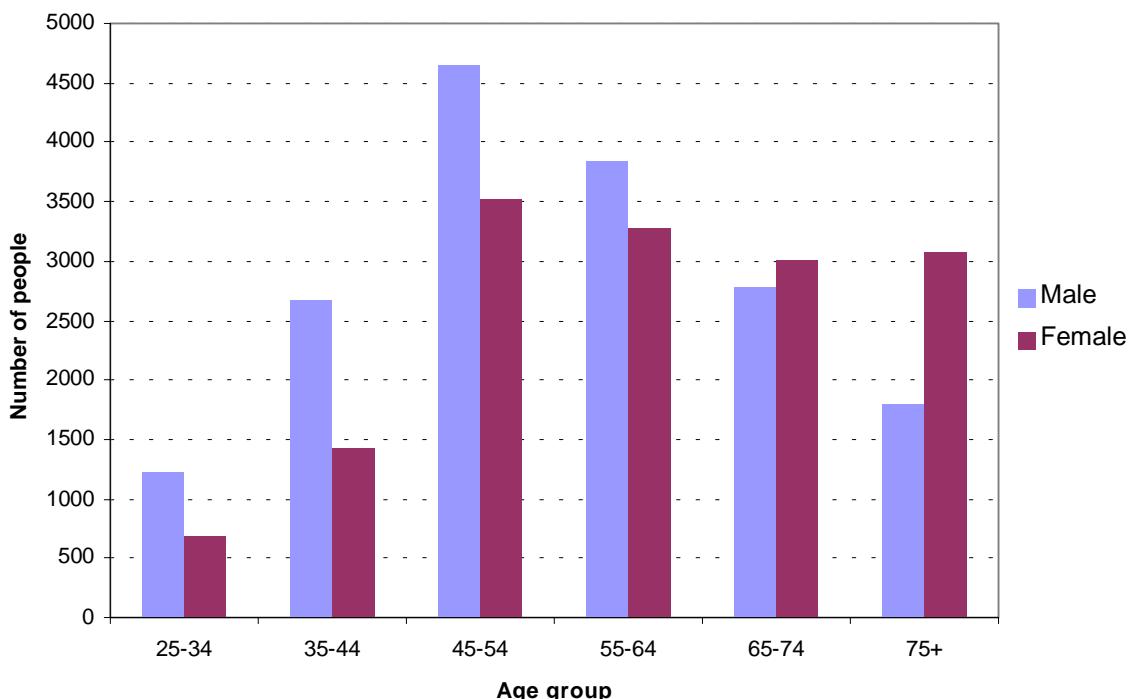
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

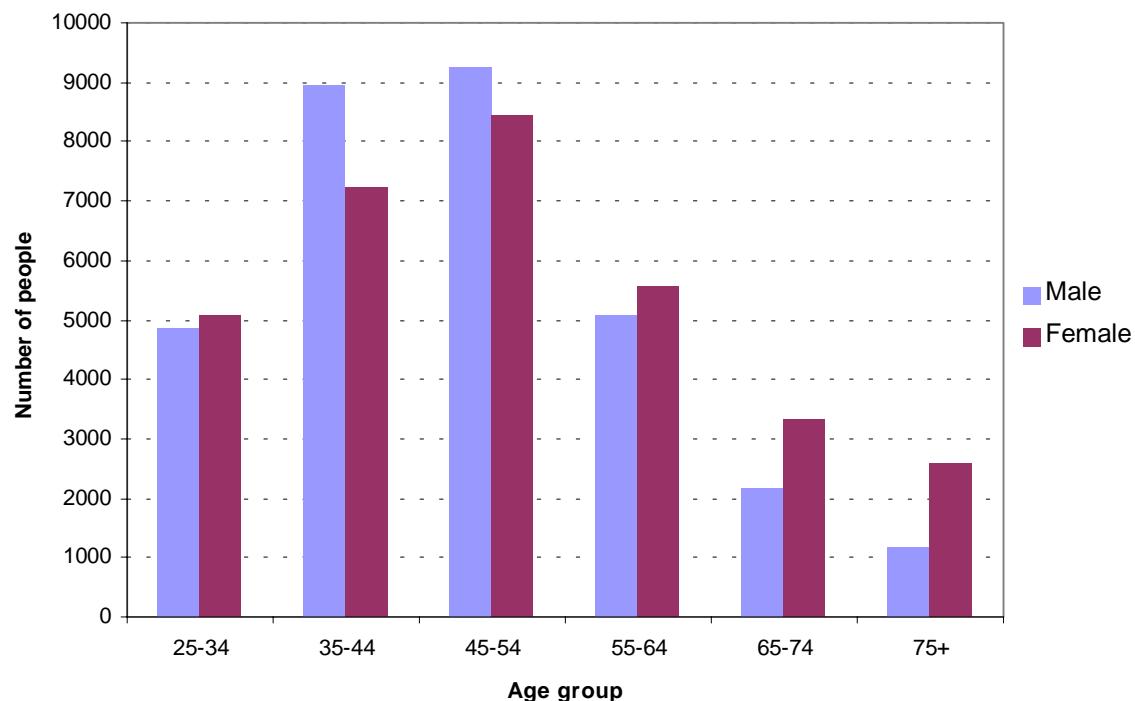
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



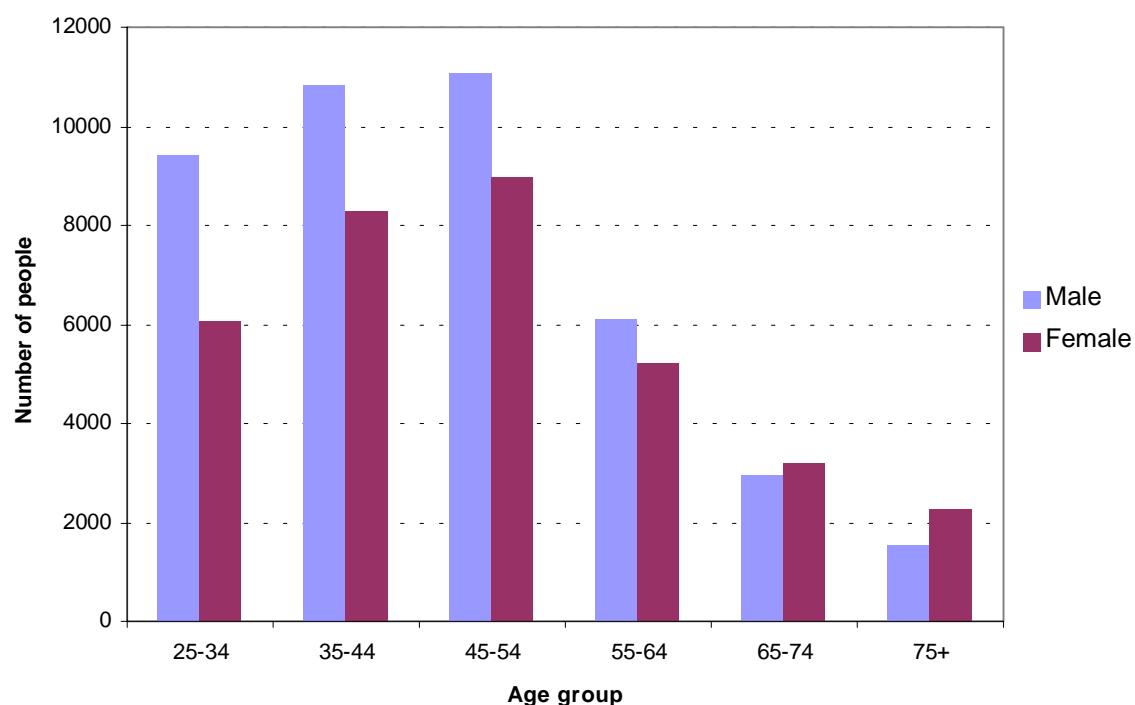
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



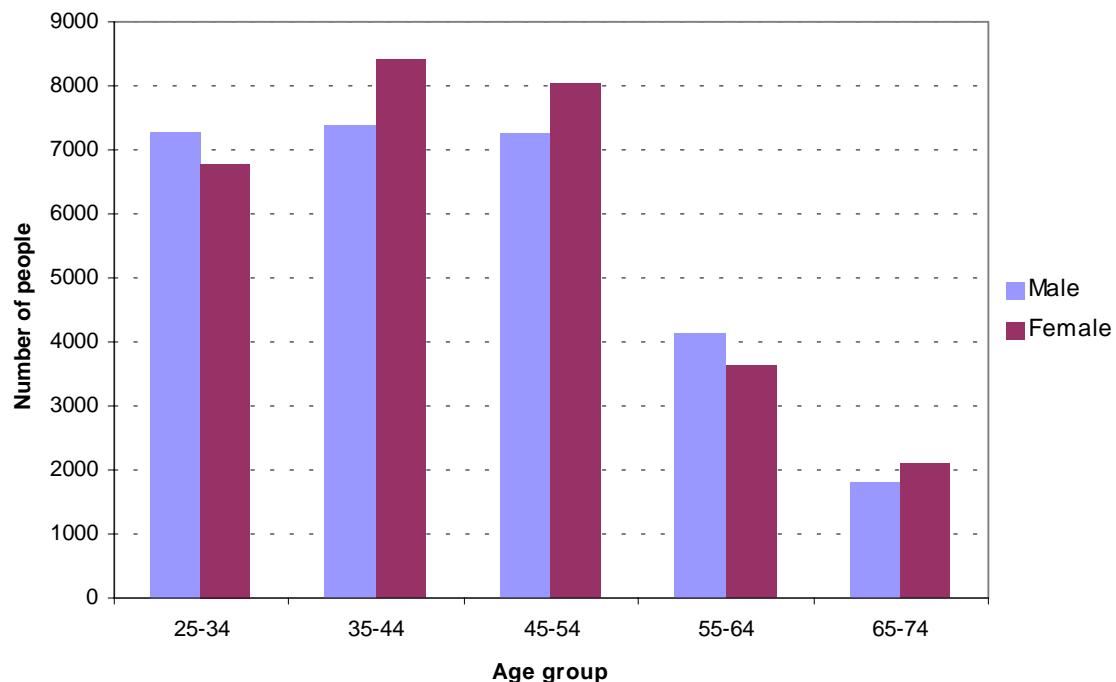
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



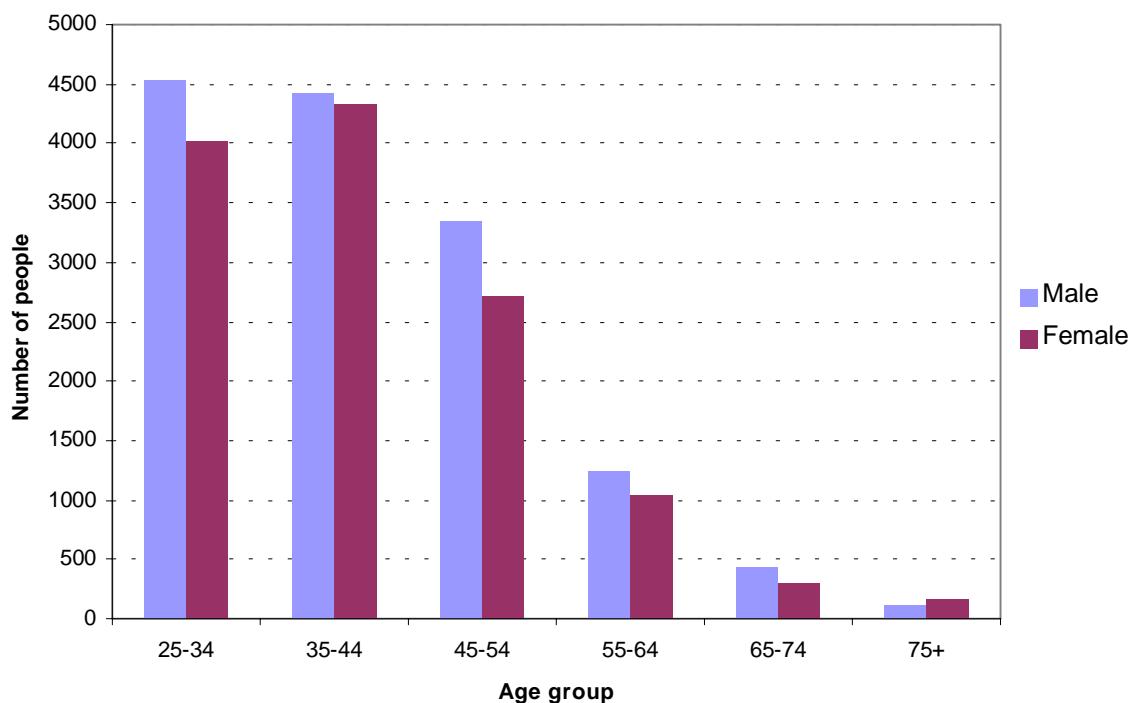
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 151 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Local branch of Diabetes Australia – sale of products, support,
 - Group education by Division and GPs,
 - Group education by Health Service educators and individual sessions,
 - Health Service dietitian group and individual sessions,
 - Division educator individual assessment, case conferencing, and care planning with GPs,
 - Private endocrinologist and private dietitian,
 - Paediatric outreach clinic (1 per month).

- What services are needed but are not available in your Division area?
 - Integrated diabetes program with health service and Division,
 - Evening group program,
 - Limited public podiatry services,
 - Limited public ophthalmology services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Diabetes register to monitor quality of diabetes care and patient recall,
 - Peer review and performance appraisal – RACGP clinical audit activity,
 - GP education workshops,
 - Individual diabetes educator assessment at GP rooms changed to only patients who were not suitable for a group program,
 - Division educator assisting GPs to initiate care planning for complex diabetes care,
 - Division diabetes educator member of diabetes care team.
 - Evening group education program ceased due to lack of health service staff,
 - Dedicated diabetes dietitian commenced with health service January 2002, referral pathways established with GPs,
 - Division educator working at Tharawal Aboriginal Medical Service 1 day per week to

assist Aboriginal Health Workers managing their own diabetes program,

- Community education on diabetes awareness and management,
- Multi-disciplinary Advisory Committee.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Implementation of enhanced primary care (EPC) for complex diabetes patients with GPs and other team members.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of health service staffing to continue evening group program,
 - Health Service staff understanding and acceptance of EPC.
- What future plans do you have for diabetes management in your Division?
 - Integrated program with Health Service,
 - Established a physical activity program for people with diabetes.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GPs and patients acceptance of team members,
 - Practice staff understanding of initiatives,
 - Available Allied Health Services with ease of referral and communication pathways,
 - Limiting paperwork.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Local branch of Diabetes Australia is member of the Diabetes Advisory Committee,
 - Division educator is member of Migrant Resource Centres Diabetes Committee and attends support groups when invited.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP/Diabetes Australia guidelines (Diabetes Management in General Practice),
 - Diabetes Australia education pamphlets,
 - MBS items diabetes flow chart.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes Program Registration and Consent,
 - Diabetes Management Review Sheet,
 - Care Plan Summary Form,
 - MBS Items Diabetes Flow Chart.

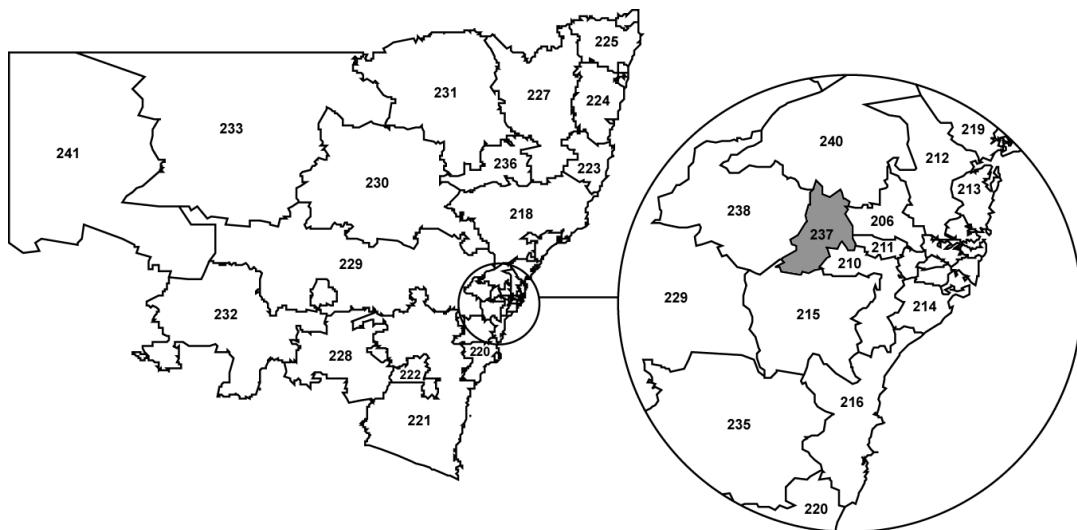
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
N/A.

- What resource materials do you provide to practices?
All of the above on request.

Division Contact Person/
Program Co-ordinator

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Nepean DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	173,574	
■ Aboriginal or Torres Strait Islander	3441	2.0%
■ Speaks language other than English at home	22,688	13.1%
■ RRMA classification ¹		
1: Capital city	173,574	100.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6429	6.2%
■ High blood pressure ⁴	25,604	24.8%
■ High blood cholesterol ⁵	50,846	49.2%
■ Obese or overweight ⁶	60,733	58.8%
■ Physical inactivity ⁷	45,412	44.0%
■ Smoking ⁸	21,443	20.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

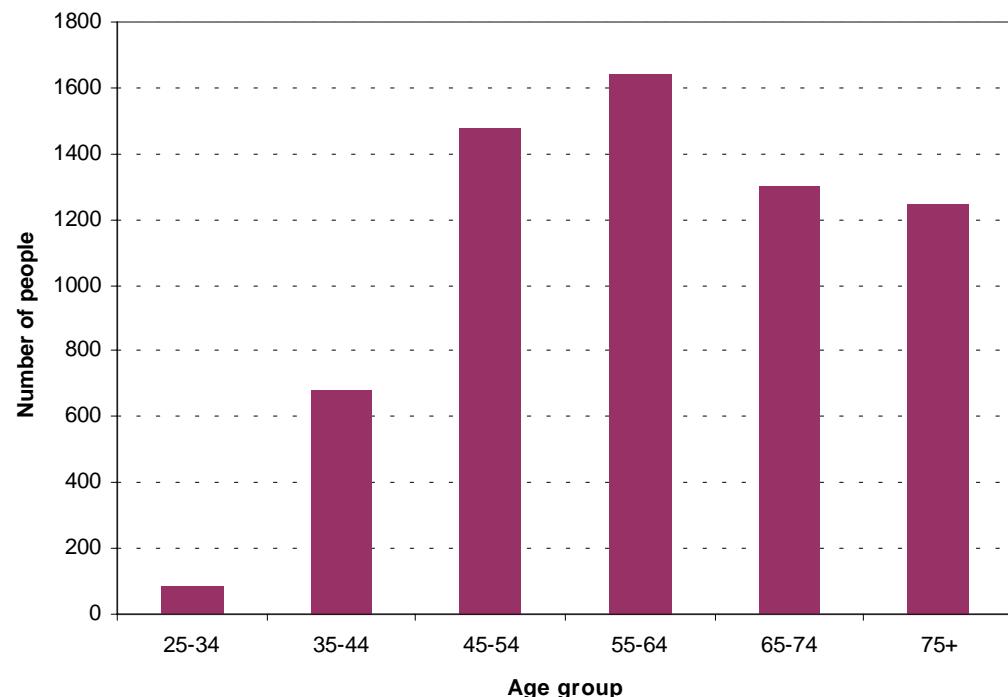
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

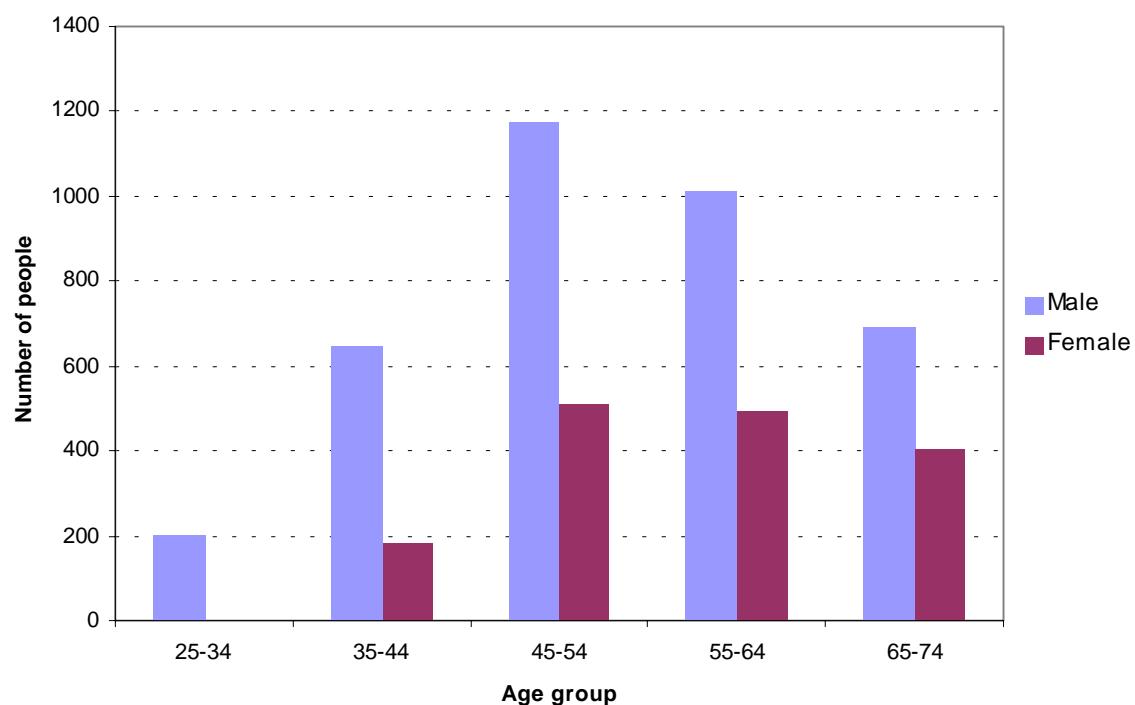
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



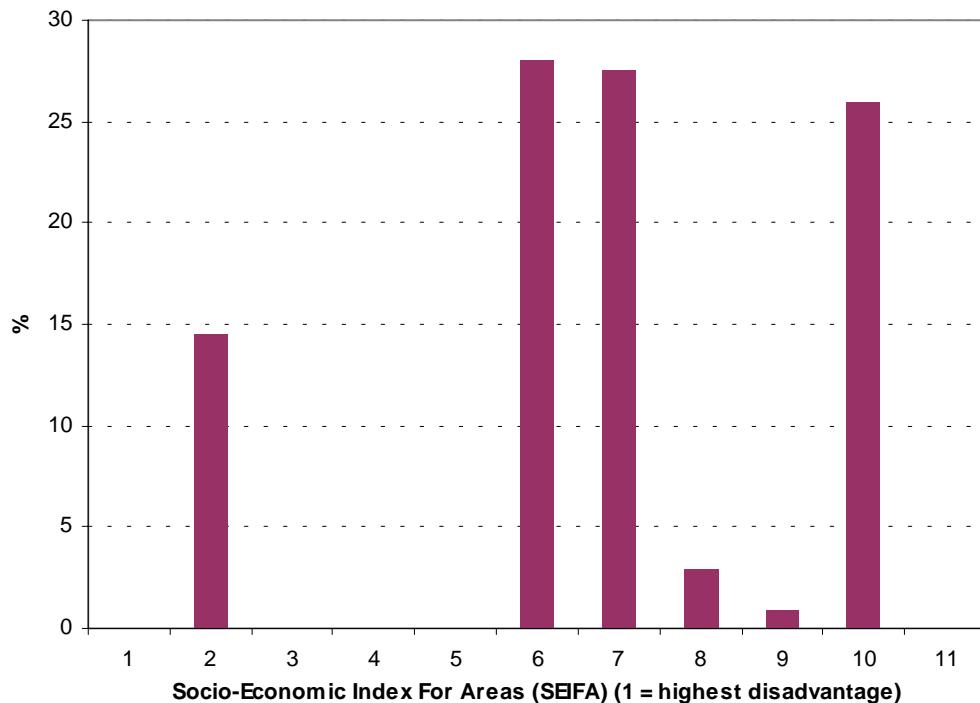
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

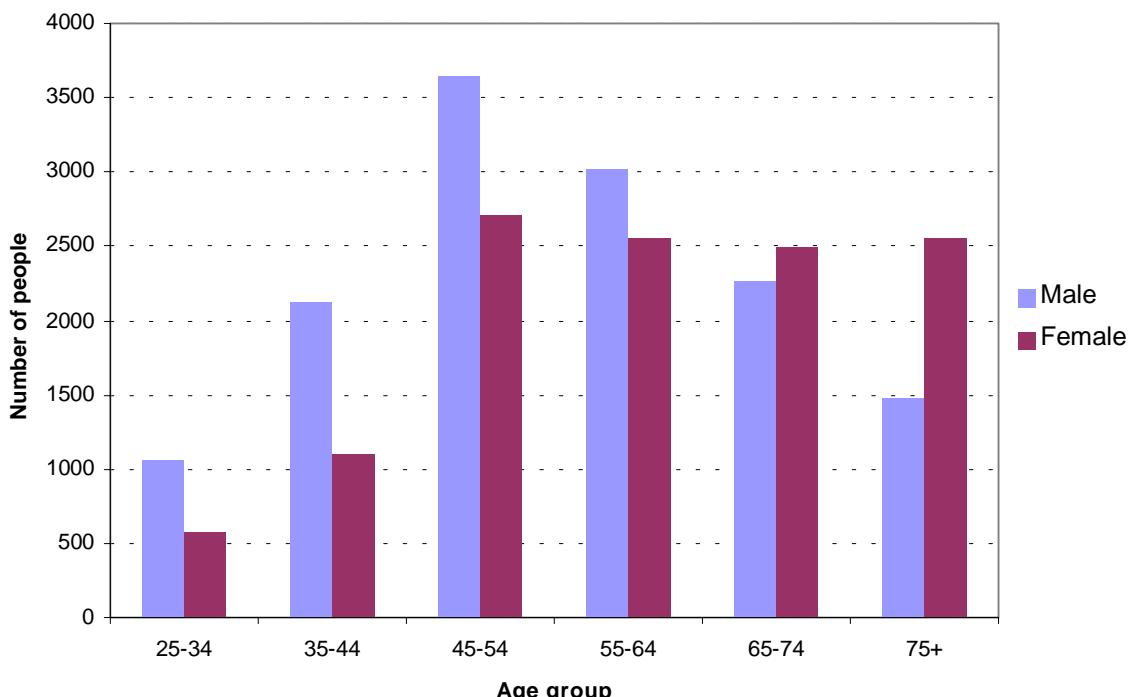
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

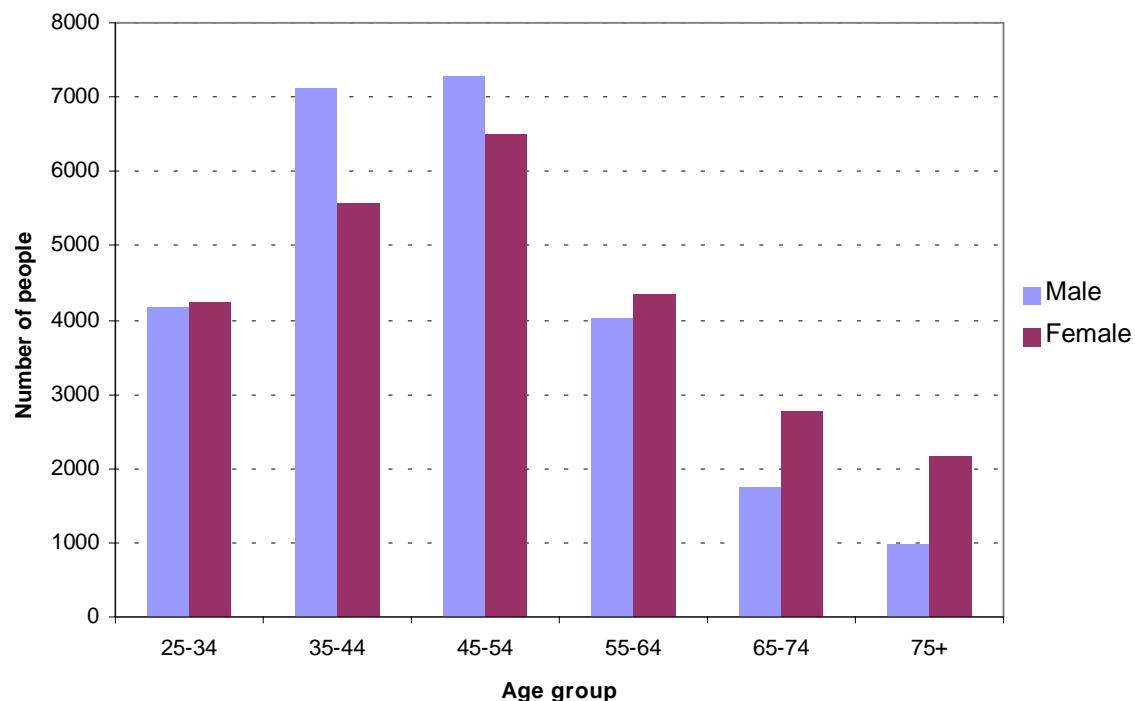
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



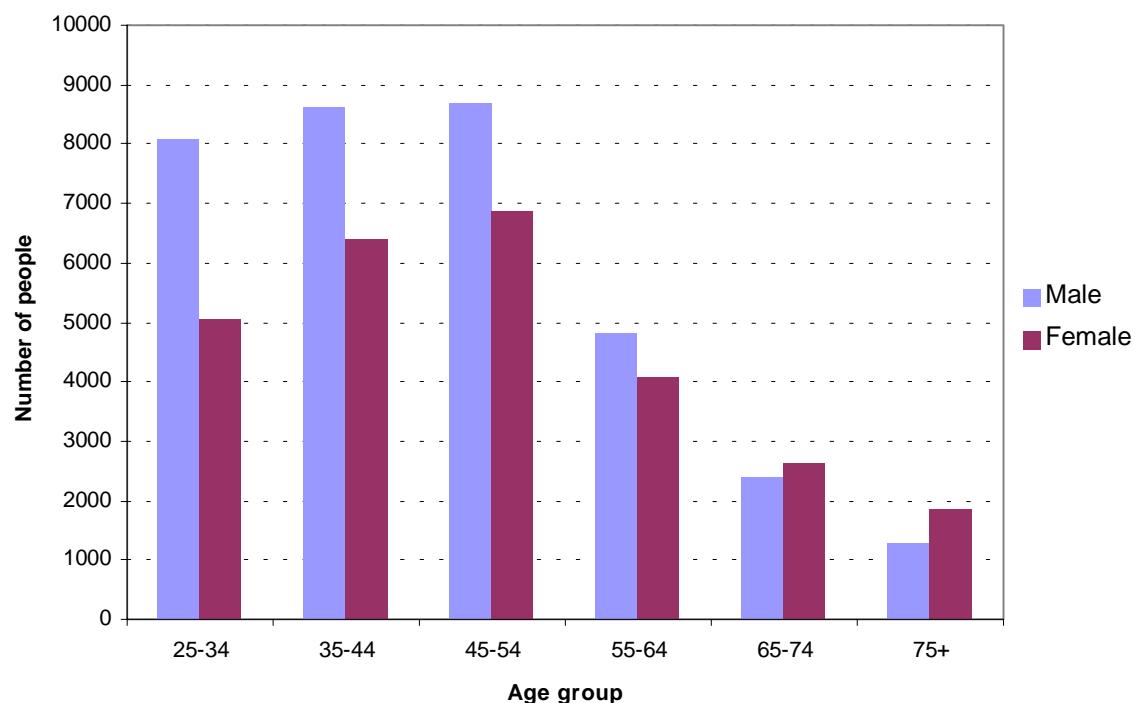
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



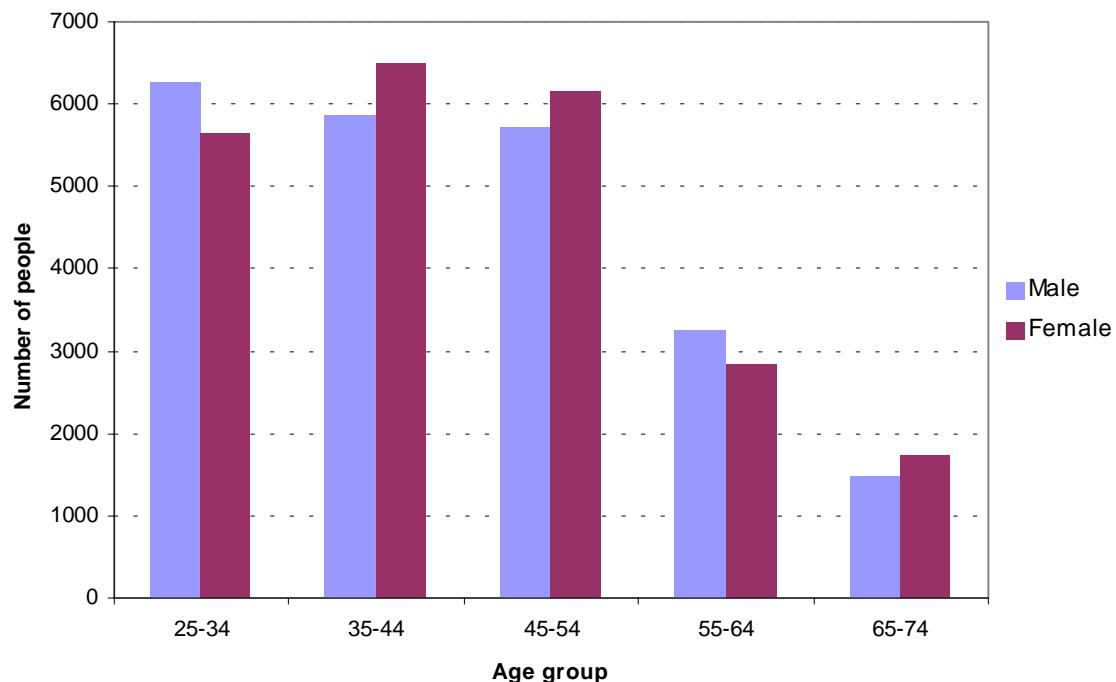
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



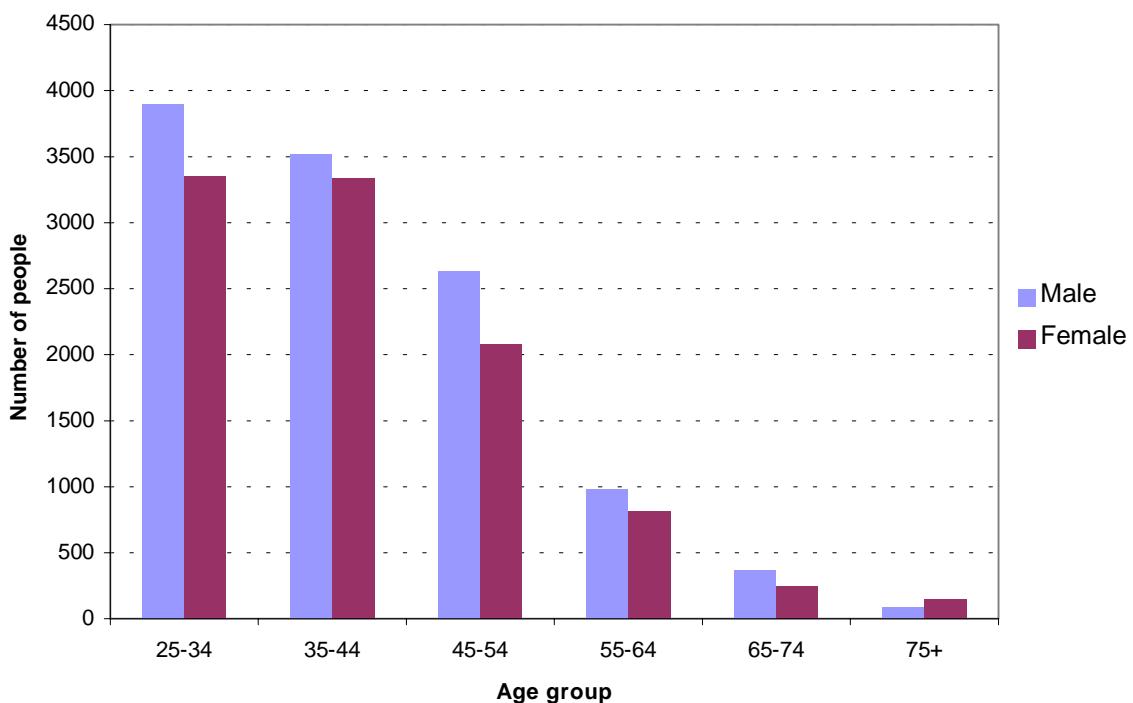
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 104 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Hospital – diabetes service,
 - Private practitioners – eg dietitians/podiatrists, etc.

- What services are needed but are not available in your Division area?

More localised services, ie services available in non-hospital based settings to increase accessibility, eg GP surgery based.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Diabetes falls under our healthy lifestyle program, which provides:

 - GP education,
 - Lifestyle education to individual patients at GP surgery and supermarket tours,
 - Assisting Area Health Services (AHS) promote CARDIAB recall system,
 - Chronic disease management – care plans/case conferences.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - More GPs taking up care plans/case conferences,
 - Accessible patient education services in GP surgeries,
 - Resources distributed to GPs and increased utilisation of patient resources by GPs,
 - Increased GP education.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Reach – capacity of educator,
 - Cost – pressure to change from a free service to cost-recovery by funders,
 - Uptake of GPs of CARDIAB due to paperwork involved.

- What future plans do you have for diabetes management in your Division?
 - Continue to promote and assist GPs set up recall/reminder diabetes systems,
 - Address GP barriers to utilising local diabetes services.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GP willingness and interest,
 - GP time initially to understand and learn about initiatives – once they know and start it is usually taken up and continued.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Local AHS – diabetes recall system for GPs. AHS promote and maintain database (CARDIAB),
 - Chronic and Complex Care Coordinator of Division funded by AHS.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Division developed resources,
 - Diabetes Australia,
 - Chronic and complex care resources.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes recall/annual tests, sheets that GP fills in and keeps at front of file,
 - Patient education sheets.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Different register-recall systems – maybe training for GPs provided on these,
 - Best Practice Diabetes Programs for Divisions.

- What resource materials do you provide to practices?
 - Info on lifestyle program and patient resources for GPs to use,
 - Case conference and care planning information,
 - Information on annual cycle of care and Practice Incentive Payment (PIP) flowchart.

Division Contact Person/
Program Co-ordinator

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Fax: 02 4721 1176
Email: lizz.reay@nepeandgp.org.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What CVD services are available in your Division area?
▪ What services are needed but are not available in your Division area? | <p>Hospital based services, eg cardiac rehabilitation, etc.</p> <p>Someone to assist GPs set up register/recall systems.</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|

CVD Program Description

- | | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|--|
| <ul style="list-style-type: none">▪ In which years did you have a CVD project or program operating:
▪ Please describe your CVD program including any changes that occurred over time? | <table border="0"><tr><td><input type="checkbox"/> 1992</td><td><input type="checkbox"/> 1993</td><td><input type="checkbox"/> 1994</td><td><input type="checkbox"/> 1995</td></tr><tr><td><input type="checkbox"/> 1996</td><td><input type="checkbox"/> 1997</td><td><input type="checkbox"/> 1998</td><td><input checked="" type="checkbox"/> 1999</td></tr><tr><td><input checked="" type="checkbox"/> 2000</td><td><input checked="" type="checkbox"/> 2001</td><td><input checked="" type="checkbox"/> 2002</td><td></td></tr></table> | <input type="checkbox"/> 1992 | <input type="checkbox"/> 1993 | <input type="checkbox"/> 1994 | <input type="checkbox"/> 1995 | <input type="checkbox"/> 1996 | <input type="checkbox"/> 1997 | <input type="checkbox"/> 1998 | <input checked="" type="checkbox"/> 1999 | <input checked="" type="checkbox"/> 2000 | <input checked="" type="checkbox"/> 2001 | <input checked="" type="checkbox"/> 2002 | |
| <input type="checkbox"/> 1992 | <input type="checkbox"/> 1993 | <input type="checkbox"/> 1994 | <input type="checkbox"/> 1995 | | | | | | | | | | |
| <input type="checkbox"/> 1996 | <input type="checkbox"/> 1997 | <input type="checkbox"/> 1998 | <input checked="" type="checkbox"/> 1999 | | | | | | | | | | |
| <input checked="" type="checkbox"/> 2000 | <input checked="" type="checkbox"/> 2001 | <input checked="" type="checkbox"/> 2002 | | | | | | | | | | | |
- Part of the lifestyle program, which includes:
- GP education,
 - Lifestyle education to individual patients at GP surgeries,
 - Supermarket tours for patients,
 - Promoting physical activity to GPs (National Heart Foundation GP Physical Activity program),
 - Care plan/case conference assistance.

Division Perspective

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What have been the major achievements or highlights of your program so far?
▪ Are there any factors or barriers that have limited the implementation of your program? Please comment: | <ul style="list-style-type: none">• Increased numbers of GPs promoting physical activity to their patients,• GP involvement in physical activity initiatives, eg pedometer challenge,• Accessible lifestyle education for CVD patients (secondary and prevention),• Increased knowledge/awareness of lifestyle modifications for CVD by patients. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
- Reach – capacity of lifestyle educator.

- What future plans do you have for CVD management in your Division?
 - Continue current program,
 - Have pedometers available through GP surgeries for patients.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Our program isn't CVD specific.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

National Heart Foundation (NHF) GP Physical Activity program – developed via networking.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - NHF resources,
 - Pedometers,
 - Active Australia resources,
 - Division developed.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

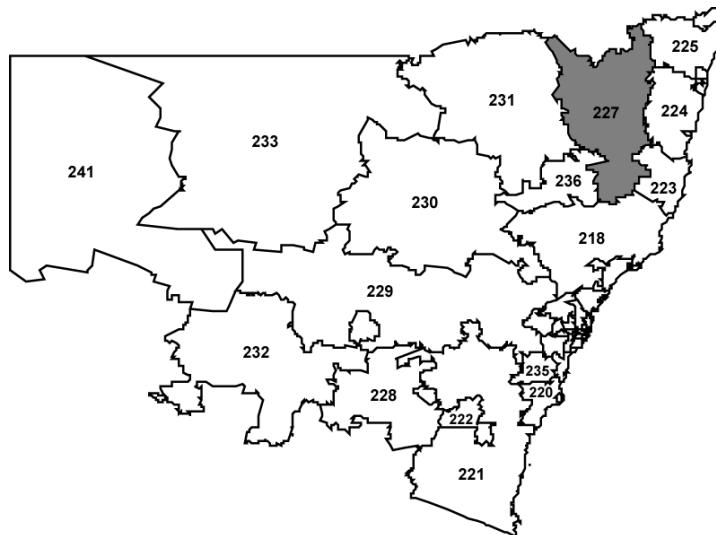
Patient education tools and lifestyle resource kit for GPs.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Register recall system assistance.
- What resource materials do you provide to practices?
 - Lifestyle program information,
 - Case conference/care planning information.

Division Contact Person/
Program Co-ordinator

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Email: lizz.reay@nepeandgp.org.au

New England DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	62,699	
■ Aboriginal or Torres Strait Islander	3257	5.2%
■ Speaks language other than English at home	1536	2.5%
■ RRMA classification ¹		
4: Small rural	25,393	40.5%
5: Other rural	37,306	59.5%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	3,449	8.8%
■ High blood pressure ⁴	12,913	32.8%
■ High blood cholesterol ⁵	20,861	52.9%
■ Obese or overweight ⁶	24,084	61.1%
■ Physical inactivity ⁷	16,545	42.0%
■ Smoking ⁸	7234	18.4%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

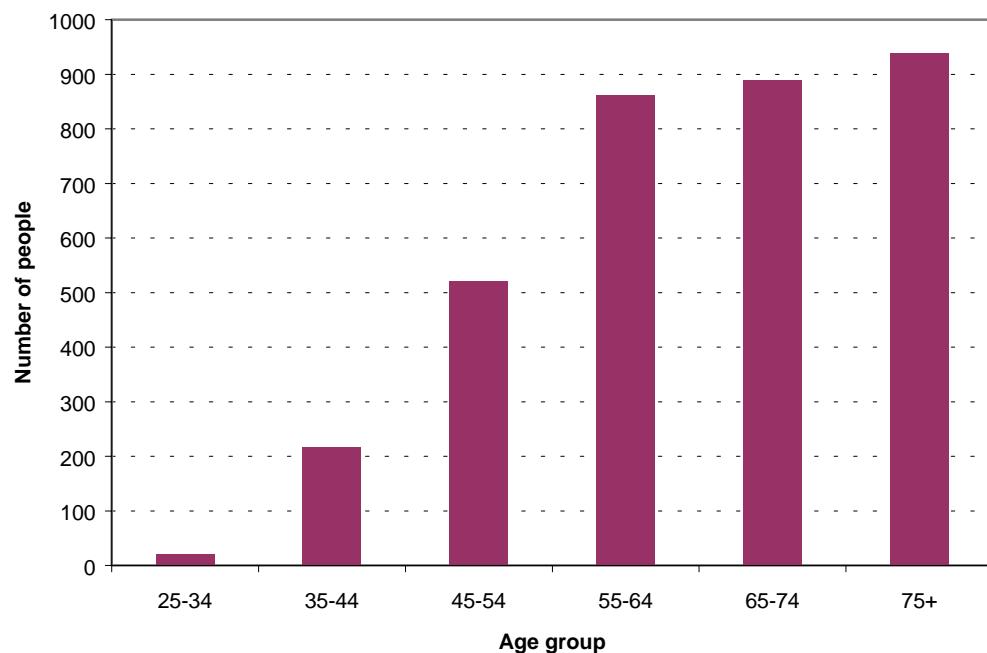
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

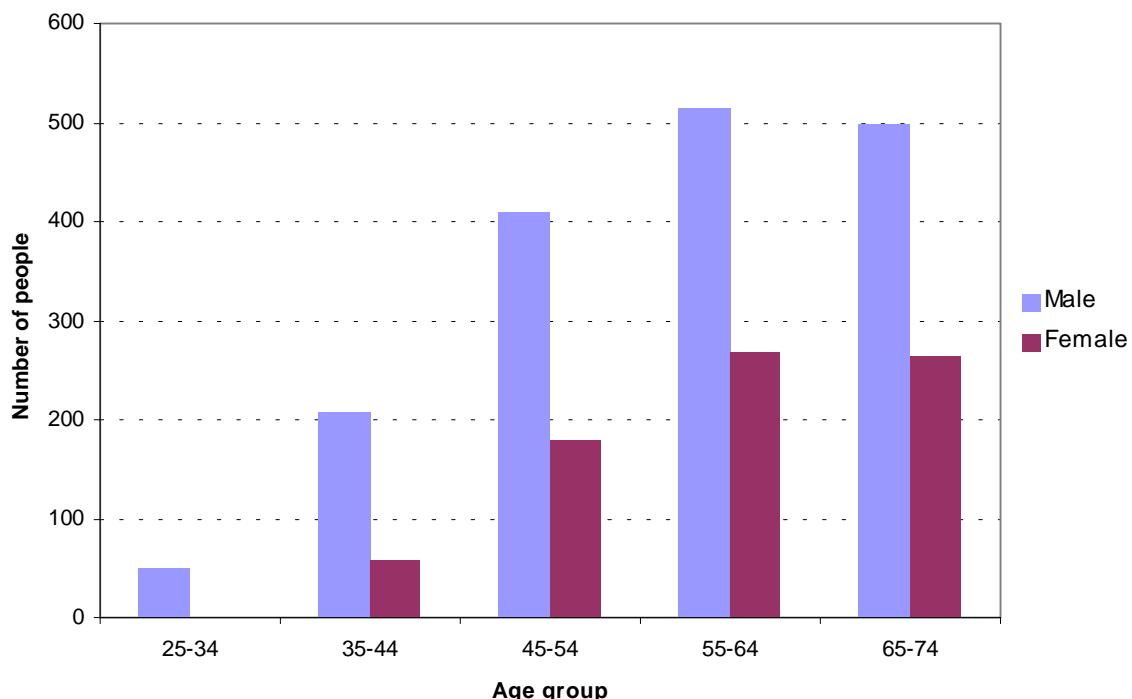
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



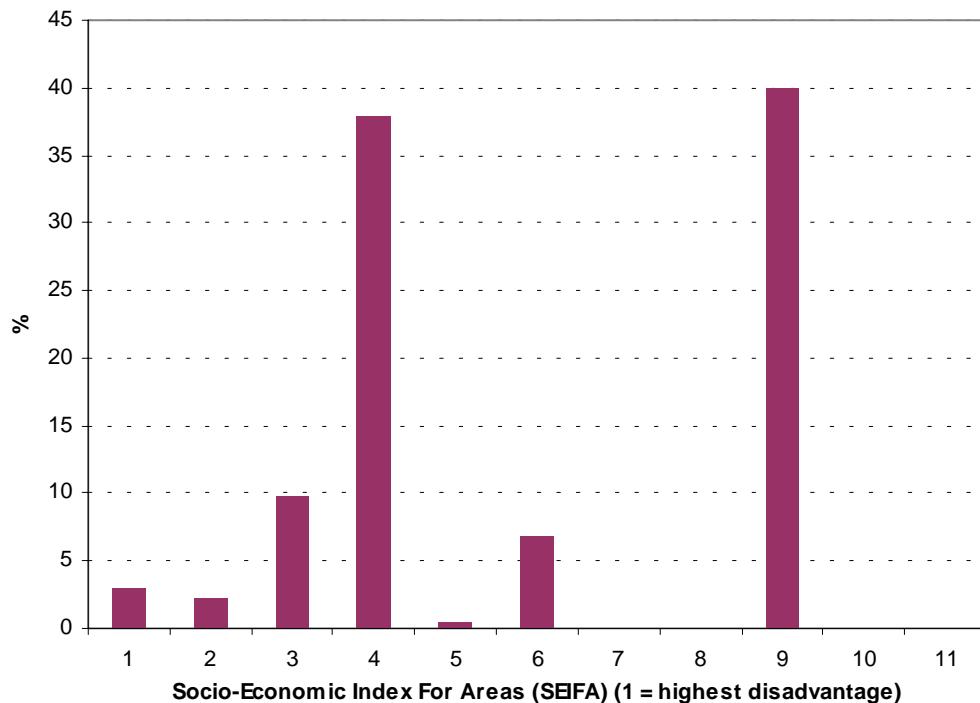
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

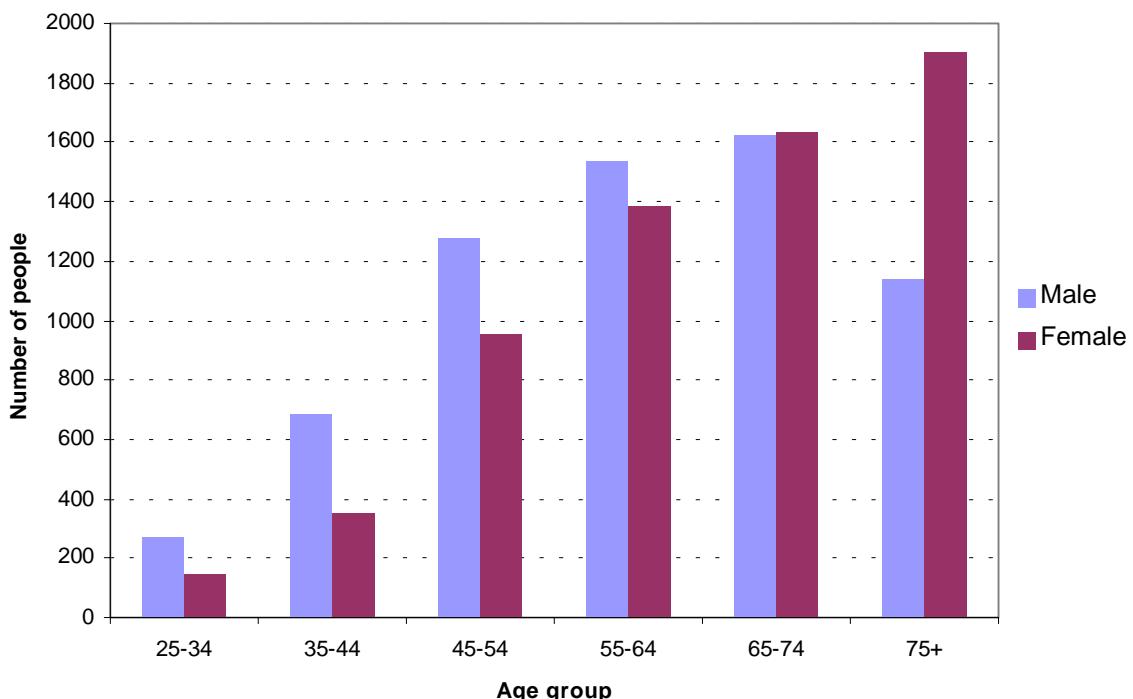
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

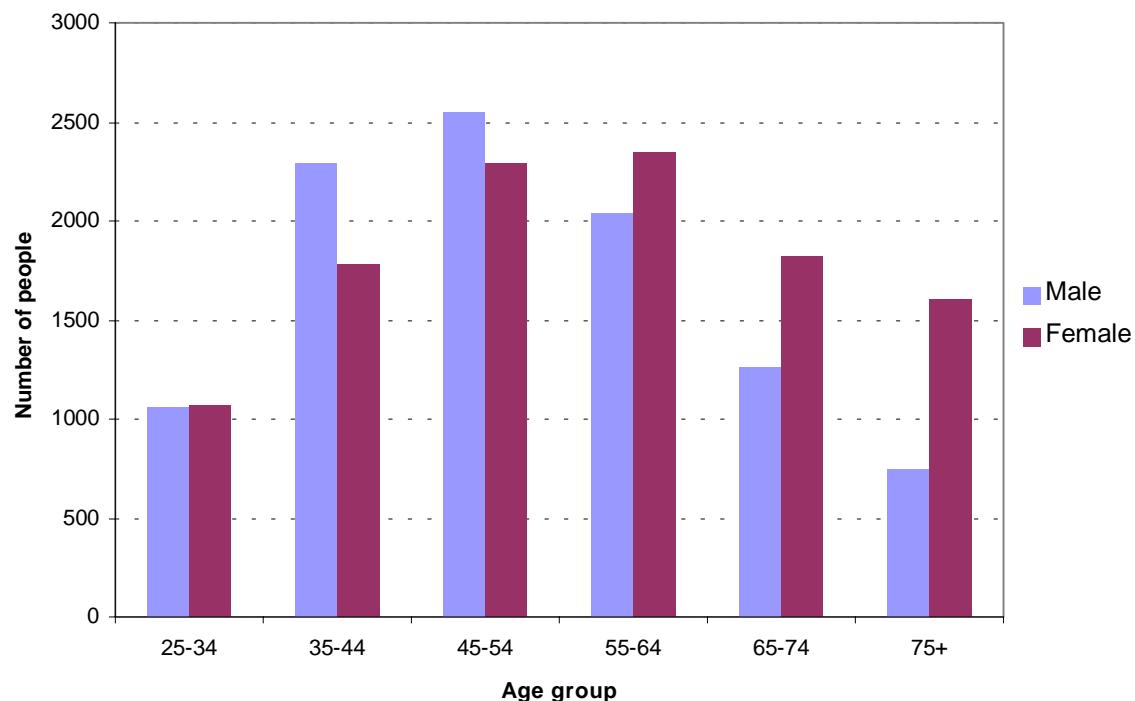
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



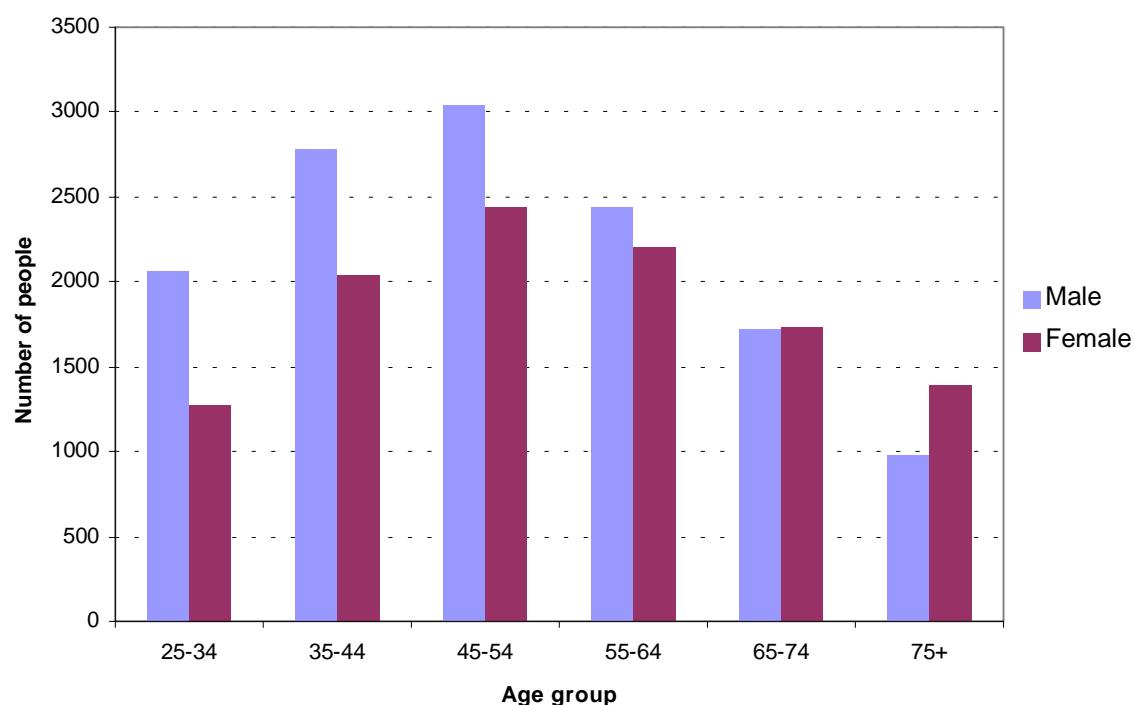
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



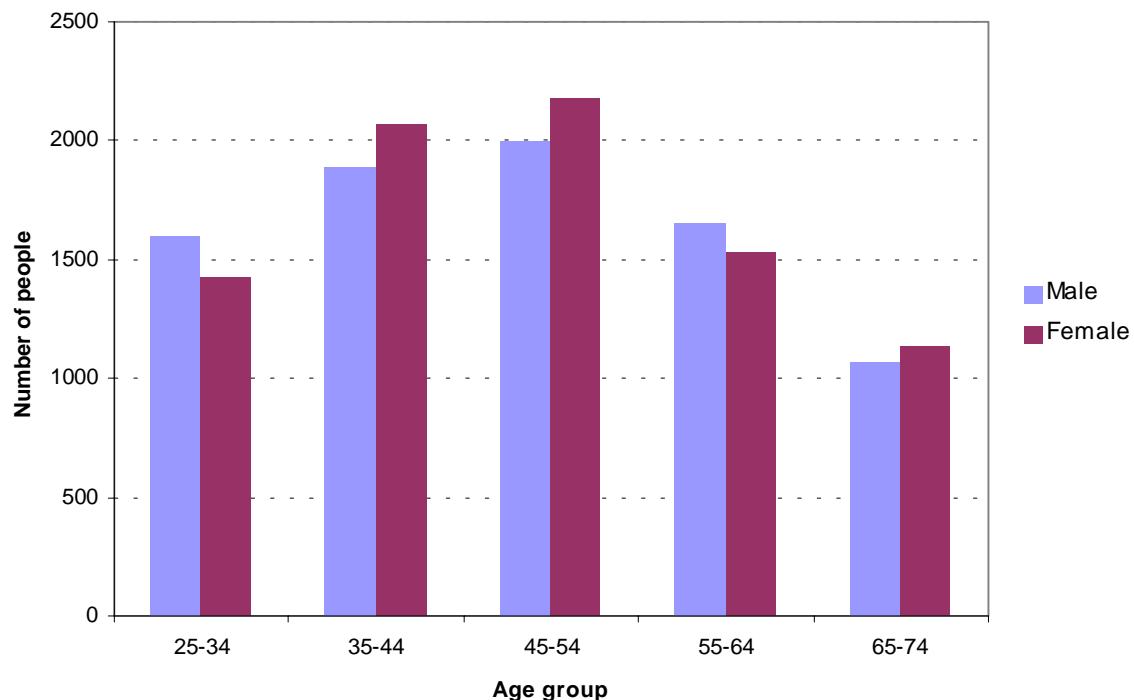
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



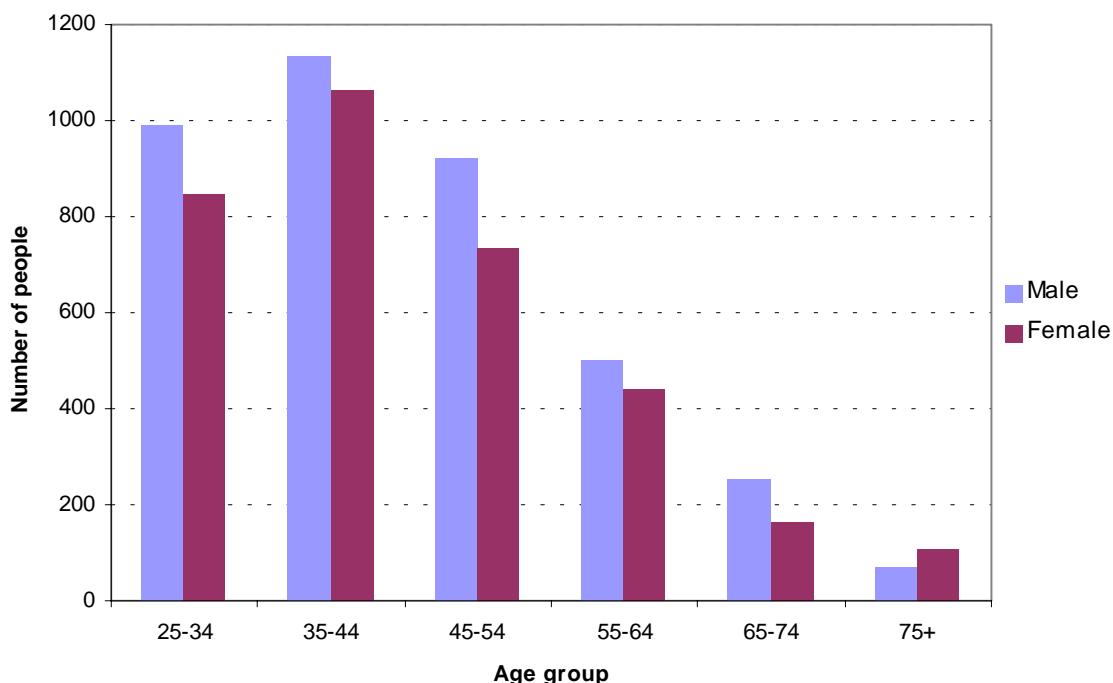
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 61 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - The New England Division Diabetes Program,
 - Diabetes educators through New England Area Health Service (NEAHS),
 - Two dietitians through NEAHS and one private dietitian,
 - One podiatrist through NEAHS and three private podiatrists,
 - Diabetes Australia branches.

- What services are needed but are not available in your Division area?
 - Diabetes educator.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input checked="" type="checkbox"/>	1997	<input checked="" type="checkbox"/>	1998	<input checked="" type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?

Annual Review Clinic – pathology/education with educator and dietitian and double appointment with GP. Reminder service, reports on progress and comprehensive database. GP provides comprehensive assessment, details entered into database.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Over 1200 registrations,
 - Successful collaboration between New England Area Health Service (NEAHS) and GP for service delivery,
 - GP involvement and support,
 - Clinics to remote towns, eg Emmaville.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Resignation (recent) of educator. Difficulty in recruiting Allied Health Services in rural areas,
 - Limited dietitian time,
 - Single and/or part-time GP with limited time for participation in the program.

- What future plans do you have for diabetes management in your Division?

Continue with diabetes in present form. Plans to include exercise component/combine with cardiac program.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Efficient practice support staff, eg practice nurse and/or manager,
 - Appropriate IT/IM support,
 - Well-coordinated approach between community allied health professionals, GPs and practice staff.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Collaboration with NEAHS and GP for service delivery (diabetes education supplied by Area Health).

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - NSW state guidelines for the management of diabetes,
 - National Health Medical Research Council (NHMRC) national draft guidelines,
 - Diabetes Australia – client resource material, updates, etc.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - GP care plan,
 - Desktop manual for GP regarding guidelines,
 - Registration forms for clients including consent.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No.
- What resource materials do you provide to practices?
 - Updated NSW guidelines for diabetes and complications screening,
 - Continuing Professional Development diabetes events,
 - Practice support program – individual practices can request information required.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Phases 1, 2 and 3 Cardiac Rehabilitation with Phases 2 and 3 offered by New England Division of General Practice (NEDGP). Coordination of Phase 1 done by New England Area Health Service (NEAHS),
 - Recall register for patients,
 - Referral services to dietitians (NEAHS), physiotherapists (NEAHS, Division and private), psychologists, and occupational therapists,
 - Home-based referral service delivered by NEAHS and coordinated in partnership with Division Cardiac Program.

- What services are needed but are not available in your Division area?
 - More community-based options for Phase 3,
 - Support network/groups for spouses/partners of those involved in Cardiac Rehabilitation,
 - Group Rehabilitation in more communities within the Division.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Phase 2 began under NEDGP coordination in 1996. Partnership with NEAHS began in 1997 with use of venue, nursing and physiotherapy services,
 - GP/Physiotherapist, RN/Coordinator involved in intake of all patients in Phase 2. Cardiac Care Plan initiated at rehabilitation for patients, individual GP to complete care plan,
 - Twelve sessions aerobic exercise and use of exercise equipment offered free of charge,
 - Education sessions offered at minimum, every second week for minimum of one hour,
 - All rehabilitation patients offered free enrolment on Heart Health Register following rehabilitation. First recall is three months post rehab, then nine months, then annually. Phase 3 includes Walking Program twice weekly (one

- hour duration) and one hour aerobic class once a week. Individual counselling etc offered as required,
- Twice annual education days for all current and past participants and partners.

Division Perspective

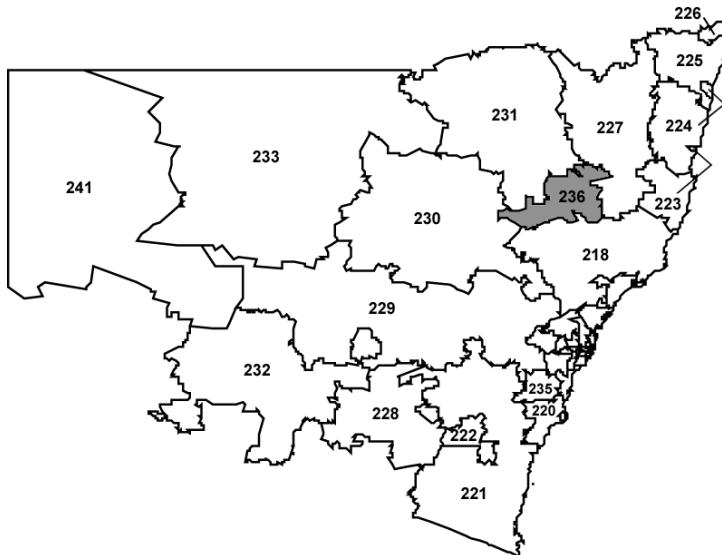
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - Risk Factor Reduction Guidelines – National Heart Foundation (NHF),
 - Lipid Management Guidelines, 2001 NHF, Hypertension Guidelines etc,
 - Best Practice Guidelines – Heart Research Centre, Victoria,
 - Heart Foundation resources for patients and GPs.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Heart Health Register flyer/enrolment form,
 - Cardiac Care Plan,
 - Program flyer(s),
 - Patient sample flyers/forms, booklets.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Standards for exercise “prescriptions” for various patients presenting with different diagnosis, ie stents, Coronary Artery Grafts (CAGs), heart failure, etc.
- What resource materials do you provide to practices?
 - Current/updated guidelines,
 - Program flyers, register flyers, etc,
 - Program changes/expansion arrangements,
 - Care Plan proformas,
 - Individual GP statistics as required,
 - Annual statistics, etc,
 - Patient resources, posters, etc.

Division Contact Person/
Program Co-ordinator

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North West Slopes (NSW) DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	57,326	
■ Aboriginal or Torres Strait Islander	3490	6.1%
■ Speaks language other than English at home	896	1.6%
■ RRMA classification ¹		
3: Large rural	40,587	70.8%
5: Other rural	16,739	29.2%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	3165	8.6%
■ High blood pressure ⁴	11,887	32.1%
■ High blood cholesterol ⁵	19,458	52.6%
■ Obese or overweight ⁶	22,515	60.8%
■ Physical inactivity ⁷	15,571	42.1%
■ Smoking ⁸	6858	18.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

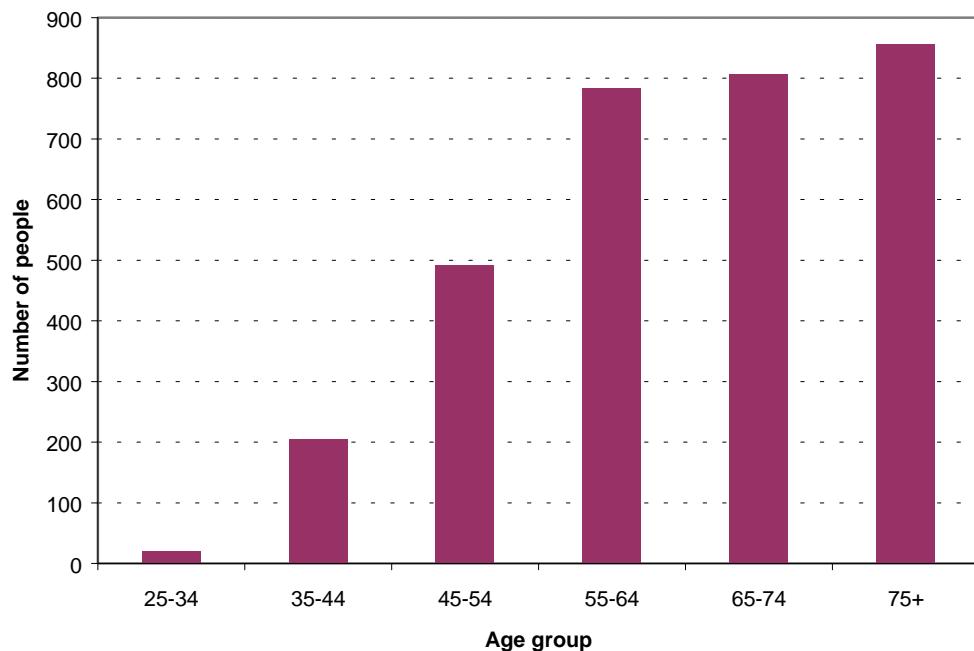
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

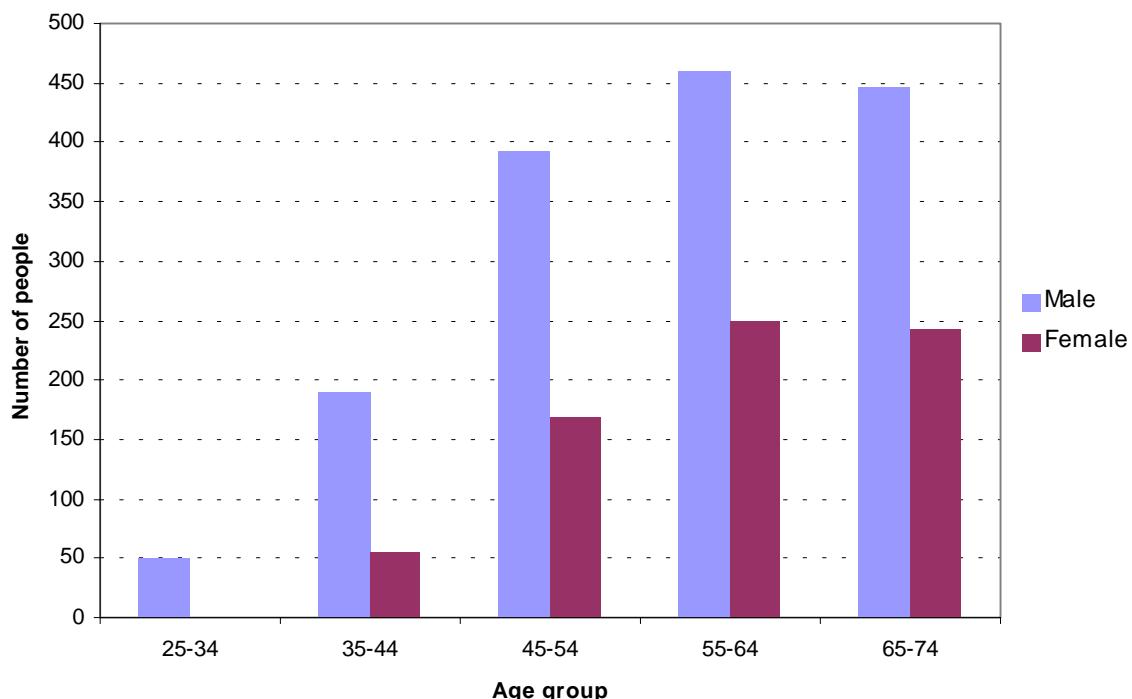
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



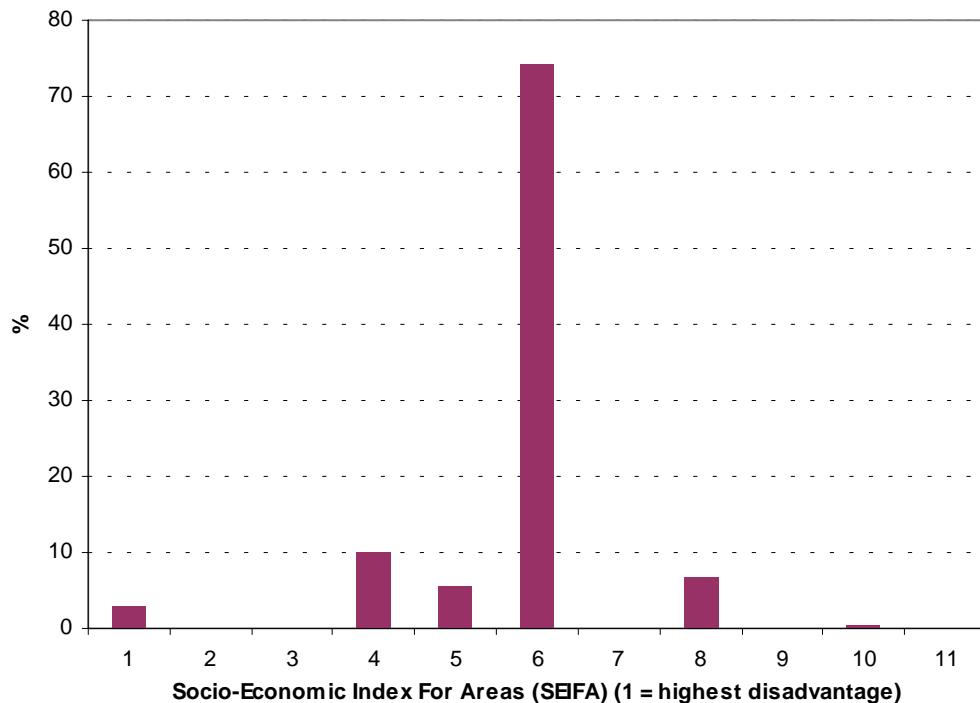
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

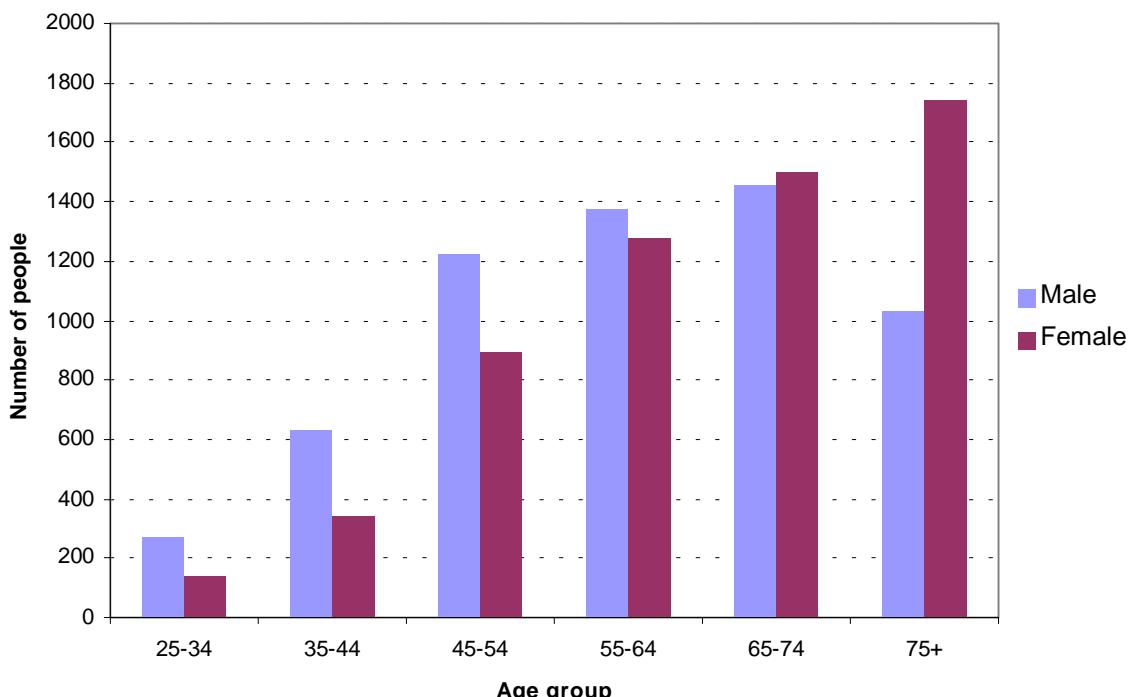
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

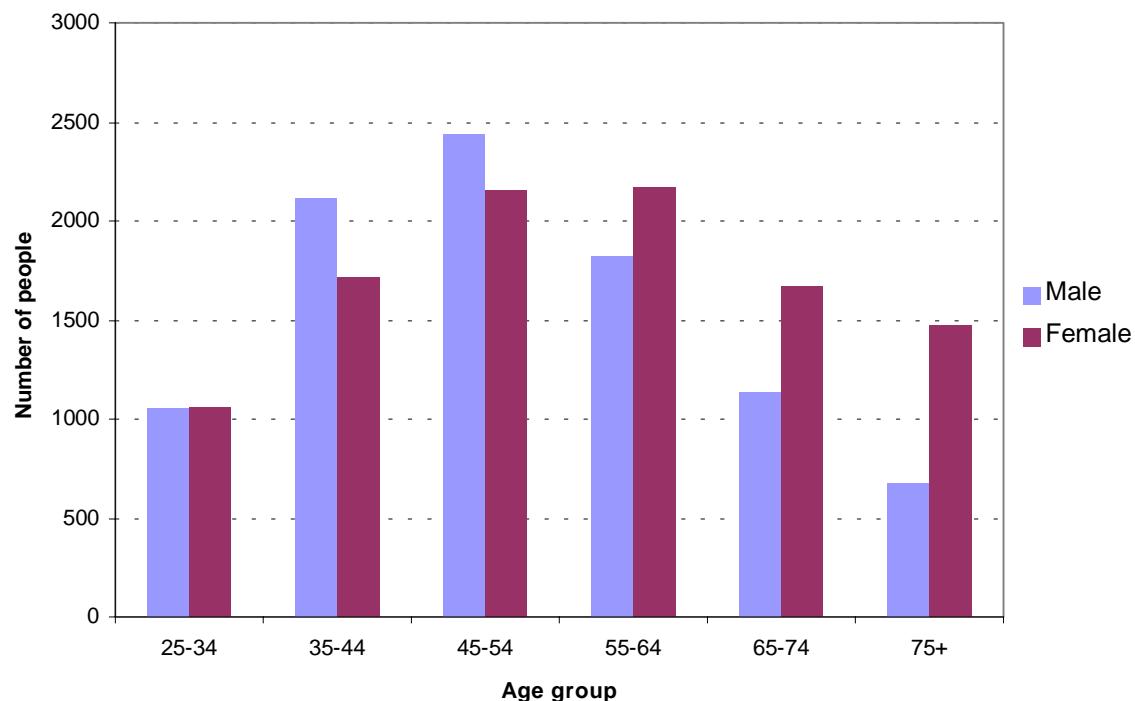
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



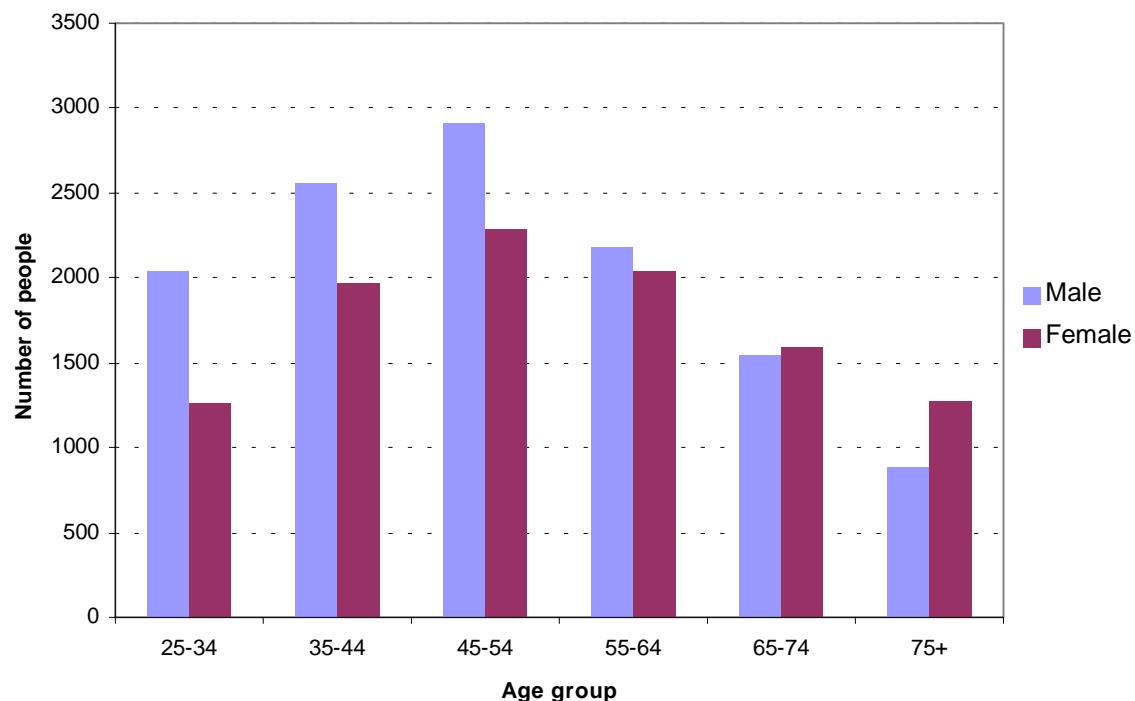
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



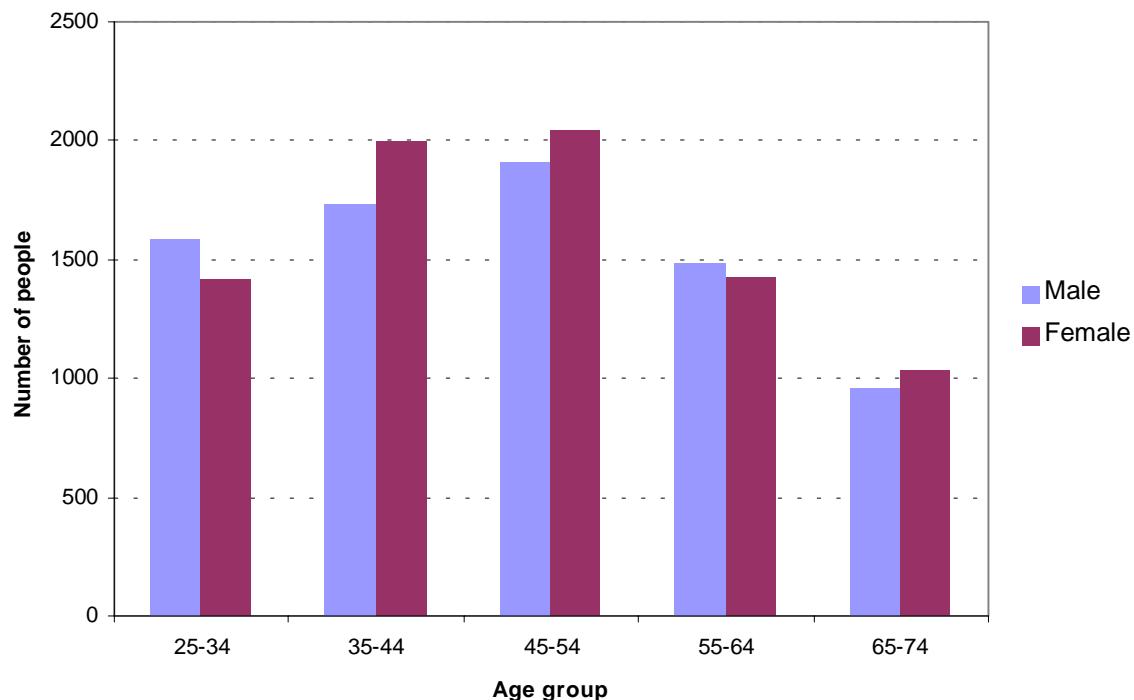
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



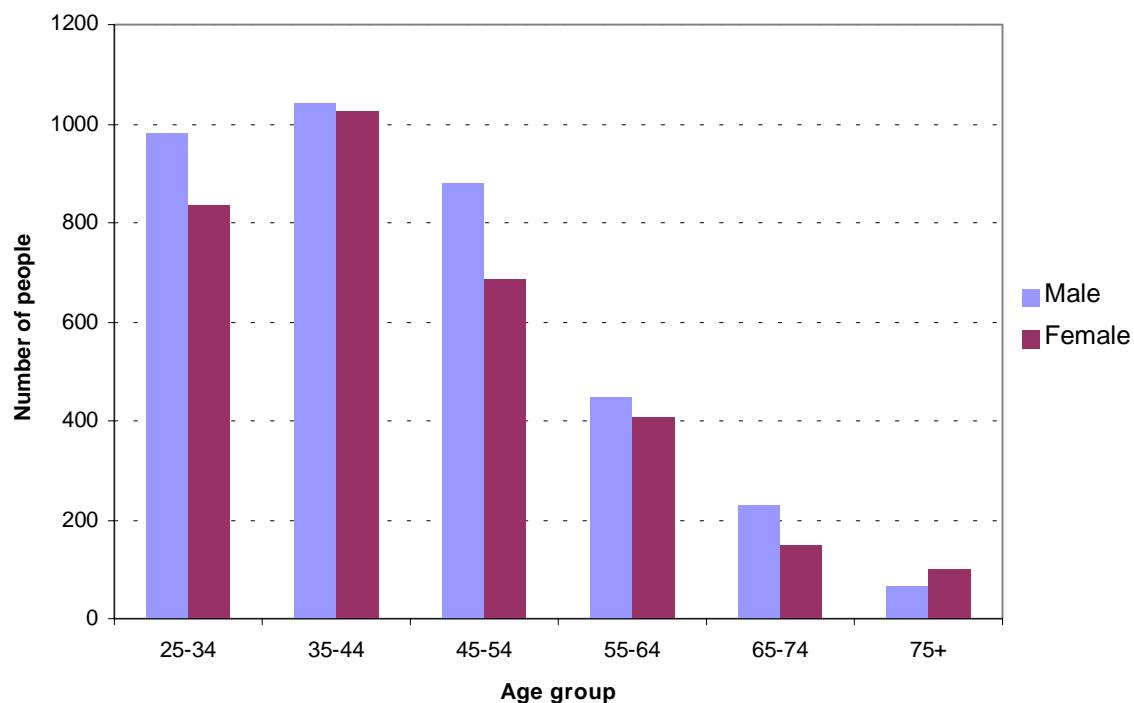
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 41 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - New England Area Health Service (NEAHS) provides dietetic clinics to Walcha & Quirindi,
 - New England Area Health Service Diabetes Centre situated at Tamworth Base Hospital has one full time and two part time diabetes educators, one dietitian, a physician and ophthalmologist,
 - Generalist Community Nurse in Walcha and Quirindi (one each), with diabetes education experience, publicly and More Allied Health Services (MAHS) funded for extra hours,
 - Dietetics services via MAHS program in Quirindi and Walcha and NEAHS.

- What services are needed but are not available in your Division area?
 - No public podiatry services within Division area, only high risk foot clinic accessed through voucher system to a private provider and paid for by NEAHS,
 - This was not seen as a top priority for MAHS by consumers or GPs,
 - Four private podiatrists in area.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Initially the program was to look at undiagnosed diabetics. The program did not commence and in July 01 the Diabetics Care Plan Program commenced involving GPs, Diabetes Centre, educators and dietitians in small towns. Progressed until July 2002 where further changes were made. Upward of 90 Care Plans completed in first 12-months. Integrated into Chronic Disease Management Program.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Enhanced communication between New England Area Health Service staff and private allied health providers with GPs and Division. Greater collaboration between all parties.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Very limited uptake of enhanced primary care (EPC), ie Care Plans in this case,
 - Time availability, limited resources forced upon already overstretched GPs, Allied Health staff and Area Health staff,
 - Reluctance to be involved in EPC for patient care from GPs and Area Health staff.
- What future plans do you have for diabetes management in your Division?

Care Plan Program to continue at GPs discretion. Program to focus on recall/register audits and clinical audits on best practice in management of diabetes mellitus.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - The availability of practice nurses in some practices,
 - GP interest in the disease in question.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Greatly enhanced collaboration with New England AHS on diabetes. Very involved in Diabetes Focus Analyse Develop Evaluate (FADE) and Expert Working Groups with continual cross feedback. These have developed because of mutual respect and desire to help patients.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Guidelines for best practice in management of diabetes mellitus – all GPs in Division have a copy of these,
 - Regular correspondence with Diabetes Australia on new programs,
 - Correspondence with State Based Organisations (SBOs).
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

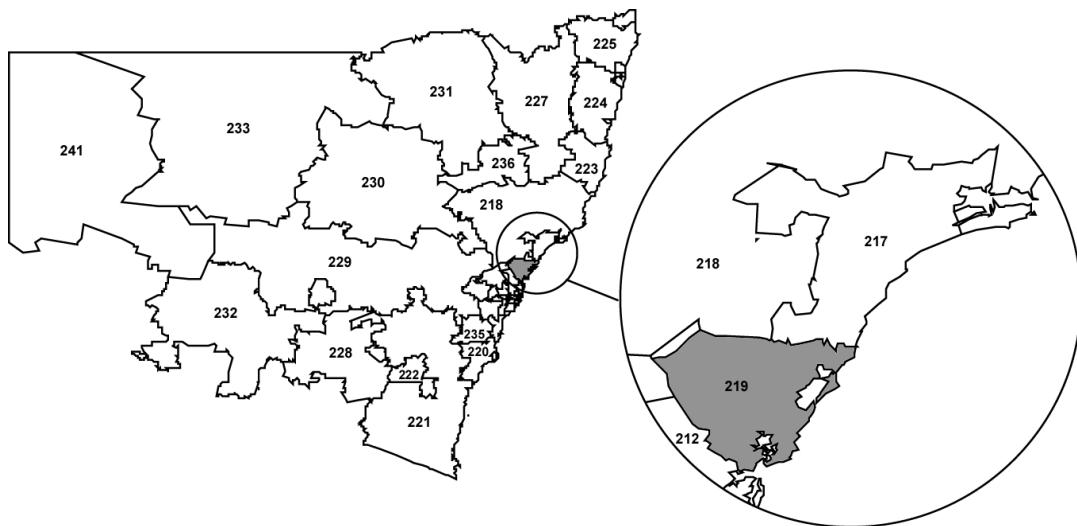
None developed at this stage.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- What resource materials do you provide to practices?
 - Any promotional material for diabetes campaigns, eg “Know your BGL!”,
 - Any stationery that is needed for program implementation,
 - Division staff to help in set up of register/recalls,
 - Guidelines for best practice management for Diabetes Mellitus, 2002.

Division Contact Person/
Program Co-ordinator

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NSW Central Coast DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	284,196	
■ Aboriginal or Torres Strait Islander	4740	1.7%
■ Speaks language other than English at home	10,106	3.6%
■ RRMA classification ¹		
1: Capital city	284,196	100.0%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	17,427	9.2%
■ High blood pressure ⁴	64,559	34.2%
■ High blood cholesterol ⁵	99,741	52.8%
■ Obese or overweight ⁶	114,810	60.7%
■ Physical inactivity ⁷	76,617	40.5%
■ Smoking ⁸	33,816	17.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

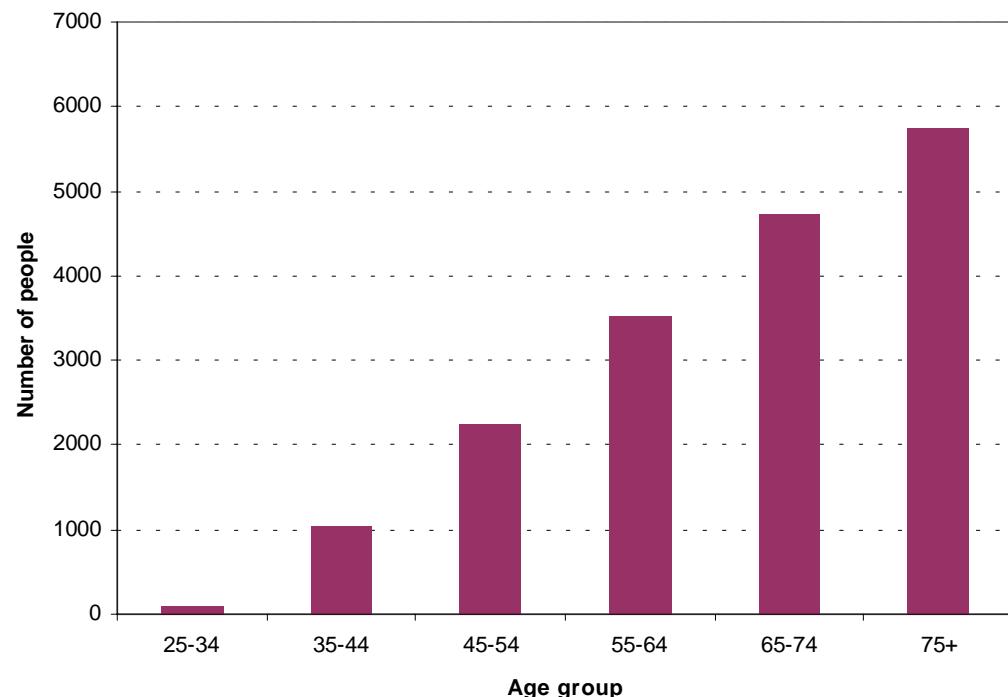
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

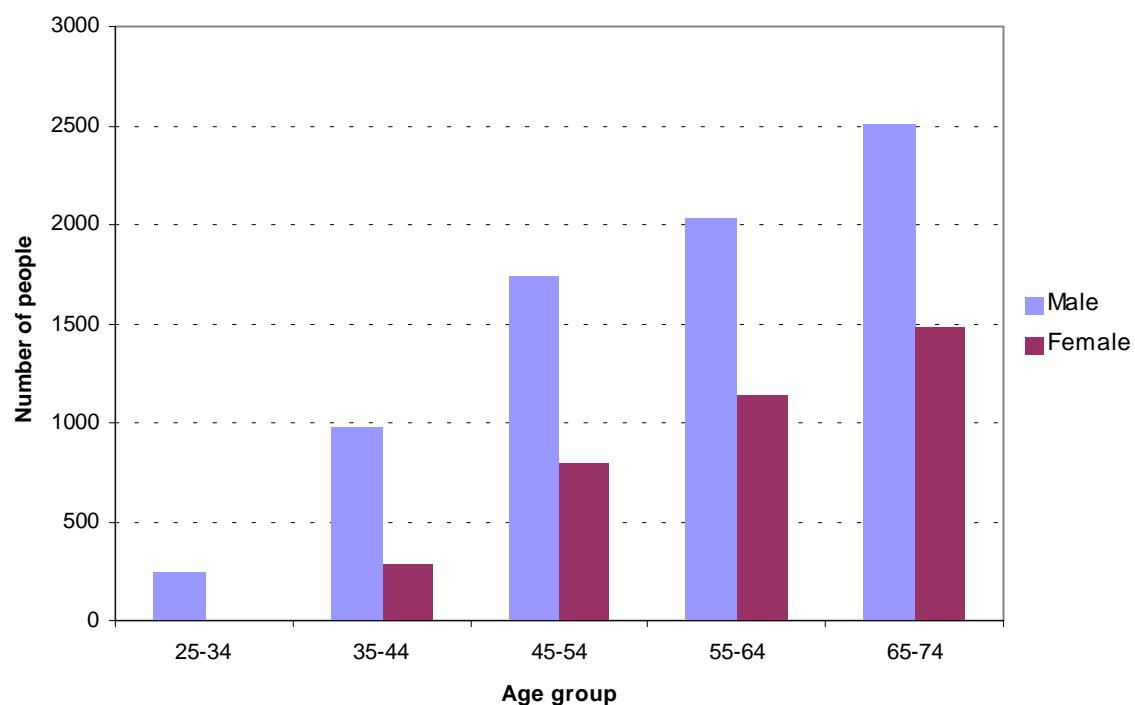
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



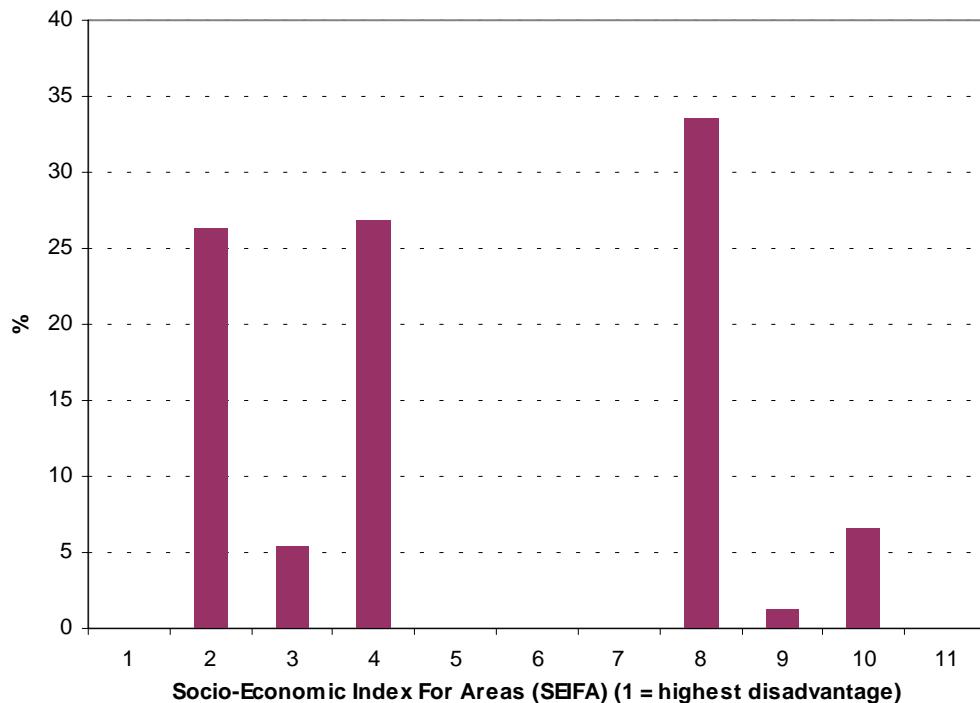
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

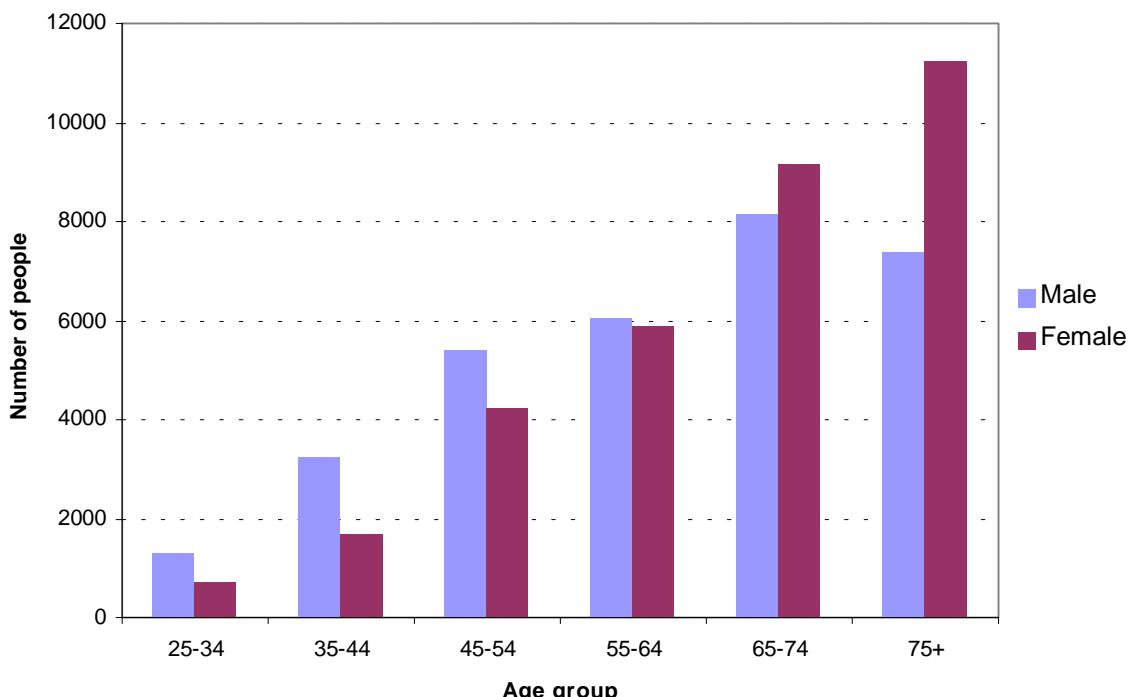
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

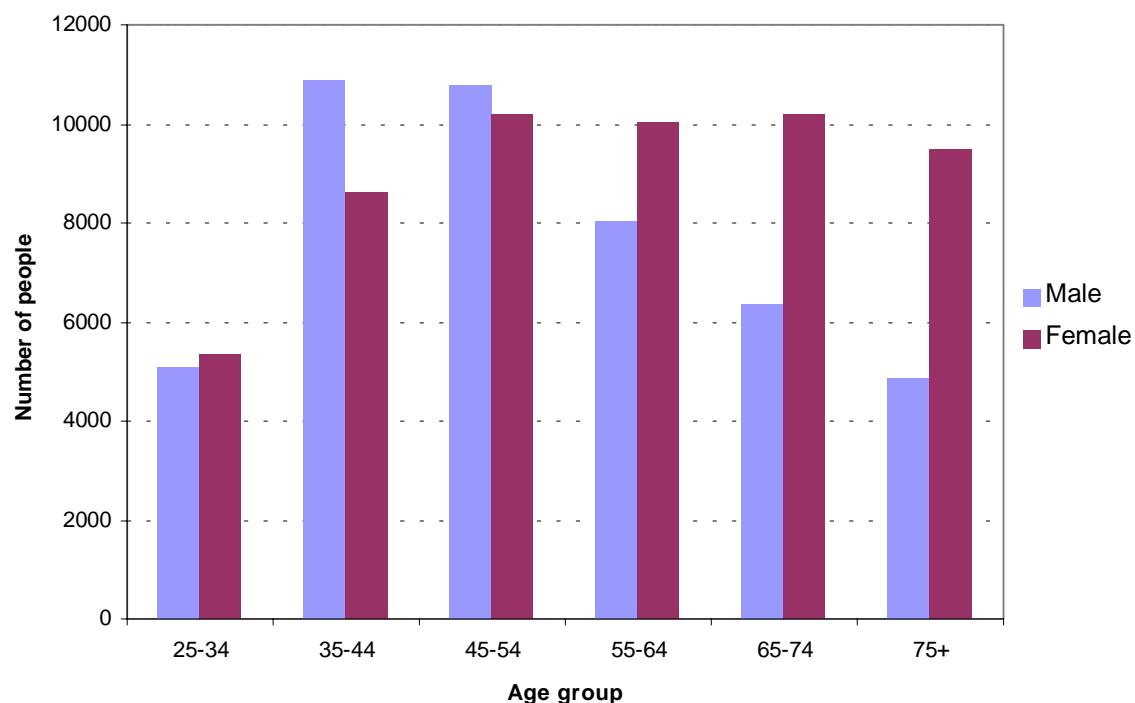
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



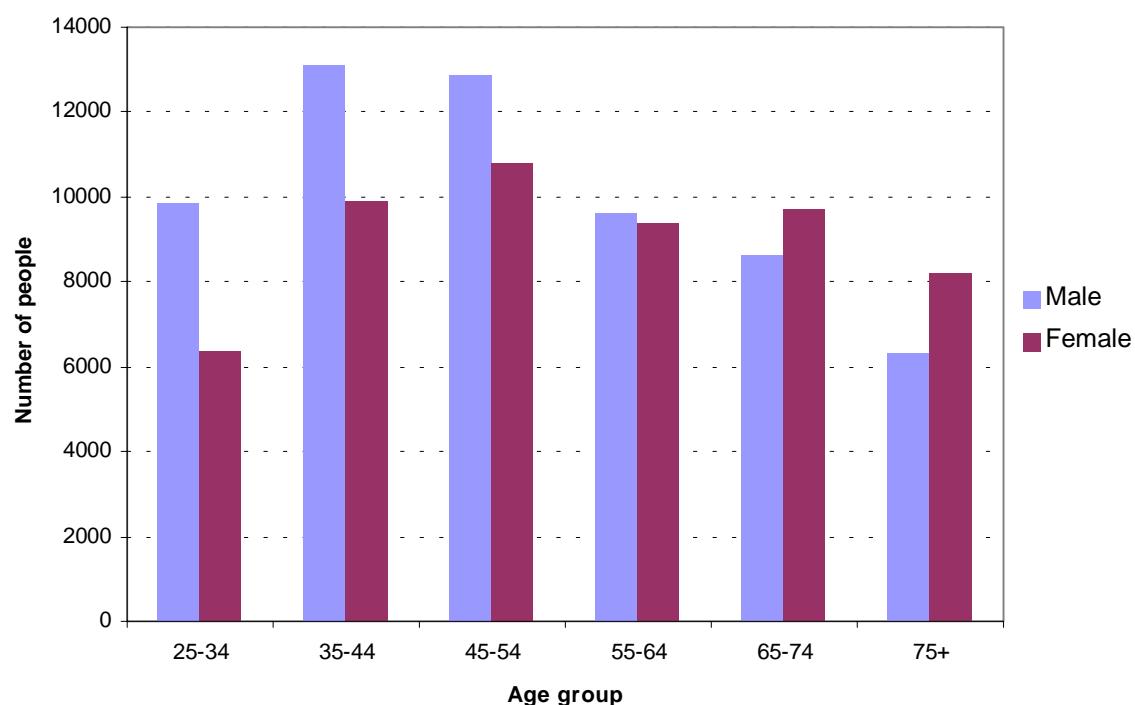
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



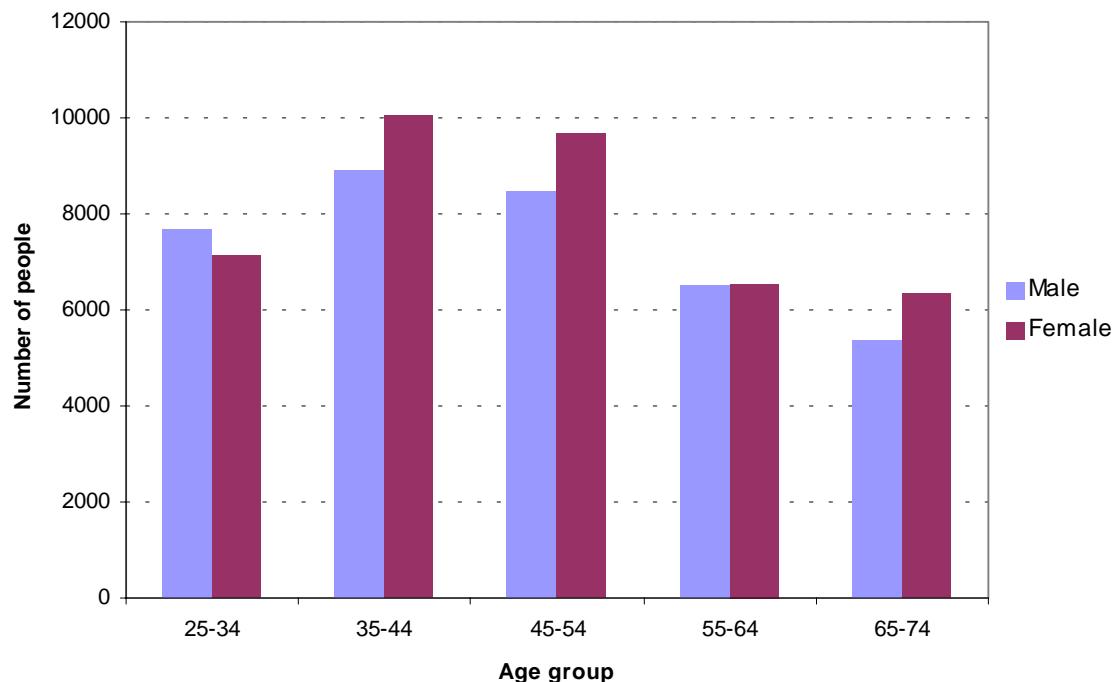
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



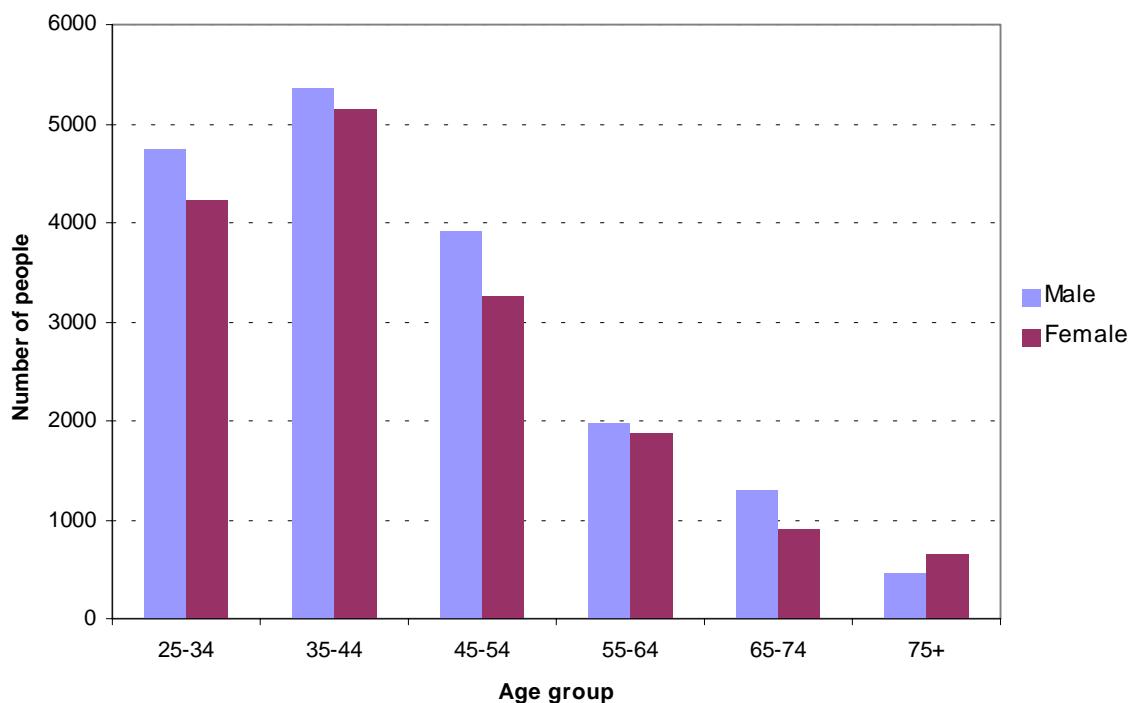
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 256 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Division Diabetes Program, hospital-based diabetes educators and dietitians who hold education group sessions at hospitals and at various Community Health Centres,
 - Paediatric Diabetes Clinic at Gosford Hospital,
 - Diabetes educators attend Aboriginal Health Centre.

- What services are needed but are not available in your Division area?
N/A.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?

Since March 2001, Care Plans have been incorporated into the diabetes program. Recalls are done six-monthly. Patients attend clinics at GP practice and are seen firstly by a diabetes educator, secondly by the GP, then referred to a third provider, (if required).

Division Perspective

- What have been the major achievements or highlights of your program so far?

It is not yet possible to demonstrate long-term outcomes, but early indications suggest an improvement in patient management according to the NSW Department of Health clinical guidelines. The number of patients registered is also something of an achievement.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for diabetes management in your Division?

To continue with this current program and expand diabetes services on the Central Coast by educating GPs, their staff and their nurses to be able to conduct diabetes clinics independently.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
- Well organised – good back-up staff,
- Self-motivated GPs.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Central Coast Health Private Health Service providers, (ie allied health, specialists), support groups – developed through proactively building relationships, meetings, newsletters, and mail outs.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- Care Plans,
- Diabetes Australia Patient Information Sheets,
- Central Coast Health Nutrition Guidelines.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

- Care Plans – consisting of Care Plan designed specifically for the diabetes program and a comprehensive checklist completed by the educator,
- Database used for recalls and patient data,
- Automated pathology requests.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

- What resource materials do you provide to practices?

- Instruction booklet for practice staff prior to first clinic,
- Clinic and recall instructions for GP prior to first clinic,
- Sample completed Care Plan,
- Each GP and practice staff member is provided with a face-to-face instructional visit from the Division's Enhanced Primary Care (EPC) Nurse Consultant for full instructions and information regarding all aspects of EPC and the diabetes program are provided.

Division Contact Person/
Program Co-ordinator

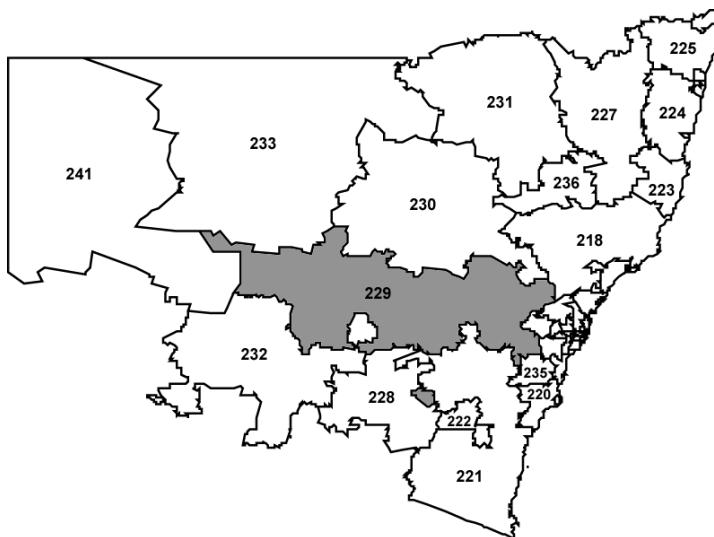
Name: Colette Paterson/
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Email: col@ccdgp.com.au
georgina@ccdgp.com.au

NSW Central West DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	172,093	
■ Aboriginal or Torres Strait Islander	6595	3.8%
■ Speaks language other than English at home	4096	2.4%
■ RRMA classification ¹		
3: Large rural	37,000	21.5%
4: Small rural	53,695	31.2%
5: Other rural	74,516	43.3%
7: Other remote	6884	4.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9192	8.4%
■ High blood pressure ⁴	34,726	31.7%
■ High blood cholesterol ⁵	57,379	52.3%
■ Obese or overweight ⁶	66,764	60.9%
■ Physical inactivity ⁷	46,264	42.2%
■ Smoking ⁸	20,564	18.8%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

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4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

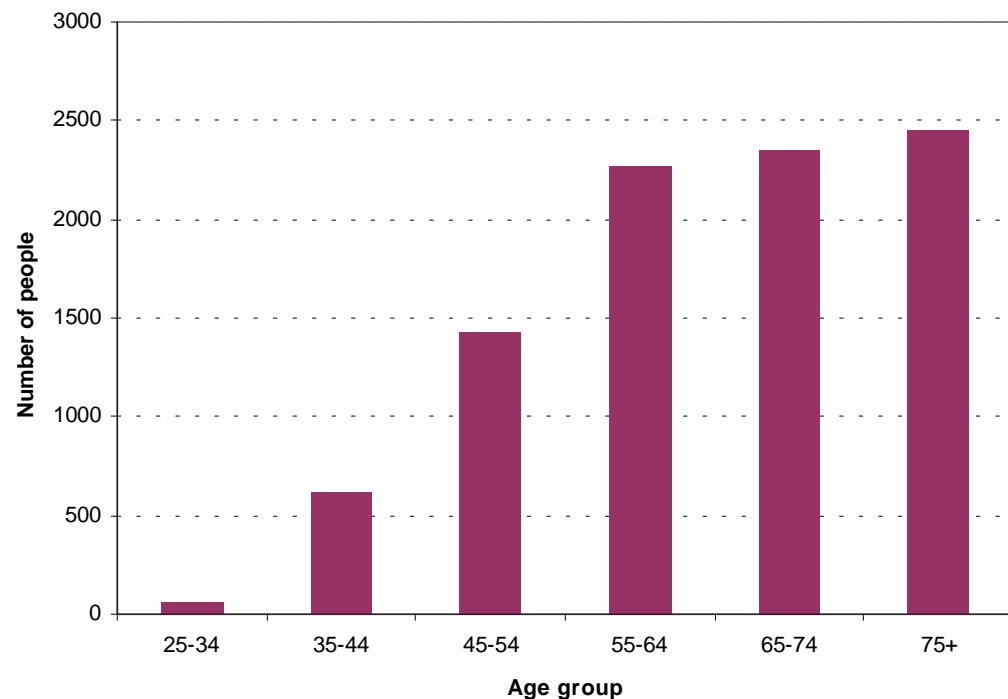
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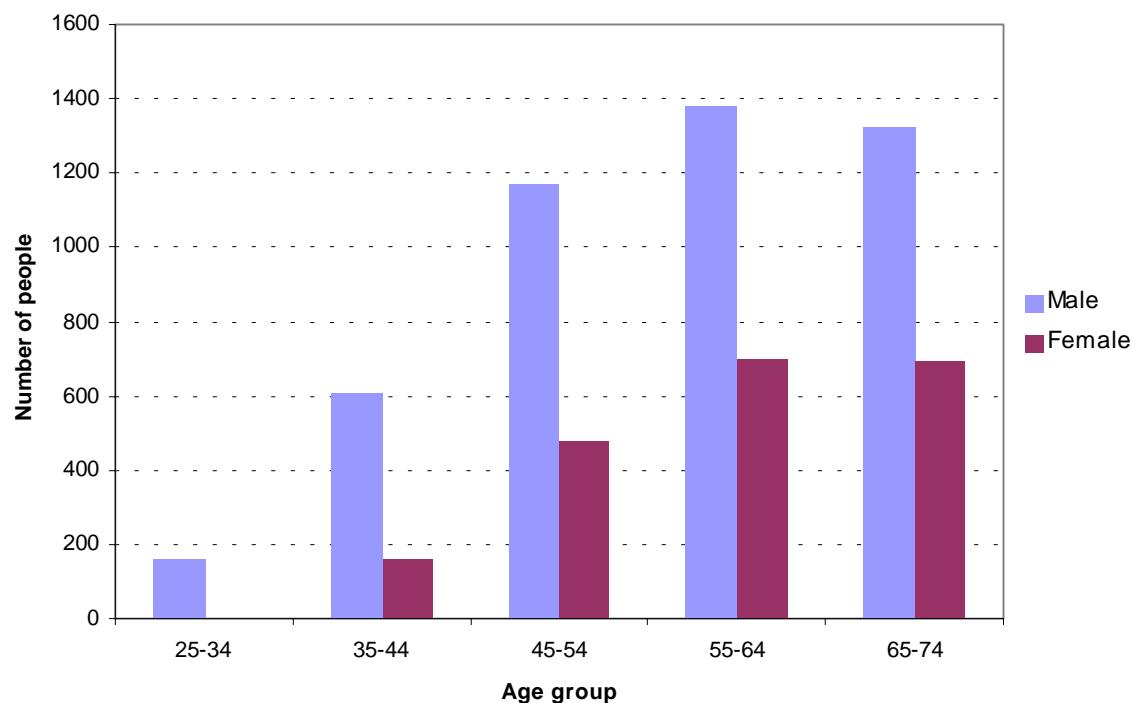
Key Descriptors of Division Population

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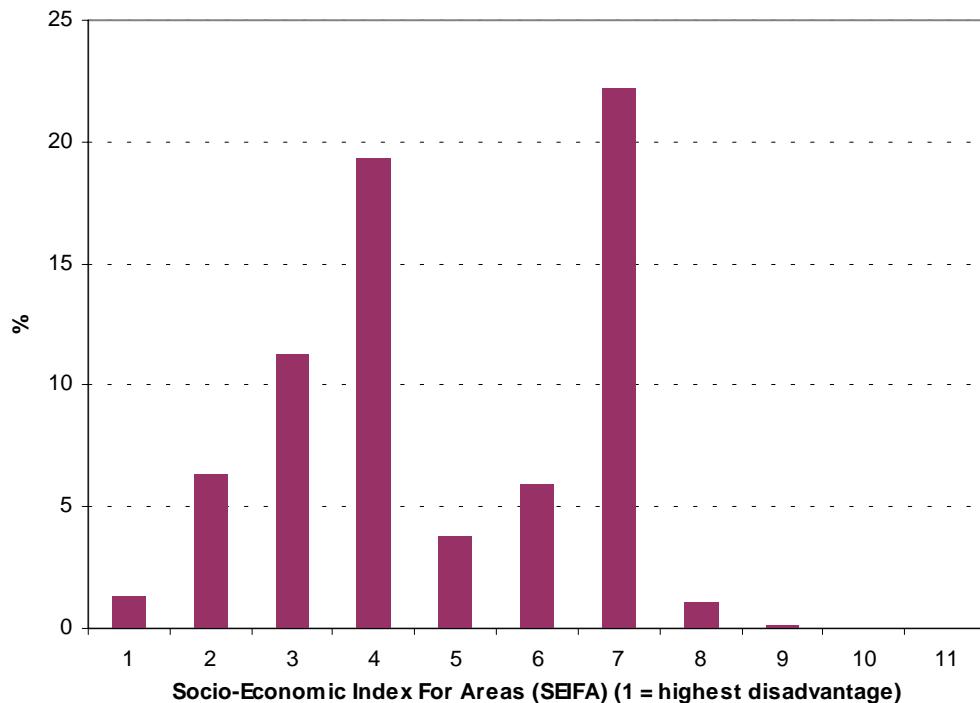
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Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

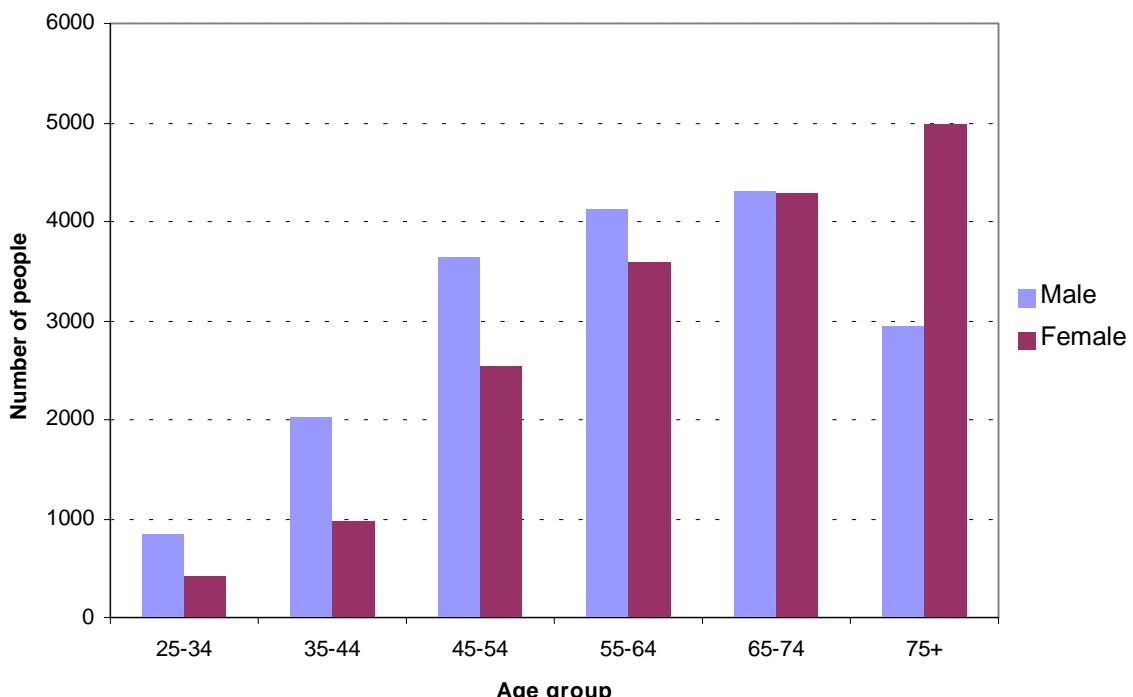
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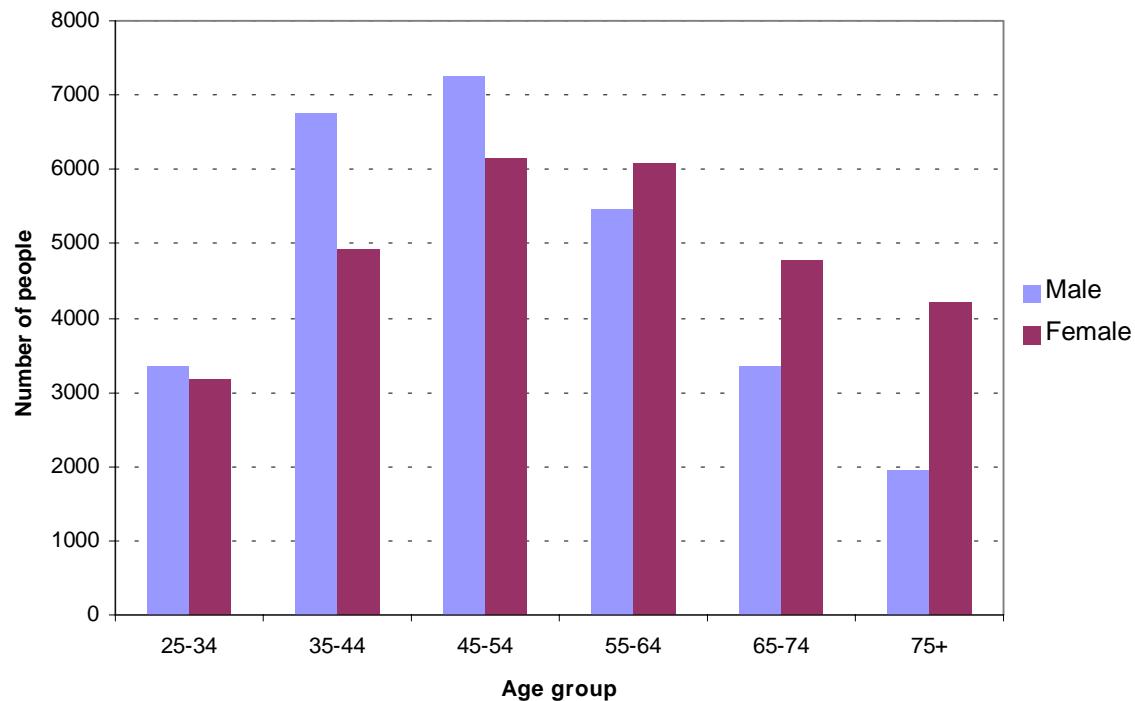
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



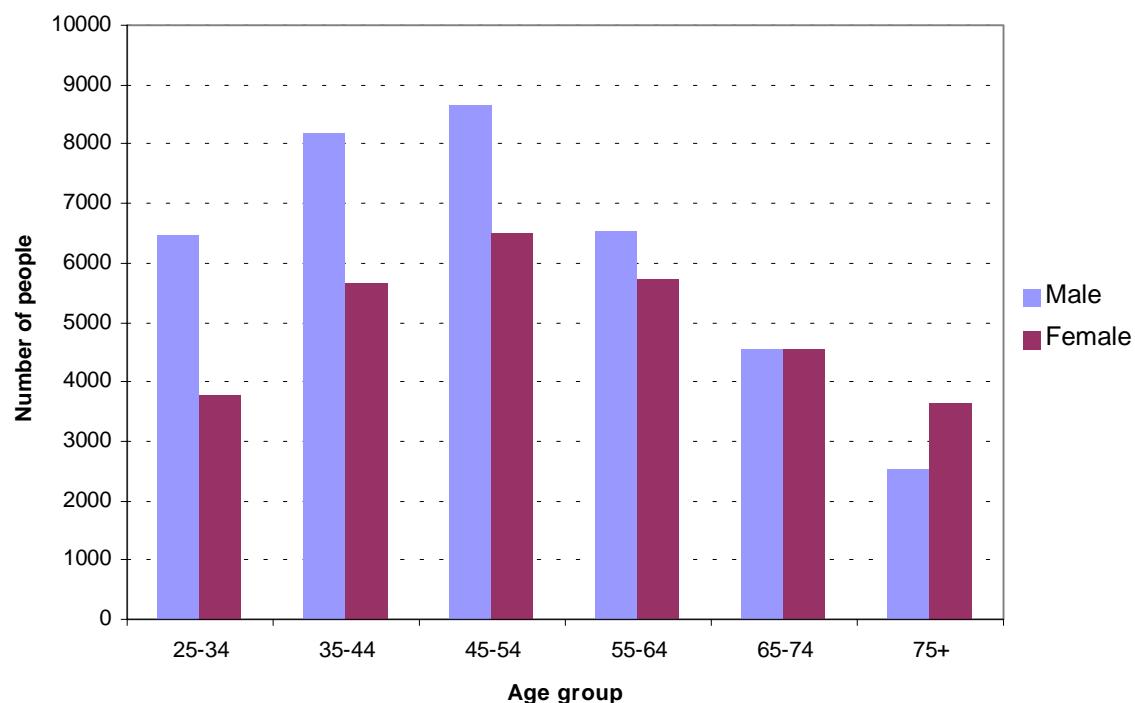
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



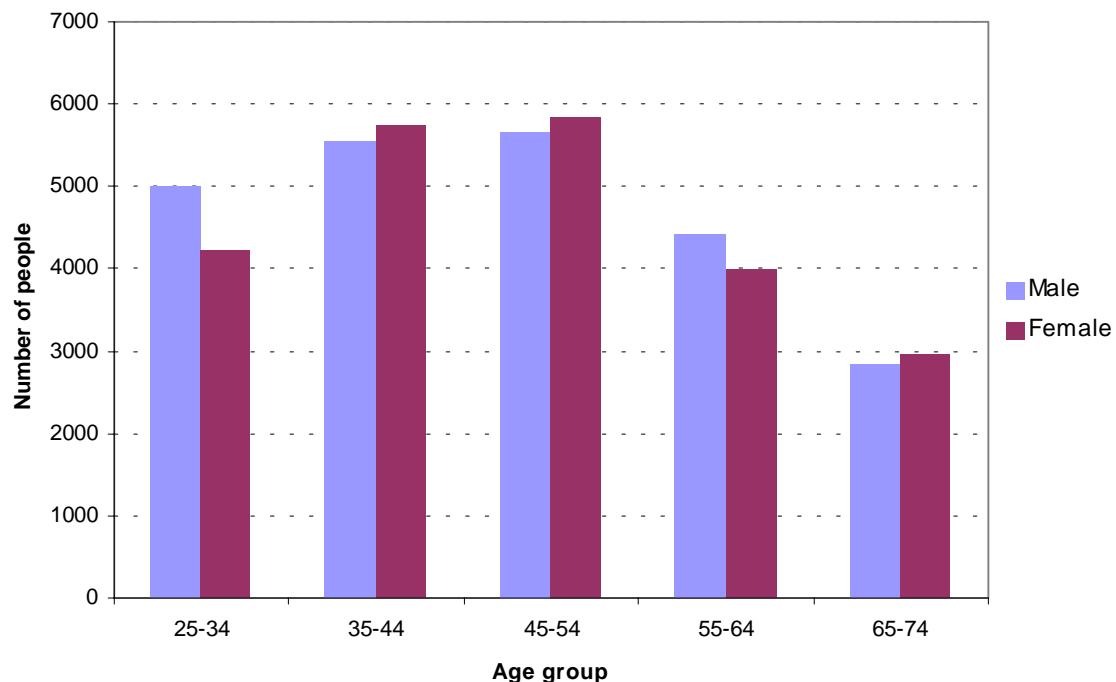
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



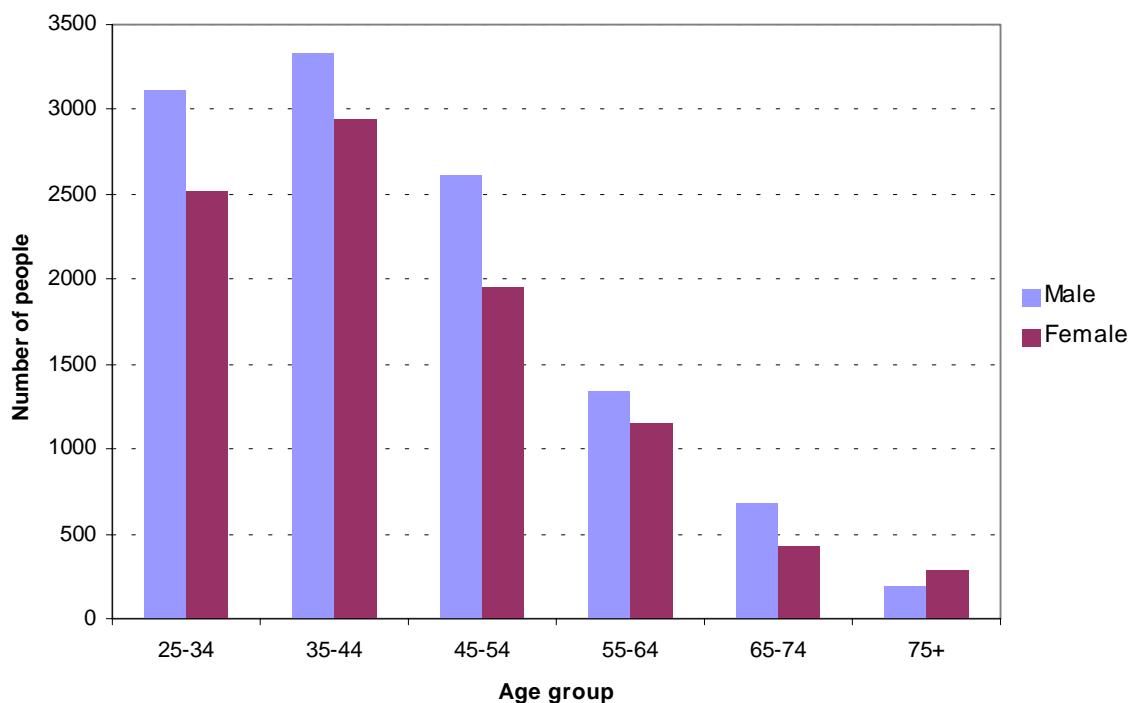
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 182 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Four diabetes educators,
 - Diabetes Australia support groups in most towns,
 - Podiatry services – public and private,
 - High risk foot clinic in Orange,
 - Diabetes resource nurses mostly in Community Health or Hospital and mainly to the west of the Division in the more remote areas,
 - Children's clinics – local and outreach,
 - Dietitians located in each major town.

- What services are needed but are not available in your Division area?
 - There is one endocrinologist in Orange three days per fortnight. This is the only endocrinologist in the Central West,
 - Limited podiatry services,
 - Limited diabetes educators,
 - Increased dietetic services needed,
 - Increased health promotion is needed.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input type="checkbox"/>	1999
<input type="checkbox"/>	2000	<input type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?
 - Maintenance of CARDIAB,
 - Production and distribution of diabetes resource folders and diabetes information kits (for newly diagnosed diabetes),
 - Education of practice nurses about management of diabetes in general practice,
 - GP and practice support to uptake Enhanced Primary Care (EPC), Practice Incentive Payment (PIP), and Service Incentive Payment (SIP),
 - Networking with stakeholders.

Division Perspective

- What have been the major achievements or highlights of your program so far?

The increasing demand by GPs for the diabetes resource folder and information kit is a highlight for this program.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - In rural and remote areas, distance and access is considered a barrier at times,
 - Time – requires greater human resource allocation, which is restricted by budgetary constraints.

- What future plans do you have for diabetes management in your Division?
 - To continue to update and distribute the resources folders and information kits,
 - Continue education events for GPs and their practice nurses,
 - Continue to support GPs in the management of diabetes,
 - Increase the uptake of EPC,
 - To increase the use of register/recall systems (practice-based).

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

The Central West Division of General Practice (CWDGP) offers ongoing support and education to encourage GP uptake of these initiatives. Additionally, the CWDGP supports practice nurses and provides education to enable the nurses to assist GPs to uptake government chronic disease initiatives.

 - Formal communication with Diabetes Australia and this link has been developed after guest speaking at the zone and local meetings,
 - Allied health, eg dietitians/podiatrists – again guest speaking and consulting with,
 - Mid Western Area Health Service – especially the diabetes educators.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Division Resources

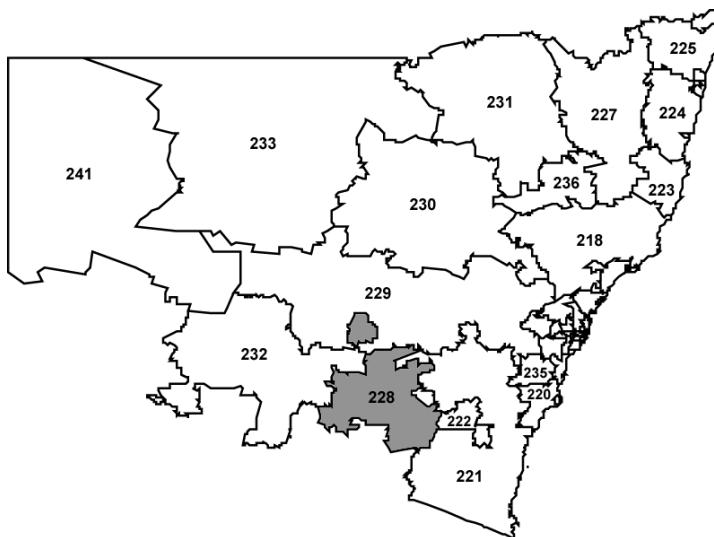
- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Royal Australasian College of General Practitioners (RACGP) diabetes management in general practice guidelines,
 - Diabetes Australia,
 - Pharmaceutical information lines,
 - Networking with other Divisions, GPs, practice nurses, consumer groups, allied health and the Area Health Service.

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? | Divisions are welcome to approach CWDGP regarding the diabetes project. Our Division is always willing to share and network with other Divisions. |
| <ul style="list-style-type: none">▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? | No. |
| <ul style="list-style-type: none">▪ What resource materials do you provide to practices? | <ul style="list-style-type: none">• Diabetes resource folder – for practices,• Diabetes information kit – for GP to provide to newly diagnosed Type 2 patients,• RACGP “Diabetes Management in General Practice”,• Monofilaments. |

Division Contact Person/
Program Co-ordinator

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Email: j.rampitsch@cwdgp.org.au

Riverina DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	110,273	
■ Aboriginal or Torres Strait Islander	3163	2.9%
■ Speaks language other than English at home	2240	2.0%
■ RRMA classification ¹		
3: Large rural	57,342	52.0%
5: Other rural	52,931	48.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5,747	8.3%
■ High blood pressure ⁴	21,743	31.5%
■ High blood cholesterol ⁵	35,973	52.1%
■ Obese or overweight ⁶	41,931	60.7%
■ Physical inactivity ⁷	28,994	42.0%
■ Smoking ⁸	12,998	18.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

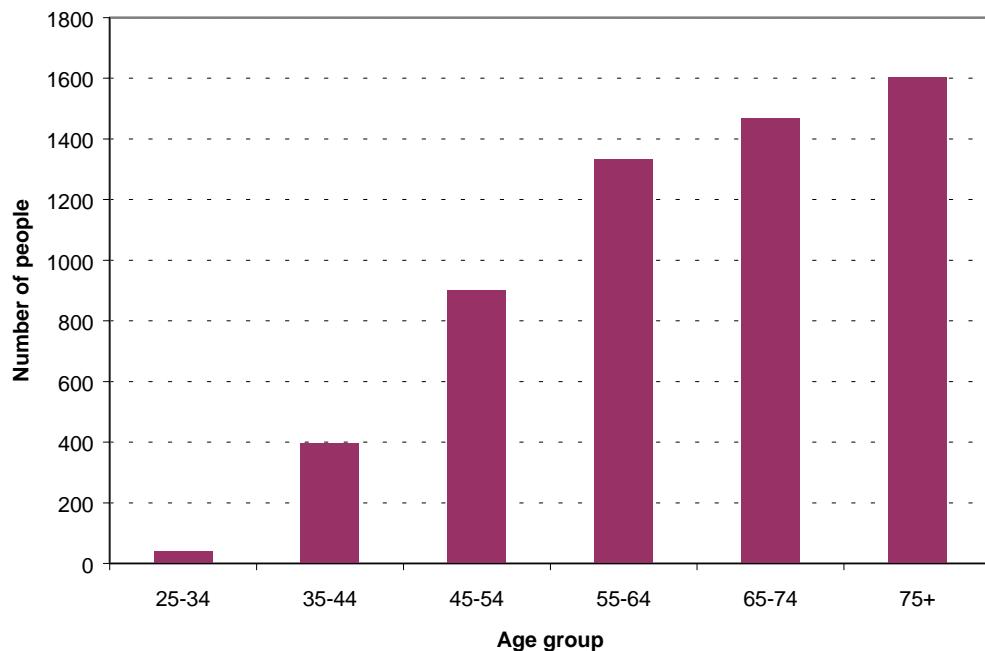
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

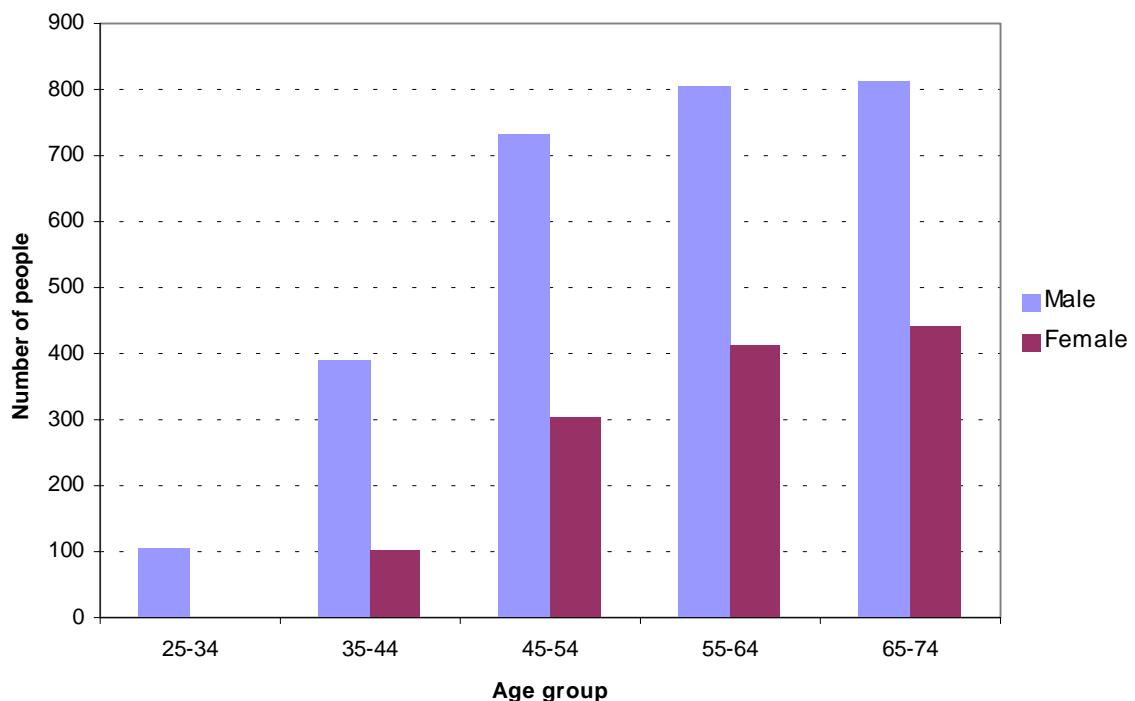
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



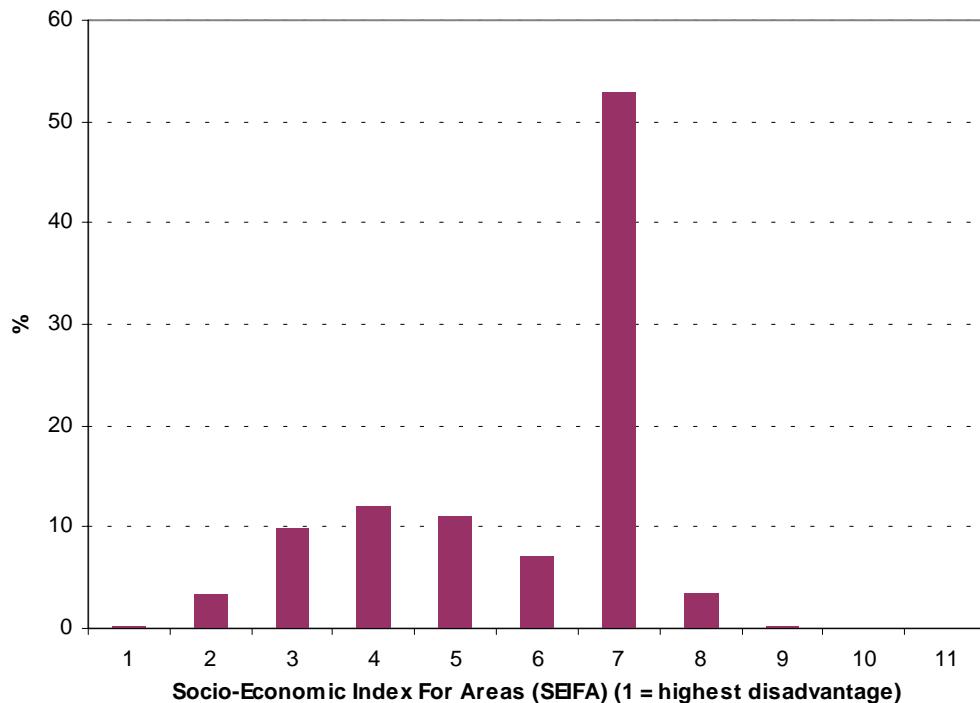
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

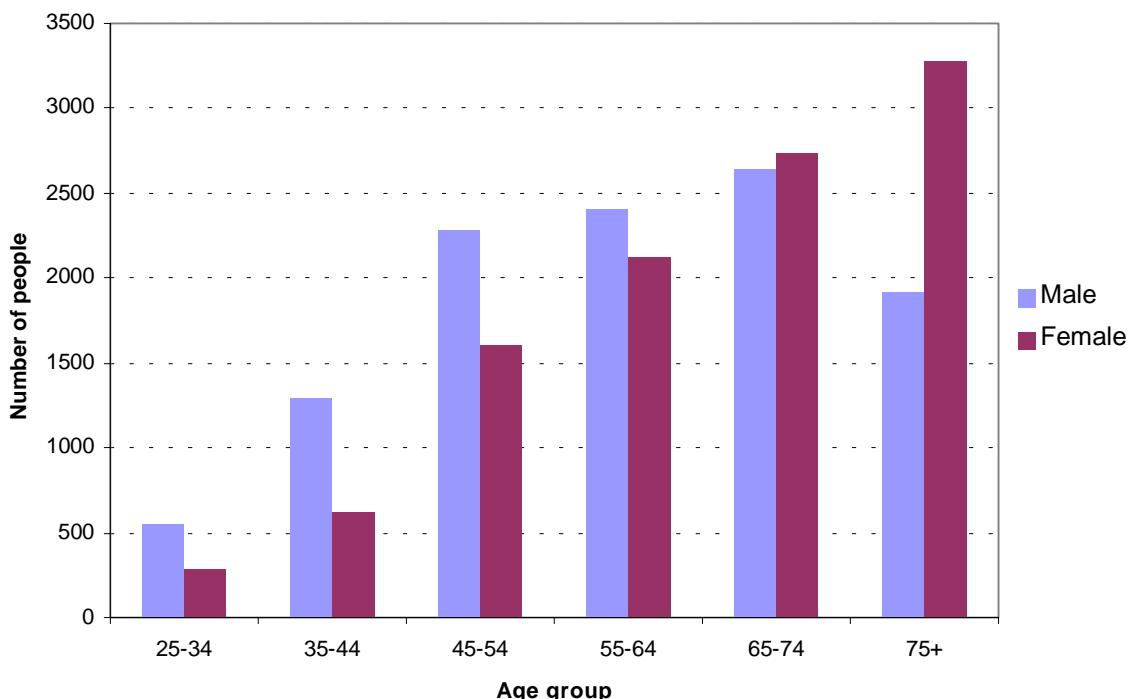
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

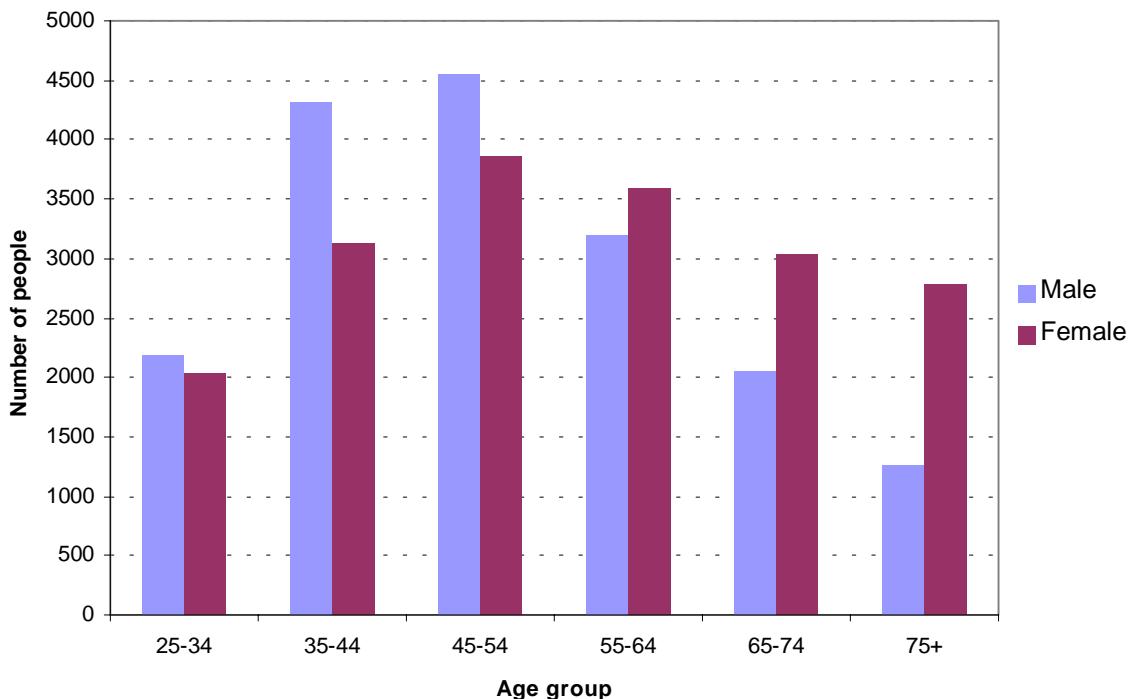
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



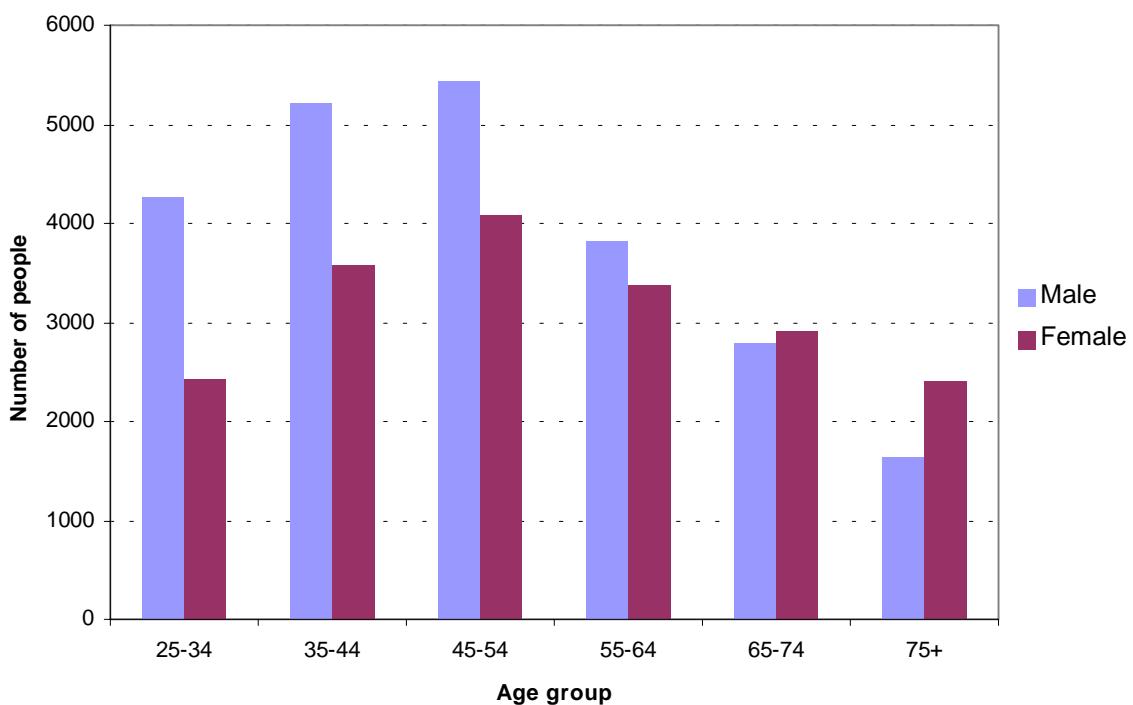
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



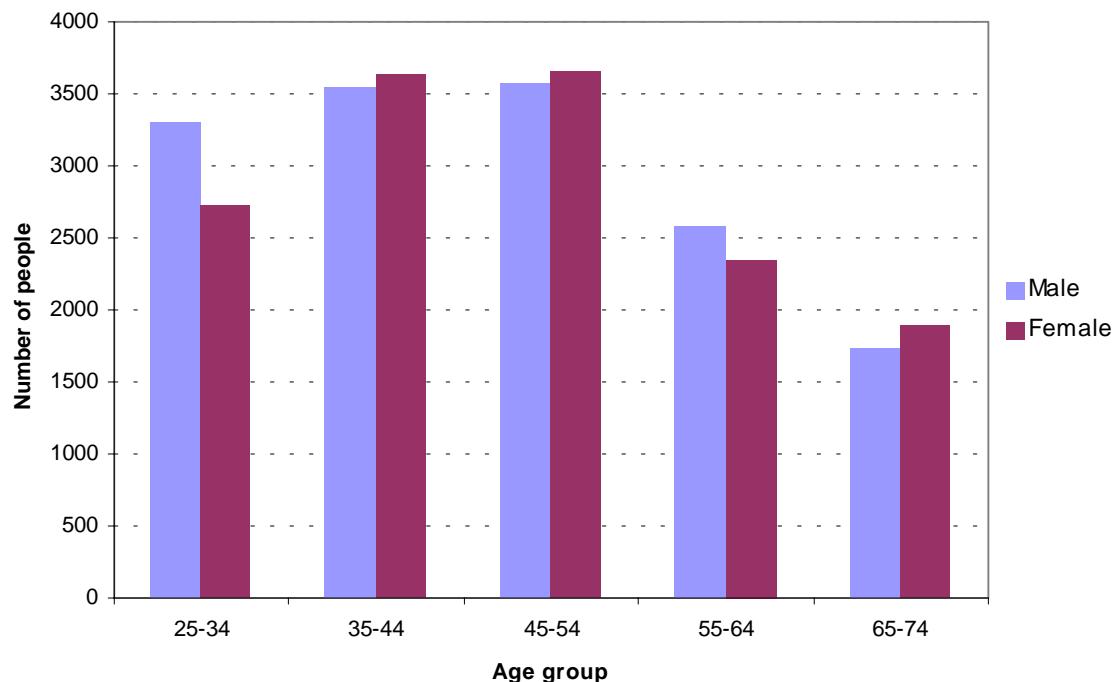
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



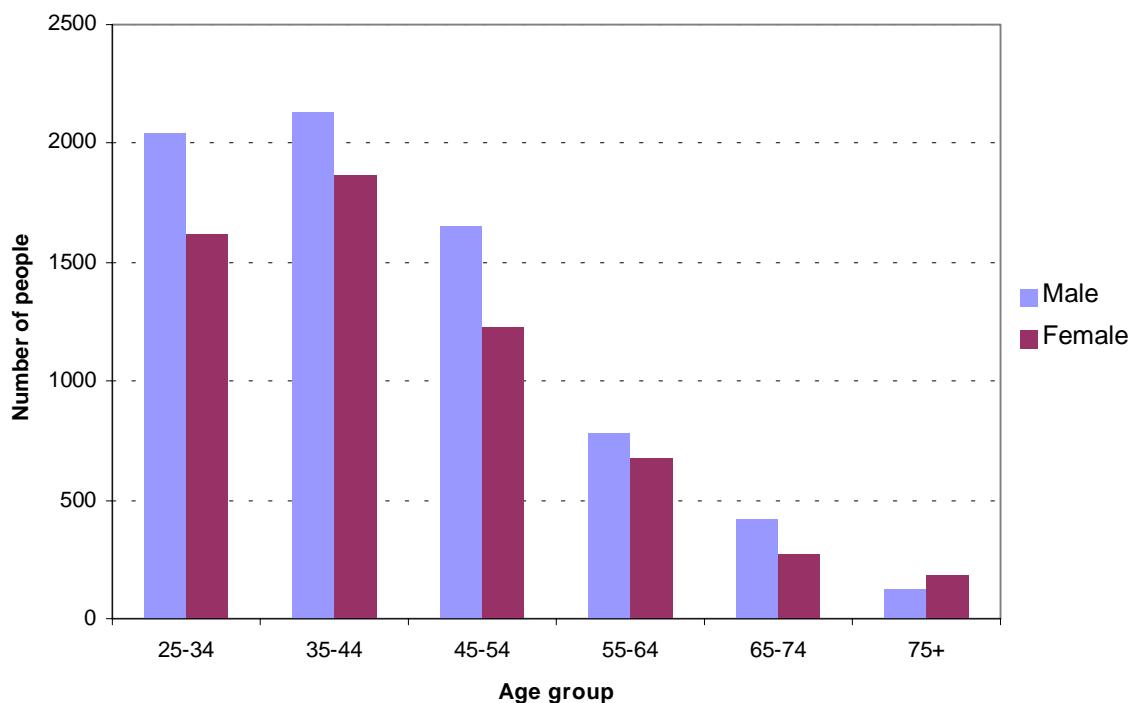
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 78 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - The More Allied Health Services (MAHS) program employs two diabetes educators servicing six towns,
 - CARDIAB,
 - Division employs diabetes educator for a Diabetes Referral Clinic one day per week within the Wagga Community Health Centre,
 - One diabetes clinical nurse consultant (CNC) and diabetes educator (Wagga – 1, Junee – 1),
 - Diabetes Association,
 - Asthma Association.

- What services are needed but are not available in your Division area?

More extensive coverage of allied health staff servicing diabetes clients.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input checked="" type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?
 - Two diabetes educators (MAHS funded),
 - CARDIAB,
 - Referral Clinic.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Collaboration and integration with GPs and Area Health Service (AHS),
 - Identified gaps minimised through MAHS resources.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Availability of suitably skilled clinicians (diabetes educators).

- What future plans do you have for diabetes management in your Division?

Expansion of training to GPs and practice nurses.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Interest and understanding of chronic disease,
 - Interest and understanding of population health,
 - Relevant referral sources (ie allied health staff, providers of physical activity),
 - Relevant support structures (ie relevant guidelines).

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Area Health Service – structured meetings and structured partnerships (programs),
 - Other nearby Divisions – joint training and collaboratives,
 - Heartmoves providers,
 - Arthritis Foundation,
 - Riverina Medical and Dental Aboriginal Corporation,
 - Local Diabetes Association.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
N/A.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
N/A.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
Guidelines.

- What resource materials do you provide to practices?
 - Information updates,
 - Training (GPs, practice staff, practice nurses).

Division Contact Person/
Program Co-ordinator

Name: Shanelle Sloan
Phone: 02 6931 7844
Fax: 02 6931 7822
Email: s.sloan@rdgp.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiac rehab sessions – dietitian, counsellor, pharmacist,
 - Cardiovascular Care Coordinator – Wagga Wagga Base Hospital,
 - Private dietitians,
 - Public dietitians,
 - Heartmoves program,
 - Cardiac rehabilitation manual for GPs,
 - Heart Foundation resources – distributed by the Division.

- What services are needed but are not available in your Division area?
 - Comprehensive cardiac rehabilitation program.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992 1993 1994 1995
 - 1996 1997 1998 1999
 - 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?
 - Cardiac rehabilitation and secondary prevention manual for GPs has been developed and distributed – May 2001,
 - June 2001 – Pharmacy education session commenced,
 - June 2001 – Nutrition session commenced,
 - June 2002 – Counselling session commenced,
 - September 2002 – Whole program being reviewed.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Program currently under review.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Relevant services (ie physiotherapy),
 - Appropriate/comprehensive referral mechanisms,
 - GP:Population ratio (ie lag time from discharge to GP visit too great),

-
- Time,
 - Adequate marketing.
-
- What future plans do you have for CVD management in your Division?
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
-
- Review to include
 - improved referral,
 - improved coordination.
 - Consult,
 - Plan,
 - Collaborate.
- Wagga Wagga Base Hospital
 - Cardiovascular Care Coordinator and ambulatory coordinator and chronic and complex care manager,
 - Meetings,
 - Collaborative,
 - Shared resources and planning.
 - Private hospital – as above,
 - Heart Foundation – guidelines/resources,
 - Other Divisions – consultations/experience.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- Following the completion of the review – any resources that have been developed would be available for sharing.
- Guidelines (Heart Foundation),
 - Brochures (Heart Foundation).
- One page flowchart,
 - One page (dot point) guidelines.

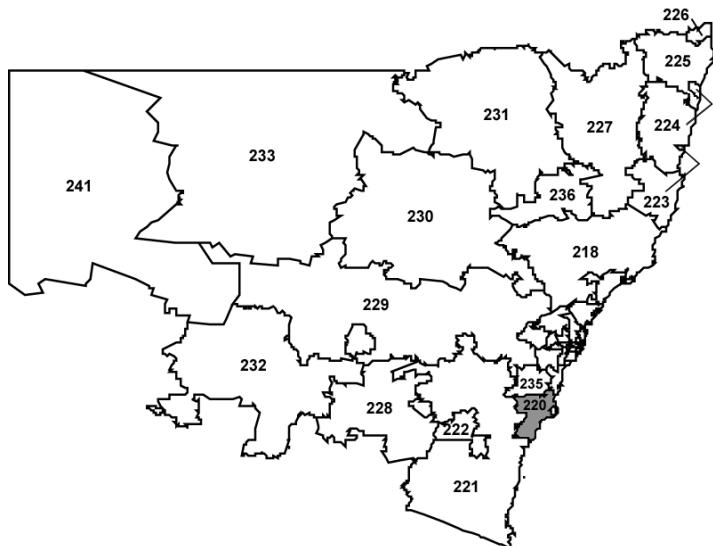
- **What resource materials do you provide to practices?**

Resource manual has been provided – not well utilised.

Division Contact Person/
Program Co-ordinator

Name: Shanelle Sloan
Phone: 02 6931 7844
Fax: 02 6931 7822
Email: s.sloan@rdgp

Shoalhaven DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	82,731	
■ Aboriginal or Torres Strait Islander	3210	3.9%
■ Speaks language other than English at home	2546	3.1%
■ RRMA classification ¹		
4: Small rural	82,731	100.0%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5537	9.9%
■ High blood pressure ⁴	20,387	36.3%
■ High blood cholesterol ⁵	30,429	54.2%
■ Obese or overweight ⁶	34,811	62.0%
■ Physical inactivity ⁷	23,167	41.3%
■ Smoking ⁸	9703	17.3%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

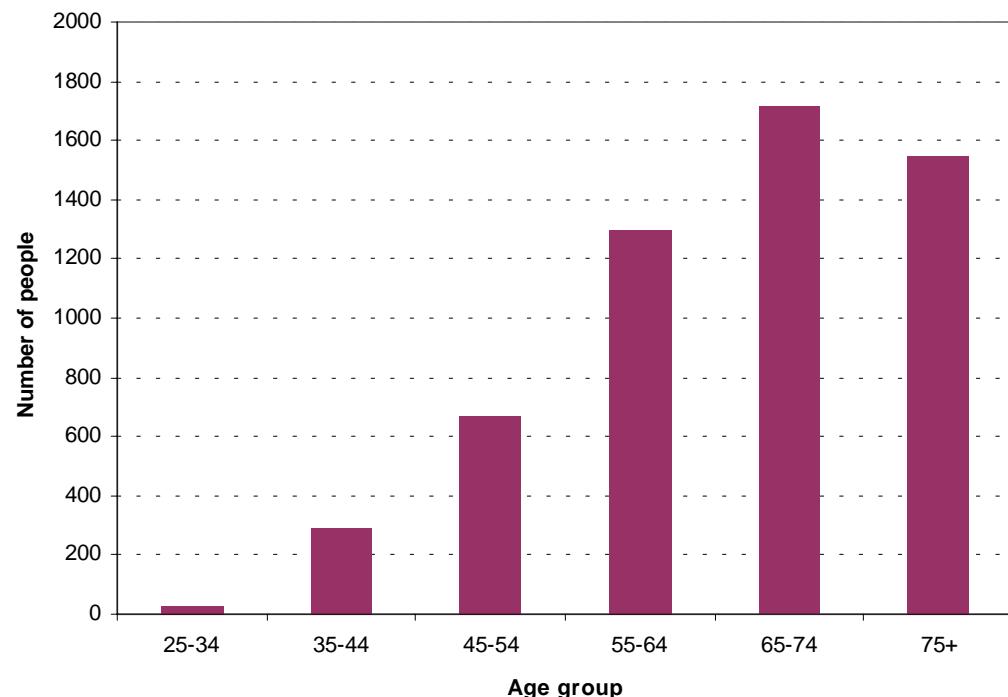
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

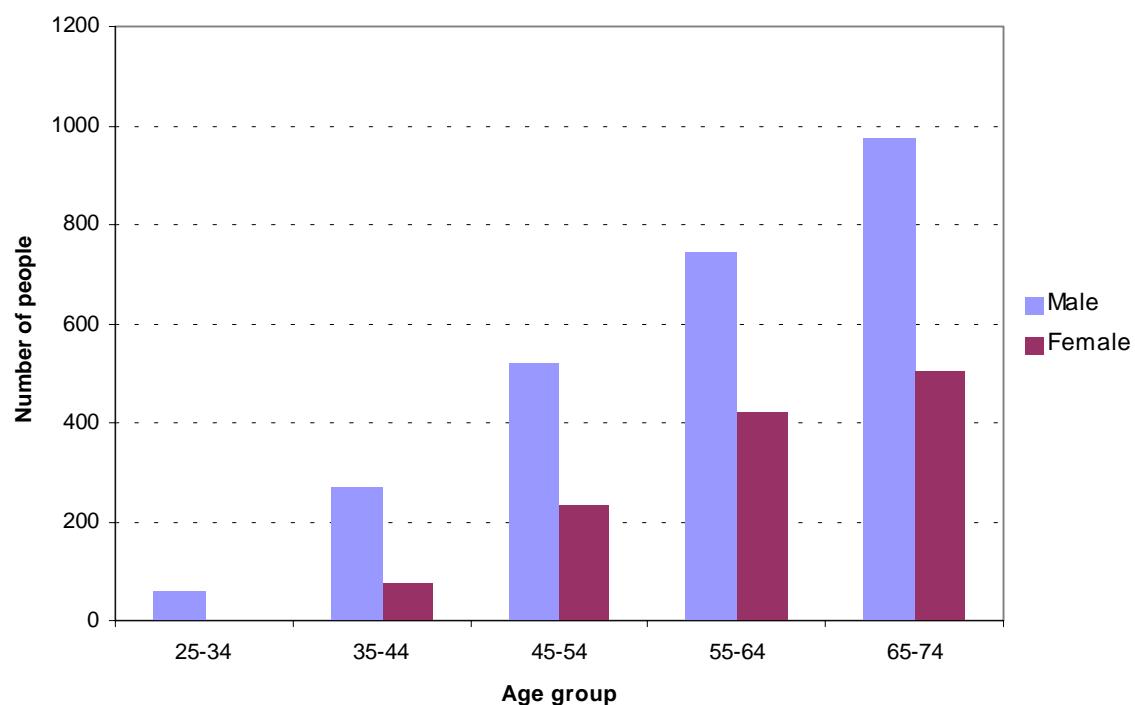
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



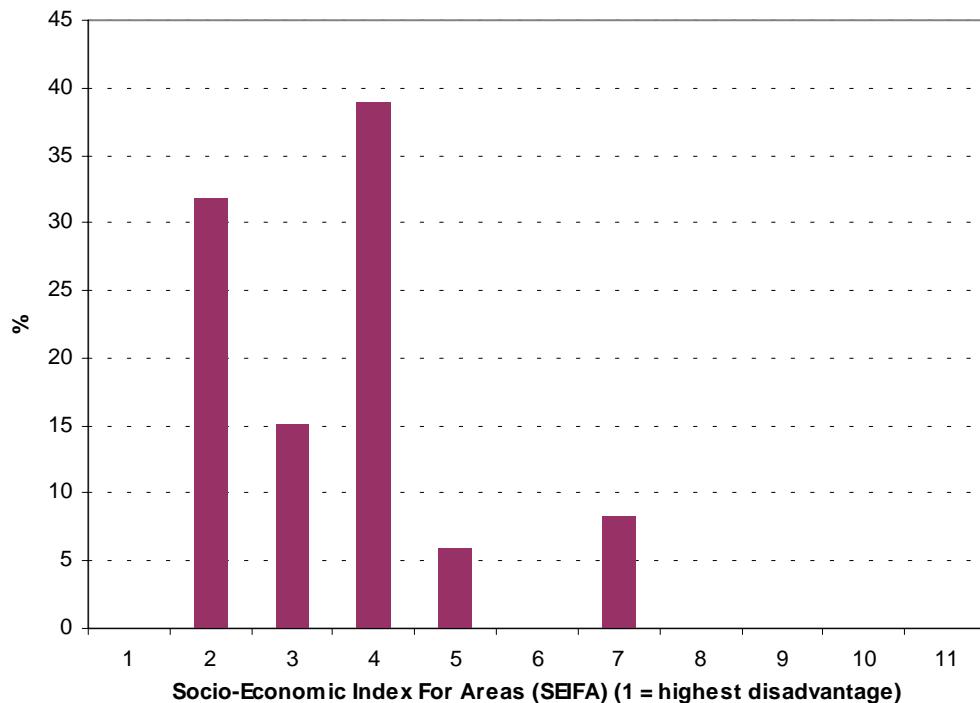
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

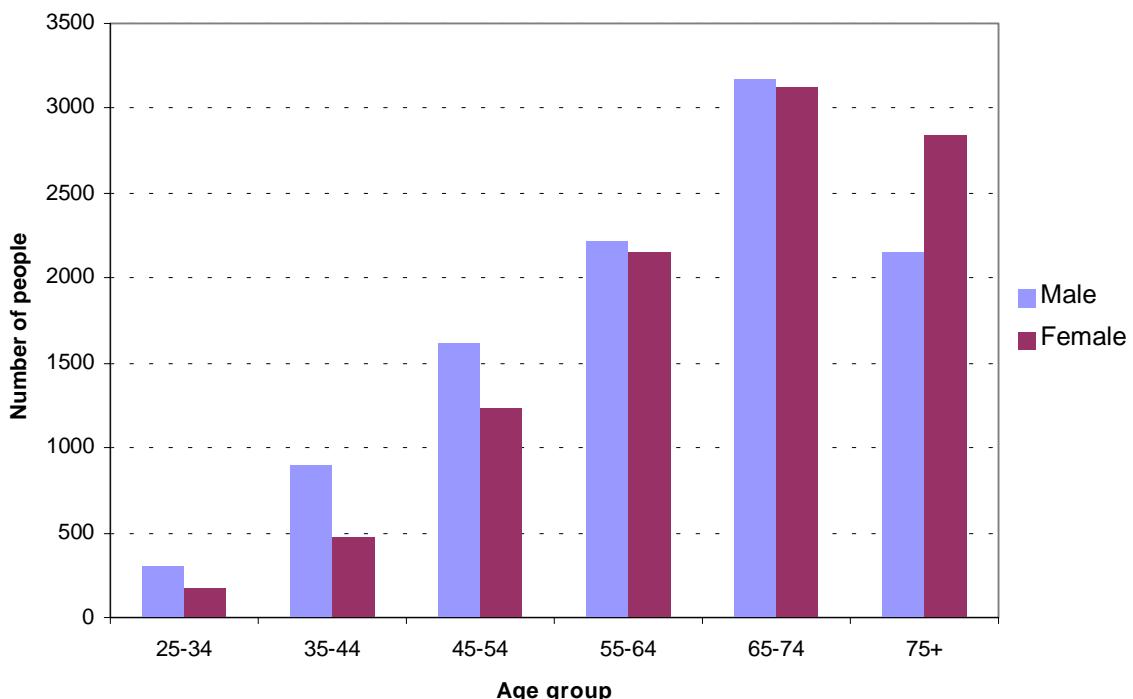
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

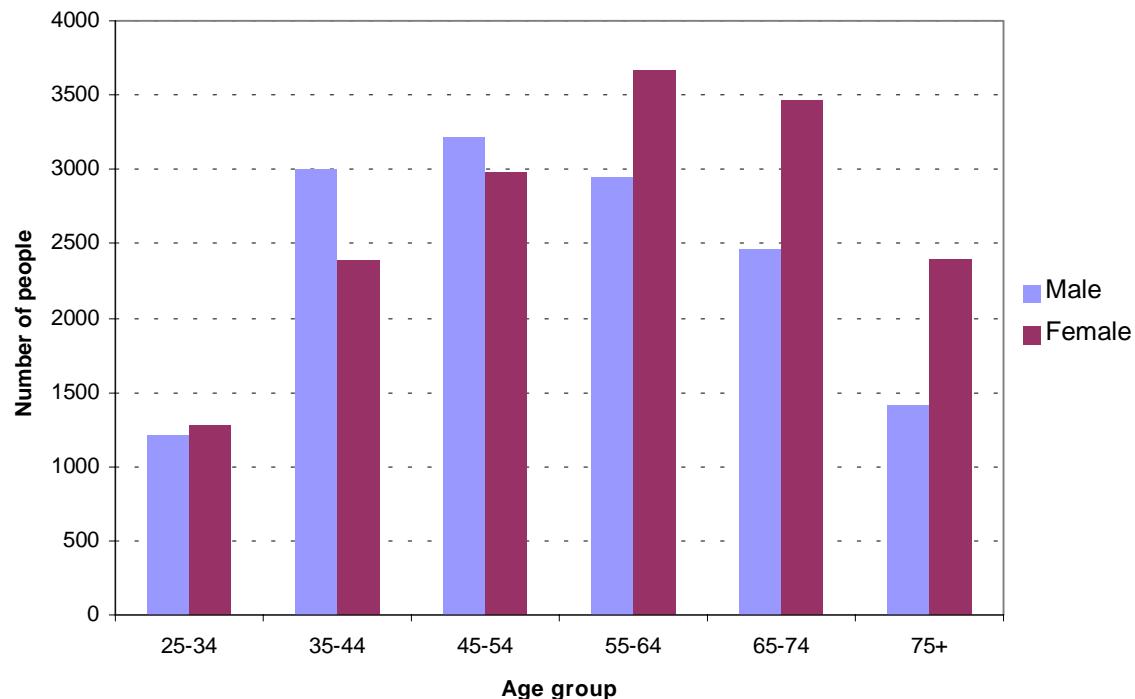
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



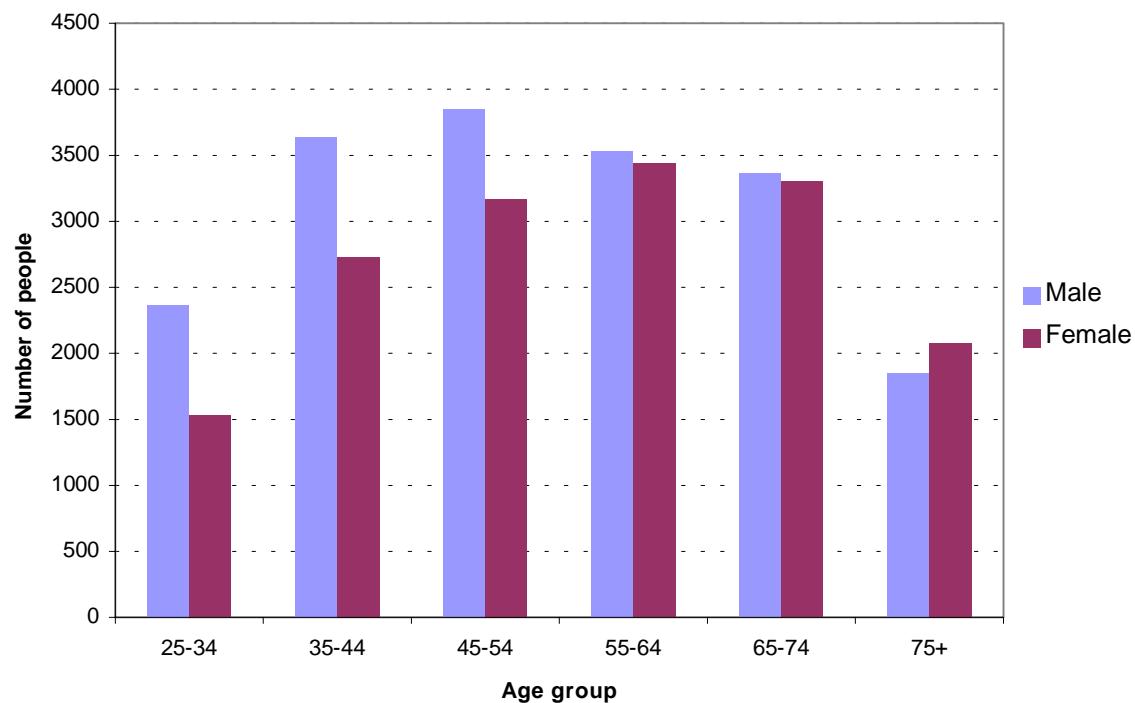
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



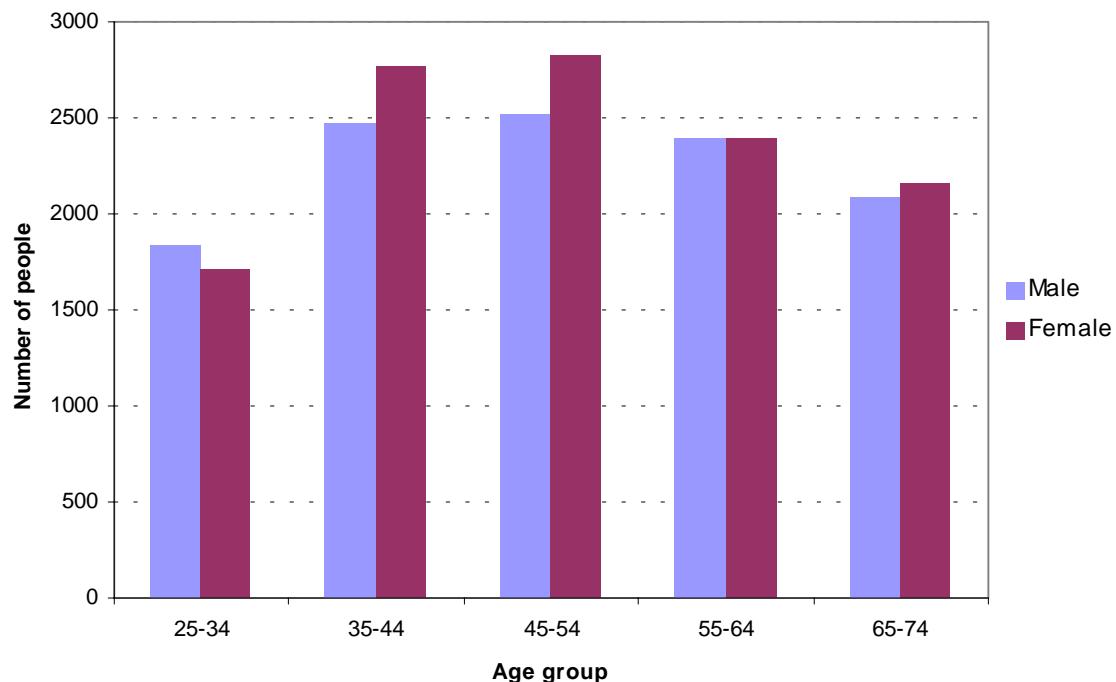
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



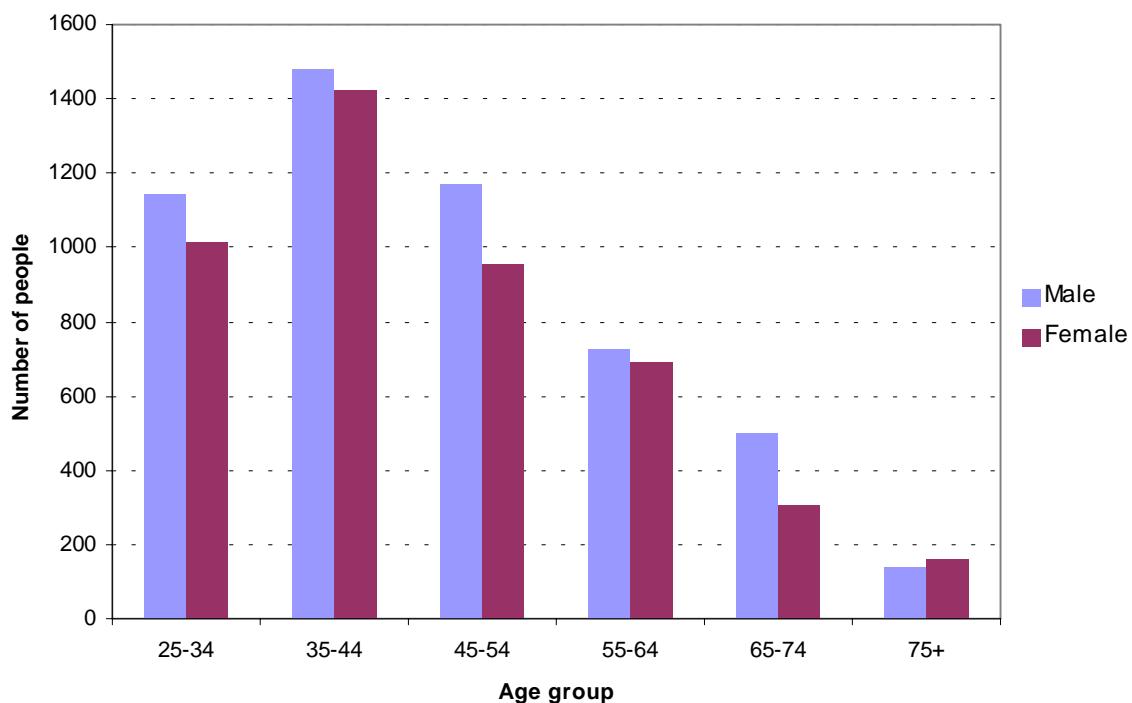
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 84 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Illawarra Area Health Service (IAHS):
 - Hospital podiatrist – not solely for people with diabetes,
 - Hospital dietitians – not solely for patients with diabetes,
 - Community health – diabetes educators and dietitian (referrals from specialists).
 - Private:
 - Podiatry clinics,
 - Private dietitians.
 - More Allied Health Services (MAHS):
 - Dietitian and podiatrist supplied to GP surgeries.
- What services are needed but are not available in your Division area?
 - Public – counselling (psychology) services – free of charge,
 - Public – exercise physiologists – supervised exercise sessions – free of charge.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

MAHS – through Shoalhaven Division of General Practice (SDGP) supply a dietitian and podiatrist to GP surgeries on a roster basis – for patients with diabetes. Consultations are “one-on-one”, via a referral system. Patients may also attend “private podiatry rooms” under MAHS. Most “changes” are evolutionary adaptations to the GPs surgeries and local community. MAHS is currently developing and implementing “group sessions” encompassing:

- Activity,
- Behavioural change,
- Dietary advice for healthy lifestyles.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Achieving funding requirements,
 - GP support for the period 2001 – 2002. The program received 2700 referrals with patient attendance over 85%,

- Providing a consistent reliable “grass roots” service from within GP surgeries,
- Collaborating effectively with other stakeholders,
- Working from within the GP surgeries.

-
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Attracting and retaining Allied Health professionals,
 - Cynicism from GPs and community – “How long will MAHS be here?” due to government funding,
 - Physical location – not all GPs have rooms available for the Allied Health professionals to work from (minor problem).
 - What future plans do you have for diabetes management in your Division?
 - Implementing “group education” covering exercise and psychology,
 - Continue to work collaboratively with other diabetes providers to ensure there is a range of sustainable professional support for GPs and their patients with diabetes – at no cost to the patient,
 - To encourage these services to be consistent and reliable and then encourage GPs to refer to them.
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

“Communication, understanding and organisation” are essential. Allied Health working from GP surgeries seems to be a big contributing factor.
 - What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Alliance via “contracts” with private podiatry services,
 - Alliance with other stakeholders – diabetic educators and local endocrinologist in the development of a “Resource” folder,
 - Continual collaborative communication and management to ensure:
 - All services complement each other, and
 - There is no “doubling” up on services.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Local resource (described previously),
 - Local diabetes educators,
 - Local endocrinologists,
 - Diabetes Australia resources,
 - Dietitians have developed own set of resources and booklets.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - MAHS “Resource” folder – developed for practice demonstration and diabetes management,
 - Dietitians – own resources and booklet,
 - Group sessions content kit.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

- What resource materials do you provide to practices?

No – we usually develop our own resources from a range of resources for our local needs. We have good access (via internet) to external resources and guidelines.

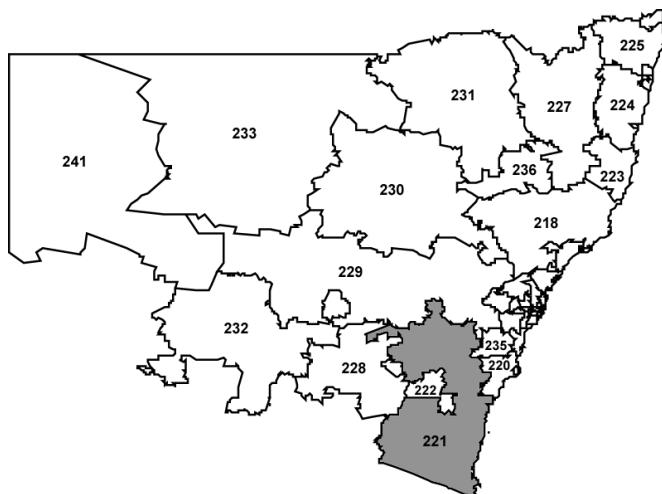
“Resource” folder – containing:

- Diabetes Management flow chart – colour coded within the flow chart, Practice Incentive Payment (PIP) and Service Incentive Payment (SIP) procedures.
- Local Allied Health Services available in Shoalhaven for people with diabetes. We try to keep it simple though we are adding to the folder all the time.

Division Contact Person/
Program Co-ordinator

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South East NSW DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	168,123	
■ Aboriginal or Torres Strait Islander	3572	2.1%
■ Speaks language other than English at home	7205	4.3%
■ RRMA classification ¹		
2: Other metro	17,317	10.3%
4: Small rural	27,236	16.2%
5: Other rural	123,570	73.5%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9853	8.8%
■ High blood pressure ⁴	36,995	32.9%
■ High blood cholesterol ⁵	59,516	53.0%
■ Obese or overweight ⁶	69,048	61.4%
■ Physical inactivity ⁷	47,484	42.3%
■ Smoking ⁸	20,660	18.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

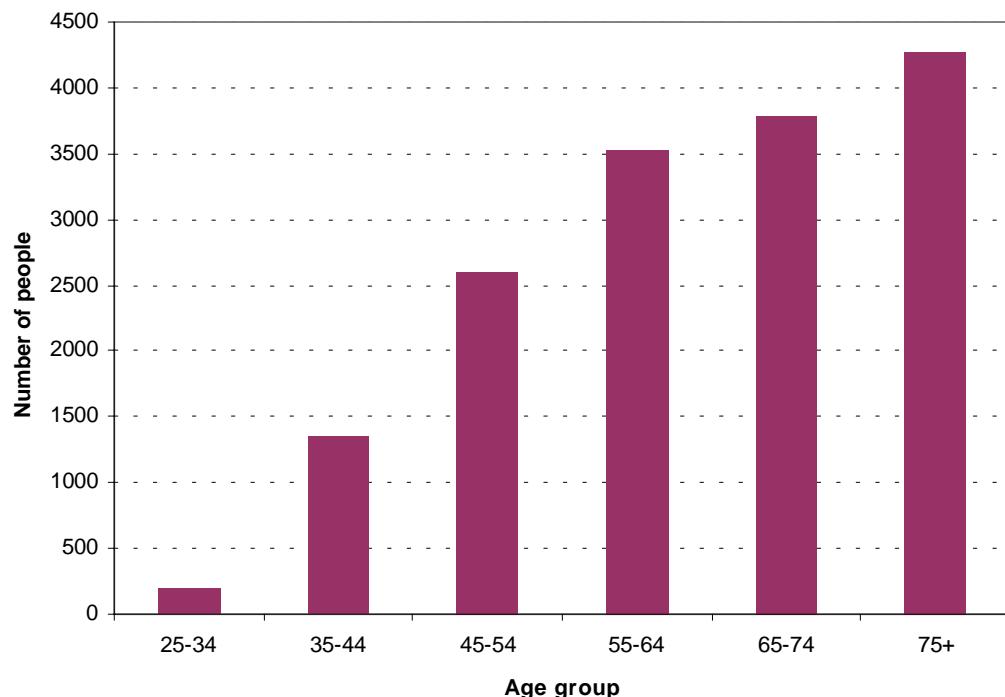
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

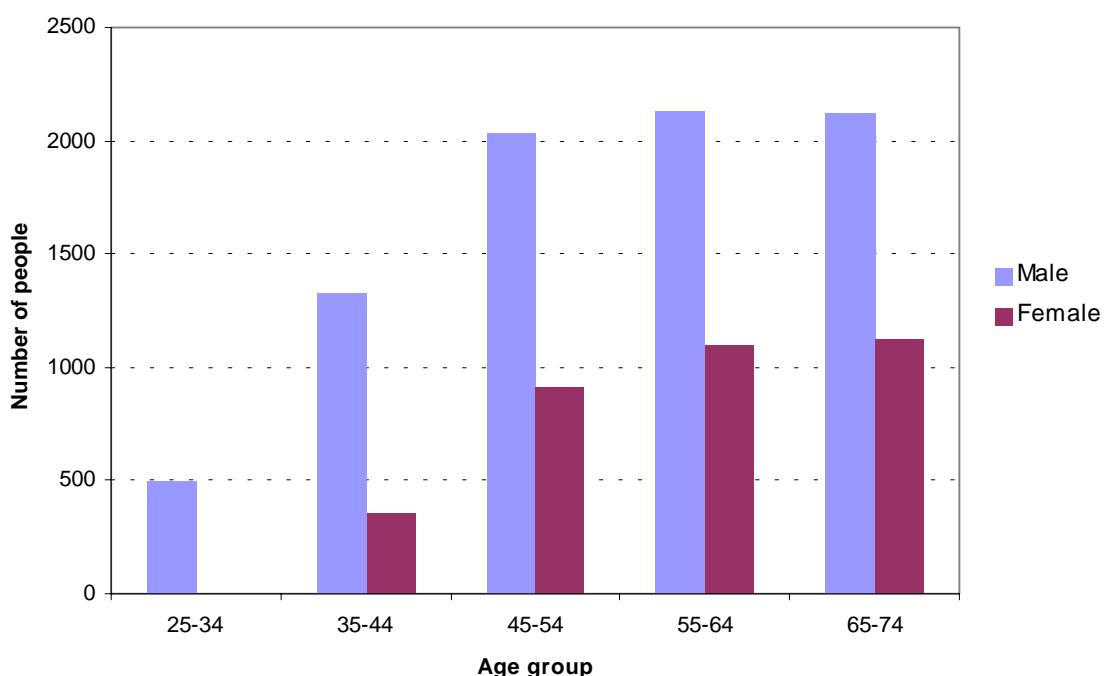
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



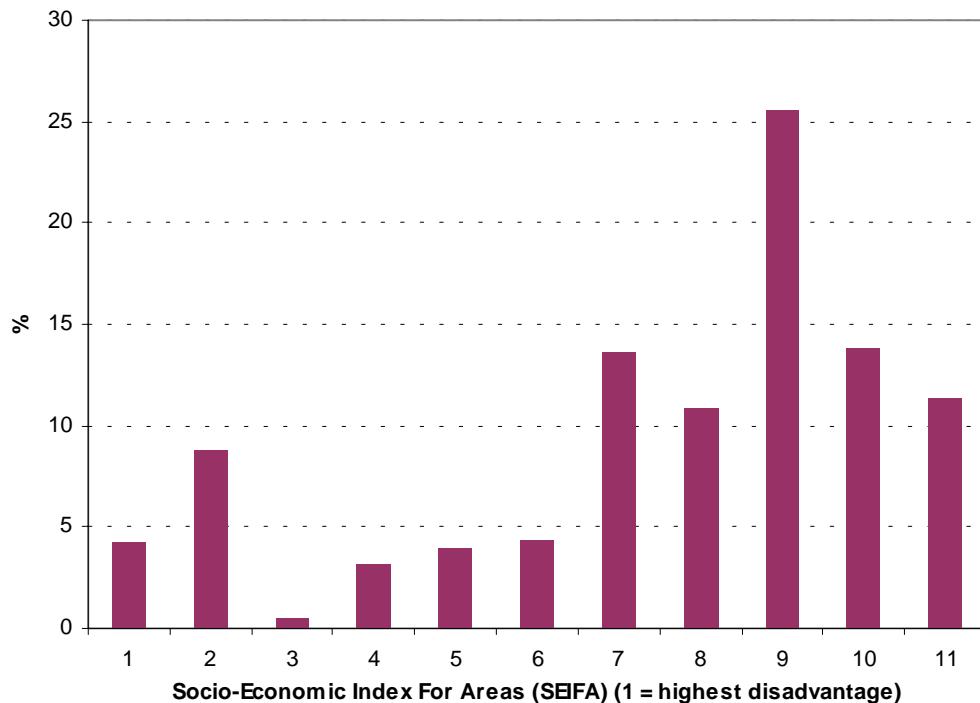
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

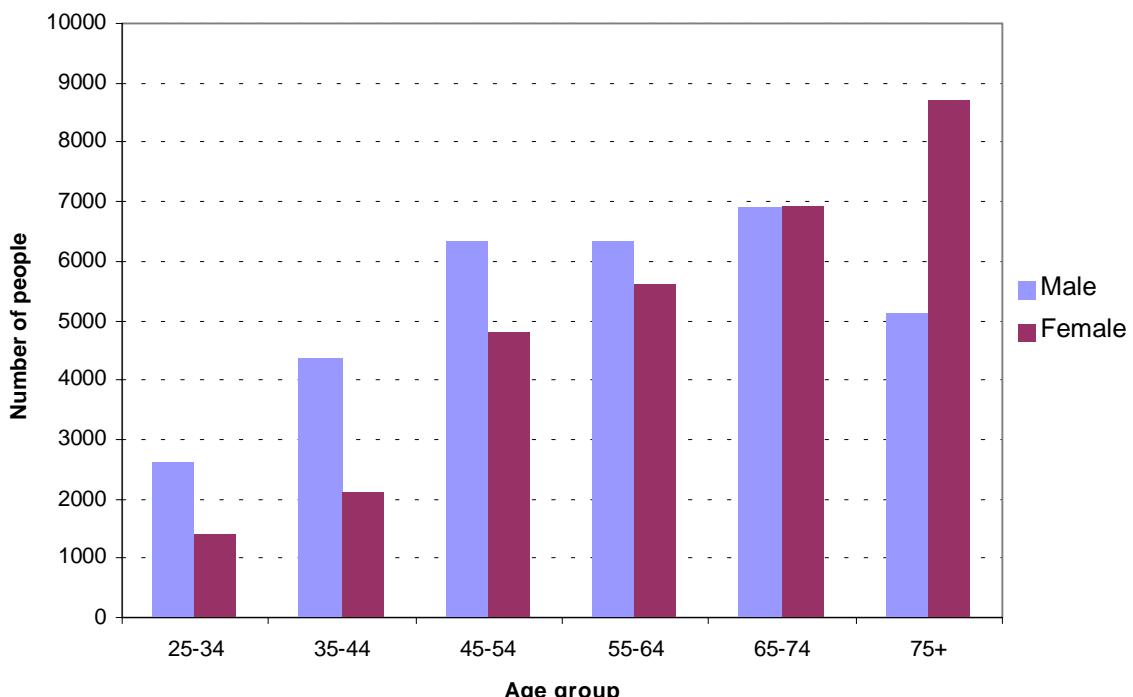
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

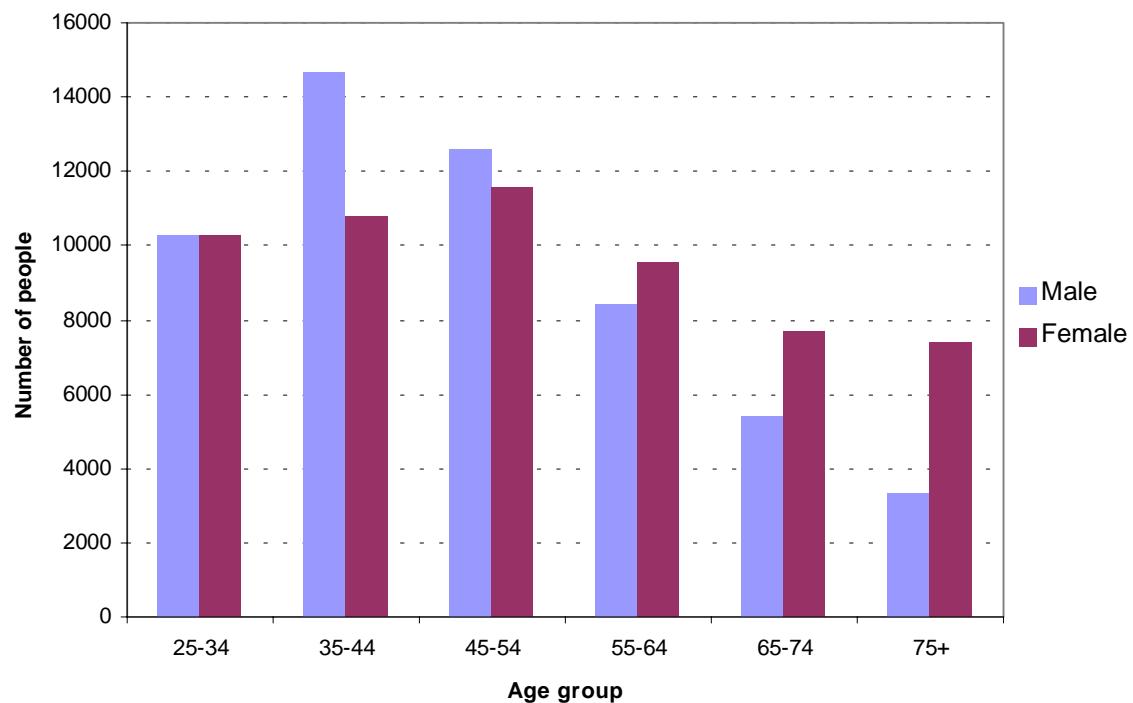
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



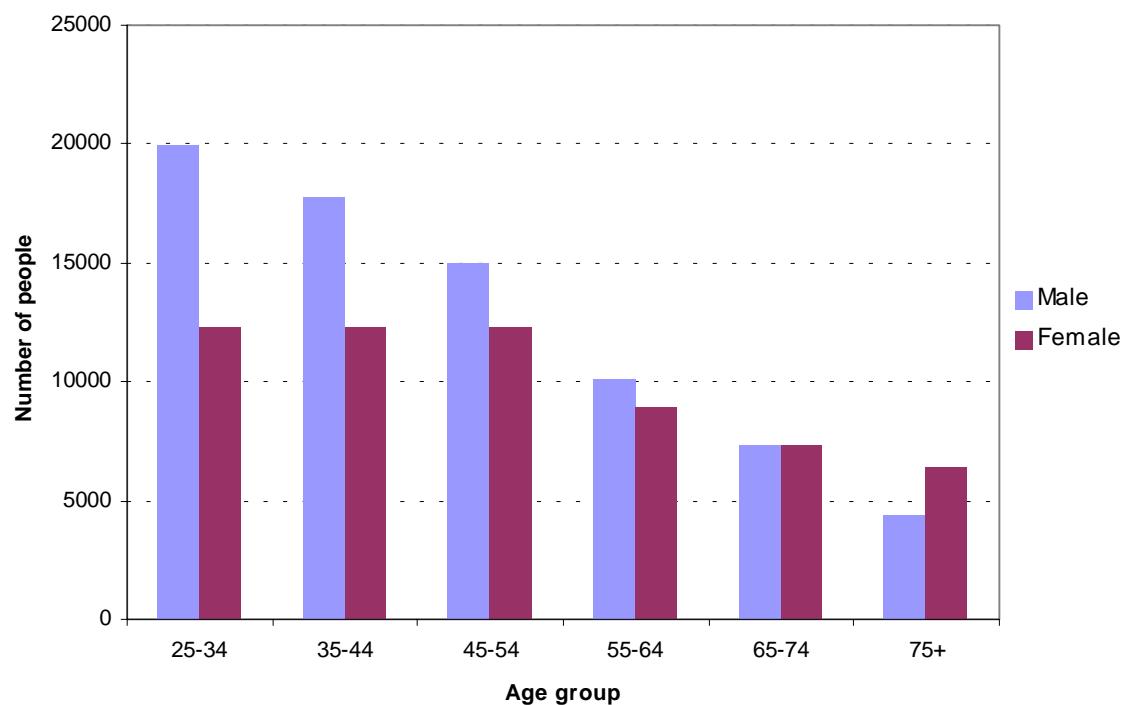
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



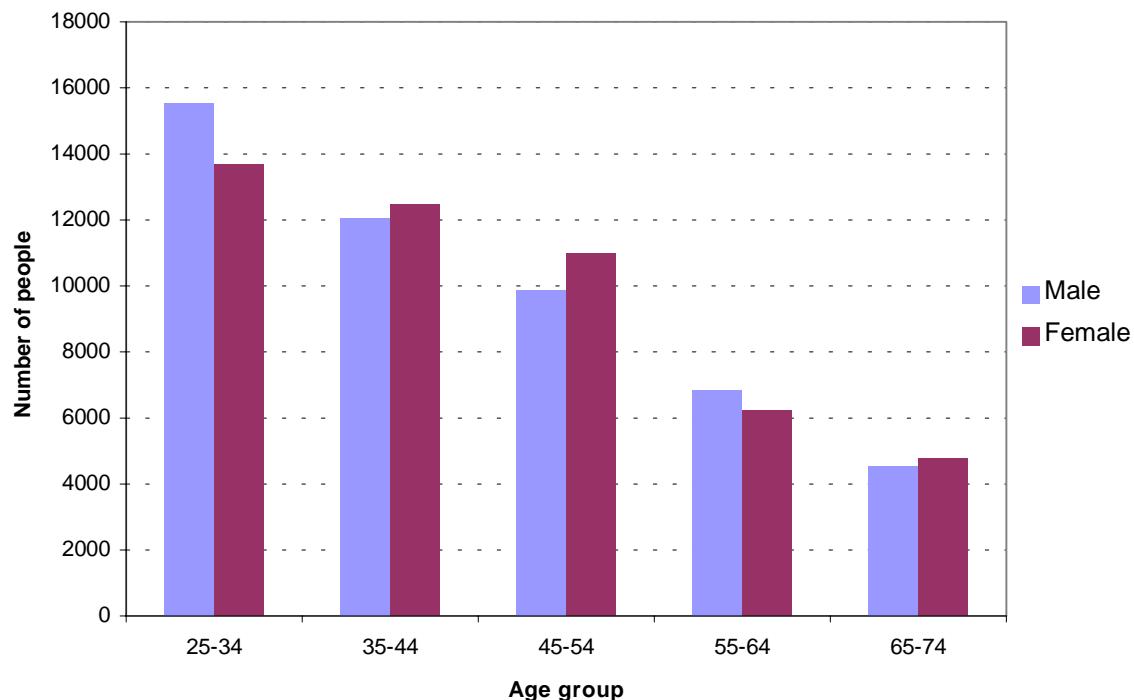
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



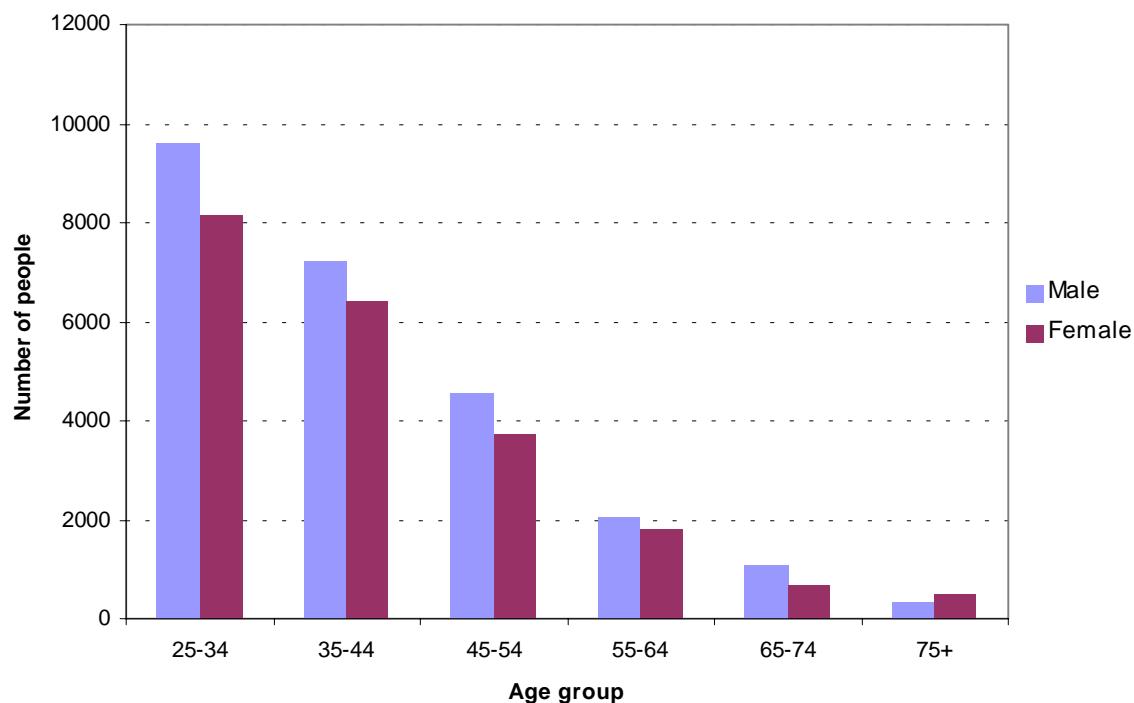
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 169 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Public diabetes education services provided by Area Health Services (AHS) including diabetes nurse, dietitians and occasionally podiatry – usually operating from community health centres,
 - Extremely limited private endocrinology.

- What services are needed but are not available in your Division area?
 - Public podiatry,
 - More diabetes education,
 - More specialist endocrinology.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Initially focused on encouraging clinical management against guidelines and monitoring outcomes, as well as integration with local AHS providers through local diabetes committees and a shared data system has become more Division-centric with advent of Practice Incentive Program (PIP) diabetes incentives and difficulties with data management. Now provides diabetes register and clinical audit feedback to GPs.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Anecdotal reports of improved diabetes care delivered through general practices,
 - Greater dialogue between providers, (especially GPs and DNEs),
 - Some GPs with excellent process/outcomes data,
 - Attaining reasonably reliable data quality in some areas.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Perceptions around ownership,
 - Paperwork and relevance of data collection,
 - Old attitudes and provider behaviour,
 - Lack of strong commitment from other stakeholders,
 - Resistance to change.

- What future plans do you have for diabetes management in your Division?
 - To explore possibilities for meaningful integration, given recent changes to structure of the program,
 - To use the available data more effectively to inform and support clinicians providing care.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - A “systems” approach that recognises outputs will flow from an appropriately designed process = planning,
 - Efficient utilisation of resources/people and recognition of roles,
 - Willingness to change.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Service agreement with AHS governing joint responsibility for the program,
 - Joint diabetes expert advisory group (with AHS),
 - Consumer representation via this group and local implementation committees.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Royal Australian College of General Practitioners (RACGP) diabetes management in general practice,
 - Department of Health and Ageing (DoHA) diabetes PIP incentive requirements,
 - National Diabetes Strategy 1998,
 - National Health and Medical Research Council (NHMRC) guidelines for diabetes management,
 - NSW Health clinical guidelines for management of diabetes mellitus,
 - South Australian Divisions of General Practice (SADI) guidelines.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes management using Medical Director guide,
 - PIP incentive guides,
 - Options for establishing registers,
 - Diabetes management review sheet,
 - History and assessment,
 - Consent,
 - Patient information sheets,
 - GP management feedback proforma,
 - Local diabetes education standards.

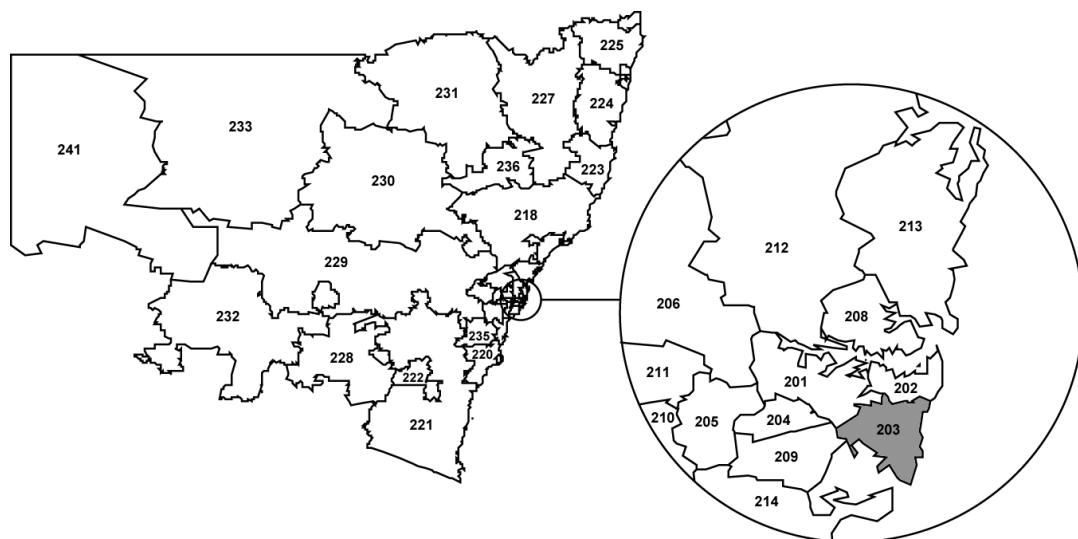
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - The Diabetes Messaging Module – urgently,
 - Ability to generate custom reports simply.

- What resource materials do you provide to practices?
 - Diabetes management using Medical Director guide,
 - PIP incentive guides,
 - Options for establishing registers,
 - Diabetes management review sheet,
 - History and assessment,
 - Consent,
 - Patient information sheets,
 - GP management feedback proforma,
 - Local diabetes education standards,
 - Clinical audit feedback every six months,
 - Recall listings,
 - Patient summaries on request,
 - In-practice recall system advice and support,
 - System analysis.

Division Contact Person/
Program Co-ordinator

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South Eastern Sydney DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	173,403	
■ Aboriginal or Torres Strait Islander	2256	1.3%
■ Speaks language other than English at home	55,790	32.2%
■ RRMA classification ¹		
1: Capital city	173,403	100.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9025	7.5%
■ High blood pressure ⁴	34,577	28.8%
■ High blood cholesterol ⁵	59,795	49.9%
■ Obese or overweight ⁶	70,908	59.2%
■ Physical inactivity ⁷	50,123	41.8%
■ Smoking ⁸	23,426	19.5%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

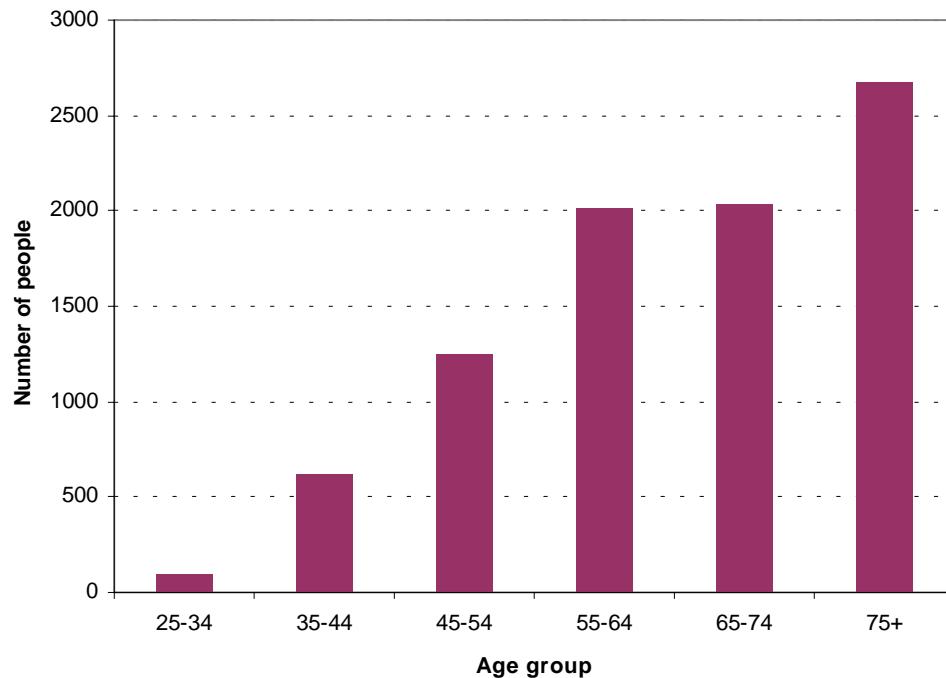
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

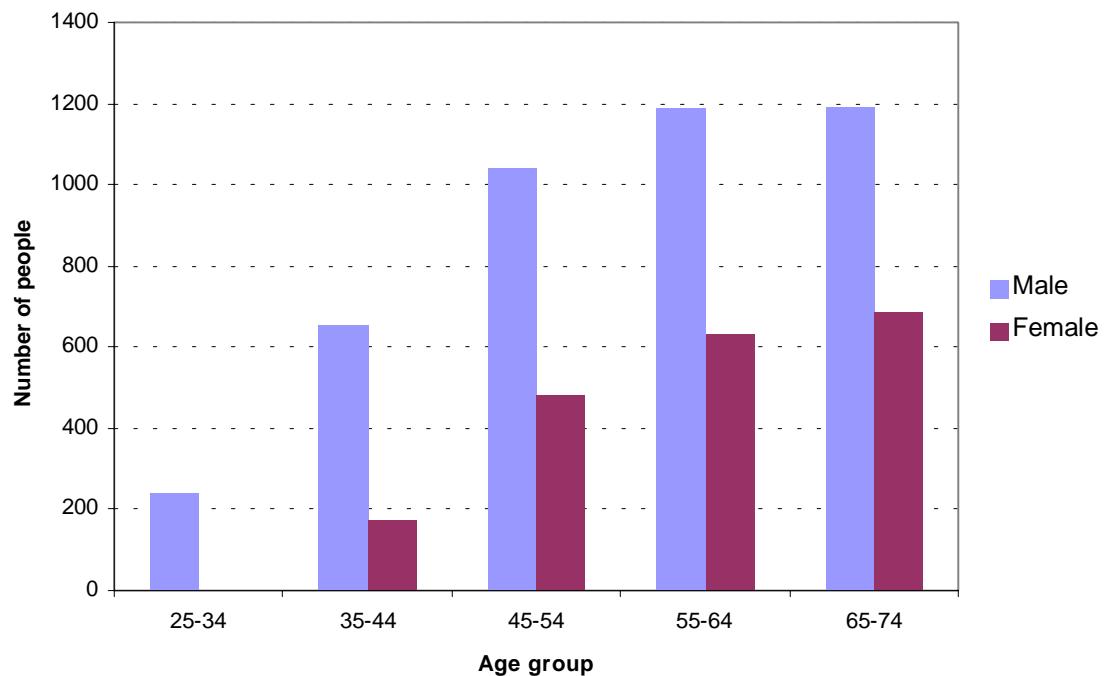
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



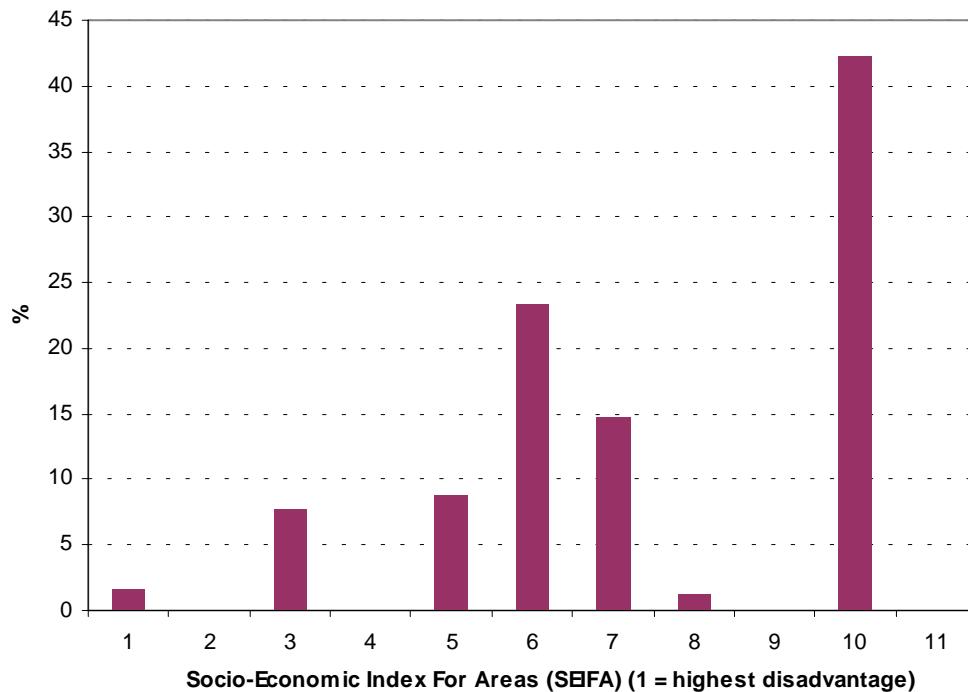
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

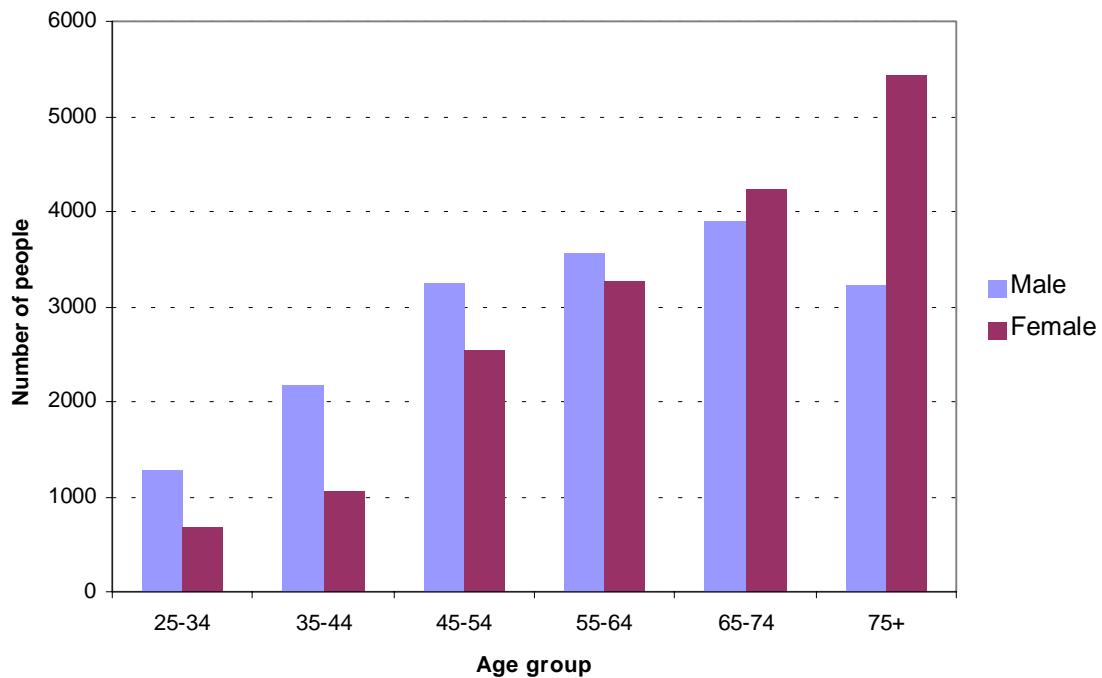
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

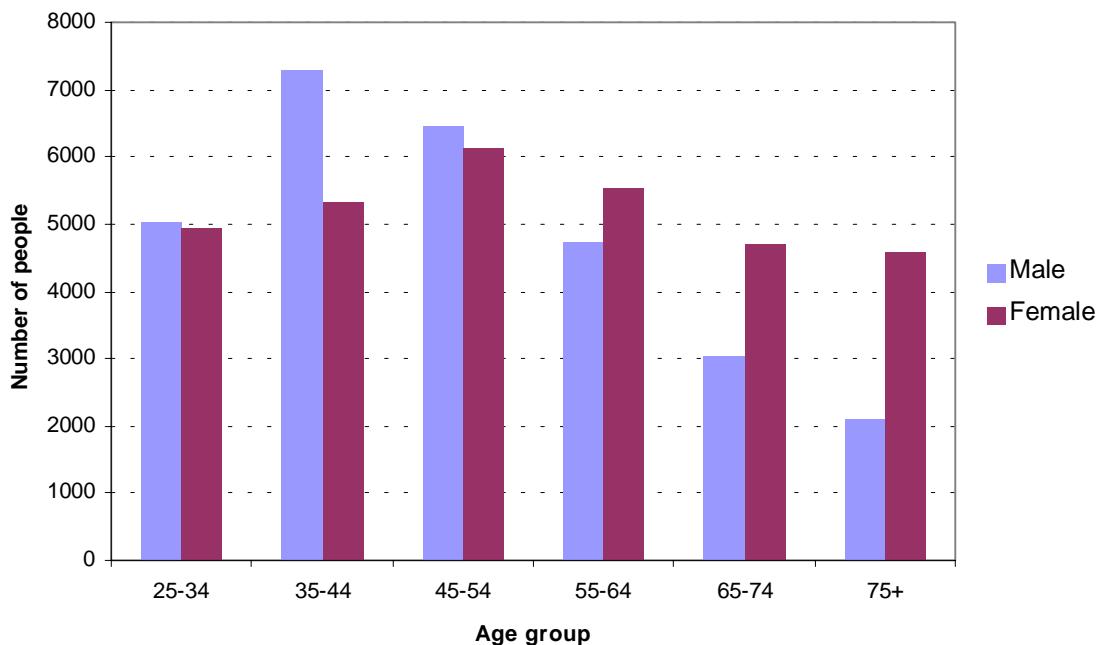
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



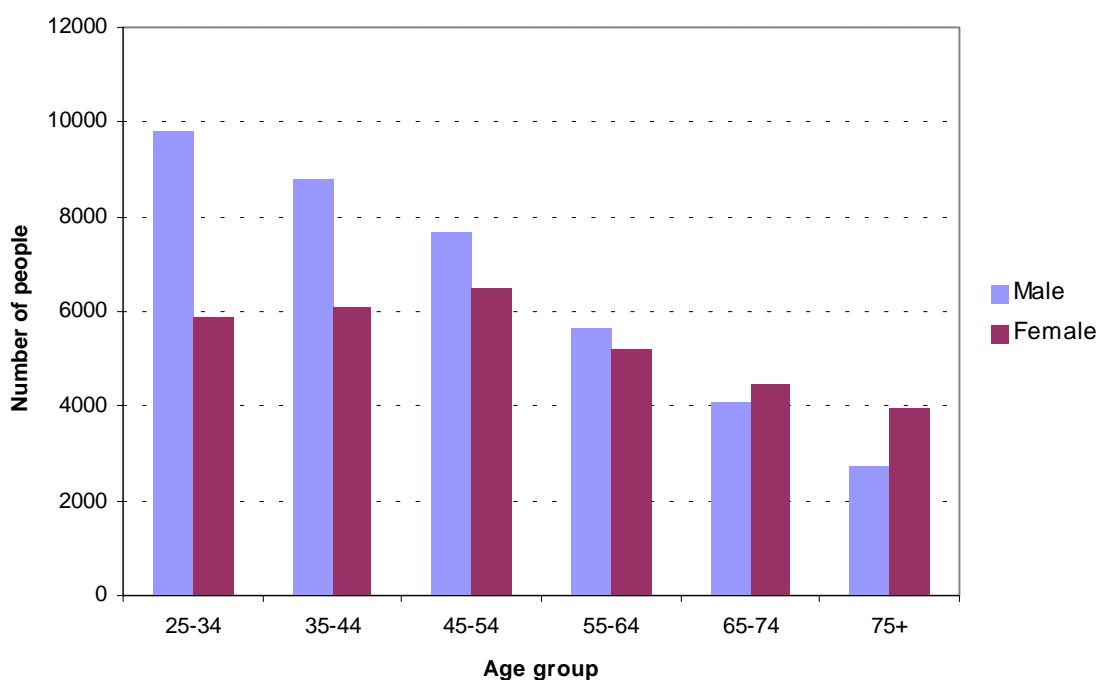
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



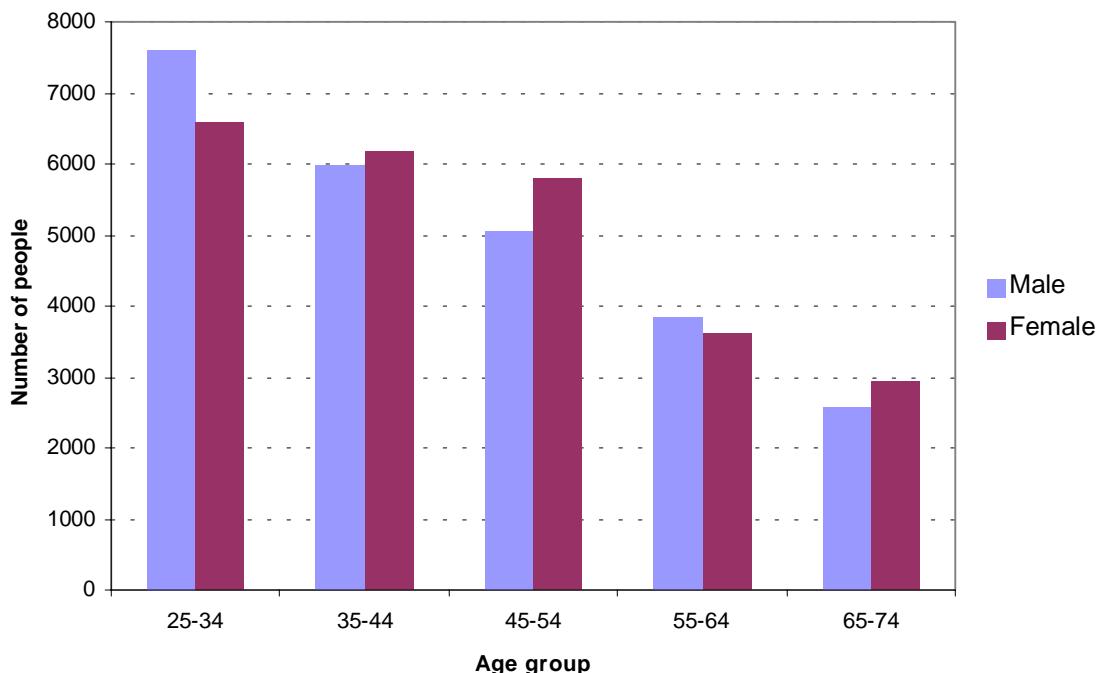
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



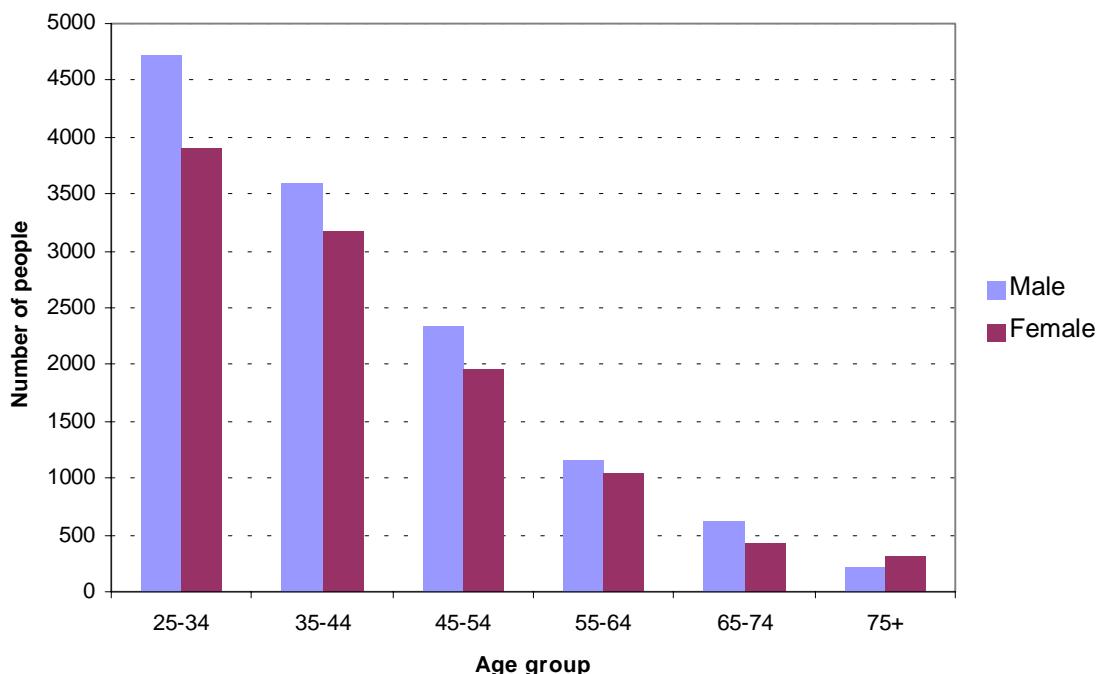
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 179 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Centre, Prince of Wales Hospital,
 - Royal Hospital for Women,
 - Sydney Children's Hospital,
 - Aboriginal Health Service.

- What services are needed but are not available in your Division area?

Podiatry services though available are not adequate with long waiting times.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The diabetes program provides education regarding the current topics to the GPs. Audits provide GPs with the opportunity to compare data on their own management practices with that of their peers. Practice visits to detail GPs on the new Practice Incentive Payment (PIP).

Division Perspective

- What have been the major achievements or highlights of your program so far?

Screening for the hitherto undiagnosed people with diabetes.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

A lack of interest on part of GPs.

- What future plans do you have for diabetes management in your Division?

A commitment to continue providing education to GPs.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

Interested GPs/practice staff.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- We have links with the Diabetes Centre and Diabetes Australia – but only on an informal basis.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

N/A.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Resource directory – it won't be relevant to the other Divisions in terms of the actual information contained, but it can give people an idea of what to include in such a directory.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No.
- What resource materials do you provide to practices?

We have provided practices with:
 - An area specific resource directory,
 - Referral forms for Diabetes Centre.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Prince of Wales Hospital,
 - Eastern Heart Clinic,
 - Other private cardiology clinics.

- What services are needed but are not available in your Division area?
None.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The program involves Continuing Professional Development (CPD) programs for the GPs. These include didactic lectures and hands-on patient workshops.

Division Perspective

- What have been the major achievements or highlights of your program so far?
The Public Health Forum 2001, which was attended by 250 members of the community.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
No.

- What future plans do you have for CVD management in your Division?
Continue providing education.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
Look around and see what activities have really worked.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Informal linkage with the Eastern Heart Clinic and Heart Foundation.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

National Heart Foundation.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

We haven't developed any resources except perhaps for a poster for GP surgeries, which other Divisions might like to have.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

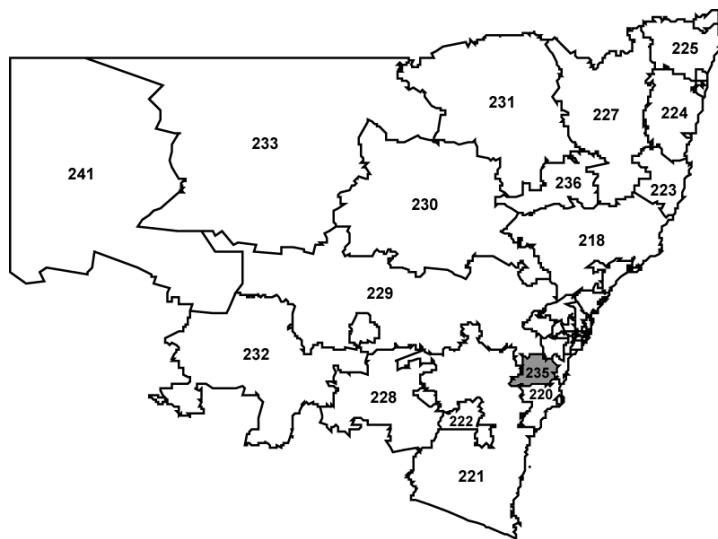
No.
- What resource materials do you provide to practices?

We have provided practices with resources from National Heart Foundation with posters.

Division Contact Person/
Program Co-ordinator

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Southern Highlands DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	46,069	
■ Aboriginal or Torres Strait Islander	574	1.2%
■ Speaks language other than English at home	1973	4.3%
■ RRMA classification ¹		
1: Capital city	2948	6.4%
5: Other rural	43,121	93.6%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2657	8.8%
■ High blood pressure ⁴	9912	33.0%
■ High blood cholesterol ⁵	15,972	53.2%
■ Obese or overweight ⁶	18,383	61.2%
■ Physical inactivity ⁷	12,663	42.1%
■ Smoking ⁸	5483	18.3%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

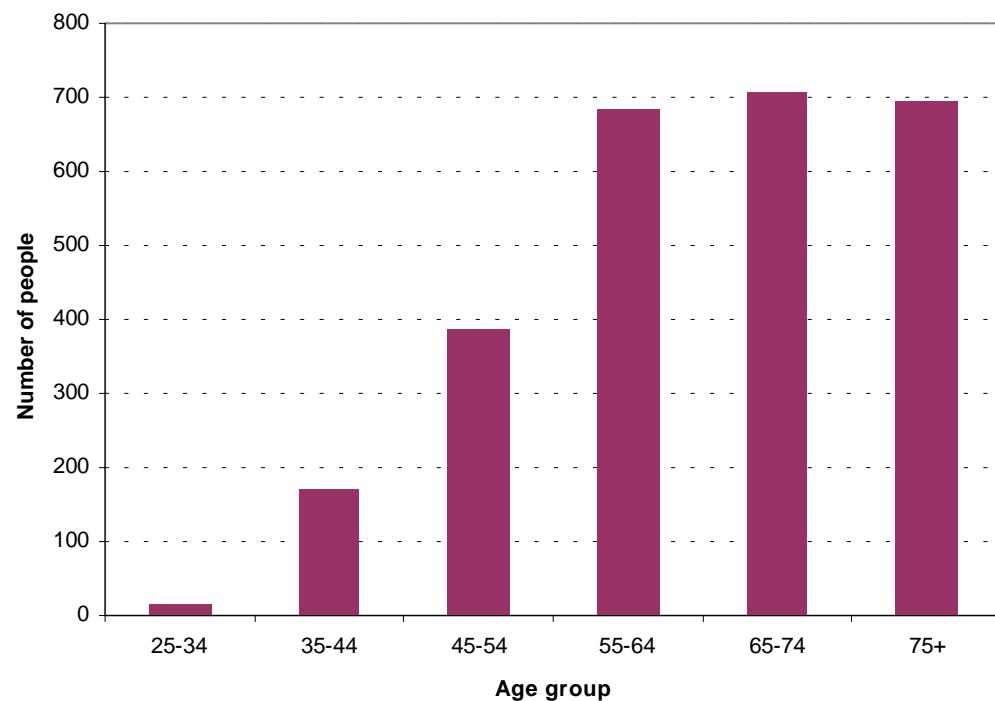
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

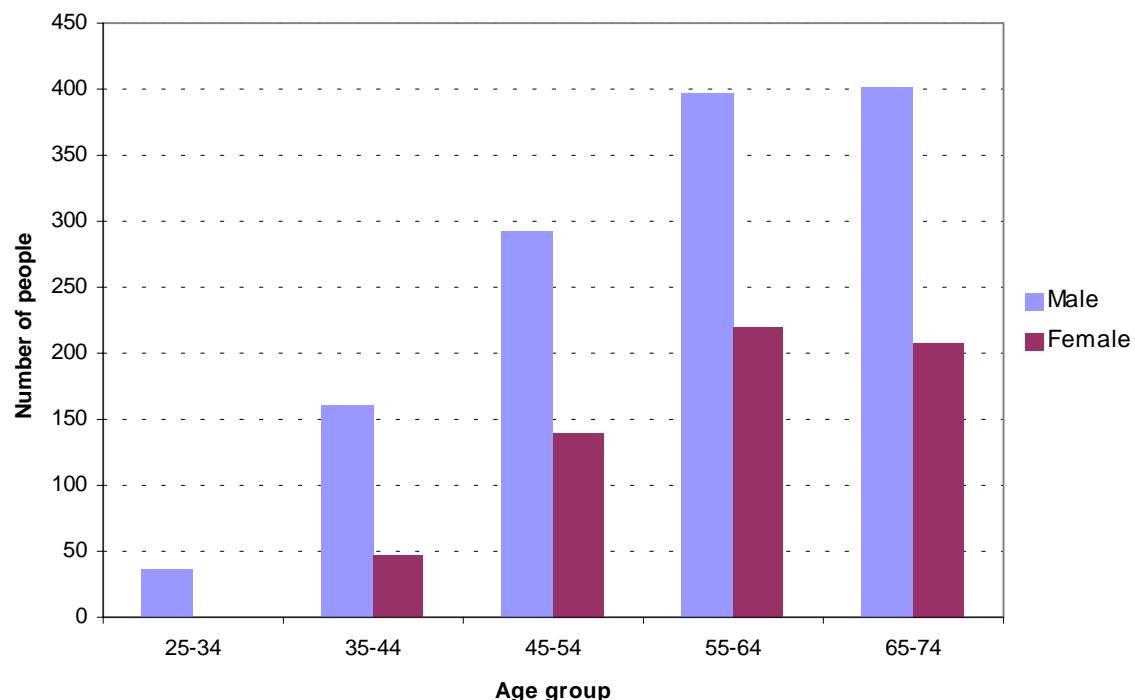
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



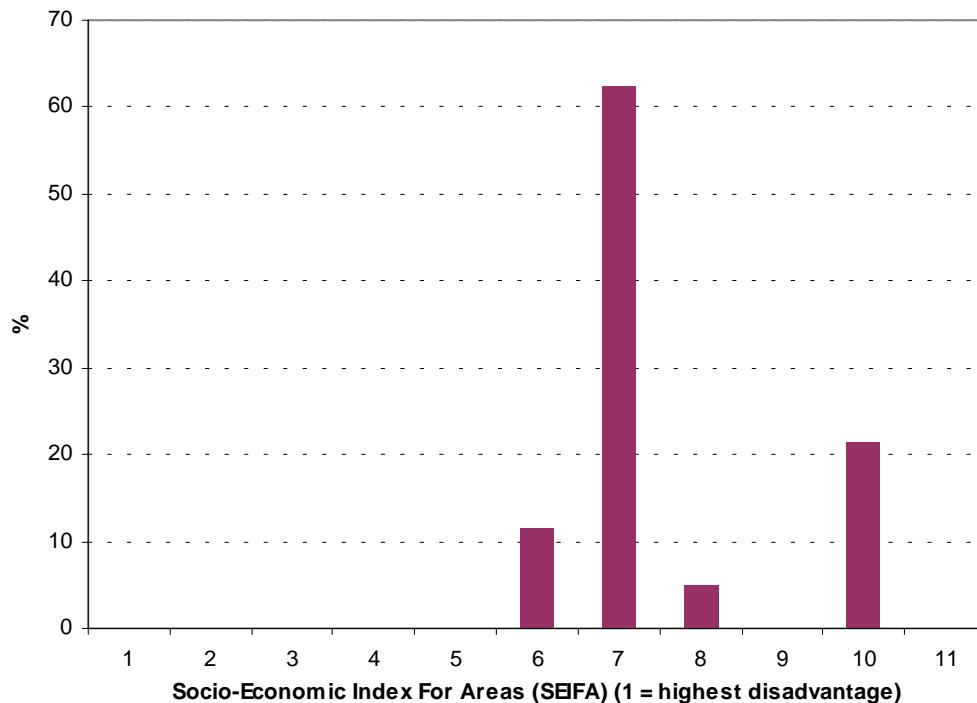
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

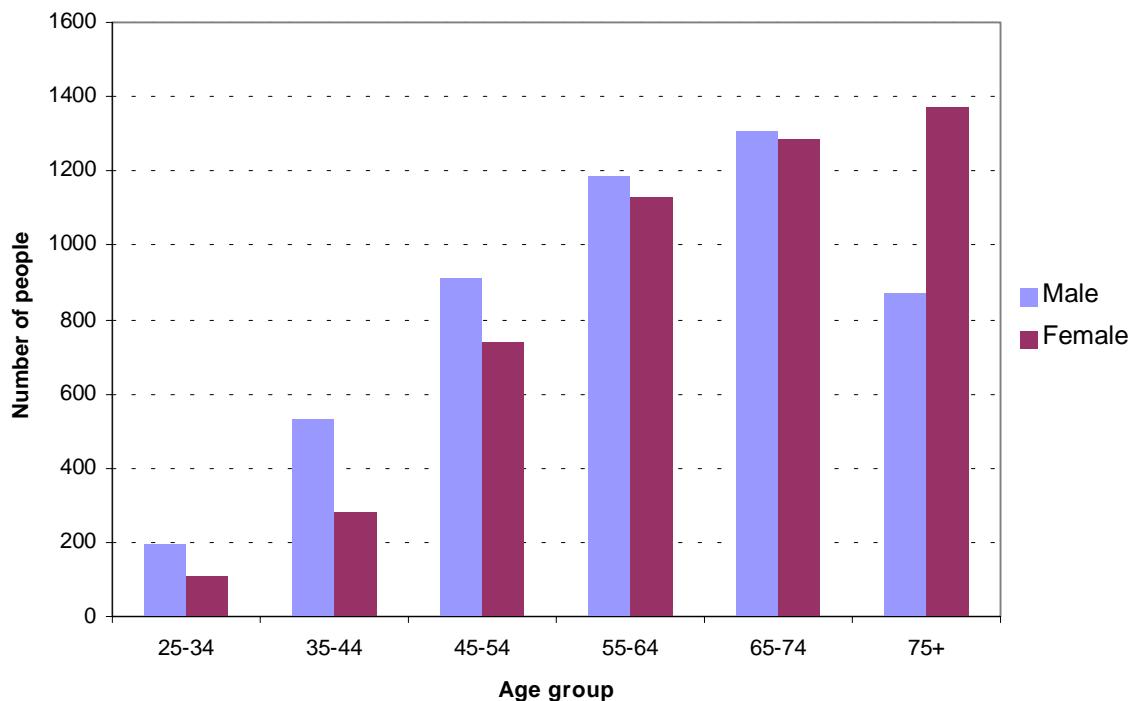
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

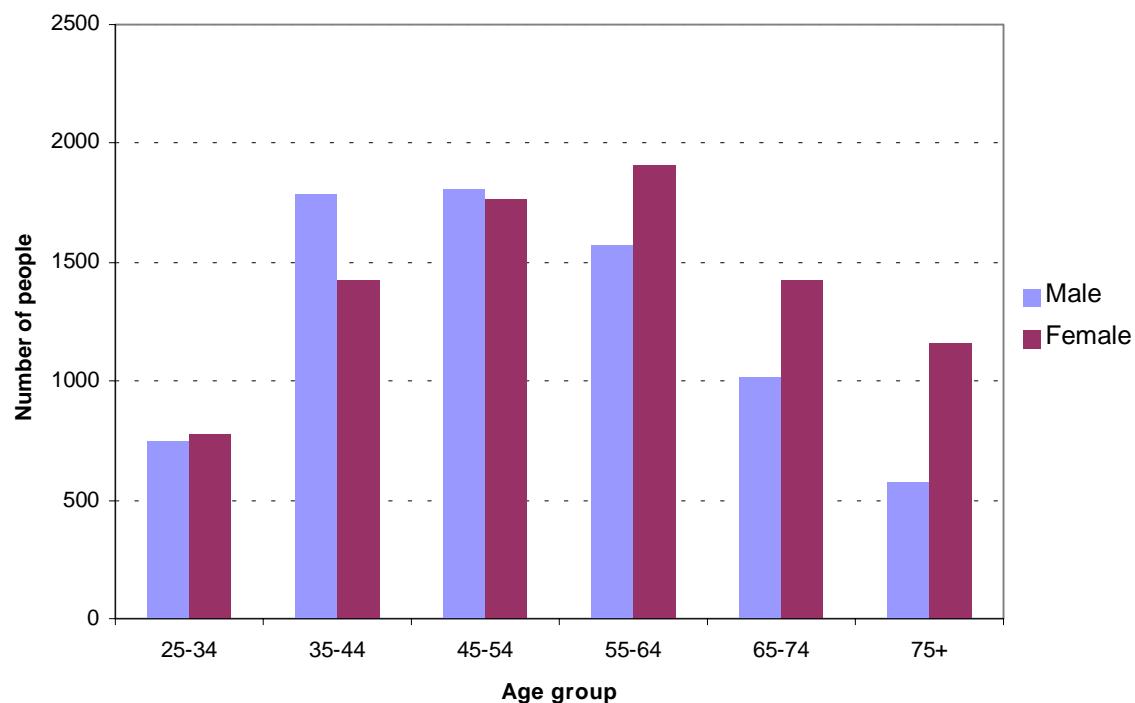
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



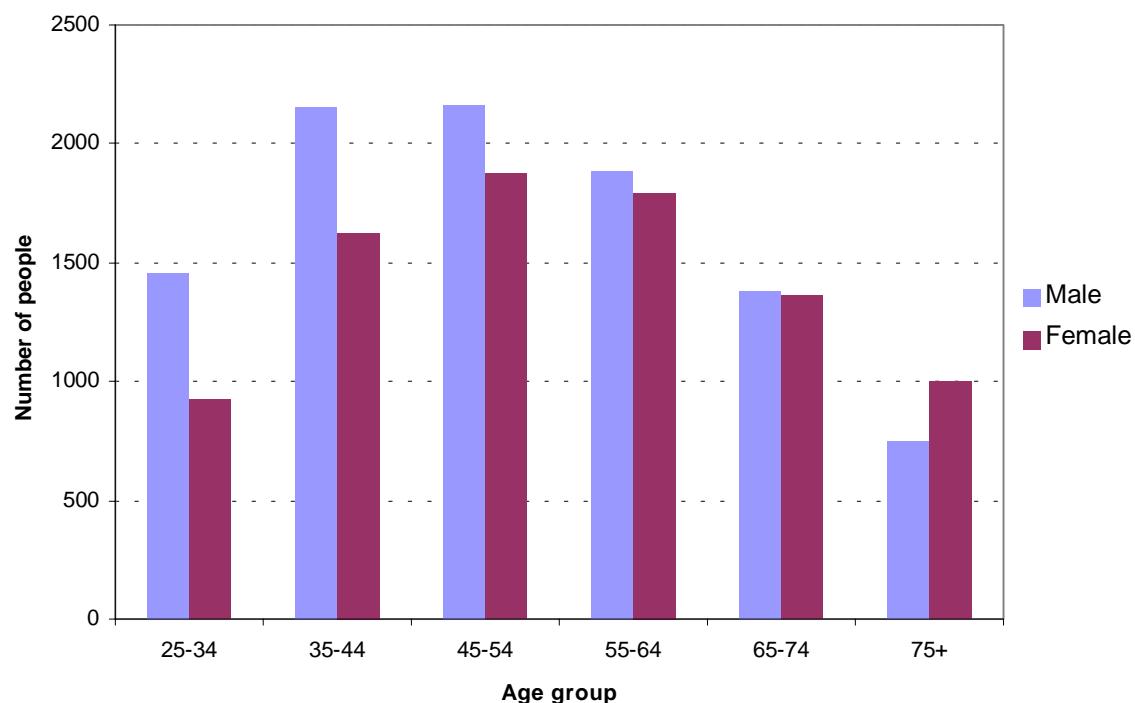
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



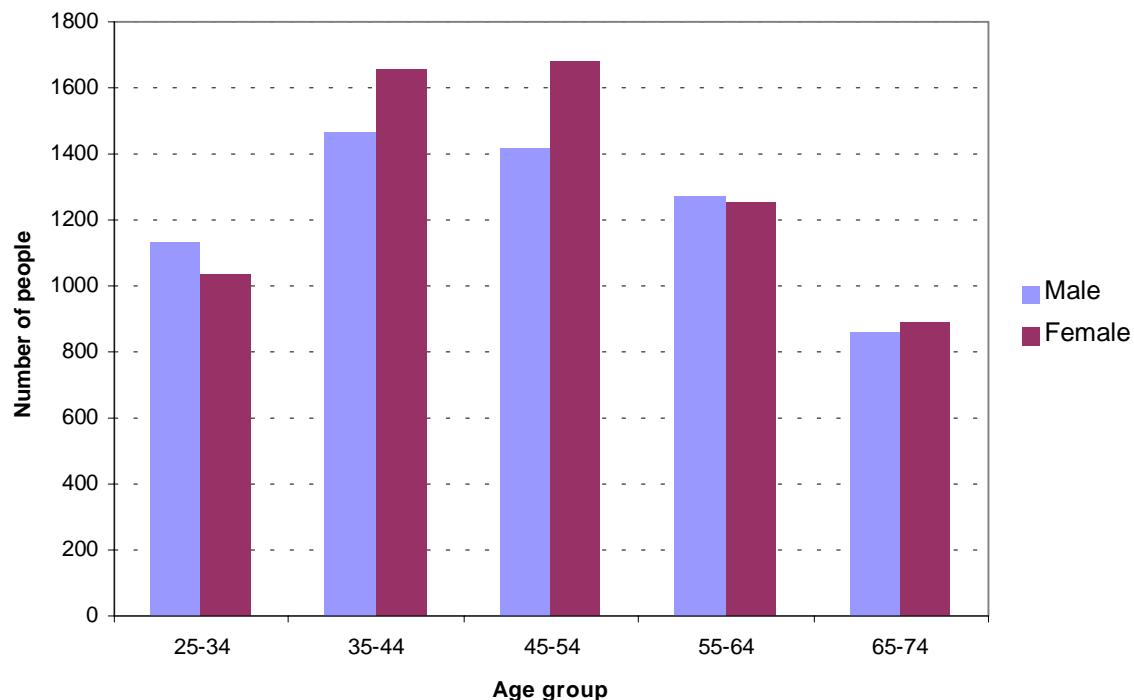
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



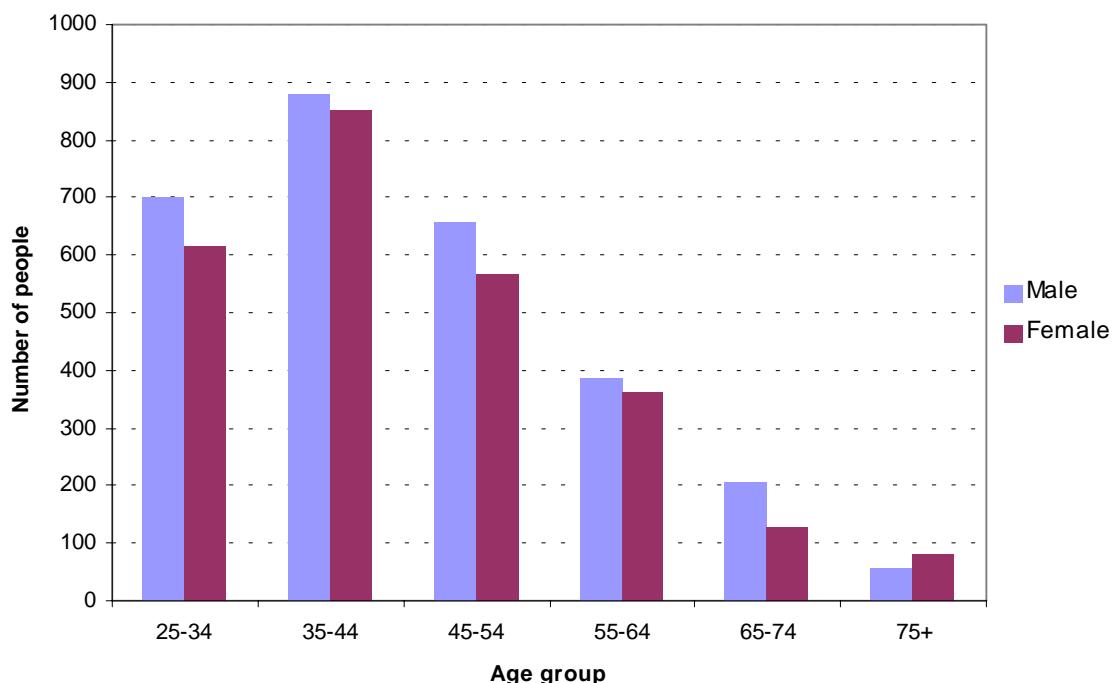
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 40 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Individual patient education – Impaired Glucose Tolerance (IGT), Type 1, Type 2, Gestational Diabetes Mellitus (GDM),
 - In-patient services,
 - Lectures to service clubs/schools,
 - Podiatry,
 - High risk patient case conferencing,
 - Diabetes Resource Centre,
 - Local branch of Diabetes Australia,
 - Group education,
 - Dietetics service for individuals and groups.

- What services are needed but are not available in your Division area?
 - Psychology/Counselling,
 - High risk foot service (on site) – is available through Liverpool.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Diabetes Education and Management Program is Division-run – employment of diabetes educator,
 - Shared care for in-patients/GDM,
 - Generated by CARDIAB,
 - Recall, audit (GP), and quality improvement,
 - Ongoing GP Continuing Medical Education (CME).

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - One hundred percent GP participation,
 - Good uptake of Enhanced Primary Care (EPC) – Care Planning and Service Incentive Program (SIP),
 - Evolution of Chronic Cardiac Failure (CCF) program,
 - Exercise/lifestyle program – primary prevention of diabetes.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Time,
 - Information overload of GPs.
- What future plans do you have for diabetes management in your Division?
 - Improved identification and management of high risk patients,
 - Earlier identification of patients with diabetes,
 - Identification and establishment of best practice guidelines for pre-diabetes.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Advent of EPC initiative,
 - Comprehensive and flexible database,
 - Liaison with Centre for GP Integration Studies (CGPIS),
 - Diabetes database and program processes have facilitated uptake of other chronic disease management.

Activities	Strategies
1. Provide Education	<ul style="list-style-type: none">• to people with diabetes,• to people with pre-diabetes,• people with gestational diabetes. <ul style="list-style-type: none">• continue existing one-to-one education sessions as well as groups,• commence one-to-one and group education,• continue to provide education to this group. Improve collaboration with specialists.
2. To assist GPs	<ul style="list-style-type: none">• implement guidelines for Type 2 diabetes,• identify and target high risk diabetes patients, <ul style="list-style-type: none">• continue existing program; update and review best practice guidelines in line with research,• through database; liaison and collaboration with GPs; implement Healthy Eating Activity and Lifestyle (HEAL) program,

- target people with pre-diabetes.
- through database; liaison and collaboration with GPs; implement HEAL program.

3. Data Collection

- maintain database,
- continue to receive data from surgeries and enter onto database; encourage and assist e-transfer of data,
- implement cardiac component of CARDIAB
- work with Heart Failure Liaison Nurse; collect data from HEAL program.

4. Collaborate

- with other health providers.
- continue existing,
- improve podiatry services.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Macarthur Division of General Practice – a sister Division relationship,
- Alliance NSW/Australia,
- Liasing with Diabetes Australia to be involved in community group education.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP management guidelines,
 - Diabetes Australia FAX BACK patient information,
 - CGPIS – web site emails.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - “Feet for Life” – Diabetes Foot Assessment and Management,
 - “Food Choices for Diabetes” – sugar, fat and fibre.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Insulin resistance – best practice guidelines.

- What resource materials do you provide to practices?
 - Patient education – Diabetes Australia FAX BACK,
 - Management guidelines for diabetes each year,
 - Whatever they ask for.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiac rehabilitation,
 - Heart Failure program.

- What services are needed but are not available in your Division area? N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Heart Failure Management and patient education program for GPs,
 - Project Officer Hospital Staff – shared care.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Its potential link to CARDIAB Heart Failure program.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Program not under direct management of Division.

- What future plans do you have for CVD management in your Division?

Cardiac rehab – tertiary arm implementation with database connection.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Make sure your expectations are the same as any shared care partners,
 - Ensure GPs are represented on hospital committees.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them? CGPIS.

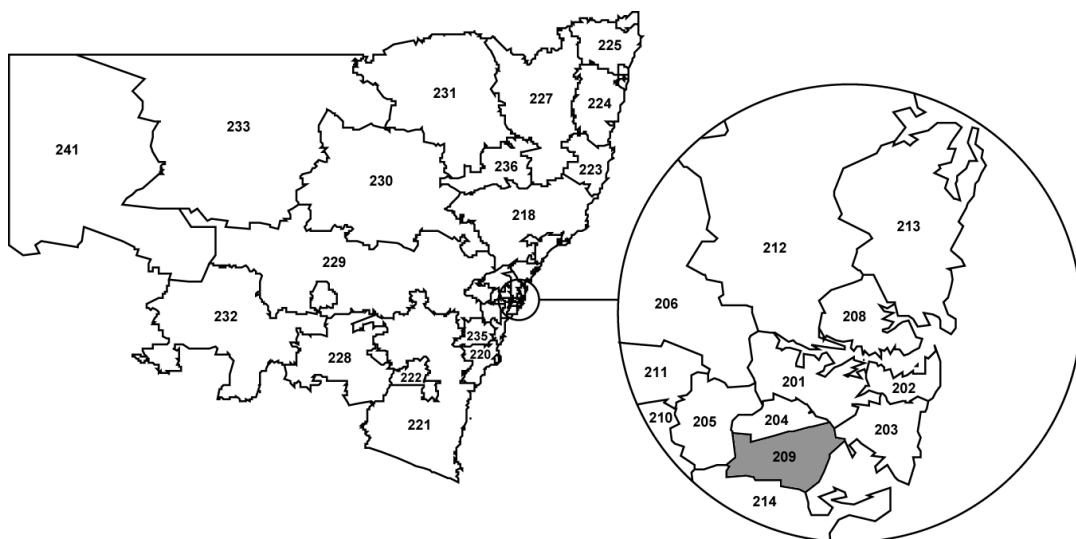
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)? National Heart Foundation.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? GP – Manual for Management of CVD.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices?
 - Manuals,
 - Pedometers.

Division Contact Person/
Program Co-ordinator

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St George DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	210,606	
■ Aboriginal or Torres Strait Islander	1008	0.5%
■ Speaks language other than English at home	89,778	42.6%
■ RRMA classification ¹		
1: Capital city	210,606	100.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	12,212	8.4%
■ High blood pressure ⁴	45,846	31.6%
■ High blood cholesterol ⁵	74,629	51.5%
■ Obese or overweight ⁶	86,954	60.0%
■ Physical inactivity ⁷	59,454	41.0%
■ Smoking ⁸	27,092	18.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

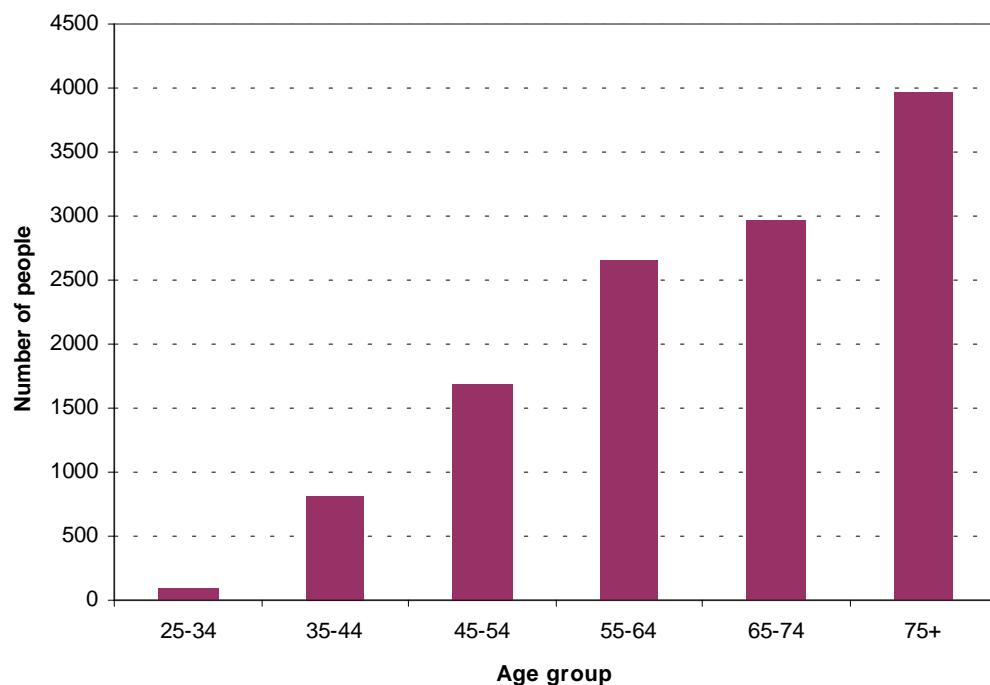
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

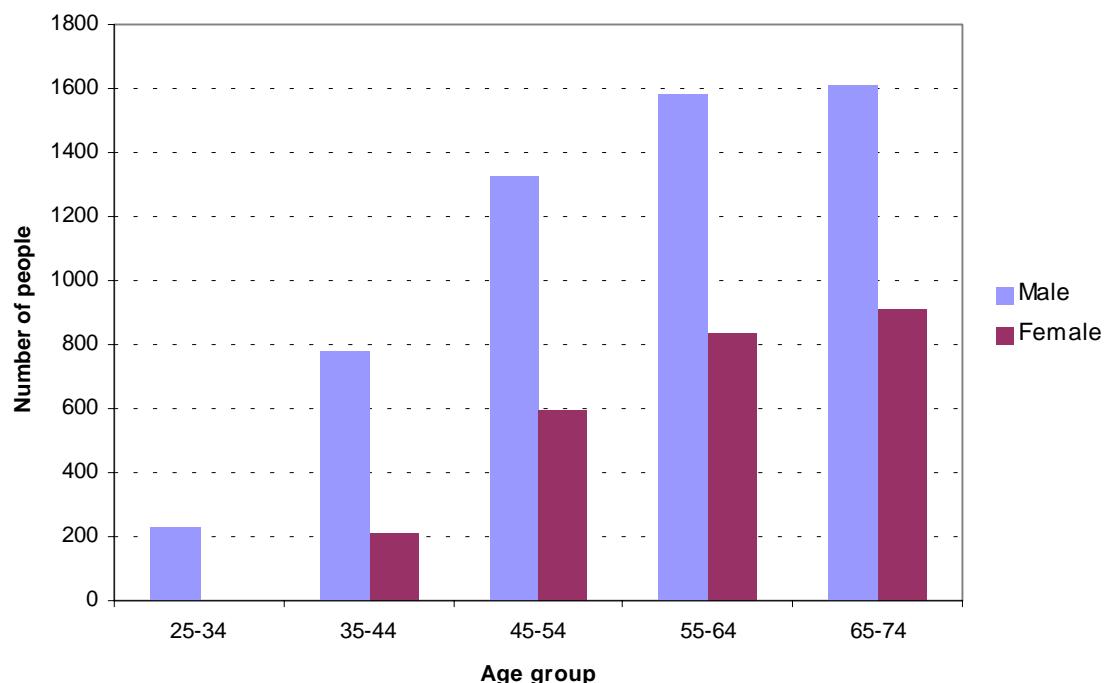
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



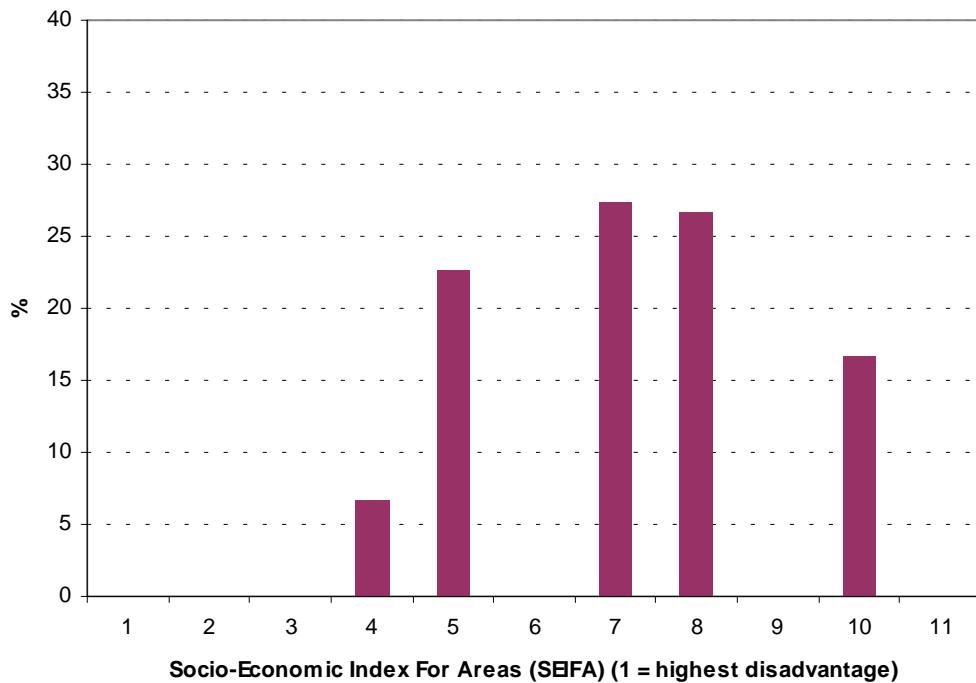
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

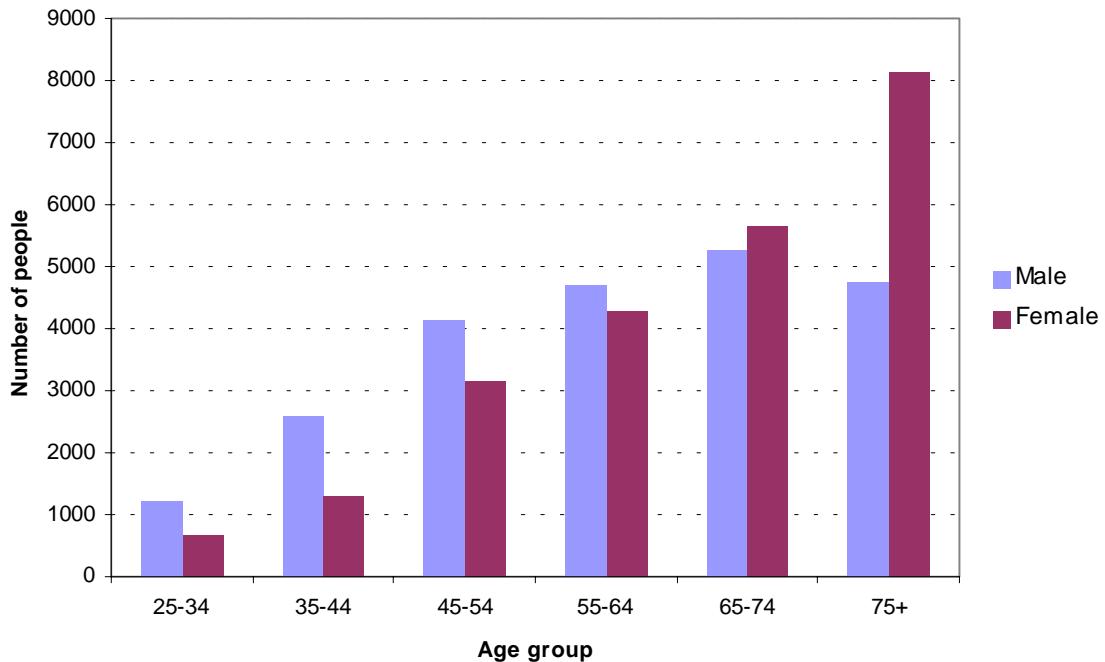
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

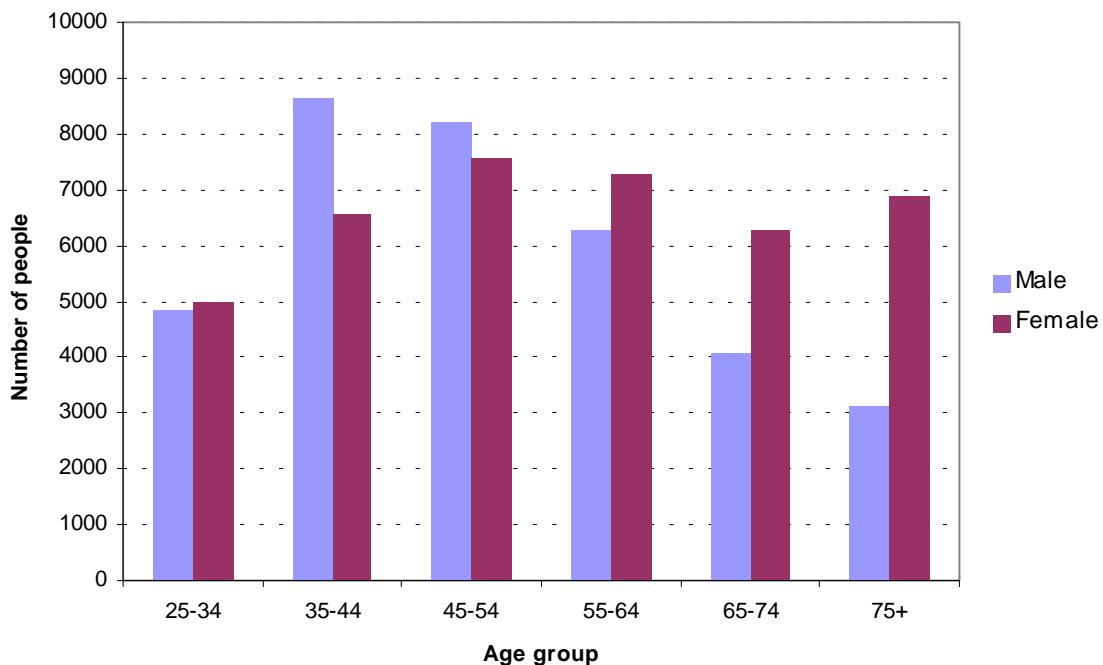
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



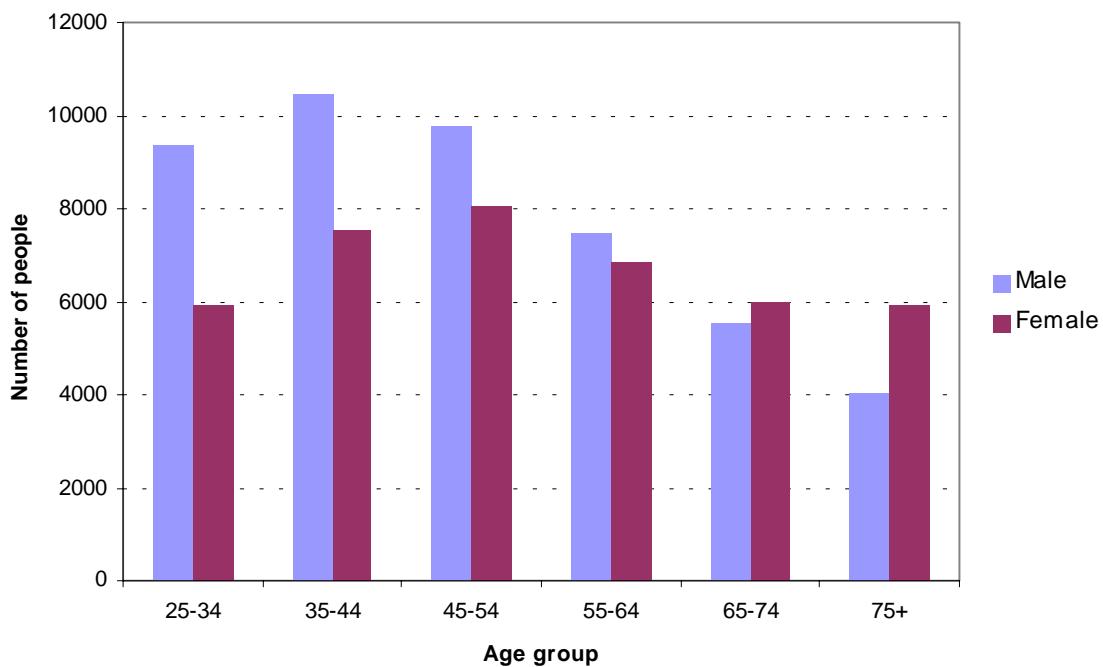
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



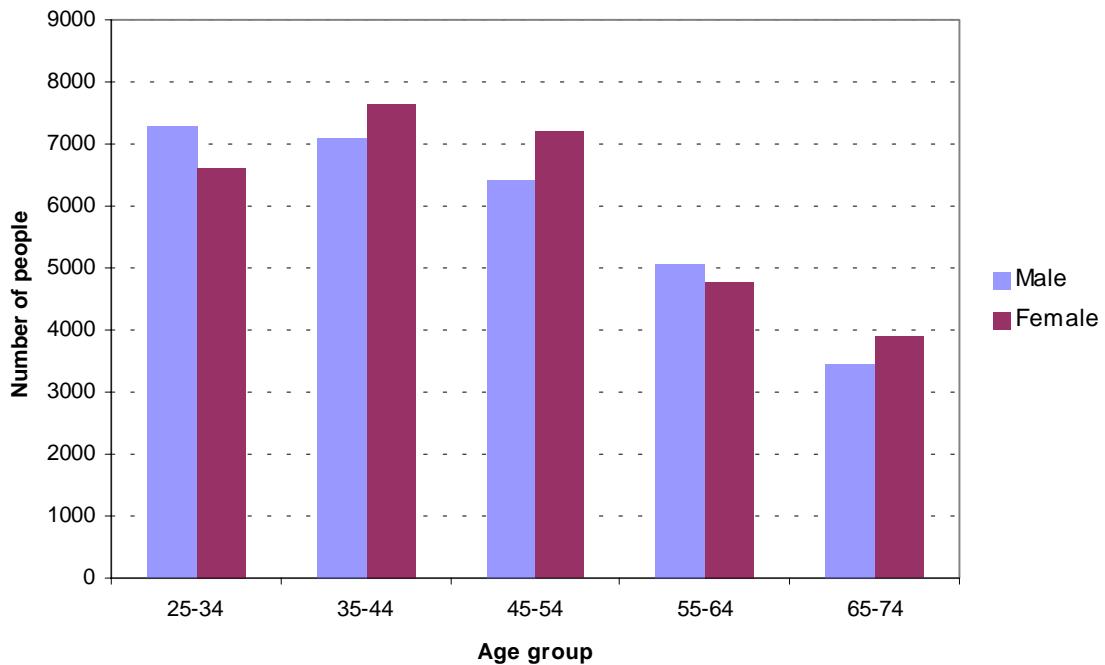
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



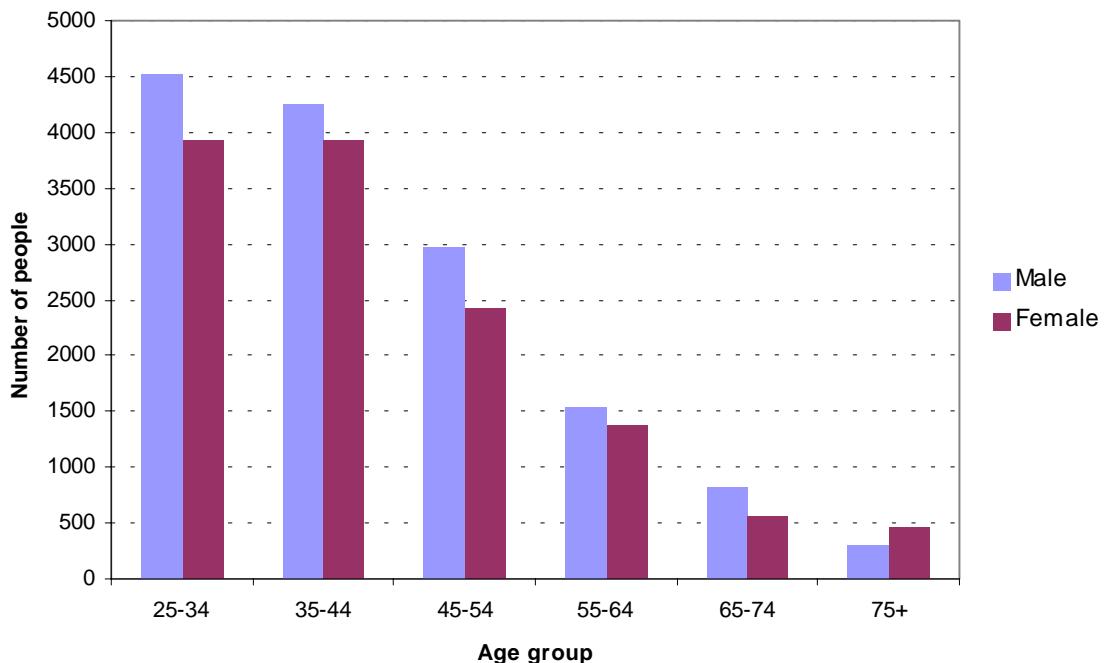
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 248 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - St George Hospital Diabetes Education Centre:
 - Outpatient ambulatory insulin stabilisation program,
 - Podiatry services,
 - Group education (including Non-English Speaking Background (NESB), children and parents, and patients with Type 2),
 - Individual patient education and follow up,
 - Inpatient dietetic and psychology services,
 - Telephone support and information services,
 - School visits,
 - Walking program,
 - Individual exercise assessment and review,
 - Shared care with local GPs,
 - Clinical and education research,
 - Division run dietetic service,
 - Podiatry services:
 - Calvary Hospital Kogarah (for aged pensioners only, services for high risk including ulcer care, education and footwear assessment),
 - Peakhurst Community Health Centre (services to both general public and high risk patients; education, ulcer care and footwear assessment),
 - Private podiatrists,
 - Physical Activity:
 - SHARE gentle exercise programs targeted at the over 45 years age group held throughout the St George Division,
 - Independent Community Diabetes Walking Groups.
 - Private ophthalmologists, endocrinologists (including paediatric endocrinologist) and dietitians available in the area.
- What services are needed but are not available in your Division area?
 - Mini-clinics (to be held in GP surgeries for small groups of patients and partners that are having difficulty managing their diabetes),
 - Adequate referral system between GPs and Diabetes Education Centre (currently being improved).

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The project that operated between 1993 – 1996 “Dietary Clinics for Diabetes Project” was resource intensive, employing two dietitians and a data entry clerk. The dietitians operated clinics in GP surgeries and a series of Continuing Professional Development (CPD) activities were run for the GPs and a database maintained, which held patient data forms, faxing them back to the Division, and a data entry clerk then input the data into the database. This method was extremely time consuming and resource intensive.

As the Division and GPs became more IT focused, the Division made plans to pilot a new program. This new program utilised and further built on the IT systems currently in place and focused on health outcomes in the form of changes to parameters such as HbA1C, lipids, weight and blood pressure. This new program relied heavily on an IT component. Patient data was downloaded from Medical Director to the database. This program proved to be significantly more labour-orientated than first thought and was pulled from the diabetes program in May earlier this year.

CPD events continue to be a major focus of the program. With recent topics, the focus has turned more towards educating GPs to maintain their own computerised records via the register and recall system in association with the PIP incentive introduced in November 2001.

Division Perspective

- What have been the major achievements or highlights of your program so far?

- Collaboration between Diabetes Education Centre and Division,
- Developed relationships with other Divisions,
- Well attended CPDs,
- Increased use of register/recall systems.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Always attract same GPs to educational events. Approximately 40% of GPs don't get involved,
 - Difficulty in changing the “old school” mind frame,
 - Problems with CARDIAB program being too labour intensive.

- What future plans do you have for diabetes management in your Division?
 - Small group learning lunches localised to specific areas to reach uninvolved GPs,
 - CPD events increasing in practicality and interaction, including upcoming 5 Points Per Hour (PPH) activity in November,
 - Diabetes has been included in the new population health program. The focus will be increasing the use of practice guidelines, increasing GP management and diagnosis of both Type 1 and Type 2,
 - An extremely interactive CPD is in the planning stages and is anticipated to run in mid-November to cover diagnosis and management of diabetes.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Available time, interest and motivation,
 - Associated financial incentives,
 - Level of computerisation,
 - Number of patients in practice with disease/condition.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Strong alliances with St George Diabetes Education Centre who is represented on the diabetes sub-committee.
 - Relationships between ourselves and national organisations such as Diabetes Australia, through implementation of nationwide programs.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes
 - Royal Australian College of General Practice (RACGP) Diabetes Management Guidelines,
 - Diabetes NSW Information Sheets.

management in general practice guidelines, state based resources)?

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Local service directory for people with Diabetes,
 - Key Diabetes Management Points for adults,
 - CARDIAB Program Resource Kit.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
N/A.

- What resource materials do you provide to practices?
 - Guidelines,
 - Diabetic booklet for patients
 - Referral pads,
 - Diabetic fax pads for patients,
 - Dietetic referral pads,
 - Education sheets in Arabic, Chinese, and English.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiovascular department at St George Hospital,
 - Healthy Heart Program/Heart Failure Rehabilitation Program to address risk factor modification and behavioural lifestyle modifications in patients with CVD (except those with unstable angina).

- What services are needed but are not available in your Division area?
 - Available in Division area are:
 - Cardiovascular Department at St George Hospital including specialist diagnostic service and inpatient treatment. Eight cardiologists are located in the hospital and three outside the hospital,
 - Healthy Heart Program, Heart Failure Rehabilitation Program, Maintenance Group and Merry Hearts Club (all address risk factor modification and behavioural lifestyle modifications, in patients – Healthy Heart, and carers – Heart Foundation (HF) Rehabilitation Program, at different stages of CVD).

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The CVD program is relatively new to our Division. CVD program has focused on the collaborative care for congestive heart failure program, which has been developed in St George Hospital. The program encourages GPs to undertake case conferencing and care plans in conjunction with the hospital.

Division Perspective

- What have been the major achievements or highlights of your program so far?

The Collaborative Care for Congestive Heart Failure Program (which aims to improve the quality of life of CHF patients, carers and families through coordinated cardiac rehabilitation, enhanced education to patients (largely in the home) and GPs), currently has 520 active patients.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

CVD/Diabetes Program Officer largely committed to CARDIAB program, therefore, a much smaller focus was placed on CVD.
- What future plans do you have for CVD management in your Division?
 - Increased focus on primary prevention in association with Smoking, Nutrition, Alcohol, Physical Activity (SNAP) framework,
 - Increased use of small group learning format,
 - Increased implementation of active and interactive programs such as pedometer challenges and GP referral schemes (refer patient to exercise specialist at local leisure centre).
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Many cardiovascular departments in hospitals will already be running programs so find out what they are before you implement new ones.
 - Develop strong relationships with someone, (eg Clinical Nurse Consultant), working in the CVD department.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Strong association with CVD Clinical Nurse Consultant at St George Hospital.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation Guidelines,
 - Needs Assessment (Divisional),
 - GP Needs Survey (Divisional).
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

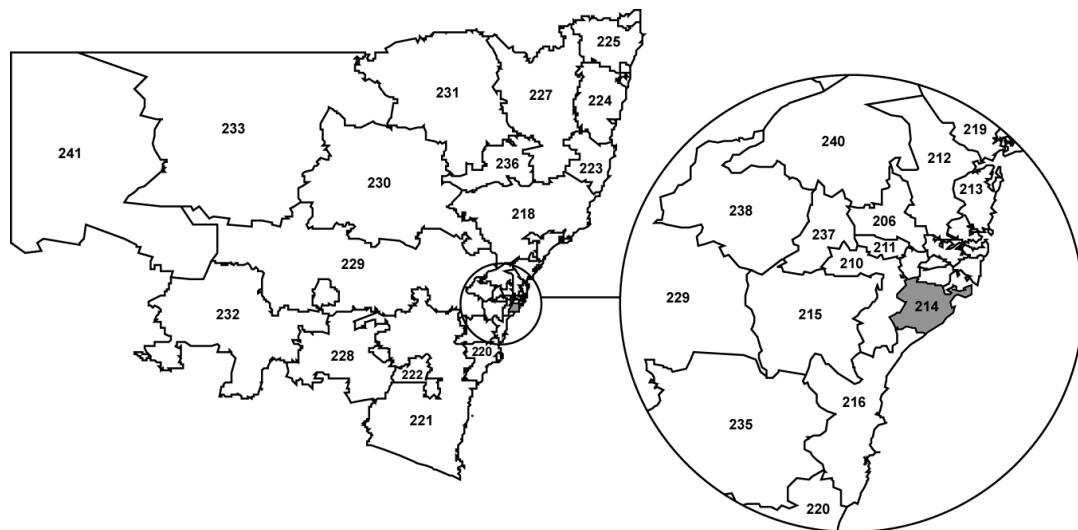
Discharge care plans.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Referral template for heart failure service,
 - Directory of CVD services.

- What resource materials do you provide to practices?
 - National Heart Foundation Guidelines on Contemporary Management of the Patient with Chronic Heart Failure,
 - National Foundation Guide to CVD Risk Reduction.

Division Contact Person/
Program Co-ordinator

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Sutherland DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	201,625	
■ Aboriginal or Torres Strait Islander	1138	0.6%
■ Speaks language other than English at home	20,587	10.2%
■ RRMA classification ¹		
1: Capital city	201,625	100.0%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	10,245	7.7%
■ High blood pressure ⁴	39,145	29.5%
■ High blood cholesterol ⁵	67,961	51.2%
■ Obese or overweight ⁶	79,608	60.0%
■ Physical inactivity ⁷	56,426	42.5%
■ Smoking ⁸	25,635	19.3%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

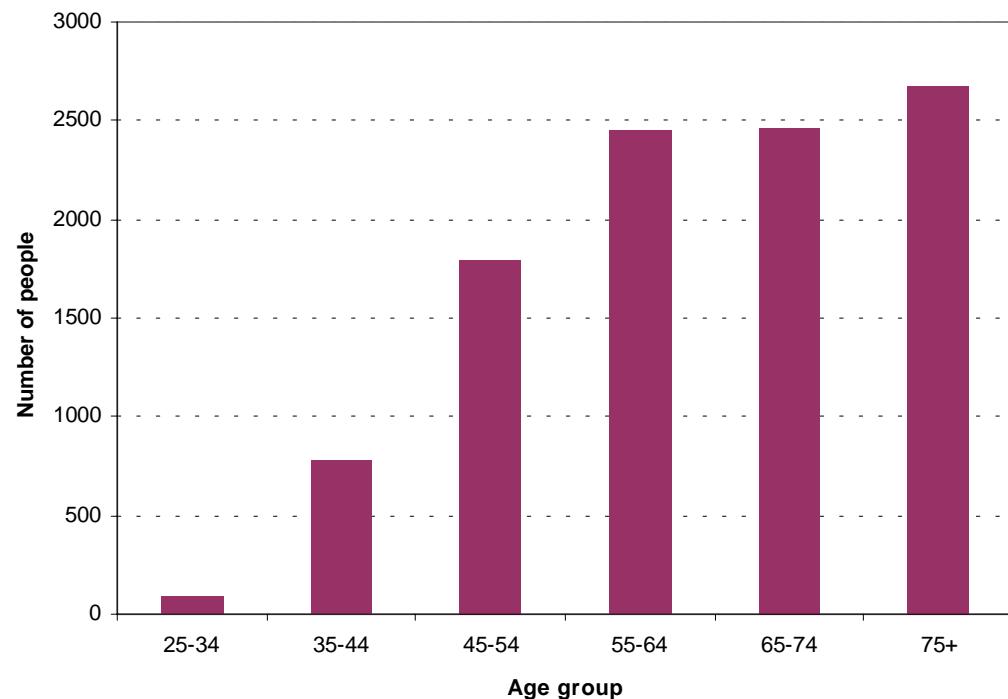
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

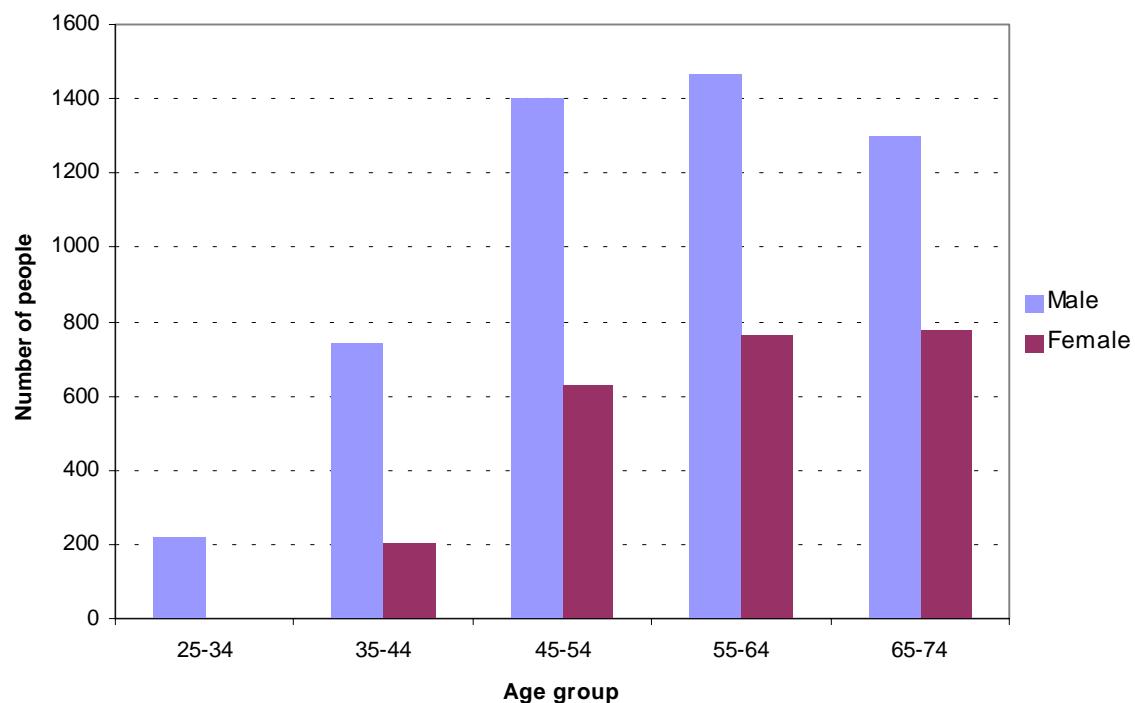
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



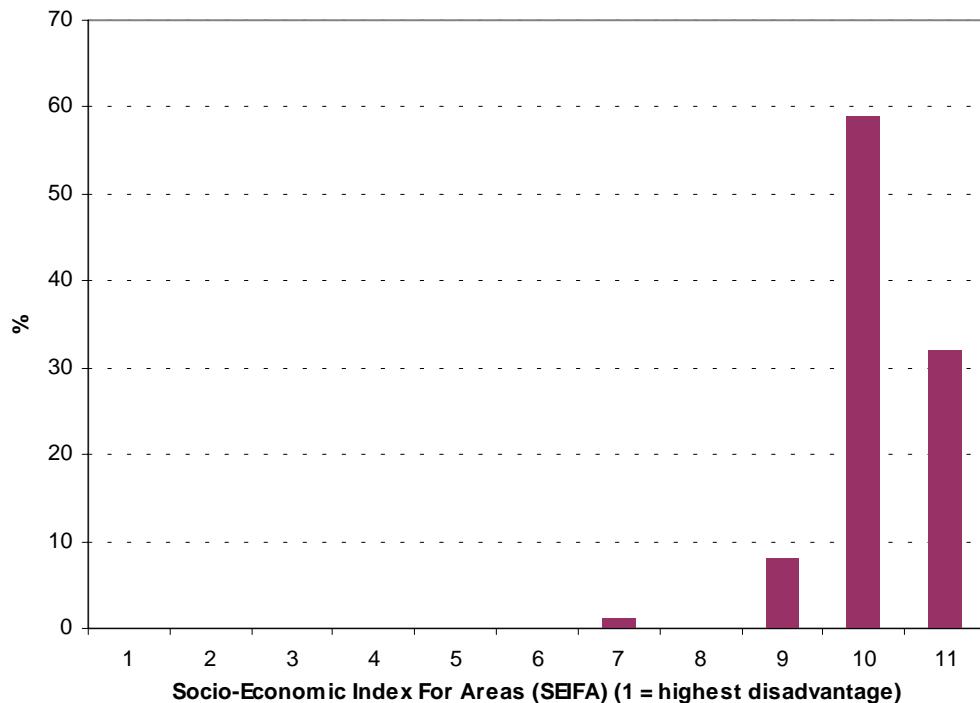
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

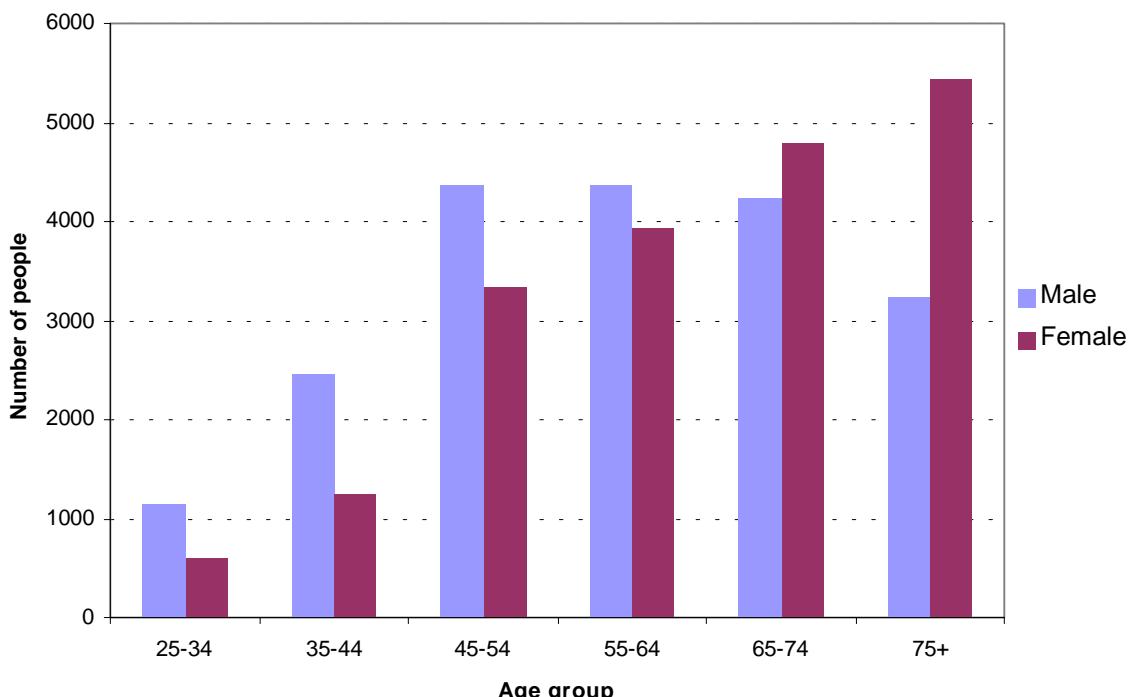
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

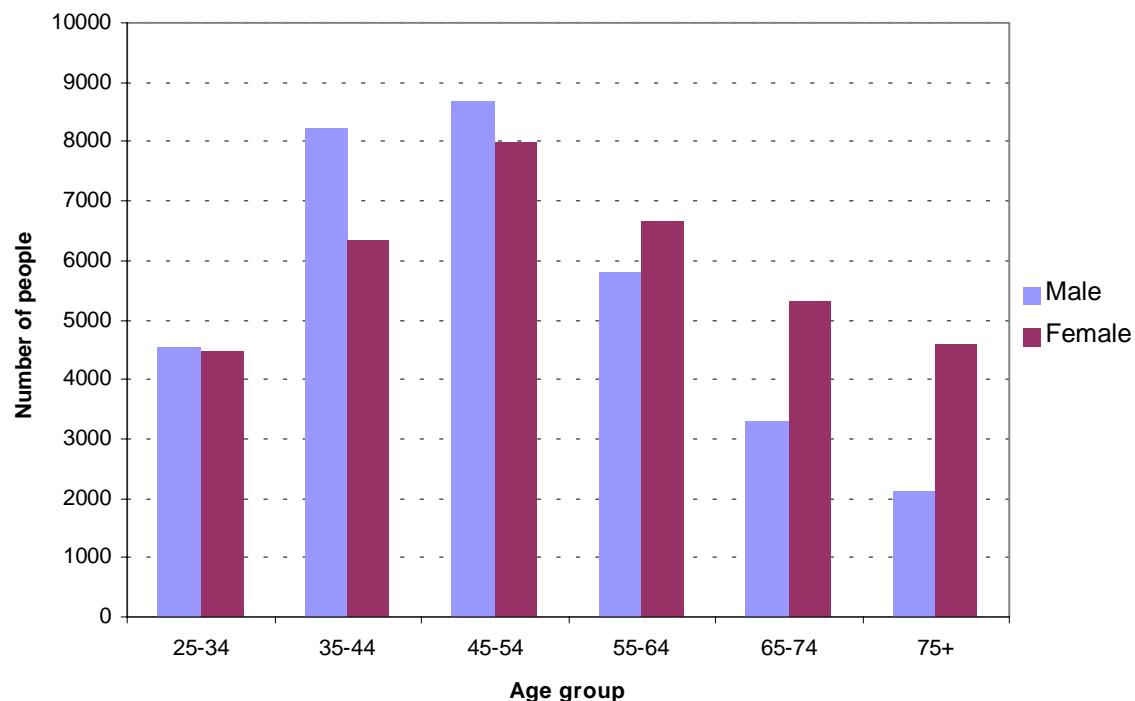
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



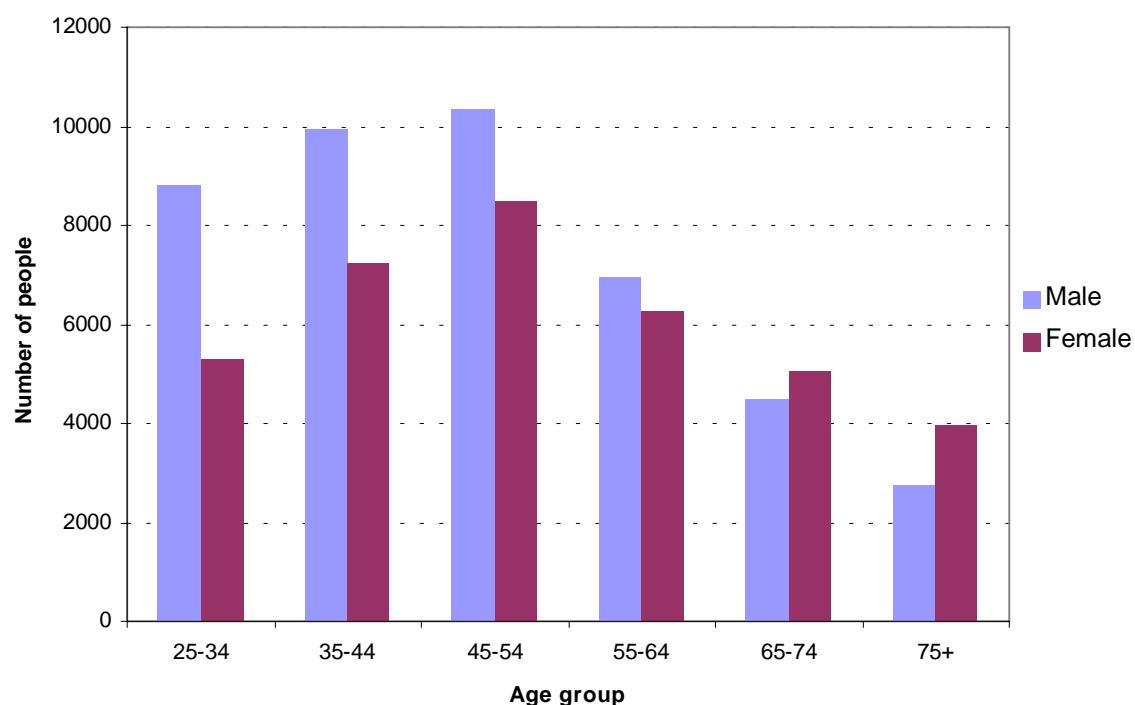
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



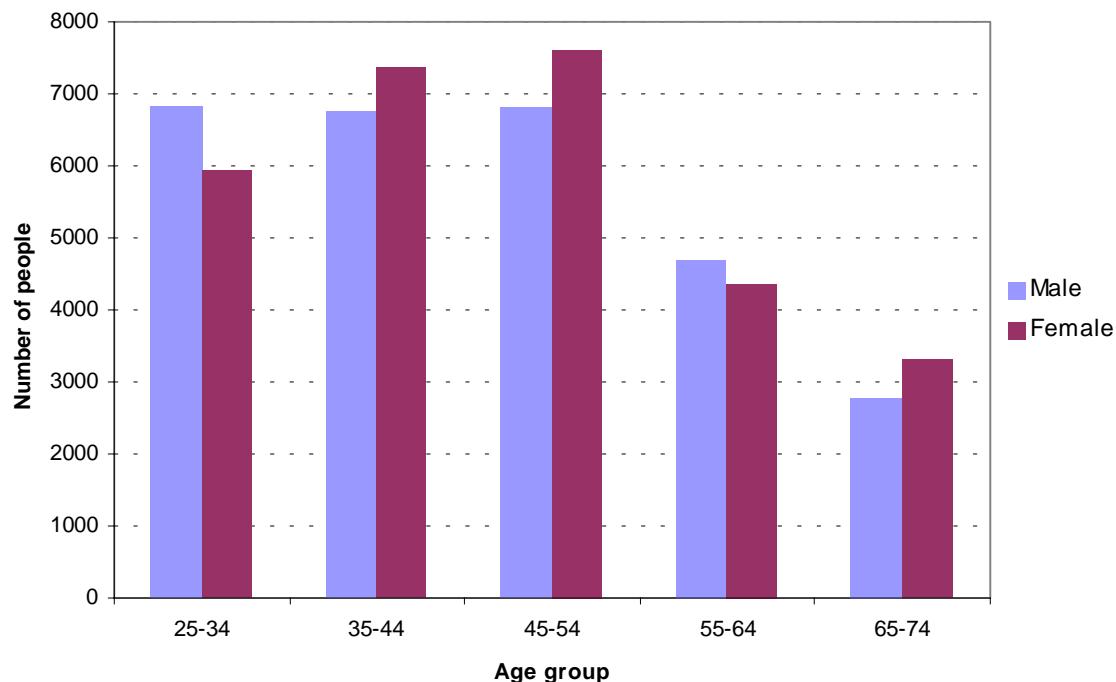
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



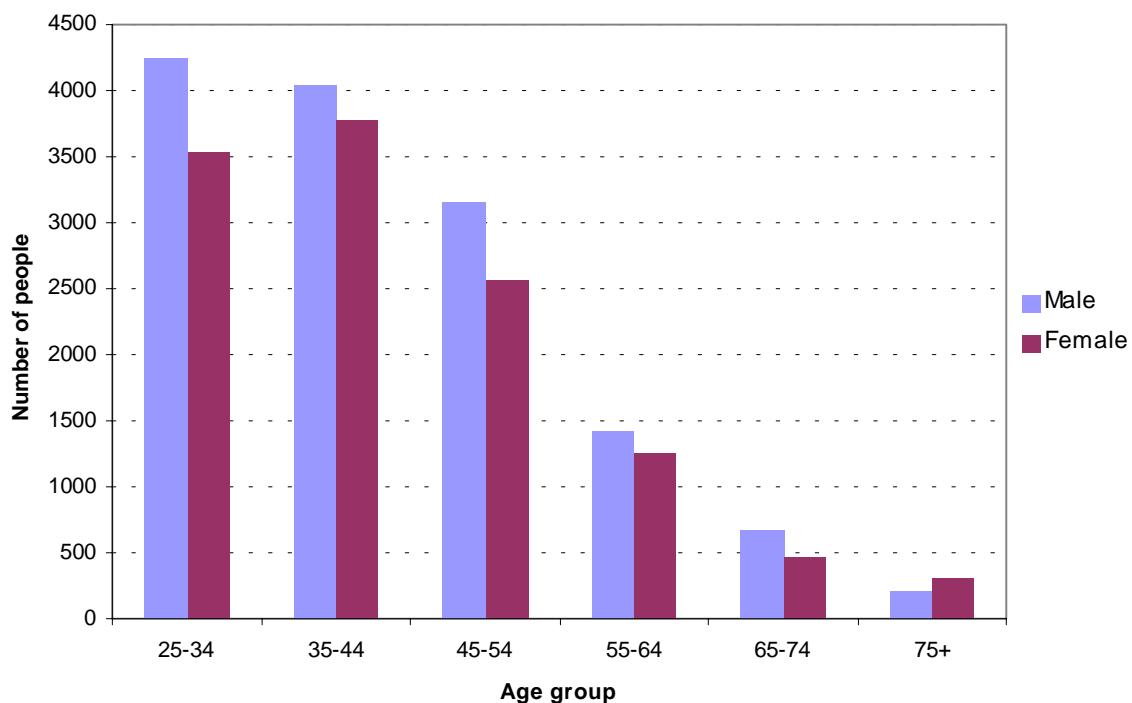
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 212 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Sutherland Hospital – diabetes education centre, which has two full time equivalent (FTE) diabetes educators and one FTE dietitian. The centre provides group and individual education; two ophthalmologists; one endocrinologist; allied health nurses; diabetes high risk foot clinic,
 - Diabetes screening service at the Aboriginal centre once every two months,
 - Diabetes support group,
 - Private podiatrists, endocrinologists, ophthalmologists, and dietitians,
 - Local exercise group.

- What services are needed but are not available in your Division area?
 - Improved resources for prevention and early detection,
 - Improved co-ordination of care between Area Health Services and GPs,
 - Improved referral and communication between Area Health Services, eg diabetes centre and GPs,
 - Improved documentation of incidence and complications, eg through the diabetes education centre.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1992	1993	1994	1995
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1996	1997	1998	1999
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2000	2001	2002	

- Please describe your diabetes program including any changes that occurred over time?
 - GP exercise referral scheme looks at increasing the opportunities for the GP to prescribe physical activity and actively referring identified “low risk” patients to the local leisure centre,
 - Provision of professional development opportunities for GPs and practice staff,
 - Provision of information management training in recall and reminder systems and ongoing support for GPs and practice staff in setting up a diabetes recall and reminder system,
 - Provision of evidence based guidelines in clinical management,
 - Practice visits to promote resources, Practice

Incentive Program (PIP), Service Incentive Payment (SIP) and Enhanced Primary Care (EPC),

- Collaboration and partnership with Area Health Services in the management of chronic diseases,
- Increased opportunities to promote physical activity,
- Diabetes messaging system is currently underway, though the implementation has been slow due to technical difficulties. Recent issues regarding privacy and security are currently being addressed through the promotion of Public Key Infrastructure (PKI) to members,
- Advisory committee formed. This consists of diabetes education centre, cardiac services, GP's, consumer rep and specialists.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The diabetes referral and management kit distributed two years ago has been updated, distributed and evaluated,
 - Diabetes referral form is now available as a Medical Director template,
 - Assisted in the establishment and ongoing support of the local diabetes support group. The support role includes organising speakers and provision of resources,
 - Collaboration with local Area Health Services in the management of macro vascular conditions,
 - Promoted and increased the use of EPC Medical Benefits Scheme (MBS) items and diabetes incentive payments (PIP, SIP),
 - Increased GP access to best practice guidelines and evidence based resources,
 - Provision of continual professional development opportunities for GPs in accordance to best practice guidelines,
 - Provision and support of information management training to both GPs and practice staff,
 - Development and promotion of the physical activity prescription kit to GPs. Evaluation results showed that 64 percent of GPs had used the kit, provision of written material during consultation slightly increased, satisfaction with the National Heart Foundation (NHF) prescription pad and directory of local exercise groups was very high, nearly half of the GPs

indicated that it changed their regard for prescribing physical activity and nearly one-third of GPs increased their own level of physical activity.

-
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - The Diabetes Education Centre (DEC) is under staffed and under resourced which could ultimately have an effect on the quality of services provided to the clients and the GPs,
 - Technical delays in the diabetes messaging program,
 - Uptake of practice-based recall for diabetes is slow due to: time involved, competing demands on GPs time, use of dual records systems (paper and computer), lacking GP skills in Medical Director (MD) and difficulty getting cooperation from all GPs and practice staff,
 - Communication between the DEC and GP could be improved.
 - What future plans do you have for diabetes management in your Division?
 - Focusing on a population health approach to diabetes,
 - Continuation of professional development activities including interactive workshops in collaboration with the quality use of medicines program for GPs and practice staff,
 - Ongoing practice visits to promote programs, incentives and clinical management guidelines,
 - Continual update and promotion of diabetes resource kit for GPs,
 - Enhance collaboration with Area Health Services, Diabetes Education Centre and other chronic disease related services with the aim of improving links with GPs,
 - Information management – ensuring quality assurance of diabetes care through the diabetes messaging system coupled with implementation and ongoing support to GPs and practice staff,
 - Working with other organisations to identify the barriers to diabetes recall and reminder systems at the practice level.
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Taking a multidisciplinary approach to facilitating information to GPs and practice staff. The approach incorporates communication through the monthly newsletter, practice visits and professional development activities,

- Ongoing Divisional support through the provision of training and upskilling of GPs and practice staff. Increased awareness of PIP, SIP and EPC inclusion criteria.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Possible integration with SNAP and chronic disease research opportunities,
 - GP exercise referral scheme – Sutherland Leisure Centre, Fitness NSW, Area Health Promotion Service,
 - Physical activity prescription kit – Area Health promotion physical activity team,
 - Diabetes/CVD Advisory Committee – Diabetes Education Centre, Endocrinologists, heart and lung team – funded by the Area Health Service. The Division is actively involved through representation on the program's management committee,
 - Diabetes/CVD GP program advisor is represented at the Area Health clinical reference group for chronic and complex care programs,
 - The Sutherland hospital health promotion committee.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - The Division compiled a type 2 diabetes management and referral GP resource kit which consists of three sections: Management (includes National Health and Medical Research Council (NHMRC) guidelines, claiming incentive payments), referral and patient education (includes services available for consumers, local exercise groups and footcare),
 - Diabetes Australia has a diabetes faxback which offers diabetes information for newly diagnosed patients,
 - Physical activity prescription kit is promoted to GPs,
 - The Division's monthly newsletter regularly features clinical journal articles detailing latest research in the area of diabetes, including primary and secondary prevention.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

All our resources for each program have been provided to practices and are available on the Division's website.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

- Diabetes Australia produces excellent patient education information sheets and this would be very useful if it was incorporated into Medical Director,
- Local clinical data on diabetes.

- What resource materials do you provide to practices?

- Type 2 diabetes management and referral GP resource kit,
- Diabetes Australia has a diabetes faxback which offers diabetes information for newly diagnosed patients,
- Physical activity prescription kit is promoted to GPs,
- The Division's monthly newsletter regularly features clinical journal articles detailing latest research in the area of diabetes,
- All resources have been provided to practices and most are available on the Divisions website,
- A list of physical activity opportunities in the local area.

Division Contact Person/
Program Officer

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Heart support Australia group,
 - The Sutherland Hospital – Sutherland Heart and Lung Team, cardiac rehabilitation, aged care team, one cardiologist and two visiting medical officers,
 - Local exercise groups,
 - Private dietitians, private cardiologists.

- What services are needed but are not available in your Division area?
 - Improved resources for prevention,
 - Improved coordination of care between Area Health Services and the GPs.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - GP exercise referral scheme – looks at increasing the opportunities for the GP to prescribe physical activity and actively referring identified “low risk” patients to the local leisure centre,
 - Education and professional development opportunities for GP and practice staff including smoking cessation,
 - Physical activity active script prescription pad incorporated into a kit and promoted to the GP through practice visits,
 - Provision of evidence based resources in clinical management,
 - Collaboration and partnership with Area Health Services in the management of chronic diseases,
 - Increase opportunities to promote physical activity,
 - Advisory committee formed which consists of Diabetes Education Centre, cardiac services from the hospital, GPs, consumer rep and specialists.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Continuing Professional Development on smoking cessation, which provided the latest evidence concerning the physiology of nicotine addiction and the effectiveness of various cessation strategies including brief intervention strategies,
 - Continuing professional development on heart failure combined with the launch of the Sutherland Hospital Heart and Lung Team (SHALT),
 - Over 70 GPs have contributed to over 110 care plans for the heart and lung team,
 - The Division and the SHALT project officer co-presented a paper on the partnerships formed in the program and the Division's role,
 - Establishment of the care plan protocol with the SHALT,
 - Evaluation of GP satisfaction with the SHALT.
 - Development and promotion of physical activity kit to GPs. Evaluation results showed that 64 percent of GPs had used the kit, provision of written material during consultation slightly increased, satisfaction with the National Heart Foundation (NHF) prescription pad and directory of local exercise groups was very high, nearly half of the GPs indicated that it changed their regard for prescribing physical activity and nearly one-third of GP's increased their own level of physical activity.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - GPs have many barriers when participating in program activities. These include: the amount of time involved, competing demands on GPs time, difficulty getting cooperation from all GPs and practice staff,
 - Physical activity prescription kit evaluation revealed that the development of computerised resources by NHF may assist in the greater use of prescribing.
- What future plans do you have for CVD management in your Division?
 - Professional development on stroke/Transient Ischaemic Attack (TIA); hypertension case studies in collaboration with the “quality use of medicines” program,
 - Enhance collaboration with SHALT, health

promotion, other Area Health Services and other chronic disease related services with the aim of improving links with GPs,

- CVD and its place in recall and reminder systems, but only once the diabetes messaging system (CARDIAB) has been implemented and evaluated,
 - Potentially supporting the research other organisations are conducting in identifying chronic disease management issues as identified by GPs and practice staff,
 - Focusing on a population health approach to CVD,
 - Ongoing practice visits to promote program, incentives and clinical management guidelines.
-

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

- Establish an advisory committee that is represented throughout the departments that are key in the management of chronic diseases,
 - Provision of information and resources based on best practice, evidence and GP needs,
 - Reinforce resources and distribution of information with practice visits, continuing professional development and newsletter articles. Collaboration and partnership are good and important foundations to build your program on. The establishment of good links will facilitate and enhance the CVD program profile,
 - Remember that CVD is a very broad priority that overarches a number of issues.
-

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- GP exercise referral scheme – Sutherland Leisure Centre, Fitness NSW, South East Health Area Health Promotion Service,
 - Physical activity prescription kit – Area Health Promotion Physical Activity Team,
 - Diabetes/CVD Advisory Committee – Diabetes Education Centre, endocrinologists, Sutherland Hospital Heart and Lung Team, Cardiac Rehabilitation Unit, consumer-based Heart Support Australia group representative,
 - TSH Heart and Lung Team. The Division is actively involved through representation on the programs management committee,
 - Diabetes/CVD GP program advisor is represented at the Area Health clinical reference group for chronic and complex care programs,
-

- Support the consumer-based Diabetes Support Group,
- Possible integration with Smoking, Nutrition, Alcohol, Physical activity (SNAP) and chronic disease research opportunities.

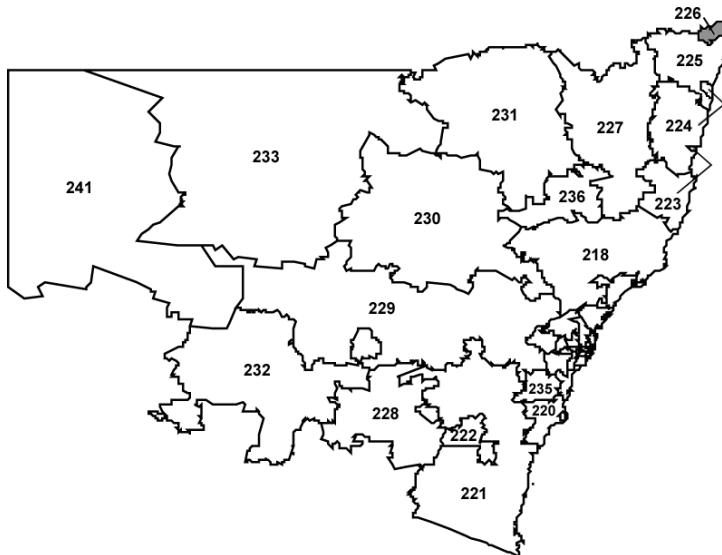
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)? N/A.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? N/A.

Division Contact Person/
Program Officer

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Email: vfirenze.sdgp@shiregps.org.au

Tweed Valley DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	78,338	
■ Aboriginal or Torres Strait Islander	1922	2.5%
■ Speaks language other than English at home	2194	2.8%
■ RRMA classification ¹		
2: Other metro	50,920	65.0%
5: Other rural	27,418	35.0%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5994	10.7%
■ High blood pressure ⁴	21,819	38.9%
■ High blood cholesterol ⁵	30,759	54.8%
■ Obese or overweight ⁶	34,955	62.3%
■ Physical inactivity ⁷	22,387	39.9%
■ Smoking ⁸	9254	16.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

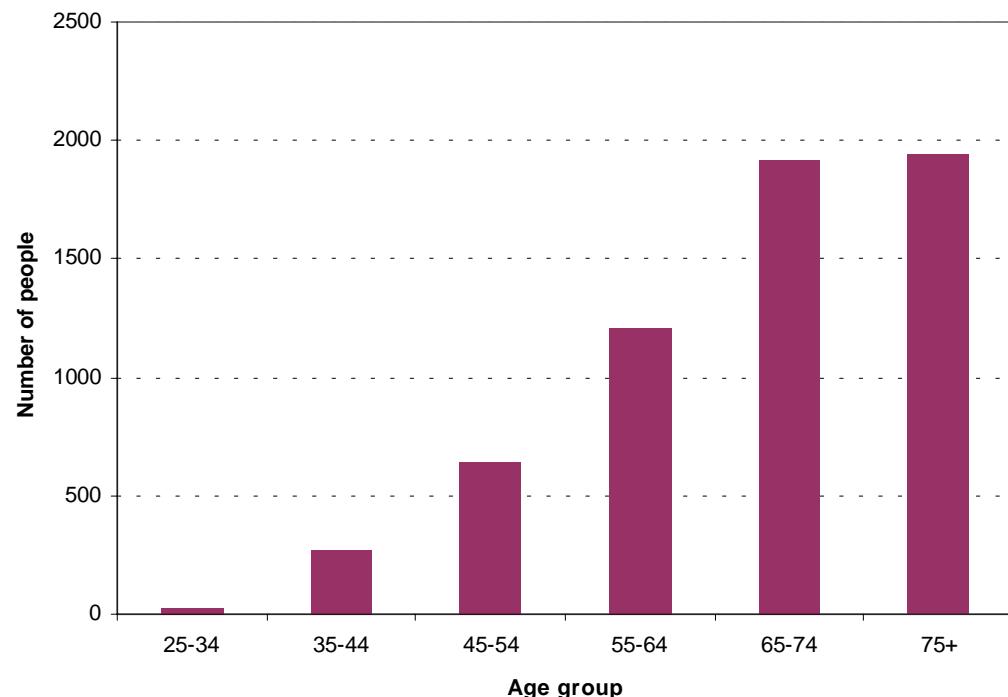
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

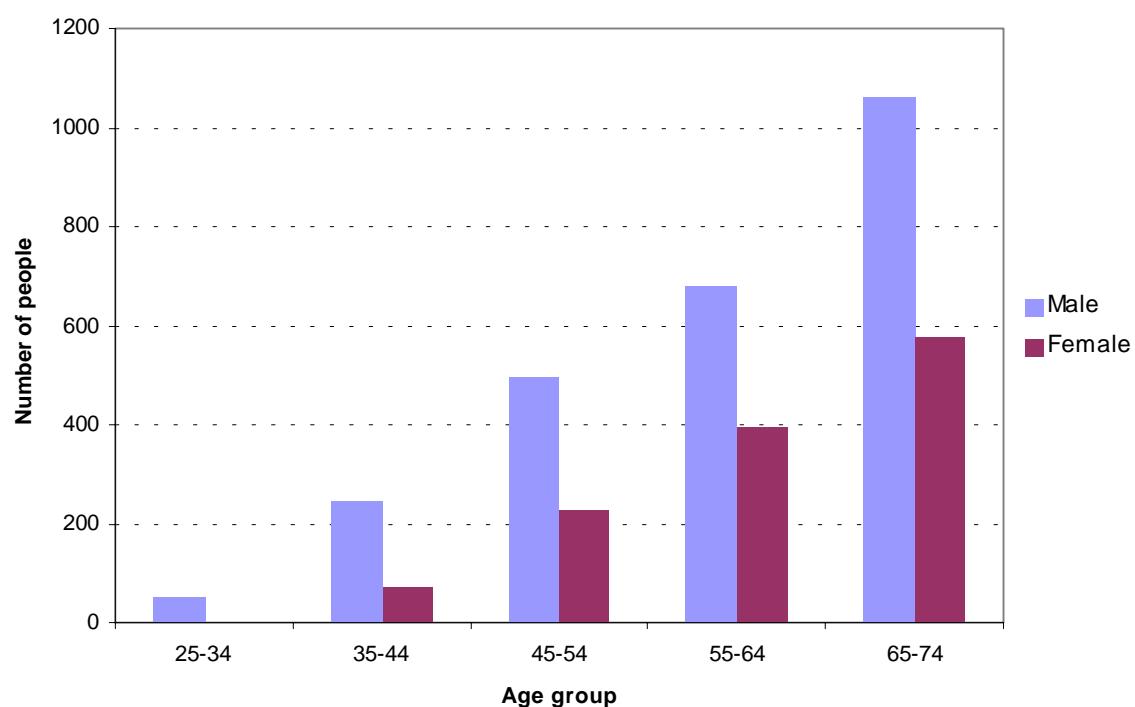
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



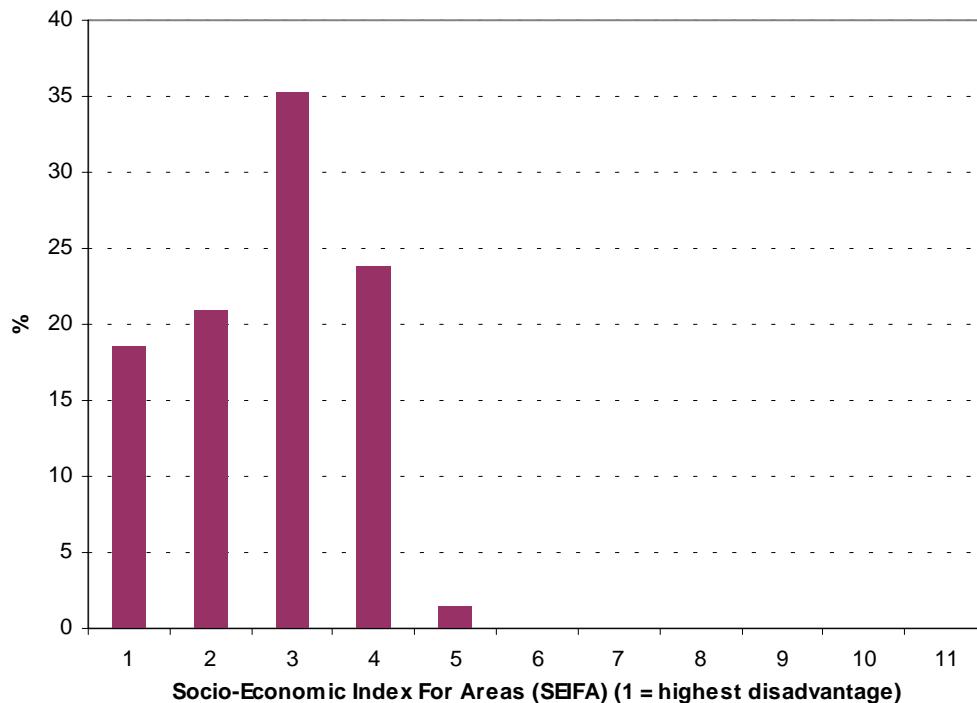
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

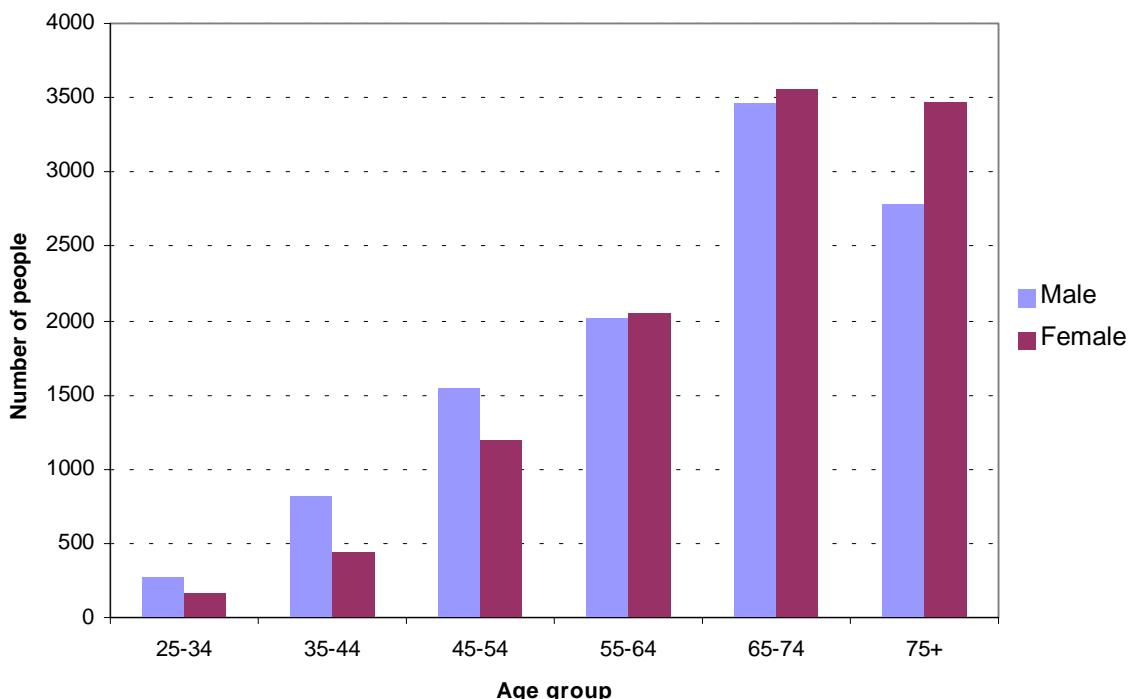
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

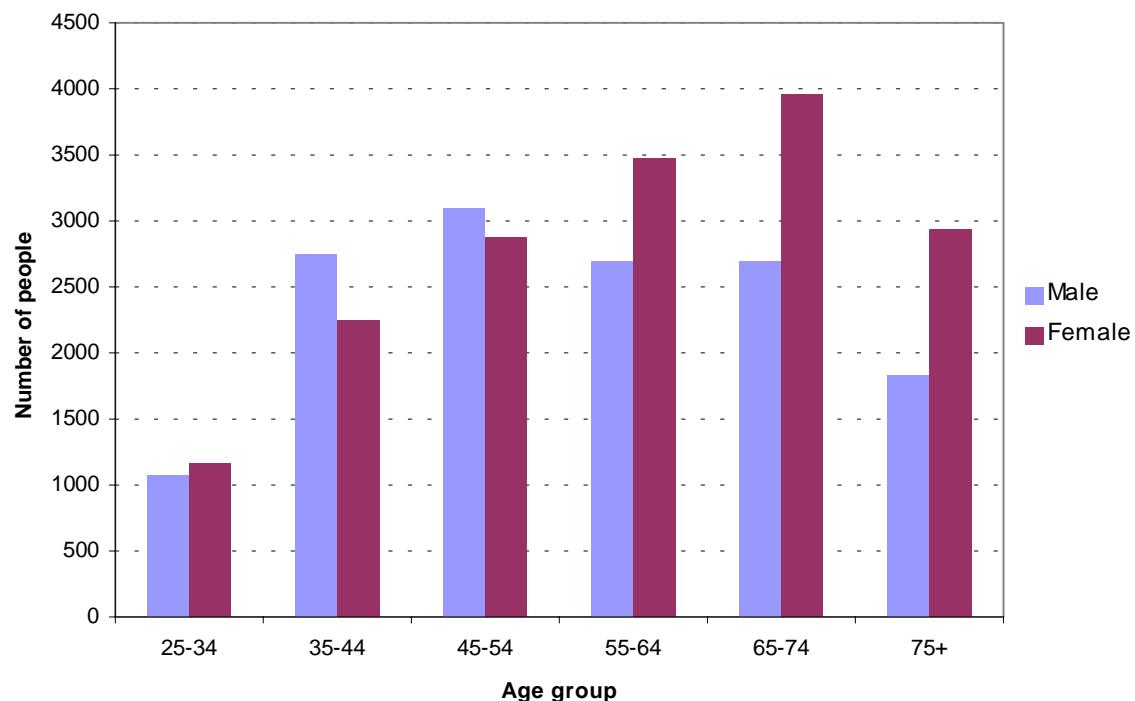
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



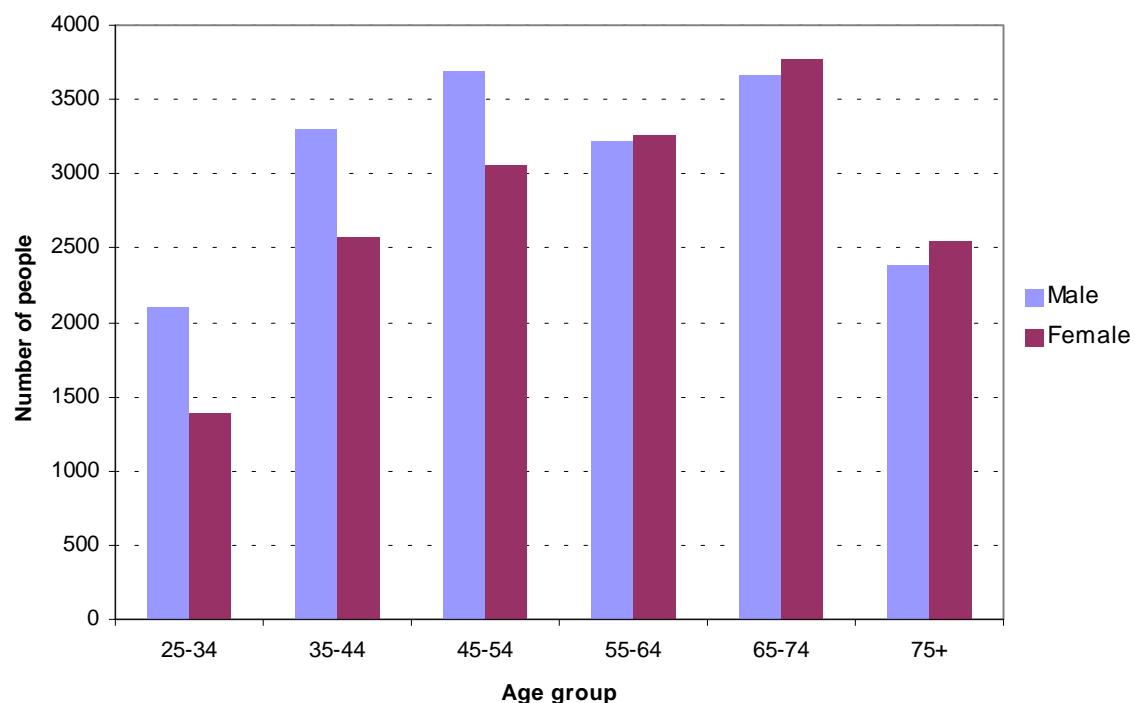
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



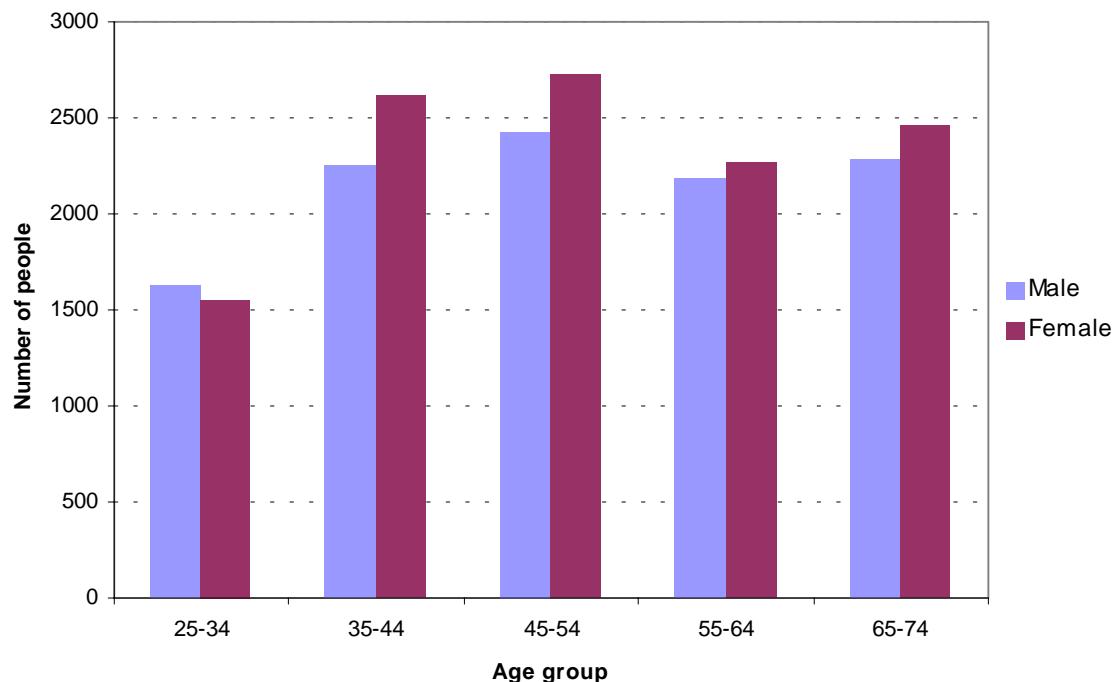
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



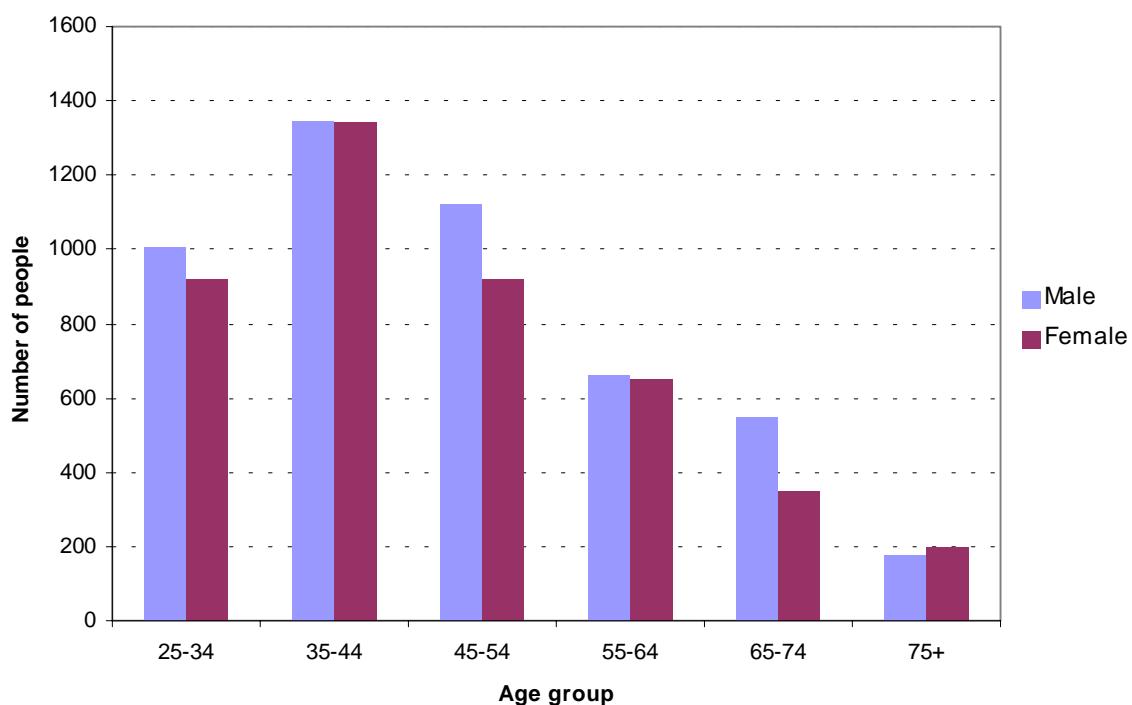
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 88 |
|-----------------------------------------------|-------|----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Area Health Service (AHS) Community Health Diabetes Educators – approximately two educators. “Bugalweena”, the Aboriginal and Torres Strait Islander Community Health Centre (ATSIC), has a dedicated Aboriginal/Torres Strait Islander diabetes centre. Various practices throughout the Division area have dedicated diabetic educators available through the practice.

- What services are needed but are not available in your Division area?

A previous dedicated diabetes project implemented diabetes clinics within practices. This model is often referred to as being ideal by a number of GPs, hence re-implementation of such clinics would be warmly welcomed by GPs. Although a number of practices are currently running such clinics, perhaps a Division-wide approach may be needed.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Division currently has no dedicated diabetes project. At present, the Division offers support to practices through information dissemination – Practice Incentive Payments (PIP), Enhanced Primary Care (EPC) etc. In the past the Area Health Service (AHS) collaborated with the Division to implement a diabetic education workshop, which was open to practice nurses. A similar initiative will be offered to practice nurses in the near future through the Commonwealth Chronic Disease Management (CDM) funding.

Division Perspective

- What have been the major achievements or highlights of your program so far?

As mentioned above, the Division has no dedicated diabetes project at present.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Funding and hence sustainability was the difficulty in continuing the previous diabetes program.

- What future plans do you have for diabetes management in your Division?
 - Practice nurse education: This will enable GPs to maintain or implement “in-house” clinics which would cater to Enhanced Primary Care (EPC) care plan guidelines and relieve pressure on AHS diabetes educators.
 - Continued promotion of initiatives to practices and implementation of a GP determined educational program.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Multi-GP practices, well resourced practices and practices that have implemented a comprehensive infrastructure (ie, staff who are aware of and capable at implementing and understanding the various initiatives on offer).

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - The Division has created and nurtured a good working relationship with the local AHS. This has come about through past projects, sharing of common goals and effective communication.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Promotion of “best practice” guidelines is ongoing.
 - Information from other Divisions is invaluable - this information is obtained through newsletters, web sites and direct contact with Division program officers.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - The Tweed Valley Division of General Practice (TVDGP) has not developed any resources specifically, however, information on the past diabetes project would be gladly made available to other Divisions. This could be important as it may prevent any implementation problems encountered from being repeated elsewhere.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - None specifically.

- What resource materials do you provide to practices?
- Examples of “cycle of care” care plans that may be further developed/utilised to specific practice dynamics.
- Information regarding PIP/EPC.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Outpatient cardiac rehabilitation, both education and exercise,
 - Heart Moves,
 - Various cardiology services (Interventional cardiac catheterisation at John Flynn Hospital, Qld),
 - Area Health Service (AHS) Priority Health Care Program (PHCP).

- What services are needed but are not available in your Division area?
Unsure.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The Tweed Valley Division of General Practice (TVDGP) CVD program concentrates on supporting the role of liaison workers from the PHCP (heart failure) by actively promoting the service to GPs and practice nurses/staff. The Division also funds GPs to present talks on CVD risk factors, A&P etc) to patients participating in the two Area Health Service (AHS) cardiac rehabilitation programs run through Murwillumbah and Tweed Heads Hospitals.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Increased referral rate by GPs into the above mentioned programs with a resultant increase in the development of care plans. Continued and beneficial collaboration with local AHS.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Non-existence of exercise component in rehabilitation program at Tweed Heads Hospital. Finding interested GPs to present to rehabilitation patients at Tweed Heads.

- What future plans do you have for CVD management in your Division?

To continue with the above-mentioned initiatives. Further collaboration with the AHS to determine increased roles where possible.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

None at present.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Division has a good working relationship with the AHS cardiac rehabilitation and Priority Health Care Program (PHCP) personnel, these have been developed through regular and meaningful communication and a respect for the role they are playing.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

 - National Heart Foundation (NHF) literature/resources,
 - Journal articles of relevance,
 - Alliance of NSW Divisions (ANSWD) and other Divisions.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

No specific resources developed.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

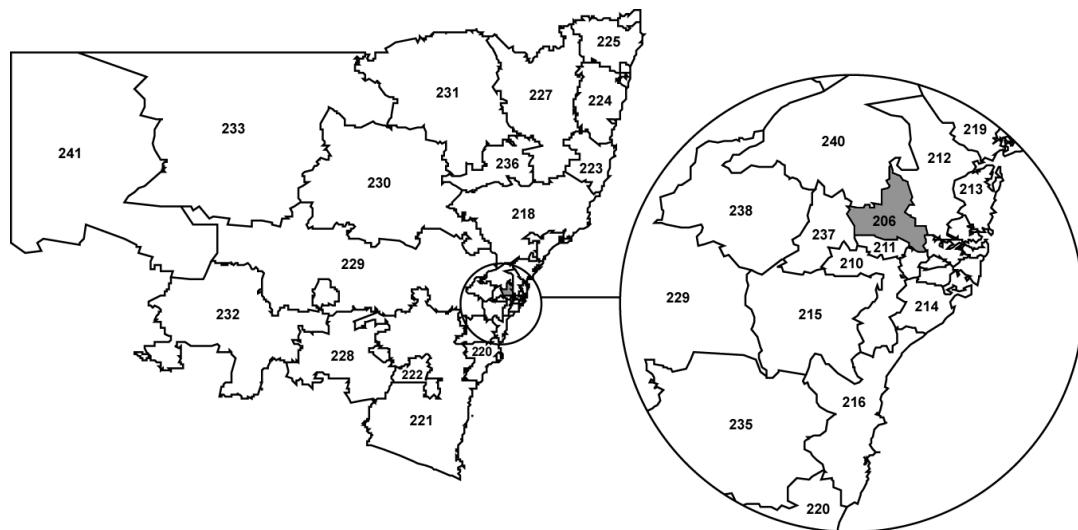
N/A.
- What resource materials do you provide to practices?

Nil, unless resources become available that are pertinent.

Division Contact Person/
Program Co-ordinator

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Western Sydney DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	557,892	
■ Aboriginal or Torres Strait Islander	7912	1.4%
■ Speaks language other than English at home	189,846	34.0%
■ RRMA classification ¹		
1: Capital city	557,892	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	24,169	6.9%
■ High blood pressure ⁴	94,322	27.0%
■ High blood cholesterol ⁵	175,028	50.0%
■ Obese or overweight ⁶	207,684	59.3%
■ Physical inactivity ⁷	151,471	43.3%
■ Smoking ⁸	70,478	20.1%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

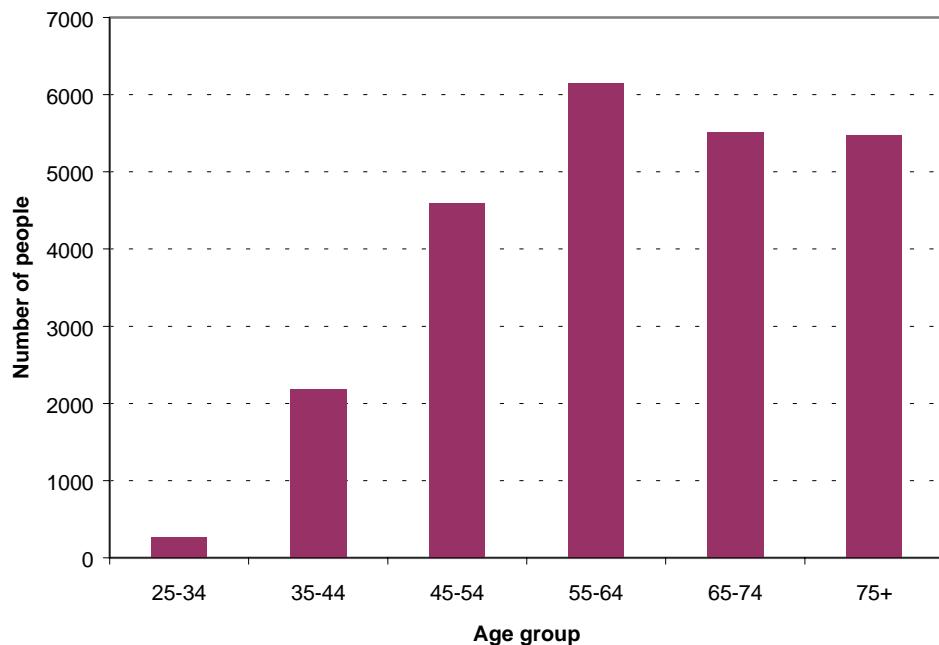
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

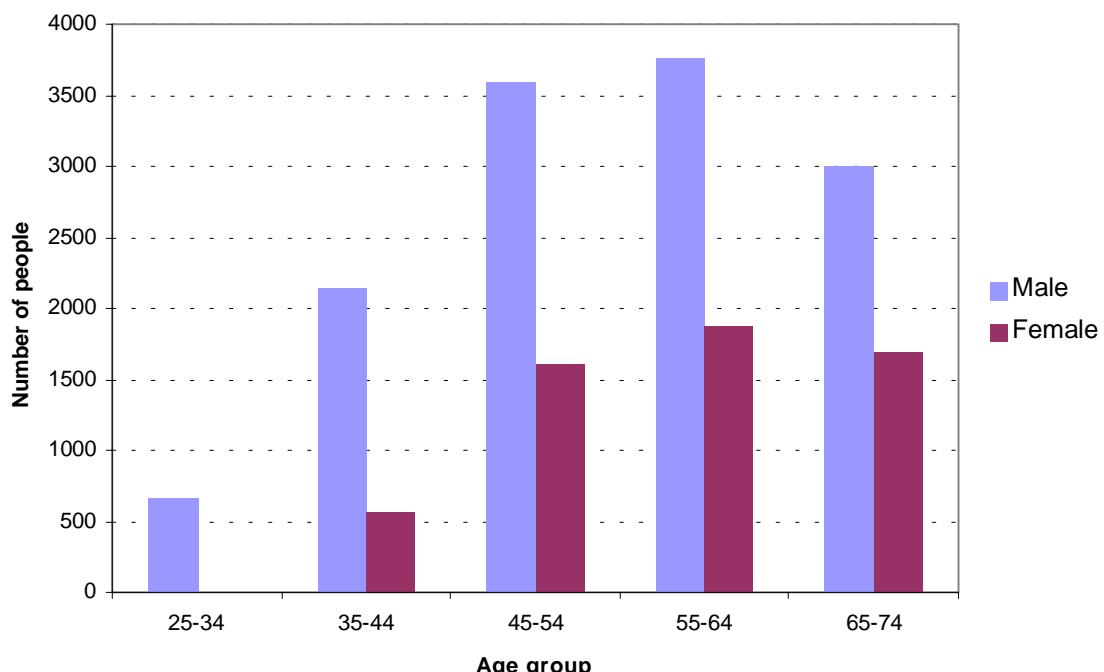
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



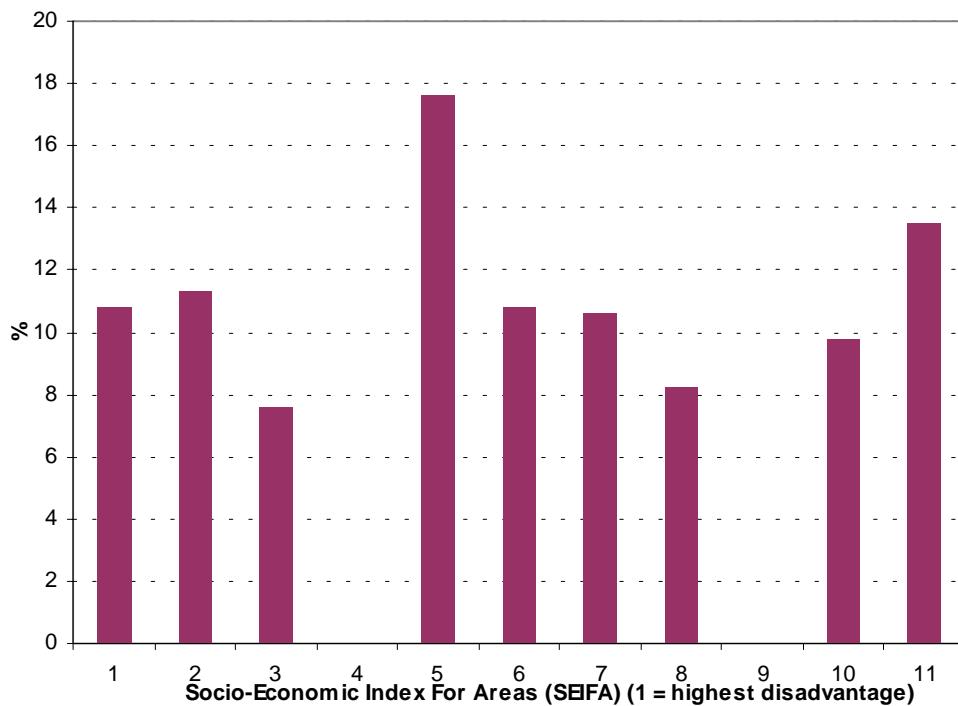
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

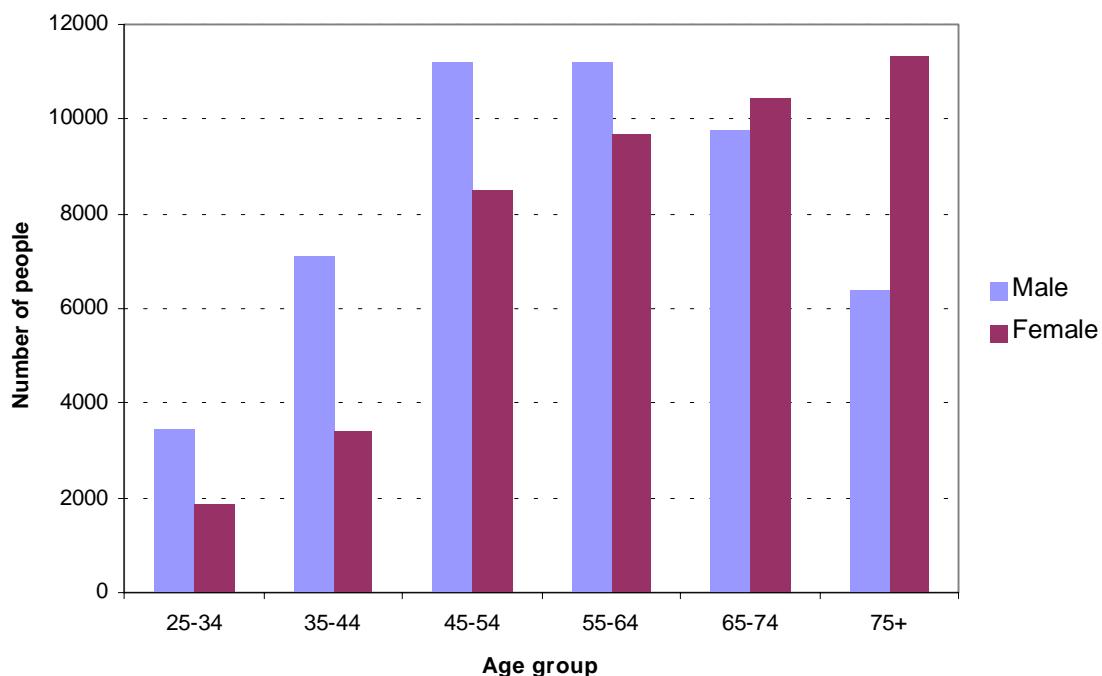
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

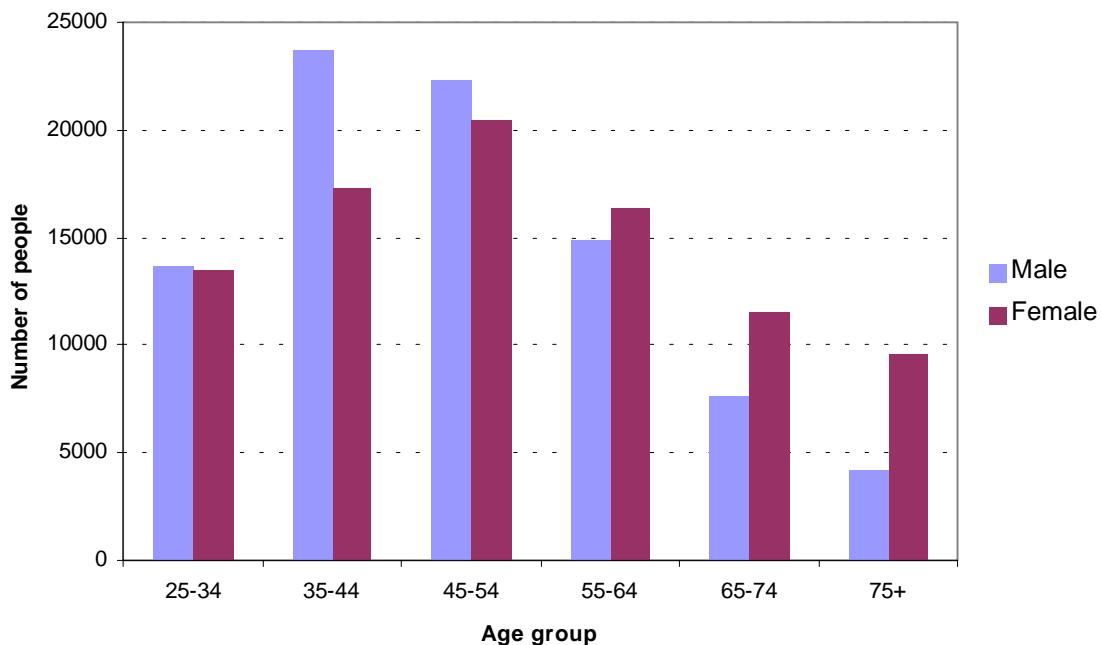
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



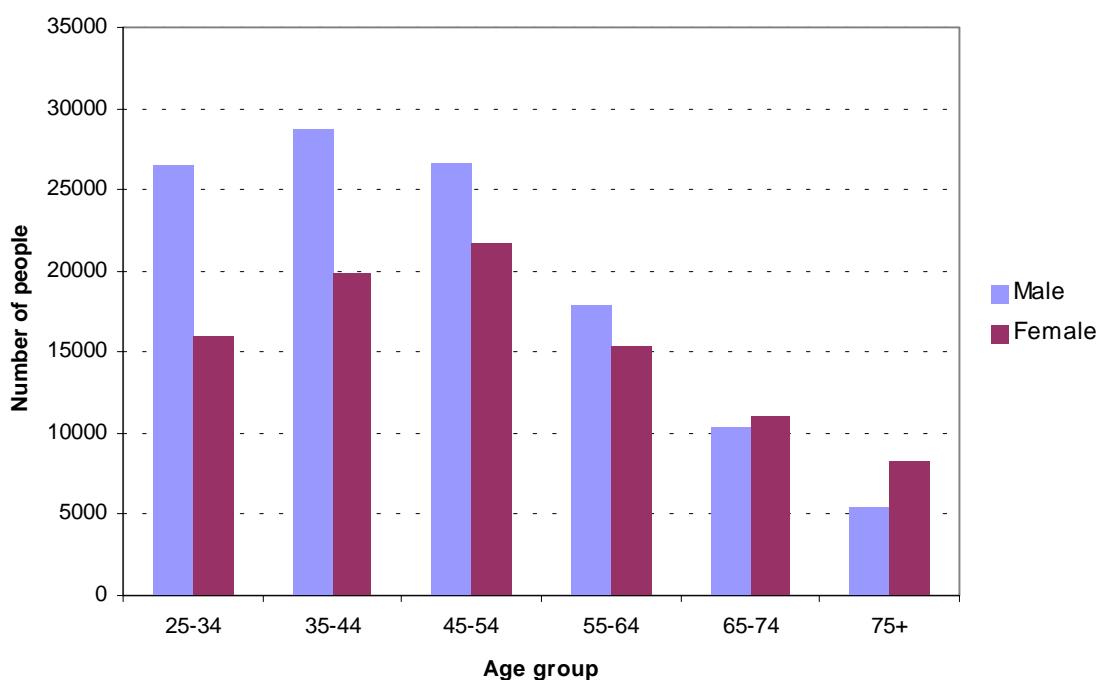
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



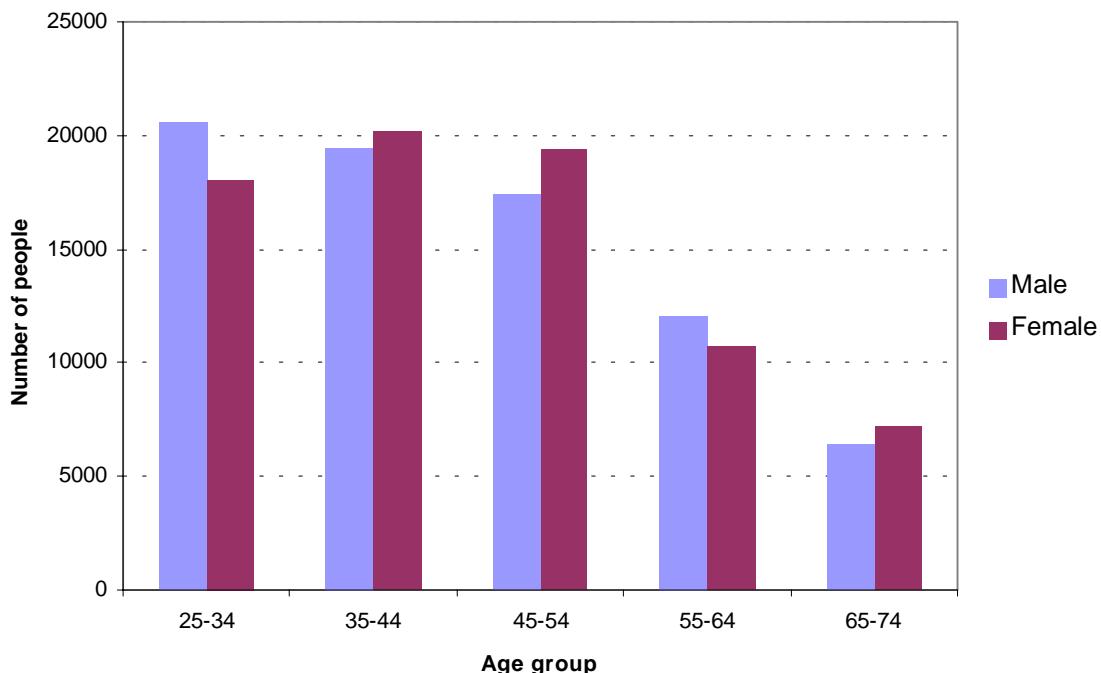
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



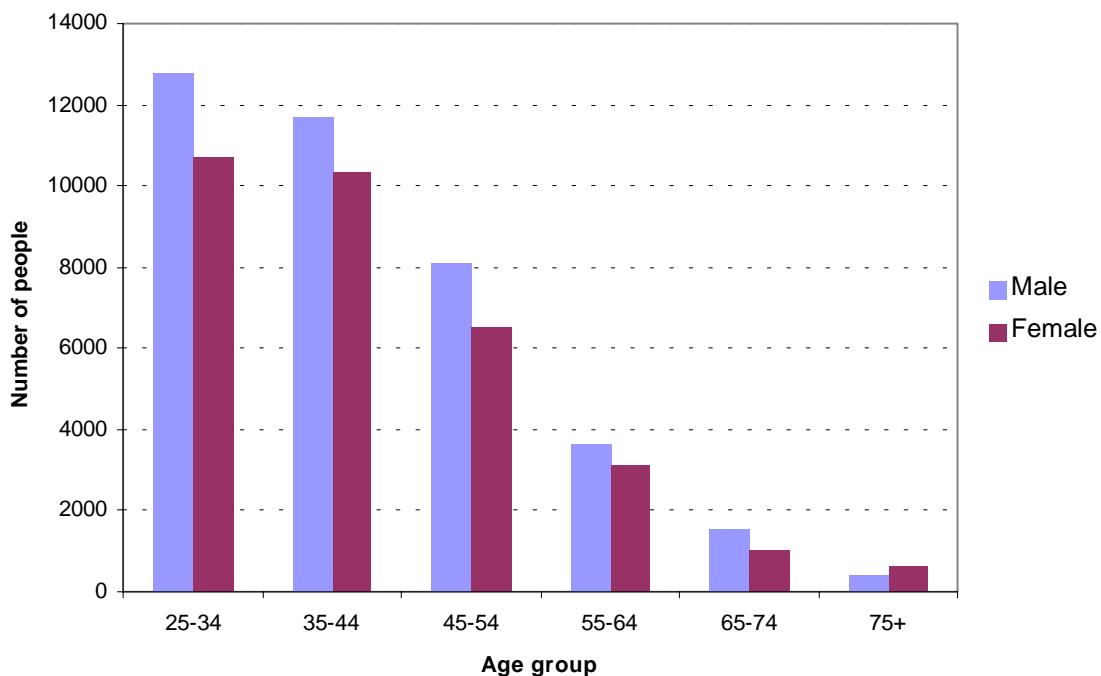
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 429 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Endocrinologist, diabetes centres, diabetes educators, podiatry services (private and public), nutritional services (dietitian – private and public), ophthalmologists, community exercise programs and support services (stress management, smoking cessation and HeartMove).

- What services are needed but are not available in your Division area?

No study done to assess this – it is possible that there is a shortage of podiatrists in Western Sydney. Waiting times for public diabetes educators, podiatrists, dietitians vary in each local area.

Blacktown

- Diabetes educator – 3 weeks,
- Dietitian individually – 4 months (if group education – within a month),
- Podiatrist – for education and assessment – up to 4 weeks – for treatment in a community centre – no bookings until next year – this is only available to aged pensioners, other people have to see a private podiatrist unless they fit the high risk service criteria,
- Diabetes clinic – 5 weeks.

Mt Druitt

- Diabetes educator – 6 weeks,
- Dietitian – individually – 2 months (Blacktown – earlier if suitable for a group),
- Podiatrist – education and assessment sessions held 2nd monthly – high-risk foot service at Mt Druitt diabetes centre,
- Diabetes clinic – 5 weeks.

Westmead

- Educator waiting times – 4 weeks,
- Podiatrist – none available at Westmead except for high-risk ulcer clinic though there was podiatrist education session held twice a month,
- Community podiatrist if available it was 3-6 months, some are not taking new patients,
- Doctors waiting time – depending on doctor 2 – 6 weeks.

Auburn

- Diabetes assessment/education with diabetes CNC/educator – 4 weeks,
- No staff specialist in Auburn.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

- Quality Prescribing Service staff has been providing:
 - GP academic detailing on management of Diabetes 2 – Nov 01 to April 02,
 - Diabetes 2 workshops at 2 local groups,
 - Clinical audit on dyslipidaemia,
- Various options for register and recall systems were explored, with the ultimate decision to adopt the CARDIAB system,
- Workshop on new MBS items,
- A manual on new MBS items – a GP guide,
- GPs trained on recalling patients with diabetes (using Medical Director software).

Division Perspective

- What have been the major achievements or highlights of your program so far?

- Educational visits on diabetes 2 – provided to 93 practices,
- Two local group workshops on diabetes 2 – maximum of 15 GPs per workshop (attendance of 14 and 12 respectively). As there were GPs in waiting list, more workshops are being organised for next year,
- Clinical audit on dyslipidaemia – 32 participants,
- Workshop on new MBS items.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for diabetes management in your Division?

- Implementation of CARDIAB,
- Training of GPs to better use Medical Director for recalls, recording medical information on patients,
- Practice visitors providing academic

detailling/assisting GPs in care planning including diabetic management plan,

- Four local group workshops on diabetes,
- Collaboration with Western Sydney Division of General Practice (WSDGP) in implementing Cardiovascular Risk Assessment and Management Program (CVRAMP).

-
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

Internal:

- Belief that it will make a difference to patient health, awareness of concepts of practice population/population health,
- Perseverance,
- Practices with existing chronic disease management (CDM) systems – whether paper or informatics based – or those willing to upgrade their practice systems and processes,
- Presence of practice nurses.

External:

- Availability of appropriate financial reward,
- Availability of divisional support services.

-
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- Regular meetings with the Western Sydney Area Health Service (WSAHS) Chronic & Complex Care Stream and the WSAHS Priority Health Care Program (three NSW Health funded CDM Programs including CVRAMP) and the WSAHS Vascular Risk Steering Committee,
- Formation of the GP Liaison Officer (GPO) Unit where the GP is the link between GPs and Area Health,
- GPs are represented by a GP member of the Division in most relevant Area Health initiatives,
- External links – diabetes educators, podiatrists, dietitians (private and public), endocrinologists – in all 6 local groups,
- Links/contacts with Diabetes Australia, National Prescribing Service (NPS), Health Promotion, other Divisions, Alliance etc.

Developed via the progressive building of collaboration and joint chronic disease management (CDM) initiatives over a number of years.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - National Prescribing Service (NPS) material,
 - Diabetes Australia,
 - Allied Health professional material,
 - RACGP and NSW Health Department guidelines.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Division's GP resource manual,
 - A manual on new MBS items – a GP guide,
 - Medical Director training manual on recalls of patients with diabetes.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

- What resource materials do you provide to practices?
 - Division's resource manual,
 - NPS material is available to all practices that have an NPS facilitator,
 - Manual on the new MBS items – a GP guide,
 - In the process of developing “A guide to risk reduction for patients with/or “at risk” of developing vascular disease”.

Division Contact Person/
Program Co-ordinator

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Email: sothy.selvaratnam@wsdgp.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiologists,
 - Cardiac rehabilitation at two hospitals,
 - Nutrition services,
 - Community exercise programs and support services (stress management, smoking cessation and HeartMoves).

- What services are needed but are not available in your Division area?
Community education in patient self-management.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The program attempted to bring about coordinated referral of patients from cardiology department back to their GPs. The Division had difficulties in progressing this objective.

At the same time, Area Health Service Vascular Risk Steering Committee embarked on a program (CVRAMP – Cardio Vascular Risk Assessment and Management Program) targeting patients with diabetes and cardiac co-morbidity. This project addressed the same facilitated referral component as the Division's previous program. The CVRAMP program also involves revised transfer of care and care planning processes, promotion of best practice clinical guidelines etc. A decision was made by the Division to suspend this program and work in partnership with CVRAMP. It is envisaged that with Area Health Service (AHS) facilitating the process from the hospital end and with staff based at the hospital to speak to patients about the program, this is likely to progress more effectively.

Division Perspective

- What have been the major achievements or highlights of your program so far?

CVRAMP program undertook an audit to map existing processes of care, identify areas for improvement and ensure selected strategies addresses the issues identified. Following the audit,

the Cardiology Unit at Westmead Hospital has agreed to address the issues identified.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Major issues identified with the previous program were:

- Ambivalence concerning the program's usefulness by many cardiologists and nursing staff,
- Lack of willingness to address the discharge summary and referral processes due to inability of cardiology staff taking on additional work,
- The Division's inability to manage the initial patient contact, discussion and referral process,
- The structured Cardiac Recovery Program being perceived as too time consuming by many GPs and patients.

- What future plans do you have for CVD management in your Division?

- Collaboration with Western Sydney Area Health Service (WSAHS) to implement CVRAMP,
- Implementation of CARDIAB,
- Encourage GPs to maximise use of recalls, recording medical information and data management via training and help desk service,
- Practice visitors providing academic detailing/assisting GPs in care planning including diabetic management plan,
- Academic detailing on antithrombolytics in 2003,
- Continue to promote/make available to GPs – relevant and updated guidelines and resources, audits and other educational programs to continue enhancing GP skills including the value of employing practice nurses/nurses.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

In the planning, address:

- Practice support services on Enhanced Primary Care (EPC), informatics, accreditation support, practice management, academic detailing,
- Close collaborations with Area Health Services at all levels,
- GPs effectively using informatics to manage patient data and recalls.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Regular meetings with the WSAHS Chronic and Complex Care Priority Health Care Programs and the WSAHS Vascular Risk Steering Committee,
 - Formation of the General Practice Liaison Officer (GPLO) unit where the GP is the link between GPs and Area Health,
 - GPs are represented by a senior GP member of the Division in most Area Health initiatives,
 - External links/contacts – Heart Foundation, Health Promotion, other Divisions, Alliance, etc.

Developed via the progressive building of collaboration and joint Chronic Disease Management (CDM) initiatives over a number of years.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - Heart Foundation,
 - NSW Health Department publications.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Resource manual – “A guide to risk reduction for patients with/or ‘at risk’ of developing vascular disease” – once it is completed.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

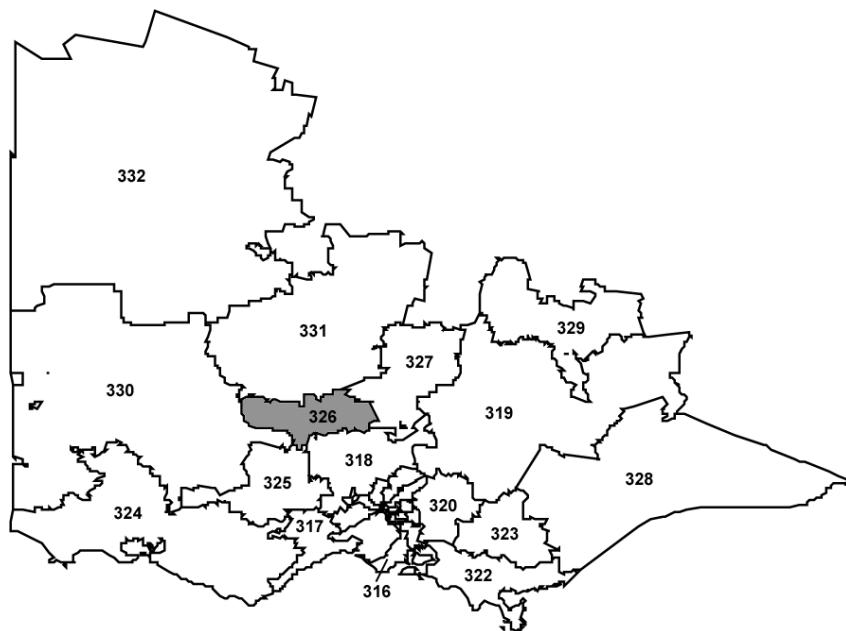
N/A.
- What resource materials do you provide to practices?
 - Heart pack for patients (containing a booklet of information about caring for the heart and medication, community support and exercise programs and self-management activity booklet) for patients with cardiac disease about the heart and medication). Sample is given to GPs then GPs call the Division to post to patient(s),

- GP resource manual – consisting of information to best practice guidelines, list of resource and referrals.
- In the process of developing “A guide to risk reduction for patients with/or ‘at risk’ of developing vascular disease.”

Division Contact Person/
Program Co-ordinator

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Bendigo and District DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	93,647	
■ Aboriginal or Torres Strait Islander	864	0.9%
■ Speaks language other than English at home	1910	2.0%
■ RRMA classification ¹		
3: Large rural	79,881	85.3%
5: Other rural	13,766	14.7%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5100	8.5%
■ High blood pressure ⁴	19,155	31.9%
■ High blood cholesterol ⁵	31,353	52.3%
■ Obese or overweight ⁶	36,304	60.5%
■ Physical inactivity ⁷	25,004	41.7%
■ Smoking ⁸	11,139	18.6%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

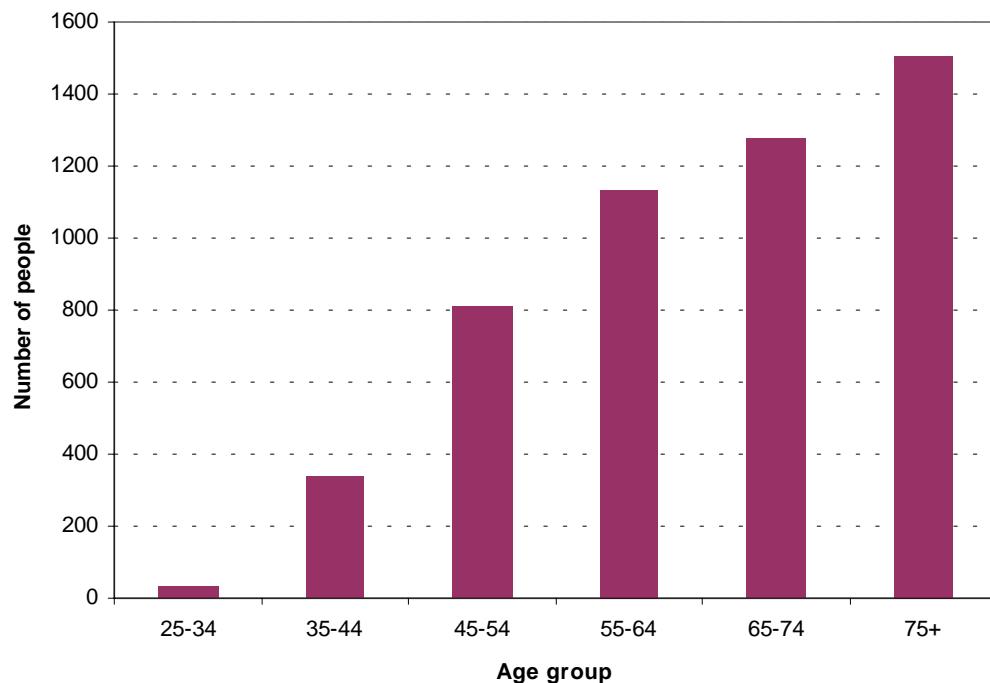
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

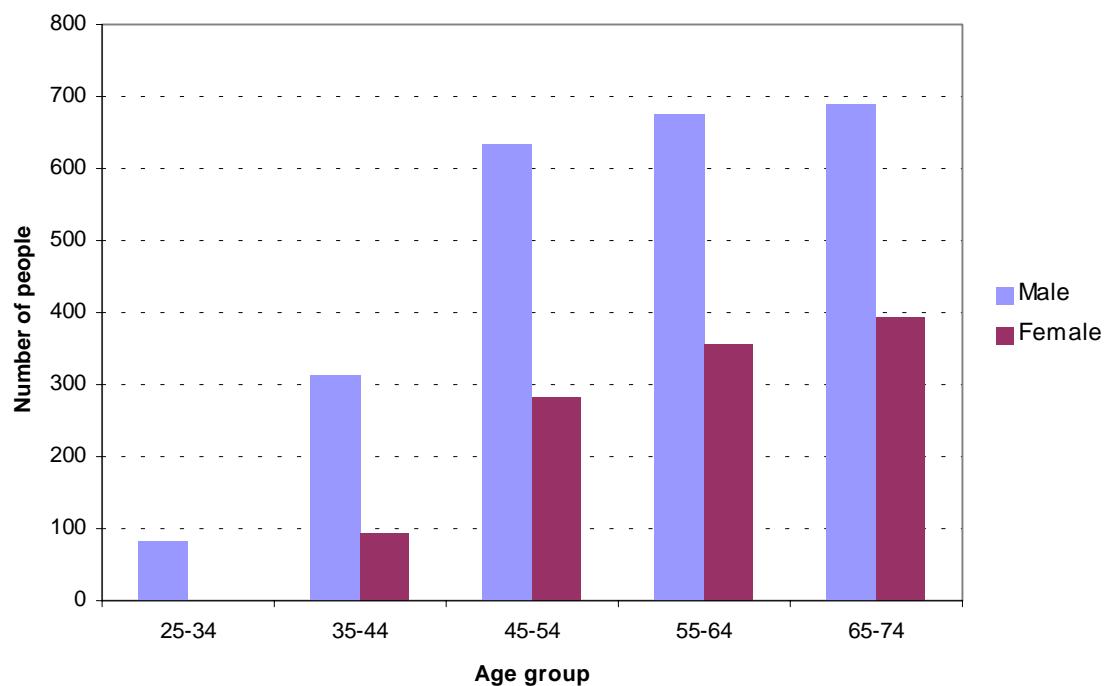
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



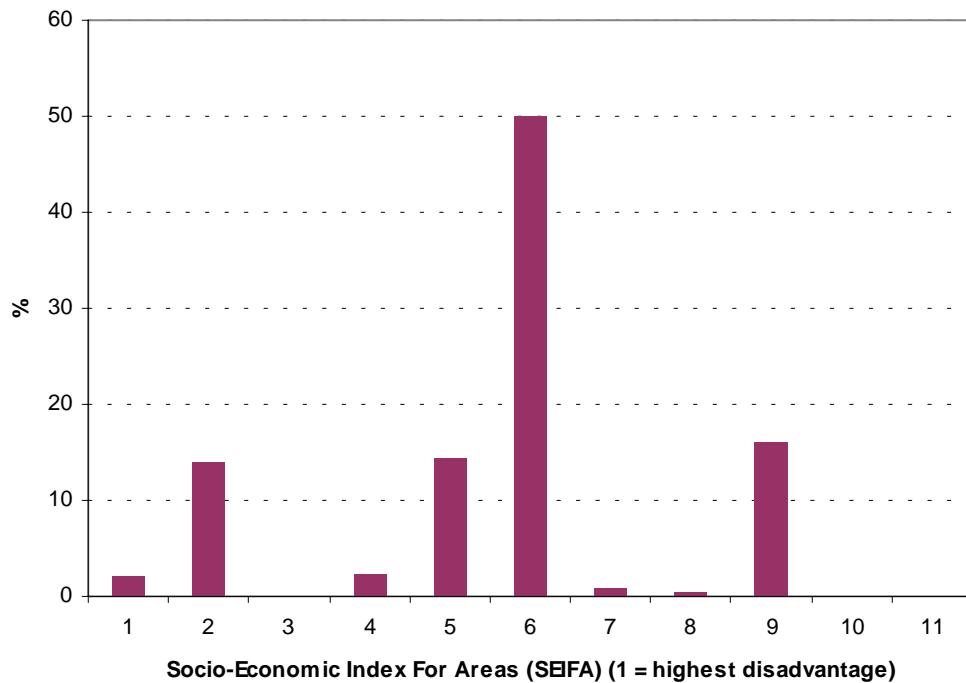
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

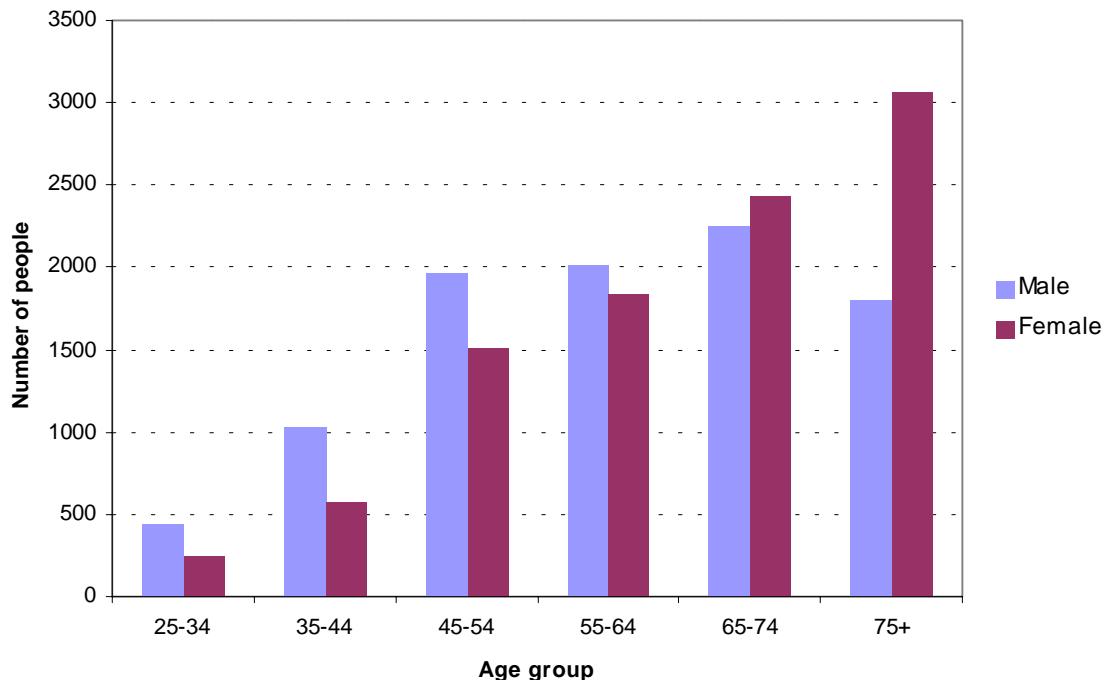
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

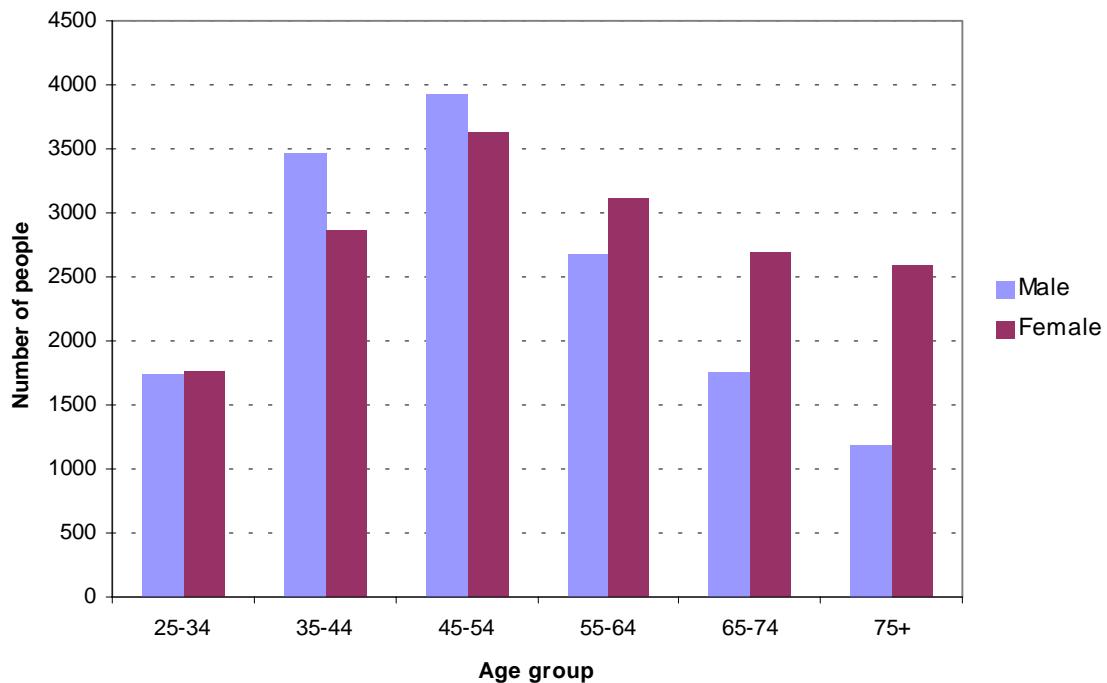
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



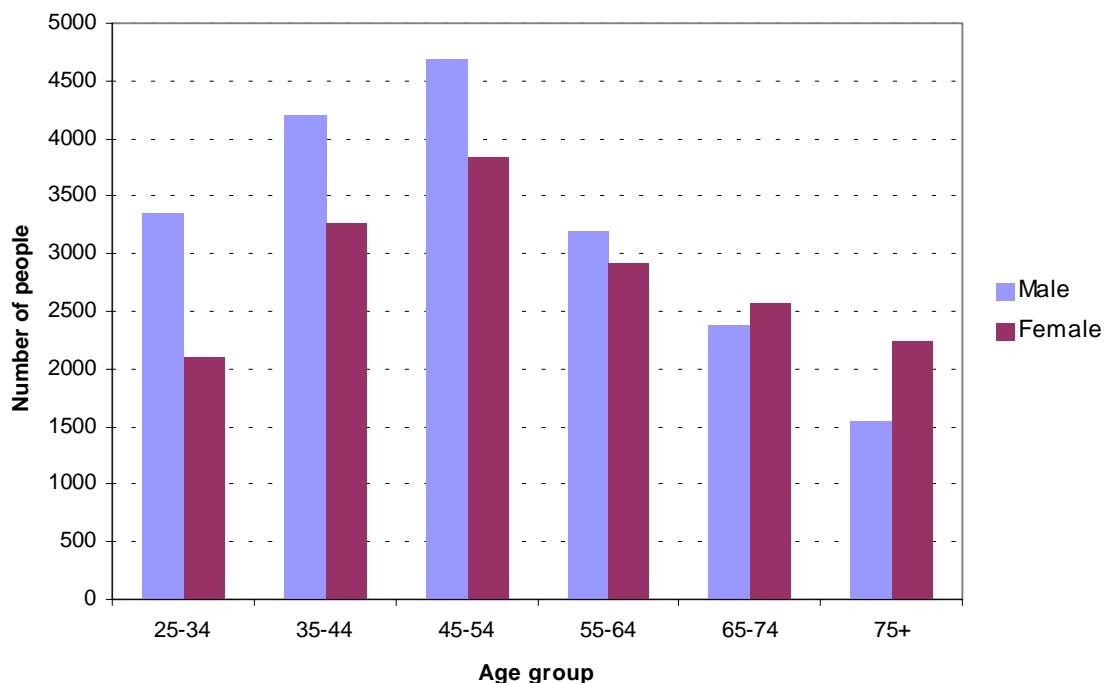
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



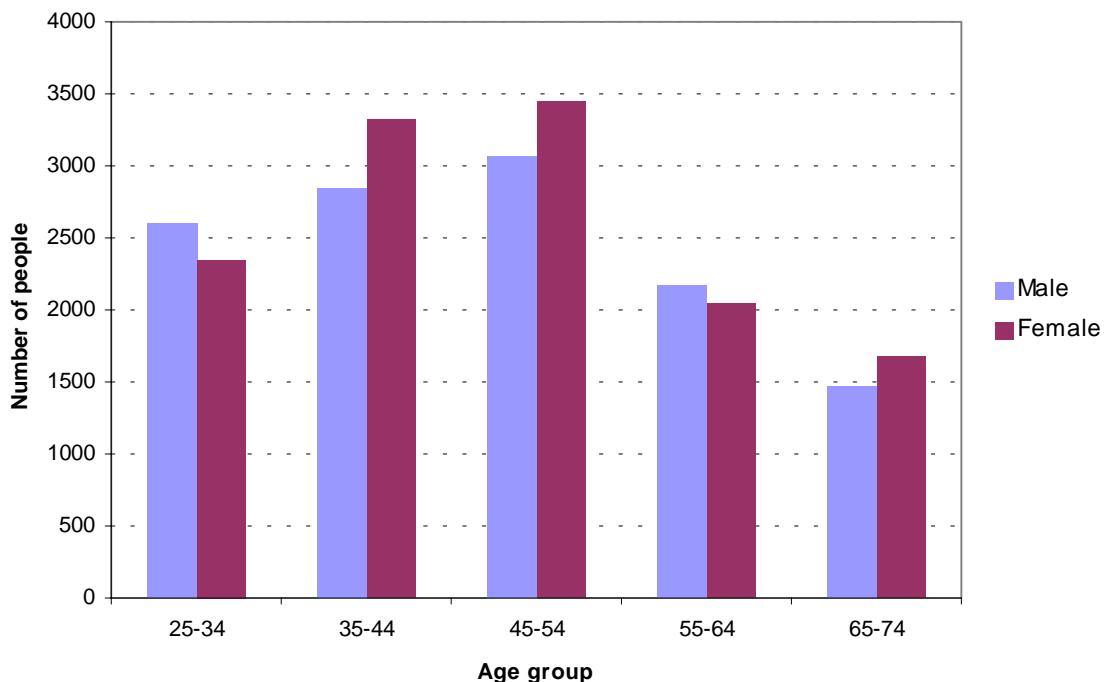
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



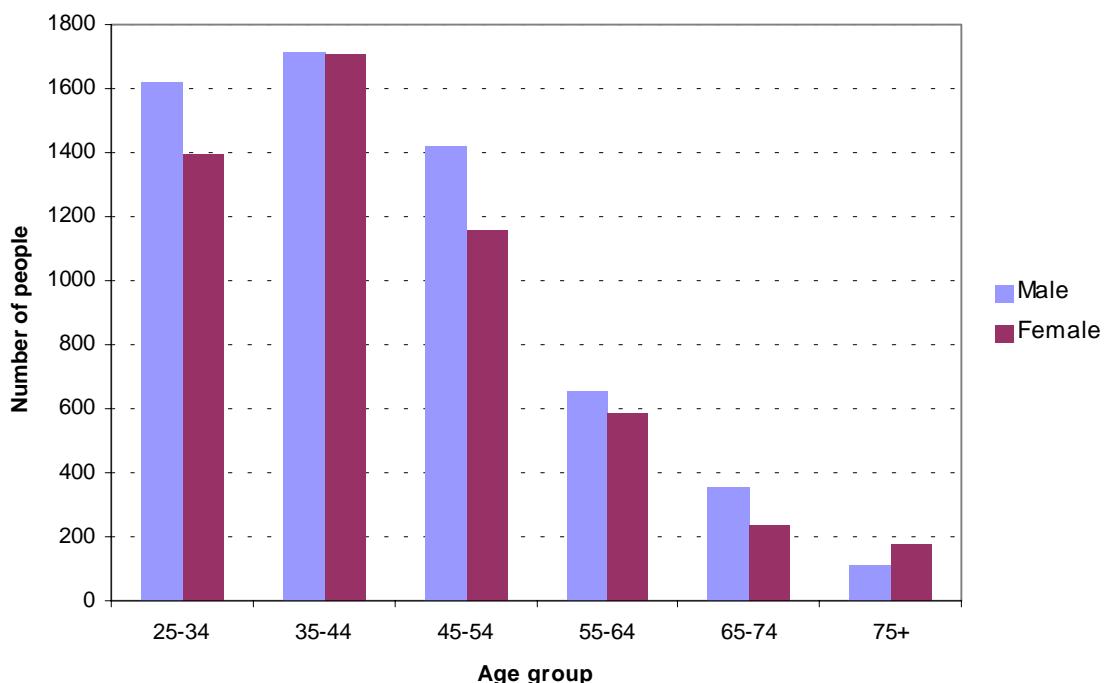
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 89 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Endocrine clinic – weekly,
 - Diabetes educators – private, public, More Allied Health Services (MAHS) community health – diabetes education,
 - Podiatry – public/private/rural health team, GPs,
 - Practice nurses – one day diabetes workshop,
 - Diabetes support groups,
 - Ophthalmologists/optometrists,
 - Physical activity organisations,
 - Walking tracks.

- What services are needed but are not available in your Division area?
 - More podiatry and diabetes education,
 - Ophthalmologist.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Development of diabetes network group. All health professionals concerned with diabetes care meet to develop – service mapping, consensus guidelines and Health Promotion.

Division Perspective

- What have been the major achievements or highlights of your program so far?

N/A.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for diabetes management in your Division?
 - Development of Koori diabetes services,
 - Continued education and update of practice nurses, GPs and practice staff.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Primary Care Partnership (PCP),
 - Development of a diabetes network group,
 - Through the roll out of Enhanced Primary Care (EPC) links to services established.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP diabetes management in GP,
 - International Diabetes Institute,
 - Annual cycle of care,
 - Practice Incentive Payment (PIP) and Service Incentive Payment (SIP) incentives.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
Annual cycle of care chart.

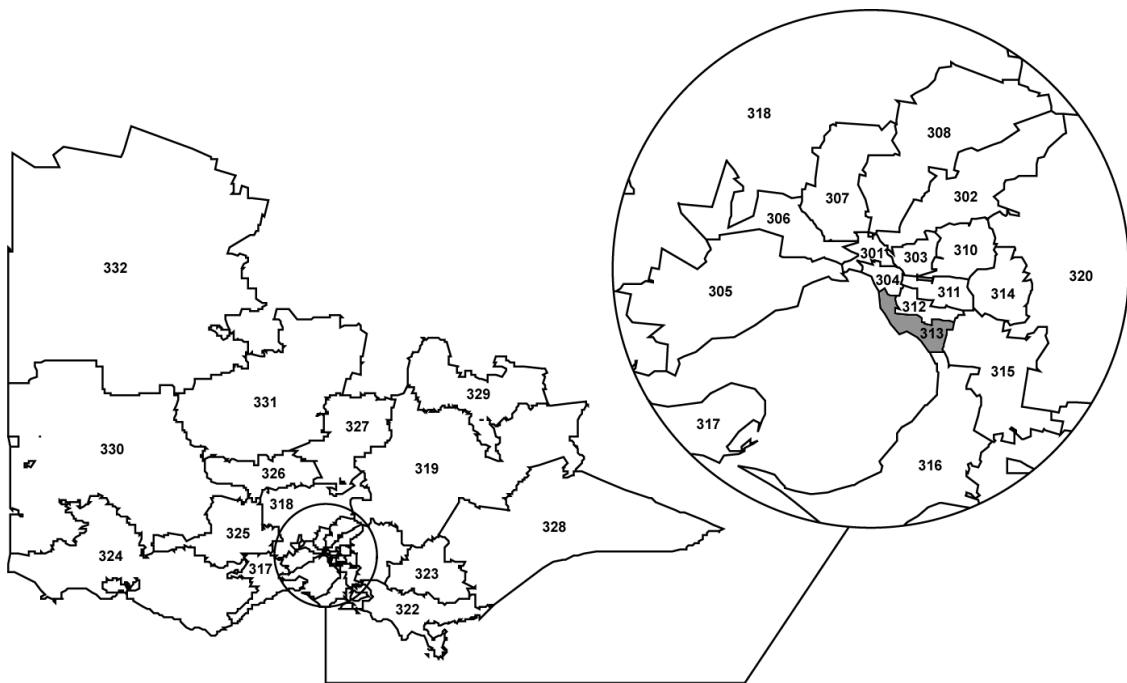
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
Patient education resources.

- What resource materials do you provide to practices?
Some RACGP diabetes management in General Practice.

Division Contact Person/
Program Co-ordinator

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Central Bayside DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	164,066	
■ Aboriginal or Torres Strait Islander	262	0.2%
■ Speaks language other than English at home	27,367	16.7%
■ RRMA classification ¹		
1: Capital city	164,066	100.0%
■ SEIFA category containing population median: ²	9	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9784	8.7%
■ High blood pressure ⁴	36,506	32.3%
■ High blood cholesterol ⁵	59,125	52.3%
■ Obese or overweight ⁶	68,146	60.2%
■ Physical inactivity ⁷	46,219	40.9%
■ Smoking ⁸	20,827	18.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

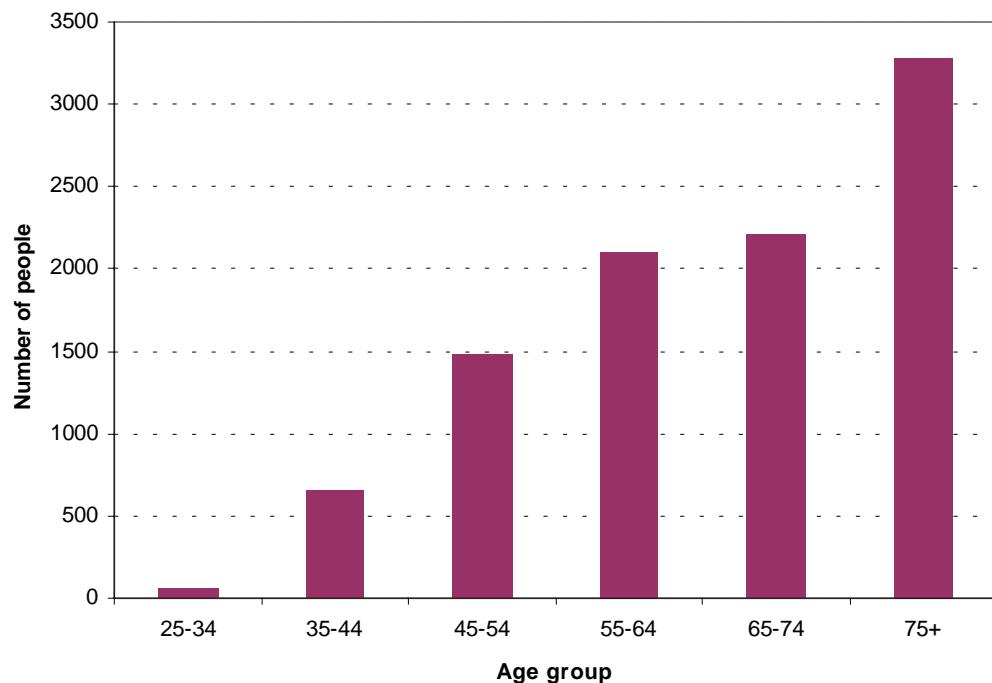
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

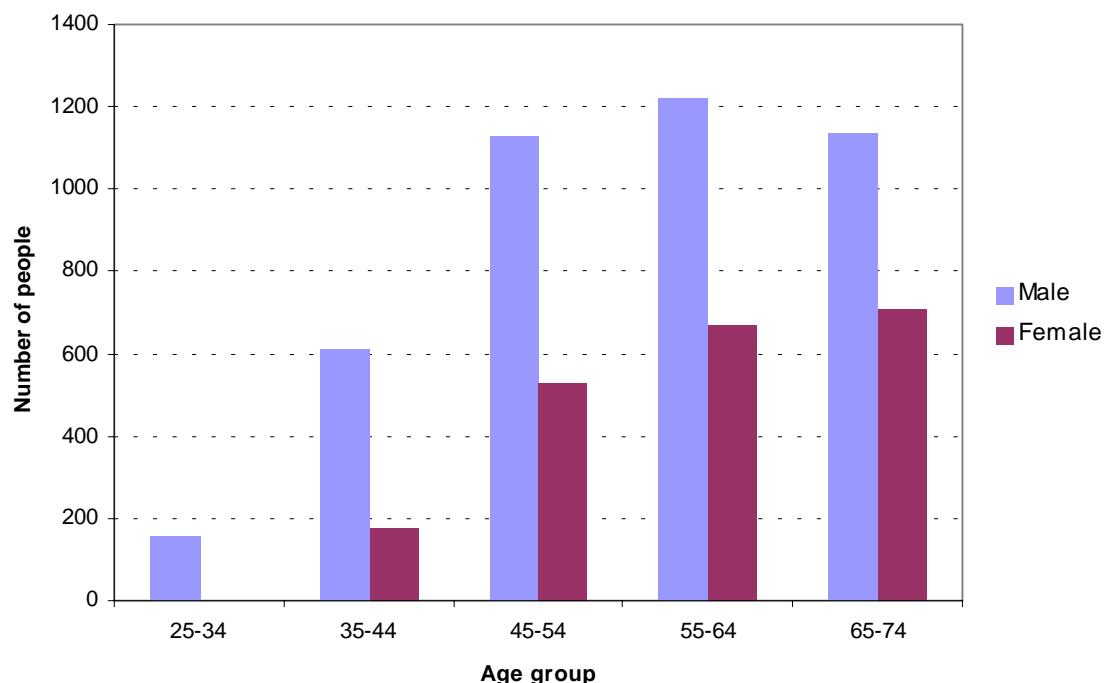
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



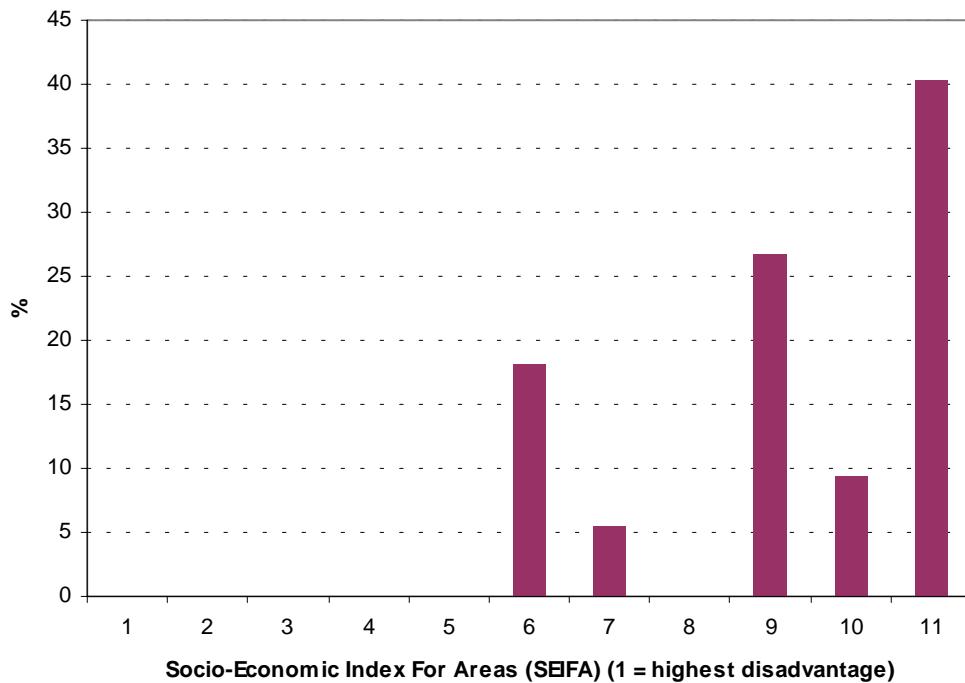
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

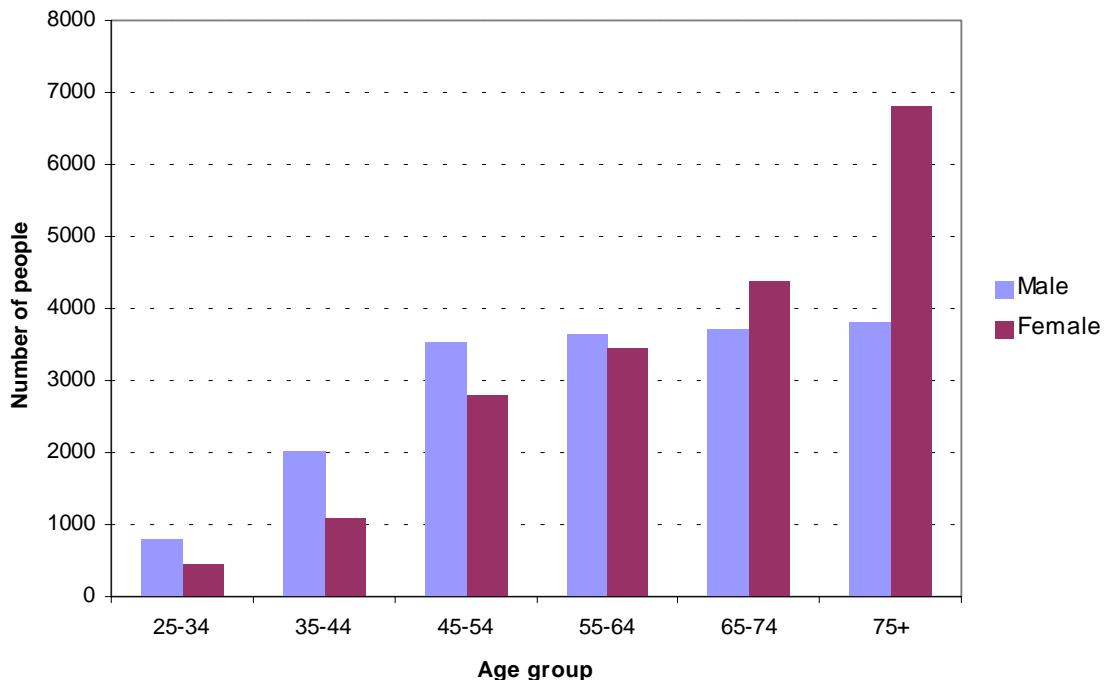
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

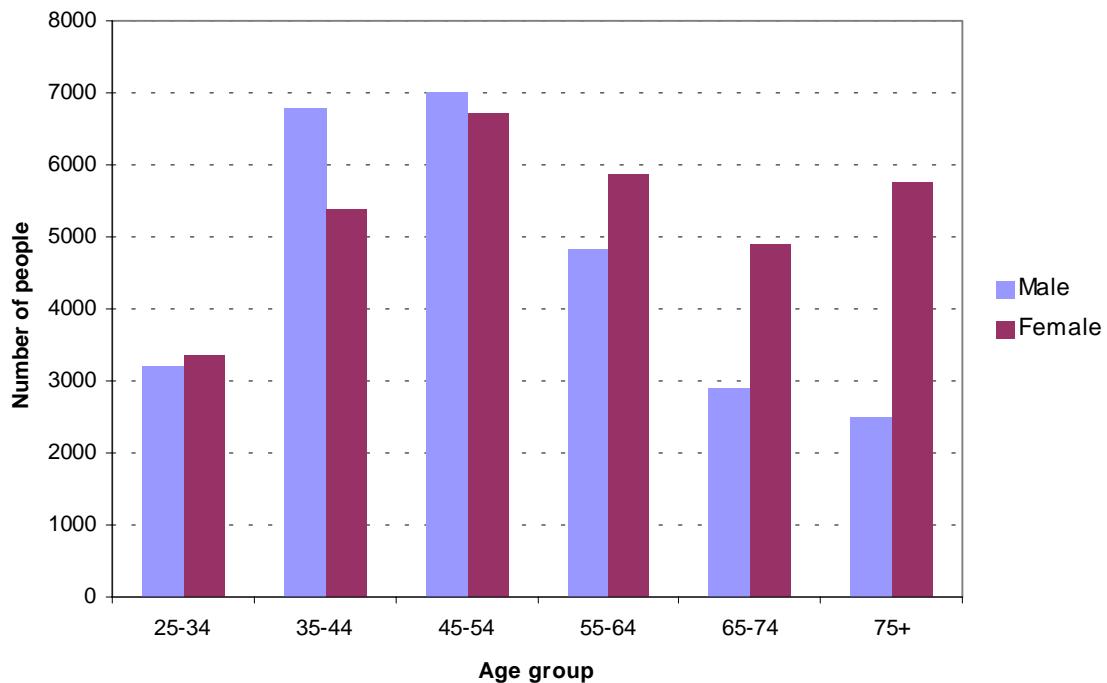
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



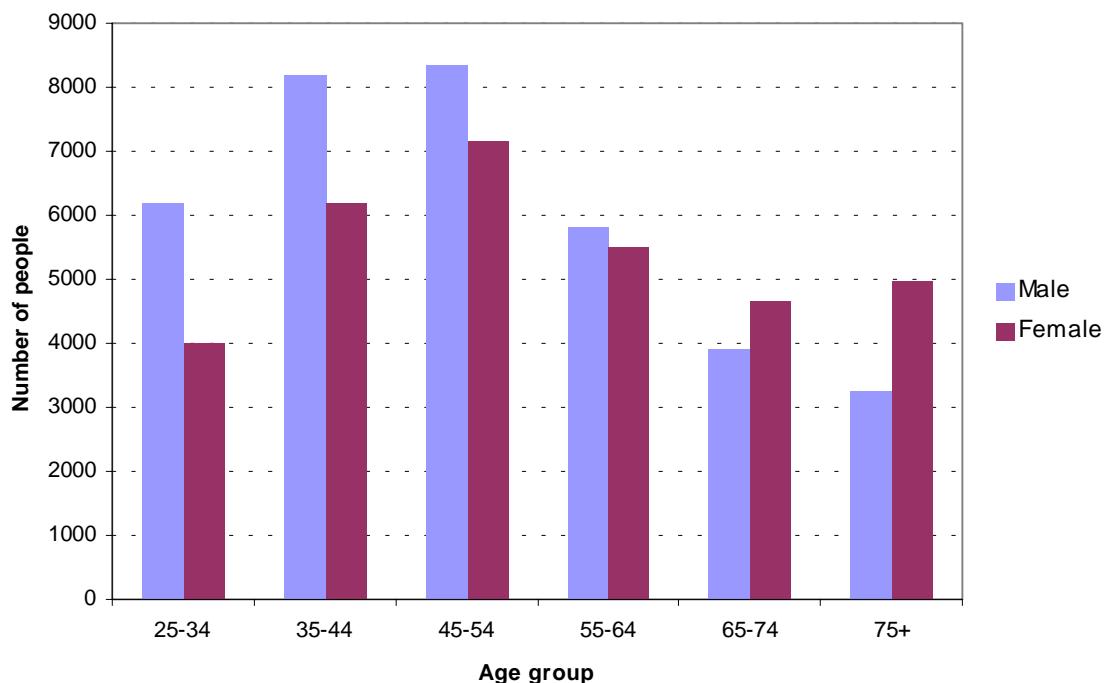
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



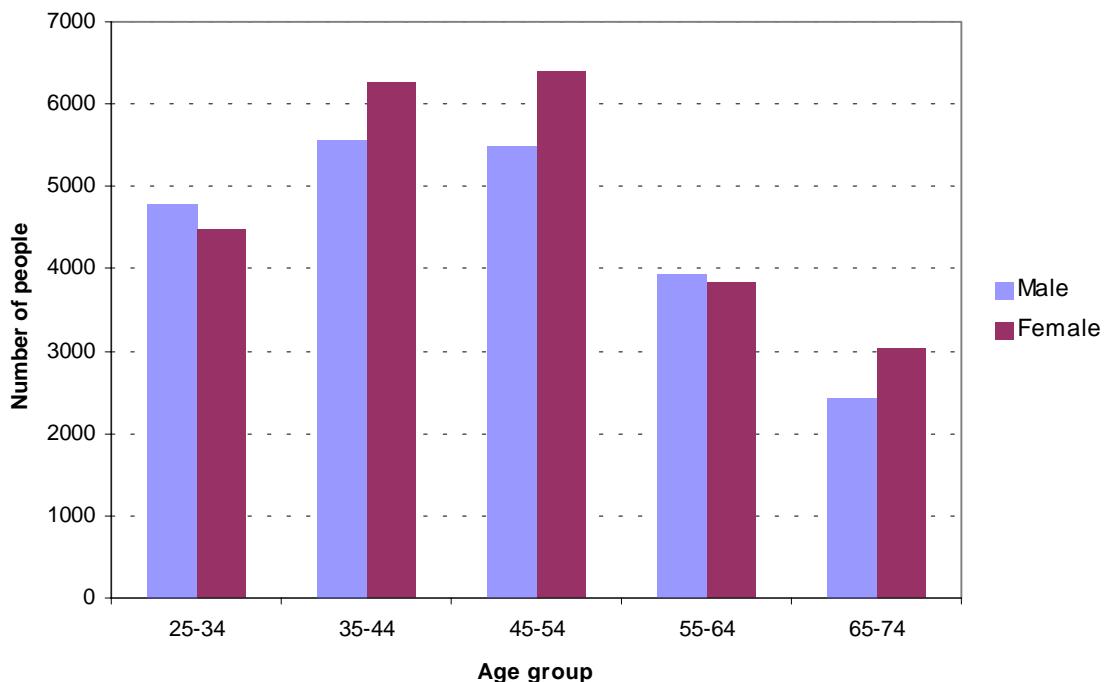
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



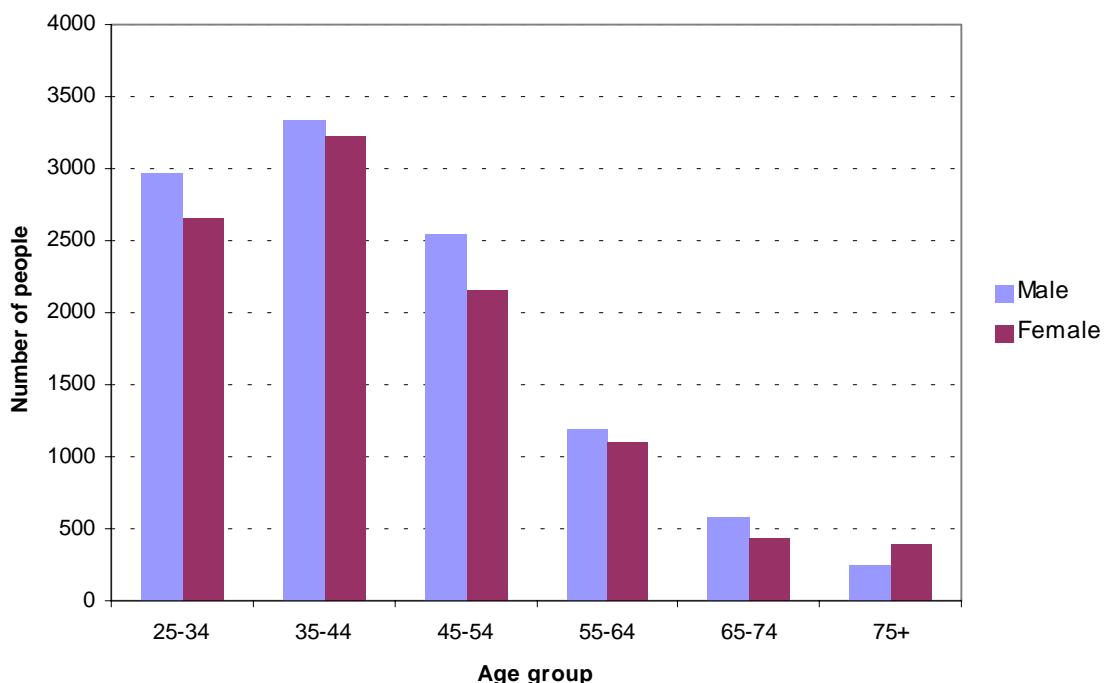
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 197 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Podiatry,
 - Ophthalmology/Optometry,
 - Community Health Centres,
 - Dietitians,
 - Nutritionists,
 - International Diabetes Institute (Caulfield).

- What services are needed but are not available in your Division area?

There is anecdotal evidence that the waiting lists in Community Health Centres are extremely long for: podiatry, dietitians, nutritionists, diabetes education.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

- 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Our program is focused on the chronic disease initiatives which involves implementation of the following education activities:

- Academic detailing National Prescribing Service (NPS) visits on diabetes management,
- Small groups (diabetes module to be rolled out shortly),
- Use of targeted data (clinical audit),
- Practice nurse and staff networks (education),
- Large groups Continuing Professional Development (CPD),
- Division wide material (newsletters),
- IT/IM support for register/recall systems.

Division Perspective

- What have been the major achievements or highlights of your program so far?

- The participation in small group learning with approximately seventy percent of the GPs within the Division involved,
- Ninety five percent of practices have signed on for the diabetes initiative.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Staff Resources: The Division is running a chronic diseases program so diabetes is part of a larger, integrated program. We have a quality practice coordinator and education consultants.
 - Complex Messages: GPs are being inundated with new initiatives including the Enhanced Primary Care package and the chronic disease initiatives. How they impact on one another is important in the context of general practice. A source of difficulty for GPs is determining when it is best to initiate a care plan versus an annual cycle of care.
 - Annual cycle of care can be too prescriptive.
 - Financial burden on patients, eg 6 monthly podiatry can be expensive and not affordable to some patients.
- What future plans do you have for diabetes management in your Division?
 - Small group learning: We have devised a diabetes module to address management of diabetes.
 - Promote consistent Information Management (IM) practices to identify, manage and monitor the care of patients with chronic diseases, eg coding, recall, pathways.
 - Education on diabetes for practice staff (eg managers, nurses, allied health) to meaningfully participate in integration activities at the local level.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - We have systems in place, which involve practice managers and practice nurse networks. One of the aims is to provide education around diabetes to facilitate the uptake of the chronic disease initiatives by a practice.
 - Strong IT/IM support to assist with many aspects of the diabetes initiative. Strong division staff support (a Program Coordinator).

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Primary Care Partnership (PCP): Collaboration fostered through meetings with PCPs, key stakeholders and workshops.

We are also managing joint projects with external stakeholders and have forged relationships with the Pharmacy Guild.

Through the Division, the Falls Prevention Collaboration project has developed bi-lateral agreements with community service agencies. These relationships could provide opportunities for future collaborations.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- RACGP Diabetes Management Guidelines,
- International Diabetes Institute (IDI),
- Diabetes Australia,
- Medical Director,
- National Prescribing Service (NPS) resources,
- Enhanced Primary Care (EPC),
- Program information from other Divisions,
- Information from DoHA regarding the chronic disease initiatives,
- State based organisations – GPDV.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Once evaluated, the Division would be willing to share the diabetes module for small group learning.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Collection of data for the Division's records from register/recall is limited.

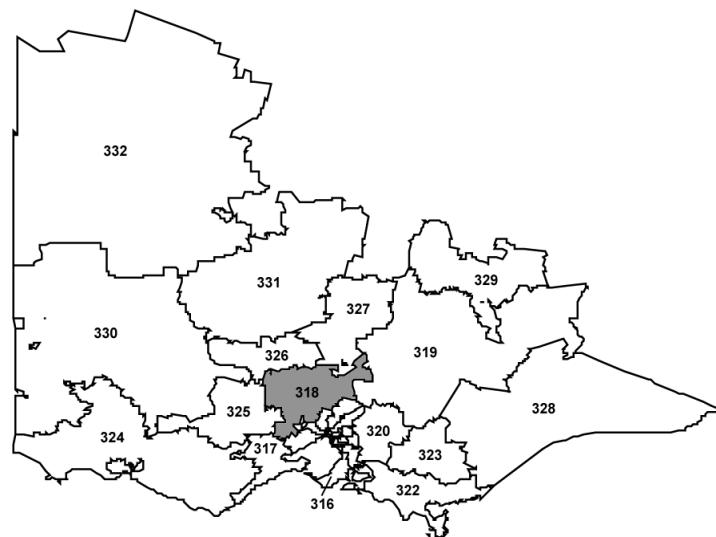
- What resource materials do you provide to practices?

- Staff,
- Time,
- IT/IM,
- Academic detailing on management of diabetes (NPS),
- Practice nurse/manager education,
- Guideline dissemination,
- Care planning templates.

Division Contact Person/
Program Co-ordinator

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Central Highlands DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	144,498	
■ Aboriginal or Torres Strait Islander	766	0.5%
■ Speaks language other than English at home	8469	5.9%
■ RRMA classification ¹		
1: Capital city	55,054	38.1%
5: Other rural	89,444	61.9%
■ SEIFA category containing population median: ²	8	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6,220	7.0%
■ High blood pressure ⁴	24,216	27.2%
■ High blood cholesterol ⁵	45,296	50.8%
■ Obese or overweight ⁶	53,230	59.7%
■ Physical inactivity ⁷	38,898	43.6%
■ Smoking ⁸	17,856	20.0%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

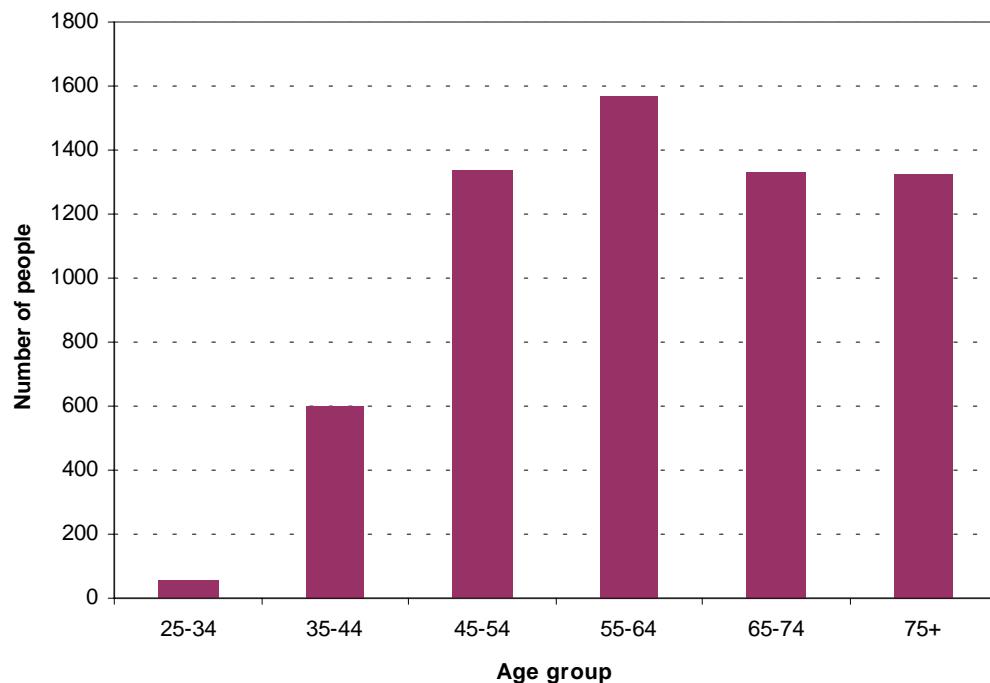
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

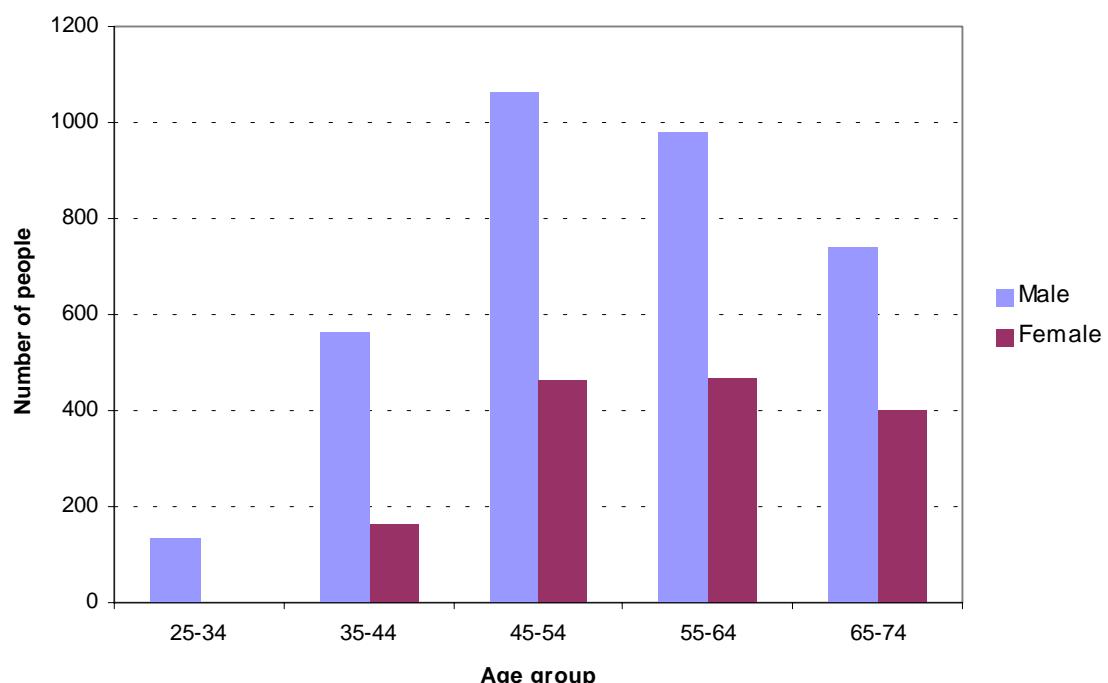
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



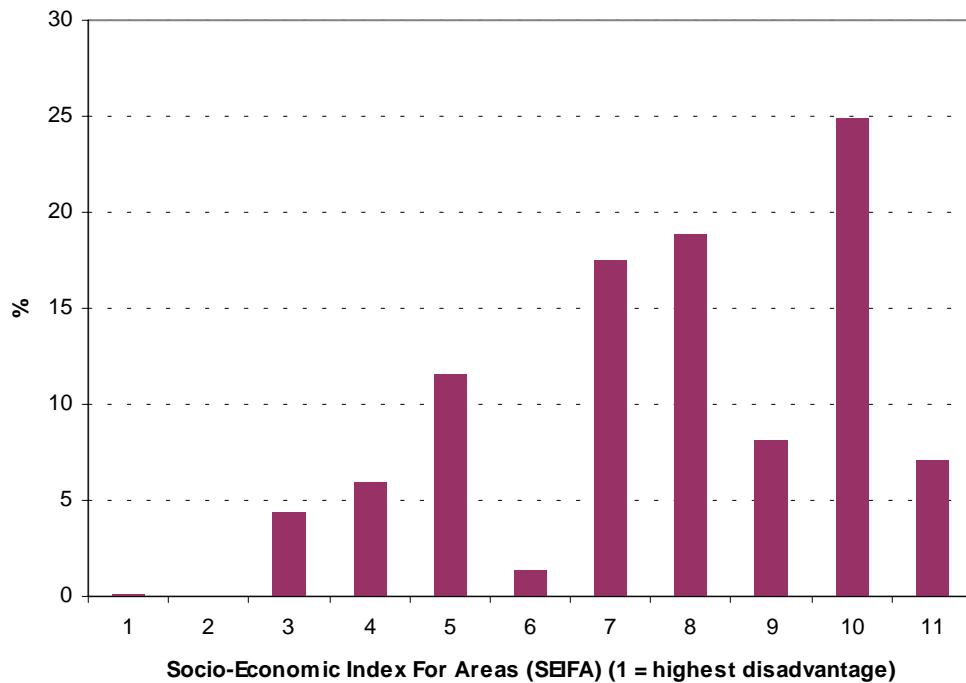
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

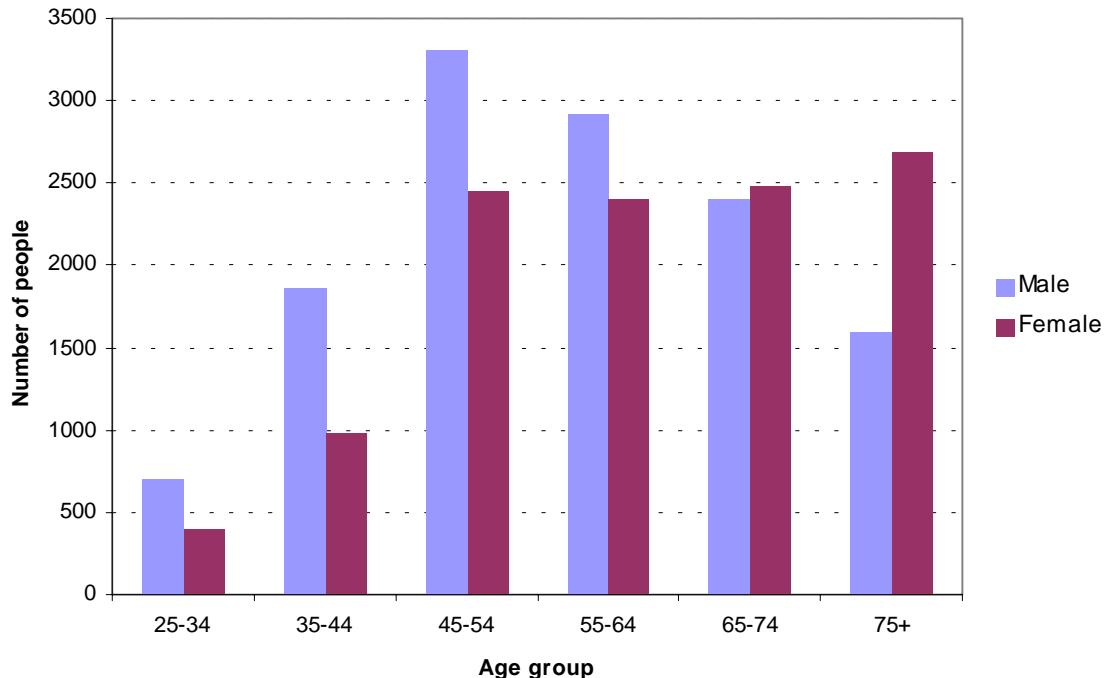
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

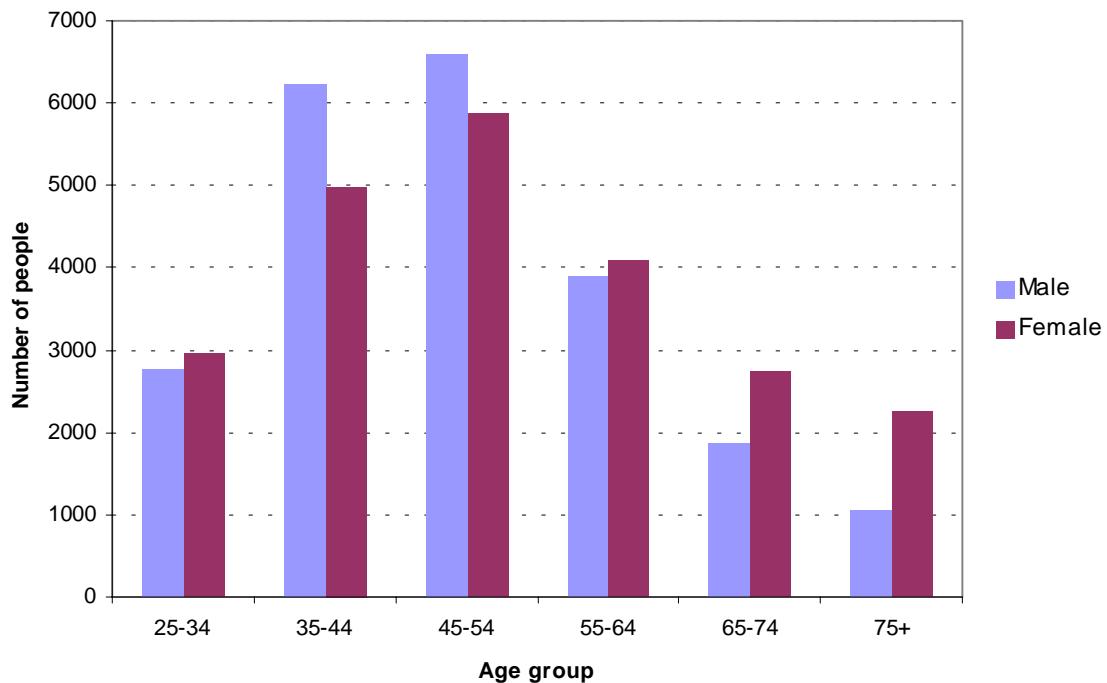
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



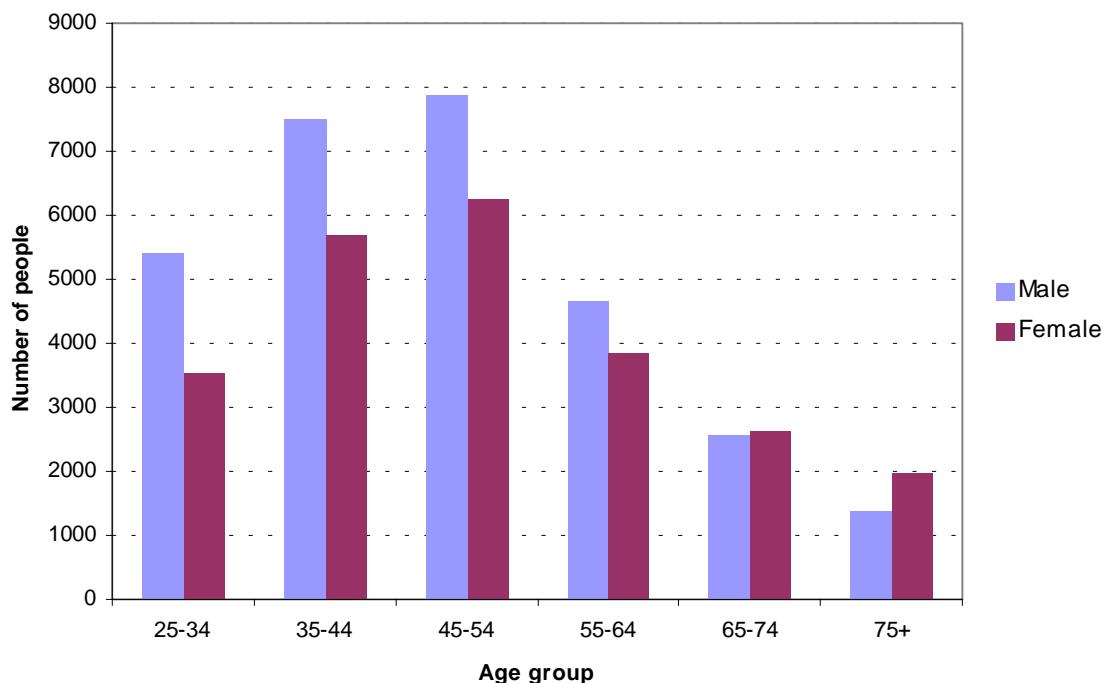
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



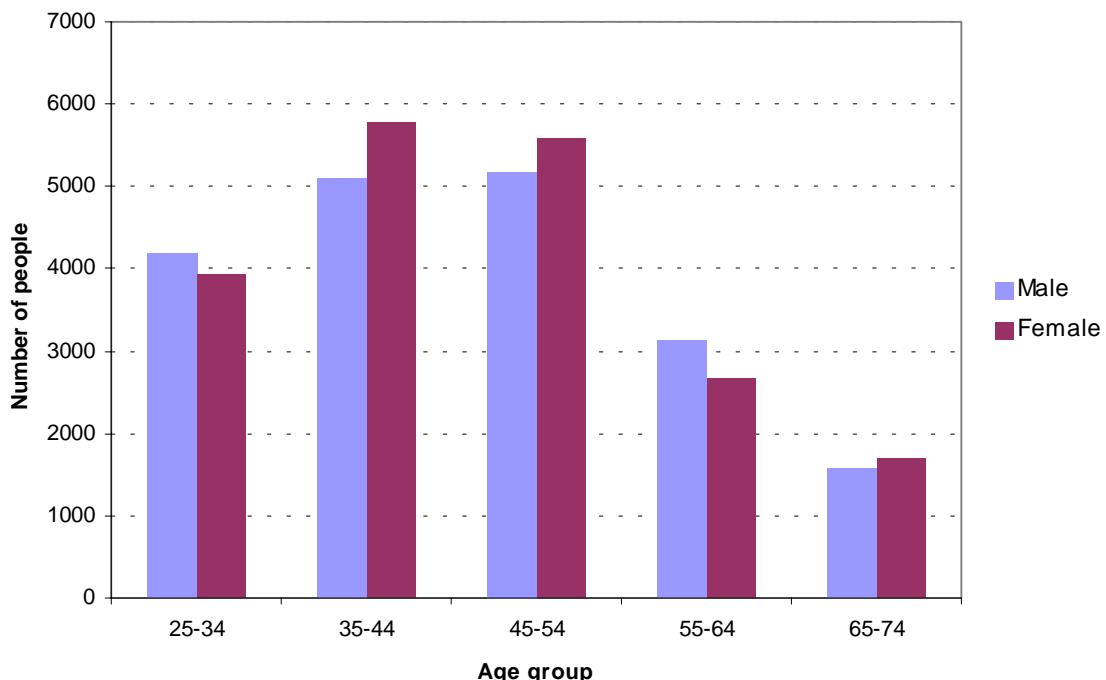
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



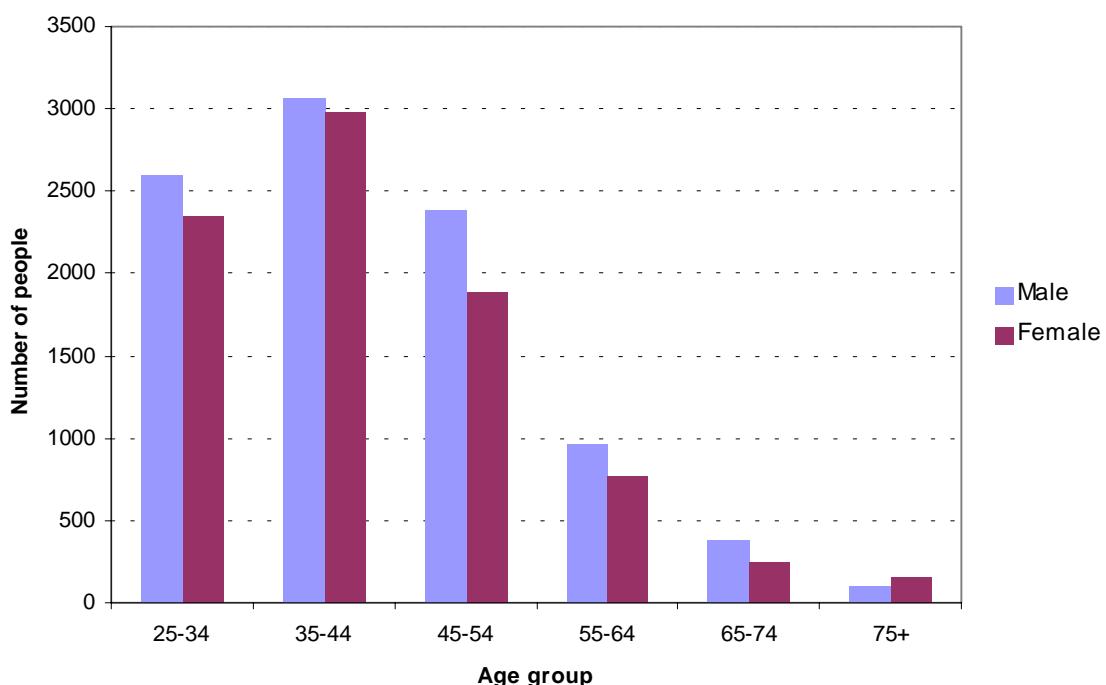
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area | Total | 176 |
|-------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Seven community health services,
 - Four public hospitals,
 - One private hospital,
 - Diagnostic referral services (private – outreach echocardiography and stress electrocardiogram).

- What services are needed but are not available in your Division area?
 - No coronary care beds in Division.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your CVD program including any changes that occurred over time?

A one-off program funded by the Department of Health and Ageing (DOHA) that delivered 47 multidisciplinary heart health clinics in towns of 5000 or less.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Involvement of Aboriginal community,
 - Involvement of clients of Psychiatric Disability Support Services (PDSS),
 - Involvement of regional employers,
 - Fifty percent of clinic participants modified their CVD risk factors in a moderate or major way.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Were unable to continue the model utilised without dedicated funding.

- What future plans do you have for CVD management in your Division?
 - Working with local Primary Care Partnerships (PCPs) around service coordinator and Enhanced Primary Care (EPC) for sustainability,
 - Improving GP systems to increase prevention activities within practices.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Changing GP systems to improve prevention and management should be undertaken in conjunction with community-based activities targeting vulnerable groups.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Services were delivered by six community health services and one Aboriginal health service. Clinic participants were recruited through regional employers, community groups, a PDSS and Aboriginal community members. Links were developed through face to face communication and establishing credibility over time.

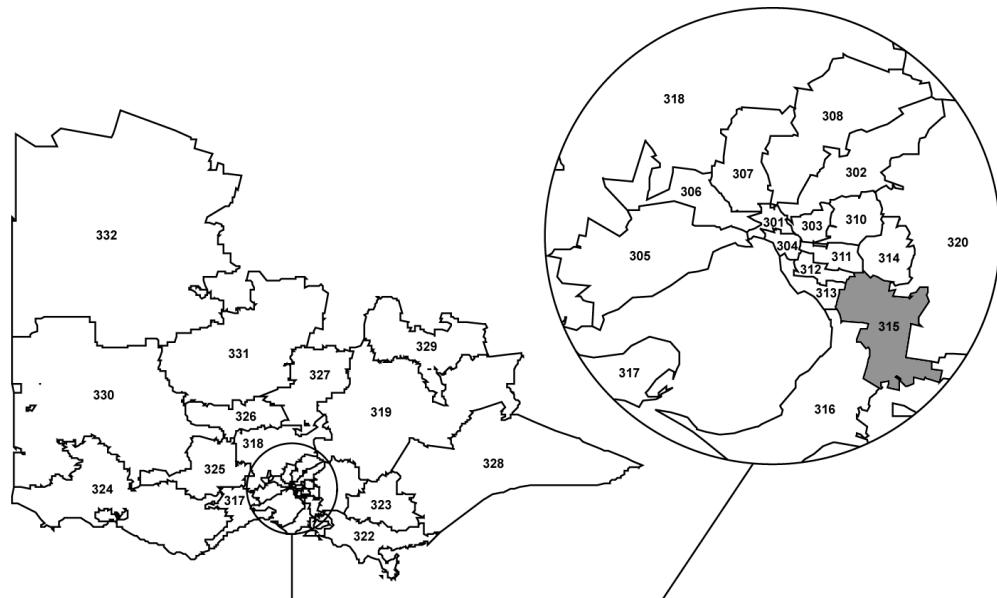
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation (NHF) literature,
 - EPC guidelines,
 - Active Script resources.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Clinic ads,
 - Proformas,
 - Surveys.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? N/A.

Division Contact Person/
Program Co-ordinator

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Email: gabi.bini@chdgp.com.au

Dandenong DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	266,763	
■ Aboriginal or Torres Strait Islander	1276	0.5%
■ Speaks language other than English at home	81,631	30.6%
■ RRMA classification ¹		
1: Capital city	266,763	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	10,978	6.7%
■ High blood pressure ⁴	43,138	26.2%
■ High blood cholesterol ⁵	81,908	49.7%
■ Obese or overweight ⁶	97,352	59.1%
■ Physical inactivity ⁷	71,689	43.5%
■ Smoking ⁸	33,541	20.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity Survey; Australian Diabetes, Obesity & Lifestyle Report.

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication.

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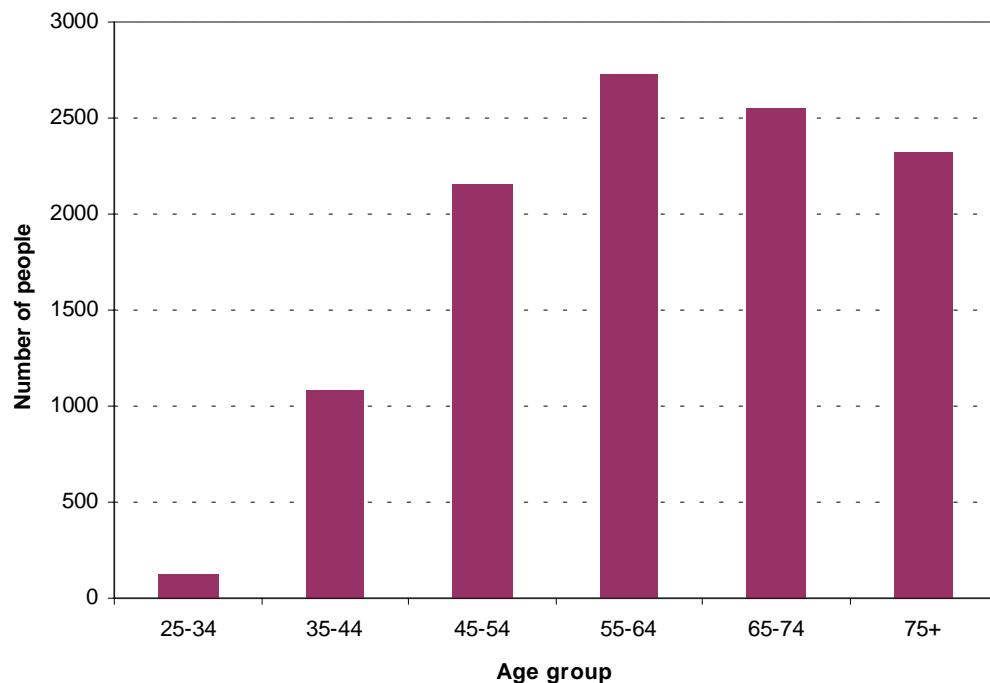
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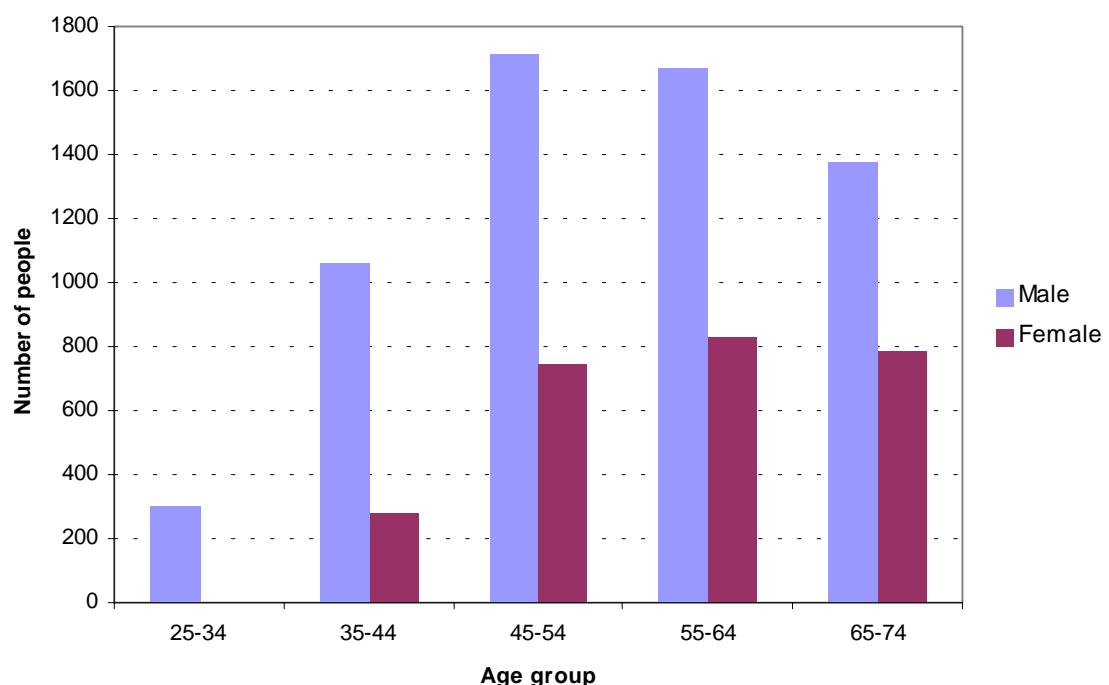
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



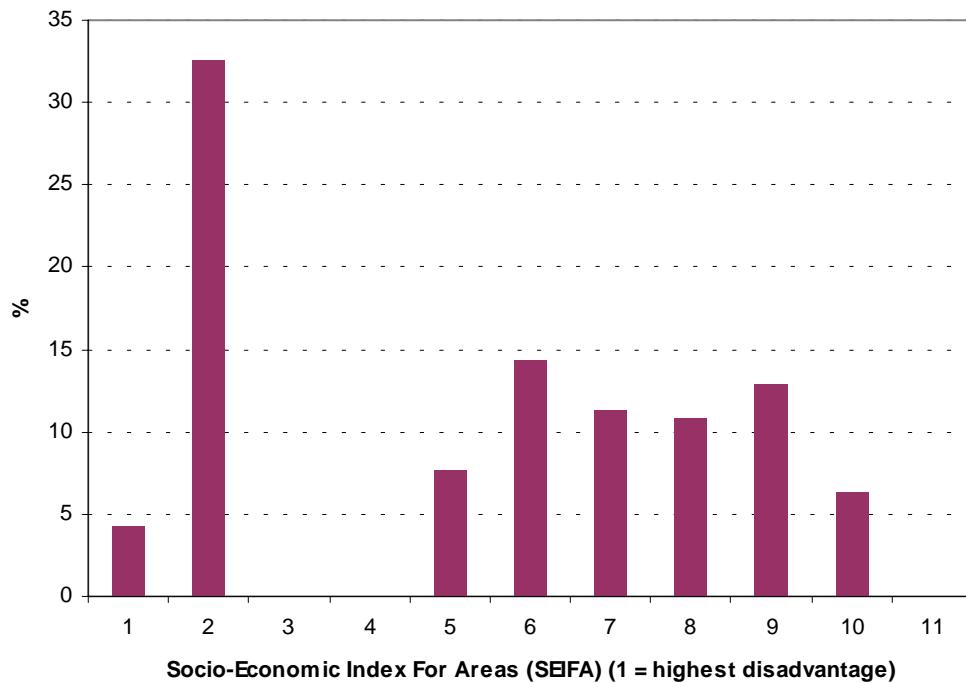
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Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

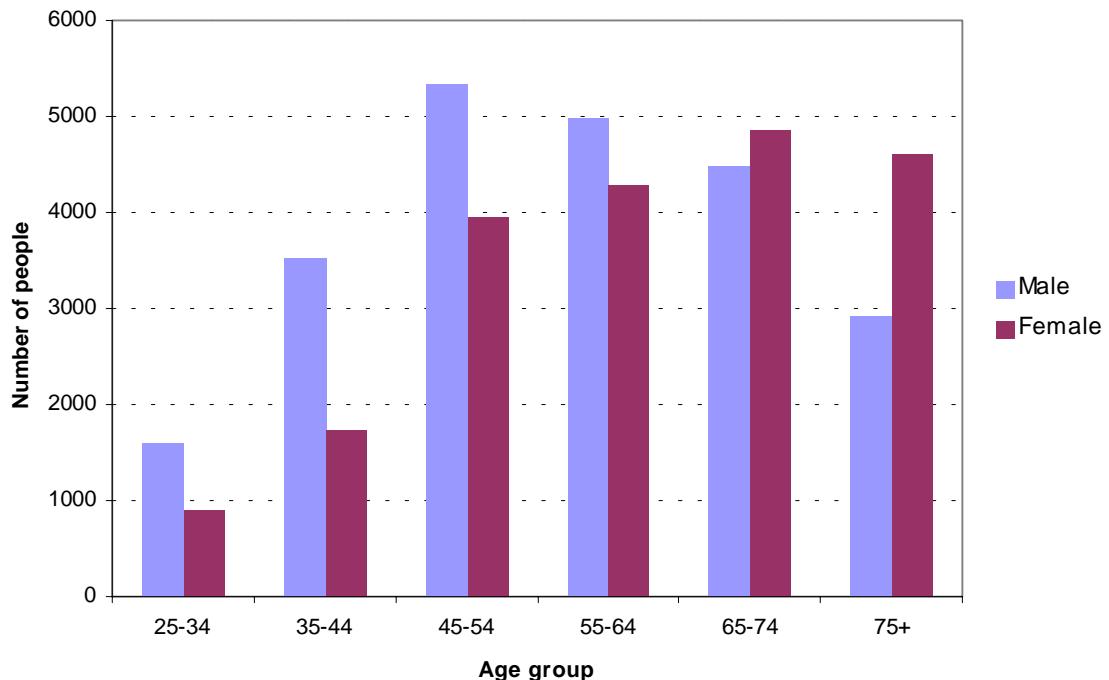
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

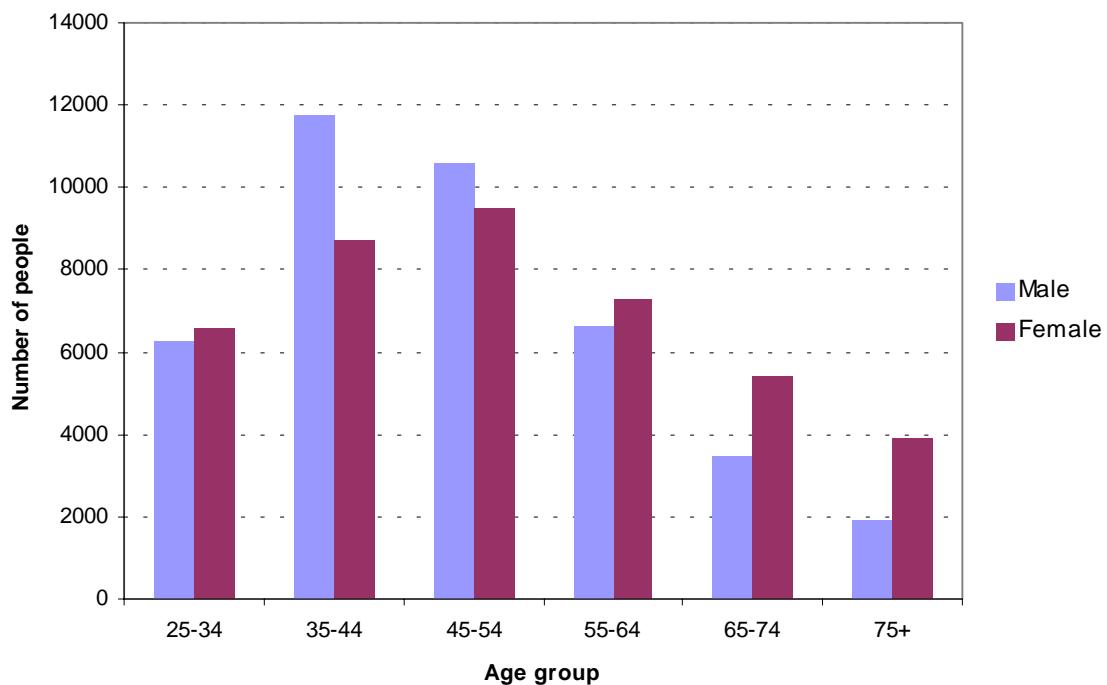
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



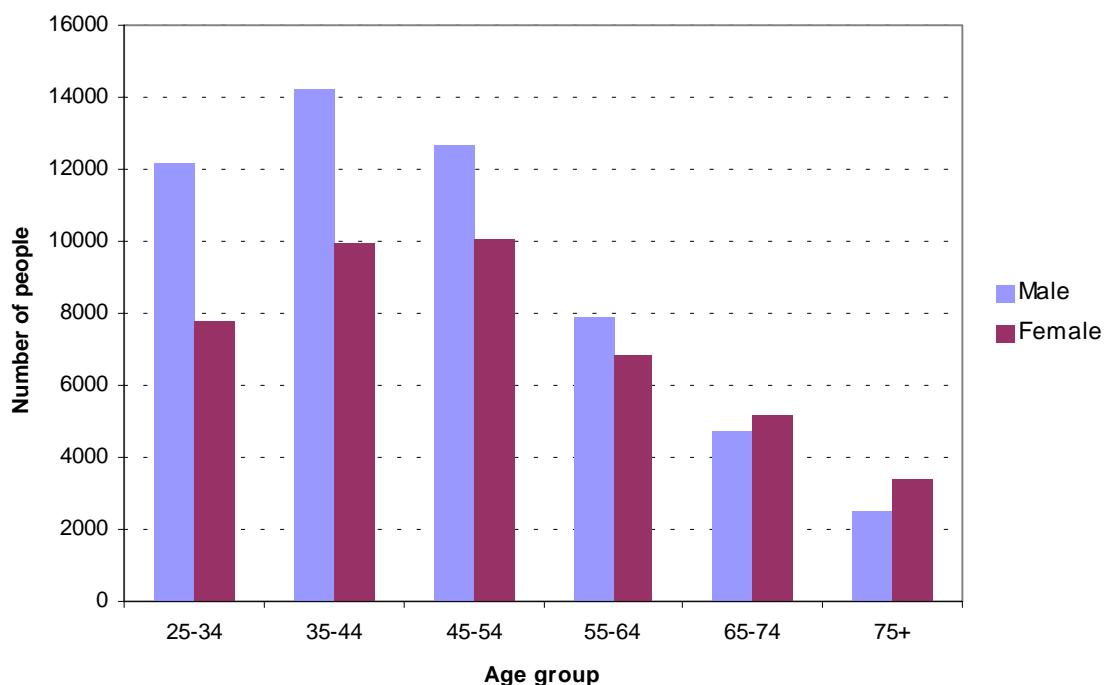
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



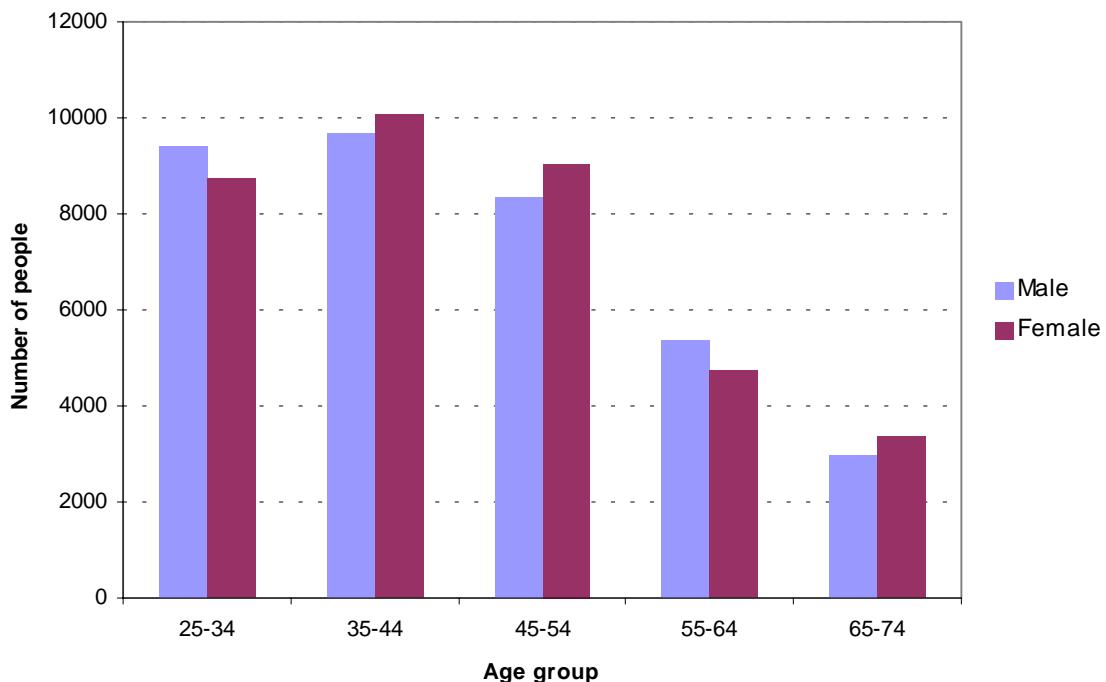
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



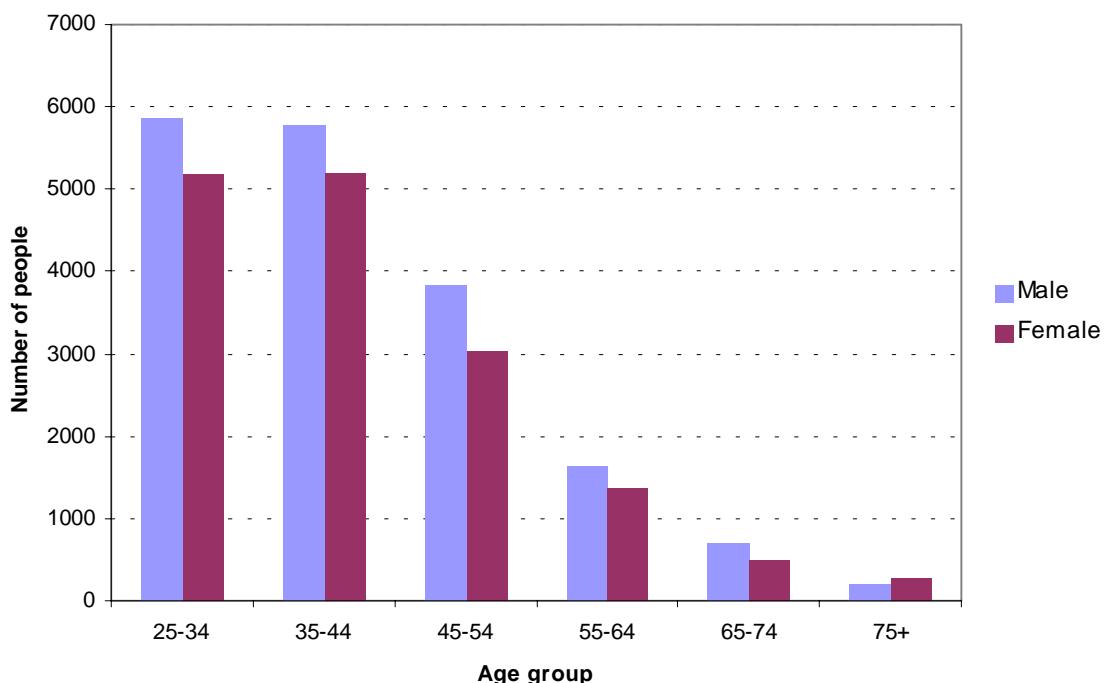
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 256 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Some private diabetes educators and dietitians,
 - Local endocrinologists,
 - Division is working collaboratively with the South East Primary Care Partnership – Integrated Disease Management – Diabetes Project. Diabetes Self-Management Program at Dandenong (Greater Dandenong Community Health Service) and Doveton (Casey Community Health Service) – no longer at Division. DCAS – Diabetes Coordination and Assessment Service is based at Division and involves staff.

- What services are needed but are not available in your Division area?
 - Diabetes education not available to entire Division area,
 - Lack of allied health professionals publicly funded,
 - Need more general services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input checked="" type="checkbox"/> 1992	<input checked="" type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - The Division has always provided ongoing Continuing Professional Development (CPD) events for GPs,
 - The Division has always been involved in community education activities,
 - The diabetes education program has included:
 - Individual consultation with diabetes nurse educator and dietitian,
 - Group education (5 week program),
 - First Steps Education (1 x 3 hour session),
 - Diabetes Self-Management Program (current).
 - Introduction of CARDIAB database,
 - Introduction of the Retinal Screening Project.

Division Perspective

- What have been the major achievements or highlights of your program so far?

More recently being involved in integrated services and education of GPs regarding new referral forms and procedures. GPs following CMG integrated service.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Electronic transfer of CARDIAB data not established which has less GPs using database.
- What future plans do you have for diabetes management in your Division?
 - Continued involvement in the CARDIAB diabetes project using PKI,
 - Conduct relevant CPD events,
 - Undertake education with GPs and practice staff re data collection and clinical management guidelines, Diabetes Annual Cycle of Care,
 - Involvement in community awareness activities, including those with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) groups.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Computerised,
 - Work well as team,
 - Have employed practice managers/nurses with clear responsibilities for recall/reminders and processes in place.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Linkages to local Community Health Centres both for patient referral and professional development.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - NSW Diabetes Management Guidelines,
 - Diabetes Australia information/International Diabetes Institute (IDI) information.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes Practice Incentive Payment (PIP) guidelines – on line access,
 - CARDIAB resources.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.

- What resource materials do you provide to practices?
 - Care planning tools on line,
 - Diabetes PIP guidelines on line.

Division Contact Person/
Program Co-ordinator

Name: Michelle Broadbent
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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Several cardiac rehabilitation services in both public and private centres,
 - Dietitians/physiotherapists available at local community health centres.

- What services are needed but are not available in your Division area?
N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Introduction of Active Script Program/Healthy Heart Patient education program (HHP ceased since),
 - Introduction of CARDIAB – CVD component,
 - Regular Continuing Professional Development (CPD) activities,
 - Working with Merck Sharpe Dome (MSD) Heart Care Program,
 - Working with local council/Community Health Centres/VicFit to establish local “Mall Walk”.

Division Perspective

- What have been the major achievements or highlights of your program so far?
Establishing local “Mall Walk” activity.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
Electronic transfer of data not established which has less GPs utilising CARDIAB.

- What future plans do you have for CVD management in your Division?
 - Implementing Active Script activities/support “Mall Walk”,
 - Promote CARDIAB register,
 - Provide CPD activities.

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
▪ What type of strategic alliances or linkages do you have with external organisations and how have you developed them? | N/A.

<ul style="list-style-type: none">• Developed a link with the Heart Care program (MSD) to provide dietitians advice to patients,• Developed link with local community health centres/council/shopping centre to establish “Mall Walk”. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

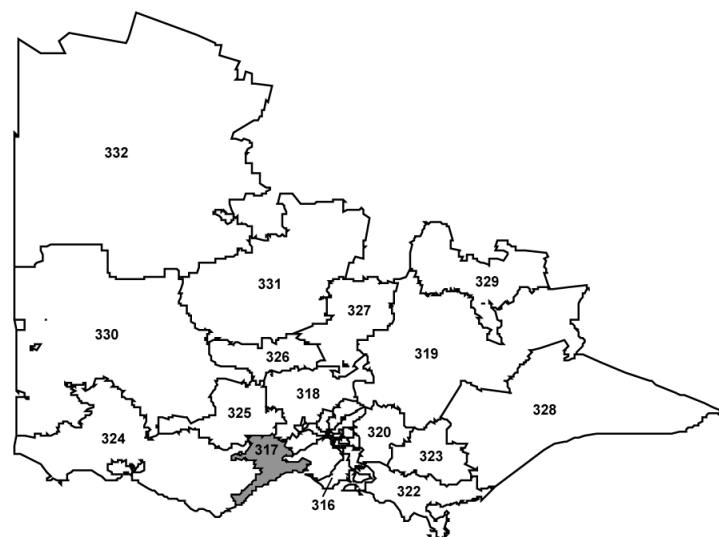
Division Resources

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
▪ What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
▪ What resource materials do you provide to practices? | <ul style="list-style-type: none">• National Heart Foundation (NHF) Risk Factor Management Guidelines,• NHF Information Sheets,• AHS/VICFIT/Active Australia resources on activity.
<p>CARDIAB register sheets.</p>
<p>N/A.</p>
<ul style="list-style-type: none">• Active Script resources,• Care Planning tools. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Division Contact Person/
Program Co-ordinator

Name: Michelle Broadbent
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Fax: 03 9793 4050
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General Practitioners Association of Geelong DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	207,167	
■ Aboriginal or Torres Strait Islander	1324	0.6%
■ Speaks language other than English at home	18,747	9.0%
■ RRMA classification ¹		
2: Other metro	157,033	75.8%
4: Small rural	27,760	13.4%
5: Other rural	22,374	10.8%
■ SEIFA category containing population median: ²	9	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,509	8.4%
■ High blood pressure ⁴	43,275	31.8%
■ High blood cholesterol ⁵	70,818	52.0%
■ Obese or overweight ⁶	82,244	60.4%
■ Physical inactivity ⁷	56,593	41.5%
■ Smoking ⁸	25,384	18.6%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

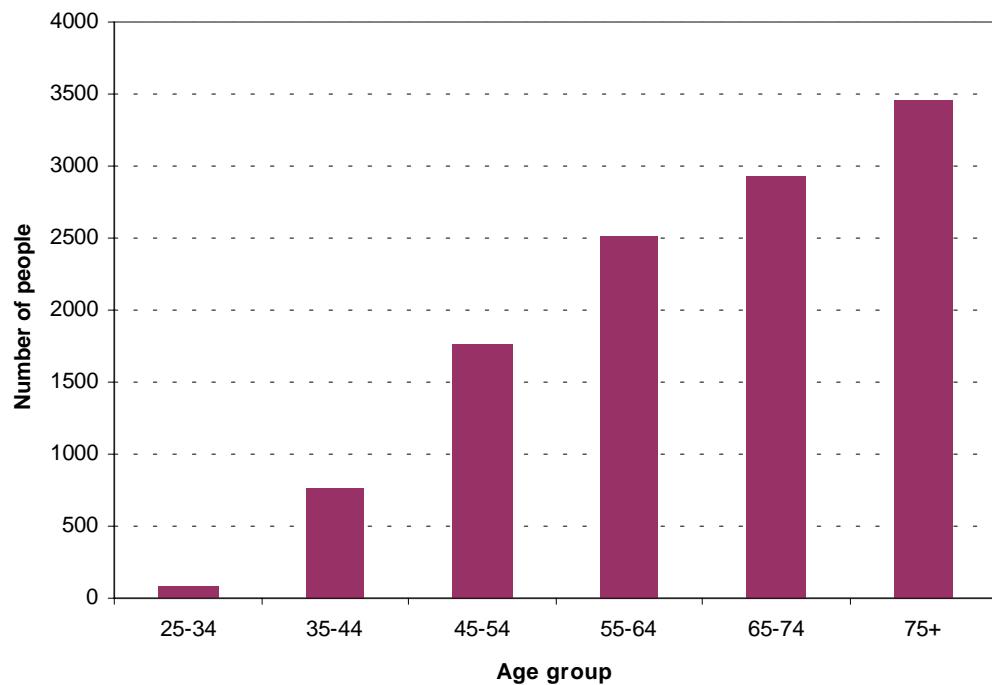
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

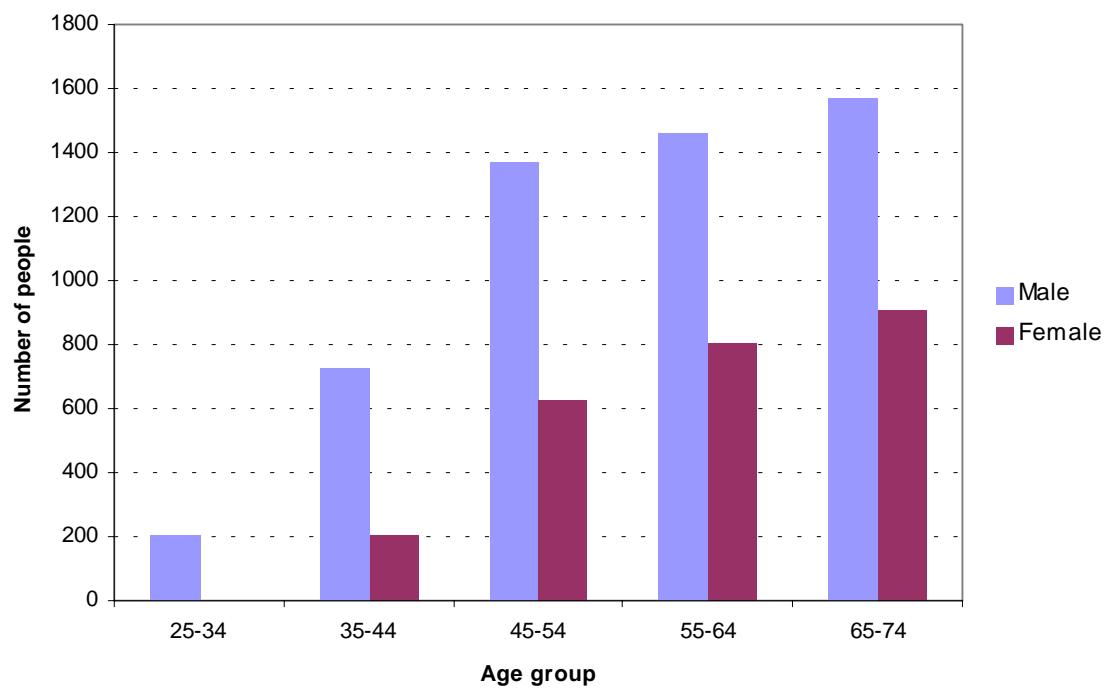
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



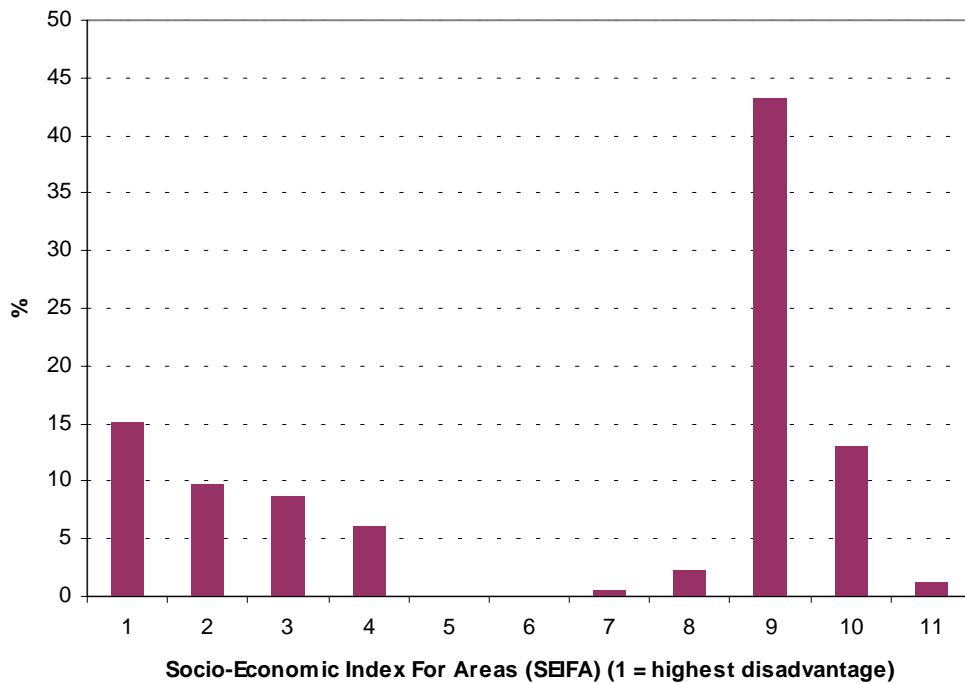
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

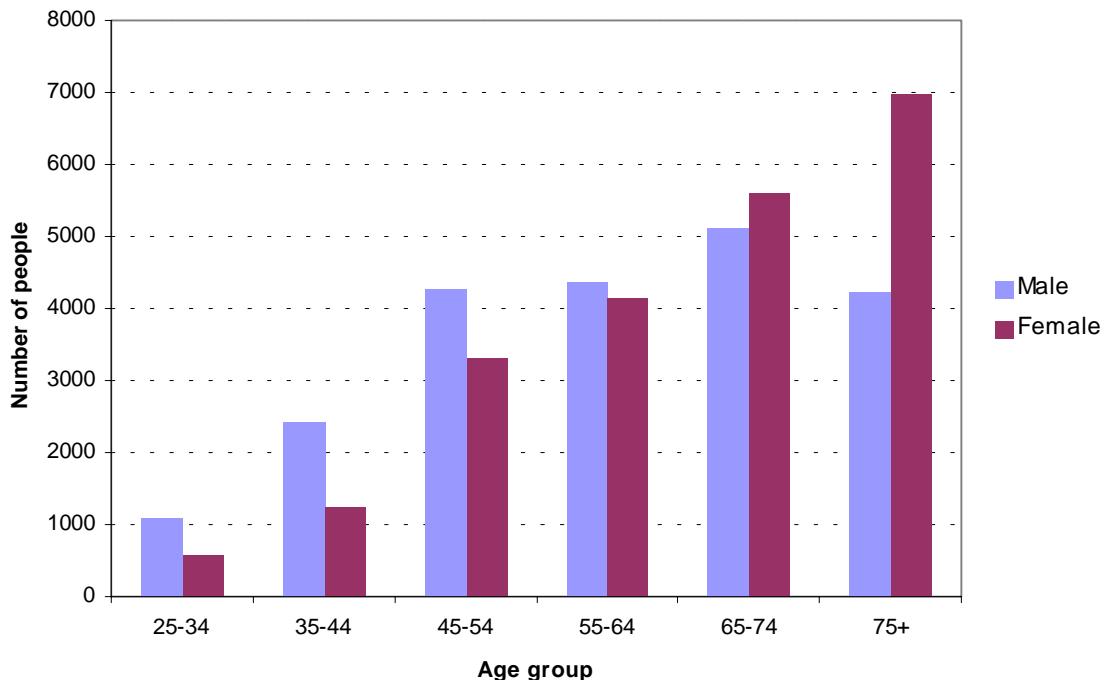
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

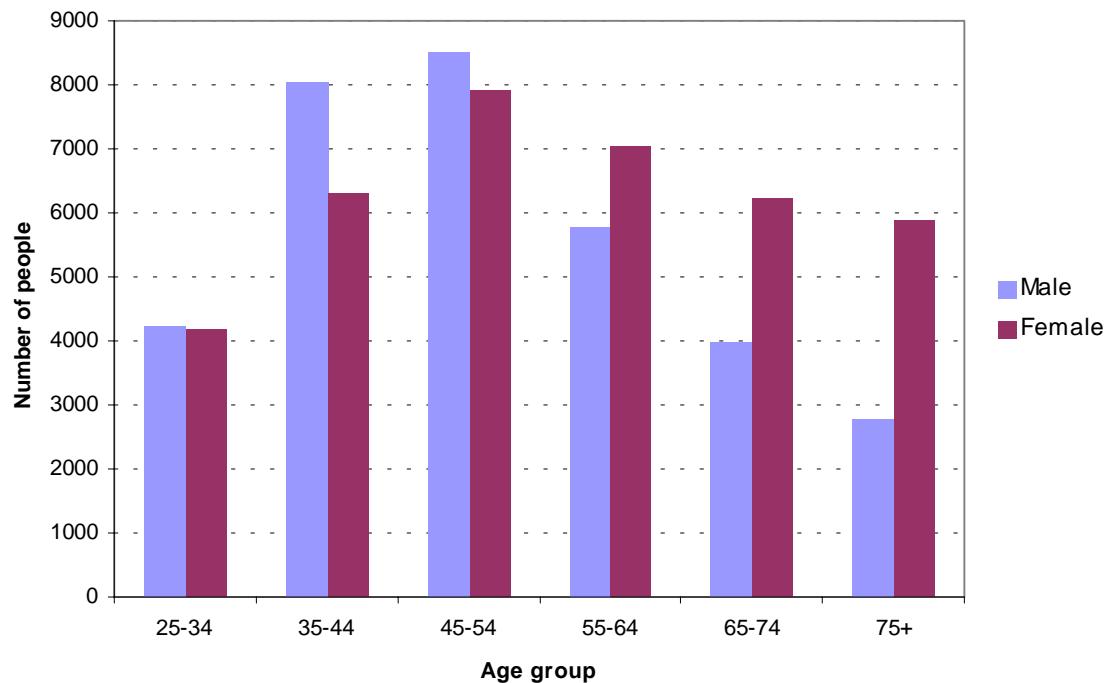
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



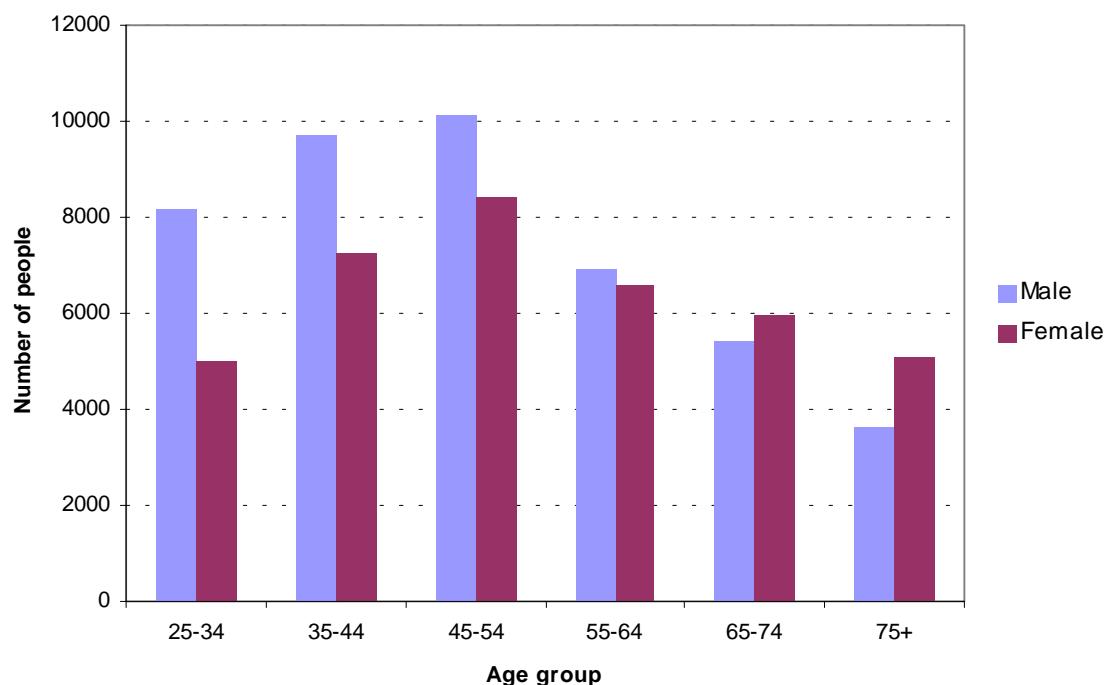
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



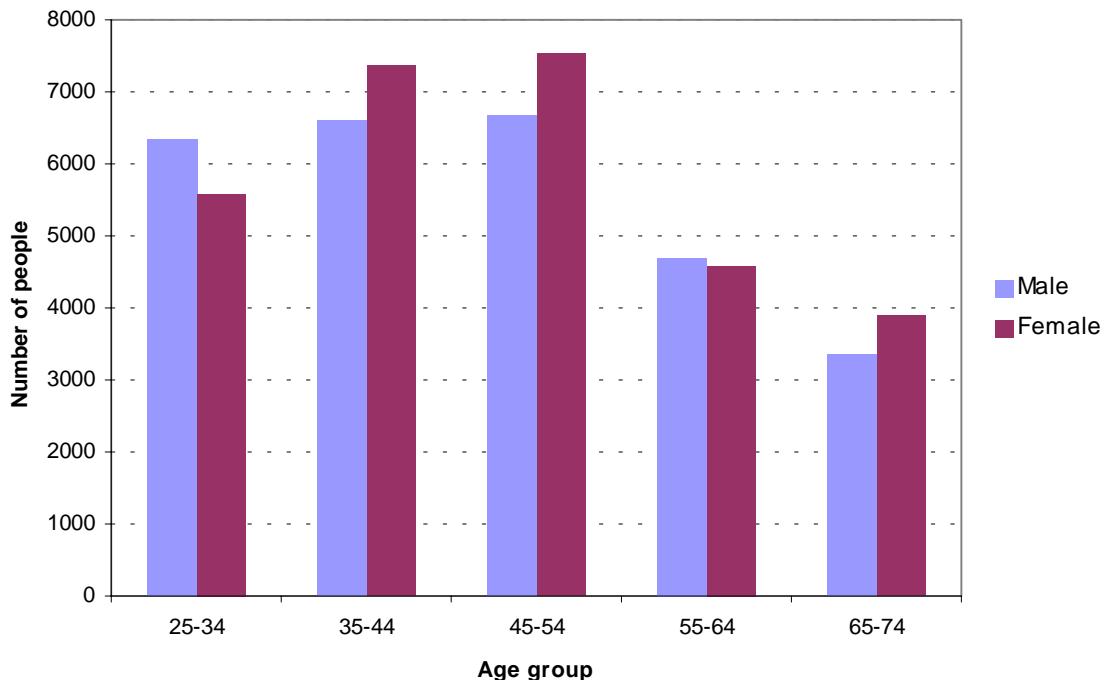
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



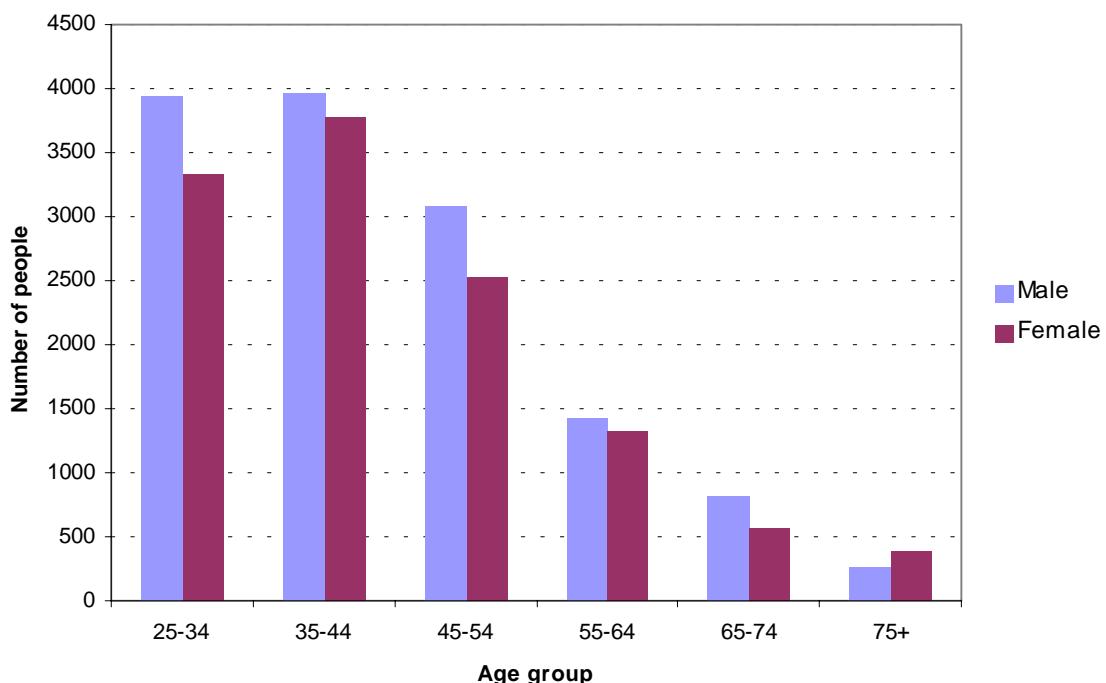
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 211 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Retinal camera service,
 - Diabetes referral centre,
 - Diabetes Australia,
 - Diabetes educators public/private,
 - Support groups – juvenile/older,
 - More Allied Health Service (MAHS) – diabetes education and podiatrists.

- What services are needed but are not available in your Division area?
 - The area is well serviced, but there is a lack of podiatrists, dietitians and diabetes educators in the public system.
 - Diabetes Australia has moved community services from a central location to three satellite areas, which has created confusion in the region, i.e. supplies/education sessions.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The GP Association of Geelong (GPAG) is committed to best practice guidelines for the regions GPs and community:

- The GPAG provides a retinal camera service in GP practices and ongoing upskilling for participating GPs,
- The GPAG provides ongoing education for practice nurses – half day workshops with diabetes educator/dietitian/podiatrist,
- More Allied Health Services (MAHS) to rural GPs, podiatrist/diabetes educator/dietitian,
- Funding for nurse practitioner pilot diabetes outreach service – residential care and development of clinical practice guidelines,
- Practice Incentive Payment (PIP) annual diabetes assessments, education and practice visits.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Retinal camera,
 - Numbers of GP and practice nurse attendees at workshops and requiring practice visits,
 - Participation in development of clinical guidelines for diabetes nurse practitioner project,
 - MAHS figures – 352 clients over 2001 – 2002.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Funding,
 - GP workforce shortage,
 - Staff increased workload.
- What future plans do you have for diabetes management in your Division?
 - Workshops for practice nurses/GPs/allied health staff,
 - Continuation of the retinal camera program and the MAHS program,
 - Visit all practices in the region, diabetes recall/reminder systems.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

N/A.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - GP Association and Diabetes Australia partnership Nurse Practitioner project. Funding auspice through GPAG, nurse practitioner candidate seconded from Diabetes Australia for ten hours per week. A representative from Diabetes Australia is on steering committee,
 - Barwon Health Diabetes Referral Centre, education workshops, collaboration with specialists,
 - Local diabetes support groups, GPs from GPAG speak at meetings on a range of topics,
 - Life Activities Club auspice by the GPAG weight resistance training program for those in the community with diabetes,
 - Bellarine Community Health Centre – use of podiatrist/diabetes educator through MAHS funding

Division Resources

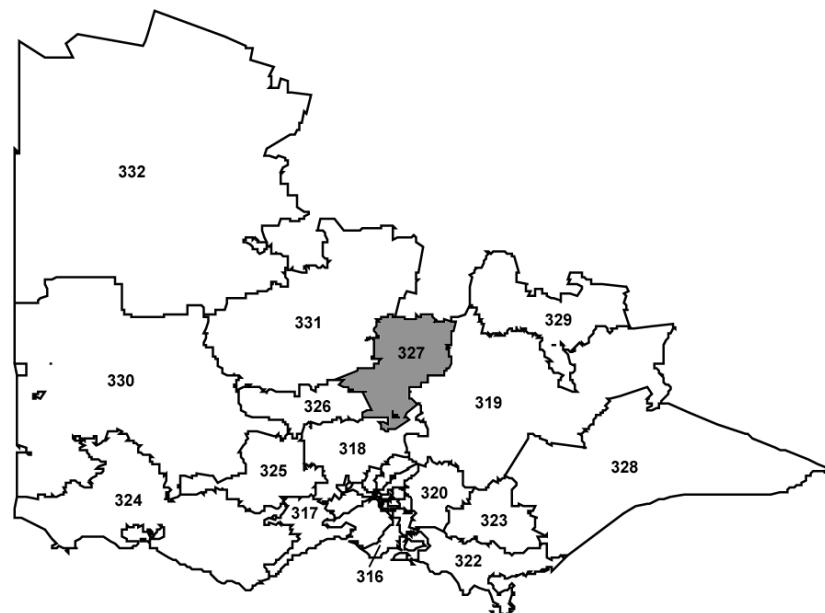
- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Recall/reminder Medical Director,
 - Diabetes Australia,
 - Australian Diabetes Institute,
 - Publications through medical journals,
 - RACGP guidelines,
 - Other Division's web sites.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Weight resistance training leaflets for community and general practice,
 - Resources for GPs and community retinal camera.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Dedicated project officer for diabetes to research and educate due to financial restraints.
- What resource materials do you provide to practices?
 - GPAG purchased copy of RACGP/Diabetes Australia Clinical Guidelines 2002 for each GP/practice nurse,
 - Library at GPAG practice staff/GPs may borrow,
 - PIP annual diabetes cycle easy reference guide,
 - Care plans/case conferencing reference guide.

Division Contact Person/
Program Co-ordinator

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Email: division@gpageelong.com.au

Goulburn Valley DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	96,542	
■ Aboriginal or Torres Strait Islander	1881	1.9%
■ Speaks language other than English at home	6982	7.2%
■ RRMA classification ¹		
3: Large rural	34,755	36%
5: Other rural	61,787	64%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5116	8.3%
■ High blood pressure ⁴	19,358	31.3%
■ High blood cholesterol ⁵	32,140	51.9%
■ Obese or overweight ⁶	37,516	60.6%
■ Physical inactivity ⁷	26,039	42.0%
■ Smoking ⁸	11,676	18.9%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

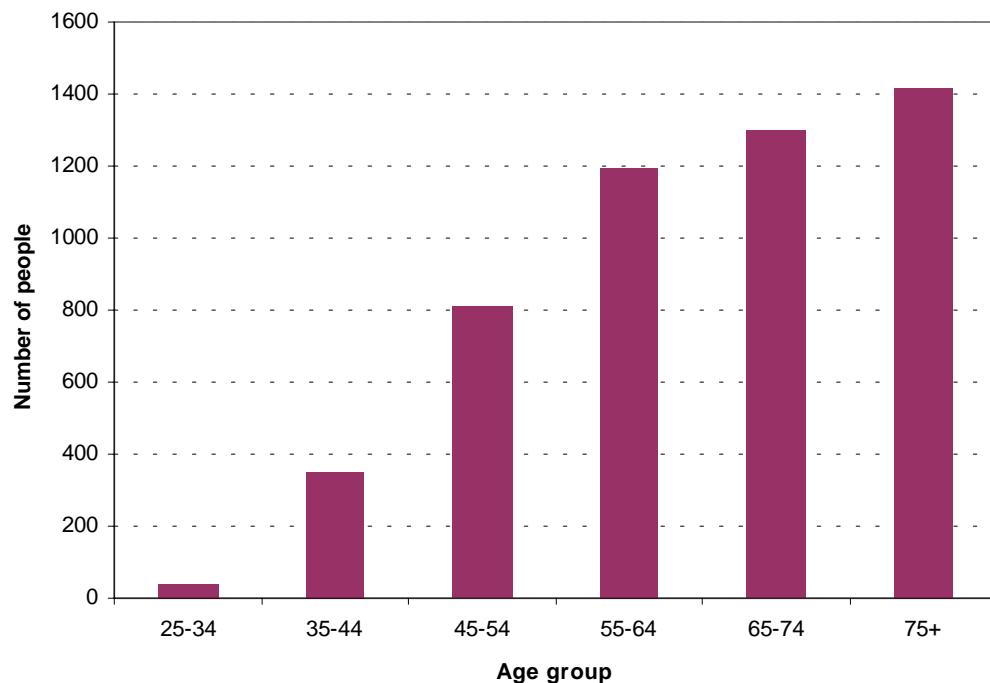
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

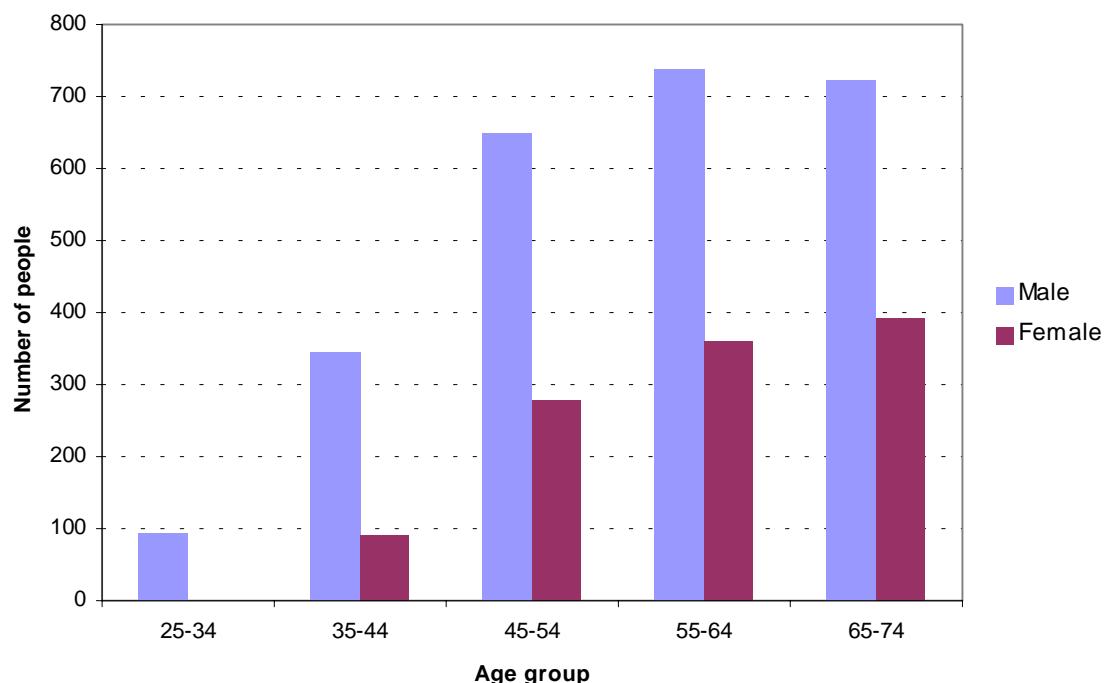
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



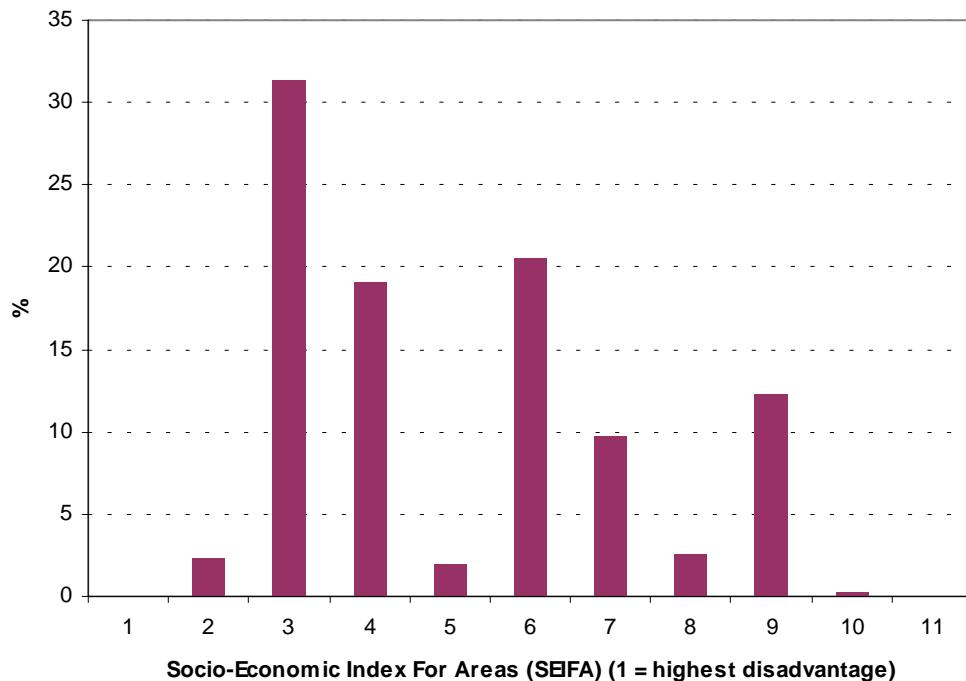
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

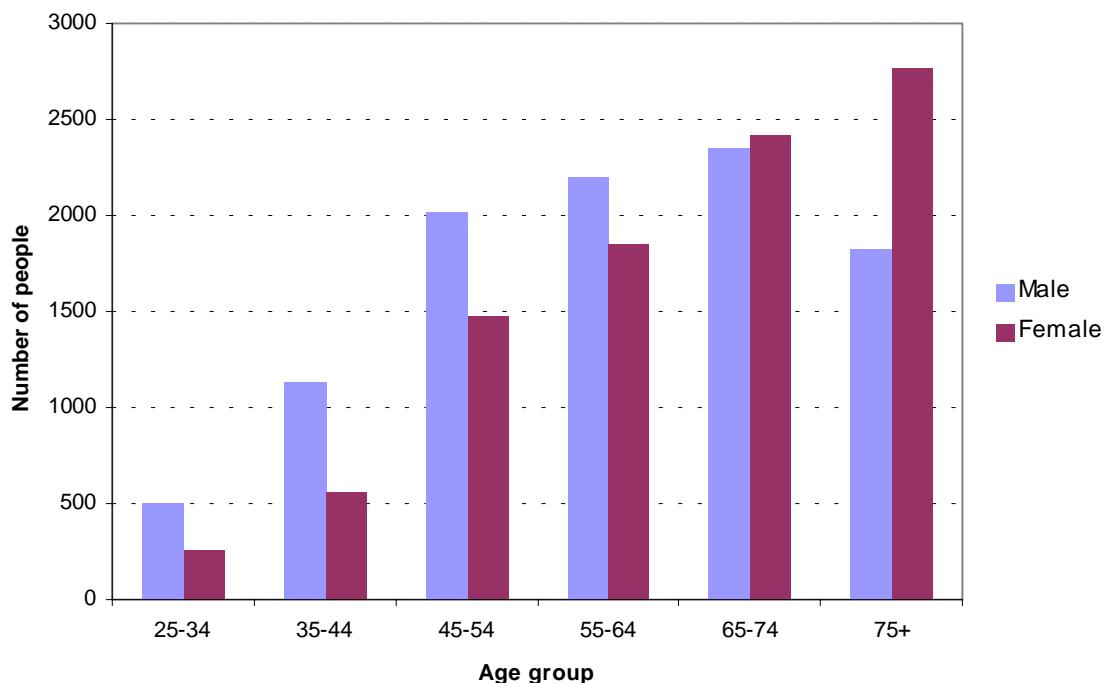
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

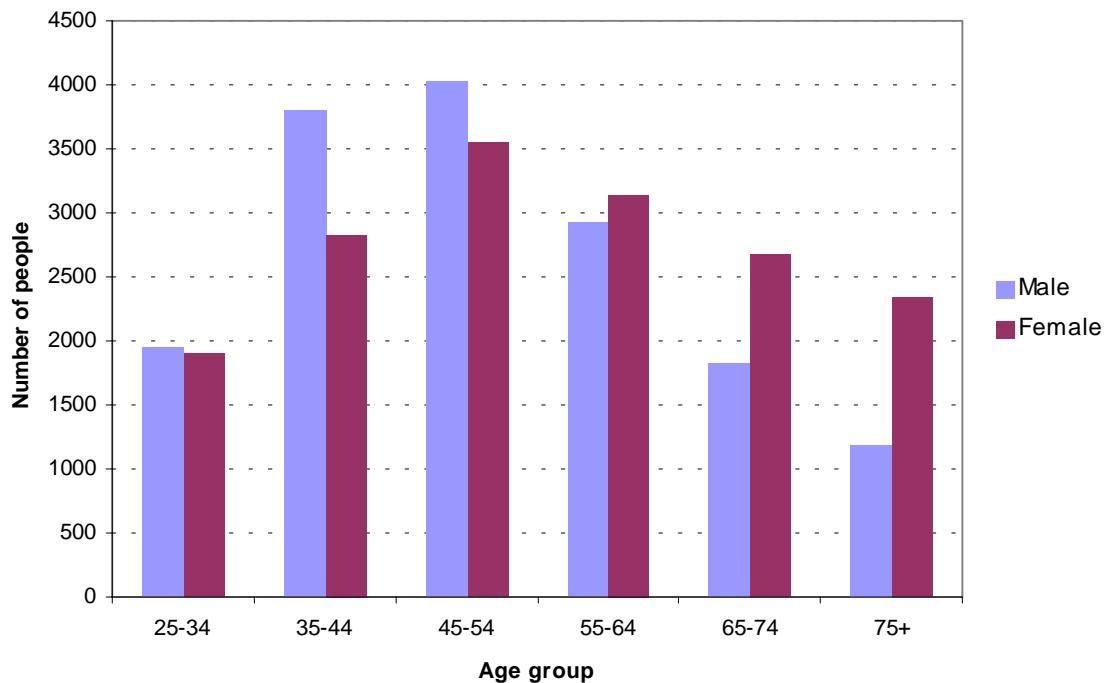
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



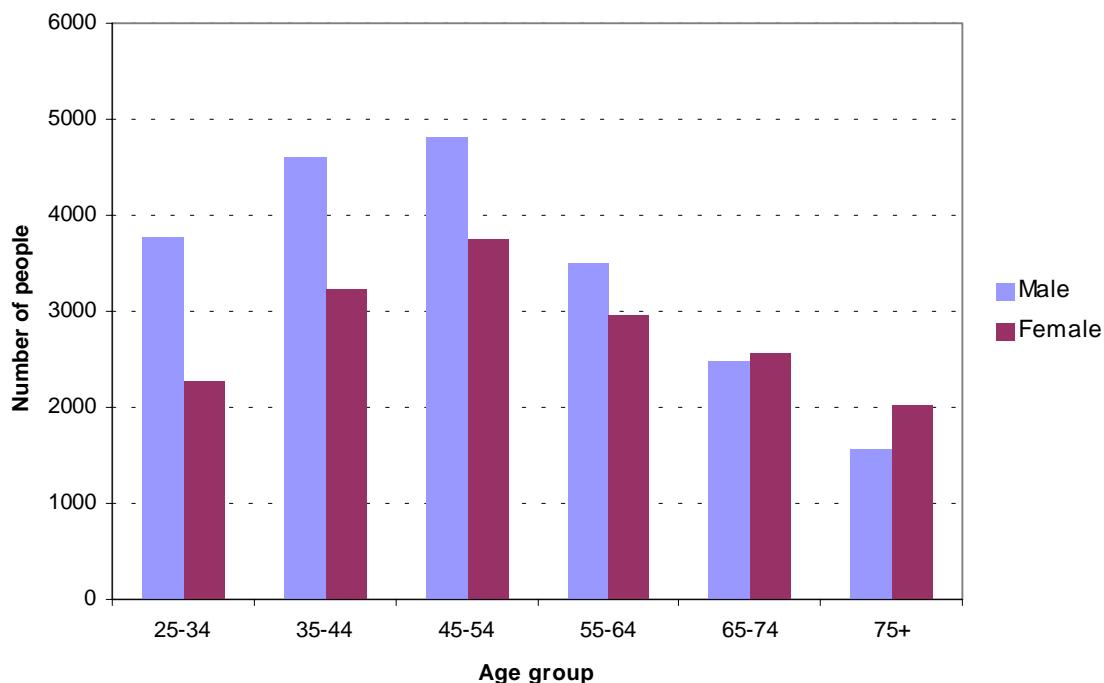
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



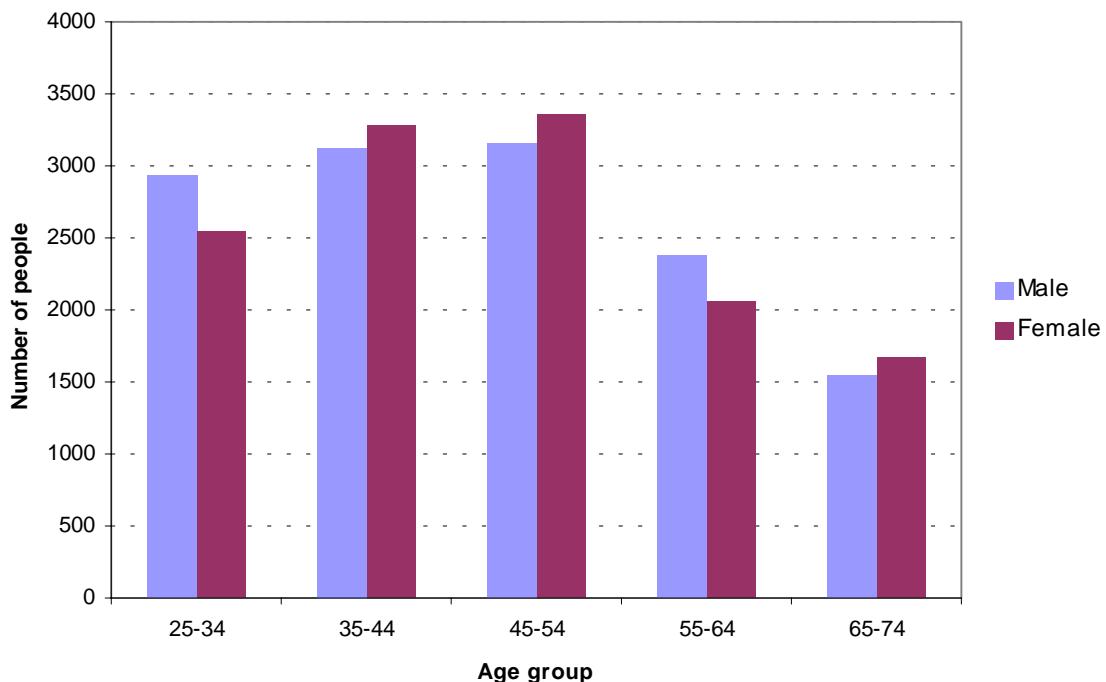
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



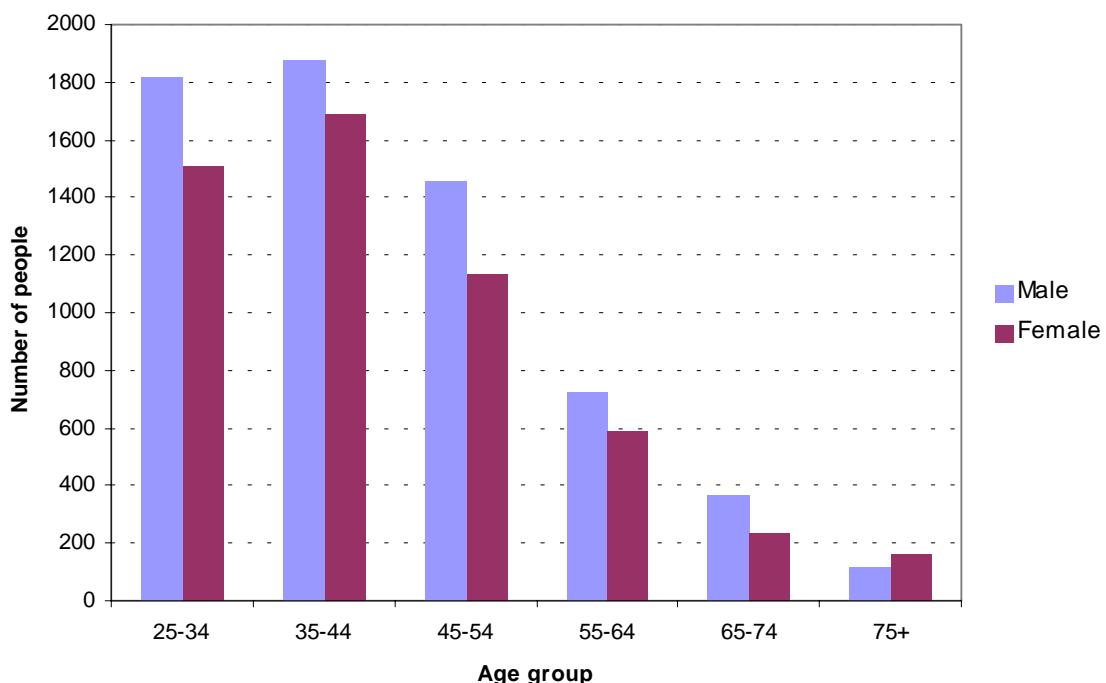
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 79 |
|-----------------------------------------------|-------|----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Public hospital-based diabetes service with three diabetes educators,
 - Dietitians:
 - Public hospital - 3,
 - Community Health Service - 1,
 - Private practice – 1.
 - Podiatrists:
 - Public hospital outservice for rural areas only – 1,
 - Private practice podiatrists – approximately 4.
- What services are needed but are not available in your Division area?

As these above services cover a rural area with a population of approximately 130,000 they are in short supply. Diabetes educators for example, can only offer group information sessions to newly diagnosed type 2 diabetics and for the 75,000 people living in the greater Shepparton area there is only access currently to publicly funded podiatrists.

We need more diabetes educators and more public podiatrists and dietitians.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input checked="" type="checkbox"/> 1992	<input checked="" type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	
- Please describe your diabetes program including any changes that occurred over time?
 - We don't have a specific "diabetes" program, however, conduct numerous relevant activities that are part of other programs.
 - Educational visiting to general practitioners by a GP to detail best practice management of type 2 diabetes,
 - Practice visits to encourage diabetes annual cycles of care and provide resources to GPs,
 - IT/IM support to practices to help set up registers and recall systems for systematic management of diabetes,
 - Continuing Professional Development (CPD) seminar this year on management of Type 2 diabetes and transition to insulin therapy,

- Newsletter articles on management of diabetes, including promotion of physical exercise,
- Active promotion of National Prescribing Service (NPS) audits and facilitation of NPS case study on diabetes,
- In the past, the Division ran a program that provided podiatry services for diabetic patients at the local Aboriginal Community Controlled Health Service. This project ran in 1992-93,
- Over 1999 we worked with the local Aboriginal Community Controlled Health Service (ACCHS) to develop proformas, guidelines for management of diabetes.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Increased awareness of prevalence risks of diabetes among GPs,
 - Increased knowledge of best practice management of diabetes by GPs.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Financial resource.
- What future plans do you have for diabetes management in your Division?

If we are able to secure funding we would like to set up a visiting diabetes service, with educator, podiatrist and nurse – to work with and from general practices on a regular basis. We would like to model this on our current service delivery of practice-based care in the area of mental health through the More Allied Health Services (MAHS) program.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Motivation – awareness of benefits and peer group testimonials,
 - Awareness of cost recovery aspects of program,
 - IT support to set up computer systems for register and recall,
 - Education about best practice management of chronic disease,
 - Practice nurse in the practice.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Participation in local forums to improve multidisciplinary approach to management of diabetes in this region,
 - Participation on regional base hospital steering committee for a project to improve local resources/upskilling of staff in the area of diabetes.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice,
 - National Prescribing Service (NPS) resources.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - NHMRC guidelines currently in development will be good when finalised,
 - Increased funding for IT support,
 - Expansion of MAHS type funding for delivery of a diabetic service to practices.
- What resource materials do you provide to practices?
 - NPS,
 - Active Script materials,
 - Laminated sheets detailing item numbers and requirements for new incentives,
 - Directions of use of Medical Director for data collection, recalls, etc.

Division Contact Person/
Program Co-ordinator

Name: Dr Sue Furphy
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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Diagnostics including stress testing, echocardiography, holter monitoring and ambulatory BP recording,
 - Specialist physicians – five private and public,
 - Cardiac rehab group (public hospital).

- What services are needed but are not available in your Division area?

Greater access to diagnostic services, eg ambulatory monitoring and holter monitoring are available, however, cost patients about \$30.

CVD Program Description

- In which years did you have a CVD project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?
 - Newsletter articles about management of CVD, promotion of physical exercise to improve cardiovascular risk,
 - Active script – educational visiting to detail benefits of physical activity in CVD,
 - IT/IM support to set up registers, recall systems, eg lipid, hypertension monitoring.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Increased GP awareness of the risks and appropriate management of CVD.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Limited financial resource – determines scope of program.

- What future plans do you have for CVD management in your Division?

Probable continuing professional development (CPD) event in the forthcoming year.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

N/A.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- National Prescribing Service (NPS) – contractual arrangement,
- Active Script – contractual arrangement.

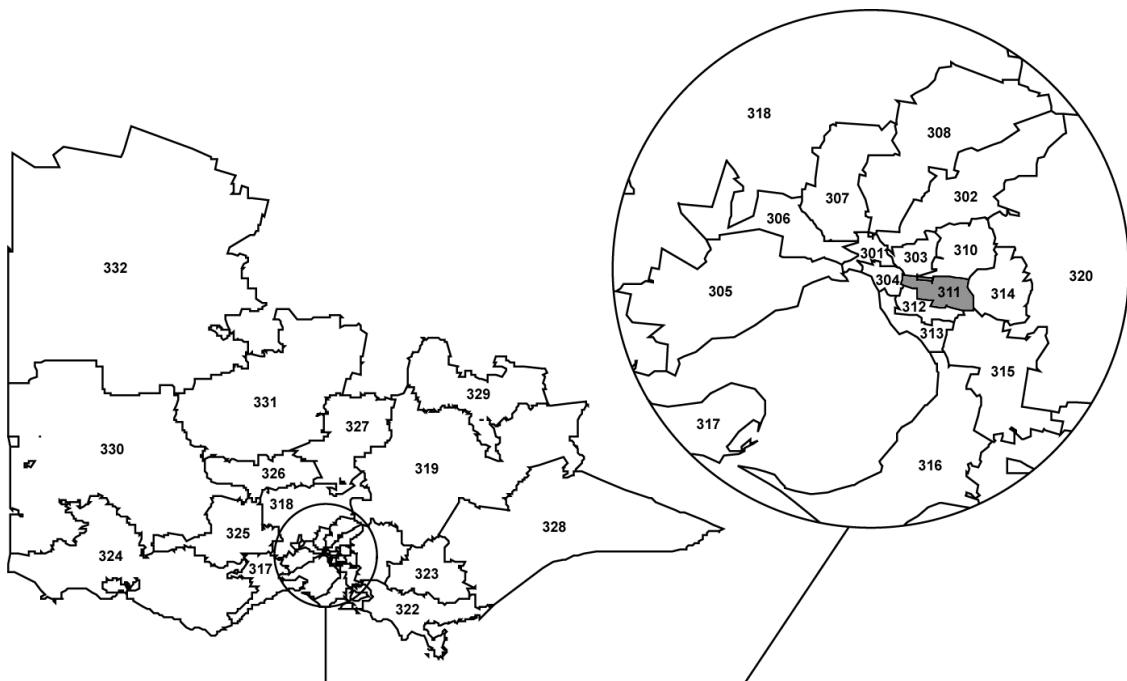
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - NPS resources,
 - Active Script resources,
 - National Heart Foundation guidelines for management of hypertension.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
Financial resource to increase practice support in setting up registers and recall systems – education for staff, practice nurses, increased IT/IM support.
- What resource materials do you provide to practices?
As above.

Division Contact Person/
Program Co-ordinator

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Greater South Eastern DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	177,919	
■ Aboriginal or Torres Strait Islander	330	0.2%
■ Speaks language other than English at home	56,027	31.5%
■ RRMA classification ¹		
1: Capital city	177,919	100.0%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	10,164	8.4%
■ High blood pressure ⁴	38,229	31.6%
■ High blood cholesterol ⁵	62,843	52.0%
■ Obese or overweight ⁶	73,156	60.6%
■ Physical inactivity ⁷	50,934	42.2%
■ Smoking ⁸	22,532	18.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

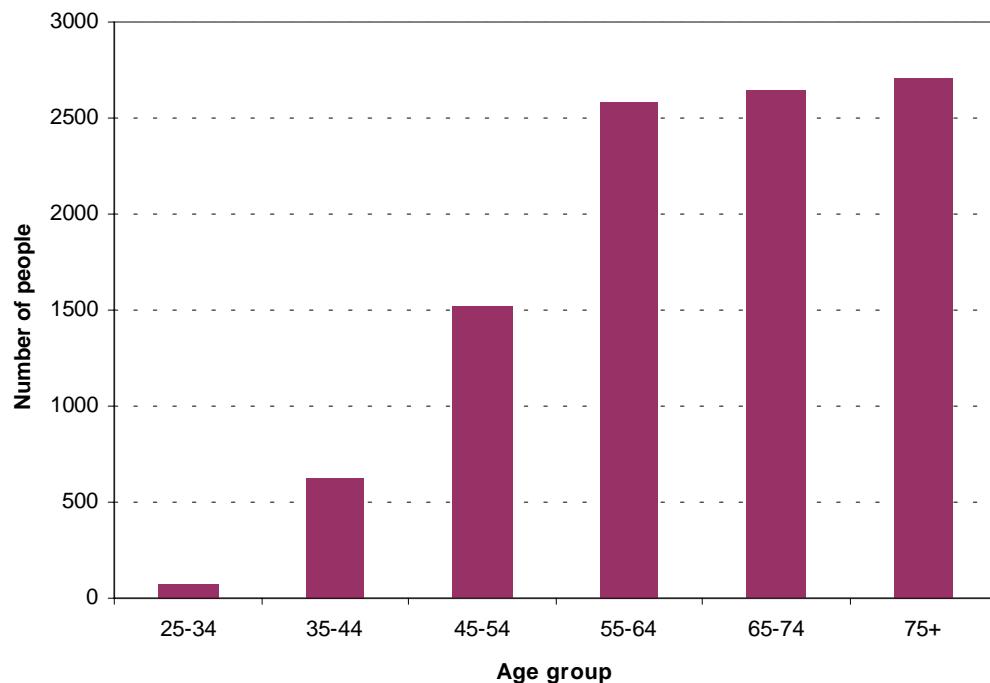
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

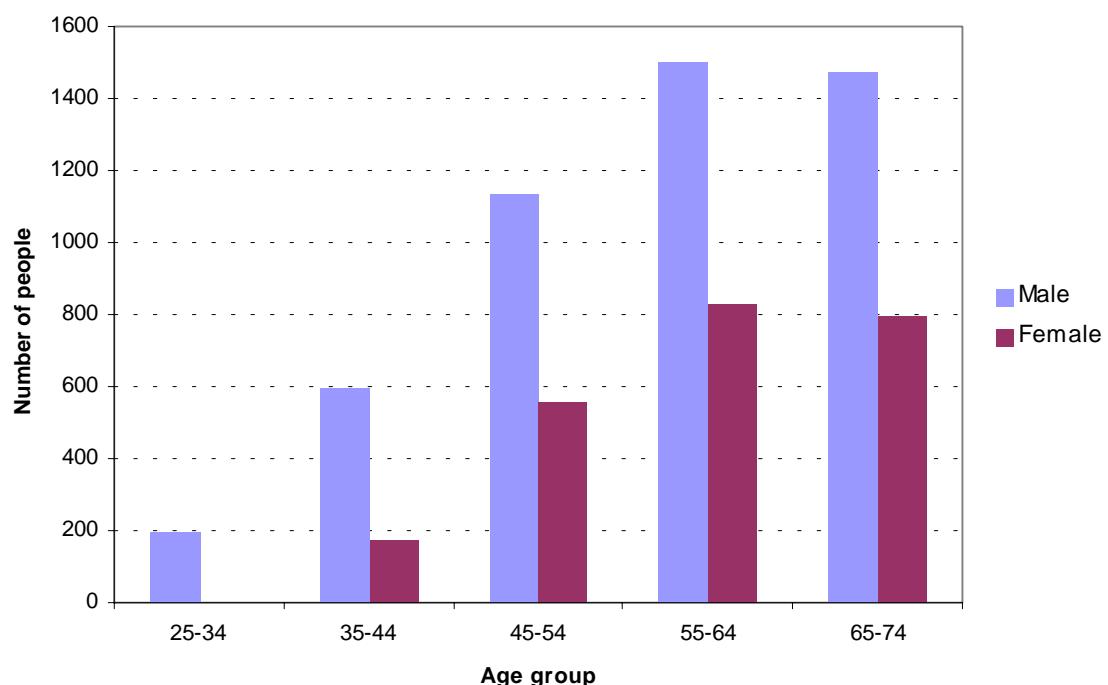
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



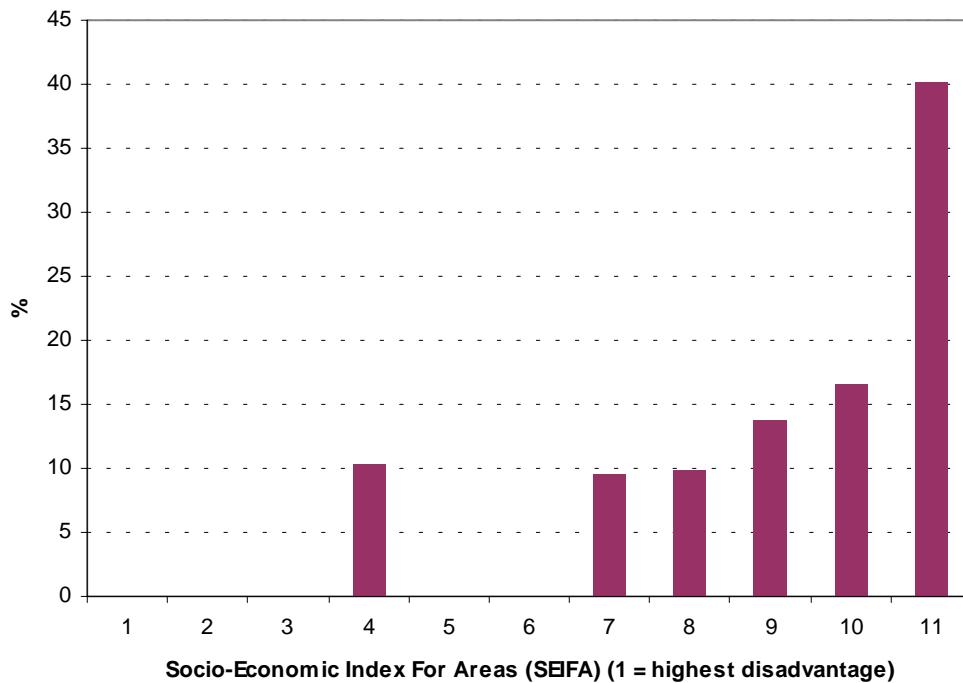
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

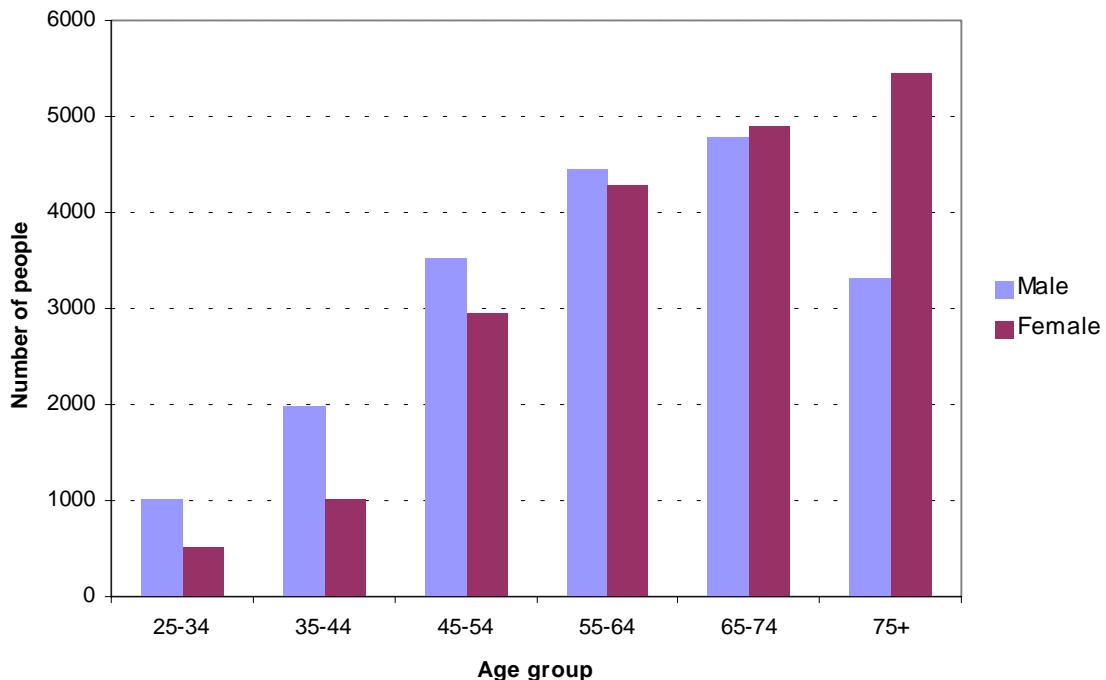
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

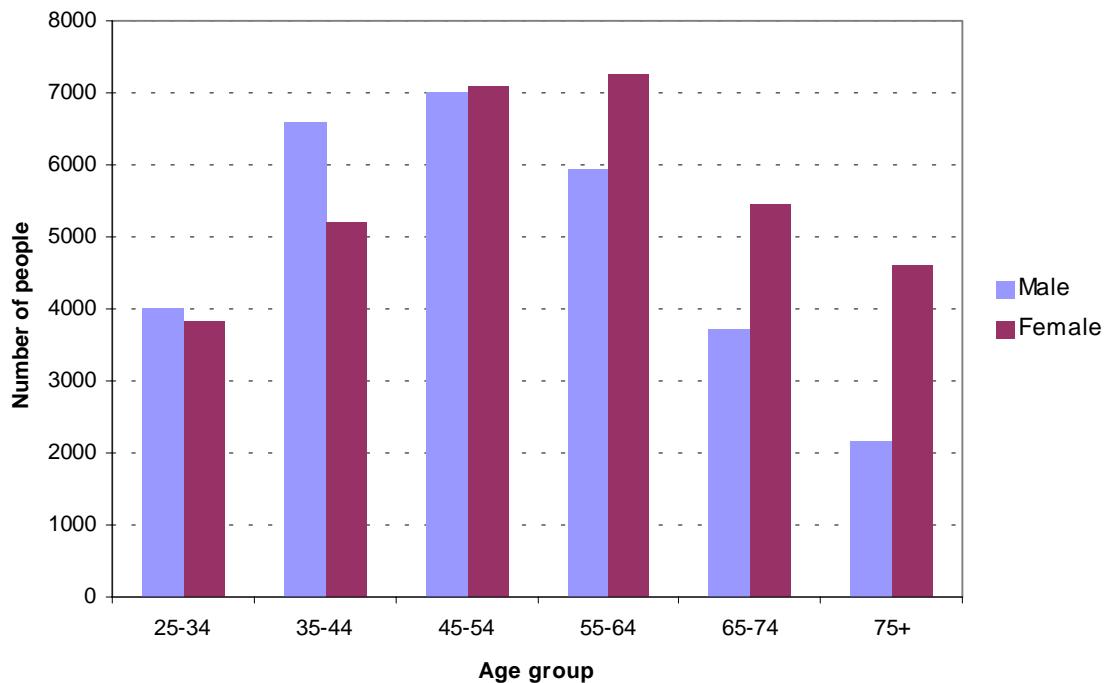
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



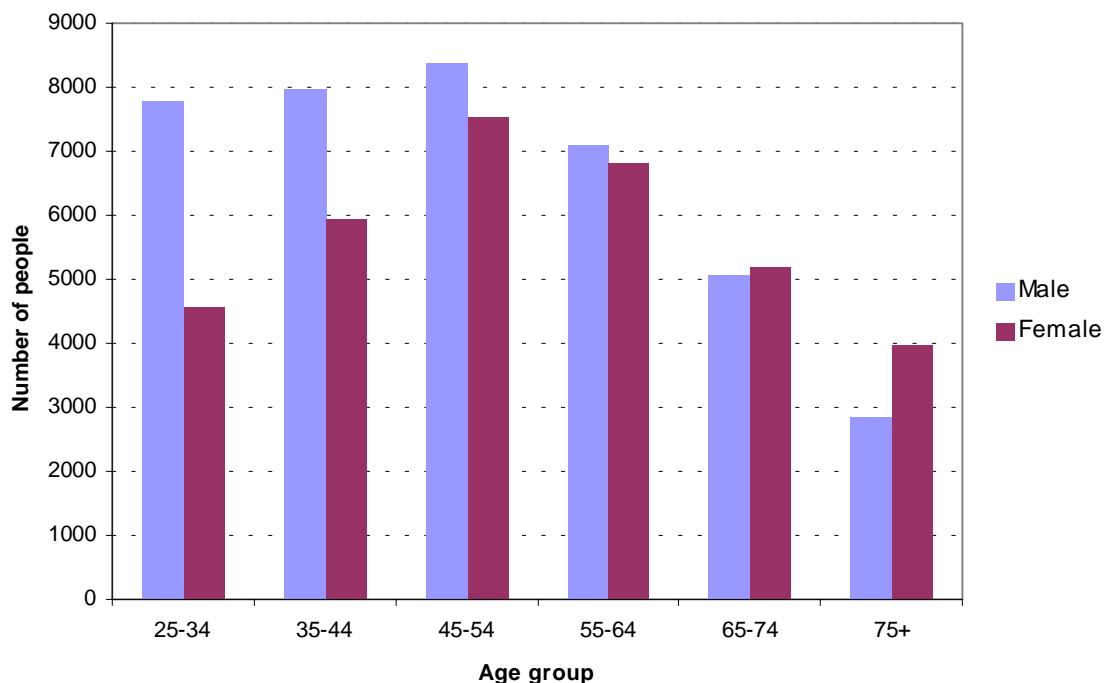
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



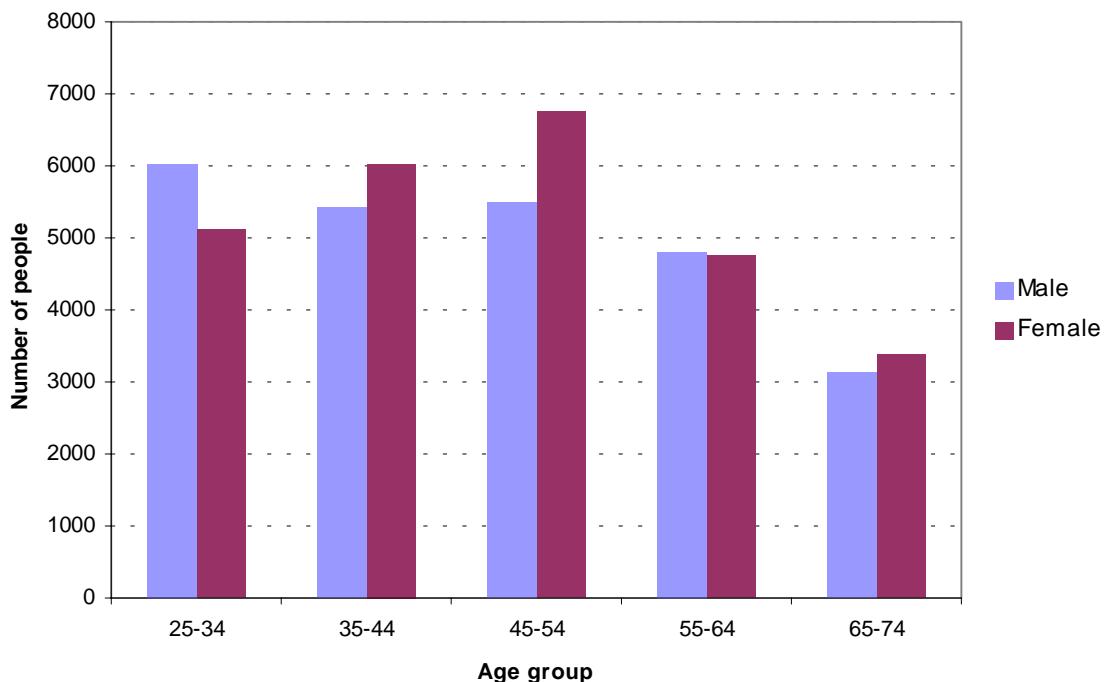
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



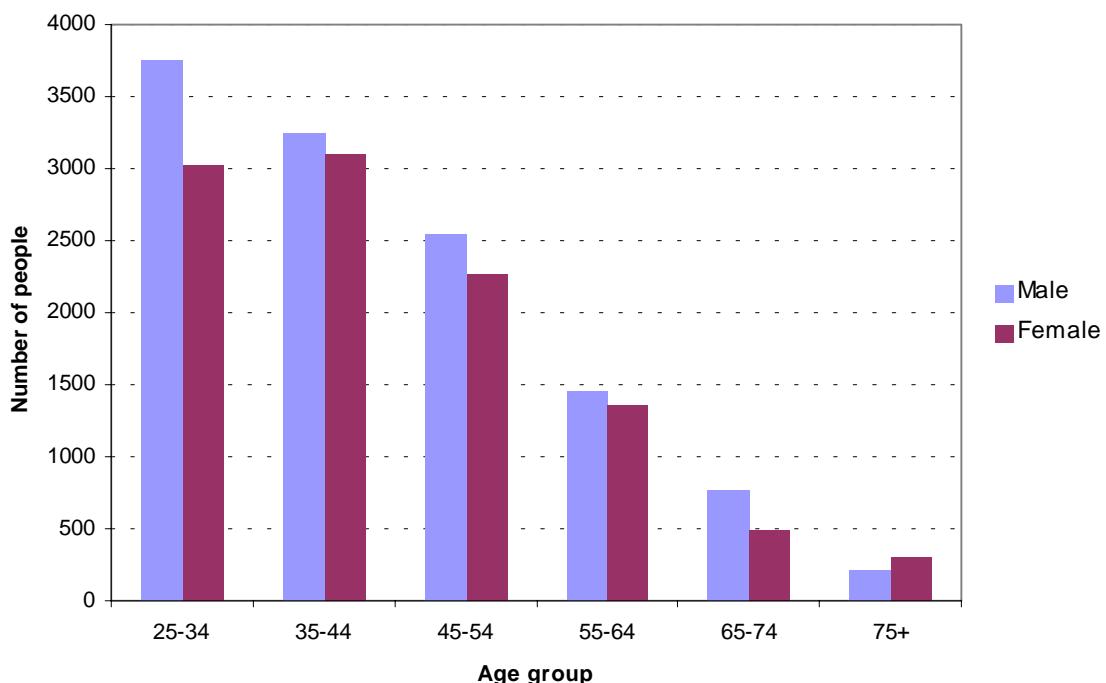
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 255 |
|--------------------------------------------------|-------|-----|
-

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes education is available at two local Community Health Services – Monash Link (Hughesdale) and East Bentleigh,
 - In addition, both Greater South Eastern Division of General Practice (GSEDGP), and Dandenong Division conduct a diabetes register, which encourages GPs to participate and, in turn, provide patients best practice and management.
- What services are needed but are not available in your Division area?
 - Better access to diabetes educators. Waiting times can be long for allied help such as podiatry at Community Health Services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002
- Please describe your diabetes program including any changes that occurred over time?
 - GSED currently runs a diabetes register in conjunction with Dandenong Division, which promotes national guidelines and best practice. In addition, the two Divisions offer a Diabetic Retinopathy Screening Program and regular Continuing Professional Development (CPD) activities for GPs and practices.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Establishment of “Complete Diabetes Care” Register and Diabetic Retinopathy Screening Service,
 - Education and upskilling.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - The main barrier has been attracting GPs to join the Register. Once GPs join they are good at treating patients according to guidelines. The difficulty is convincing them to participate in register.

- What future plans do you have for diabetes management in your Division?
 - To continue to facilitate the “Complete Diabetes Care” Register,
 - To continue to provide Continuing Professional Development (CPD) activities for EPS/practices,
 - To continue to offer a Diabetic Retinopathy Screening Service.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

Time/resources available to take up initiation. Practices are overwhelmed by the amount of information that comes into their practice.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

We have established good links and working relationships with our local community health service – Monash Link. We were recently invited to participate in a review of Monash Links (Diabetic) Education program.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

National guidelines.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Information re:

 - Complete Care Register,
 - Diabetic Retinopathy Screening Program.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

- What resource materials do you provide to practices?
 - English and translated materials regarding management of diabetes from Diabetes Institute, Diabetes Australia, Community Health Services, and other Divisions,
 - Complete Care Register – National Guidelines.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area? N/A.
- What services are needed but are not available in your Division area? Ambulatory blood pressure monitoring.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002
- Please describe your CVD program including any changes that occurred over time?

Greater South Eastern Division of General Practice (GSEDGP) currently runs a CVD register in conjunction with Dandenong Division of General Practice, which promotes best practice.

GSEDGP also conducts regular Continuing Professional Development (CPD) activities for GPs and practice staff.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Establishment of the CVD Register,
 - Development of “Exercise Prescription”, a CPD activity that promotes healthy lifestyles and physical activity.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Lack of incentives for GPs to participate in the CVD Register.

 - Expansion of the “Exercise Prescription” program,
 - Introduction of Healthy Schools Program.
- What future plans do you have for CVD management in your Division?

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Look at a variety of programs, and see which has worked best.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

We have established links with local council and VICFIT.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

VICFIT Infoline.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

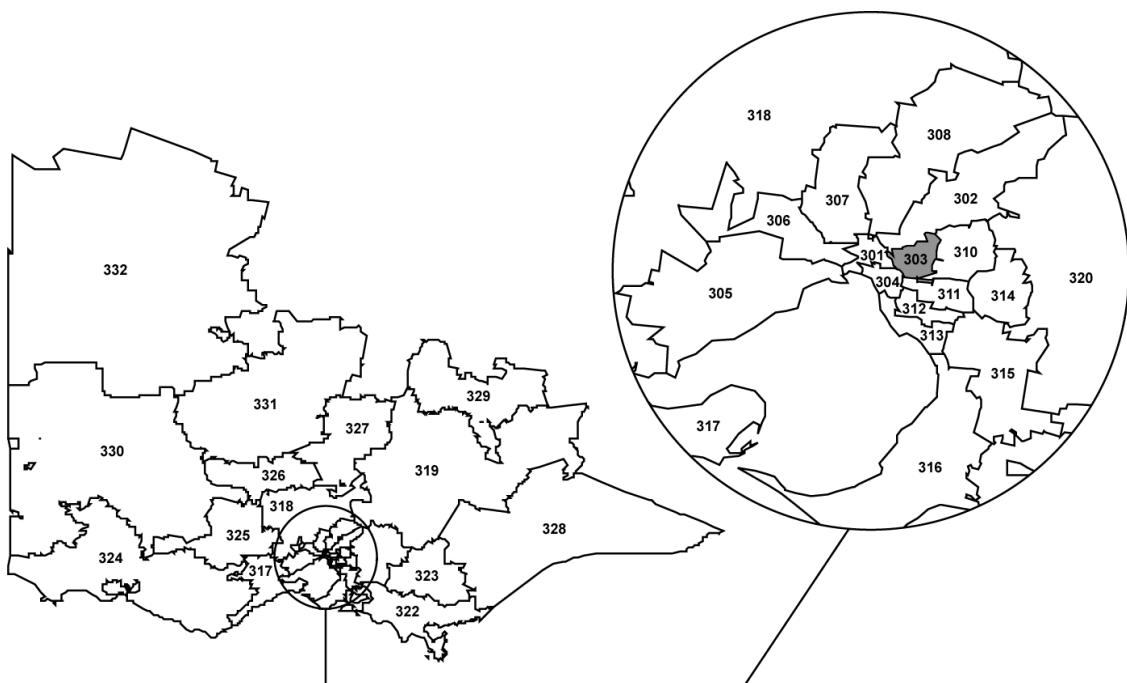
Exercise prescription.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Incentive payments for GPs to participate in CVD register.
- What resource materials do you provide to practices?
 - CVD register,
 - Exercise prescription manuals.

Division Contact Person/
Program Co-ordinator

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Inner Eastern Melbourne DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	191,106	
■ Aboriginal or Torres Strait Islander	238	0.1%
■ Speaks language other than English at home	42,251	22.1%
■ RRMA classification ¹		
1: Capital city	191,106	100.0%
■ SEIFA category containing population median: ²	11	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,092	8.6%
■ High blood pressure ⁴	41,417	32.0%
■ High blood cholesterol ⁵	67,211	52.0%
■ Obese or overweight ⁶	77,628	60.1%
■ Physical inactivity ⁷	53,009	41.0%
■ Smoking ⁸	23,837	18.4%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

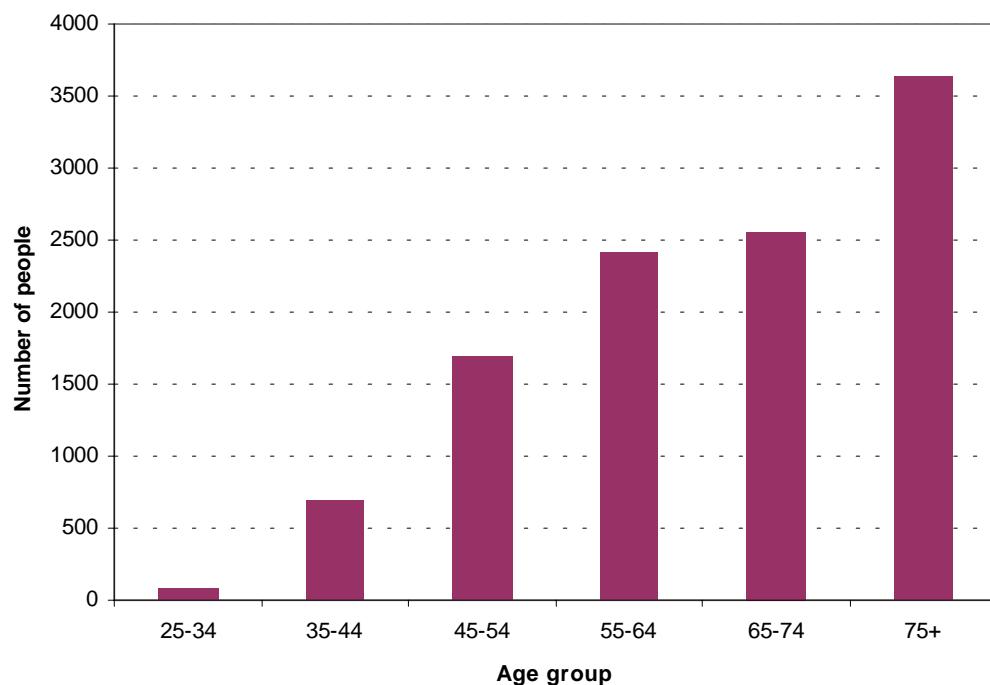
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

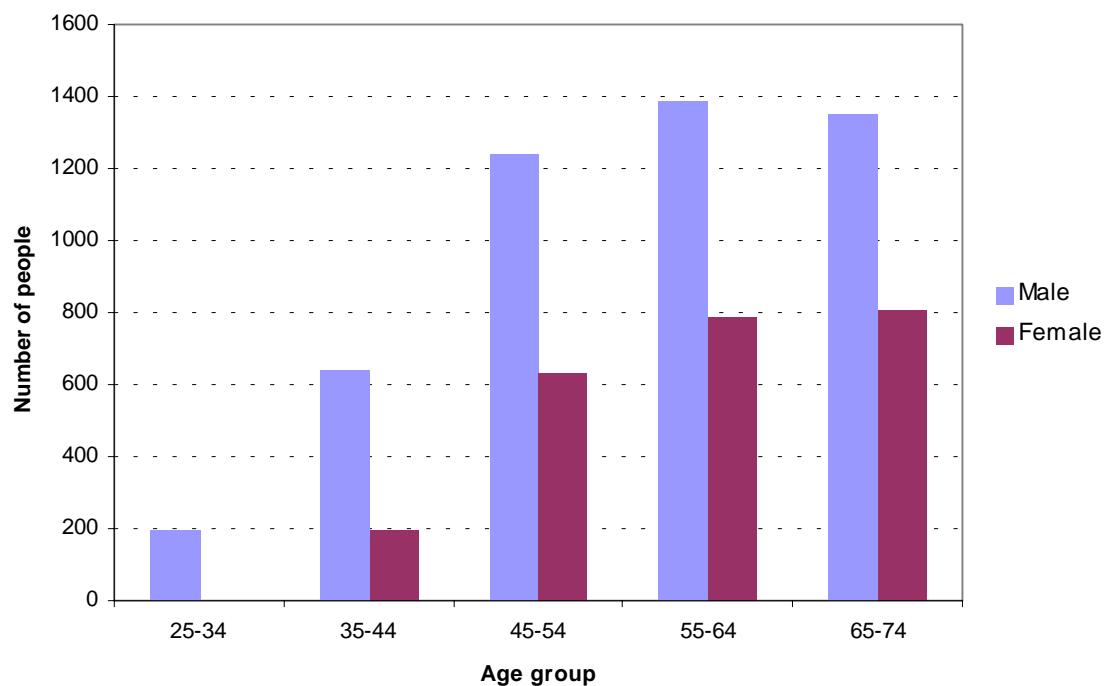
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



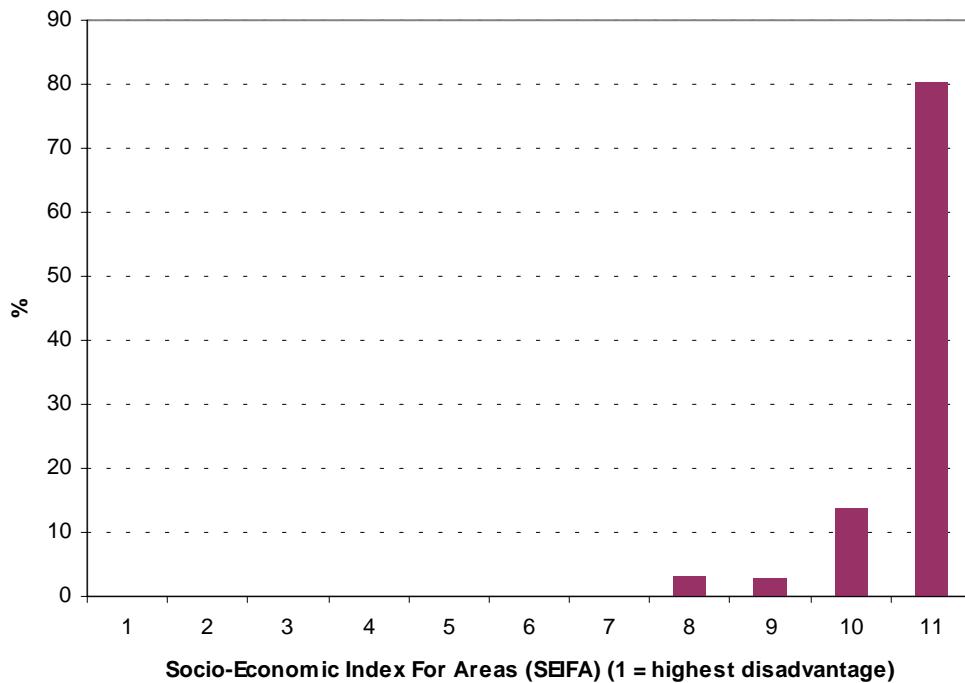
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

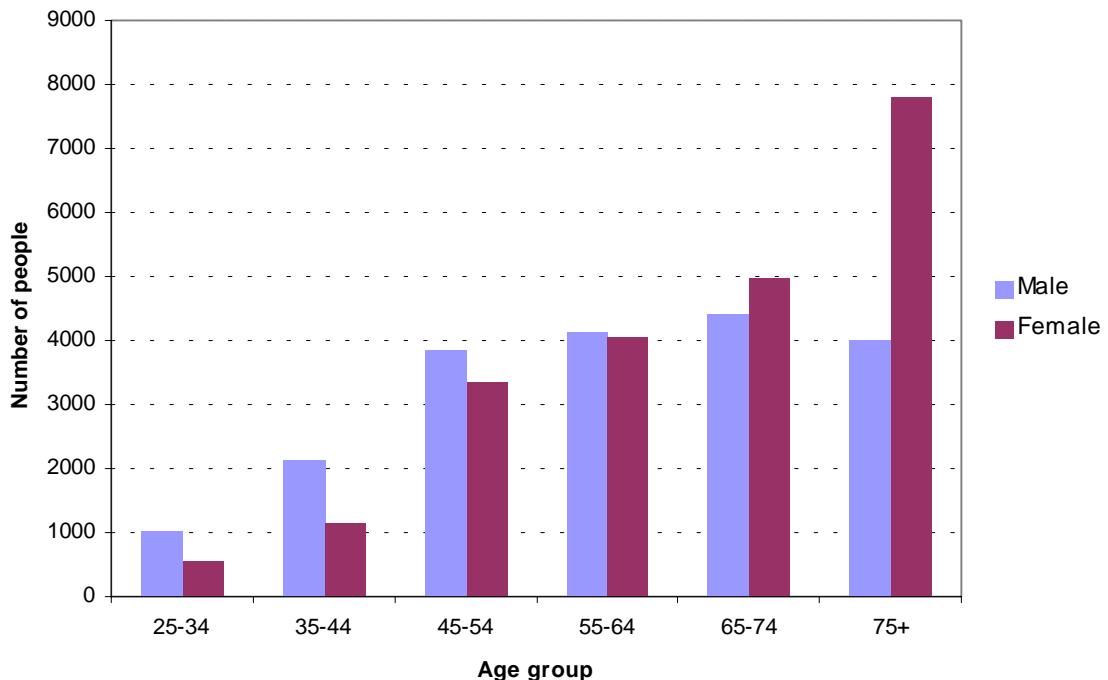
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

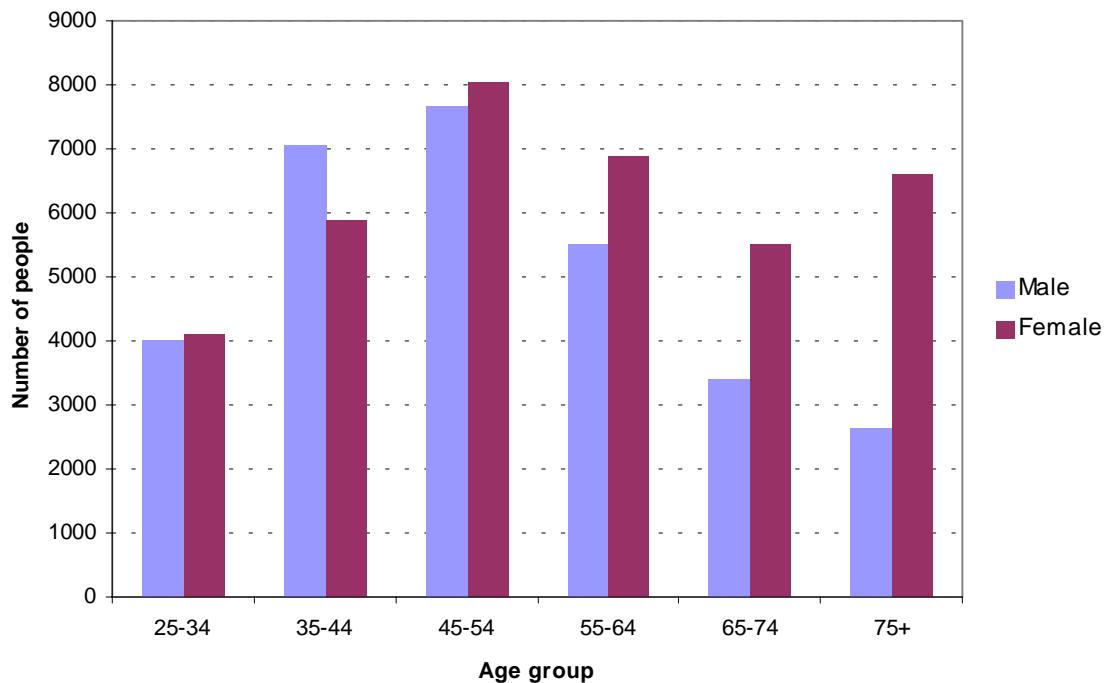
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



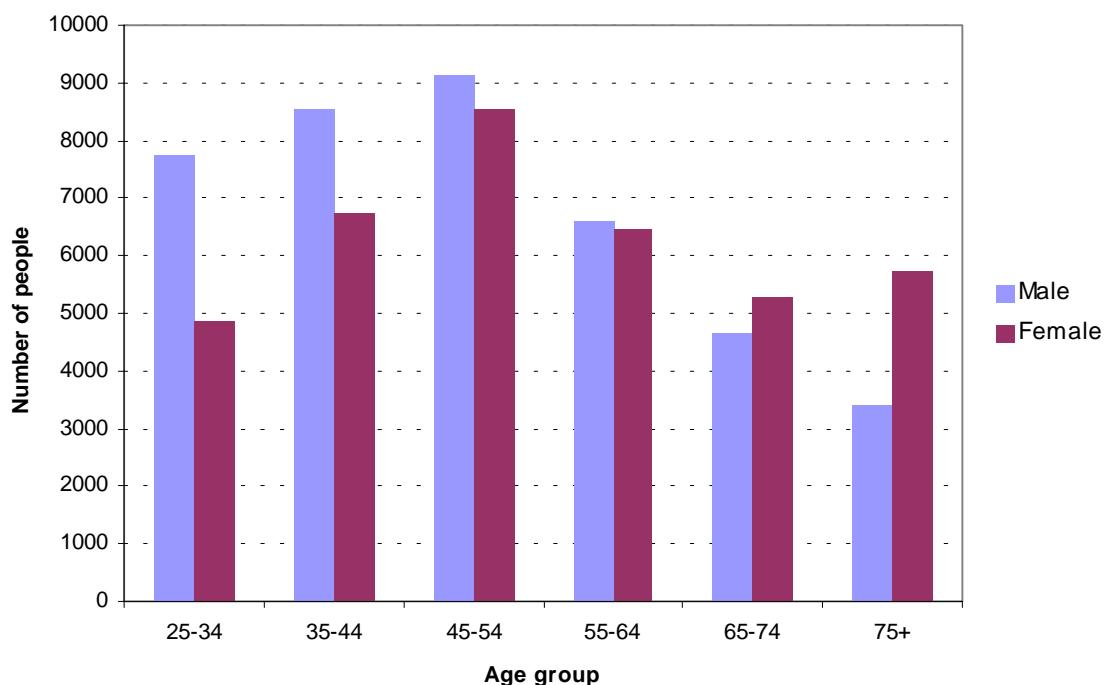
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



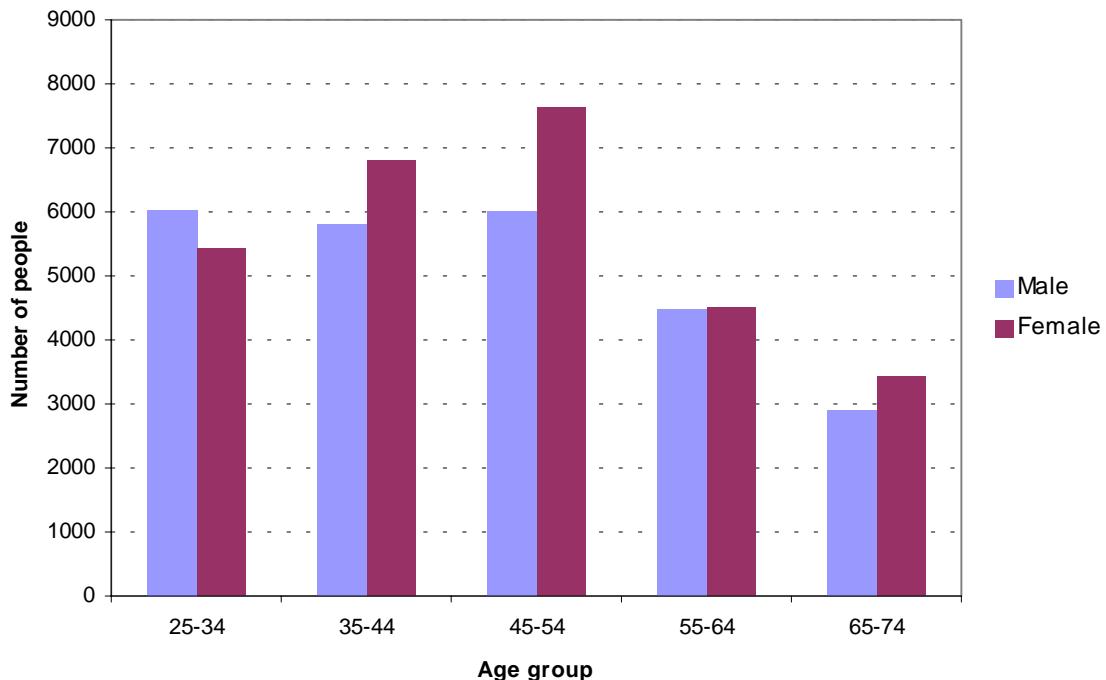
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



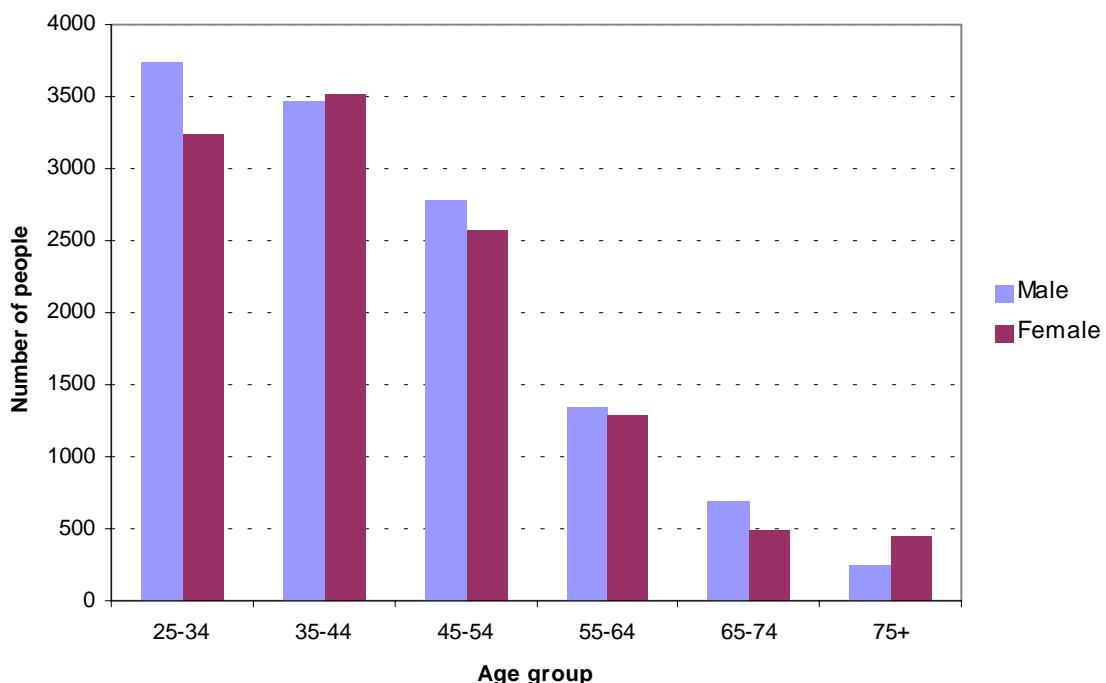
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 221 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes education program for people with type 2 diabetes and their families. Patients are referred by GPs,
 - Private – diabetes educators and dietitians, optometrists and endocrinologists. Boroondara Community Health Centre (BCHC) – has dietitian and podiatrist,
 - GPs also use International Diabetes Institute (IDI) in Caulfield for patients (out of our area),
 - Shopping tours for diabetics,
 - Psychologist for diabetics – Boroondara Community Health Centre.

- What services are needed but are not available in your Division area?
 - Diabetes one-on-one individual education sessions,
 - Interim education info packs/education in the home.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?

Program is run the first three Friday mornings of alternate months. It is located at the BCHC. Duration of three hours. Topics covered: understanding diabetes, healthy eating, blood sugar monitoring, importance of exercise, footcare and avoiding complications. Health professionals involved include diabetes nurse educator, dietitian, physiotherapist, and podiatrist. A six month follow up education session for patients is also offered. In one year, in conjunction with Rotary we have also offered diabetes education to the Italian and Greek communities. In 2003, we have commenced shopping tours.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Sustained GP referral and patient attendance to sessions. Positive feedback from those that attend,
 - Providing local residents with diabetes education to manage their own condition,

- Providing diabetics with resources,
- Italian and Greek education session in conjunction with Rotary,
- Annual community festival,
- Blood sugar level checks and cardiovascular risk factor,
- Six month follow up sessions for diabetic patients:
 - Good numbers,
 - Positive evaluation,
 - Different focus,
 - Psychiatry,
 - Complementary therapies,
 - Pharmaceuticals.
- Pharmaceutical reps – providing information on blood glucose meters.

▪ Are there any factors or barriers that have limited the implementation of your program? Please comment:

Finding appropriate stakeholders that could provide funds to the partnership.

▪ What future plans do you have for diabetes management in your Division?

- Continue and expand diabetes program to include:
 - Shopping tours – we have commenced this,
 - Interim education with patients prior to program,
 - Psychologist – discussing stress and management of chronic illness,
 - Education for GPs and practice nurses supporting GPs with government incentives to manage diabetes.

▪ What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

- Upskilling by division staff to practices,
- Practice managers and nurses – having time to do paperwork,
- Division training in computer software and support services,
- Collaboration with other organisations interested in the program – BCHC, Council, GPs, Royal District Nursing Service (RDNS),
- Collaboration with external agencies – Diabetes Australia – Victoria (DAV), Diabetes Institute,
- Collaboration with pharmaceutical reps in regards to sponsorship,
- Collaboration with GPs and specialists interested in the area of diabetes.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- BCHC – Primary Care Partnerships (PCP) and diabetes program,
- RDNS – PCP and diabetes program,
- Council – PCP.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Pharmaceutical reps (trade displays, meter demonstration),
 - DAV/Diabetes Australia (resources and speakers),
 - BCHC (provide diabetes educator, dietitian, physiotherapist and podiatrist).
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Brochure and referral pads for diabetes program,
 - Recall system in GP clinics.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? No.
- What resource materials do you provide to practices?
 - Laminated chronic care initiative sheets,
 - National Prescribing Service (NPS) – case studies, diabetes education sessions,
 - Software recall and reminder system guidelines and user manuals,
 - Diabetes education program,
 - Diabetes pamphlets and referral pads.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Private – dietitians, cardiologists, GPs, fitness centres, community groups, fitness for older population.
 - Public and private hospitals providing cardiac rehabilitation are mostly out of our postcodes.
 - Cedar Court Rehab provides cardiac rehab.
 - Public – dietitian, physiotherapist.

- What services are needed but are not available in your Division area?
 - More publicly funded access to dietitians,
 - Improvement in cardiac discharge liaison between GPs and cardiologists/hospital staff,
 - An improvement in lifestyle/risk factors generally.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your CVD program including any changes that occurred over time?

The shared care angioplasty program with Epworth Hospital was piloted January – December 2000 with 12 months GP follow up visits to December 2001. Evaluation will be completed September 2002. A proposal involving a large public hospital and private hospital is being developed to expand and continue the pilot program.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Exploring the process of patient hospital discharge to GP care,
 - Interim results have been disseminated through three cardiac conferences to date,
 - The steering committee represented private health insurance, pharmaceutical company, Heart Foundation, hospital and GP Divisions. Good collaboration was achieved.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Funding allowed for pilot program only. Further funding is being sought for an expanded cardiac program.

- What future plans do you have for CVD management in your Division?

Current focus is on the diabetes program. Should funding be attained, we shall be involved in establishing a short rehabilitation program at the public hospital plus having a case manager that contacts GPs on discharge and at certain time points to encourage intervention in CVD risk management.

National Prescribing Service (NPS) has been educating on lipid therapy and diabetes as well.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

If planning a hospital/community linkage program I would make sure you had key stakeholders involved and a protocol in place for all to follow, adequate funding for personnel, adequate personnel and funding for evaluation. Have a plan for dissemination of results. Look for sustainability.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

National Heart Foundation (NHF) has had a representative on the SCAP steering committee. He has been an invaluable resource. Epworth is the hospital we have had most links with through this program but it really is just links with individual people not the organisation as such. Recent links have been made with cardiologists, rehabilitation acute care nurses and case managers at a public hospital.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

- NHF guidelines for secondary prevention,
- NPS,
- Patient hand held record,
- IT/IM support for GPs and practice staff for clinical history taking and recall systems.

- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Shared care angioplasty program resource manual, which includes hand held record.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Some way of staying abreast of the changes in CVD research outcomes.
- What resource materials do you provide to practices?

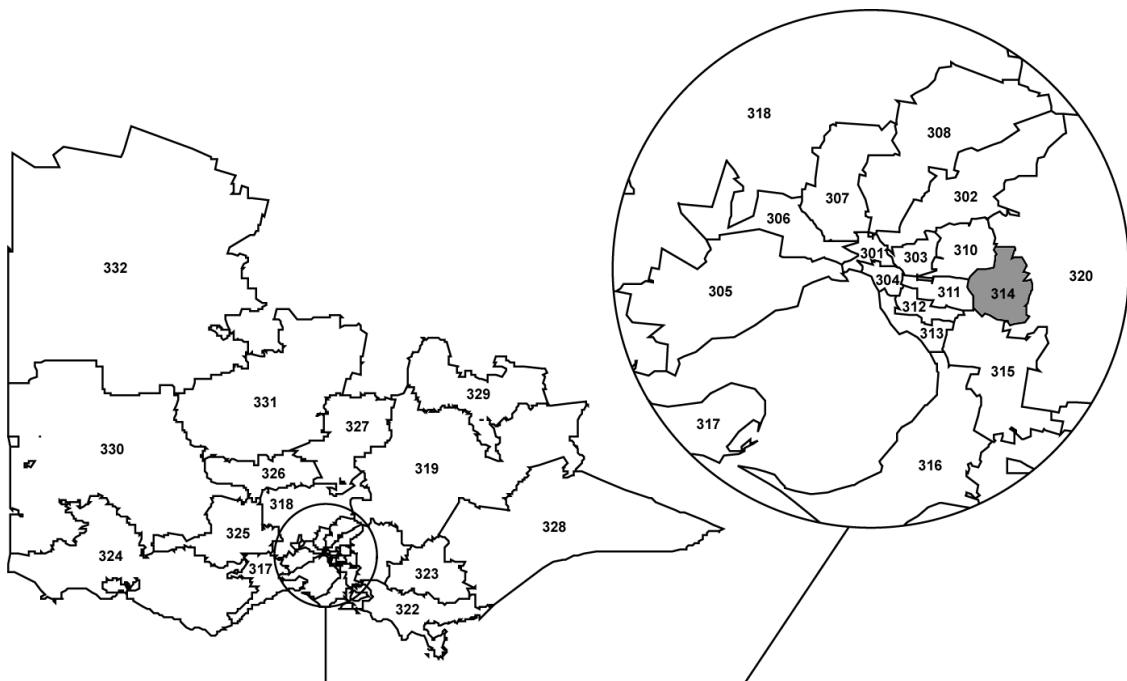
In the program we gave resource kits with contacts for local dietitians and exercise for the elderly. Plus info on diabetes programs, cardiac rehabilitation, cardiologists and their specialists.

There are now some electronic databases of services available.

Division Contact Person/
Program Co-ordinator

Name: Tracy McNeair
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Email: tracym@iemdgp.com.au

Knox DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	187,885	
■ Aboriginal or Torres Strait Islander	532	0.3%
■ Speaks language other than English at home	26,178	13.9%
■ RRMA classification ¹		
1: Capital city	187,885	100.0%
■ SEIFA category containing population median: ²	9	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	8190	6.9%
■ High blood pressure ⁴	31,848	26.9%
■ High blood cholesterol ⁵	59,624	50.4%
■ Obese or overweight ⁶	70,201	59.4%
■ Physical inactivity ⁷	51,169	43.3%
■ Smoking ⁸	23,717	20.1%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

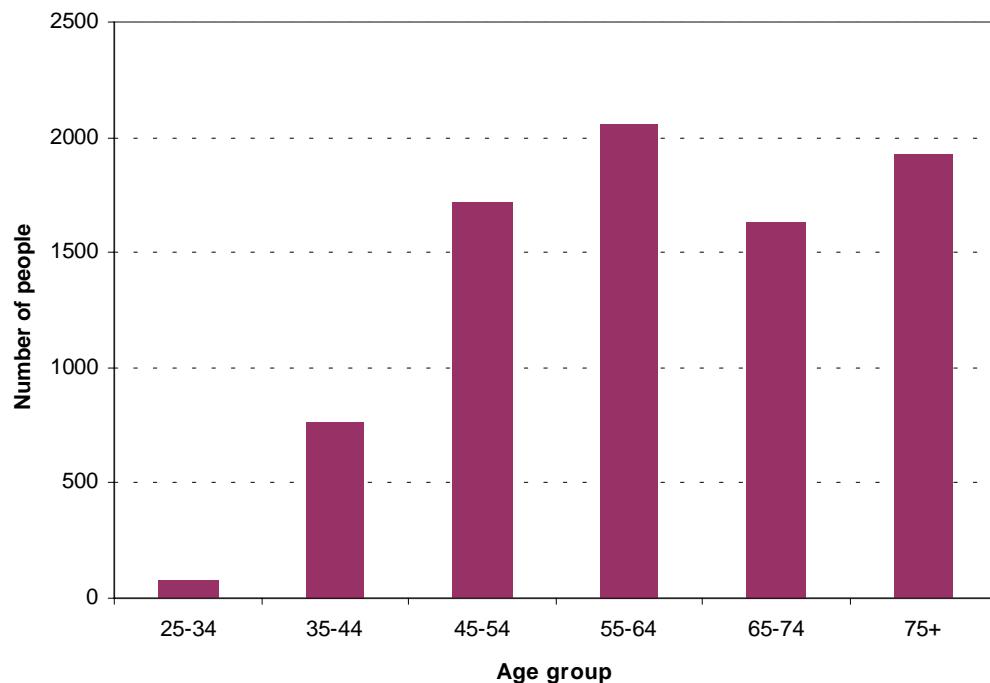
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

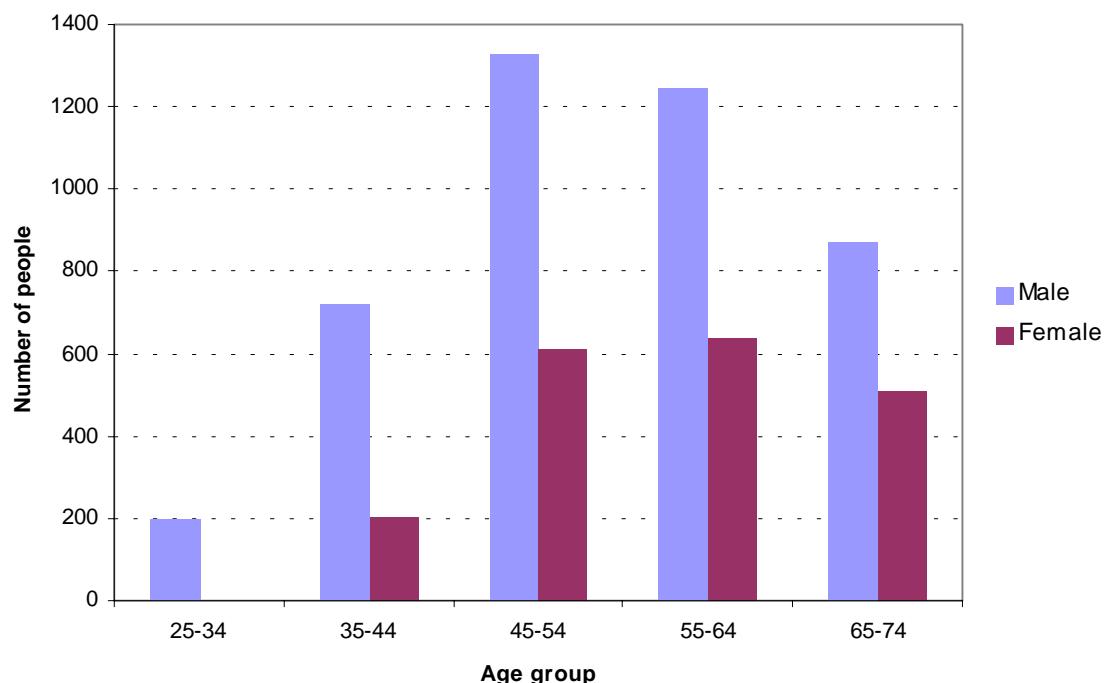
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



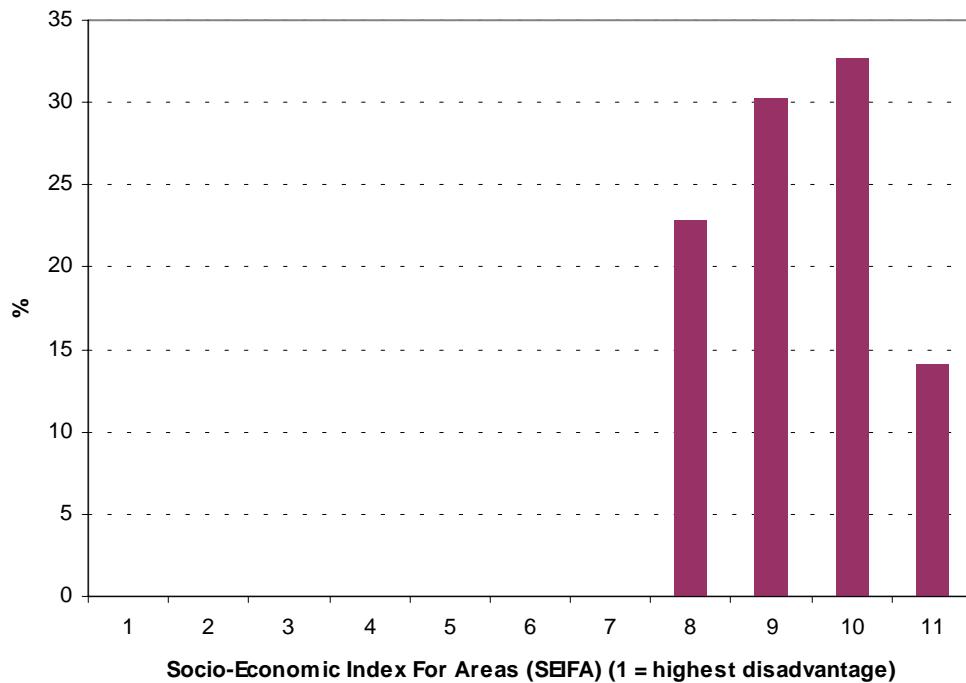
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

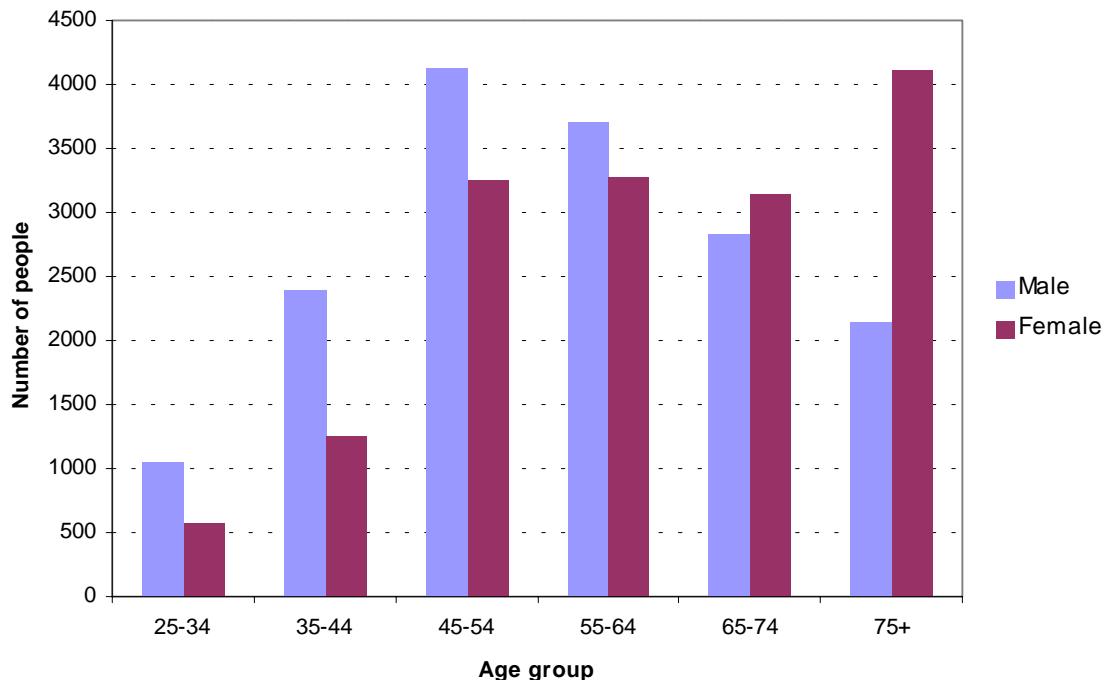
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

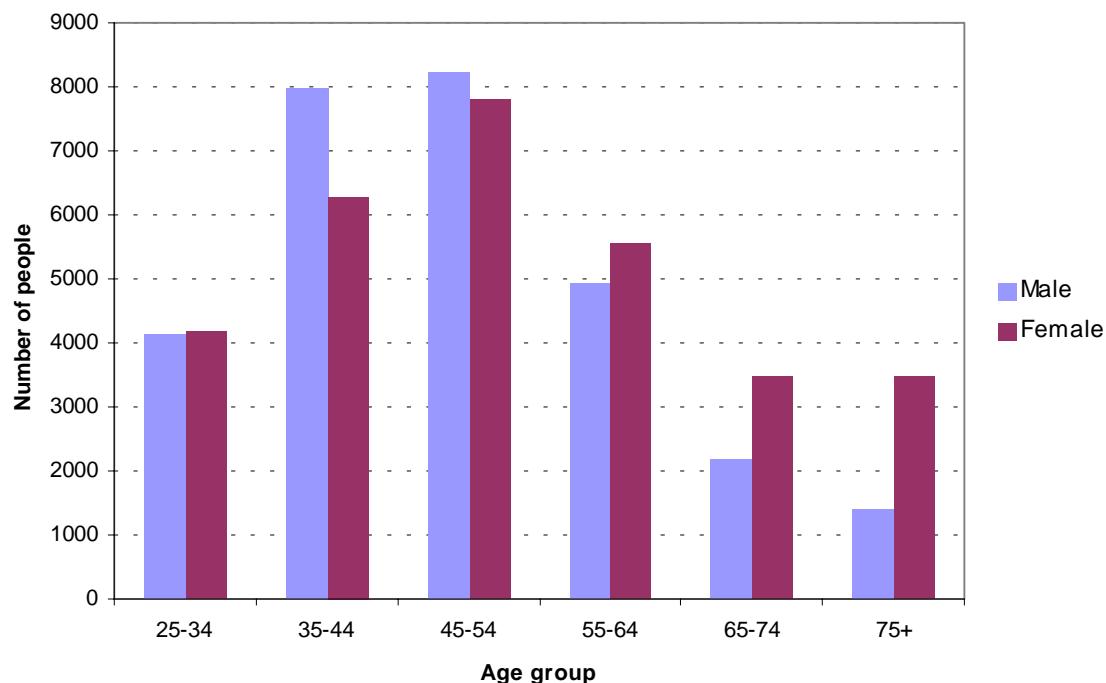
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



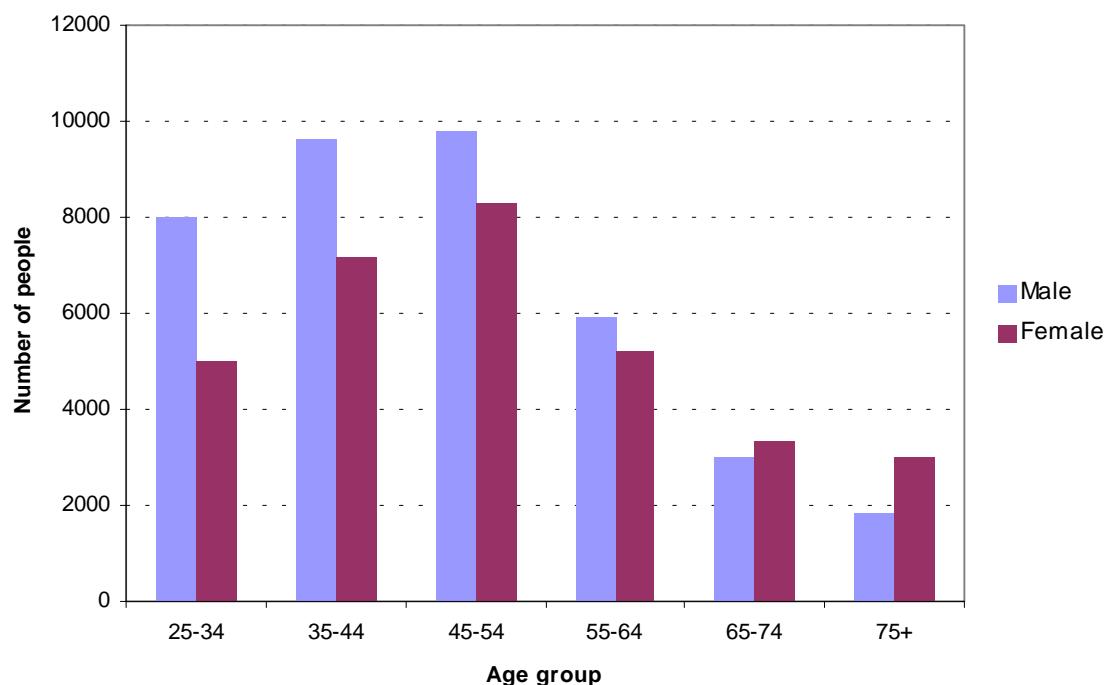
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



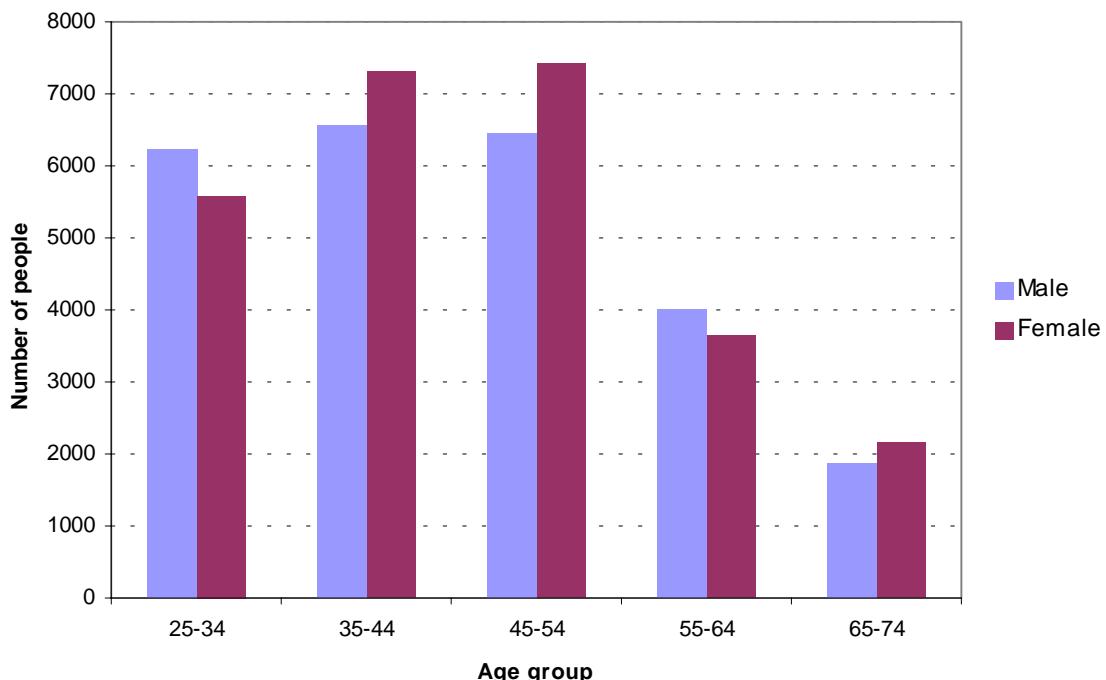
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



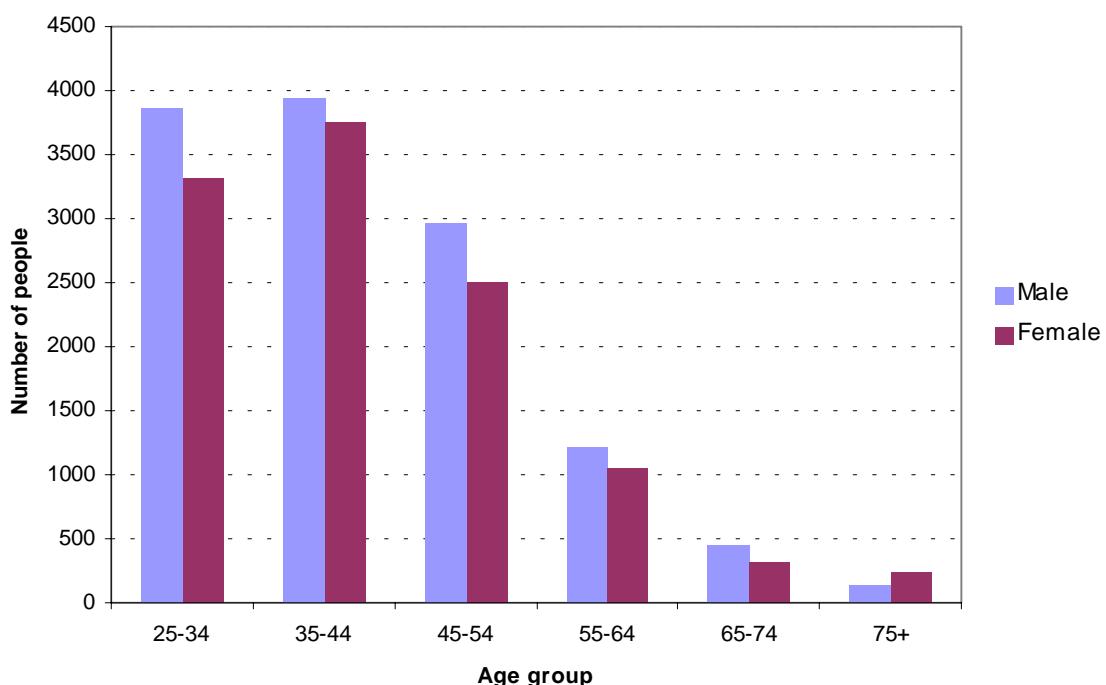
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 203 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Education Service – Diabetes nurse educator and dietitian:
 - local community health (20 hrs pw) group and individual,
 - two local public hospitals by appointment – individual,
 - one local public hospital by appointment – individual.
 - Diabetes Specialist:
 - one local hospital – general,
 - one local hospital – gestational.

- What services are needed but are not available in your Division area?

More group education. Current wait time is almost six months.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002
- Please describe your diabetes program including any changes that occurred over time?

We've withdrawn from direct services (after four plus years) and Community Health have taken over the service.

The Division still provides GP speakers and GP representatives on the program steering committee.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The fact that the Community Health Service have kept it going at some level with GP referral,
 - 1999 Public Health Commendation Award,
 - 1998 cited in La Trobe Unit report as good collaboration between Community Health and GPs.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of specific funding,
 - Chronic Disease Management (CDM) funding insufficient to support information management needs alone without adding diabetes, asthma, cervical screening, practice nurse support, and HIC business initiatives!

- What future plans do you have for diabetes management in your Division?

Moved focus to supporting GPs in their clinics to set up patient register and recall systems, and training clinic nurses.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - MBS items,
 - Dedication of diabetes nurse educators,
 - Division design and production of GP-friendly referral and feedback forms.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Community Health – strong, built through collaboration over time and helping them to develop easy-use GP feedback systems.
 - Hospitals – work in progress.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - NSW Diabetes Management guidelines,
 - MBS – Cycle of Care guidelines,
 - Diabetes Association of Victoria – handouts and session guide,
 - International Diabetes Institute – resources and DNE support.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Easy-use GP feedback form,
 - Easy-use GP referral form,
 - Sample Care Plans for newly diagnosed and those with established type 2 diabetes.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

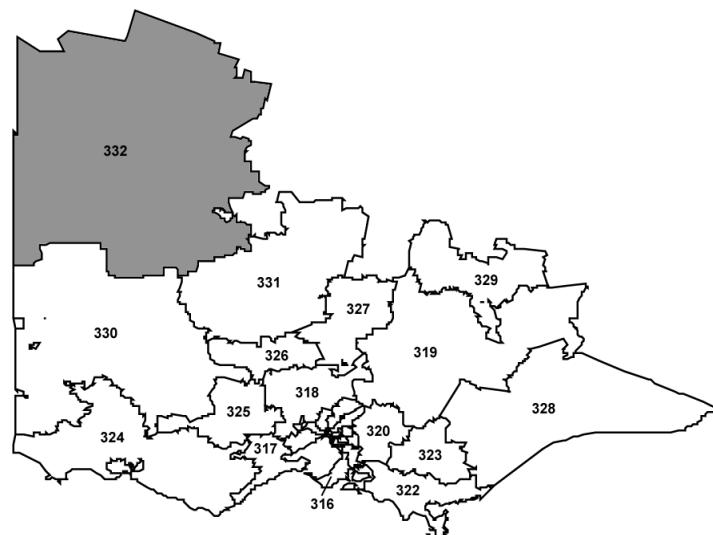
- What resource materials do you provide to practices?

Poster highlighting Diabetes Cycle of Care, as patient point of sale prompt.

Division Contact Person/
Program Co-ordinator

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Mallee DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	83,510	
■ Aboriginal or Torres Strait Islander	2,690	3.2%
■ Speaks language other than English at home	6335	7.6%
■ RRMA classification ¹		
4: Small rural	45,013	53.9%
5: Other rural	25,638	30.7%
7: Other remote	12,861	15.4%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	4517	8.4%
■ High blood pressure ⁴	17,085	31.7%
■ High blood cholesterol ⁵	28,141	52.2%
■ Obese or overweight ⁶	32,806	60.8%
■ Physical inactivity ⁷	22,726	42.1%
■ Smoking ⁸	10,127	18.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

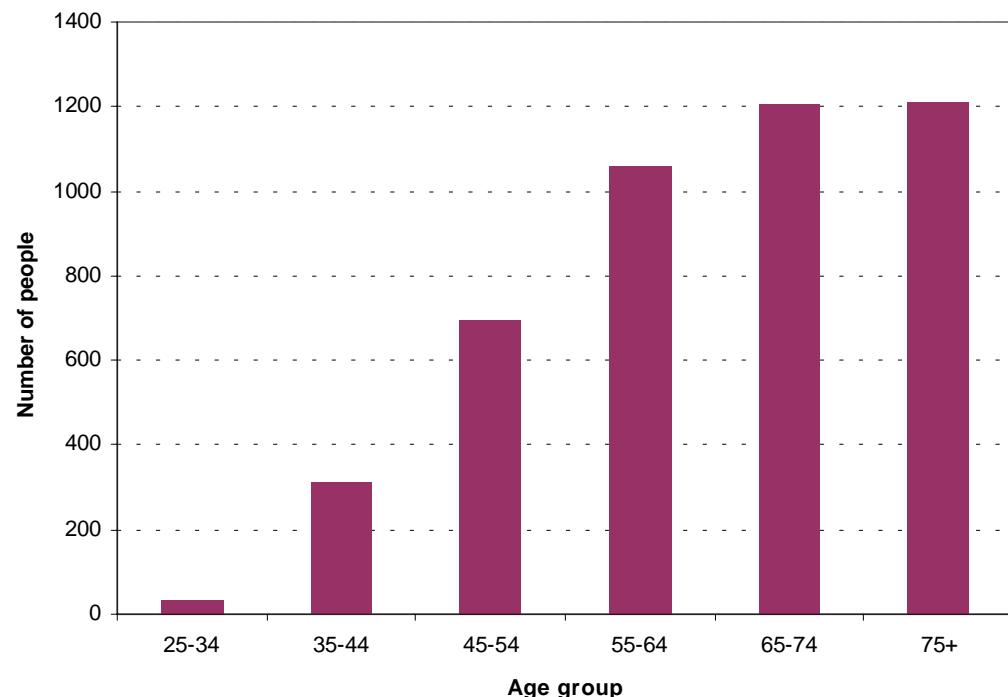
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⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

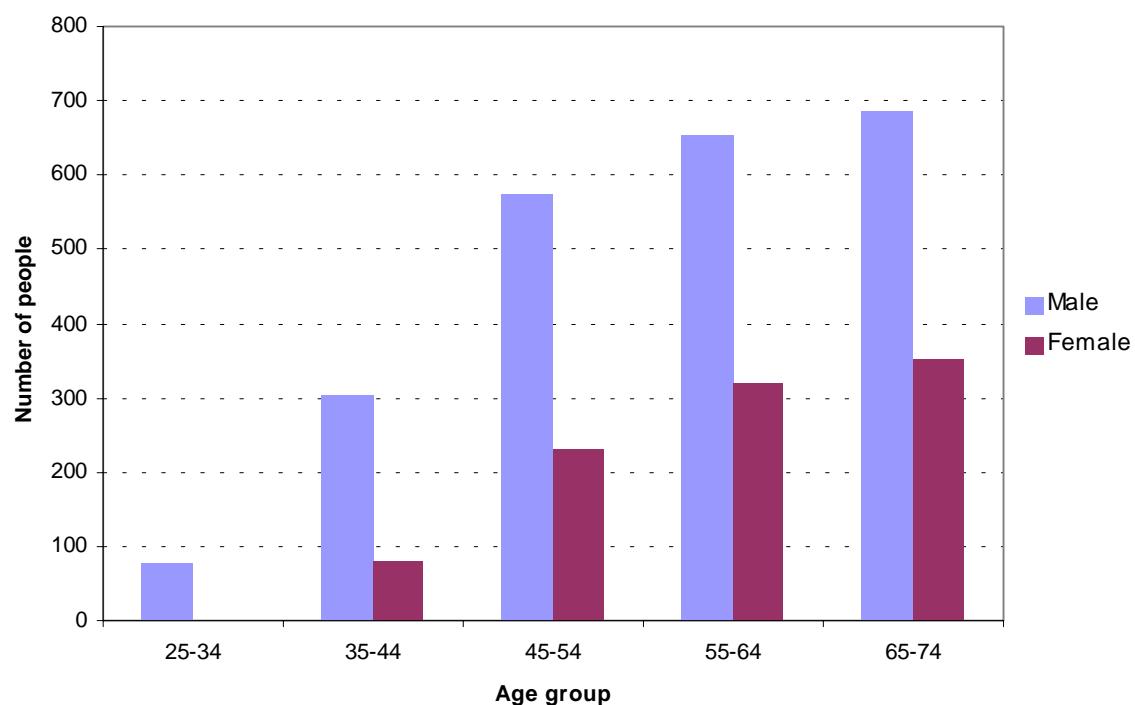
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



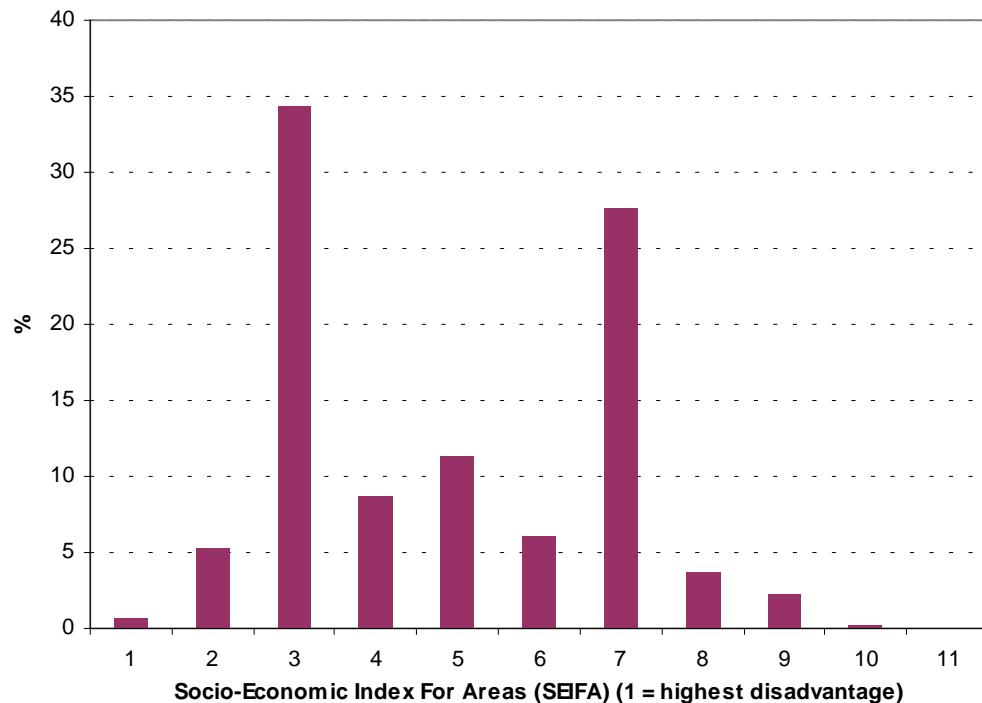
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

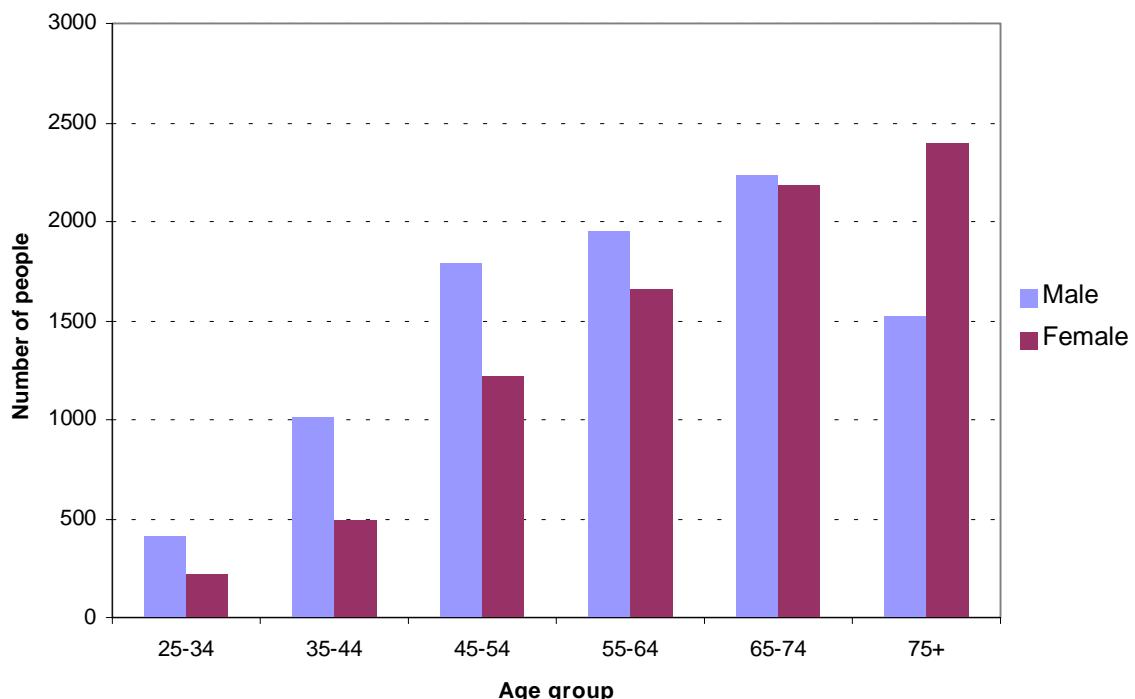
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

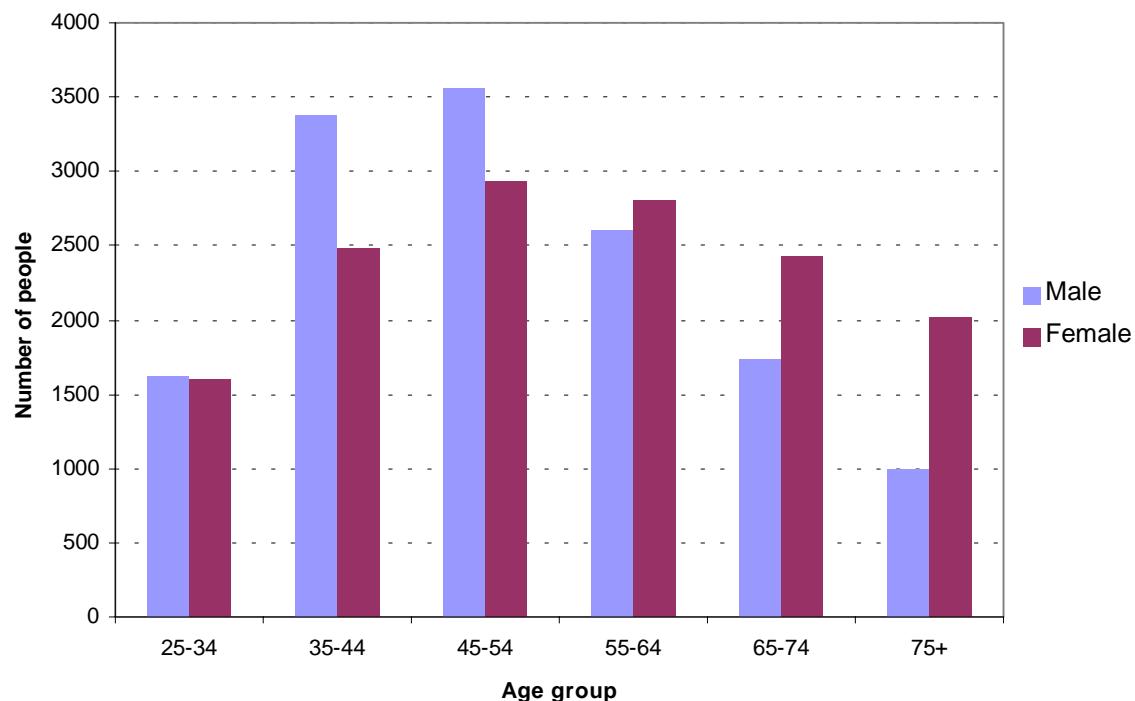
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



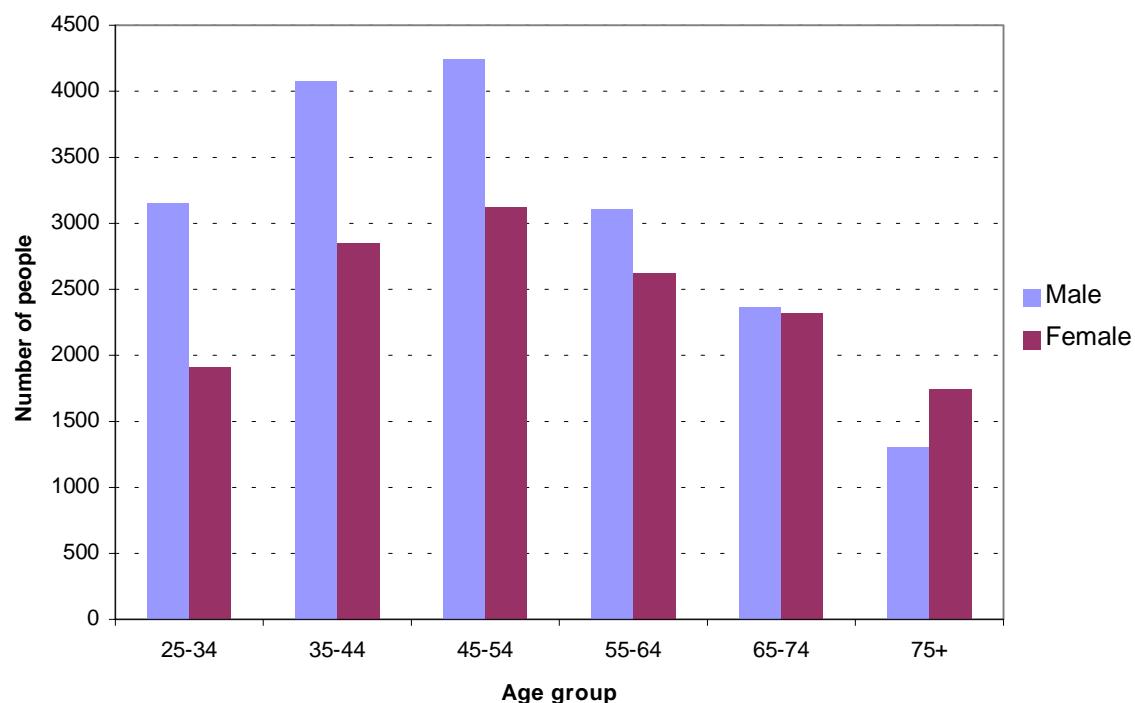
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



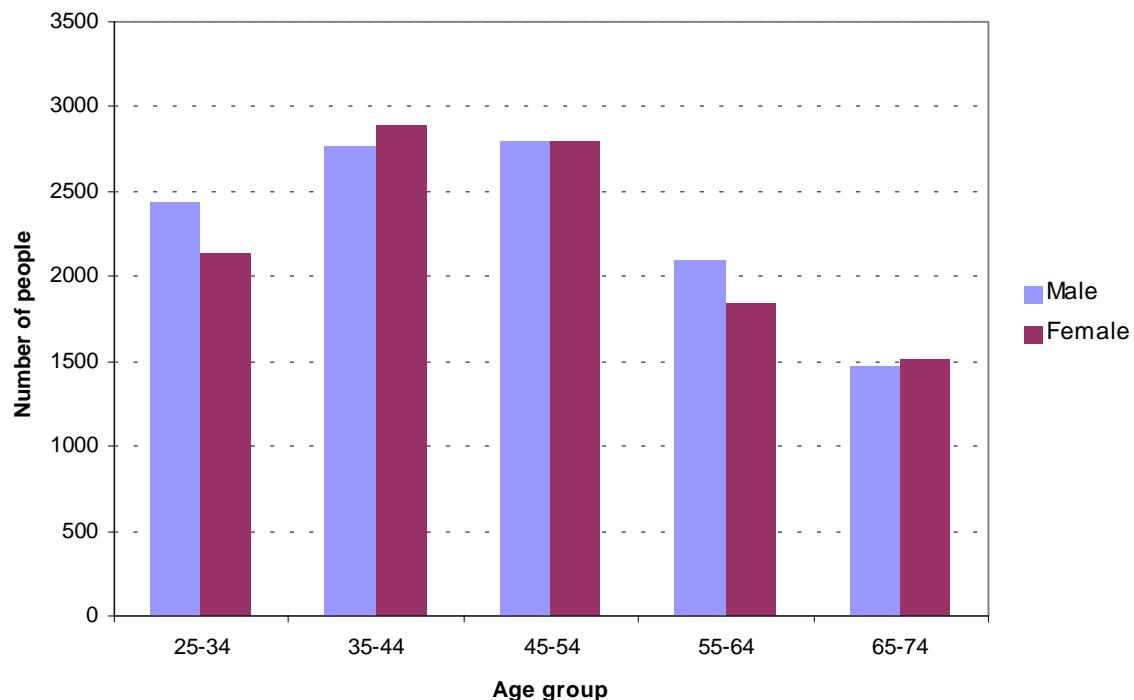
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



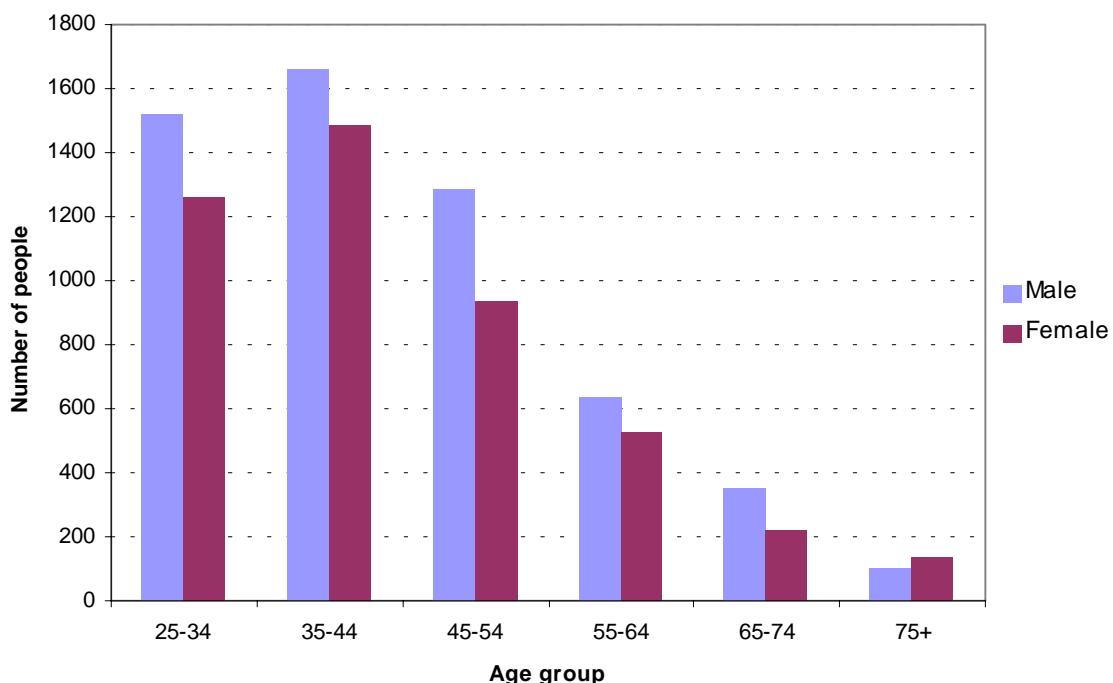
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ■ Number of GPs working in
the Division area: | Total | 59 |
|--------------------------------------------------|-------|----|
-

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes educator based at Sunraysia Community Health Service (SCHS Mildura),
 - Fortnightly diabetes education clinics at Swan Hill and monthly education in Cluyen funded by More Allied Health Services (MAHS),
 - Unconfirmed diabetes educators working in conjunction with local pharmacies.

- What services are needed but are not available in your Division area?

Diabetes educators – only one educator for region.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?
 - Education and support in conjunction with current chronic disease initiatives,
 - Diabetes integrated disease management program in conjunction with SCHS and Mildura Aboriginal Co-Op and Northern Mallee Primary Care Partnership (NMPCP).

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Ongoing education by local endocrinologist,
 - Regular networking with local allied health providers,
 - Initial establishment of diabetes database.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Diabetes integrated disease management program commenced prior to chronic disease initiatives – seen by some GPs as “competition”,
 - Lack of allied health staff to complement diabetes treatment.

- What future plans do you have for diabetes management in your Division?
 - Ongoing education and practice support,
 - Support of chronic disease initiatives.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Computer literacy of GPs and staff,
 - Support from Division staff.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Joint education sessions,
 - Use of MAHS funding to complement GP services.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

Adaptation of other Divisional resources with local perspectives.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Nil new resources,
 - Power Point presentation for Practice Incentive Payments (PIP) – Diabetes.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

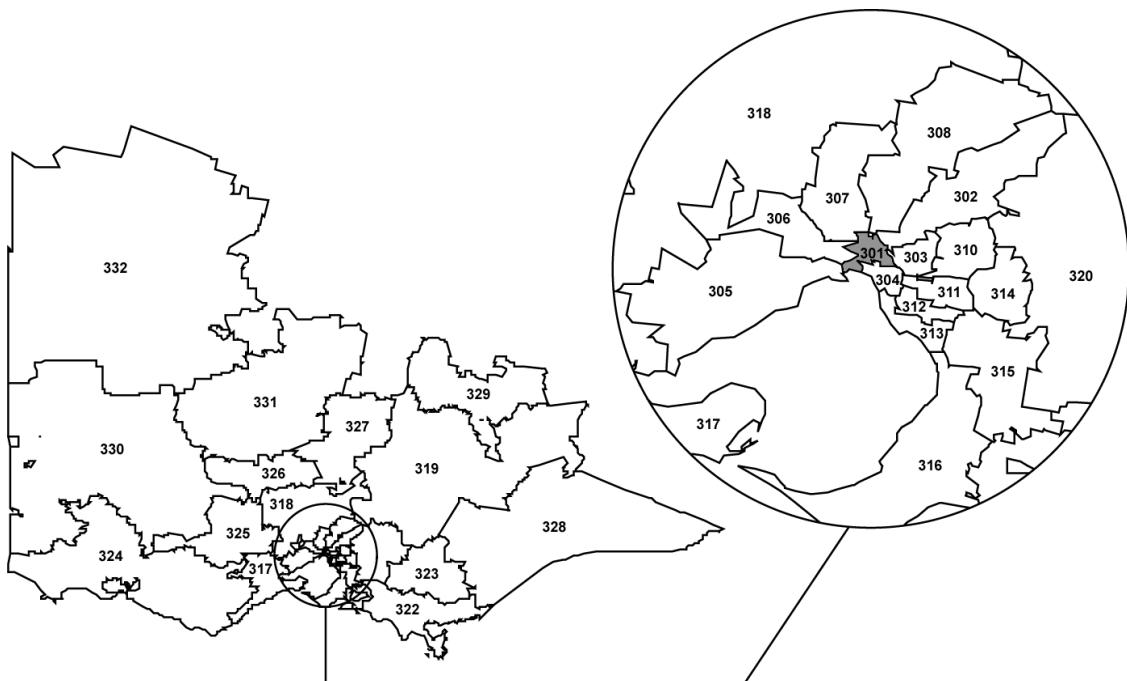
- What resource materials do you provide to practices?

Any resource material that will benefit the GP, practice staff or practices in general.

Division Contact Person/
Program Co-ordinator

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Or bdietrich@malleedgp.com.au

Melbourne DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	175,754	
■ Aboriginal or Torres Strait Islander	693	0.4%
■ Speaks language other than English at home	52,960	30.1%
■ RRMA classification ¹		
1: Capital city	175,754	100.0%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7459	6.1%
■ High blood pressure ⁴	29,842	24.5%
■ High blood cholesterol ⁵	57,441	47.2%
■ Obese or overweight ⁶	70,341	57.8%
■ Physical inactivity ⁷	52,137	42.8%
■ Smoking ⁸	25,488	20.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

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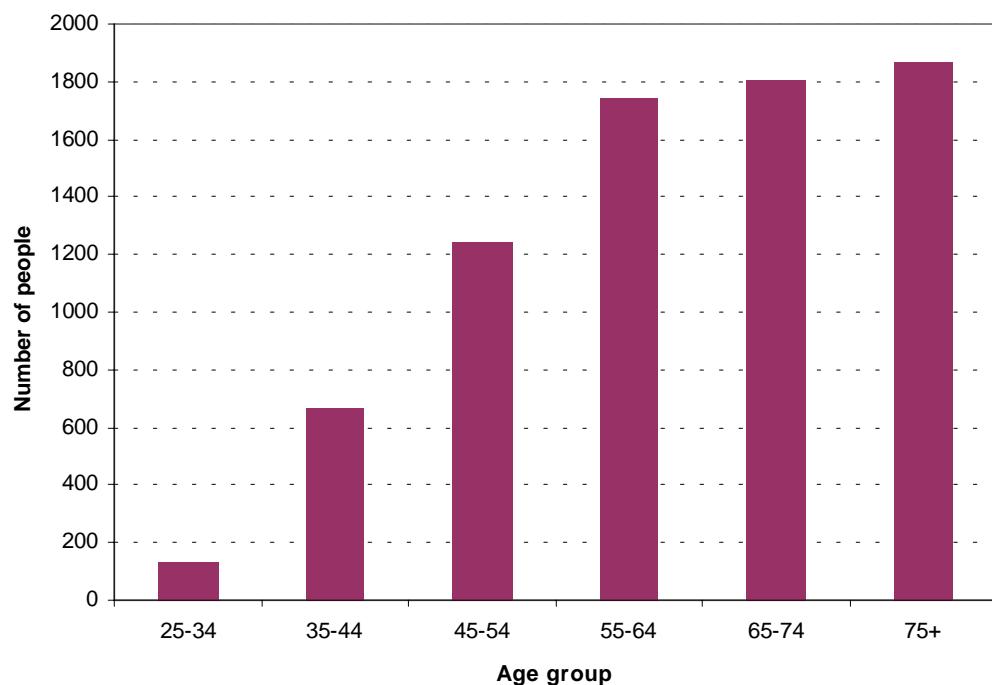
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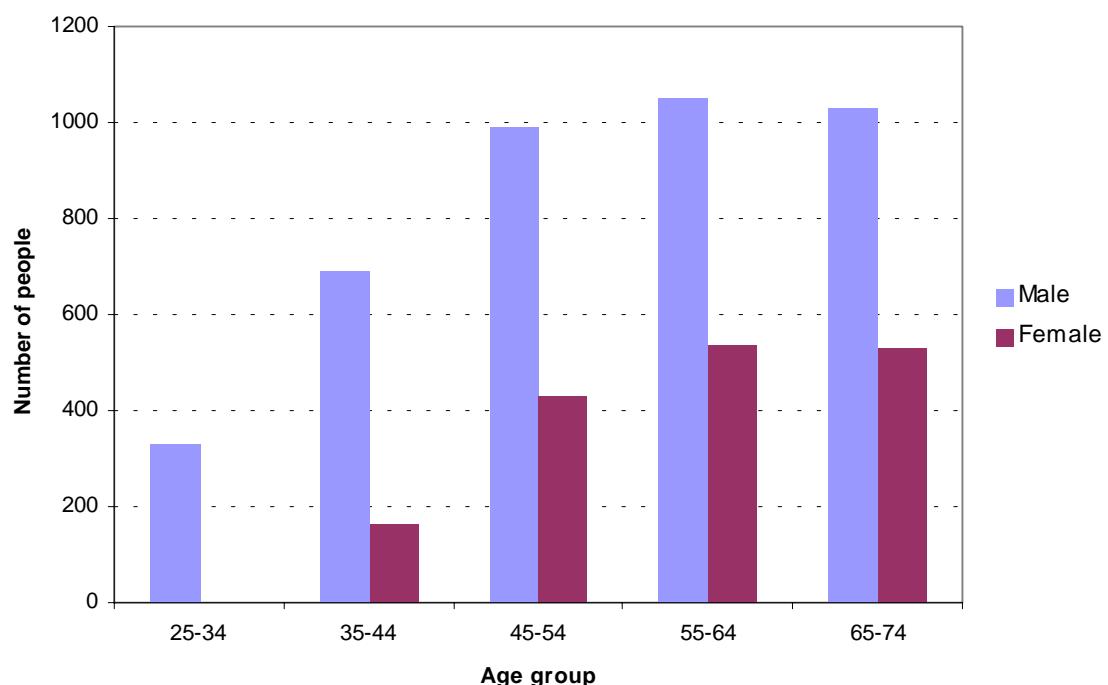
Key Descriptors of Division Population

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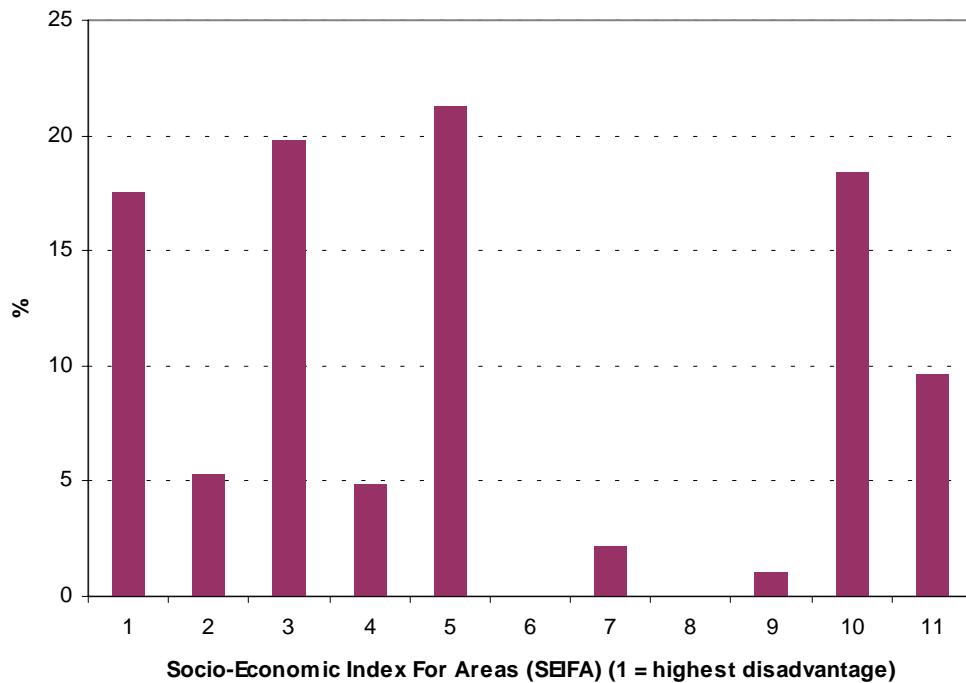
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

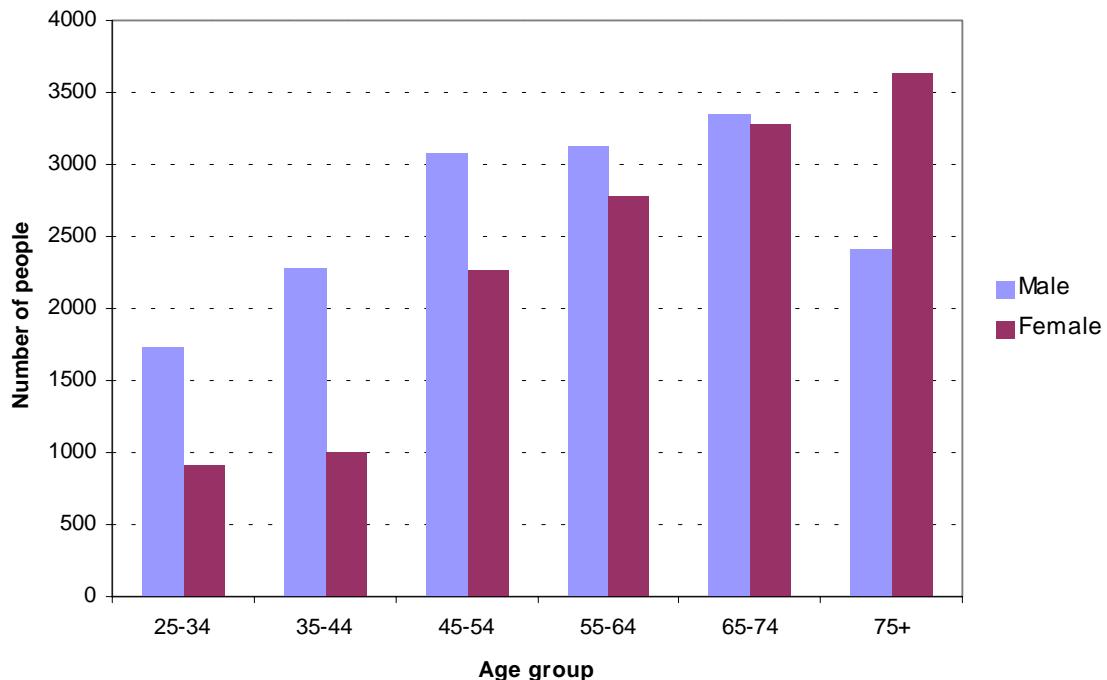
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

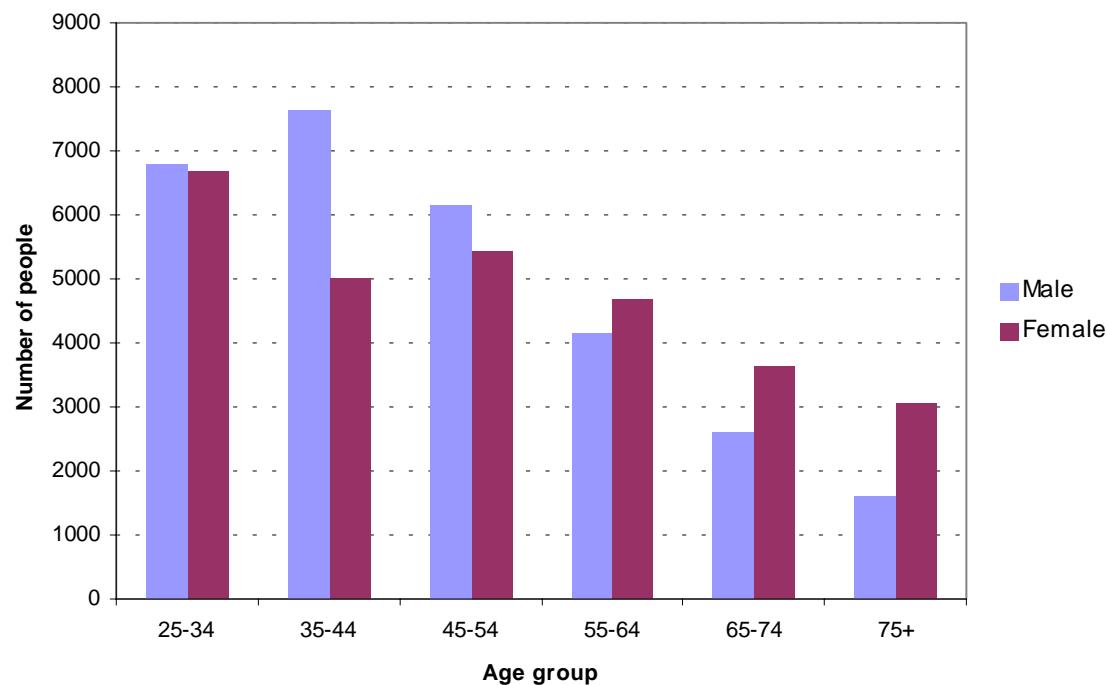
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



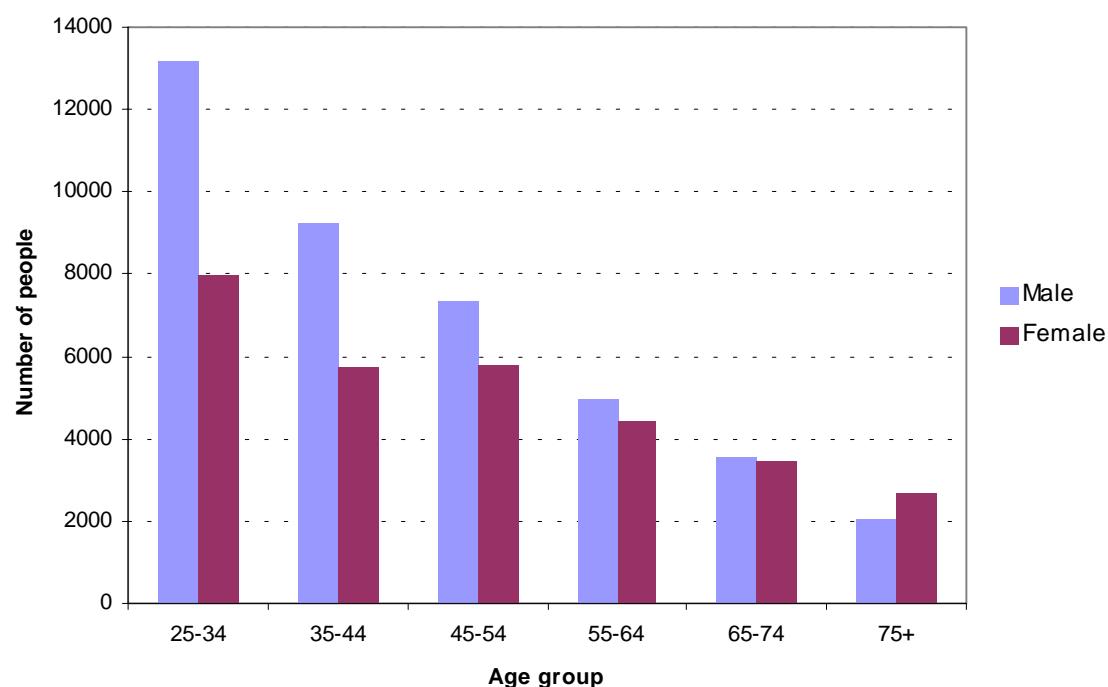
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



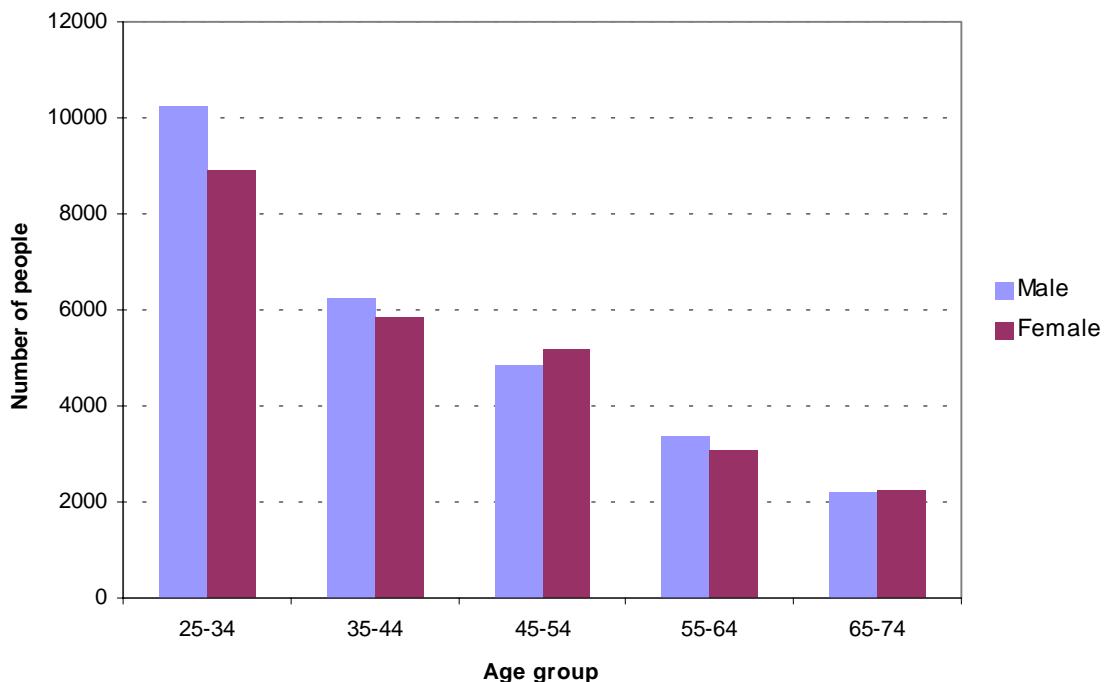
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



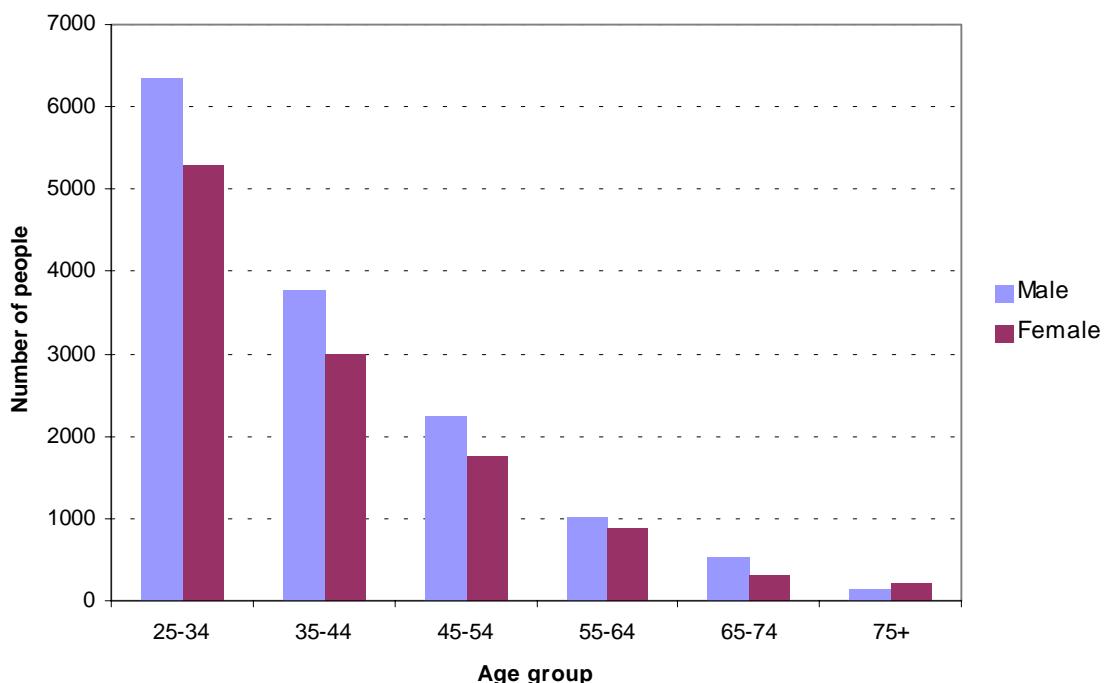
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 431 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Australia – Victoria,
 - St Vincents, Royal Melbourne Hospital,
 - Moreland & Richmond Community Health Centre,
 - Royal Victoria Eye and Ear Hospital,
 - Private endocrinologists at Epworth Hospital, Mercy Private and Freemasons,
 - Insulin stabilisation program through Diabetes Alliance Group.

- What services are needed but are not available in your Division area?
 - Adequate and affordable diabetes nurse educators,
 - Enough GPs,
 - More podiatry,
 - Affordable exercise programs.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

The diabetes program at Melbourne Division of General Practice is run through the Diabetes Alliance Group (DAG), which holds numerous events through the year, produces resources for GPs and accesses funding for providing some services.

Division Perspective

- What have been the major achievements or highlights of your program so far?

The annual weekend conference is always a good drawcard for GPs wanting to stay up-to-date with the latest developments in diabetes management.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Being part of a five Division Alliance helps us achieve far more than we would otherwise. But more time and money would certainly take us even further.

- What future plans do you have for diabetes management in your Division?
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Continuing to provide GPs with the education they require and the resources that make management of diabetes more achievable.
- Good systems support,
 - An interest in these conditions,
 - An ability to analyse their patient data and to communicate with individual patients,
 - Access to up-to-date disease specific information.

The Diabetes Alliance Group (DAG), which includes five Divisions, Royal Melbourne Hospital and Diabetes Australia – Victoria. The DAG has been an ongoing commitment, which has really paid off. It gives us the ability to offer far more than we otherwise would.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

At present the Practice Incentive Payment (PIP) summary guidelines and the patient held record and information sheet developed by the Alliance are very popular. In past, the Abbreviated Clinical guidelines.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

As all the resources are developed by the DAG this requires discussion at their level.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Not at present.
- What resource materials do you provide to practices?
 - Patient Held Record,
 - Patient Information Sheet,
 - Abbreviated Clinical guidelines,
 - PIP Information Sheet,
 - Insulin Stabilisation program notes.

Appendix

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

The purpose of the Diabetes Alliance Group is to be instrumental in the planning and implementation of diabetes services within the geographic region covered by its member Divisions of General Practice. It will:

- Provide a conduit for information flow between 5 Divisions of General Practice, 2 Hospitals and Diabetes Australia – Victoria,
- Provide ongoing education to general practitioners (GPs) on diabetes management in general practice.

The membership of the Diabetes Alliance Group consists of the Melbourne, North West Melbourne, Western Melbourne, Northern Melbourne and Westgate Divisions of General Practice, Royal Melbourne Hospital, Western Hospital (Sunshine) and Diabetes Australia – Victoria.

Terms of Reference

- To ensure appropriate communication between the Divisions and their diabetes programs,
- To facilitate communication between the Divisions and the Hospitals in the provision of care to people with diabetes,
- To facilitate communication between the Divisions and Diabetes Australia – Victoria,
- To provide a forum to discuss issues relating to the provision of care to people with diabetes by GPs,
- To provide a forum to discuss issues between GPs and hospitals within the geographical area relating to the provision of care to people with diabetes,
- To provide a forum to discuss issues between GPs and Diabetes Australia – Victoria relating to the provision of care to people with diabetes within the geographical area,
- To provide education relevant to GPs' needs,
- To develop and support programs that support GPs in providing total care of people with diabetes,
- To lobby and communicate with appropriate organisations to improve services to people with diabetes,
- To be responsive to funding opportunities in the area of diabetes.

Mission Statement

The DAG believes that the role of GPs, as the primary health care provider in the management of people with diabetes, is central to the coordinated care of this group. The DAG believes that the management of people with diabetes is enhanced when all providers involved in caring for people with diabetes, is coordinated.

Goals

The DAG aims to improve the management of people with diabetes.

The DAG aims to enhance the knowledge and confidence of GPs and practice nurses in managing diabetes.

The DAG aims to improve communication between GPs and other care providers in the management of people with diabetes.

The DAG aims to improve the self-management of people with diabetes.

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

Three district areas were identified as being group priorities. These were, GP resourcing with both training opportunities and physical resources, sharing the care of people with diabetes through the development of links with other organisations and care providers, and improved access to education and resources for people with diabetes.

Since 1997 the group has been active in organising training opportunities for GPs and practice nurses in the Northern and Western suburbs of Melbourne, and has worked to help create strategic partnerships between GPs and other health care providers working with people with diabetes. Representatives of the DAG are active on state and regional planning committees, their contributions valued for their expertise and track record of achievement in diabetes. Numerous resources for use by people with diabetes have been produced and widely distributed through GPs of member divisions.

The DAG has had consistently broad multidisciplinary representation on its committee, and currently has five Divisional representatives, two GPs, two diabetes nurse educators, and one endocrinologist. The DAG is chaired by GP, Dr Ralph Audehm.

The DAG currently meets quarterly with representatives of all member organisations present to discuss the broad direction of DAG projects, programs and resources. A subgroup of representatives from all member Divisions plus the GP chairperson, meets monthly to discuss operational matters, and conduct detailed planning for activities and resource development.

Current and recent diabetes related projects auspiced by DAG

GP Insulin Stabilisation Project

Member Divisions have access to a diabetes educator, available to assist GPs with insulin changeover and stabilisation. The educator also provides patient education with literature, brochures and insulin pens, free of charge. This service has been used by 10 GPs and 25 people with diabetes in the year to end June 2001.

Nurse Practitioner Project

Together with Diabetes Australia – Victoria, DAG has recently auspiced a nurse practitioner project in Victoria involving improved access to the services of a nurse practitioner candidate in diabetes education for people with diabetes in a GP setting.

Hospital Admission Reduction Program (HARP)

Successful submission for HARP funding was received in 2002 from the State government of Victoria. This project, funded for three years, aims to increase the capacity of selected GP practices to support their patients with diabetes by increasing their access to a diabetes educator. Diabetes educators will be available 24 hours a day to deal with diabetes related crises out of hours, and to counsel patients on an appointment basis.

Summary

The Diabetes Alliance Group is proud of its achievements. The member groups believe that the collaboration, which is the DAG, enhances the performance of each individual agency in the area of diabetes. The sustainability of the group is evident, given all founding organisations are still active within the alliance, five years after first meeting.

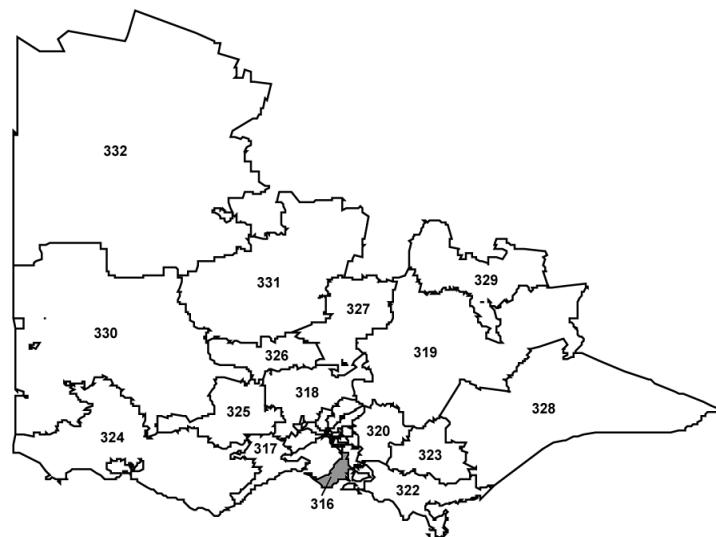
The evidence of outcomes are also clear. GP and nurse training opportunities, resources for people with diabetes, and links which have been established between GPs and other health providers in the primary care setting, clearly place the DAG as a leading collaborative group, not only within the Divisional movement, but also on a broader national basis. At an organisational level DAG representation on state and regional committees further reinforces the success of the collaboration, with external agencies keen to draw on the learning and achievements of the group.

The members of the DAG look forward to continued successes in their collaboration into the future.

Division Contact Person/
Program Co-ordinator

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Mornington Peninsula DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	252,840	
■ Aboriginal or Torres Strait Islander	1231	0.5%
■ Speaks language other than English at home	16,354	6.5%
■ RRMA classification ¹		
1: Capital city	252,840	100.0%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	14,558	8.6%
■ High blood pressure ⁴	52,646	31.2%
■ High blood cholesterol ⁵	86,181	51.0%
■ Obese or overweight ⁶	100,226	59.4%
■ Physical inactivity ⁷	68,778	40.7%
■ Smoking ⁸	30,982	18.4%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

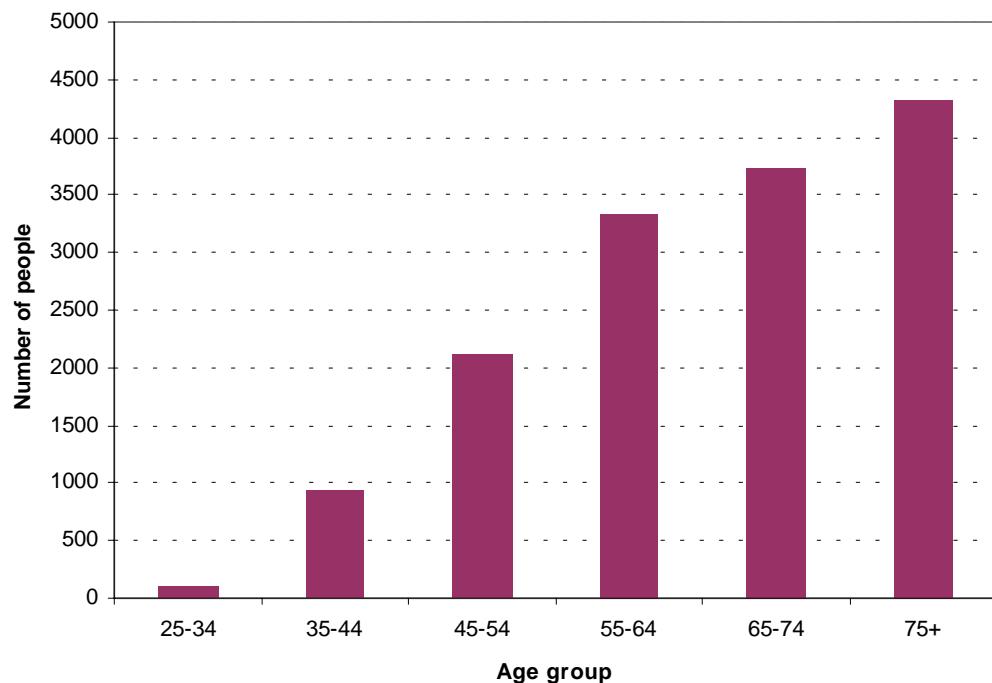
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

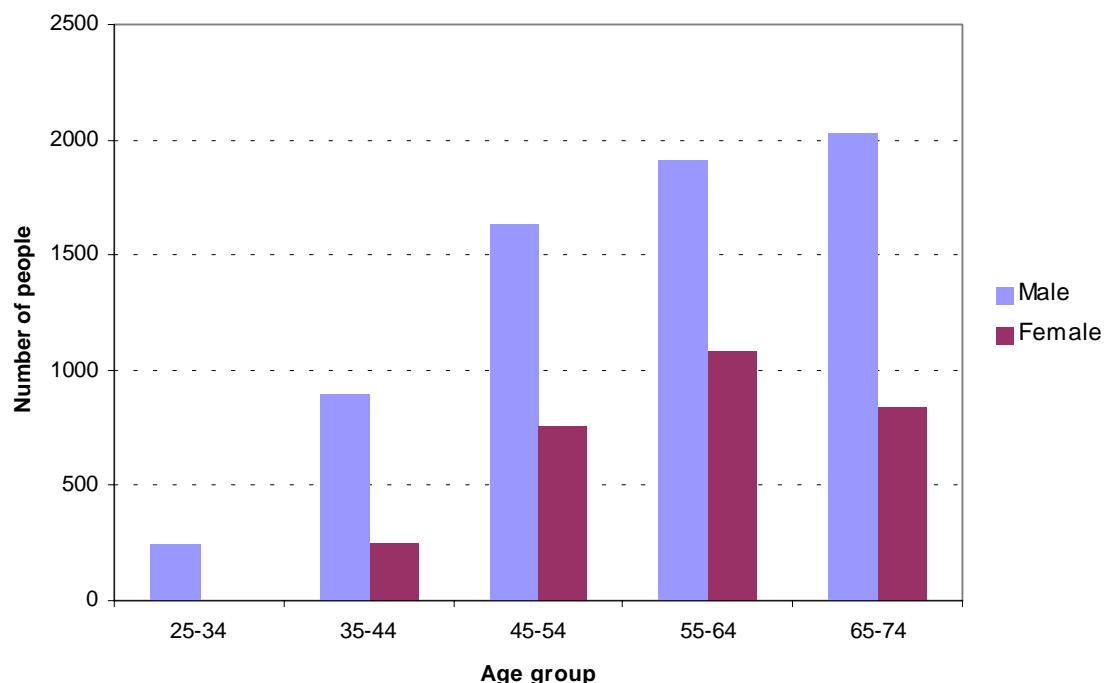
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



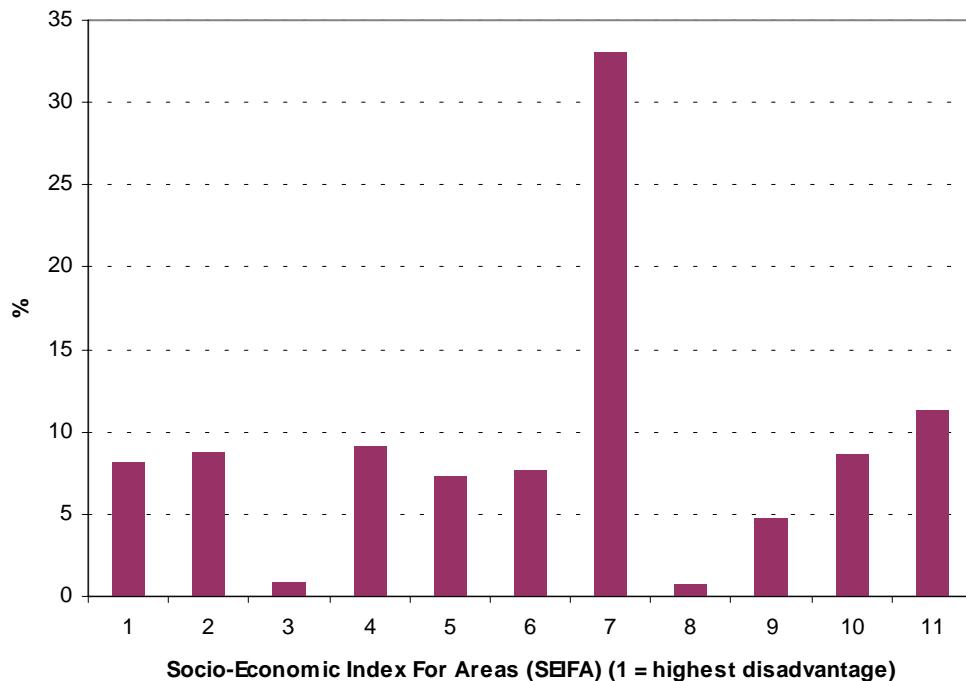
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

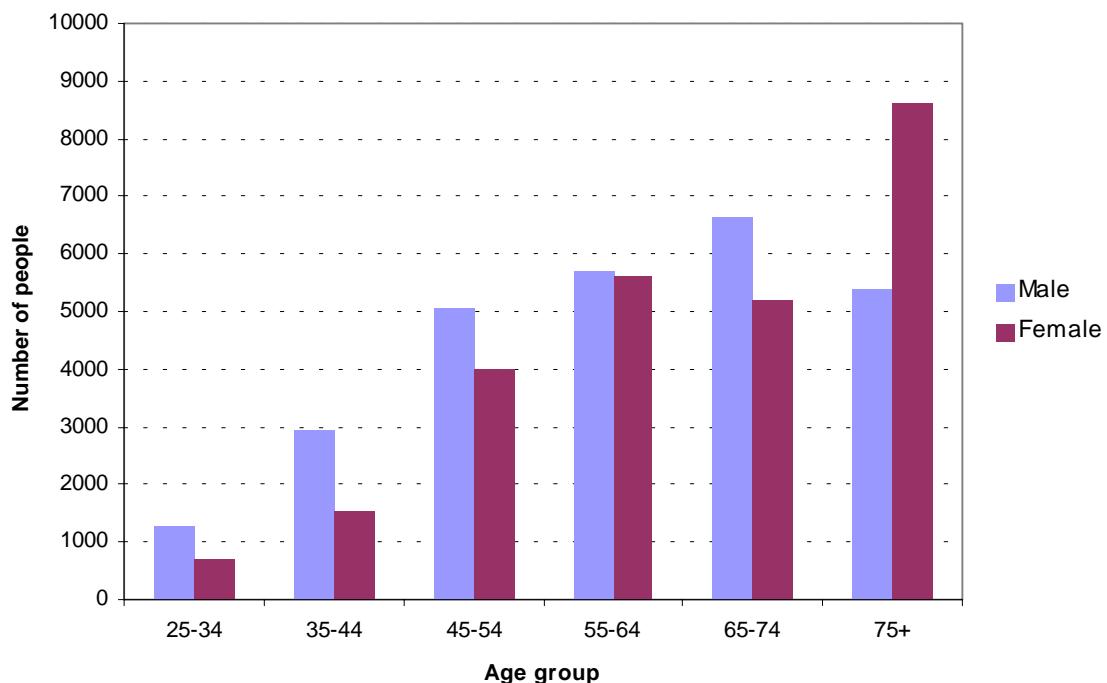
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

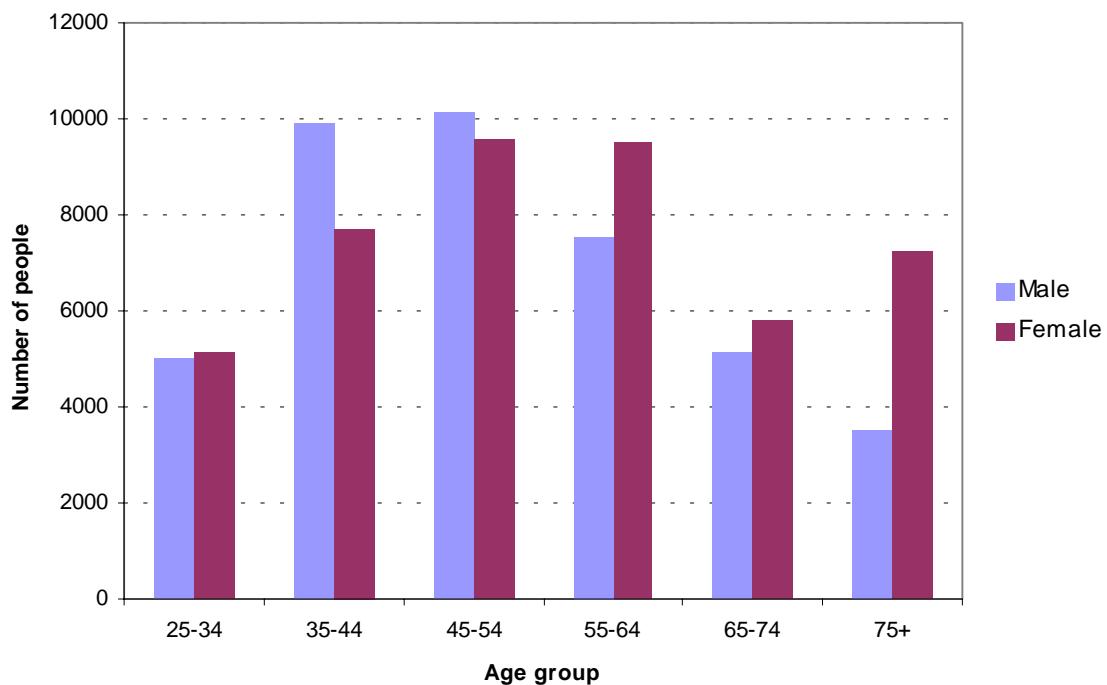
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



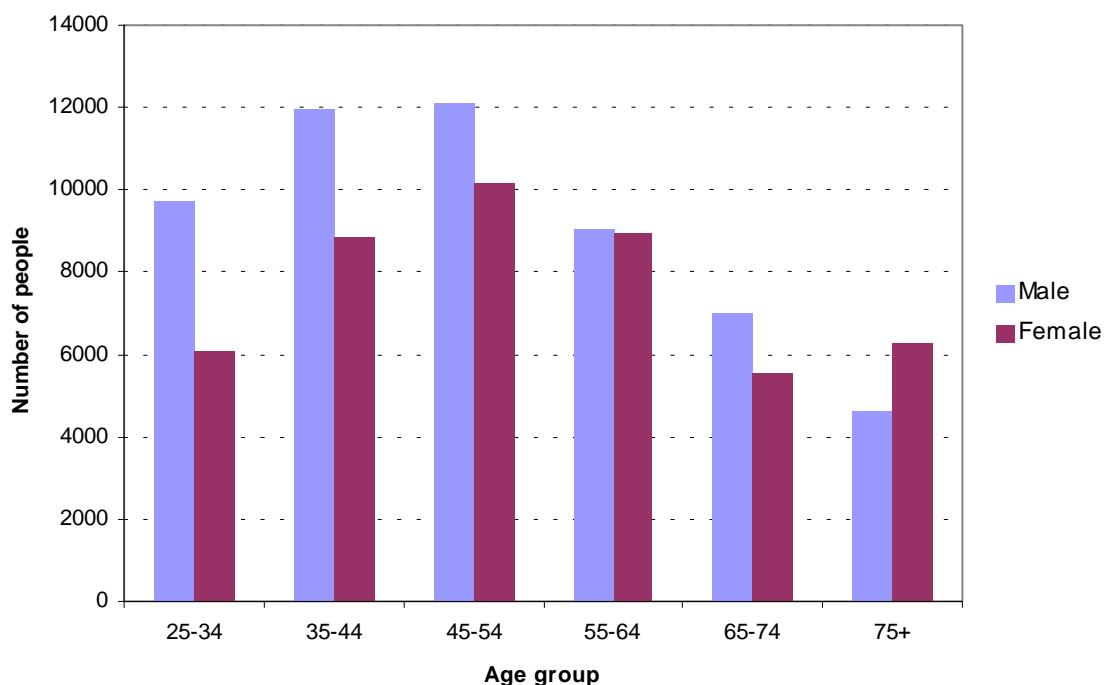
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



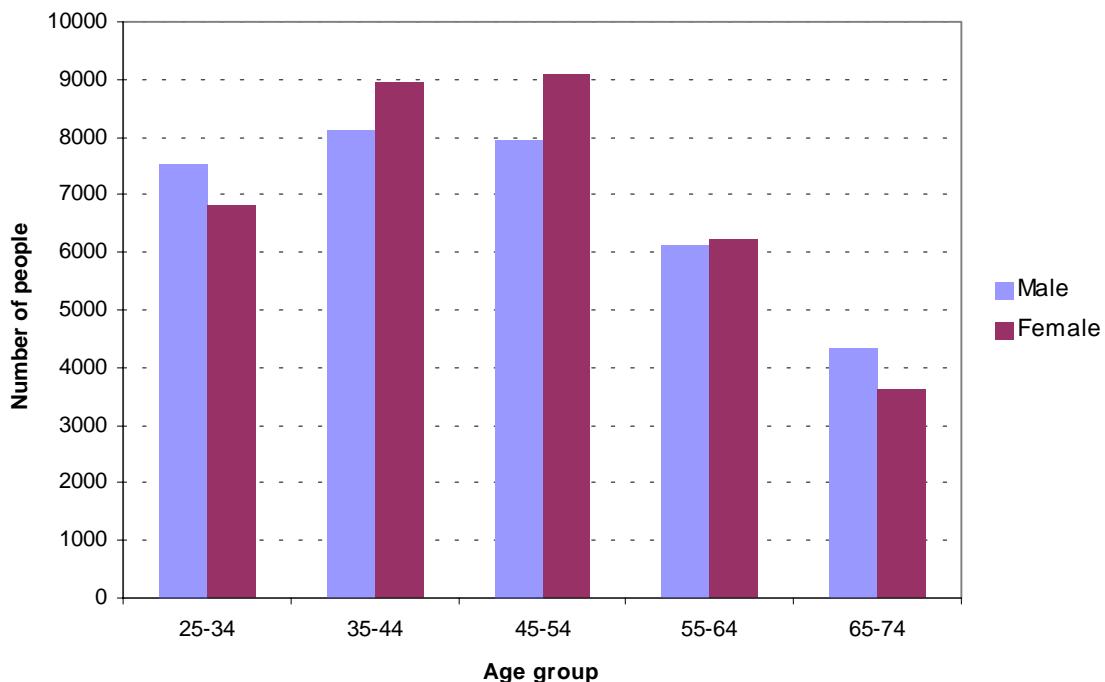
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



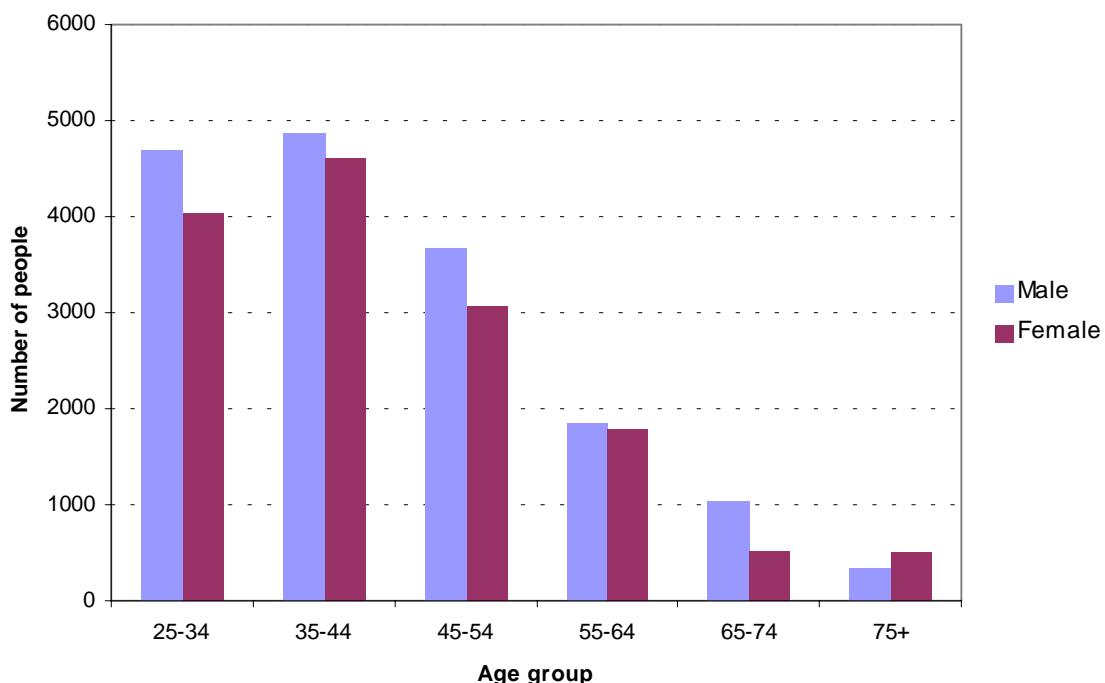
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 215 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes education groups and consultations in local Community Health Centre,
 - Diabetes consultations at local chemists,
 - Diabetes consultations at private hospitals including gestational diabetes,
 - Frankston Hospital – outpatient consultations, complication screening, gestational diabetes clinic,
 - YADS – Young Adult Diabetes Service,
 - Endocrinologists,
 - Royal District Nursing Service (RDNS) – Diabetes Education Service.

- What services are needed but are not available in your Division area?
 - More hours and more of the above, re diabetes education,
 - More dietitian services,
 - More podiatry services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

We no longer have a Diabetes Education Program for patients or Young Adult Diabetes Clinic – these have now been taken over by Peninsula Health.

Our diabetes program is now focused on the new initiatives and in upskilling practices (GPs/nurses/patients) to be able to provide better care, management, and screening for complications for people with diabetes.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The Young Adults Diabetes Services and group education, which have now been taken over by Peninsula Health (YADS),
 - Upskilling GPs and practice nurses in treatment of diabetes,
 - Chronic Disease Incentive (CDI) program is relatively new here.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Time constraints for endocrinologists and GPs to participate in joint education sessions,
 - Frustration of GPs due to length of time patients wait for allied health appointments.

- What future plans do you have for diabetes management in your Division?
 - Continue to support GP involvement and integration in community based care and in YADS clinic,
 - Focus on GP and practice nurse upskilling in diabetes management,
 - Focus on GPs conversion of patients to insulin,
 - Focus on whole of practice approach to promote optimal care to patients with diabetes.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Motivation and willingness for change and learning,
 - Advanced information management processes established,
 - Understanding of the importance of good management of chronic diseases.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Program Officer here is a diabetes educator – who works at GP practices/private hospitals and is a member of Peninsula Diabetes Professionals (PDP) special interest group and Australian Diabetes Educators Association (ADEA) and of Diabetes Australia – Victoria (DAV),
 - GPDV – Victorian Division State Based Organisation,
 - Peninsula Health Care Network,
 - Frankston Community Health Centre,
 - Peninsula Community Health Centre.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Royal Australian College of General Practice (RACGP) clinical guidelines, information sheets, etc,
 - Diabetes Australia – Victoria (DAV),
 - International Diabetes Institute (IDI),
 - General Practice Divisions Victoria (GPDV),

- Australian Diabetes Educators Australia (ADEA),
- Health and Aged Care Information,
- Peninsula Diabetes Professionals (PDP) handouts,
- Videos,
- Pharmaceutical company demos, ie insulin pens,
- United Kingdom Prospective Diabetes Study (UKPDS), Aus Diab and other studies.

▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?	Diabetes kit, which would include resource materials as below.
▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?	N/A.
▪ What resource materials do you provide to practices?	<ul style="list-style-type: none">• Local resources – list of education providers, list of services available locally/regionally,• Diagnosis and best practice guidelines,• Patient handouts,• Dietary advice handouts,• Information as requested by practices.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Cardiac Rehabilitation and Secondary Prevention program at Frankston Hospital, Beleura Private Hospital and Nepean Rehabilitation Hospital,
 - Heart Failure Program at the Division,
 - New Heart Failure Clinic currently being set up at Frankston Hospital.

- What services are needed but are not available in your Division area?
 - Education and Exercise Program particularly designed for patients with heart failure,
 - More hours provided for cardiac rehabilitation,
 - Support services for people with heart disease.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The Cardiovascular Disease Secondary Prevention Program has just been completed at the Division and a Heart Failure Program is currently being set up.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - With CVD Secondary Prevention Program decreasing risk of heart disease by GPs doing regular risk factor assessments,
 - Providing cardiology lunch time sessions to upskill GPs knowledge on CVD, treatments, management, etc.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

GP involvement – due to time constraints on GPs being busy in their practices, not having any extra time for paperwork, etc.

- What future plans do you have for CVD management in your Division?
 - Continue to support GP involvement, improve links with hospitals, GPs, Division, etc,
 - Focus on whole practice approach in treating patients with heart failure,
 - Provide best practice guidelines on heart failure management to GPs on Mornington Peninsula.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Update IM/IT equipment and knowledge,
 - Motivation and willingness to change and upskill knowledge.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Heart Foundation, or
 - Heart Support of Australia,
 - Program Officer for Heart Failure is a cardiac nurse and is a member of Australian Cardiac Rehabilitation Association,
 - Australian Society of Critical Care Nurse,
 - GPDV,
 - Peninsula Health,
 - Frankston Integrated Health Centre.

Division Resources

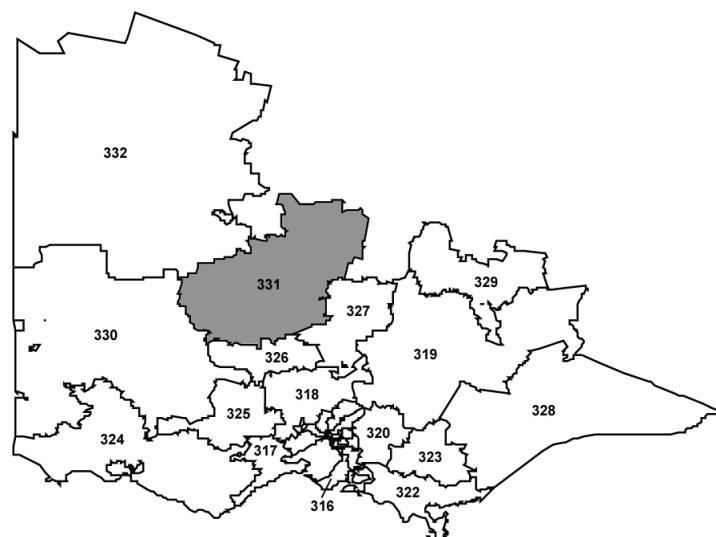
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation,
 - Baker Institute for data analysis,
 - Heart Support Australia,
 - Cardiomyopathy Association.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Management Guidelines for Heart Failure developed by National Heart Foundation and Australian and New Zealand Cardiac Society,
 - Resource kit currently being developed,
 - Support services for patients with heart failure.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - N/A.

- What resource materials do you provide to practices?
 - Local resources, ie list of education providers, services available locally,
 - Patient handout, ie medications, treatment, diet,
 - Best practice guidelines and any other information required.

Division Contact Person/
Program Co-ordinator

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Murray-Plains DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	61,177	
■ Aboriginal or Torres Strait Islander	1035	1.7%
■ Speaks language other than English at home	1025	1.7%
■ RRMA classification ¹		
4: Small rural	15,722	25.7%
5: Other rural	43,252	70.7%
7: Other remote	2264	3.7%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	3768	9.2%
■ High blood pressure ⁴	14,037	34.2%
■ High blood cholesterol ⁵	21,885	53.3%
■ Obese or overweight ⁶	25,265	61.5%
■ Physical inactivity ⁷	17,003	41.4%
■ Smoking ⁸	7388	18.0%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

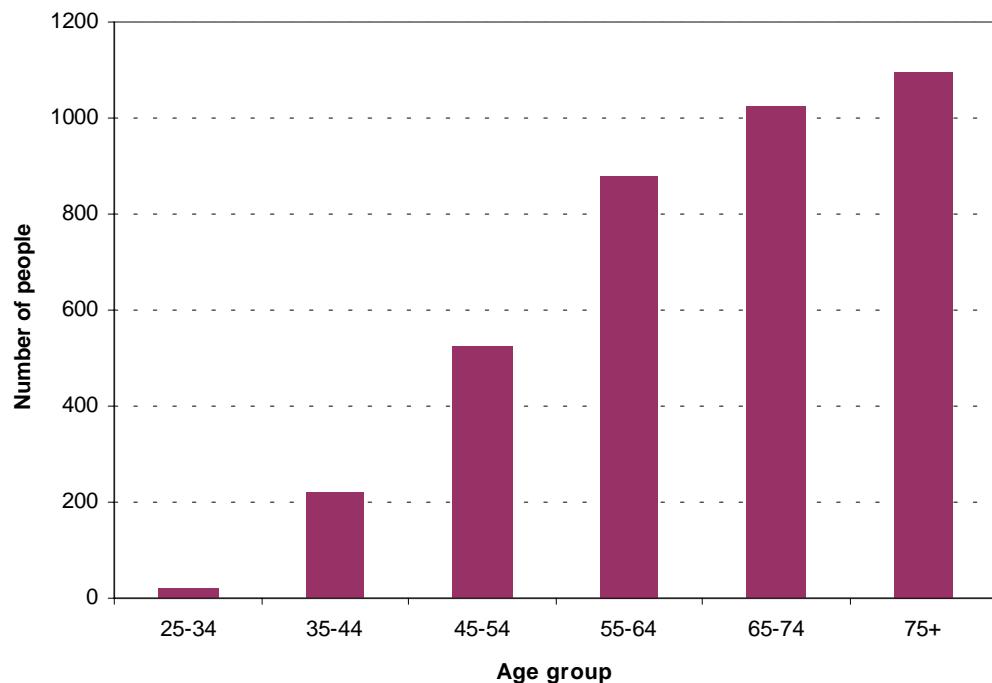
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

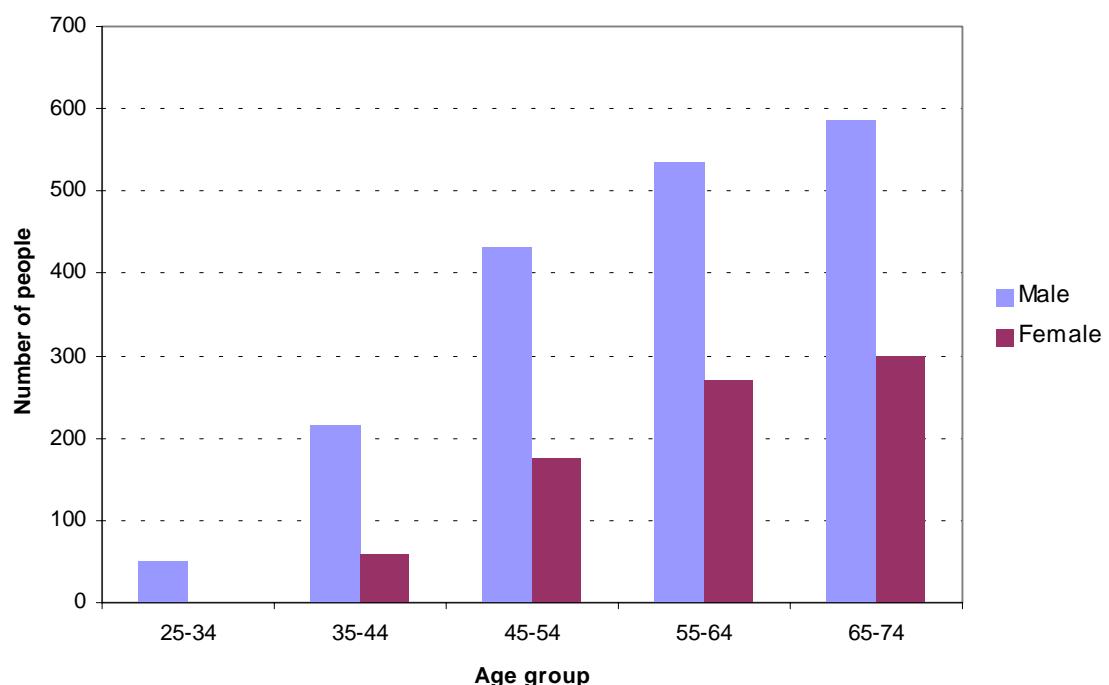
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



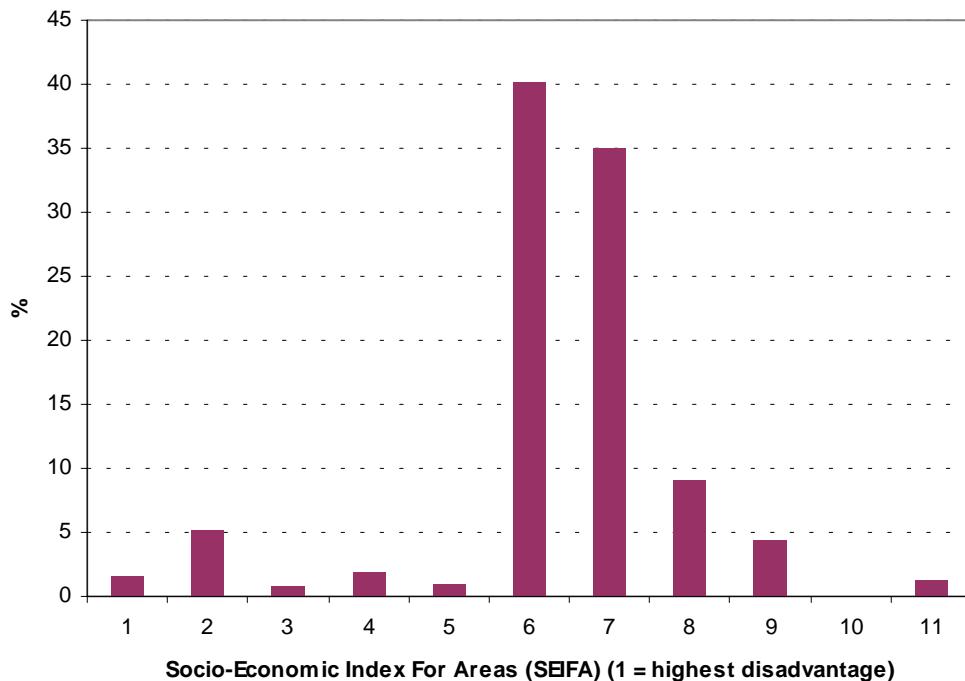
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

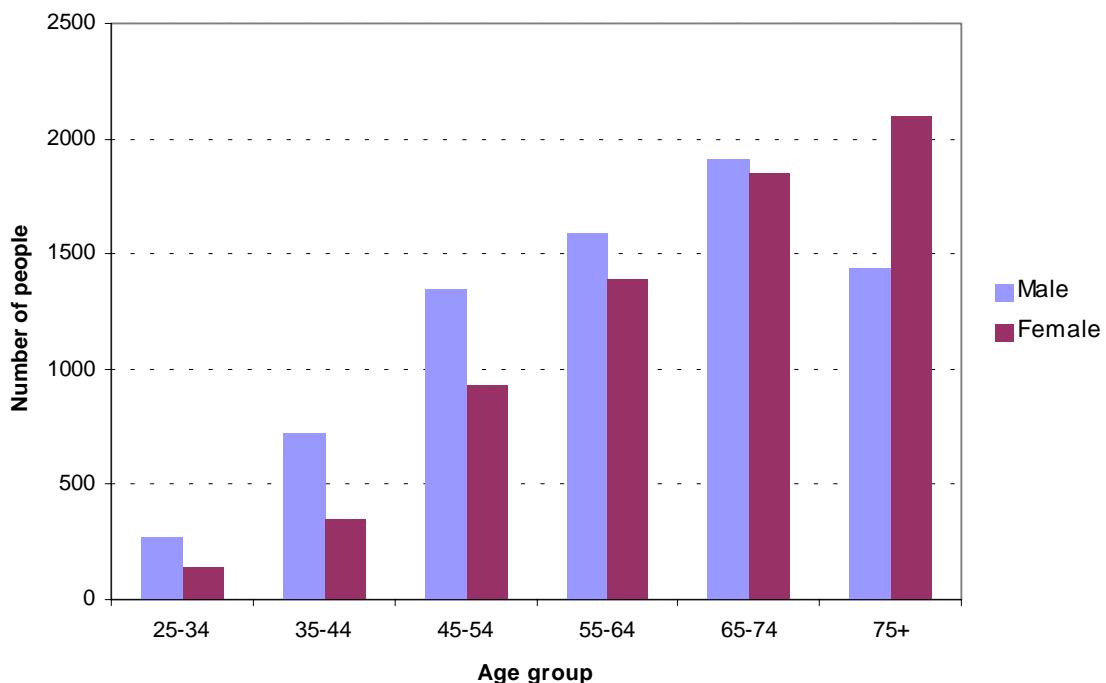
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

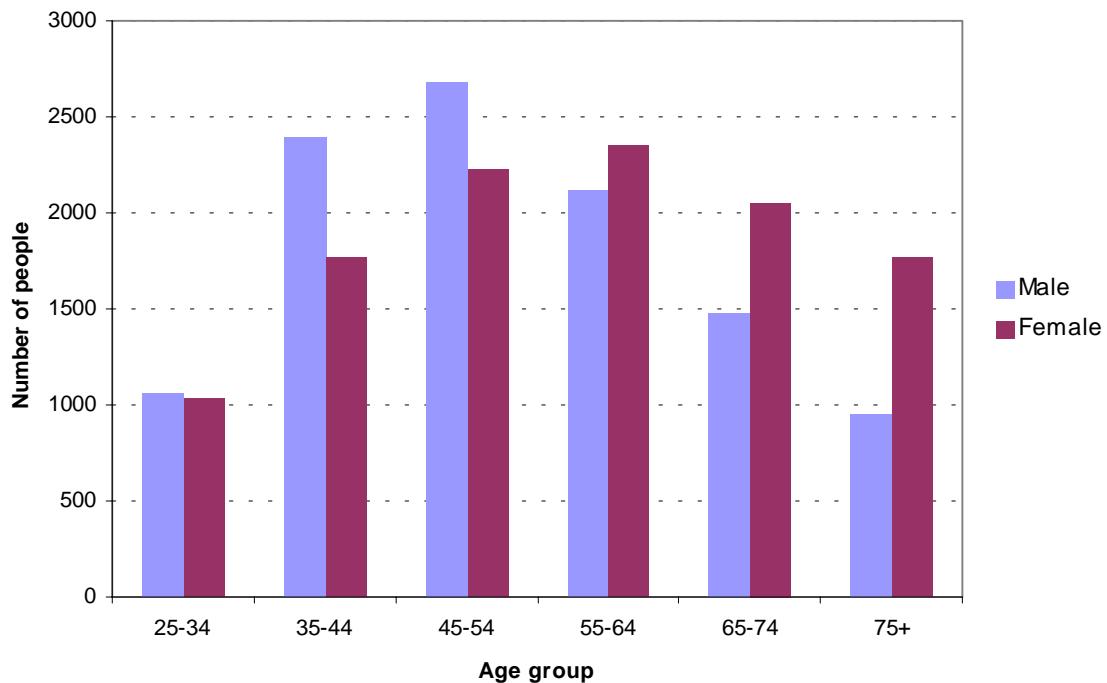
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



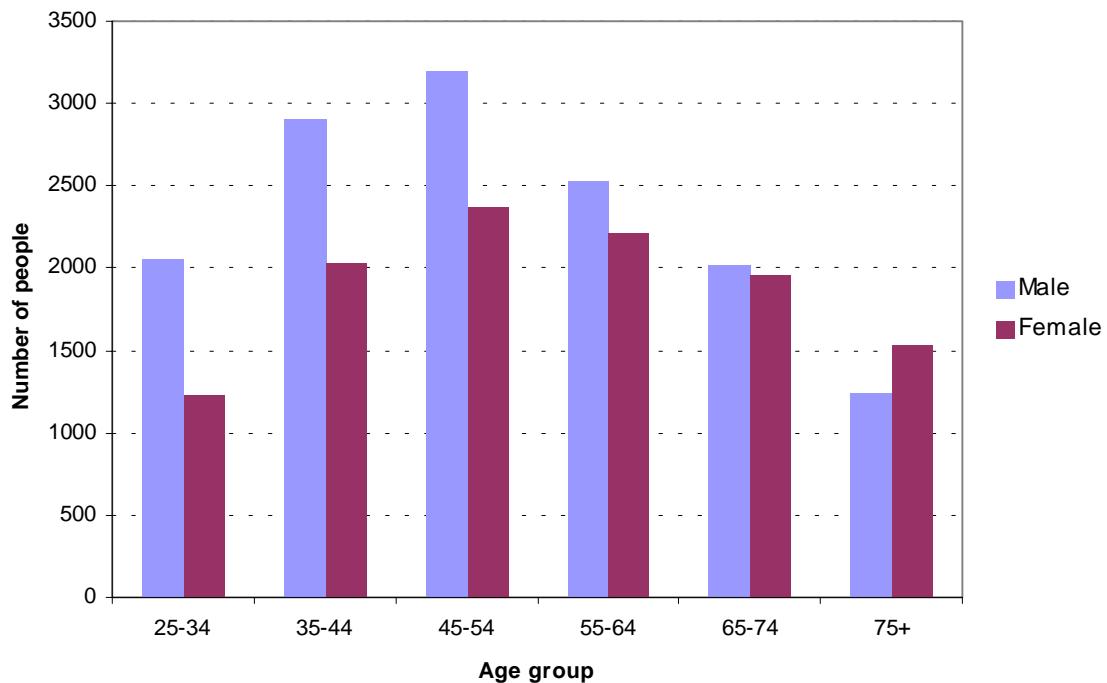
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



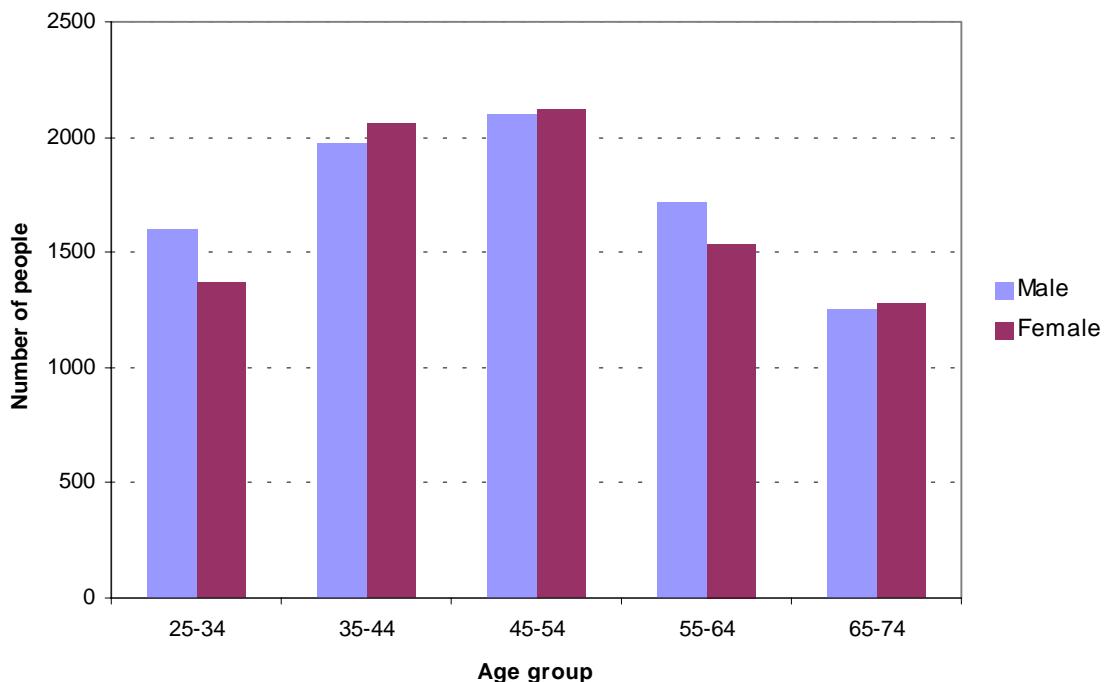
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



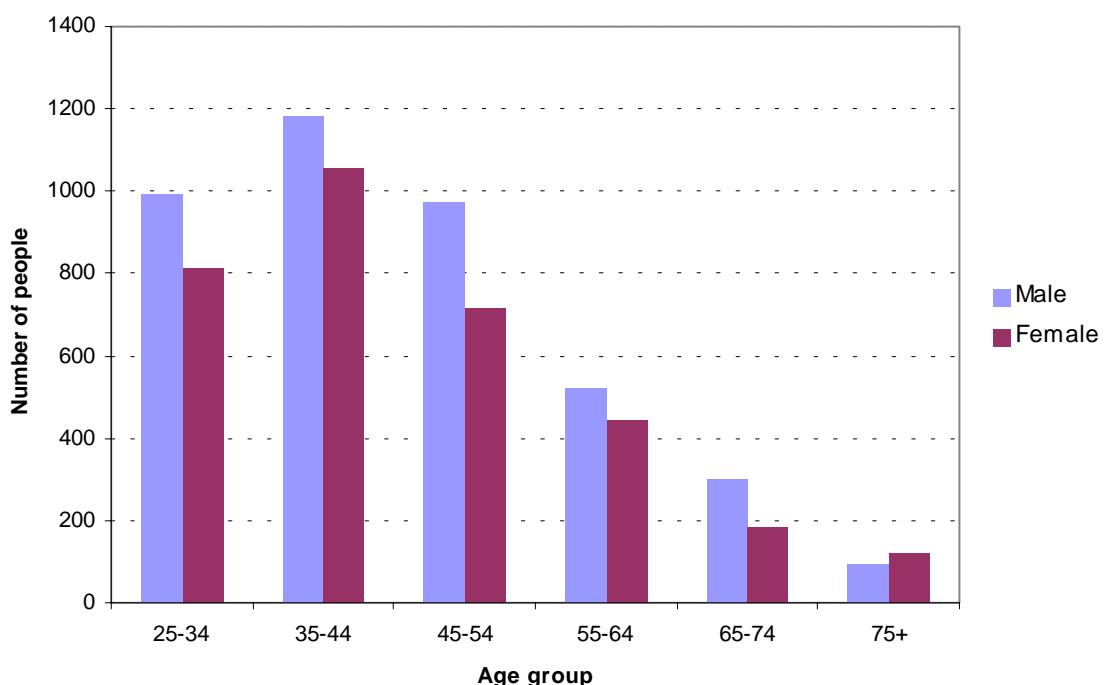
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 63 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Dietitians, diabetic educators, podiatrists – all of which are in short supply with lengthy waiting lists. Services are accessible in “pockets” only across the Division (not available in all areas).
- What services are needed but are not available in your Division area?

Dietitians, diabetic educators, podiatrists, endocrinologists, ophthalmologists – again, these services are needed in most areas of the Division.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002
- Please describe your diabetes program including any changes that occurred over time?

No specific program apart from support for GPs and staff in linking Enhanced Primary Care Planning and the Chronic Disease Management PIP items with appropriate services. Assistance has been provided with setting up diabetes registers, providing ongoing best practice in diabetes care and management, developing effective recall/reminder systems to ensure continuity of care. GPs embracing the Chronic Disease Management initiatives have improved their information management/record keeping – many of them are making the gradual change from paper-based systems to electronic records.

Division Perspective

- What have been the major achievements or highlights of your program so far?

 - Practices have set up diabetes registers,
 - Practices have improved diabetes care and management through adherence to guidelines through the Chronic Disease Management Diabetes initiative,
 - Practices have developed effective recall/reminder systems to ensure continuity of care,
 - GPs embracing the Chronic Disease Management initiatives have improved their information management/record keeping – many of them are making the gradual change from paper-based systems to electronic records,
 - Some practices have employed practice nurses

to assist with collection of information and patient education – this is an important factor considering the huge workload of many rural GPs who, in the past, have not had sufficient time to monitor diabetic patients' progress in a structured, documented format.

-
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Financial constraints,
 - GP/staff time constraints and some difficulty in tracking compliance of chronic disease management items due to electronic health record systems not having completely adequate methods of “tracking” cycles of care.
 - What future plans do you have for diabetes management in your Division?
 - Formalised training sessions in Information Management across the Division to upskill as many GPs and staff as possible,
 - Facilitated meetings between GPs, staff and services to provide optimal patient care.
 - What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Division's intervention (assistance, resources and support),
 - Committed GPs and staff (understanding the benefits of embracing change),
 - Practices' pursuance of excellence in electronic information management.
 - What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Memorandums of Understanding have been developed with three Primary Care Partnerships (funded by Department of Human Services, Victoria). We are involved at an executive and operational level with Bendigo Loddon, Campaspe and Southern Mallee PCPs, which has provided networking opportunities enhancing the linkages between allied health staff and practices. Improved relationships with community health services has assisted in the implementation of better access to services for GPs and consumers.

Division Resources

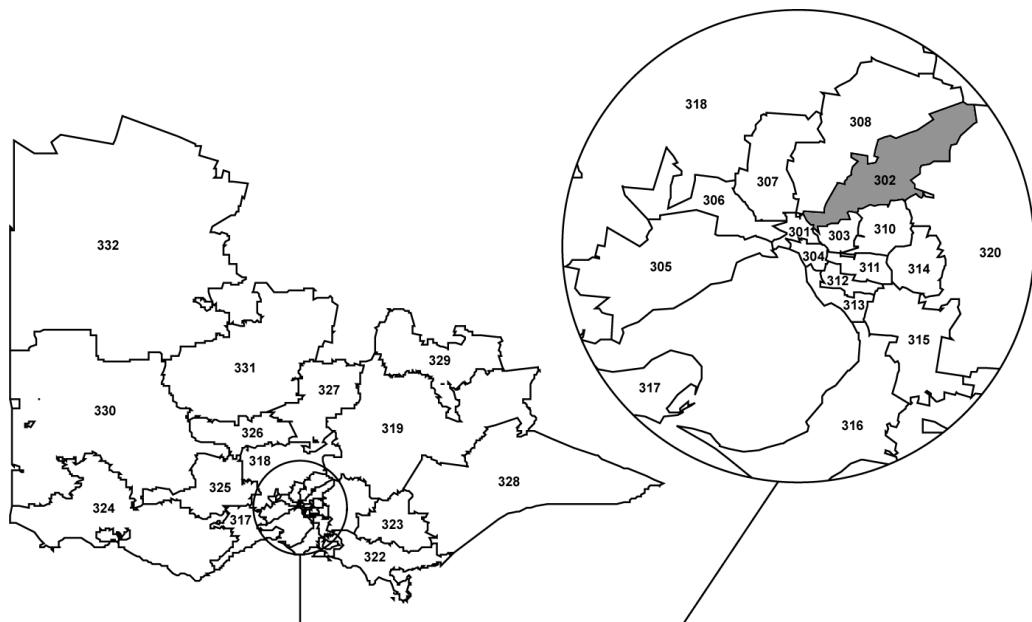
- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - State based resources provided by other Divisions and General Practice Divisions Victoria (GPDV) and adapted by our Division to meet the needs of GPs and staff. National Prescribing Service (NPS) academic detailing card on Management of Type 2 Diabetes has been utilised and distributed to most practices.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? State-based resources provided by other Divisions and General Practice Divisions Victoria (GPDV) and adapted by our Division to meet the needs of GPs and staff. National Prescribing Service academic detailing card on Management of Type 2 Diabetes has been utilised and distributed to most practices.

Division Contact Person/
Program Co-ordinator

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North East Valley DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	224,326	
■ Aboriginal or Torres Strait Islander	1015	0.5%
■ Speaks language other than English at home	43,120	19.2%
■ RRMA classification ¹		
1: Capital city	222,980	99.4%
5: Other rural	1346	0.6%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,133	7.5%
■ High blood pressure ⁴	42,673	28.7%
■ High blood cholesterol ⁵	75,405	50.7%
■ Obese or overweight ⁶	88,611	59.5%
■ Physical inactivity ⁷	63,273	42.5%
■ Smoking ⁸	29,086	19.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

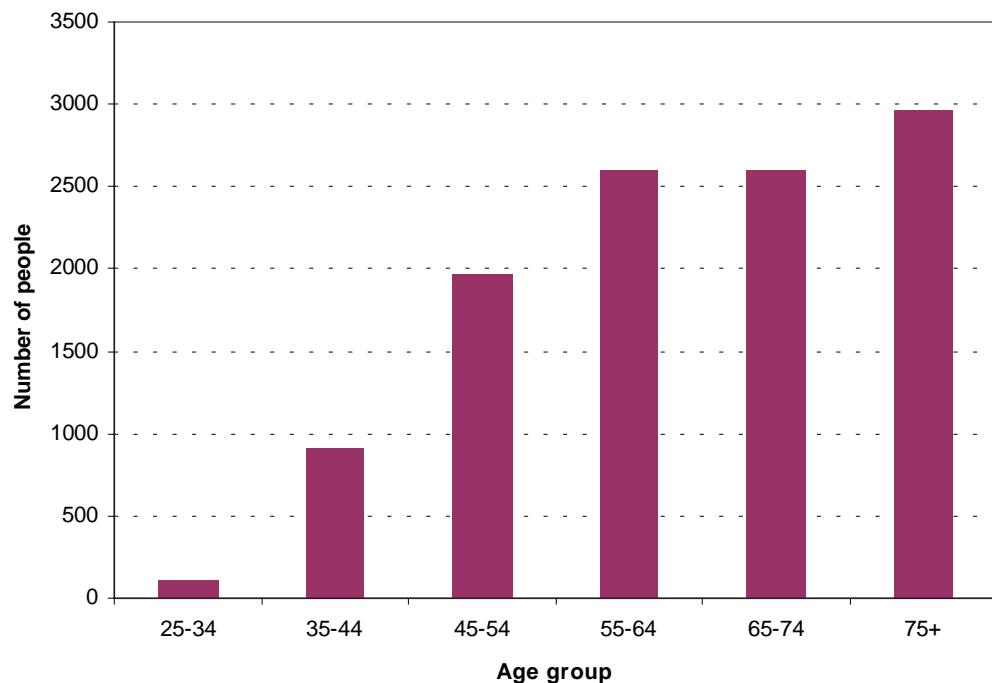
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

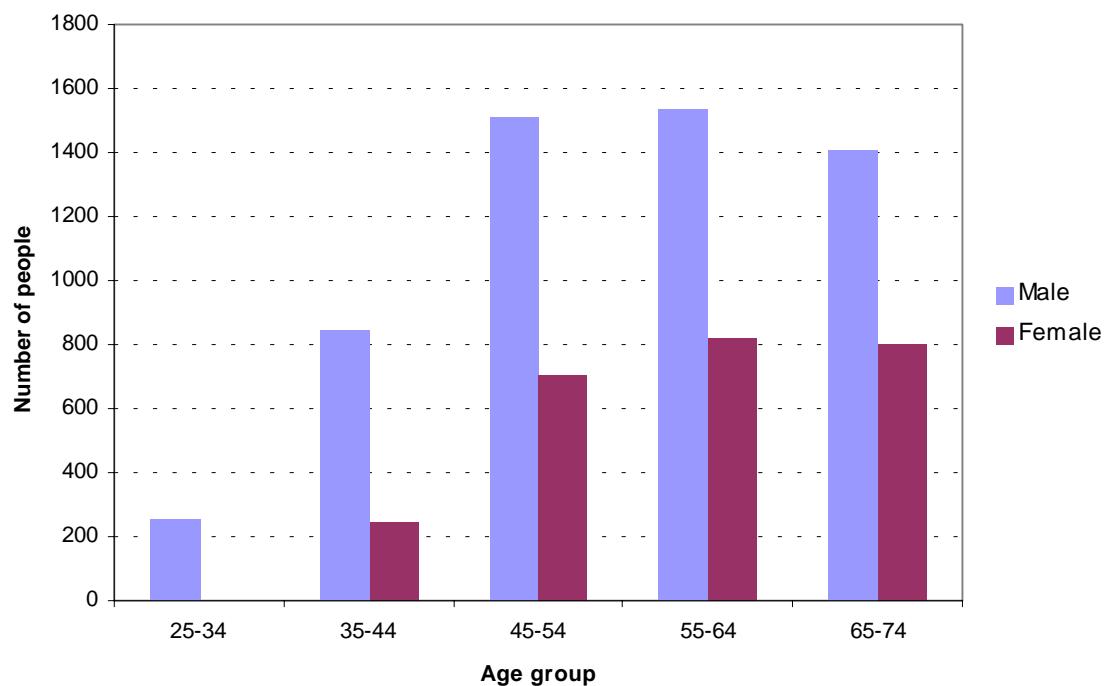
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



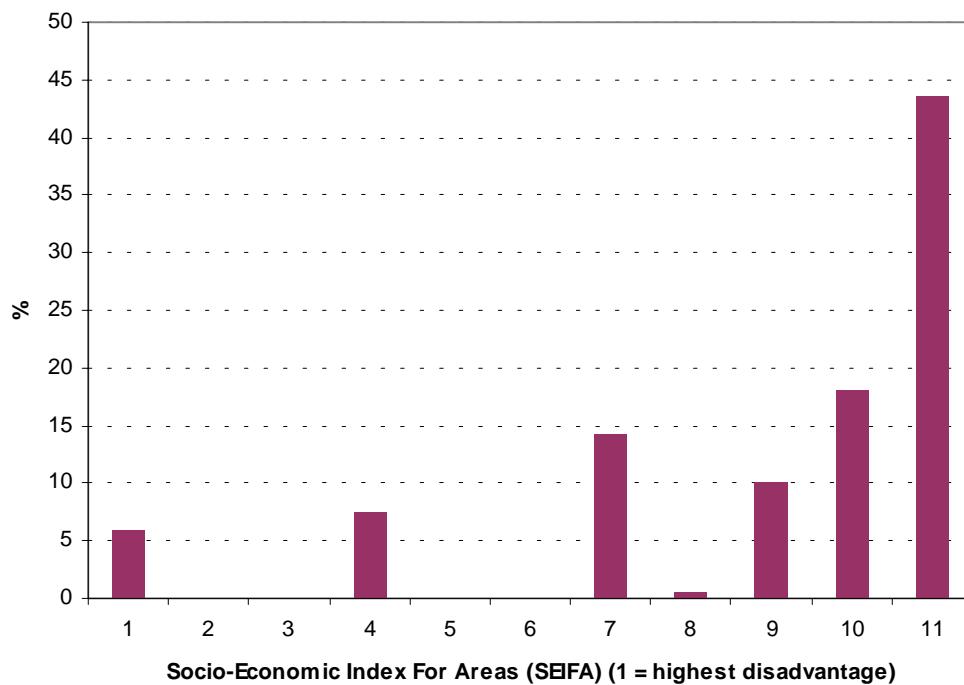
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

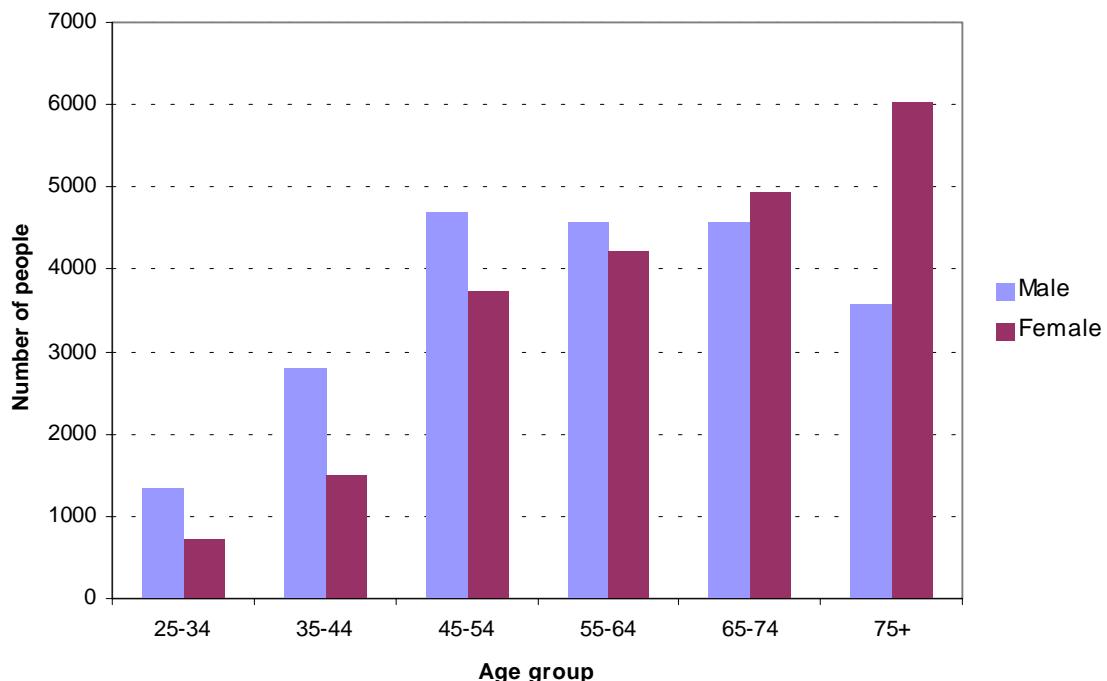
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

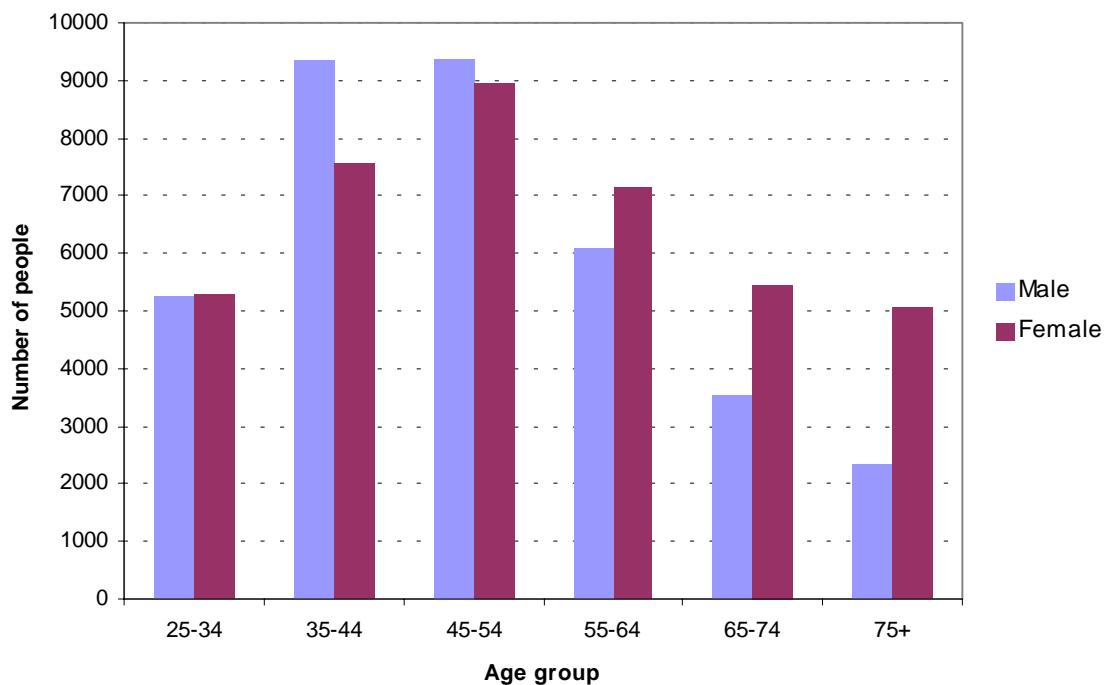
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



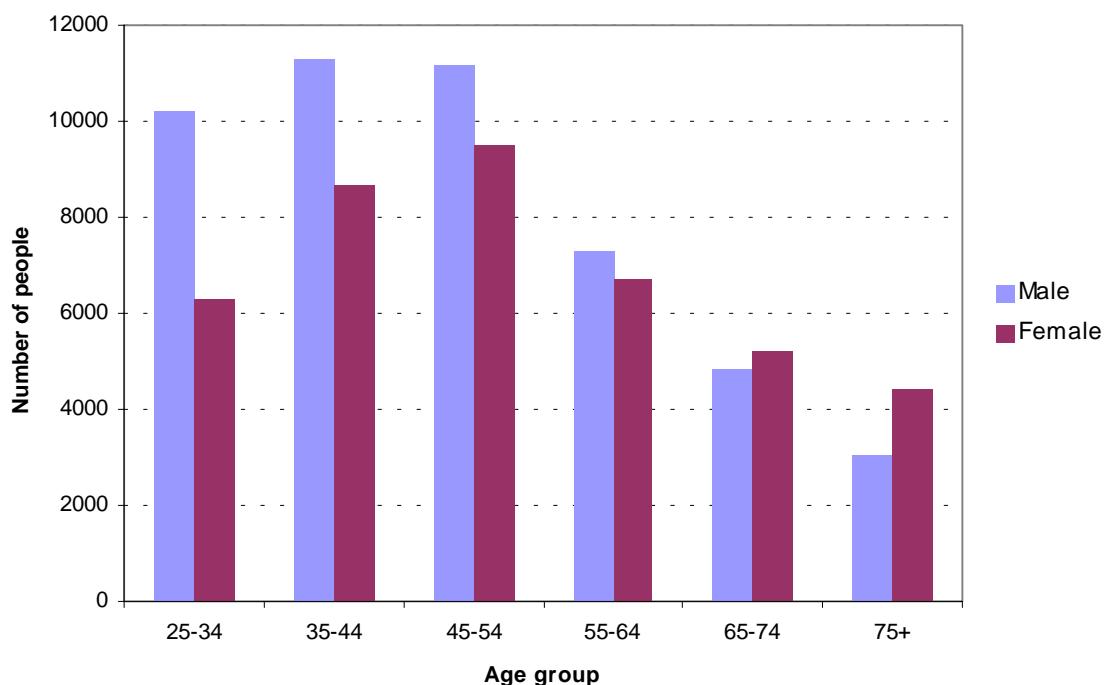
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



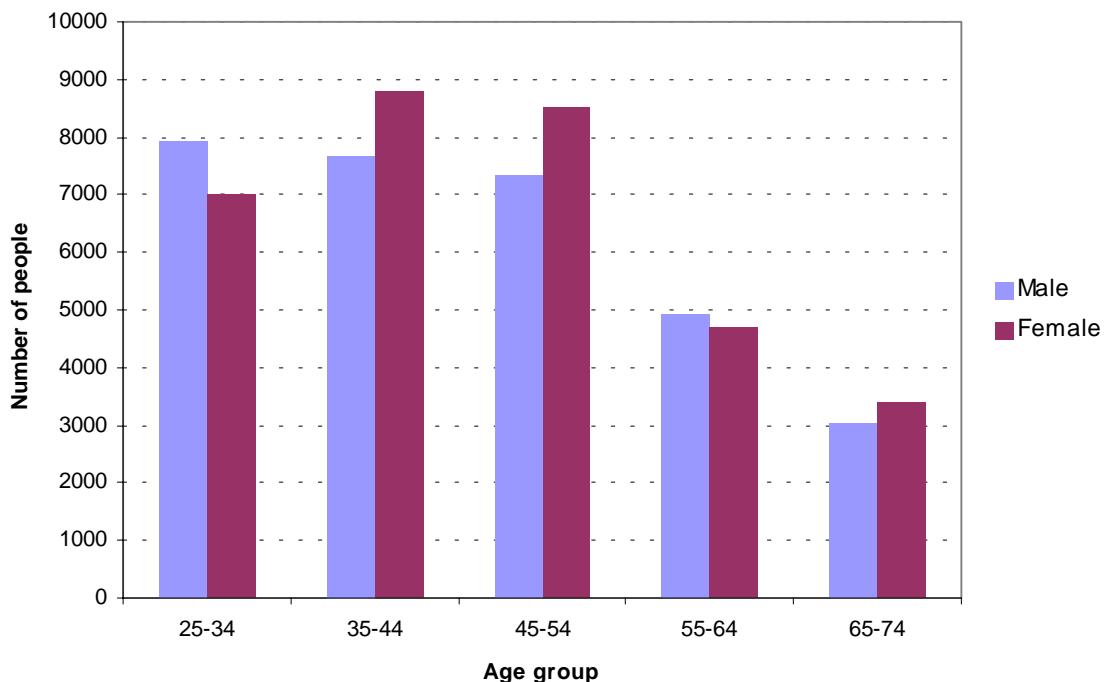
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



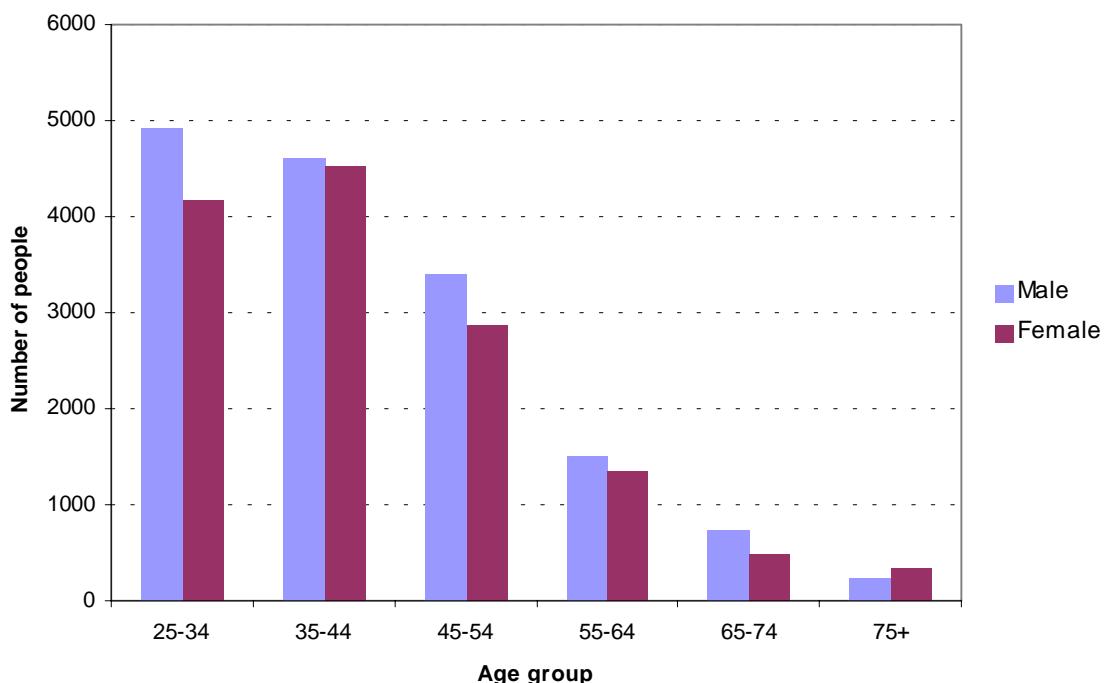
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 285 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - One public hospital (Austin & Repatriation Medical Centre),
 - One private hospital,
 - Four community health centre locations,
 - One Aboriginal Health Service – Diabetes Centre.

- What services are needed but are not available in your Division area?

All services available but long waiting lists for 'public' patients.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?
 - Patient audit: Each participant GP audits 20 long term diabetic patients retrospectively for 12 months then prospectively for 6 months,
 - Diabetes Patient Records: Each participating practice is trained in the use of medical software (principally Medical Director) to establish a comprehensive diabetes patient register, an efficient recall and reminder system and to establish comprehensive patient notes,
 - Diabetes CPD Program: Participating GPs are exposed to current 'best practice' information in the management of diabetic patients. Expert presenters from major teaching hospitals in Melbourne are engaged to inform GPs on such issues as 'New Drugs in Diabetes', 'Adolescent Diabetes', 'Gestational Diabetes', 'Management of Diabetic Retinopathy' etc. Each CPD is 2 hours in duration,
 - Clinical Attachments: Participating GPs are attached to either an outpatient diabetes or outpatient eye clinic at the ARMC for a total of 3 hours. The attachments are organised on a monthly basis usually on the third Friday and Tuesday. There are two attachments each month to a Diabetes clinic and once a month to an Eye Clinic,

- Practice Staff Training Program: A diabetes nurse educator from a Division practice visits participating member practices to conduct an upskilling program with nominated practice nurses. During fiscal 2001/2, 24 practices have participated.
- Partnership Care Program: A Hospital Admission Risk Program, which is a primary care partnership between people with diabetes, GPs, and specialist diabetes services, has been funded for 2002/2, (see attached summary of program),
- National Prescribing Service: The Division diabetes program has an ongoing, very effective, collaborative relationship with the NPS.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Popularity among GPs for the clinical attachments,
 - Well attended CPD activities – average 50+ GPs attending each activity,
 - Very high uptake of the Medical Director medical software,
 - Professional relationship with ARMC and visiting consultants,
 - Collaboration with NPS.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

No, (there is always a limit imposed on what you can do within hard pressed budgets).
- What future plans do you have for diabetes management in your Division?
 - Further development work is needed in having data, such as pathology results, and referrals uploaded and downloaded directly to/from GPs computers,
 - Expansion of the diabetes and eye clinic attachments,
 - Encouragement of greater numbers of GPs in the use of full record computerisation,
 - Continued collaboration with ARMC and community diabetes service providers to further develop the partnership concept of diabetes service.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

Internal:

- A willingness by practices to embrace the new initiatives,
- An eagerness by GPs and practice staff to be trained and to embrace new technologies,
- Established Information Management systems,
- Commitment to best practice in patient care and management.

External:

- The availability of strong practice support by the Division,
- The development of a strong working relationship between the GPs, the Division and ARMC,
- The availability of remuneration for the time required.

-
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- A & RMC/Division: Heads of Departments from ARMC are members of Division steering committees in a number of programs such as Diabetes and CVD. Permanent and visiting expert consultants are utilised in the presentation of CPD activities,
- Aboriginal Health Service/Division: GPs and health workers invited to participate in clinical attachments and Division GPs are made available to support the Aboriginal Health Service special disease ‘open’ days throughout the year.
- Community Health Centres/Division: GP speakers are made available as required for ‘practice visits’ and/or special days in the areas of CVD, Diabetes and Immunisation.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- Diabetes Australia/RACGP: Diabetes Management in General Practice,
- Diabetes Australia: Diabetes Management, A Journal for General Practitioners and other Allied Professionals,
- NHMRC: Preserving Vision in Diabetes, Management of Diabetic Retinopathy,

- Medscape Internet Site: Latest research papers in diabetes and CVD,
- National Prescribing Service: Resource materials.

-
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes Patient Audit Kit,
 - Diabetes Register & Recall System,
 - Notes on how to use Medical Director software.
 - Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - No.
 - What resource materials do you provide to practices?
 - Diabetes Patient Audit Record Form as a manual recall and reminder system,
 - Laminated sheet summarising Diabetes MBS Item Numbers and PIP Diabetes requirements.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - One public hospital (Austin & Repatriation Medical Centre),
 - One private hospital,
 - Four community health centre locations.

- What services are needed but are not available in your Division area?
 - All services available but long waiting lists for 'public' patients.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992 1993 1994 1995
 - 1996 1997 1998 1999
 - 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?
 - CVD CPD Program: Topics covered include 'Smokes & Strokes (Smoking Cessation)', 'HRT – Risks & Benefits', 'Health Needs of the Middle Aged Woman, CPR & Emergency Medicine.'
 - Shared Care Program: A collaborative care program involving Cardiology Dept, ARMC and Division GPs. The program targeted patients with a chronic heart condition and multidisciplinary care needs.
 - Banyule/Nillumbik Primary Care Alliance: The Division collaborated in the launch of the Integrated Disease Management project, 'Keep the Pressure Down.' This project aims to improve health outcomes and quality of life for consumers with or at risk of hypertension.
 - National Prescribing Service: The Division CVD program has an ongoing, very effective, collaborative relationship with the NPS.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Education gains by GPs participating in the programs,
 - Continued improvement in the relationship between the Cardiology Department of ARMC and the Division's GPs,
 - Collaboration with NPS.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - There is always a limit imposed on what you can do within hard pressed budgets. High levels of workload on public hospital cardiology department limit individual specialist availability to develop and implement shared care programs.

- What future plans do you have for CVD management in your Division?
 - Men's Health (in particular CVD issues),
 - Lifestyle Programs,
 - Clinical attachments for GPs.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Program development requires a significant initial planning time as key personnel may not be available for consultation at short notice.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - ARMC: Ongoing relationship with the Directors of Cardiology and Emergency Medicine,
 - BNPCA: Ongoing collaboration with this organisation, which has representation from Division, community health centres, ARMC and all allied health providers in the two LGAs.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation resource materials,
 - Department of Human Services (Vic) resource materials,
 - National Prescribing Service resource materials.

- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Shared Care Protocols.

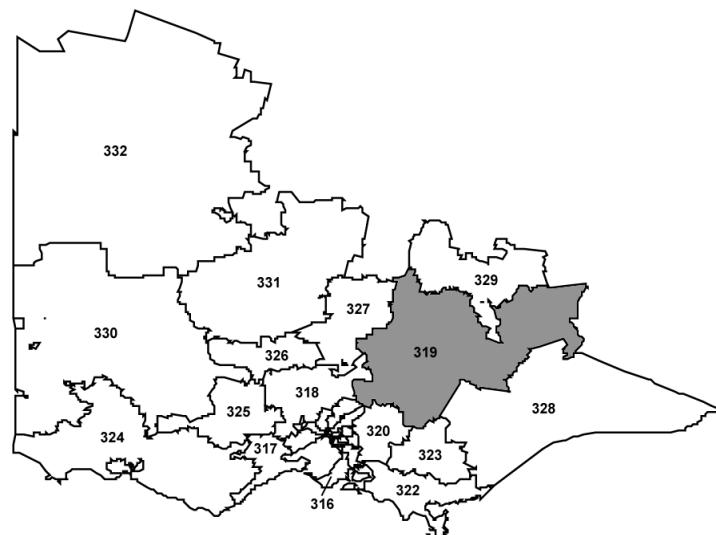
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Guidelines for GP intervention with CVD patients, eg recommended lifestyle change programs.

- What resource materials do you provide to practices? Shared Care Protocols Kit.

Division Contact Person/
Program Co-ordinator

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North East Victorian DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	106,664	
■ Aboriginal or Torres Strait Islander	658	0.6%
■ Speaks language other than English at home	4295	4.0%
■ RRMA classification ¹		
3: Large rural	747	0.7%
4: Small rural	14,400	13.5%
5: Other rural	91,518	85.8%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6360	8.9%
■ High blood pressure ⁴	23,766	33.3%
■ High blood cholesterol ⁵	37,879	53.0%
■ Obese or overweight ⁶	43,773	61.3%
■ Physical inactivity ⁷	29,738	41.6%
■ Smoking ⁸	13,032	18.2%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

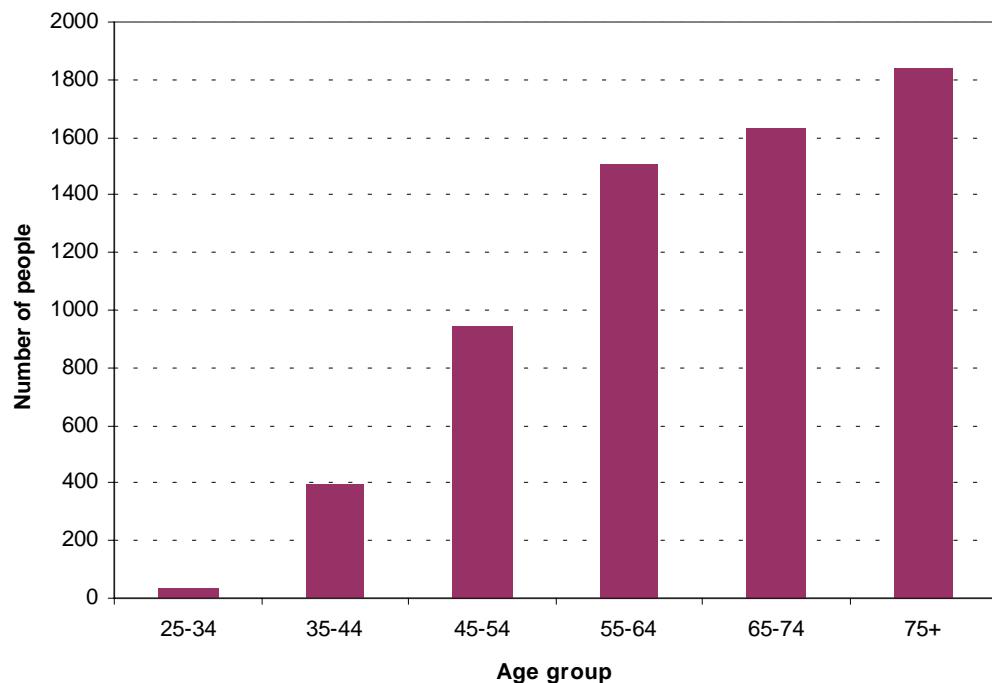
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

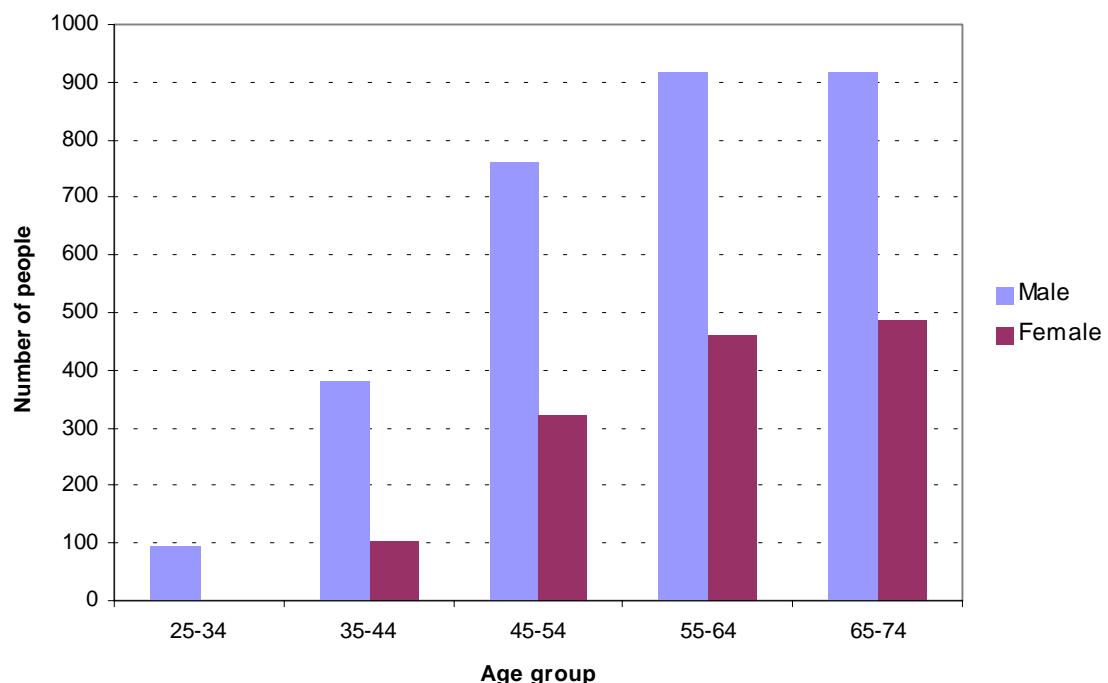
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



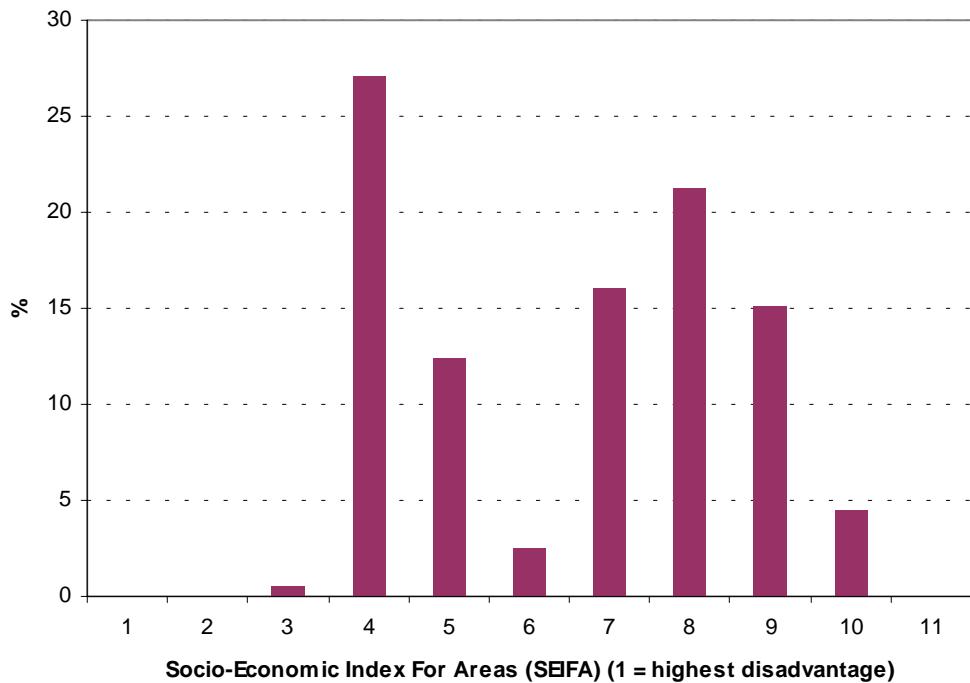
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

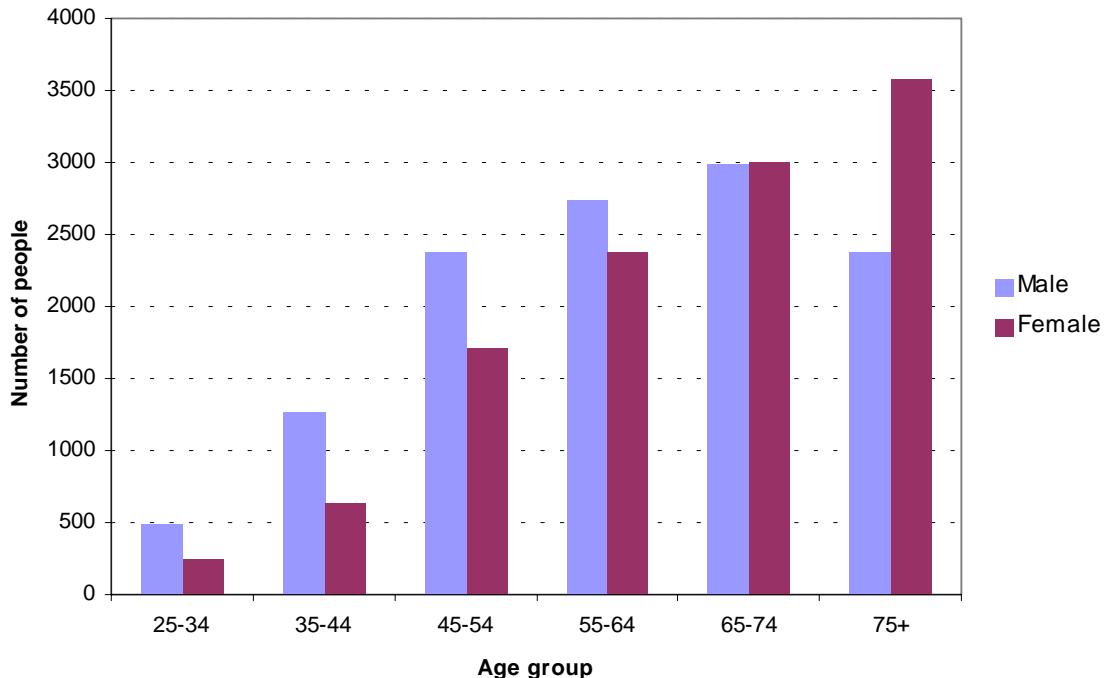
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

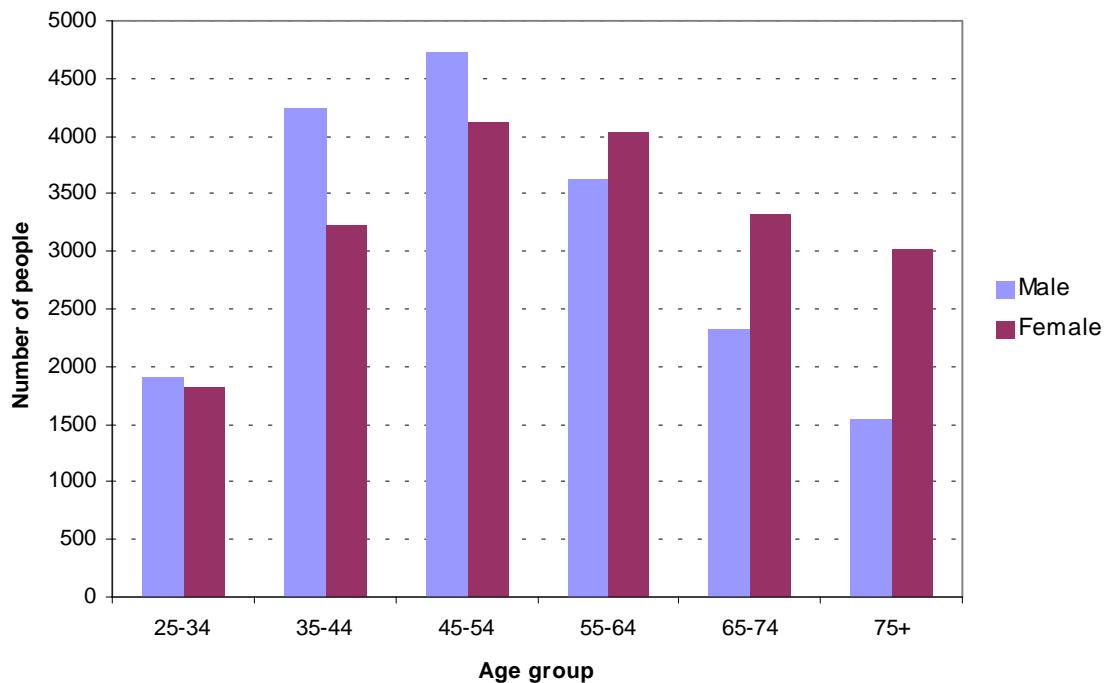
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



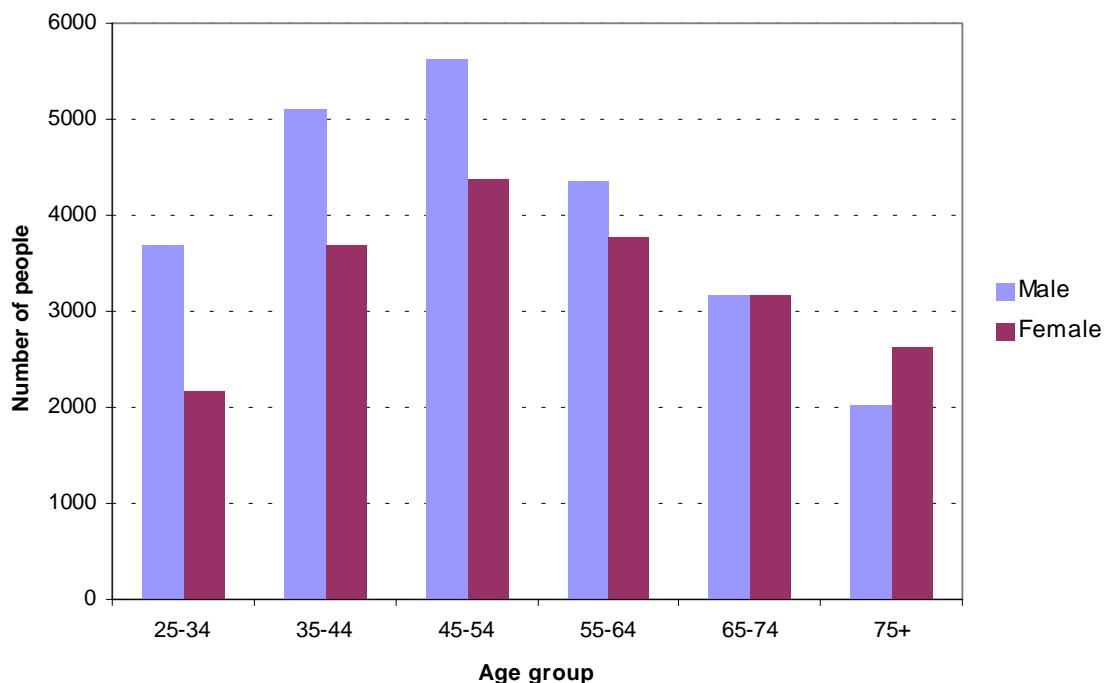
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



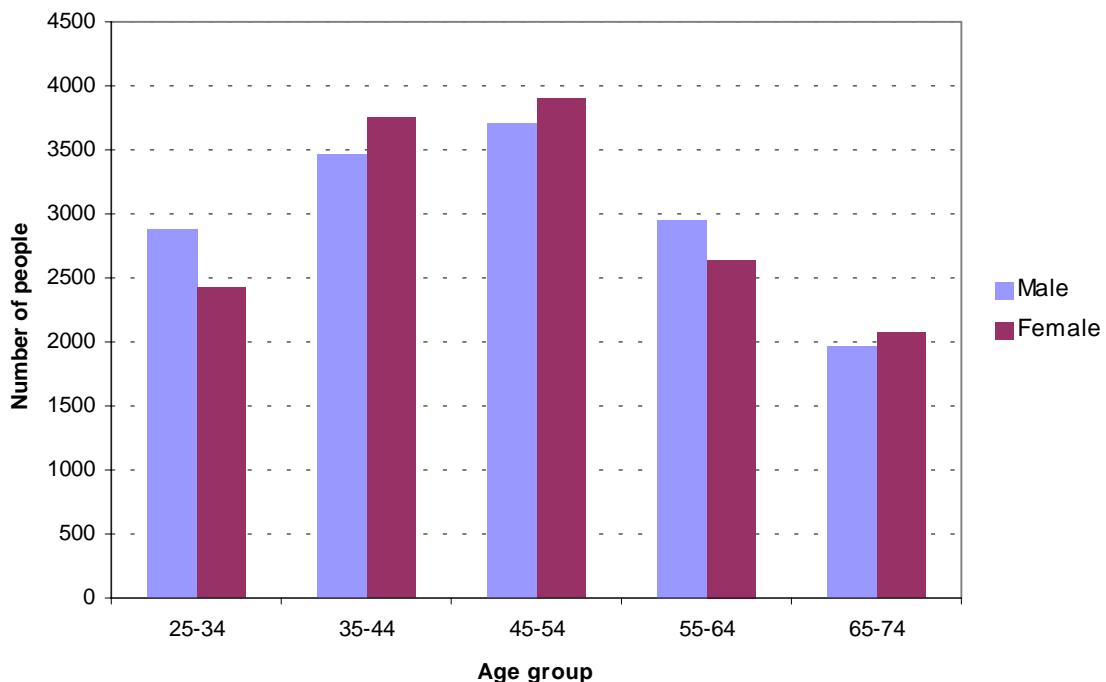
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



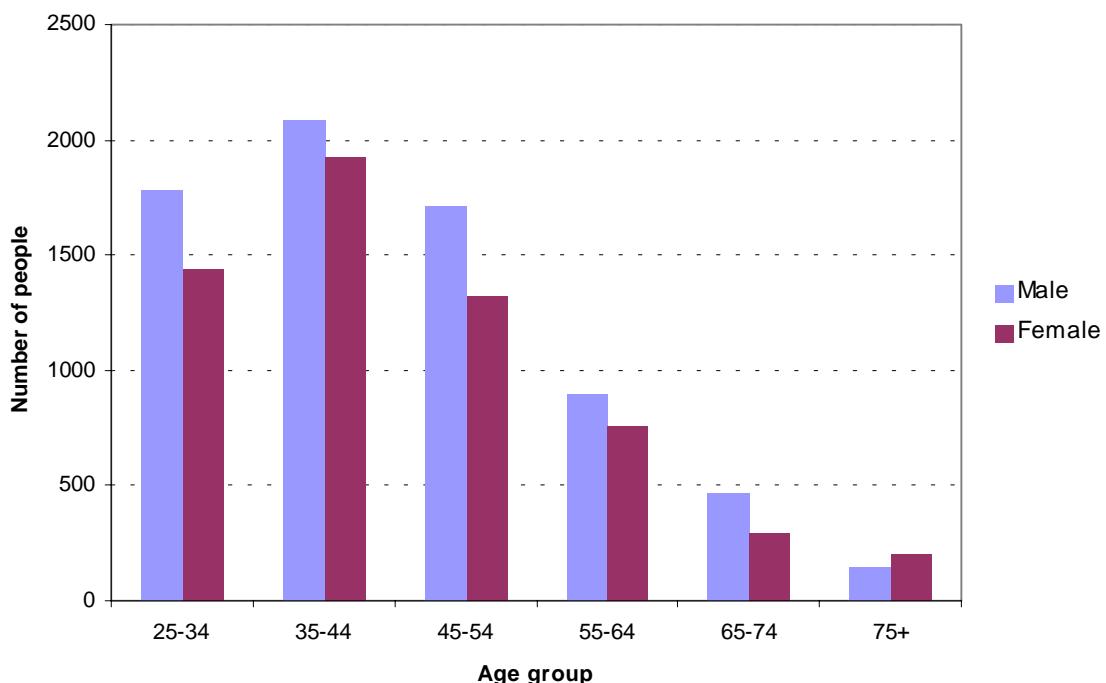
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 120 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes education and dietitian services are available via More Allied Health Services (MAHS) Commonwealth funding, (0.7 FTE dietitian and 0.8 FTE diabetes educator), to approximately two-thirds of our 120 GP members,
 - The remaining one-third of member GPs can arrange these diabetes education and dietetic services to state employed program in Wangaratta, Wodonga and Benalla.

- What services are needed but are not available in your Division area?
 - Access to dietitian services may involve a six to eight week wait for many of our GP members patients,
 - Specialist podiatry services may have longer waits,
 - Diabetes education services are considered just adequate.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

In 1995 our Division pioneered diabetes programs with three projects employing dietitians and diabetes educators working from within GP practices. These projects covered two thirds of our 120 GP members over our wide geographic area – they ran for two to three years. Now “remnants” exist, funded from State Health sources.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Improved access to dietitian and diabetes education services for clients of our 120 GP members,
 - GP involvement, ie workers work via GP practices.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Availability of funding for diabetes educators and dietitians in a long-term not piecemeal process,
 - Communication with other health agencies, Community Health, hospitals and GPs – this is improving.

- What future plans do you have for diabetes management in your Division?
 - Development/modification of a GP Consumer Health Education “Kit” specific to diabetes, (currently this is part of a cardiovascular consumer education kit developed ten years ago),
 - Improved diabetes education and dietetic access for our medical consumers.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - A more formal framework/organisational process being made available to GPs for work they have always done but in a less organised way.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - “PCPs” (primary care partnerships) involving Community Health, hospitals, etc. Our Division is involved with three of these in our area.
 - Advocacy with all other local health agencies because of MAHS and chronic initiatives payments.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP,
 - Australian Diabetes Education Association (ADEA).

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Consumer Education Kit (in development).

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? Practices have own individual recall systems.
- What resource materials do you provide to practices?
 - IT support,
 - “Practice Support” Program.

Division Contact Person/
Program Co-ordinator

Name: Dr J. Mark Robinson
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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Referral network of physicians,
 - Thrombolysis education for GPs,
 - Two ambulatory blood pressure (BP) monitoring machines shared between practices, owned by Division,
 - Cardiac type continuing professional development (CPD) by Division.

- What services are needed but are not available in your Division area?
 - Adequate cardiac rehab processes.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992 1993 1994 1995
 - 1996 1997 1998 1999
 - 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?
 - Updates in thrombolysis,
 - GPs CPD involving visits to cardiology labs in Melbourne.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Improved GP CPD in this area,
 - “Cardiovascular” GP Patient Education Kit.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Our large geographic area.

- What future plans do you have for CVD management in your Division?
 - Continued priority with GP CPD,
 - Continued priority with cardiac health promotion,
 - Continue ambulatory BP monitoring.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Involve local hospitals and specialists,
 - Avoid offending hospitals and specialists,
 - Creative application of pharmaceutical interests.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Pharmaceutical industry,
 - Local specialists,
 - Local hospitals.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation (NHF),
 - Local hospitals (Albury and Wangaratta) – protocols.

- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Consumer Education Kit.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Increased funding for ambulatory BP monitoring,
 - Continued funding for GP CPD.

- What resource materials do you provide to practices?
 - Consumer Education Kits,
 - Ambulatory BP monitoring.

Division Contact Person/
Program Co-ordinator

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North West Melbourne DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	260,143	
■ Aboriginal or Torres Strait Islander	971	0.4%
■ Speaks language other than English at home	94,104	36.2%
■ RRMA classification ¹		
1: Capital city	260,143	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	12,827	7.6%
■ High blood pressure ⁴	49,168	28.9%
■ High blood cholesterol ⁵	85,749	50.5%
■ Obese or overweight ⁶	101,136	59.5%
■ Physical inactivity ⁷	72,242	42.5%
■ Smoking ⁸	33,126	19.5%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

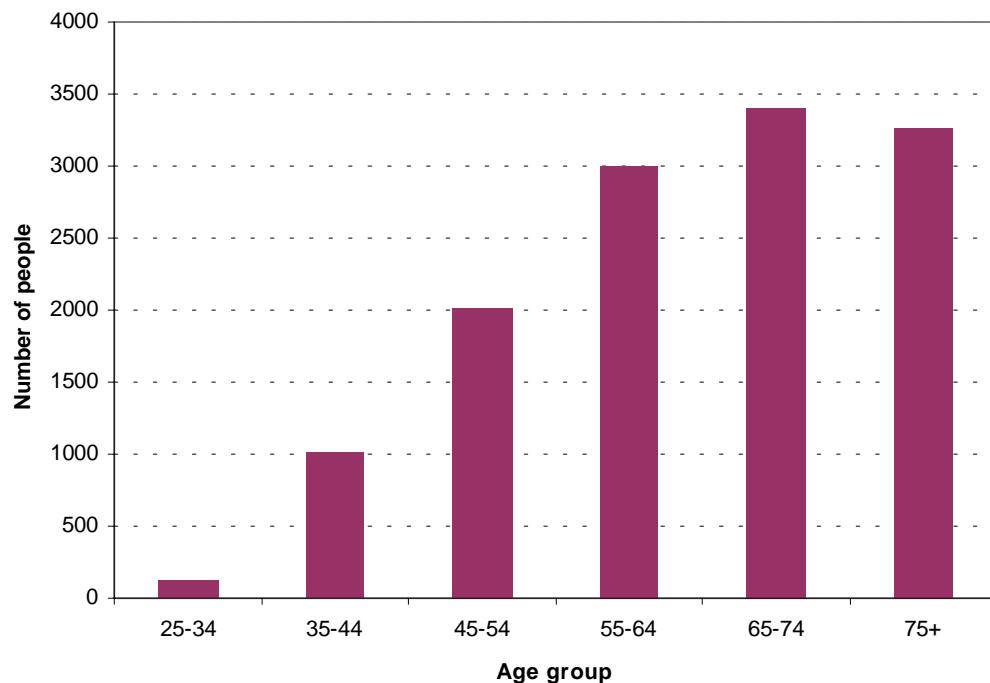
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

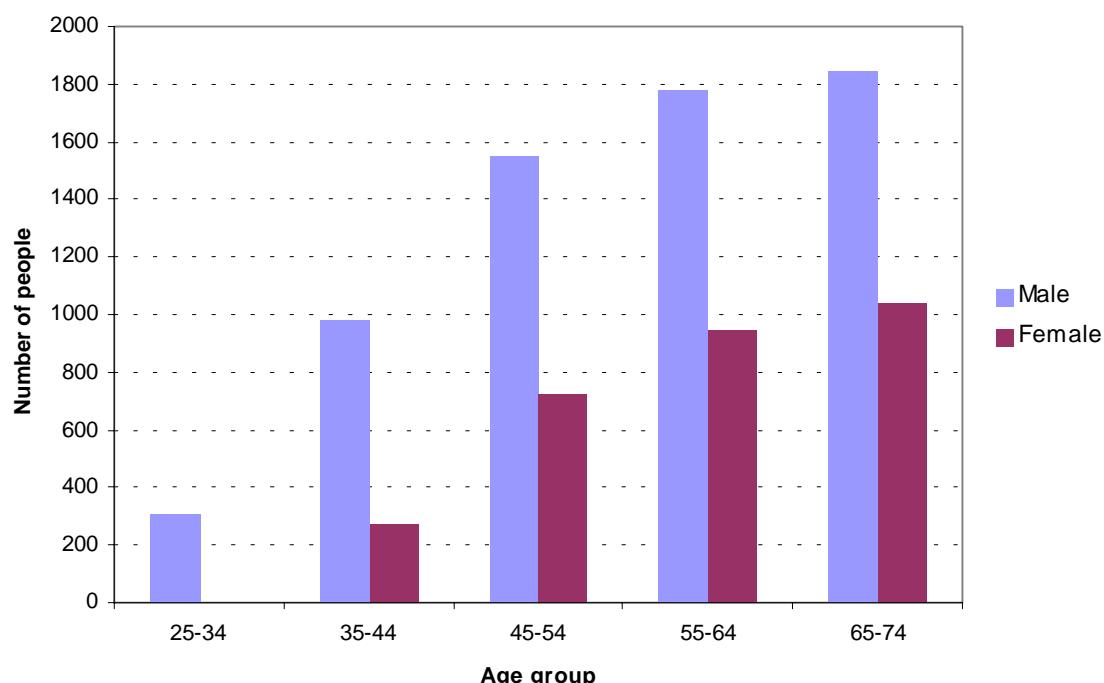
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



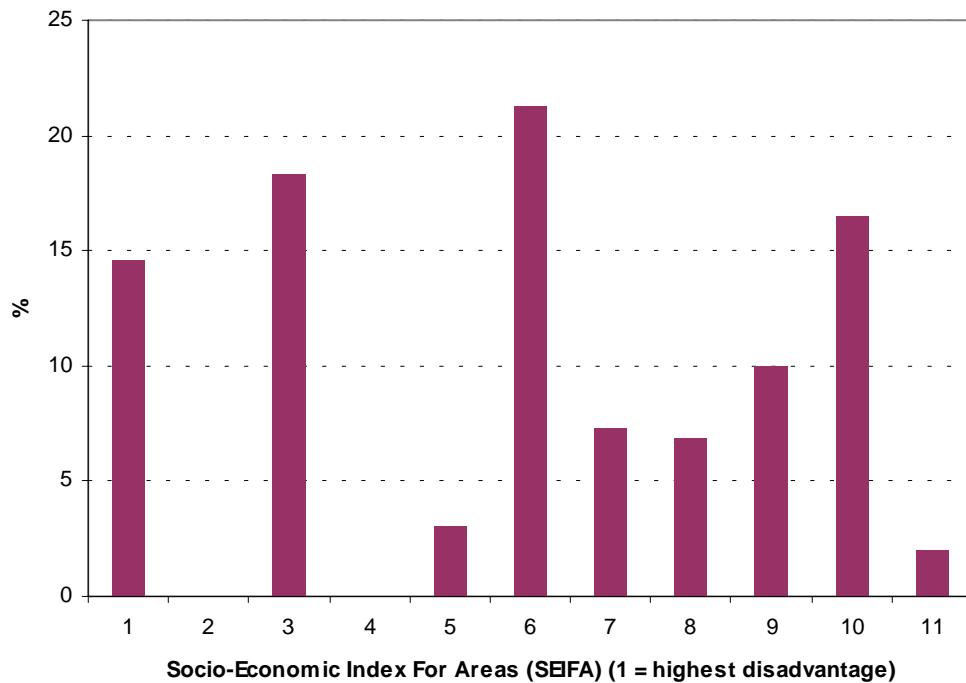
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

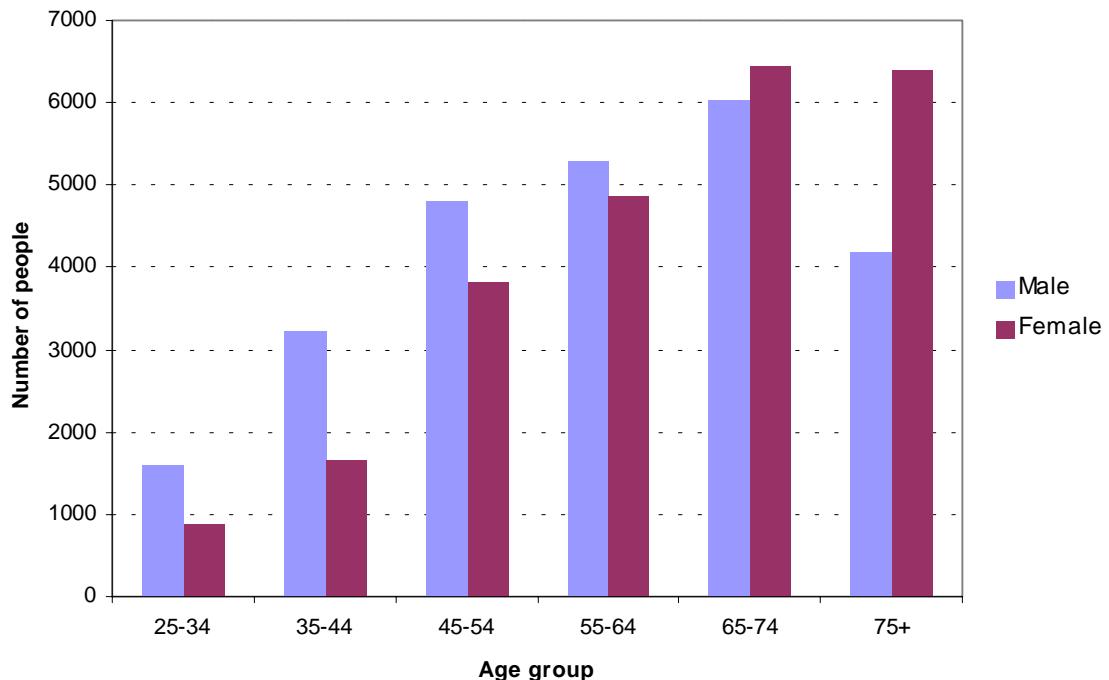
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

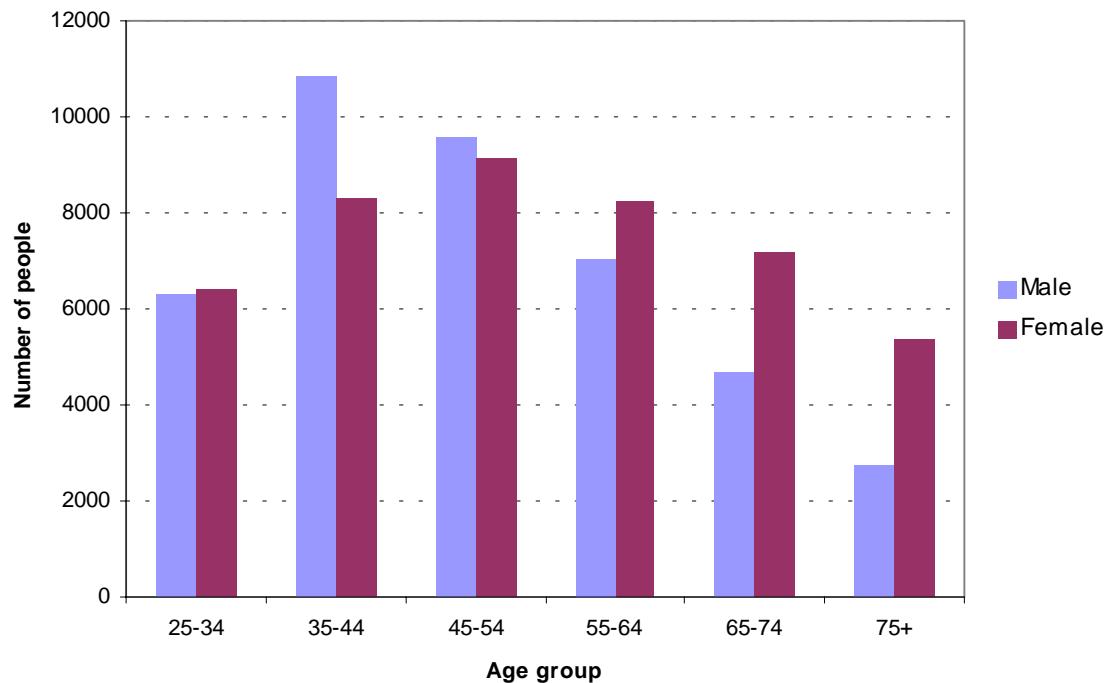
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



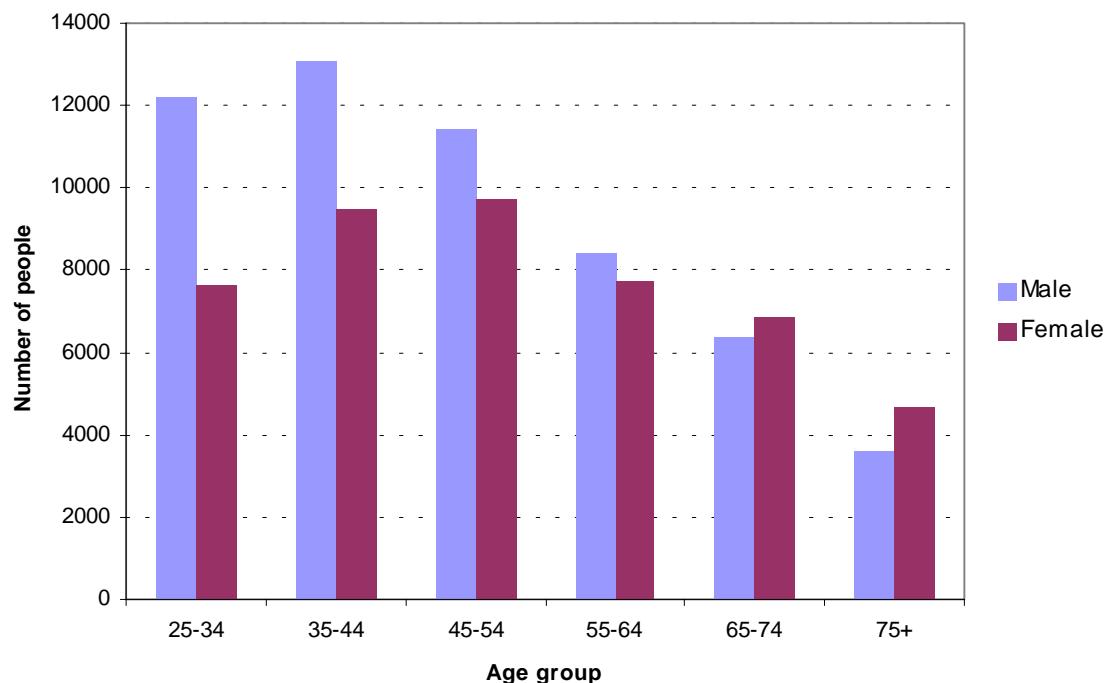
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



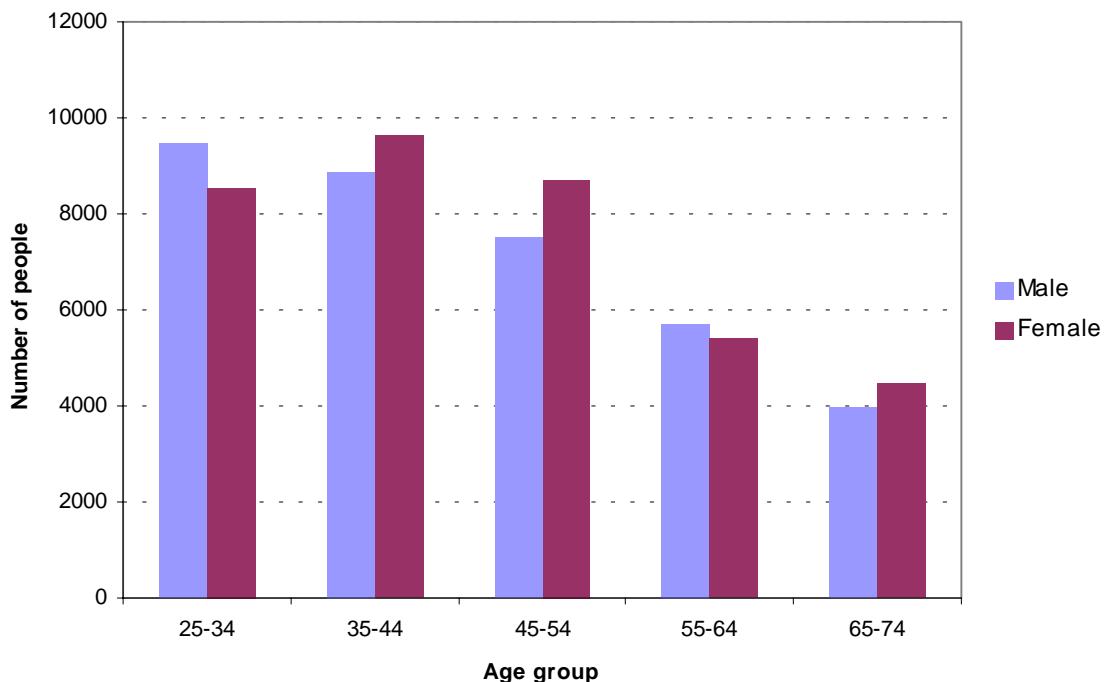
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



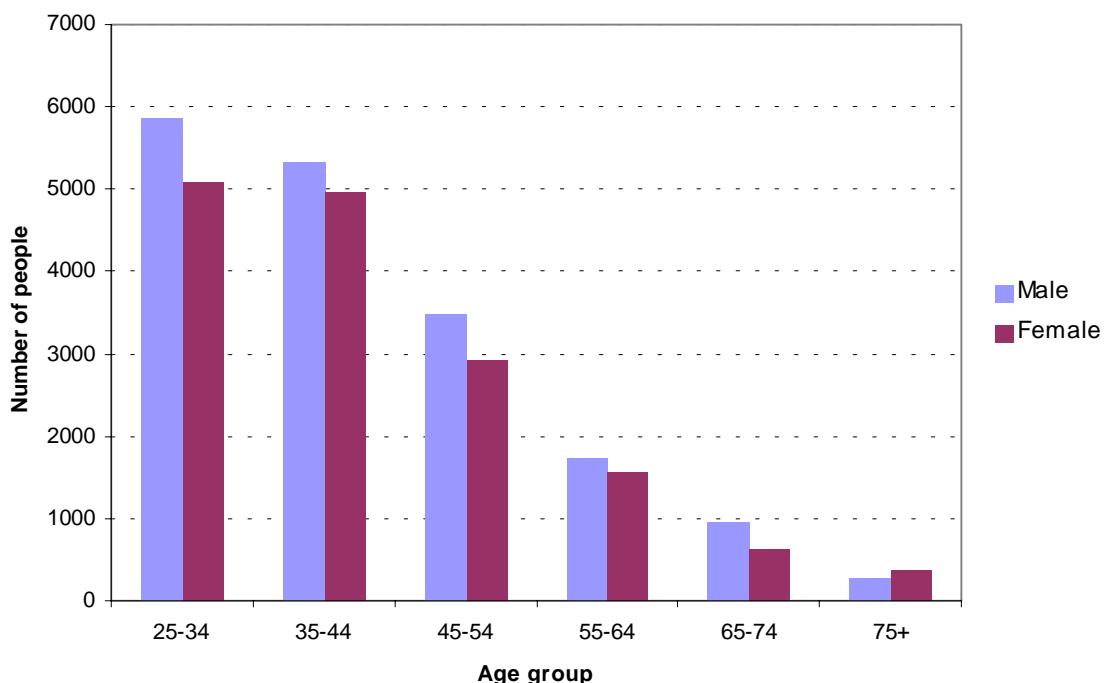
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 402 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes services available at Dianella Community Health Centre (CHC), Doutta Galla CHC, Brimbank CHC and Moreland CHC, including diabetes educators, podiatry and dietitian,
 - Royal Melbourne Hospital has a diabetes clinic with diabetes educator and endocrinologist,
 - Division conducts retinopathy screening program, available to all GPs in geographic area, ophthalmology support provided.

- What services are needed but are not available in your Division area?
 - Greater services to culturally and linguistically diverse (CALD) groups,
 - Integration of diabetes services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Division is a member of the Diabetes Alliance Group, which is five Divisions of GP, Royal Melbourne Hospital and Diabetes Australia (Vic), doing all Continuing Professional Development activities together as well as resource development, clinical audits, and diabetes projects. The North West Melbourne Division has a Diabetes and CVD Special Interest Group and is involved in many local diabetes projects including retinopathy, footcare and integration of diabetes services.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Diabetes Patient Held Record,
 - GP Insulin Stabilisation Project,
 - Patient Information Sheet,
 - GP involvement in educational activities,
 - Diabetes Practice Nurse Course.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - GP involvement,
 - Cultural barriers.

- What future plans do you have for diabetes management in your Division?
 - Continuing CPD activities,
 - Clinical Audit,
 - Development of resources – Diabetes Passport,
 - Further involvement in relevant diabetes projects – Hospital Admission Risk Project (HARP), Primary Care Partnership (PCP), Integrated Diabetes Management (IDM).
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GP support.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Diabetes Alliance Group – five Divisions of GP, Diabetes Australia – Victoria, and Royal Melbourne Hospital (RMH) – Diabetes Unit doing all diabetes activities together, including CPD activities for GPs, educational activities for practice staff, development of resources, involvement in projects, clinical audit and representation on committees.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Clinical Guidelines for the Management of People with Diabetes,
 - Diabetes Australia (Vic) resources, brochures, fact sheets,
 - Diabetes multilingual web site,
 - Patient Held Record – Diabetes Alliance Group.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Patient Held Record,
 - Patient Info Sheet,
 - Abbreviated guidelines,
 - Clinical Audit,
 - Diabetes Sticker.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - N/A.

- What resource materials do you provide to practices?

- Patient Held Record,
- Patient Info Sheet,
- Diabetes sticker,
- GP Insulin Stabilisation Project.

Division Contact Person/
Program Co-ordinator

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Email: greg@nwmdgp.org.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Various available through local community health centres and hospitals.
- What services are needed but are not available in your Division area?
 - Emergency,
 - 24 hr,
 - Culturally specific services lacking in this high culturally and linguistically diverse geographical area.

CVD Program Description

- In which years did you have a CVD project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002
- Please describe your CVD program including any changes that occurred over time?
 - The Division facilitates the Active Script Program to help GPs prescribe physical activity to their patients in a bid to reduce CVD among other diseases,
 - Division conducts Continuing Professional Development sessions on prevention of CVD.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Positive uptake of Active Script Program,
 - Increased knowledge of physical activity benefits – including CVD risk reduction,
 - Participated in activities for “Heart Week”.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Not all GPs are keen to take part in program.
- What future plans do you have for CVD management in your Division?
 - Continue all CPD activities,
 - Continue facilitating Active Script Program.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

GP involvement essential.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Links with Dianella Community Health Inc and the Broadmeadows Health Service through the development of an integrated health promotion group.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Physical Activity guidelines,
 - Active Australia and VicFit resources,
 - National Heart Foundation resources for Heart Week, etc.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
N/A.
- What resource materials do you provide to practices?
See as above.

Division Contact Person/
Program Co-ordinator

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Email: greg@nwmdgp.org.au

Northern DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	227,926	
■ Aboriginal or Torres Strait Islander	1567	0.7%
■ Speaks language other than English at home	105,516	46.3%
■ RRMA classification ¹		
1: Capital city	227,926	100.0%
■ SEIFA category containing population median: ²	2	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,245	7.5%
■ High blood pressure ⁴	43,149	29.0%
■ High blood cholesterol ⁵	75,018	50.3%
■ Obese or overweight ⁶	88,713	59.5%
■ Physical inactivity ⁷	63,441	42.6%
■ Smoking ⁸	29,077	19.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

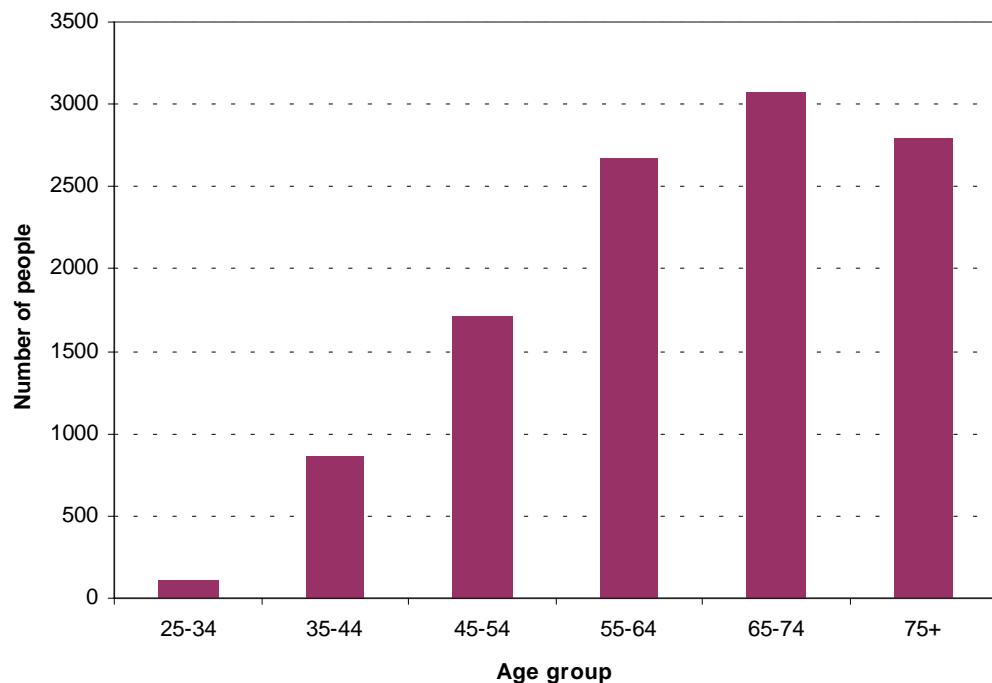
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

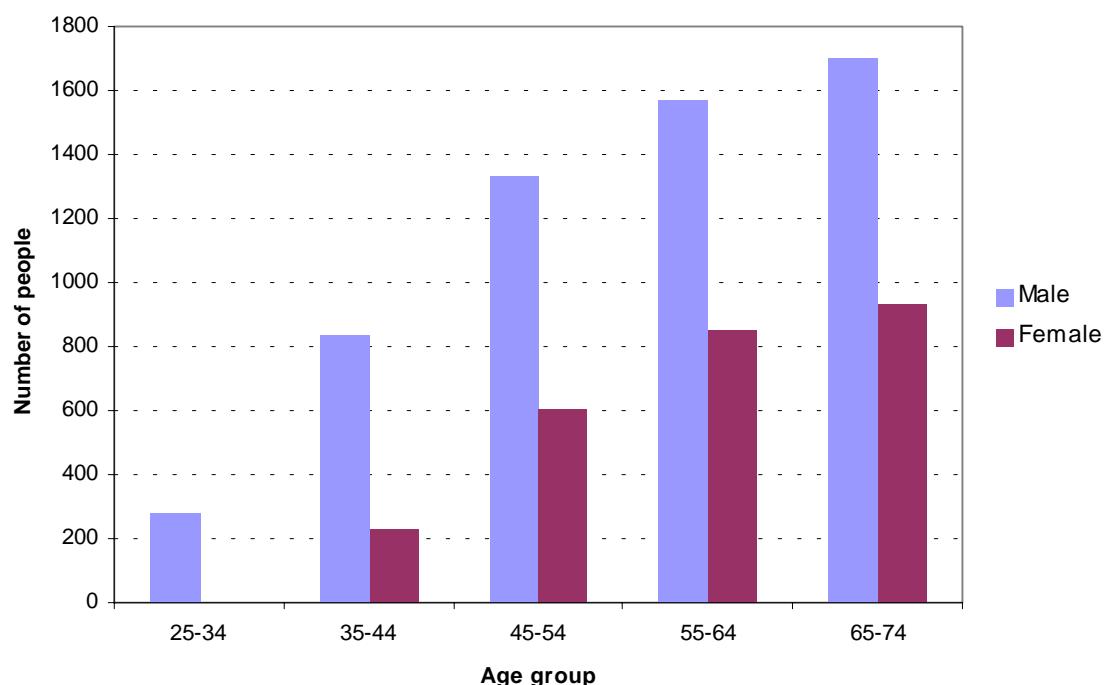
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



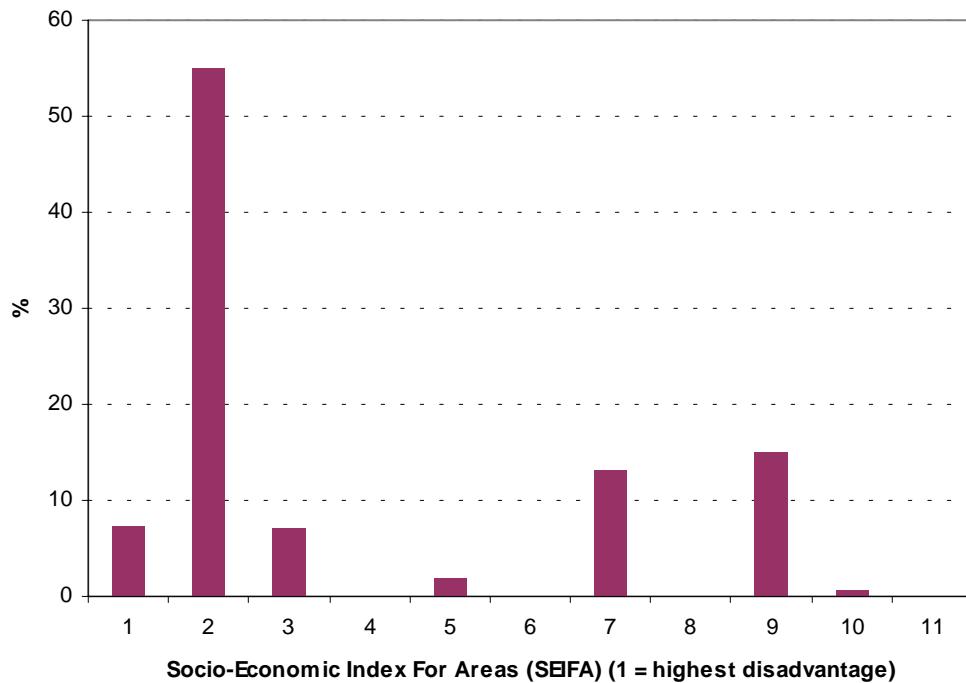
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

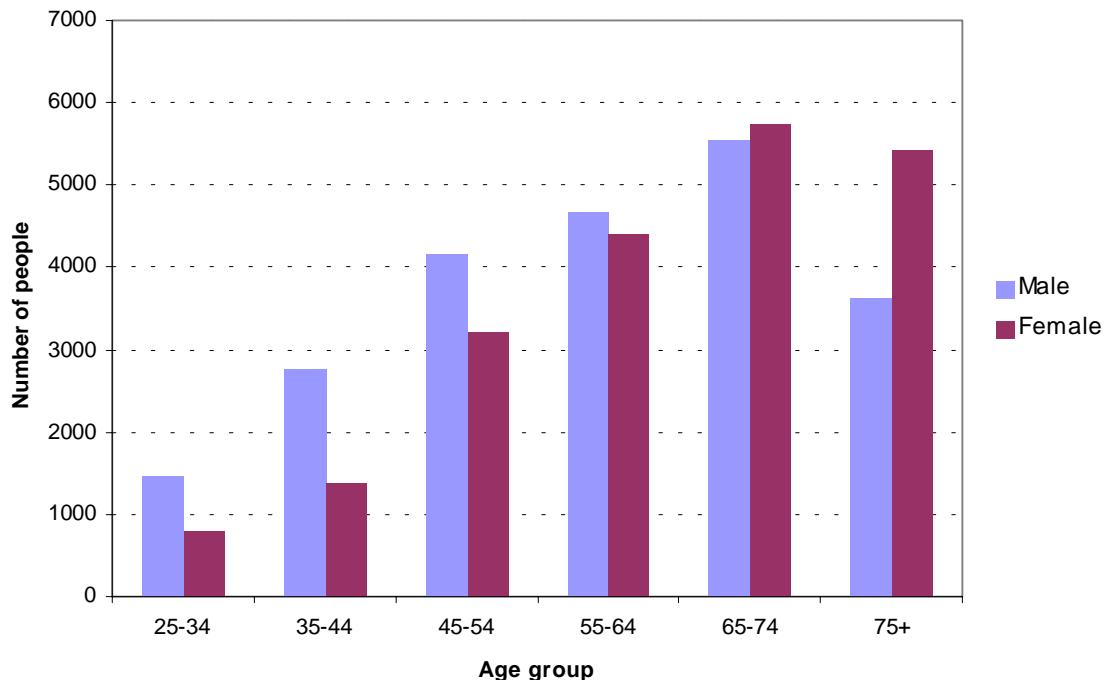
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

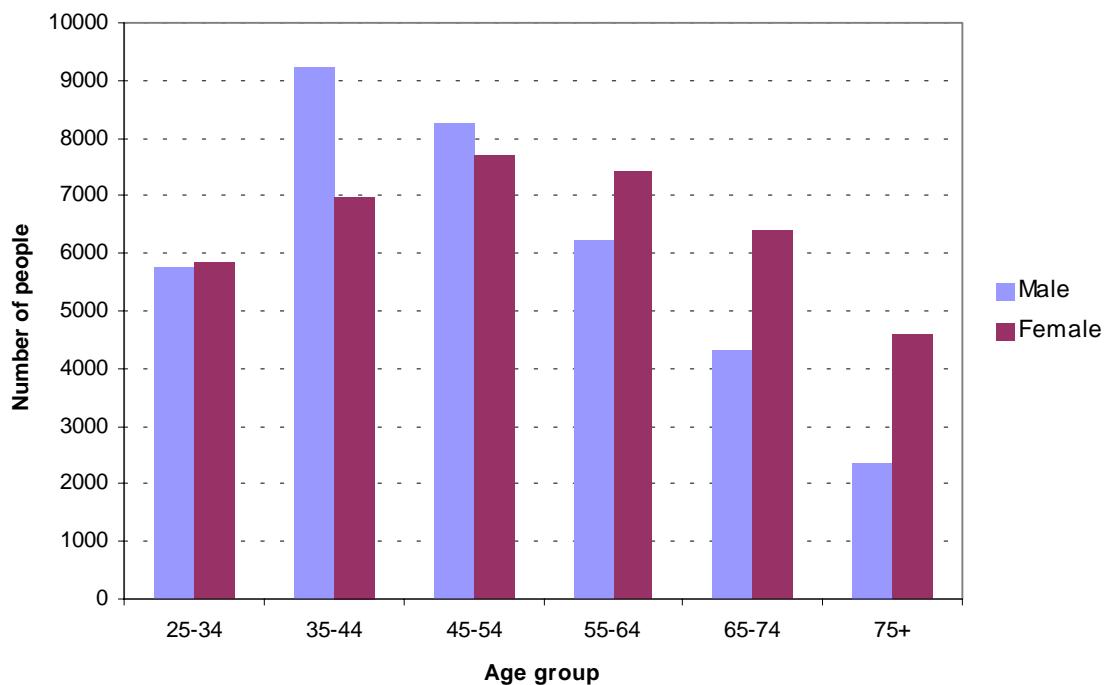
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



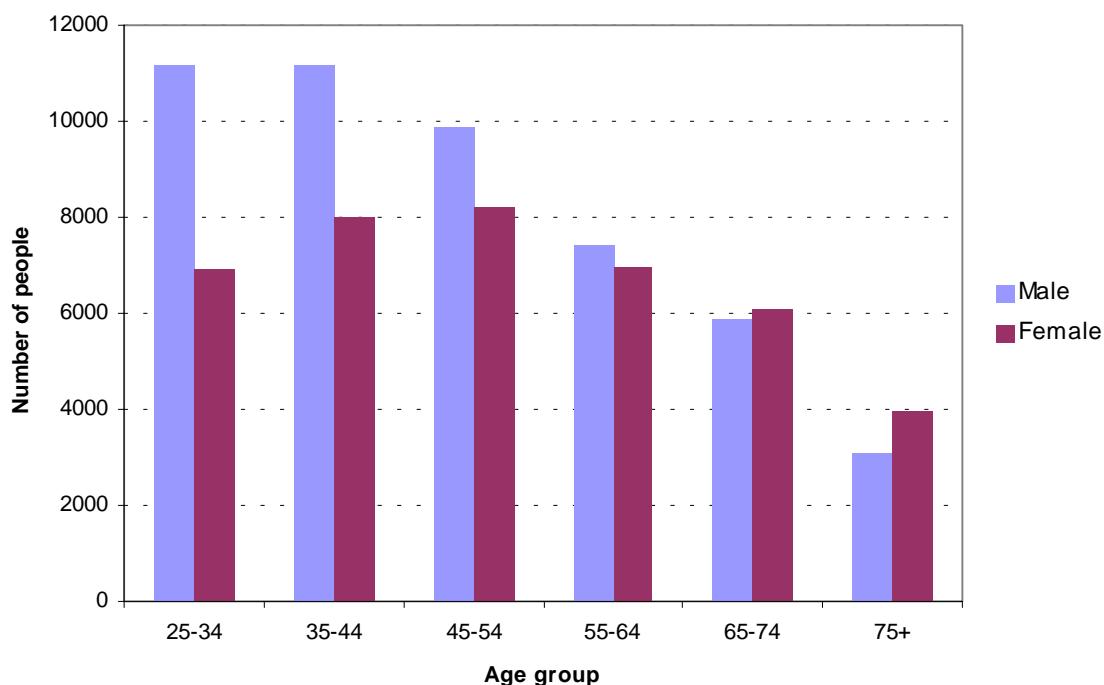
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



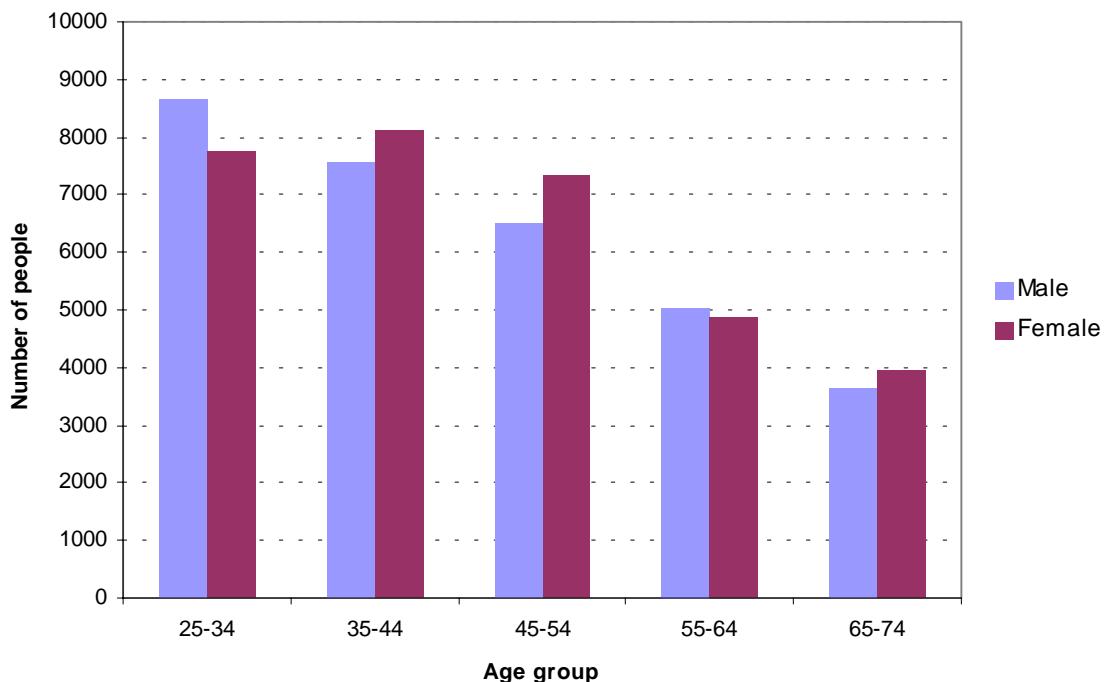
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



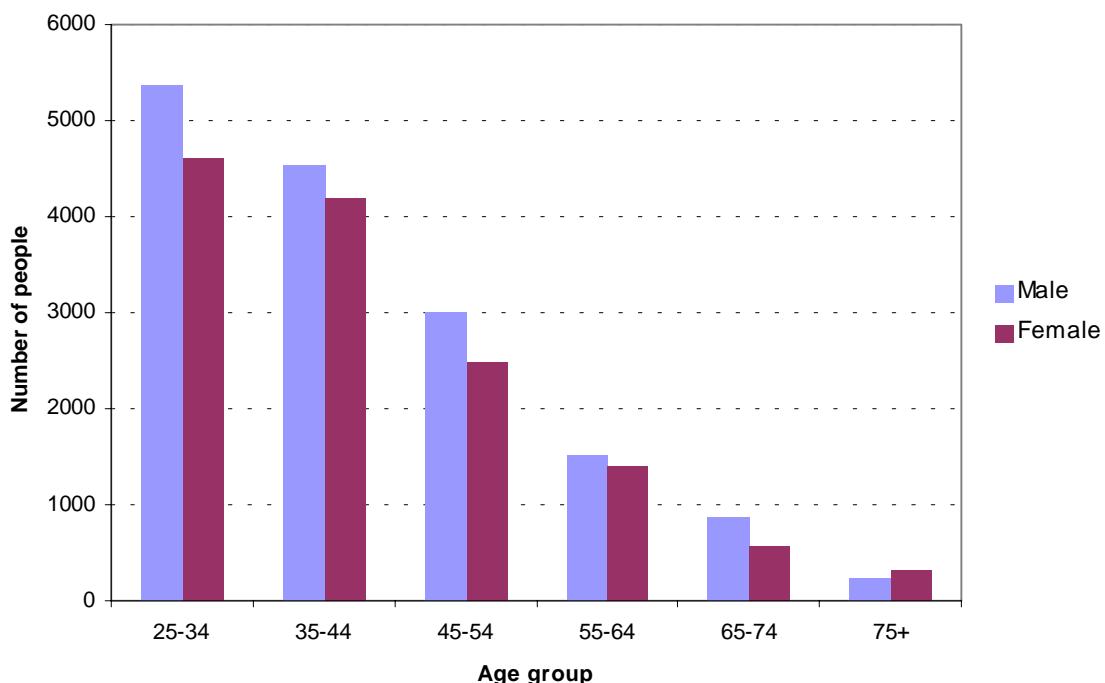
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 330 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Northern Hospital – diabetes educator (DNE), endocrinology clinic,
 - Royal Melbourne Hospital,
 - Austin and Repat Community Health Centres.

- What services are needed but are not available in your Division area?
 - More podiatry (long waiting lists in public system),
 - More diabetes nurse educators,
 - Early intervention.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time? N/A.

Division Perspective

- What have been the major achievements or highlights of your program so far? The Diabetes Alliance Group (DAG).

- Are there any factors or barriers that have limited the implementation of your program? Please comment: N/A.

- What future plans do you have for diabetes management in your Division? Future activity on diabetes management will build on DAG achievements, concentrate on the Hospital Admission Reduction Program (HARP), and be focused on increasing activity in annual cycle of care Practice Incentive Program.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Well organised/systems approach to care within the practice,
 - Good support staff including the presence of a registered nurse.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them? DAG.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)? DAG resources.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Laminated annual cycle of care flow chart,
 - Hand held record.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? N/A.

Appendix

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

The purpose of the Diabetes Alliance Group is to be instrumental in the planning and implementation of diabetes services within the geographic region covered by its member Divisions of General Practice. It will:

- Provide a conduit for information flow between 5 Divisions of General Practice, 2 Hospitals and Diabetes Australia – Victoria,
- Provide ongoing education to General Practitioners (GPs) on diabetes management in general practice.

The membership of the Diabetes Alliance Group consists of the Melbourne, North West Melbourne, Western Melbourne, Northern Melbourne and Westgate Divisions of General Practice, Royal Melbourne Hospital, Western Hospital (Sunshine) and Diabetes Australia – Victoria.

Terms of Reference

- To ensure appropriate communication between the Divisions and their diabetes programs,
- To facilitate communication between the Divisions and the hospitals in the provision of care to people with diabetes,
- To facilitate communication between the Divisions and Diabetes Australia – Victoria,
- To provide a forum to discuss issues relating to the provision of care to people with diabetes by GPs,
- To provide a forum to discuss issues between GPs and hospitals within the geographical area relating to the provision of care to people with diabetes,
- To provide a forum to discuss issues between GPs and Diabetes Australia – Victoria relating to the provision of care to people with diabetes within the geographical area,
- To provide education relevant to GPs' needs,
- To develop and support programs that support GPs in providing total care of people with diabetes,
- To lobby and communicate with appropriate organisations to improve services to people with diabetes,
- To be responsive to funding opportunities in the area of diabetes.

Mission Statement

The DAG believes that the role of GPs, as the primary health care provider in the management of people with diabetes, is central to the coordinated care of this group. The DAG believes that the management of people with diabetes is enhanced when all providers involved in caring for people with diabetes, is coordinated.

Goals

The DAG aims to improve the management of people with diabetes.

The DAG aims to enhance the knowledge and confidence of GPs and practice nurses in managing diabetes.

The DAG aims to improve communication between GPs and other care providers in the management of people with diabetes.

The DAG aims to improve the self-management of people with diabetes.

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

Three district areas were identified as being group priorities. These were, GP resourcing with both training opportunities and physical resources, sharing the care of people with diabetes through the development of links with other organisations and care providers, and improved access to education and resources for people with diabetes.

Since 1997 the group has been active in organising training opportunities for GPs and practice nurses in the Northern and Western suburbs of Melbourne, and has worked to help create strategic partnerships between GPs and other health care providers working with people with diabetes. Representatives of the DAG are active on State and regional planning committees, their contributions valued for their expertise and track record of achievement in diabetes. Numerous resources for use by people with diabetes have been produced and widely distributed through GPs of member divisions.

The DAG has had consistently broad multidisciplinary representation on its committee, and currently has five Divisional representatives, two GPs, two diabetes nurse educators, and one endocrinologist. The DAG is chaired by GP, Dr Ralph Audehm.

The DAG currently meets quarterly with representatives of all member organisations present to discuss the broad direction of DAG projects, programs and resources. A subgroup of representatives from all member Divisions plus the GP chairperson, meets monthly to discuss operational matters, and conduct detailed planning for activities and resource development.

Current and recent diabetes related projects auspiced by DAG

GP Insulin Stabilisation Project

Member Divisions have access to a diabetes educator, available to assist GPs with insulin changeover and stabilisation. The educator also provides patient education with literature, brochures and insulin pens, free of charge. This service has been used by 10 GPs and 25 people with diabetes in the year to end June 2001.

Nurse Practitioner Project

Together with Diabetes Australia – Victoria, DAG has recently auspiced a nurse practitioner project in Victoria involving improved access to the services of a nurse practitioner candidate in diabetes education for people with diabetes in a GP setting.

Hospital Admission Reduction Program (HARP)

Successful submission for HARP funding was received in 2002 from the State government of Victoria. This project, funded for three years, aims to increase the capacity of selected GP practices to support their patients with diabetes by increasing their access to a diabetes educator. Diabetes educators will be available 24 hours a day to deal with diabetes related crises out of hours, and to counsel patients on an appointment basis.

Summary

The Diabetes Alliance Group is proud of its achievements. The member groups believe that the collaboration, which is the DAG, enhances the performance of each individual agency in the area of diabetes. The sustainability of the group is evident, given all founding organisations are still active within the alliance, five years after first meeting.

The evidence of outcomes are also clear. GP and nurse training opportunities, resources for people with diabetes, and links which have been established between GPs and other health providers in the primary care setting, clearly place the DAG as a leading collaborative group, not only within the Divisional movement, but also on a broader national basis. At an organisational level DAG representation on state and regional committees further reinforces the success of the collaboration, with external agencies keen to draw on the learning and achievements of the group.

The members of the DAG look forward to continued successes in their collaboration into the future.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Community health service,
 - Public hospital,
 - Private hospital.

- What services are needed but are not available in your Division area?

More affordable services for health lifestyle programs, available on an ongoing basis for people on low and fixed incomes.

CVD Program Description

- In which years did you have a CVD project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?

CVD program is integrated into CDM/health promotion program.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Establishment of a regular weekly walking group for elderly community members.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for CVD management in your Division?

Program plan (within health promotion implementation plan) aims to assist GPs identify and manage lifestyle related risk factors related to CVD.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

N/A.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Division has close working relationships with local community health centres, hospitals (public and private) local government, PCPs (primary care partnerships), neighbouring Divisions of General Practice and locally based health maintenance organisations. Memorandums of Understanding (MOU) with many of these organisations exist because of the improved service provision, which is able to be delivered in a collaborative working environment. Personal contact seems to be the best way of developing relationships between organisations.

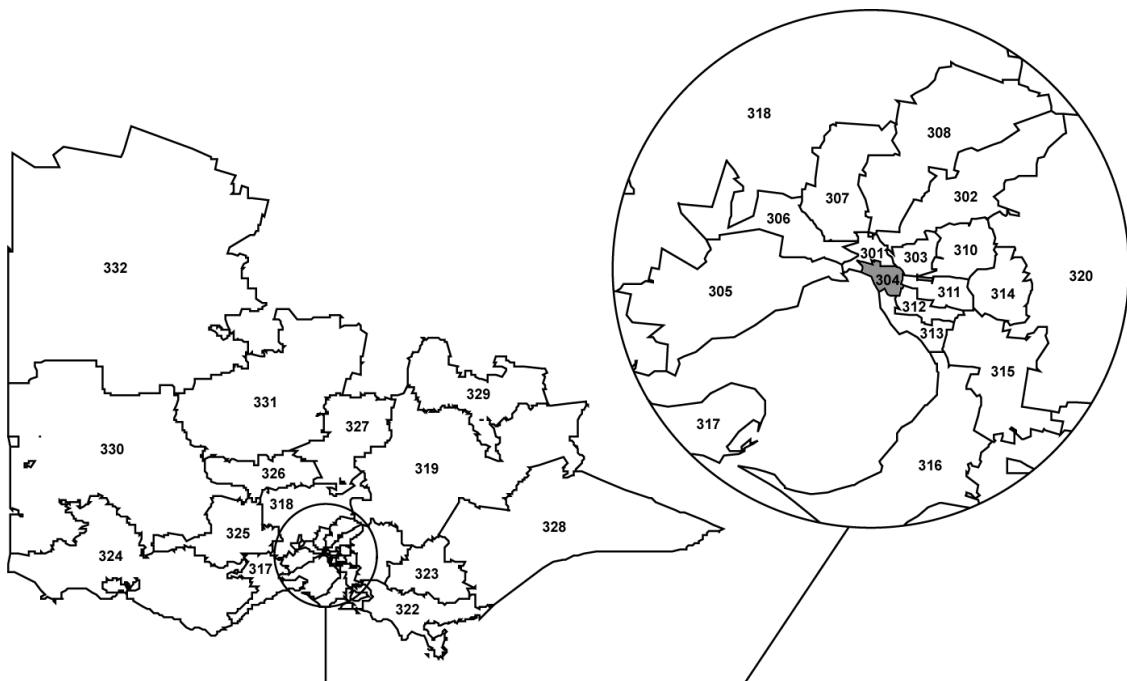
Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation leaflets,
 - VicFit information,
 - National Health and Medical Research Council (NHMRC) information,
 - Local government municipal health plans.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
N/A.
- What resource materials do you provide to practices?
Brochures from sources as listed previously.

Division Contact Person/
Program Co-ordinator

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SouthCity GP Services



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	176,932	
■ Aboriginal or Torres Strait Islander	381	0.2%
■ Speaks language other than English at home	36,094	20.4%
■ RRMA classification ¹		
1: Capital city	176,932	100.0%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9338	7.1%
■ High blood pressure ⁴	36,067	27.6%
■ High blood cholesterol ⁵	63,677	48.7%
■ Obese or overweight ⁶	76,269	58.3%
■ Physical inactivity ⁷	54,184	41.4%
■ Smoking ⁸	26,026	19.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

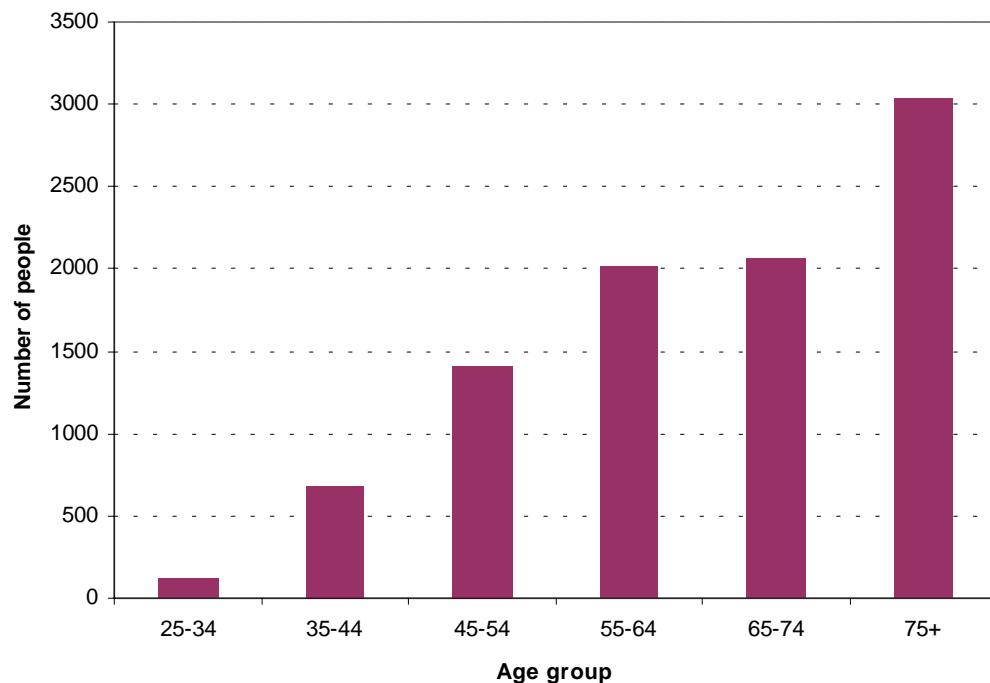
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

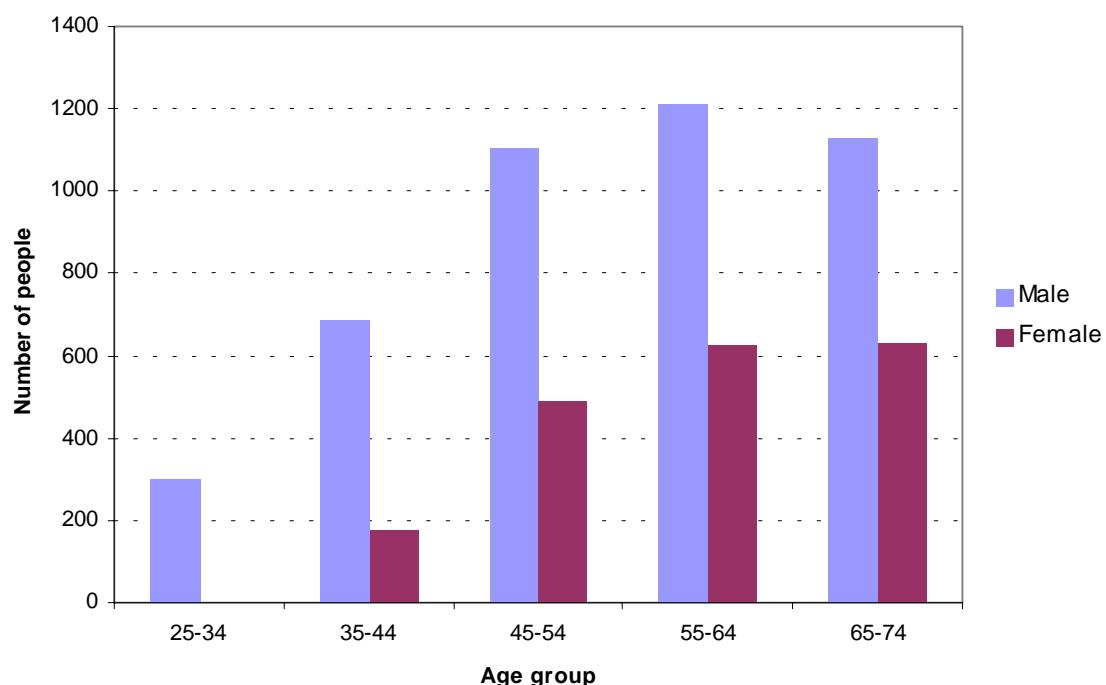
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



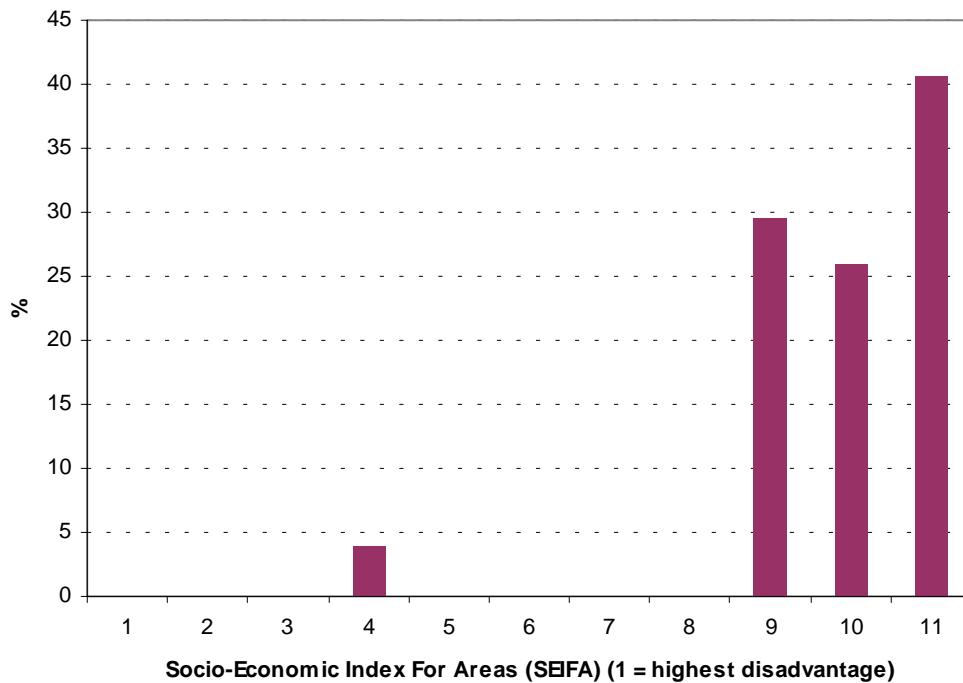
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

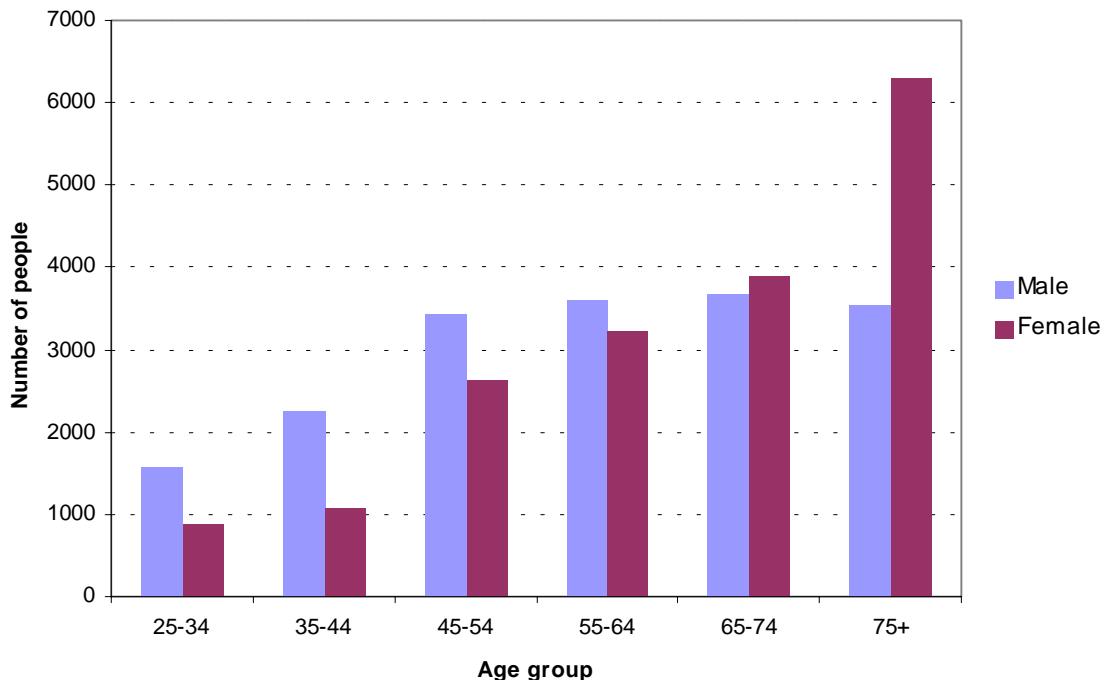
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

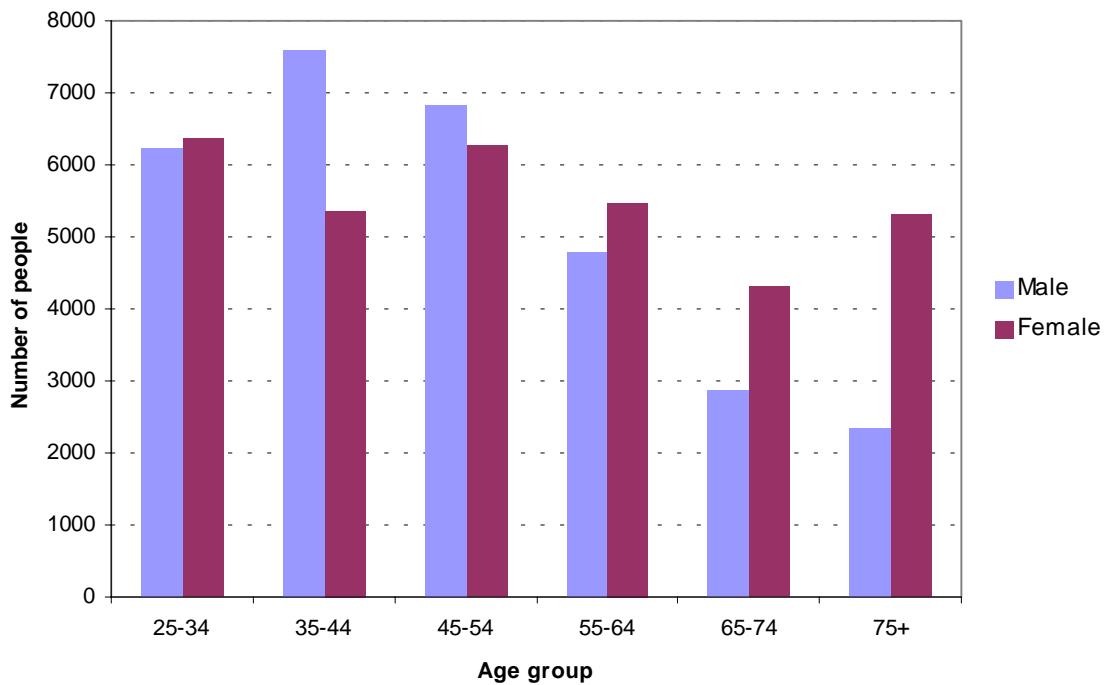
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



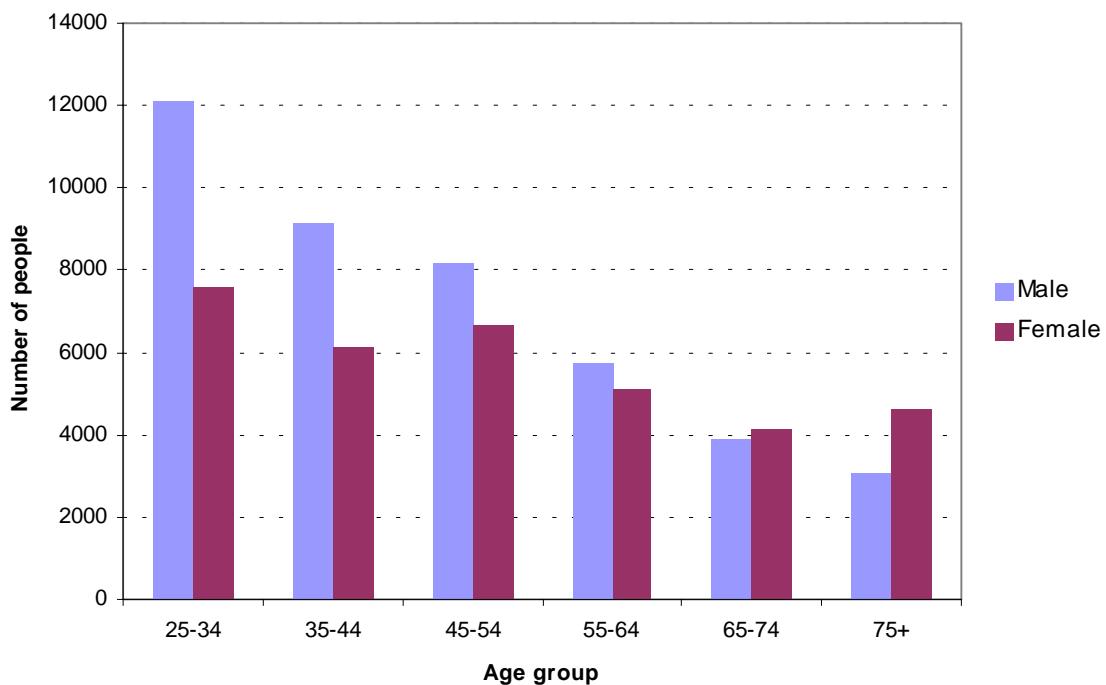
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



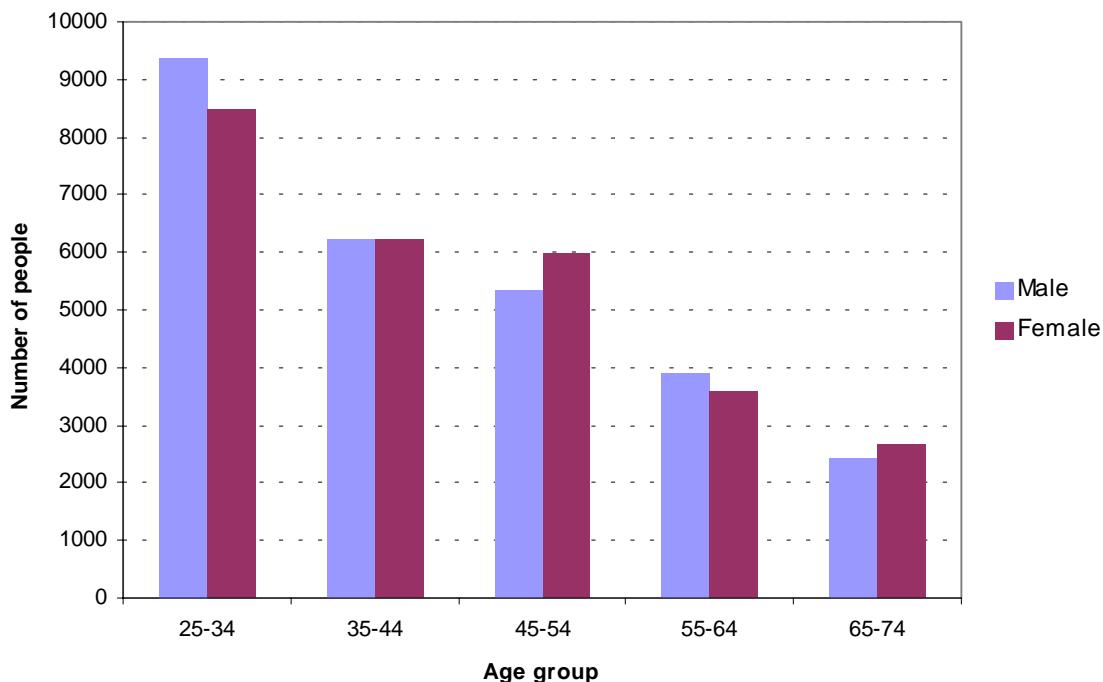
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



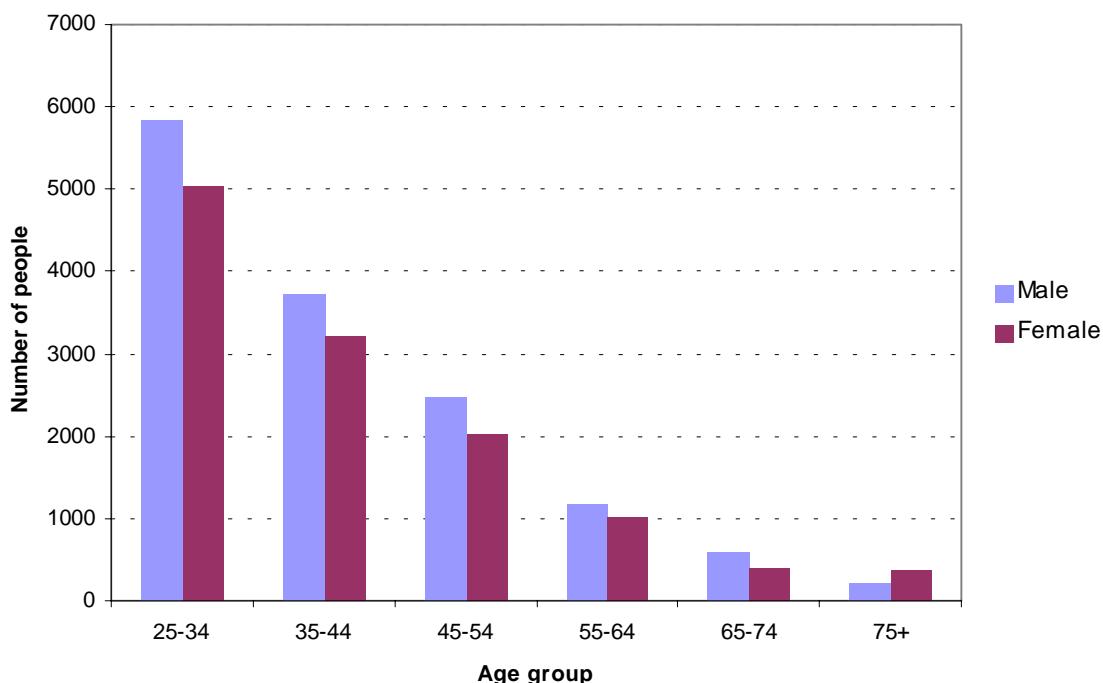
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 485 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - International Diabetes Institute,
 - Diabetes Australia (Vic Branch),
 - Juvenile Diabetes Foundation of Australia.

- What services are needed but are not available in your Division area?
N/A.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?
Division commenced formal diabetes program in July. Activities to date include GP-to-GP academic detailing on diabetes as part of National Prescribing Service (NPS) program of quality prescribing.

Division Perspective

- What have been the major achievements or highlights of your program so far?
Approximately 50 visits completed – excellent GP feedback.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
N/A.

- What future plans do you have for diabetes management in your Division?
 - Small group/case-based discussion sessions planned to run bi-monthly, commencing September,
 - Diabetes management workshops – October 2002,
 - More practice visits,
 - Training GPs and staff in setting up practice systems to screen for and manage patients.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

At least one GP-driver in practice to convince all that initiatives are worth the time, effort and expense. Willingness/ability to embrace proactive health care rather than reactive. Practice population profile that “fits”.

Establishing alliances at present – meeting with International Diabetes Institute. Speaker from Diabetes Alliance keynote at October workshop.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- What resource materials do you provide to practices?

Assembling relevant resources at present.

N/A.

Not sure.

N/A.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - National Heart Foundation (NHF),
 - Cabrini for Health,
 - Heart Centre at The Alfred,
 - Baker Research Institute,
 - Range of specialist cardiologist services.

- What services are needed but are not available in your Division area?
N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input checked="" type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your CVD program including any changes that occurred over time?
Division ran CVD risk factor program 1999 – 2001, which included risk factor workshops, production of CVD resource kit for GPs, Heartrack computerised risk analysis tool, cardiology seminars, NHF clinical audit, National Prescribing Service clinical audits, GP-to-GP academic detailing on hypertension.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Resource kit for GPs,
 - Successful workshops, particularly those related to motivating patients to make health lifestyle changes.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
Although CVD is the number one reason for seeing a GP in this Division, it has been difficult to convince GPs that they need to broaden their knowledge of CVD. Seen as so fundamental that it's not necessary to make time for Continuing Professional Development (CPD).

- What future plans do you have for CVD management in your Division?
CVD program completed except where it relates to diabetes or Quality Use of Medicines program (QUM).

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Develop strategies to convince GPs the topic isn't too boring or predictable!
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

NHF, Cabrini for Health, The Alfred Heart Centre and The Baker, Public Health Management have all been very helpful.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

• NHF patient education materials,
• Therapeutic Guidelines Cardiovascular ,
• National Prescribing Service materials.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Paper-based Patient CVD Summary Sheet.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No.
- What resource materials do you provide to practices?

NHF brochures.

Division Contact Person/
Program Co-ordinator

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Western Melbourne DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	240,627	
■ Aboriginal or Torres Strait Islander	840	0.3%
■ Speaks language other than English at home	117,564	48.9%
■ RRMA classification ¹		
1: Capital city	240,627	100.0%
■ SEIFA category containing population median: ²	2	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	10,435	6.8%
■ High blood pressure ⁴	40,894	26.6%
■ High blood cholesterol ⁵	76,177	49.5%
■ Obese or overweight ⁶	90,803	59.1%
■ Physical inactivity ⁷	66,436	43.2%
■ Smoking ⁸	31,127	20.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999–2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

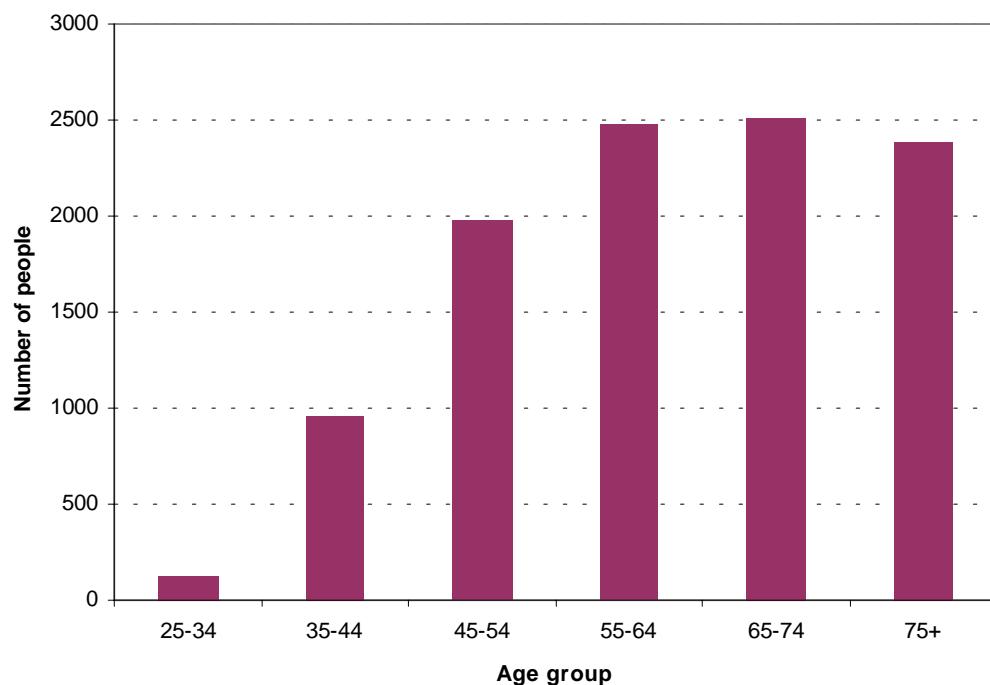
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

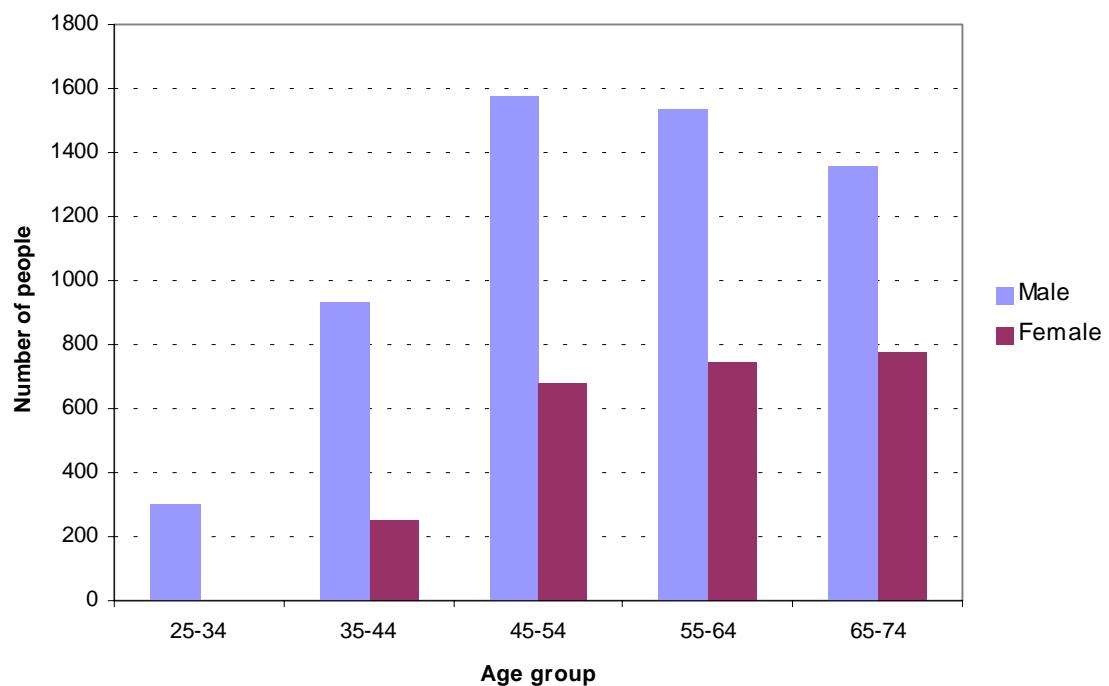
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



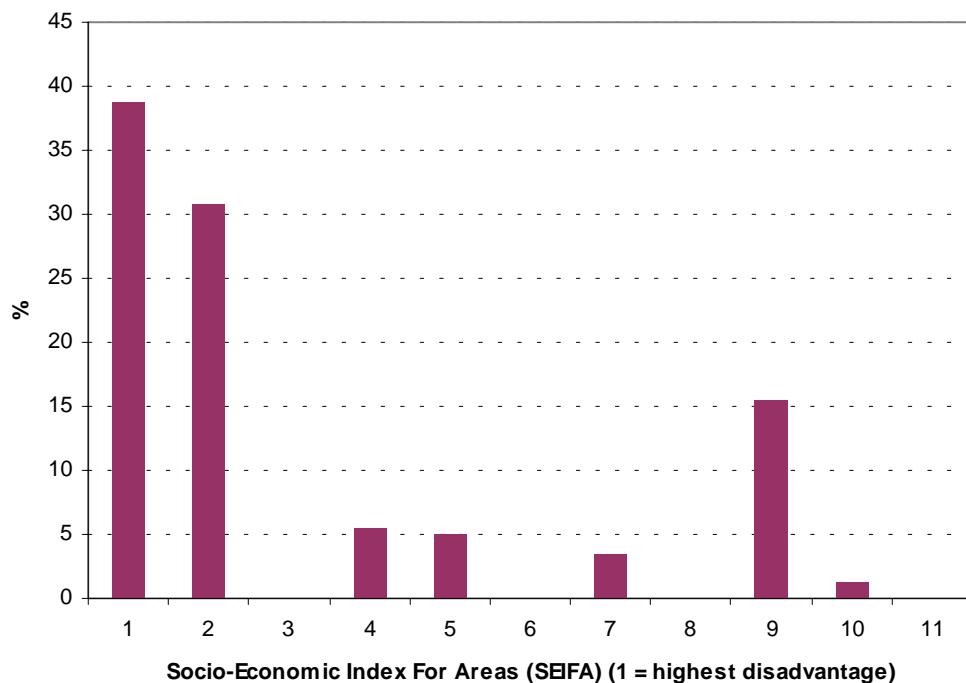
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

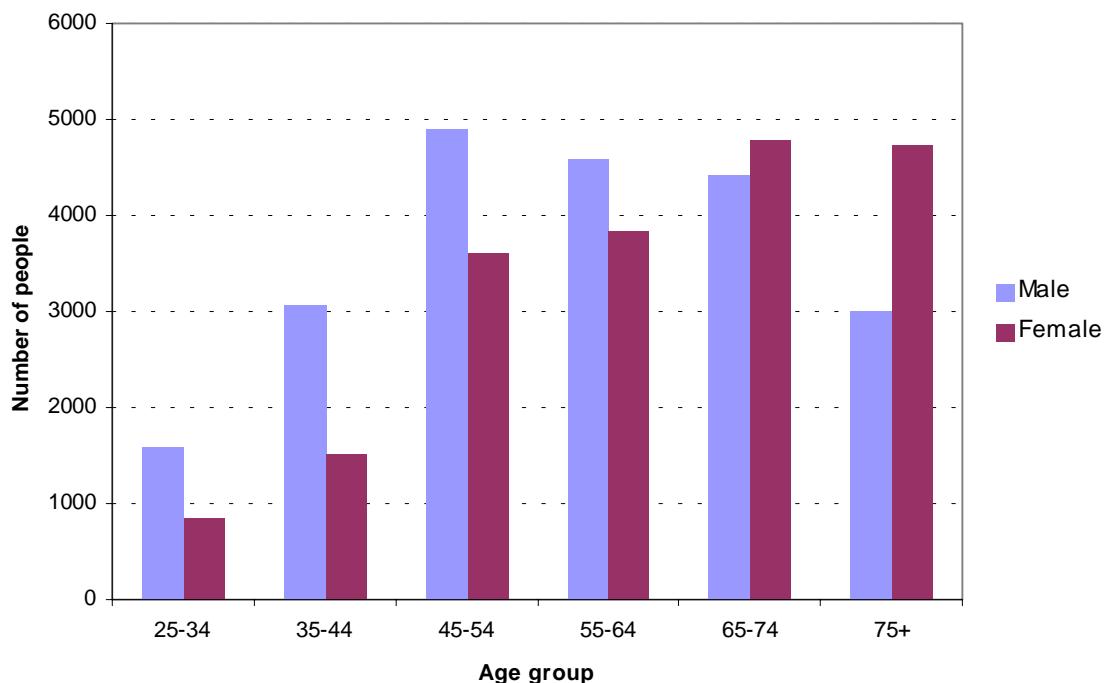
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

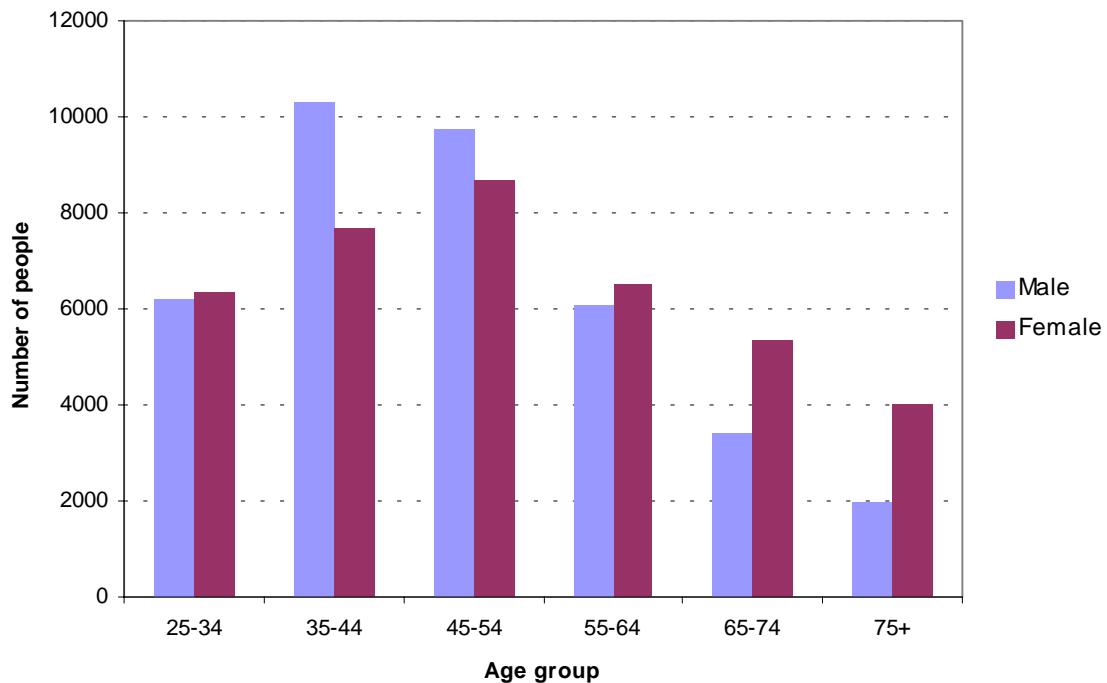
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



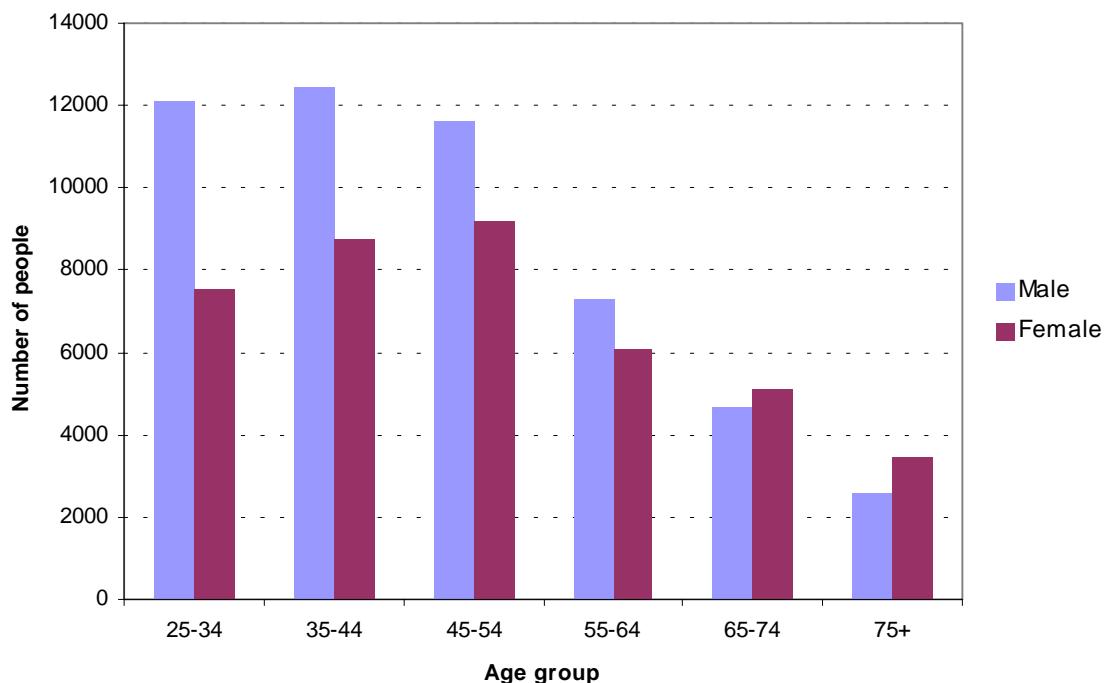
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



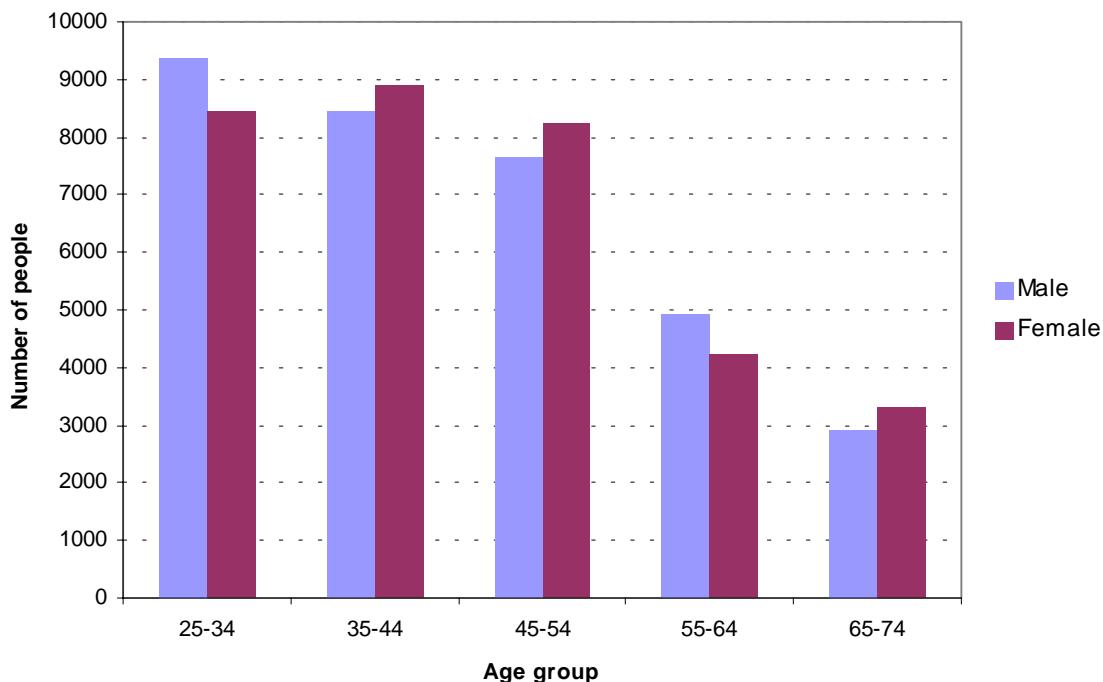
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



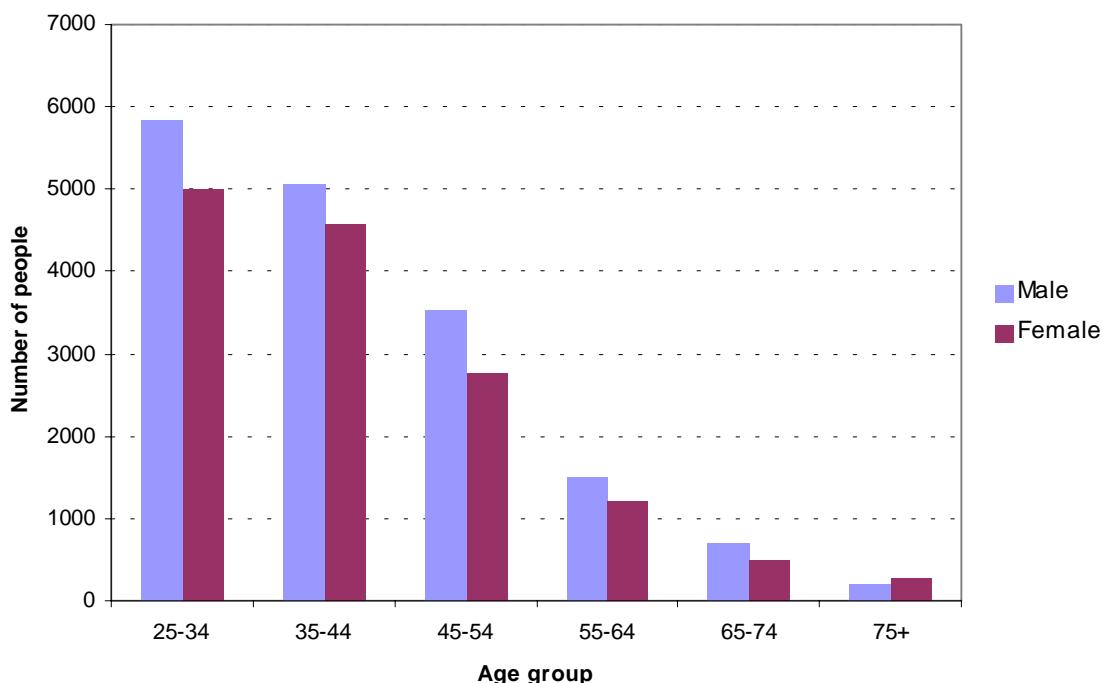
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 270 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes nurse educators,
 - Diabetes Australia Victoria (Sunshine),
 - Vietnamese diabetes education sessions,
 - National Association of Diabetes Centres (Western Hospital, Associate – Western Region Health Centre).

- What services are needed but are not available in your Division area? N/A.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Part of the Diabetes Alliance Group with four other Divisions, Diabetes Australia (Victoria) and the Royal Melbourne Hospital. Provide Continuing Professional Development (CPD) and develop and distribute resources.
 - Supporting Westbay Primary Care Partnerships (PCP) – Diabetes Pilot Project.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Development of the patient held record and patient information sheet,
 - Insulin stabilisation project.

- Are there any factors or barriers that have limited the implementation of your program? Please comment: N/A.

- What future plans do you have for diabetes management in your Division? N/A.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Practice nurses,
 - Have good systems in place already, including IT,
 - Interest and motivation.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - In Diabetes Alliance Group,
 - Work with Westbay PCP.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

Abbreviated guidelines for management of diabetes (based on Victorian diabetes taskforce clinical guidelines for the management of people with diabetes – November 1998).

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes initiative quick reference guide,
 - Have to get approval from Diabetes Alliance Group on patient held record.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Not to my knowledge – perhaps multilingual resources.

- What resource materials do you provide to practices?
 - Laminated guide to diabetes Practice Incentive Program (PCP),
 - Patient held records and patient information sheets,
 - We also distribute resources produced by other agencies.

Appendix

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

The purpose of the Diabetes Alliance Group is to be instrumental in the planning and implementation of diabetes services within the geographic region covered by its member Divisions of General Practice. It will:

- Provide a conduit for information flow between 5 Divisions of General Practice, 2 Hospitals and Diabetes Australia – Victoria,
- Provide ongoing education to general practitioners (GPs) on diabetes management in general practice.

The membership of the Diabetes Alliance Group consists of the Melbourne, North West Melbourne, Western Melbourne, Northern Melbourne and Westgate Divisions of General Practice, Royal Melbourne Hospital, Western Hospital (Sunshine) and Diabetes Australia – Victoria.

Terms of Reference

- To ensure appropriate communication between the Divisions and their diabetes programs,
- To facilitate communication between the Divisions and the hospitals in the provision of care to people with diabetes,
- To facilitate communication between the Divisions and Diabetes Australia – Victoria,
- To provide a forum to discuss issues relating to the provision of care to people with diabetes by GPs,
- To provide a forum to discuss issues between GPs and hospitals within the geographical area relating to the provision of care to people with diabetes,
- To provide a forum to discuss issues between GPs and Diabetes Australia – Victoria relating to the provision of care to people with diabetes within the geographical area,
- To provide education relevant to GPs' needs,
- To develop and support programs that support GPs in providing total care of people with diabetes,
- To lobby and communicate with appropriate organisations to improve services to people with diabetes,
- To be responsive to funding opportunities in the area of diabetes.

Mission Statement

The DAG believes that the role of GPs, as the primary health care provider in the management of people with diabetes, is central to the coordinated care of this group. The DAG believes that the management of people with diabetes is enhanced when all providers involved in caring for people with diabetes, is coordinated.

Goals

The DAG aims to improve the management of people with diabetes.

The DAG aims to enhance the knowledge and confidence of GPs and practice nurses in managing diabetes.

The DAG aims to improve communication between GPs and other care providers in the management of people with diabetes.

The DAG aims to improve the self-management of people with diabetes.

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

Three district areas were identified as being group priorities. These were, GP resourcing with both training opportunities and physical resources, sharing the care of people with diabetes through the development of links with other organisations and care providers, and improved access to education and resources for people with diabetes.

Since 1997 the group has been active in organising training opportunities for GPs and practice nurses in the Northern and Western suburbs of Melbourne, and has worked to help create strategic partnerships between GPs and other health care providers working with people with diabetes. Representatives of the DAG are active on state and regional planning committees, their contributions valued for their expertise and track record of achievement in diabetes. Numerous resources for use by people with diabetes have been produced and widely distributed through GPs of member divisions.

The DAG has had consistently broad multidisciplinary representation on its committee, and currently has five Divisional representatives, two GPs, two diabetes nurse educators, and one endocrinologist. The DAG is chaired by GP, Dr Ralph Audehm.

The DAG currently meets quarterly with representatives of all member organisations present to discuss the broad direction of DAG projects, programs and resources. A subgroup of representatives from all member Divisions plus the GP chairperson, meets monthly to discuss operational matters, and conduct detailed planning for activities and resource development.

Current and recent diabetes related projects auspiced by DAG

GP Insulin Stabilisation Project

Member Divisions have access to a diabetes educator, available to assist GPs with insulin changeover and stabilisation. The educator also provides patient education with literature, brochures and insulin pens, free of charge. This service has been used by 10 GPs and 25 people with diabetes in the year to end June 2001.

Nurse Practitioner Project

Together with Diabetes Australia – Victoria, DAG has recently auspiced a nurse practitioner project in Victoria involving improved access to the services of a nurse practitioner candidate in diabetes education for people with diabetes in a GP setting.

Hospital Admission Reduction Program (HARP)

Successful submission for HARP funding was received in 2002 from the state government of Victoria. This project, funded for three years, aims to increase the capacity of selected GP practices to support their patients with diabetes by increasing their access to a diabetes educator. Diabetes educators will be available 24 hours a day to deal with diabetes related crises out of hours, and to counsel patients on an appointment basis.

Summary

The Diabetes Alliance Group is proud of its achievements. The member groups believe that the collaboration, which is the DAG, enhances the performance of each individual agency in the area of diabetes. The sustainability of the group is evident, given all founding organisations are still active within the alliance, five years after first meeting.

The evidence of outcomes are also clear. GP and nurse training opportunities, resources for people with diabetes, and links which have been established between GPs and other health providers in the primary care setting, clearly place the DAG as a leading collaborative group, not only within the Divisional movement, but also on a broader national basis. At an organisational level DAG representation on State and regional committees further reinforces the success of the collaboration, with external agencies keen to draw on the learning and achievements of the group.

The members of the DAG look forward to continued successes in their collaboration into the future.

Division Contact Person/
Program Co-ordinator

Name: Sarah Lausberg
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Westgate DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	166,824	
■ Aboriginal or Torres Strait Islander	811	0.5%
■ Speaks language other than English at home	39,174	23.5%
■ RRMA classification ¹		
1: Capital city	166,824	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7,125	6.7%
■ High blood pressure ⁴	27,947	26.3%
■ High blood cholesterol ⁵	52,702	49.7%
■ Obese or overweight ⁶	62,640	59.0%
■ Physical inactivity ⁷	45,910	43.3%
■ Smoking ⁸	21,574	20.3%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999–2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

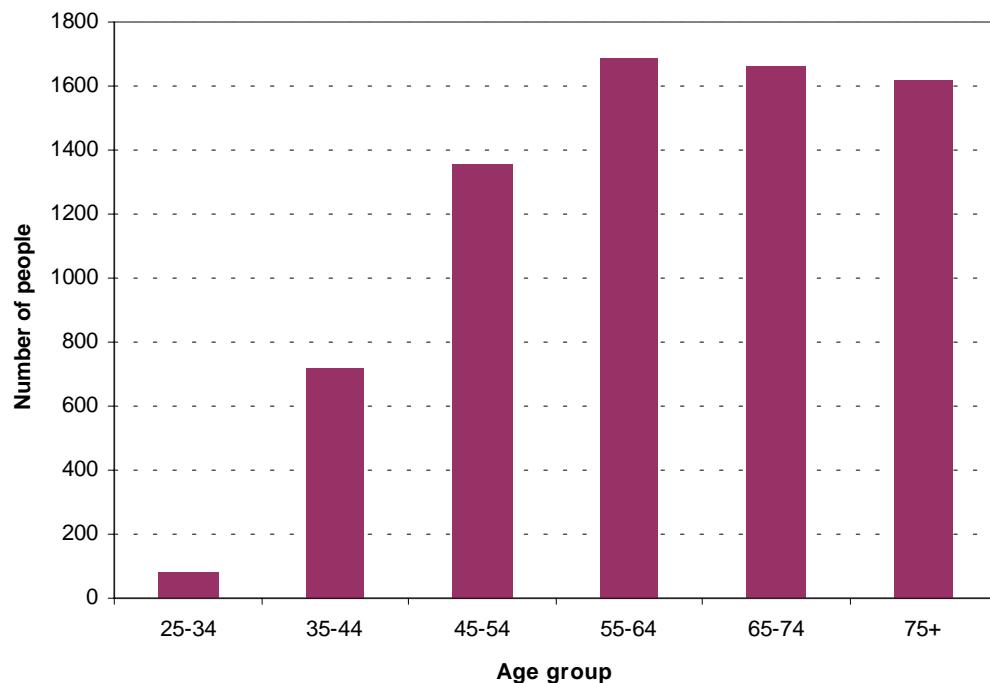
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

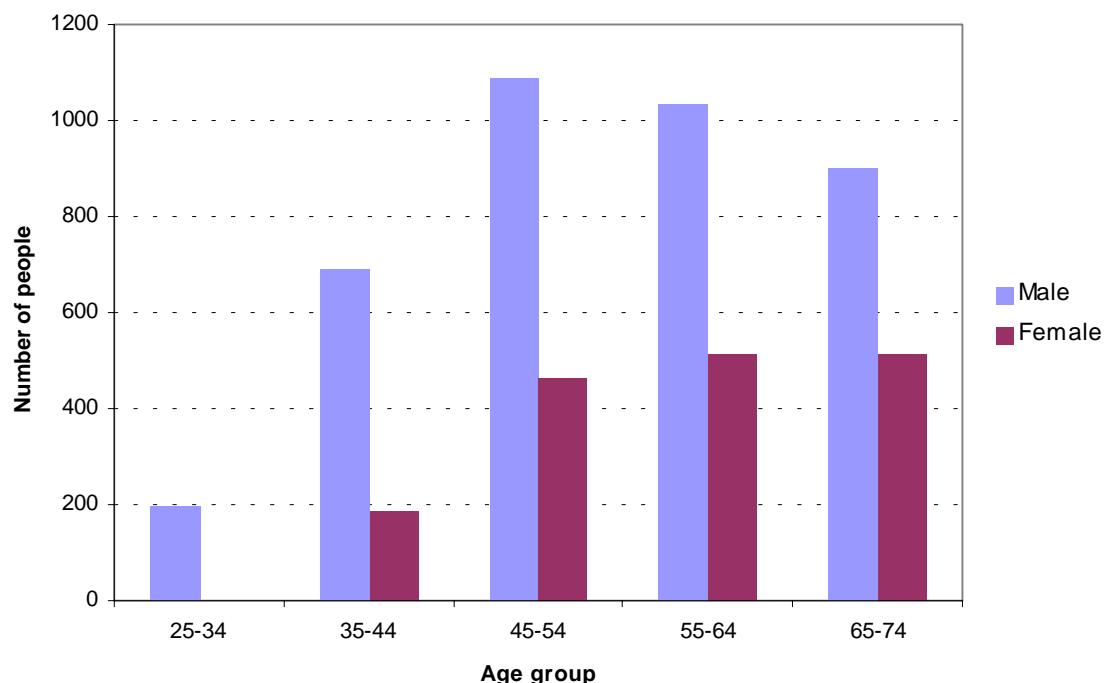
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



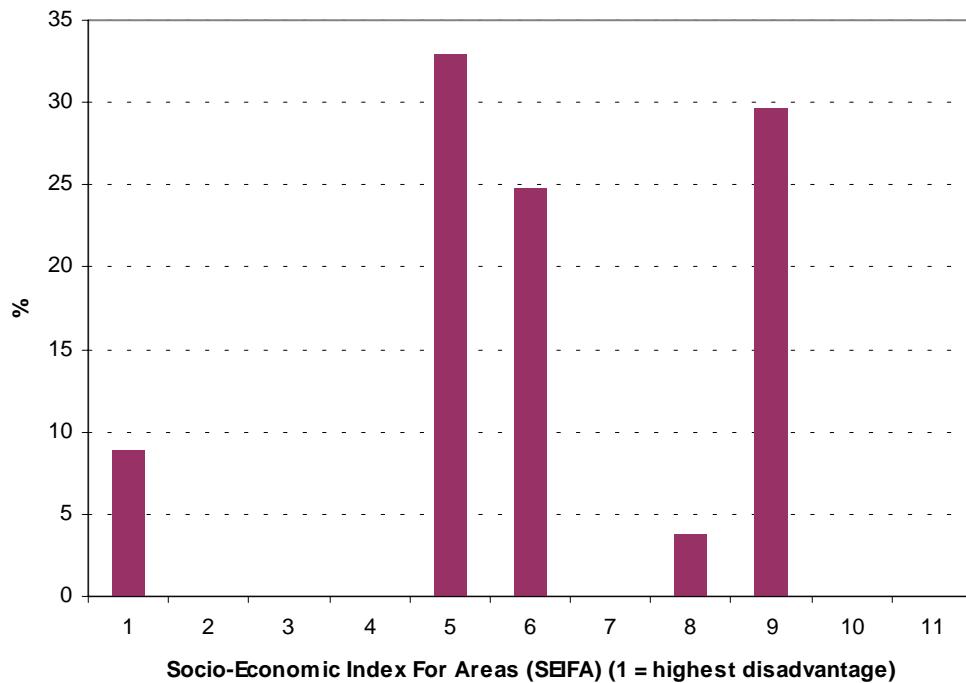
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

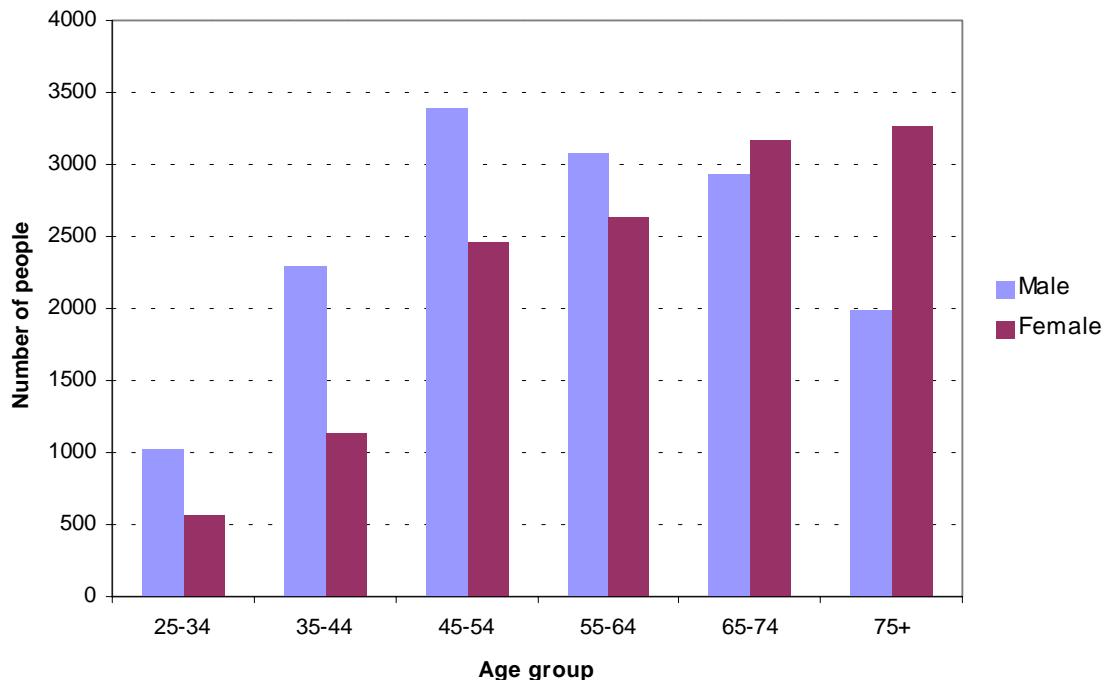
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

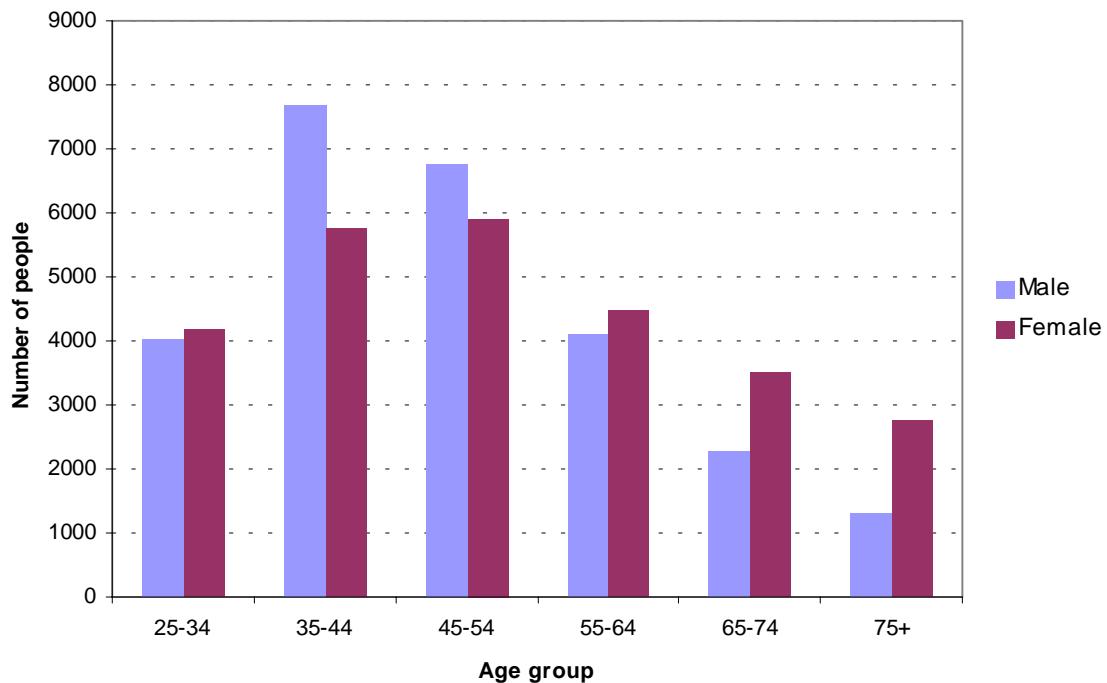
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



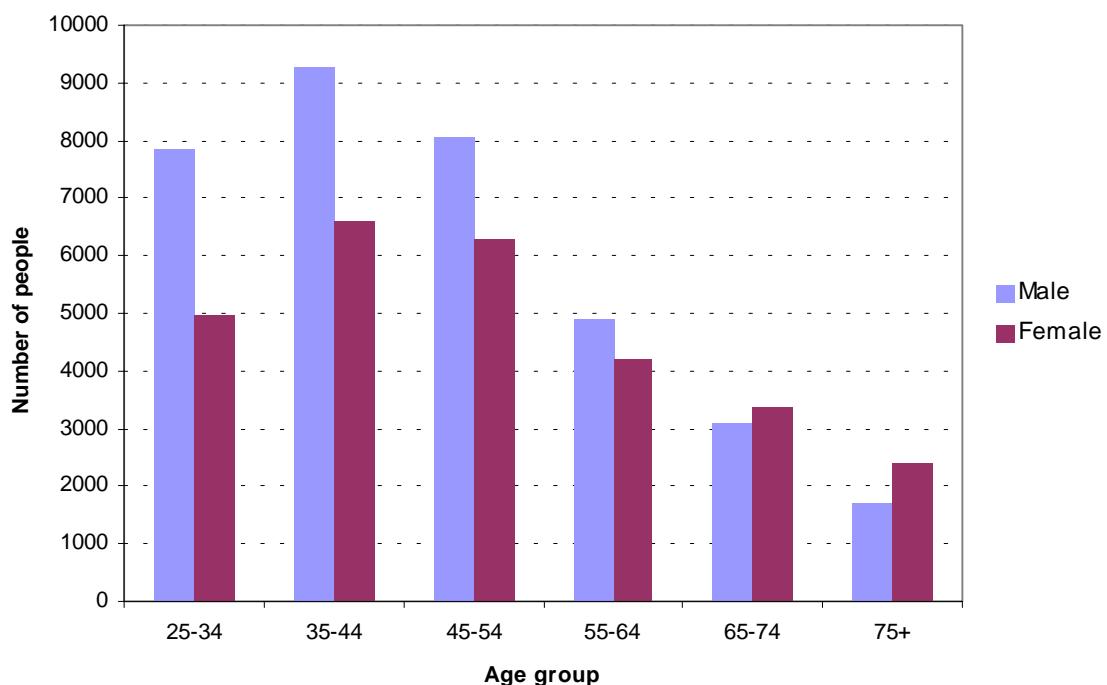
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



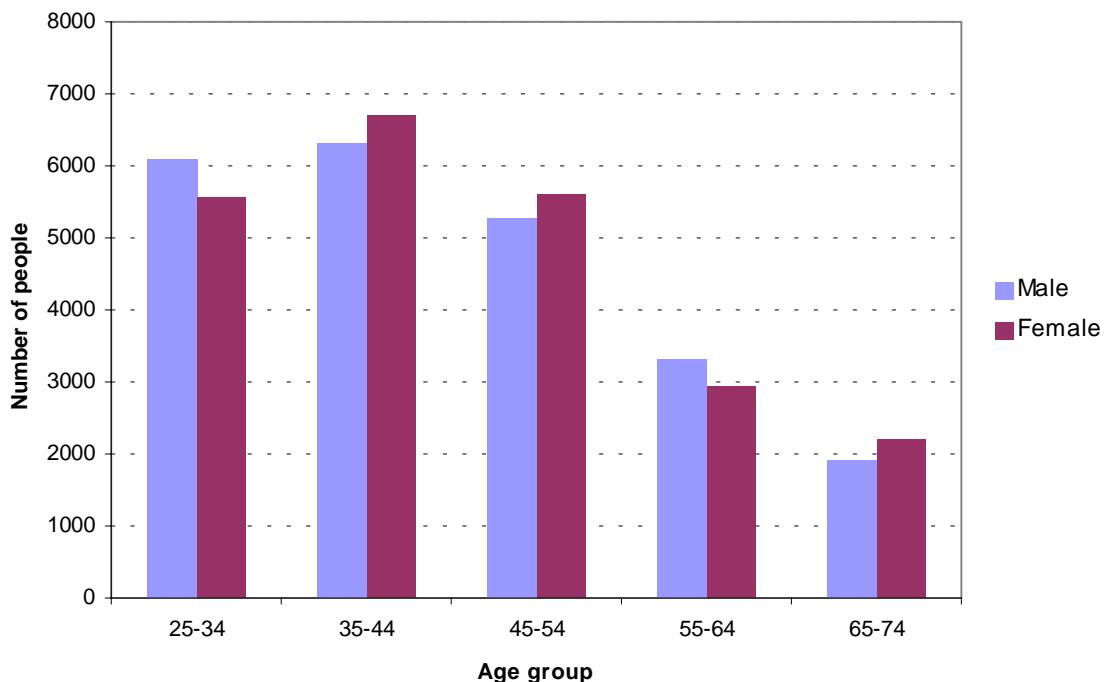
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



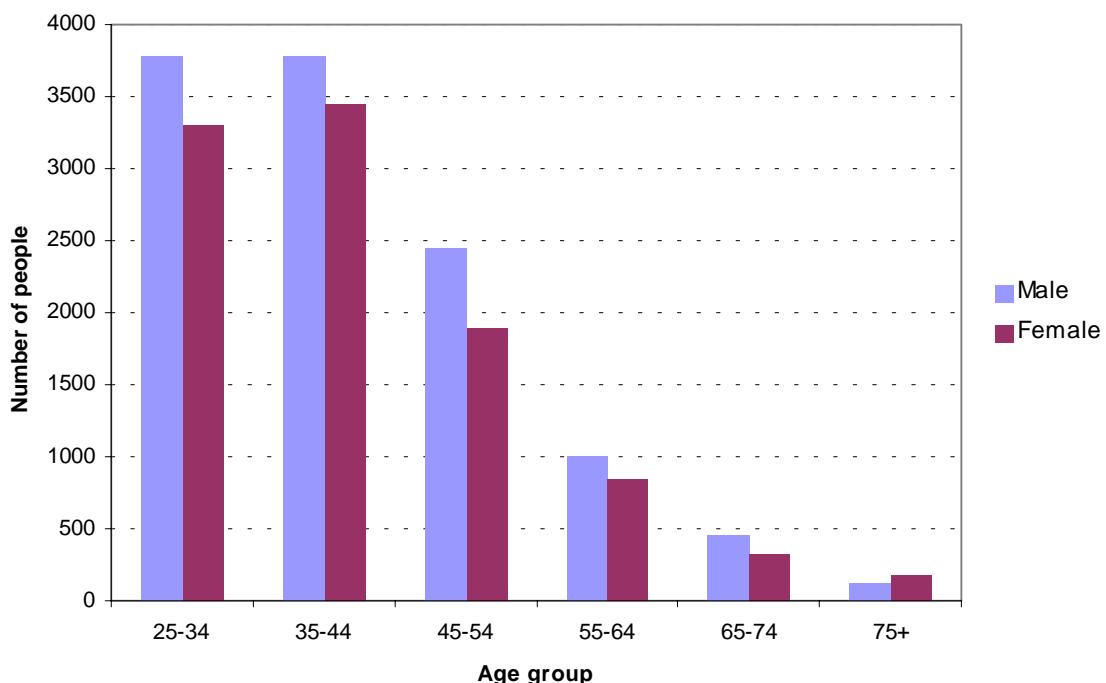
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 138 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Hospitals – dietetics, diabetes education, and ophthalmology,
 - Community Health Centre – diabetes support group, diabetes education, dietetics, podiatry and risk reduction,
 - Local government – diabetes risk reduction,
 - Diabetes Australia Victoria branch and support group – services and support,
 - Royal District Nursing Service – diabetes education,
 - Counselling services,
 - Ethno-specific support groups,
 - Private optometry, dietetics and podiatry services.

- What services are needed but are not available in your Division area?

The bigger issue is being able to access services in a timely manner. Long waiting lists to public services have been identified as an issue through the Primary Care Partnerships Integrated Disease Management (PCPIDM) Project.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Involvement in the Diabetes Alliance Group, a collaboration of 5 Divisions of General Practice, Royal Melbourne Hospital and Diabetes Australia – Victoria. The goals of the group are to provide quality care and management of people with diabetes via:

- Enhancing GP and practice staff knowledge and skills,
- Improving communication between GP and other care providers, and
- Improving patient self-management.

The Division has also been involved in the Diabetes Integrated Disease Management (IDM) Pilot Project as part of the activities of Westbay Alliance Primary Care Partnership. The project will monitor a group of diabetes patients over a period of time, assessing how well the current service system is accessed, whilst promoting best practice management guidelines.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Annual GP Diabetes Weekend Update,
 - Annual Diabetes August Update Series,
 - Diabetes Practice Nurse Course,
 - Involvement in Nurse Practitioner Projects and the GP Insulin Stabilisation Project.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Competing demands on GP available time to attend Continuing Professional Development (CPD) events and become involved in particular projects. GP-to-patient ratios have been identified as one of the largest across the nation for the Division catchment.

- What future plans do you have for diabetes management in your Division?

Continued involvement on the Diabetes Alliance Group and Westbay Alliance PCP Integrated Disease Management Diabetes Pilot Project.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Good practice management skills and resources, eg recall and reminder systems,
 - Available time to implement any changes that need to occur.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Royal Melbourne Hospital and Diabetes Australia – Victoria through the Diabetes Alliance Group,
 - Westbay Alliance Primary Care Partnership through the Integrated Disease Management Pilot Project.

Division Resources

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? | Speakers notes from CPD events.

<ul style="list-style-type: none">• All Diabetes Alliance Group resources,• Patient held record and patient information sheet,• Abbreviated guidelines for Management of Diabetes. |
| <ul style="list-style-type: none">▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? | N/A. |
| <ul style="list-style-type: none">▪ What resource materials do you provide to practices? | Those produced by the Diabetes Alliance Group. |

Appendix

Diabetes Alliance Group (DAG)

The Diabetes Alliance Group is a coalition of five Divisions of General Practice, Diabetes Australia – Victoria, and The Royal Melbourne Hospital – Diabetes Unit. The Diabetes Alliance Group first met in November 1997 to coordinate planning between member organisations to achieve joint goals. Collaboration, communication and the sharing of scarce resources, with and between diabetes care providers was then, and remains now, an important aim of the alliance.

The purpose of the Diabetes Alliance Group is to be instrumental in the planning and implementation of diabetes services within the geographic region covered by its member Divisions of General Practice. It will:

- Provide a conduit for information flow between 5 Divisions of General Practice, 2 hospitals and Diabetes Australia – Victoria,
- Provide ongoing education to general practitioners (GPs) on diabetes management in general practice.

The membership of the Diabetes Alliance Group consists of the Melbourne, North West Melbourne, Western Melbourne, Northern Melbourne and Westgate Divisions of General Practice, Royal Melbourne Hospital, Western Hospital (Sunshine) and Diabetes Australia – Victoria.

Terms of Reference

- To ensure appropriate communication between the Divisions and their diabetes programs,
- To facilitate communication between the Divisions and the hospitals in the provision of care to people with diabetes,
- To facilitate communication between the Divisions and Diabetes Australia – Victoria,
- To provide a forum to discuss issues relating to the provision of care to people with diabetes by GPs,
- To provide a forum to discuss issues between GPs and hospitals within the geographical area relating to the provision of care to people with diabetes,
- To provide a forum to discuss issues between GPs and Diabetes Australia – Victoria relating to the provision of care to people with diabetes within the geographical area,
- To provide education relevant to GPs' needs,
- To develop and support programs that support GPs in providing total care of people with diabetes,
- To lobby and communicate with appropriate organisations to improve services to people with diabetes,
- To be responsive to funding opportunities in the area of diabetes.

Mission Statement

The DAG believes that the role of GPs, as the primary health care provider in the management of people with diabetes, is central to the coordinated care of this group. The DAG believes that the management of people with diabetes is enhanced when all providers involved in caring for people with diabetes, is coordinated.

Goals

The DAG aims to improve the management of people with diabetes.

The DAG aims to enhance the knowledge and confidence of GPs and practice nurses in managing diabetes.

The DAG aims to improve communication between GPs and other care providers in the management of people with diabetes.

The DAG aims to improve the self-management of people with diabetes.

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The DAG has had consistently broad multidisciplinary representation on its committee, and currently has five Divisional representatives, two GPs, two diabetes nurse educators, and one endocrinologist. The DAG is chaired by GP, Dr Ralph Audehm.

The DAG currently meets quarterly with representatives of all member organisations present to discuss the broad direction of DAG projects, programs and resources. A subgroup of representatives from all member Divisions plus the GP chairperson, meets monthly to discuss operational matters, and conduct detailed planning for activities and resource development.

Current and recent diabetes related projects auspiced by DAG

GP Insulin Stabilisation Project

Member Divisions have access to a diabetes educator, available to assist GPs with insulin changeover and stabilisation. The educator also provides patient education with literature, brochures and insulin pens, free of charge. This service has been used by 10 GPs and 25 people with diabetes in the year to end June 2001.

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Together with Diabetes Australia – Victoria, DAG has recently auspiced a nurse practitioner project in Victoria involving improved access to the services of a nurse practitioner candidate in diabetes education for people with diabetes in a GP setting.

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Summary

The Diabetes Alliance Group is proud of its achievements. The member groups believe that the collaboration, which is the DAG, enhances the performance of each individual agency in the area of diabetes. The sustainability of the group is evident, given all founding organisations are still active within the alliance, five years after first meeting.

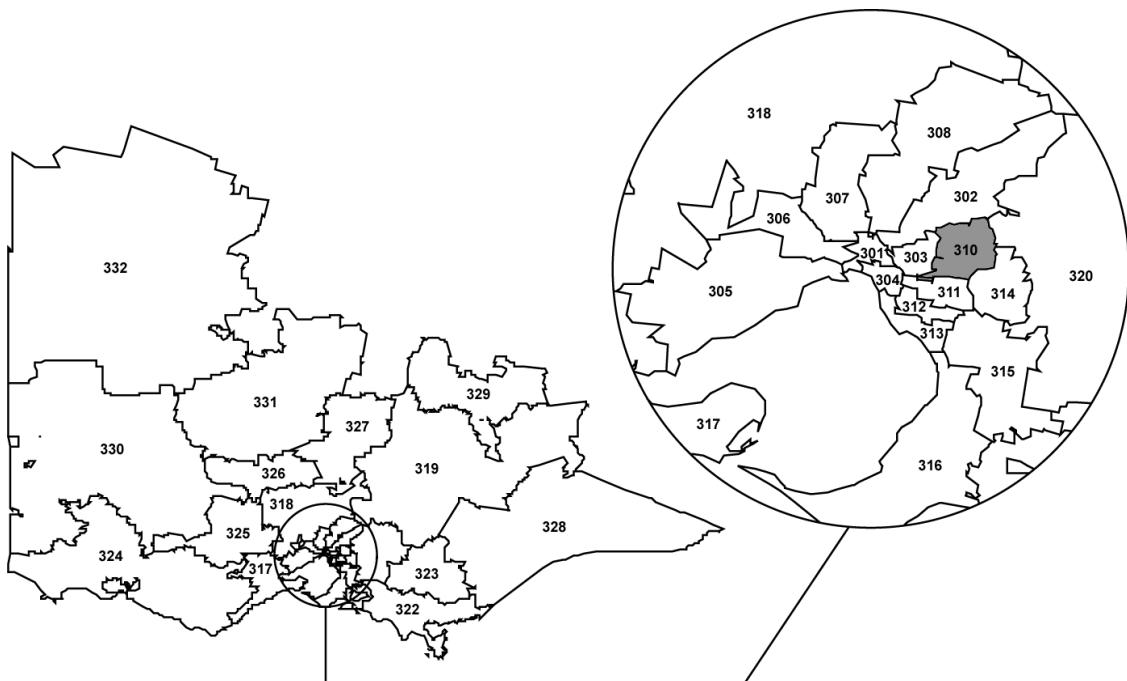
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The members of the DAG look forward to continued successes in their collaboration into the future.

Division Contact Person/
Program Co-ordinator

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Whitehorse DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	242,320	
■ Aboriginal or Torres Strait Islander	415	0.2%
■ Speaks language other than English at home	56,712	23.4%
■ RRMA classification ¹		
1: Capital city	242,320	100.0%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	13,697	8.3%
■ High blood pressure ⁴	51,516	31.3%
■ High blood cholesterol ⁵	85,457	51.9%
■ Obese or overweight ⁶	99,294	60.3%
■ Physical inactivity ⁷	69,115	42.0%
■ Smoking ⁸	30,855	18.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

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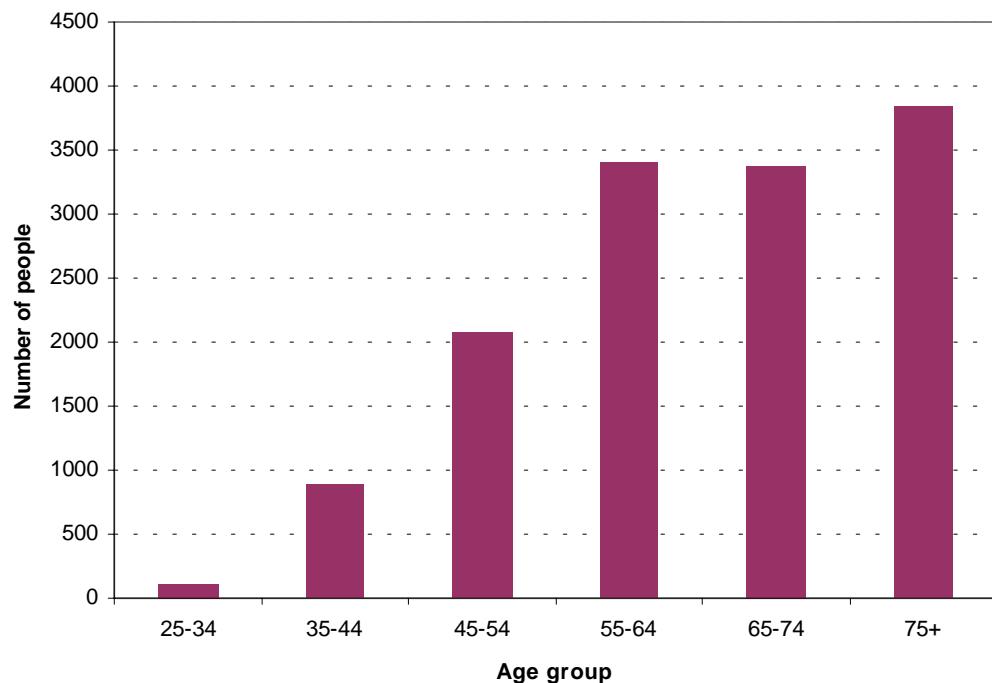
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7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

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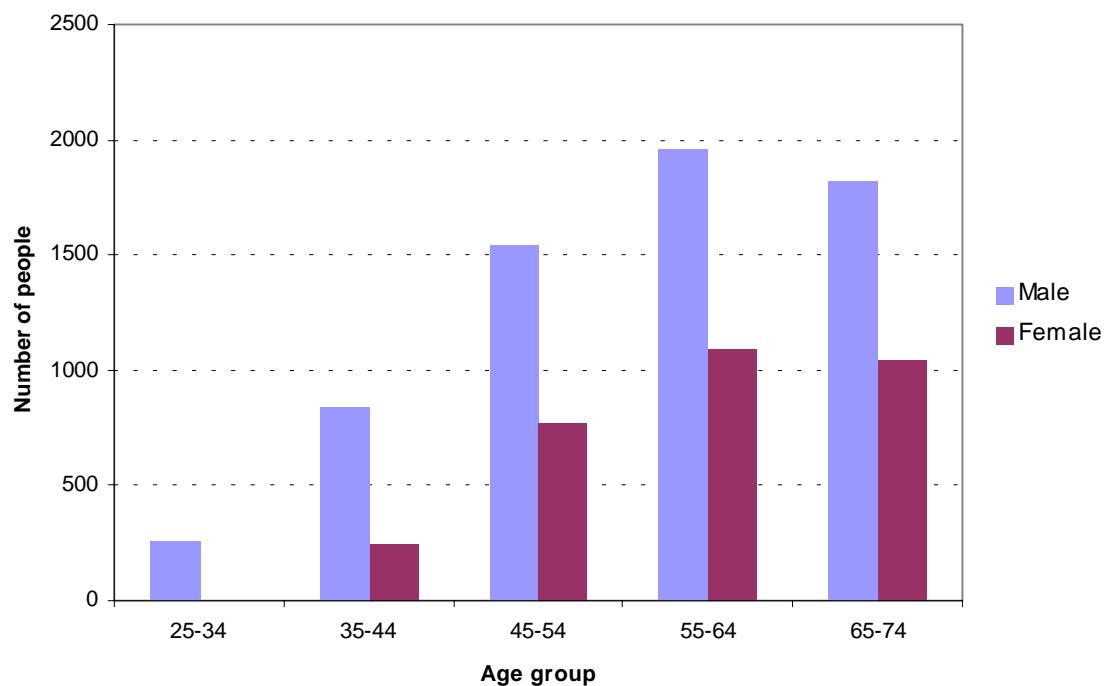
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



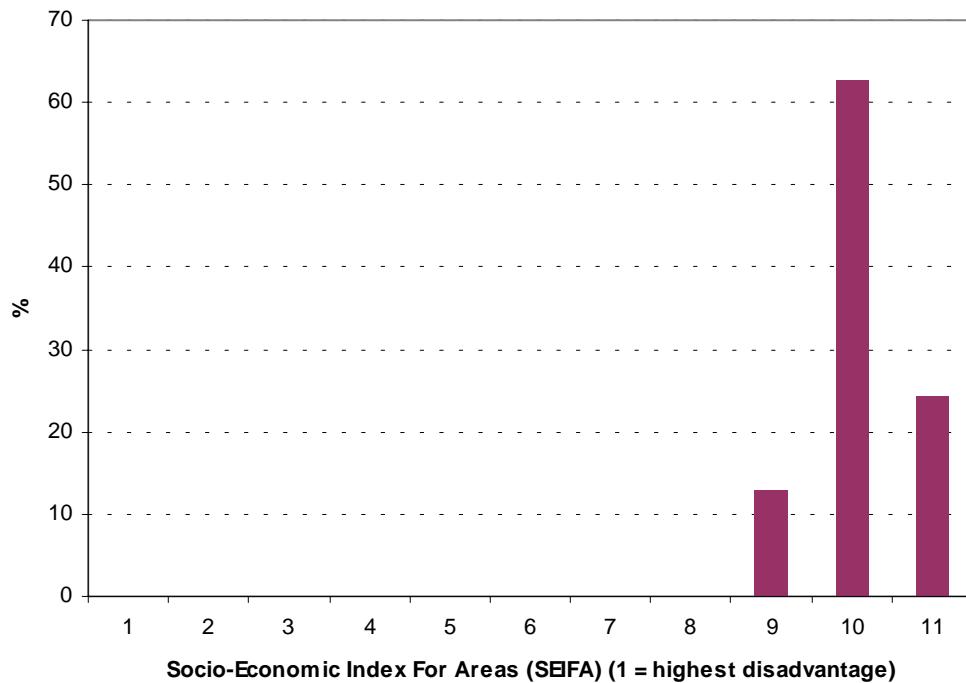
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

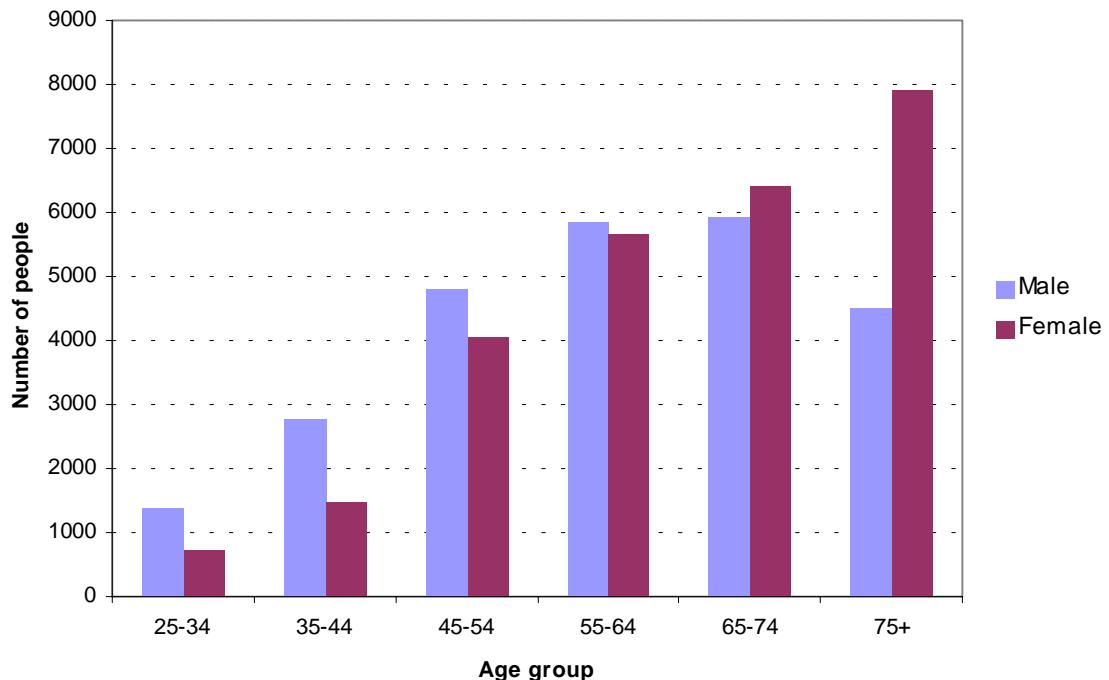
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

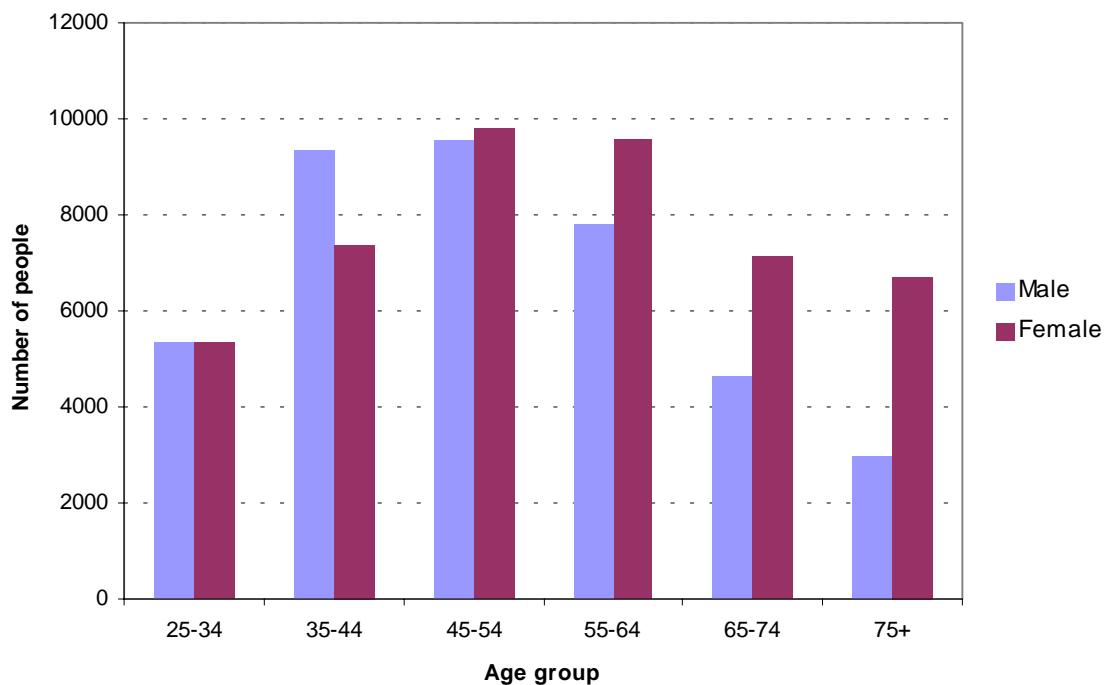
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



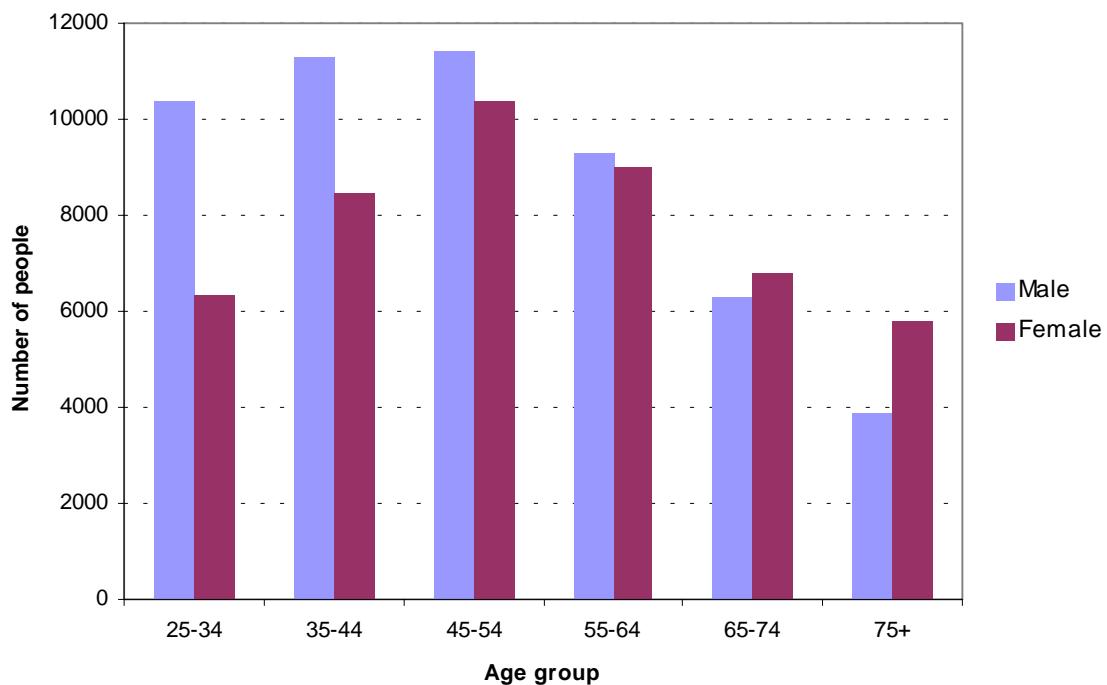
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Figure 5: Estimated prevalence of high blood cholesterol by age and sex



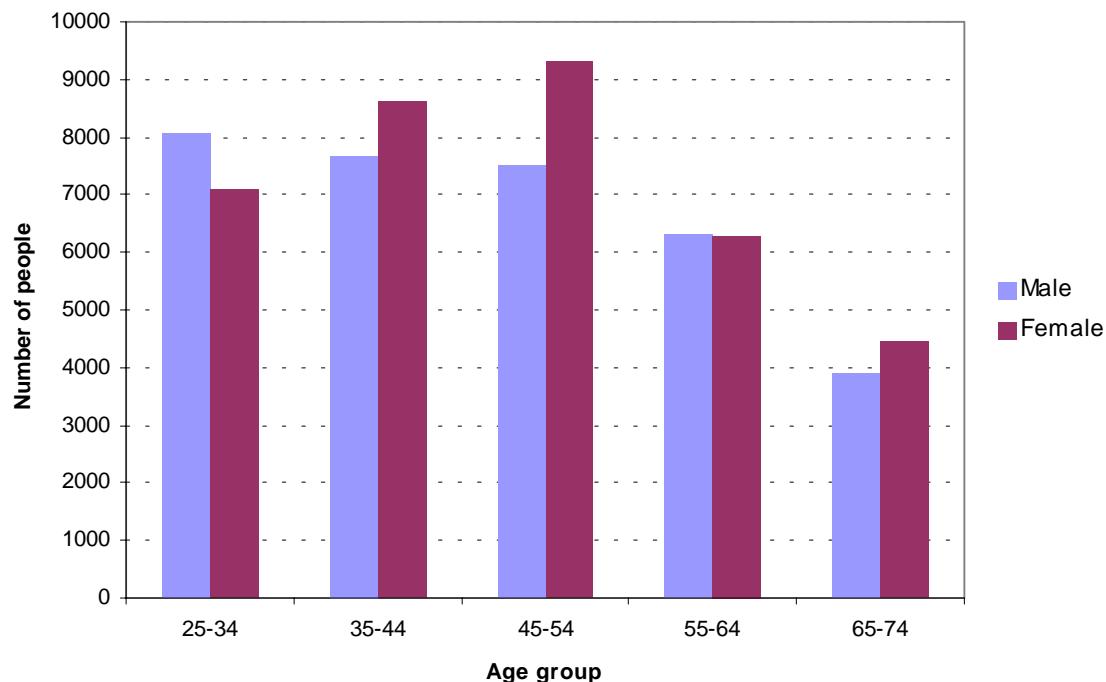
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Figure 6: Estimated prevalence of overweight and obese people by age and sex



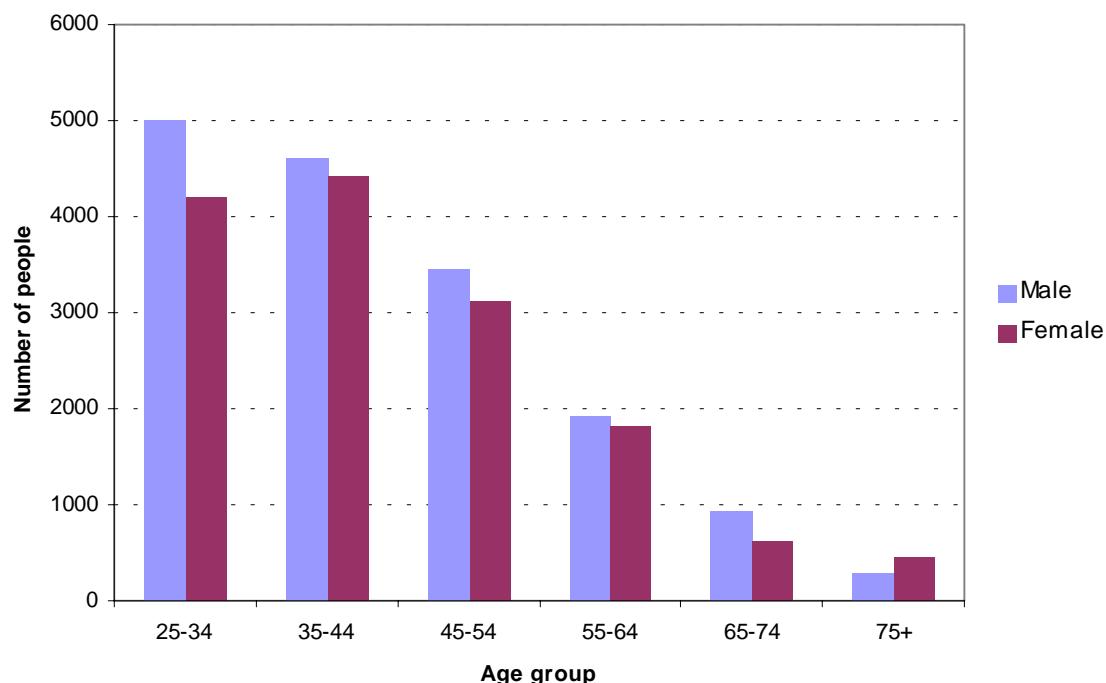
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 399 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - At the Division there is a part time diabetes educator facilitating:
 - Regular group education programs,
 - Limited individual appointments by Division GP referral only,
 - Three community health services offer generalist dietetic and podiatric services. Only one employs a diabetes educator, part time,
 - Two large public hospitals have Diabetes Centres. Both offer inpatient and outpatient services. One has a National Diabetes Supply Scheme (NDSS) outlet,
 - There are four private diabetes educators offering limited services,
 - There are at least six diabetes endocrinologists attached to local hospitals and in private practice.
 -
- What services are needed but are not available in your Division area?
 - More publicly funded diabetes educators, podiatrists and dietitians.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992 1993 1994 1995
 - 1996 1997 1998 1999
 - 2000 2001 2002
- Please describe your diabetes program including any changes that occurred over time?
 - Diabetes program 1995 to 1997
 - Full-time diabetes educator,
 - Individual patient education and management,
 - Regular miniclinic style appointments in GP practices.
 - Diabetes program 1998 to 2002, ongoing
 - Part-time diabetes educator,
 - Continuing Professional Development (CPD) for GPs,
 - Practice nurse diabetes update program and support,
 - Diabetes register and recall program – CARDIAB,

- Group education programs. Twenty-four per year plus 2 – 3 Chinese speaking programs,
- Health promotion in conjunction with other local diabetes services,
- Diabetes resource service,
- Planning pilot for fee for service diabetes educator in general practice program.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Overall improvement in HbA1c of patients registered on CARDIAB,
 - One thousand five hundred people with diabetes and their families have completed the nine-hour group education program,
 - The establishment of a culturally appropriate Chinese group diabetes education program,
 - The piloting of a fee-for-service diabetes educator in general practice program,
 - Commonwealth demonstration project “Good Life Club” to assist people with diabetes to improve their self-management skills.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - The paperwork associated with CARDIAB has proved the major barrier for GPs particularly as more practices became semi or totally paperless,
 - With the introduction of the Service Incentive Payment (SIP) diabetes item and Medical Director’s ability to track its various elements many practices chose to manage their diabetes data in house,
 - The issue of patient consent and confidentiality was time consuming for GPs to explain and record.
- What future plans do you have for diabetes management in your Division?
 - To support general practices in establishing an active diabetes register and recall system,
 - To continue to promote the diabetes clinical management guidelines,
 - To help GPs meet all the requirements of the SIP-diabetes item,
 - To establish the fee for service diabetes educator in general practice program,
 - To improve and enhance the Chinese group diabetes education program.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Commitment of the Division to the initiatives at all levels,
 - Allocation of personnel, time and financial resources for the initiatives,
 - The ability to adapt practice systems to incorporate the initiatives.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Involvement with the Central East and Outer East Primary Care Partnerships for lobbying at local, state and federal levels,
 - Strong links and support of the local community health services,
 - Regular contact with the local hospitals at an executive and service level,
 - Regular meetings with local diabetes educators for networking, information and problem solving,
 - Regular attendance at endocrine meetings.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP clinical management guidelines and SIP requirements form the basis of the diabetes program. Resources developed around these are used, eg diabetes key points summary and the “SIP strip” (a small sticker summarising the SIP requirements),
 - Local endocrinologists and specialists are used for continuing professional development.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes care plan examples,
 - SIP strip (a small sticker summarising the SIP requirements),
 - Paper based SIP-diabetes tracking form.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - We need access to more public funded diabetes educators, podiatrists, and dietitians.

- What resource materials do you provide to practices?
 - Diabetes care plan examples,
 - SIP strip (a small sticker summarising the SIP requirements),
 - Paper based SIP-Diabetes tracking form,
 - Patient education resources or access details,
 - RACGP diabetes clinical management guidelines.

Division Contact Person/
Program Co-ordinator

Name: Leigh Barnetby
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Email: lbarnetby@wdgp.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Two public and two private hospitals with Coronary Care Units,
 - Two cardiac rehabilitation programs,
 - Heart failure case management program through public hospitals,
 - Cardiologists.

- What services are needed but are not available in your Division area?
N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - 1999 CVD program worker appointed to develop program using CARDIAB,
 - 2000 CVD program incorporated into the chronic disease program along with diabetes and asthma. The main activities are CARDIAB and Continuing Professional Development (CPD),
 - Linkages to local CVD services, eg. hospitals,
 - Health promotion activities in general practices.

Division Perspective

- What have been the major achievements or highlights of your program so far?
N/A.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
The CVD component of CARDIAB has not received the same support as the diabetes program amongst GPs.

- What future plans do you have for CVD management in your Division?
To promote the CVD management guidelines through GP continuing professional development program.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

A strong working party of GPs to support and promote the CVD program.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Participation on hospital steering committee for heart failure,
 - Participation on hospital, community health services and primary care partnership committees for health promotion.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

National Heart Foundation guidelines.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

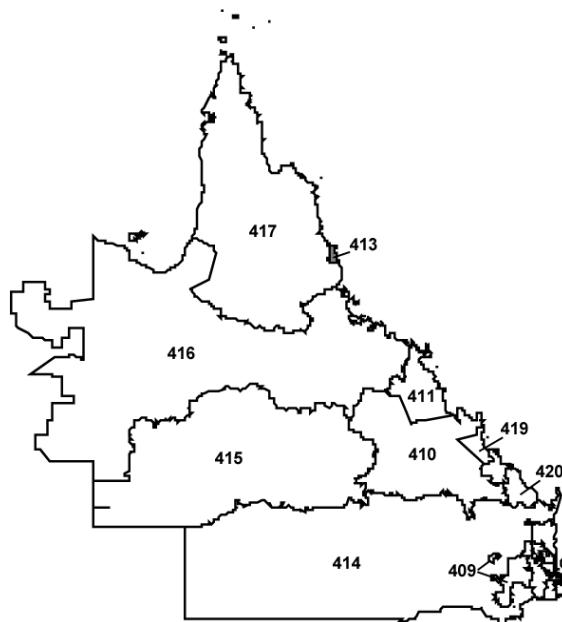
N/A.
- What resource materials do you provide to practices?

N/A.

Division Contact Person/
Program Co-ordinator

Name: Leigh Barnetby
Phone: 03 9894 3755
Fax: 03 9894 3119
Email: lbarnetby@wdgp.com.au

Cairns DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	122,076	
■ Aboriginal or Torres Strait Islander	10,306	8.4%
■ Speaks language other than English at home	10,839	8.9%
■ RRMA classification ¹		
3: Large rural	114,508	93.8%
5: Other rural	7569	6.2%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5528	6.9%
■ High blood pressure ⁴	21,584	27.0%
■ High blood cholesterol ⁵	39,979	50.1%
■ Obese or overweight ⁶	47,499	59.5%
■ Physical inactivity ⁷	34,733	43.5%
■ Smoking ⁸	16,078	20.1%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

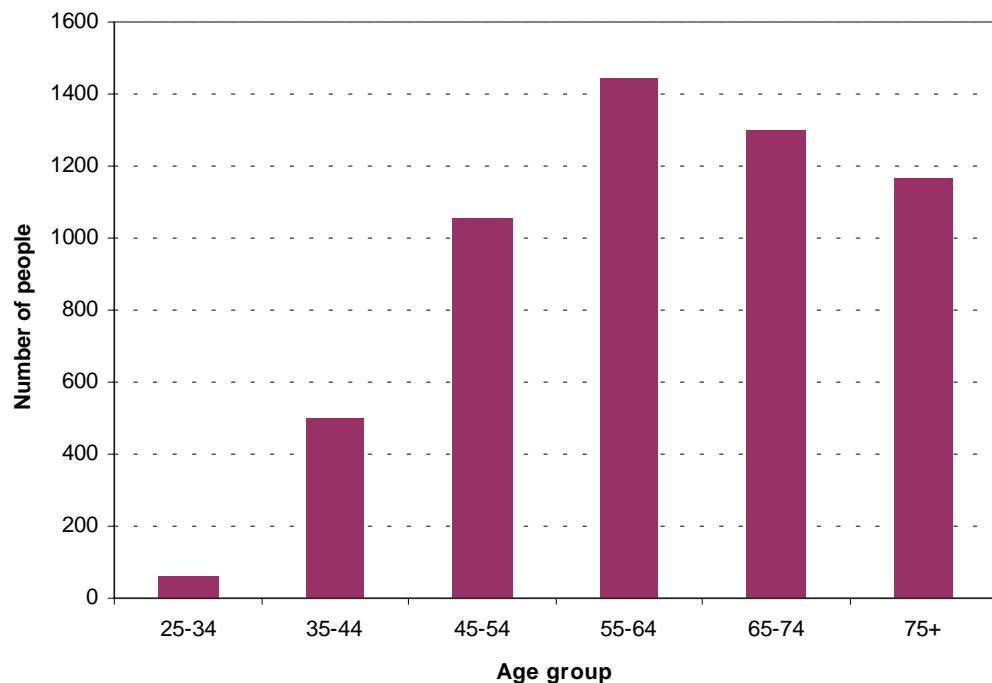
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

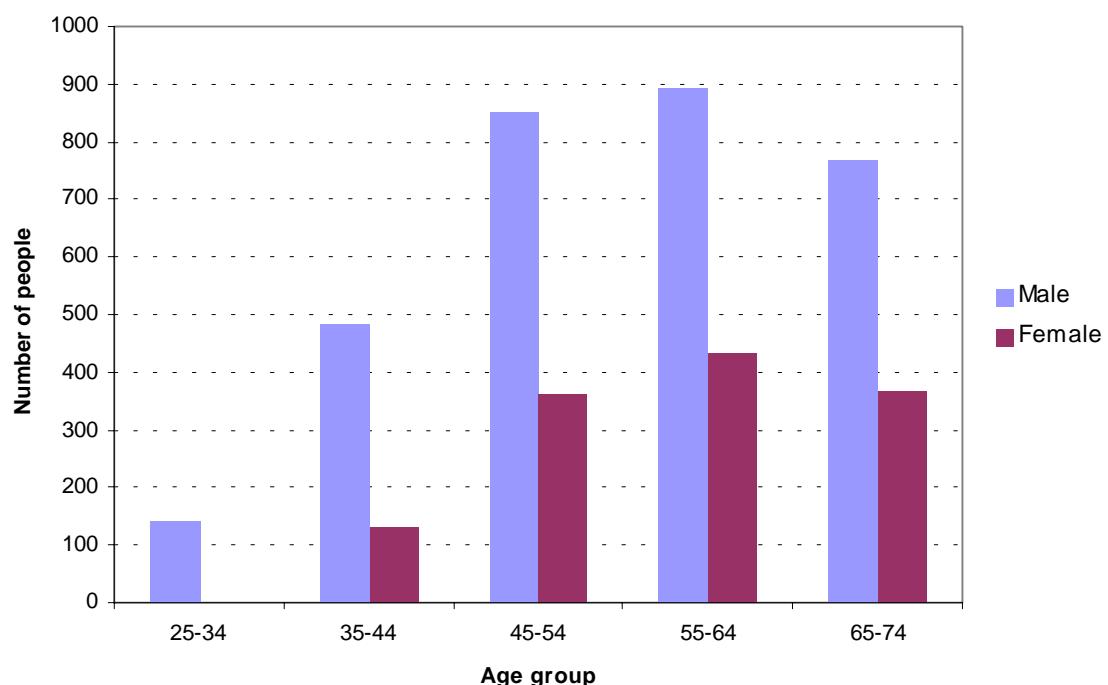
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



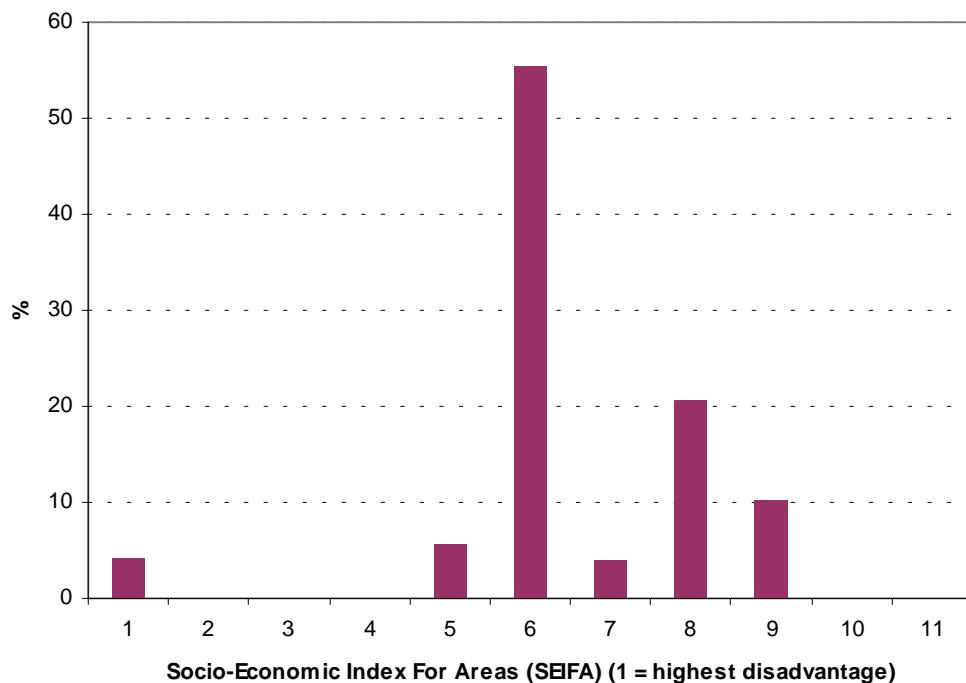
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

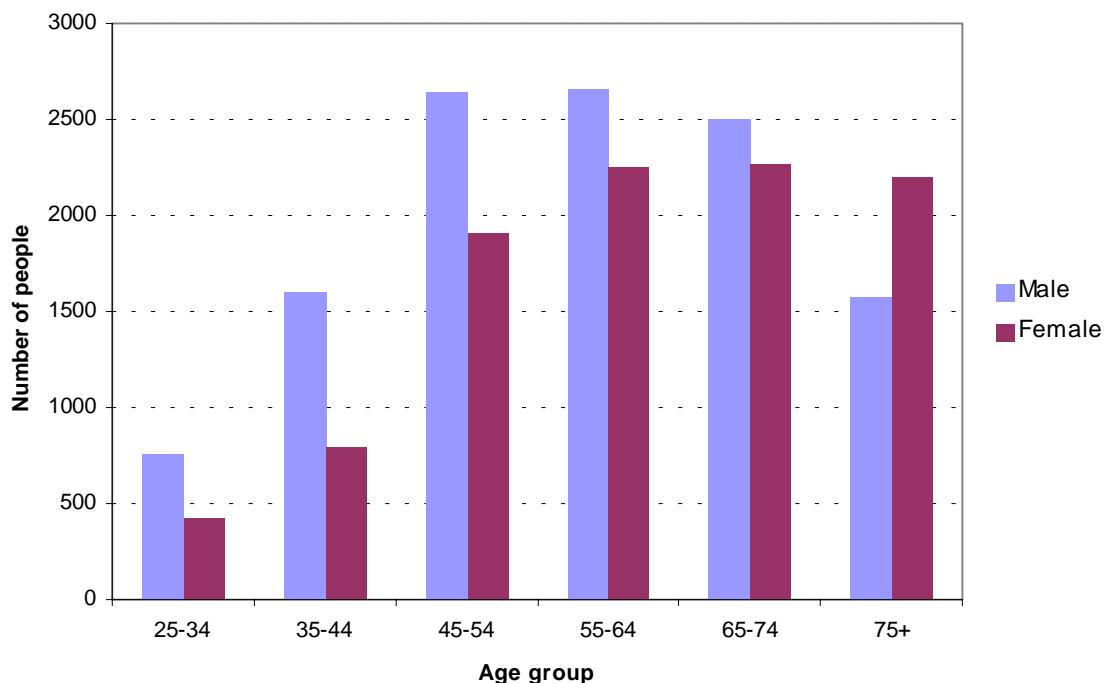
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

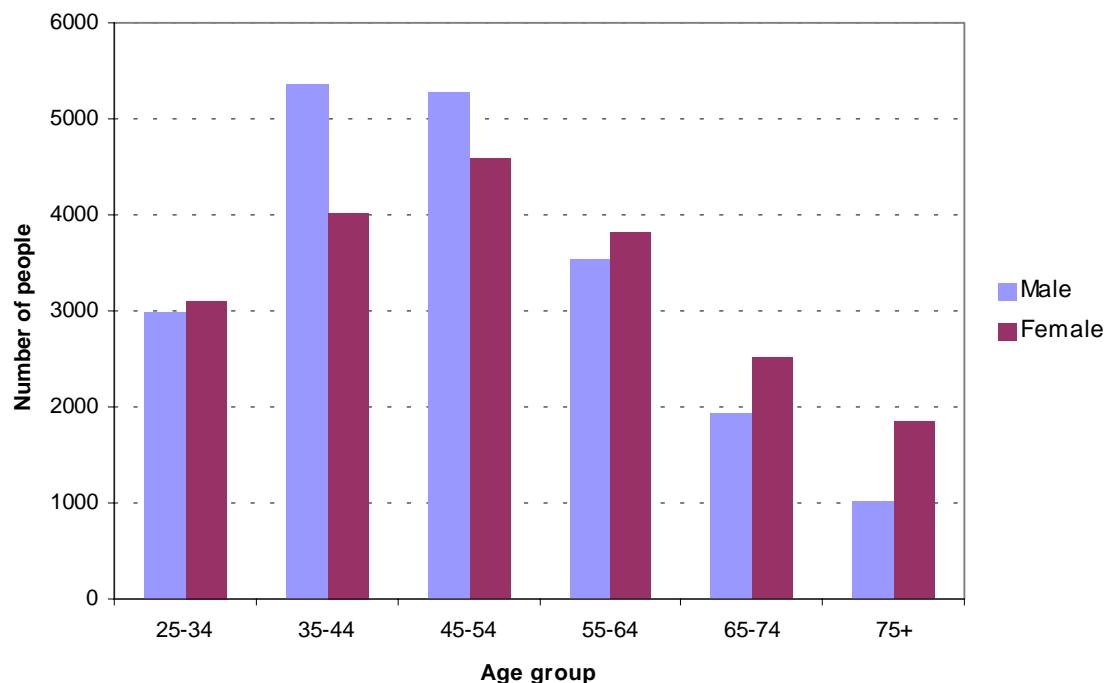
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



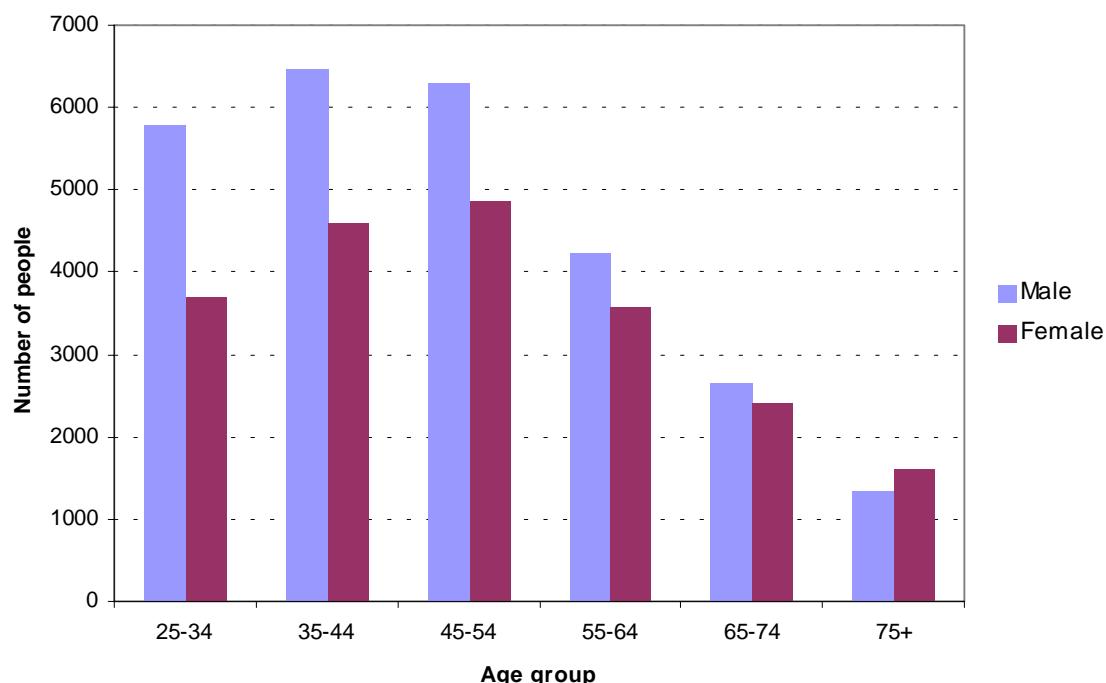
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



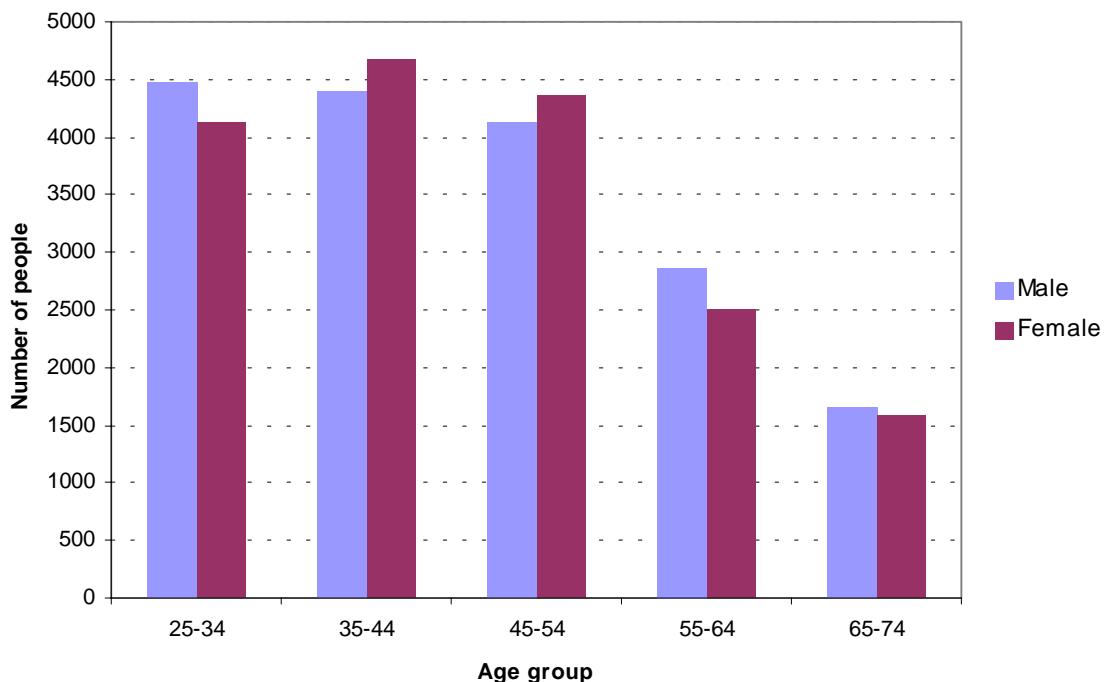
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



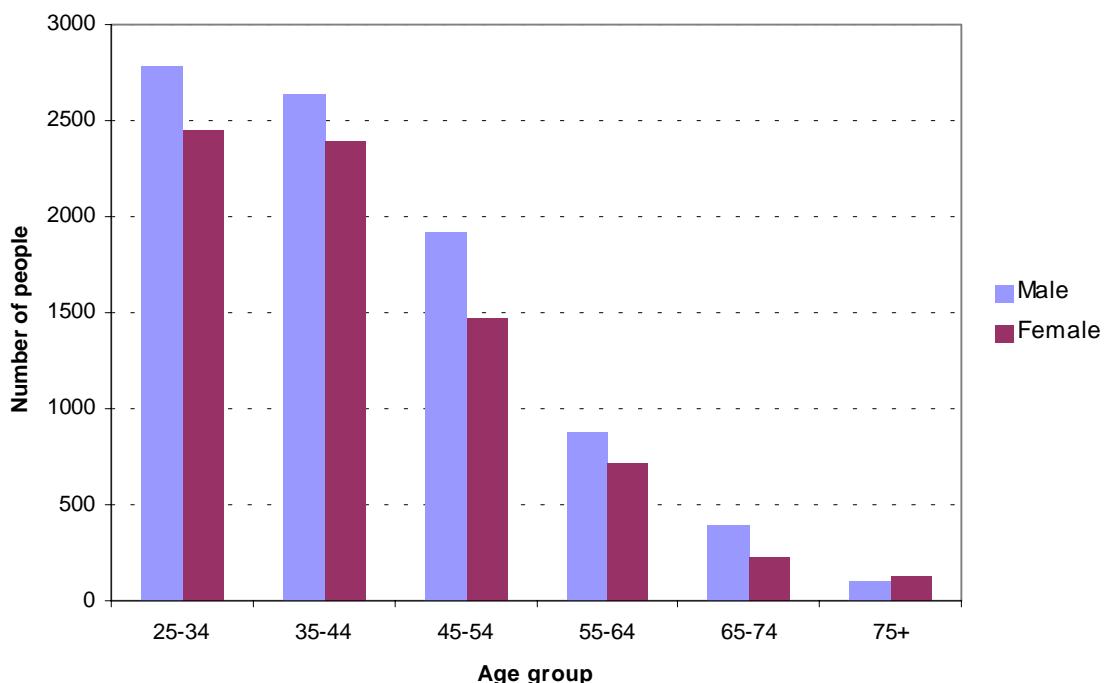
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 102 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Cairns Diabetes Centre provides a range of individual services, such as

- Foot clinic and group sessions,
- Diabetes education services with professionals, including:
 - Diabetes educators,
 - Dietitians,
 - Podiatrists,
 - Private paediatricians,
 - Visiting paediatric endocrinologist,
 - Endocrinologists,
 - Indigenous diabetes educator, and
 - Cairns Base Hospital Dialysis Unit.

- What services are needed but are not available in your Division area?
 - Accredited training program for indigenous health workers in diabetes management and education,
 - Indigenous nutritionist,
 - Diabetes psychologist, and
 - IT support at Diabetes Centre also needed.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Previously conducted two rounds of a GP diabetes management incentive program (using available CARDIAB data). Currently focusing on practice nurse education, ie basic upskilling followed by NADC Diabetes Resource Nurse Course.

Division Perspective

- What have been the major achievements or highlights of your program so far?

The incentive program allowed highlighting of the Queensland Standard Care Pathway and contribution to a National Health Department Fund (NHDF) funded pilot of care plan facilitation in three local practices. Also, commitment by practice nurses to increased role in diabetes management.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

CARDIAB version one's functionality limitations and staff turnover delayed the second round of the incentive program.
- What future plans do you have for diabetes management in your Division?

Continuing focus on practice nurse education facilitation, promote GP diabetes clinics and assess potential Division role in facilitating chronic disease self-management.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

• Public health support for general practice,
• Effective practice management, including medical software usage,
• Practice nurse capacity and upskilling,
• GP attitudes to chronic disease and team approaches.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Primarily aligned with Cairns Diabetes Centre and this relationship has developed through personal contacts, mutual recognition, and support.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

Previously used a range of Queensland and NSW developed resources with Royal Australian College of General Practice (RACGP) and Diabetes Australia documents. Currently relying on course materials and presenters supplied by Cairns Diabetes Centre.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

No resources specifically developed.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Currently investigating web site based means of providing local services information to GPs and improved referral/care plan input processes.

- What resource materials do you provide to practices?

Previously provided

- Queensland Standard Care Pathway posters,
- Medical Director recall and reminder establishment steps,
- Diabetes management incentive summary, and
- Complications screening duplicate hard copy record forms.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Investigational – echo, stress holter, thallium, coronary angiography (public and private),
 - Coronary Care Units (public and private),
 - Cardiac rehabilitation – Phase 1, 2 and 3 (public),
 - Cardiologists (public and private).

- What services are needed but are not available in your Division area?

Interventional – Percutaneous Transluminal Coronary Angioplasty (PTCA) and Coronary Artery Bypass Grafting (CABG).

CVD Program Description

- In which years did you have a CVD project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?
 - 1996 – Initiated phase 2 in collaboration with hospitals:
 - Six-week multidisciplinary education, exercise, and counselling.
 - 1997 – Initiated phase 3 in collaboration with community health ongoing education and exercise programs:
 - Yoga, stretch, aqua aerobics, gentle gym walking program at various venues and fitness centres.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Formation of CVD Strategic Planning Committee,
 - Patient retention in ongoing program – 80 people,
 - Quality award – Cairns Base Hospital,
 - Community service club support – equipment donations,
 - Continuous quality improvement,
 - Sustainability,
 - Community collaboration,
 - Patient education video produced,
 - Reduced risk factor profiles of participants.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Minimal budget – need to have guest speakers who are happy to work unpaid,
 - Skeletal infrastructure,
 - Printing,
 - Advertising,
 - Patient transport.
- What future plans do you have for CVD management in your Division?
 - Continue to improve services and community health,
 - Facility collaboration/partnerships,
 - Ongoing process and outcome evaluation,
 - More frequent strategic planning meetings (currently over 1 year between meetings),
 - Assistance to Aboriginal Medical Services to establish culturally appropriate cardiac rehab programs,
 - Establish stronger link with Diabetes Centre.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Foster partnerships with health facilities first,
 - Establish strategic planning committee first (key stakeholders),
 - Include evaluation strategies and minimal data sets from beginning.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - National Heart Foundation,
 - Queensland Cardiac Rehab Association,
 - Australian Cardiac Rehab Association (conferences, teleconferences, memberships),
 - Hospitals and cardiology services – meetings, educational events.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation (NHF),
 - Merck Sharp and Dohme,
 - Fitness Centres,
 - Queensland Health multidisciplinary personnel.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

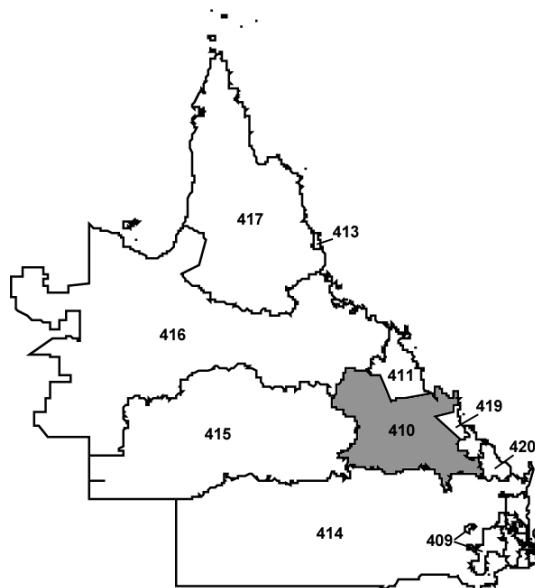
Whatever we can – video (patient education – cardiac rehabilitation).

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? Guidelines when accessed/updated.

Division Contact Person/
Program Co-ordinator

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Central Queensland Rural DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	68,696	
■ Aboriginal or Torres Strait Islander	2787	4.1%
■ Speaks language other than English at home	1139	1.7%
■ RRMA classification ¹		
5: Other rural	37,439	54.5%
6: Remote centre	23,563	34.3%
7: Other remote	7694	11.2%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2972	6.8%
■ High blood pressure ⁴	11,742	27.0%
■ High blood cholesterol ⁵	21,973	50.5%
■ Obese or overweight ⁶	26,261	60.4%
■ Physical inactivity ⁷	19,212	44.2%
■ Smoking ⁸	8852	20.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

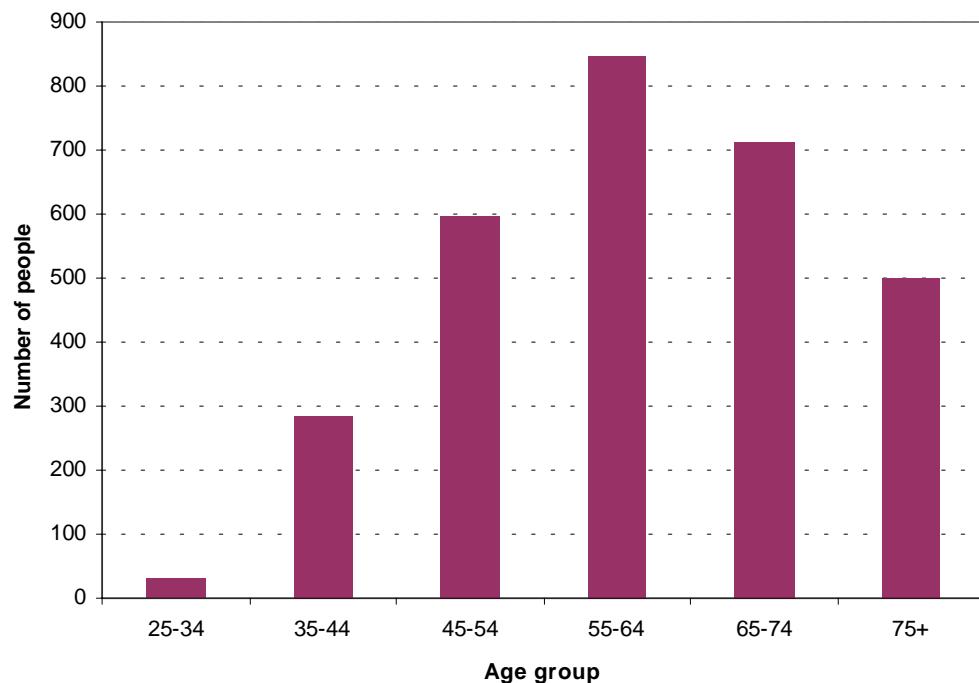
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

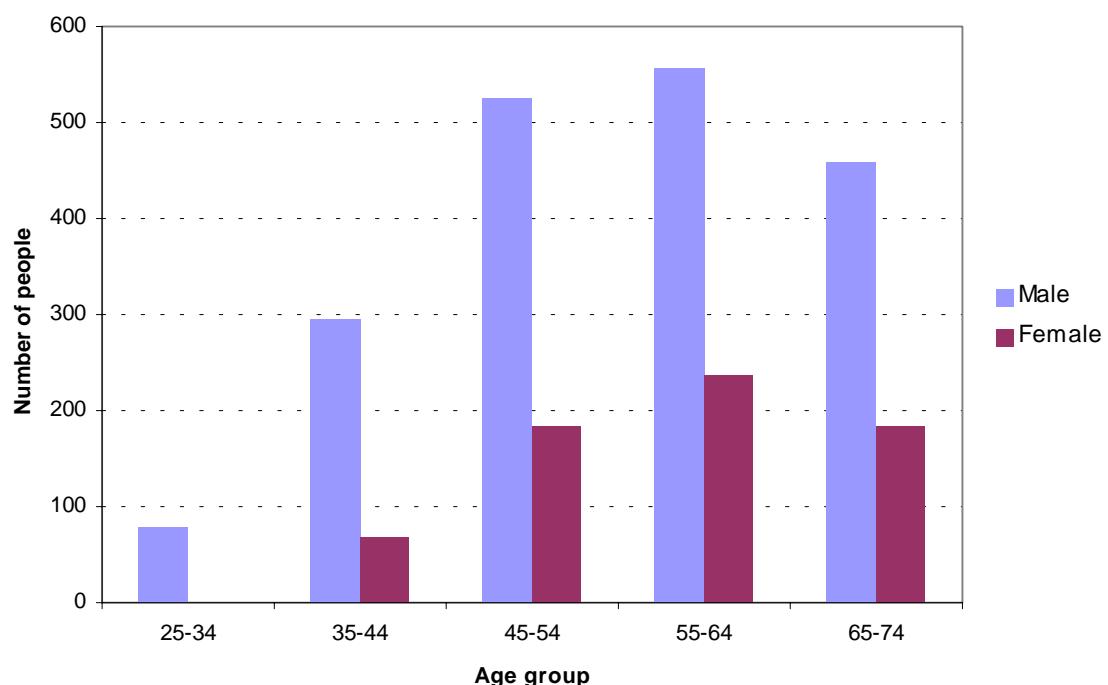
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



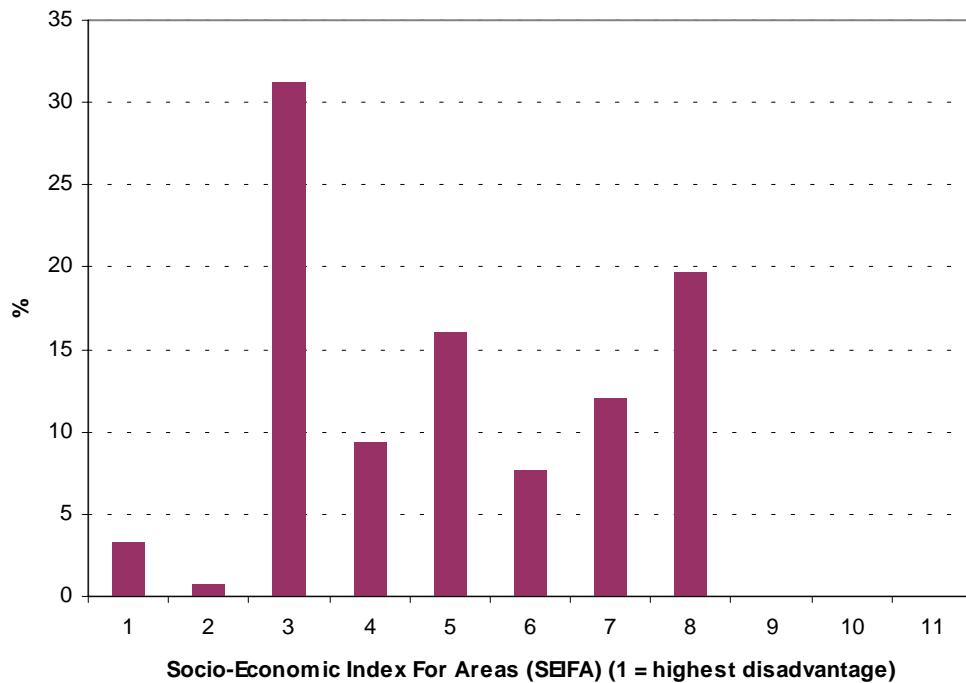
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

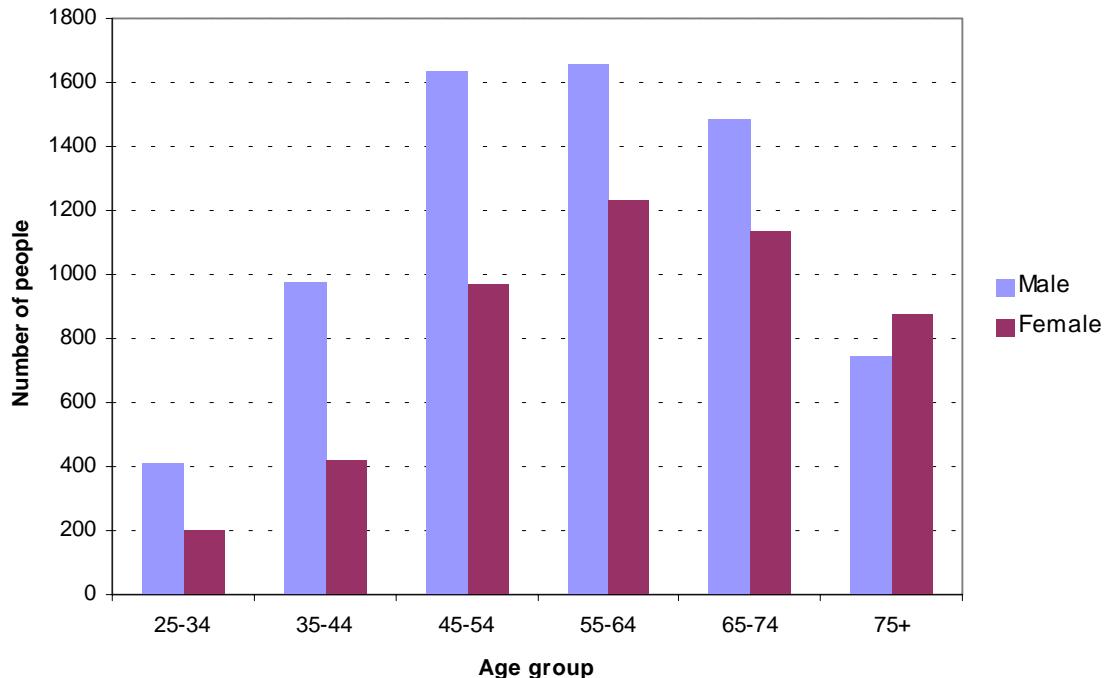
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

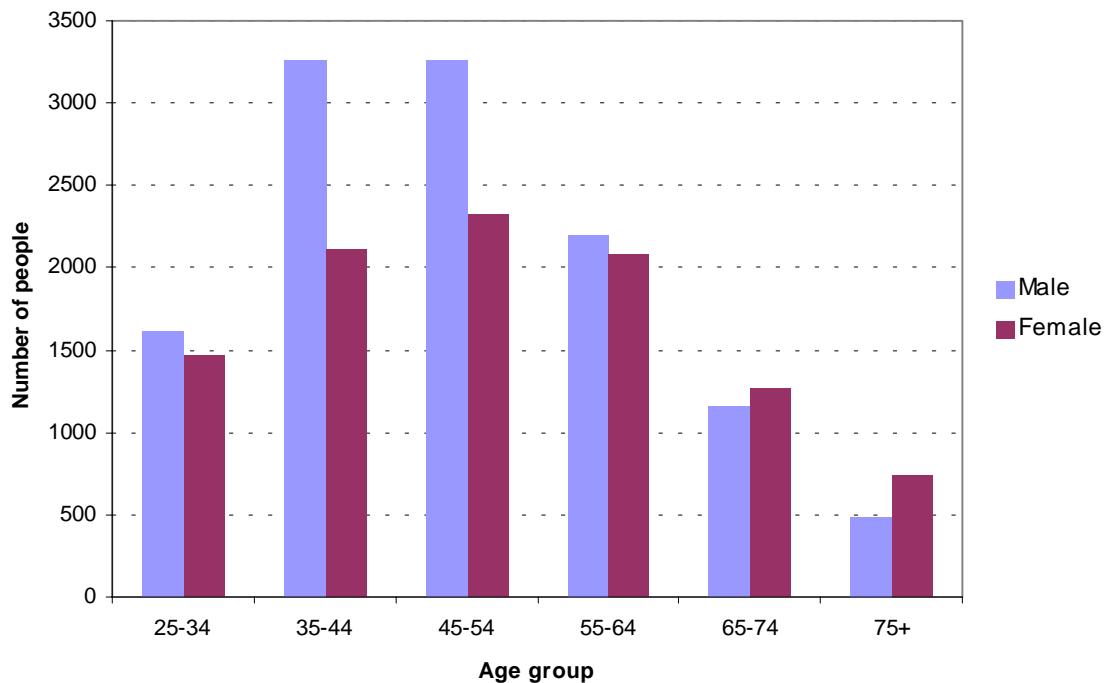
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



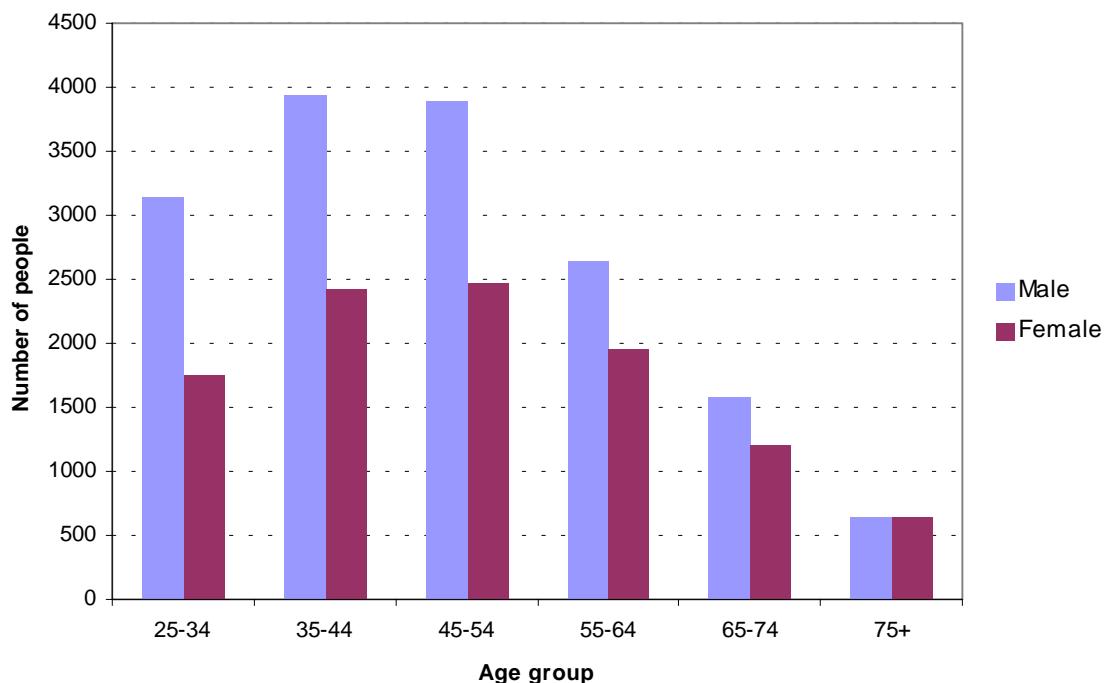
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



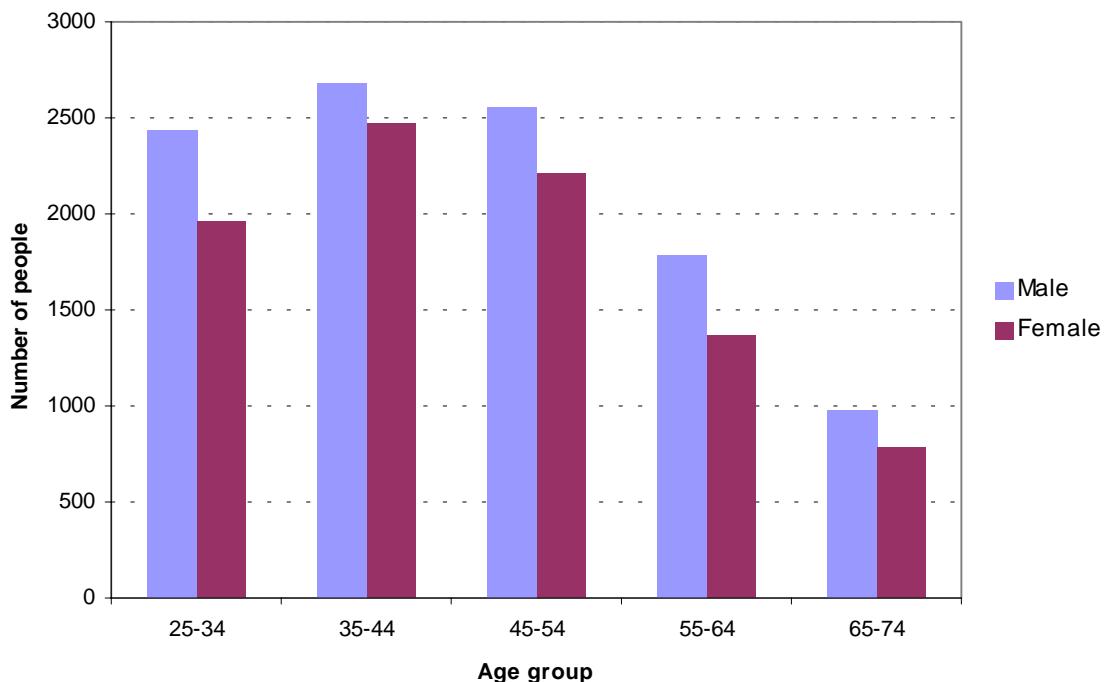
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



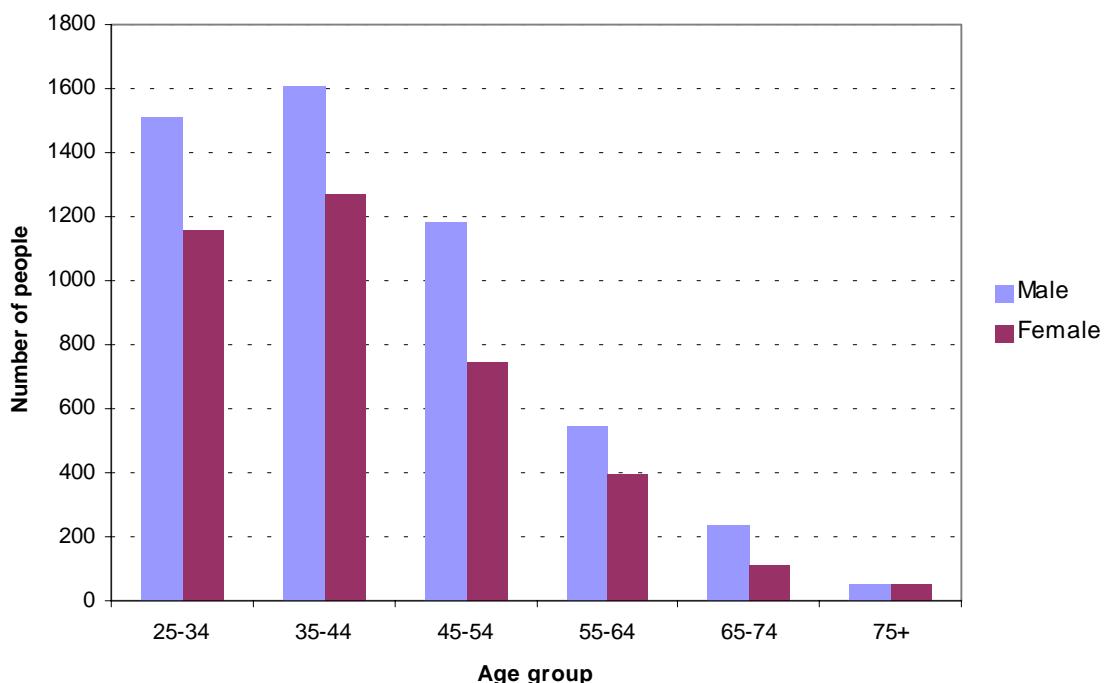
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 41 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - No endocrinology services,
 - GP consulting,
 - Diabetes education nurses (not accredited),
 - Limited access to podiatry services,
 - Ophthalmology is limited (six days per year),
 - Limited access to dietitian services.

- What services are needed but are not available in your Division area?
 - Endocrinology,
 - Ophthalmology,
 - Podiatry,
 - Accredited diabetes education,
 - Increases in podiatry and dietetics.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input checked="" type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?
 - GP upskilling in diabetes management,
 - Diabetes education for practice nurses,
 - Patient resources relevant to Division,
 - Provision of dietetic, podiatry and diabetes education through More Allied Health Services (MAHS).

Division Perspective

- What have been the major achievements or highlights of your program so far?

Regular incorporation of diabetes management plans in general practice.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Limited GP time,
 - Distance.

- What future plans do you have for diabetes management in your Division?
 - Continue to build on current activity,
 - Use Medical Specialist Outreach Access Program (MSOAP) to develop ophthalmology and endocrinology services.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Lack of time,
 - Lack of resources,
 - Lack of skills.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Diabetes Australia,
 - Australian Diabetes Educators Associations (ADEA),
 - General health.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

RACGP Best Practice Guidelines.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Diabetes Patient Handbook.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Guidelines (other versions) – preferably one that is useable in a rural setting.

- What resource materials do you provide to practices?
 - GP upskilling,
 - Practice staff upskilling,
 - Patient resources,
 - Allied Health Services through MAHS.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - No cardiologist,
 - No secondary or tertiary hospitals,
 - GP consultations,
 - A variety of staff trained in Phase II rehabilitation,
 - Limited dietetics services.

- What services are needed but are not available in your Division area?

Cardiology – one hospital able to take referrals, one in dietetic services.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Training for GPs in cardiac management intervention and prevention,
 - Training for practice staff and other allied health professionals in Phase II rehabilitation.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Limited use of Phase II rehabilitation,
 - GPs increasing use of short intervention as prevention for cardiac disease.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of GP time,
 - Lack of resources.

- What future plans do you have for CVD management in your Division?
 - Continue GP upskilling,
 - Increase use of rehab program,
 - Access cardiologist via Medical Specialist Outreach Access Program (MSQAP),
 - Increase dietetics via More Allied Health Services (MAHS) program.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Queensland Health,
• Heart Foundation.

Division Resources

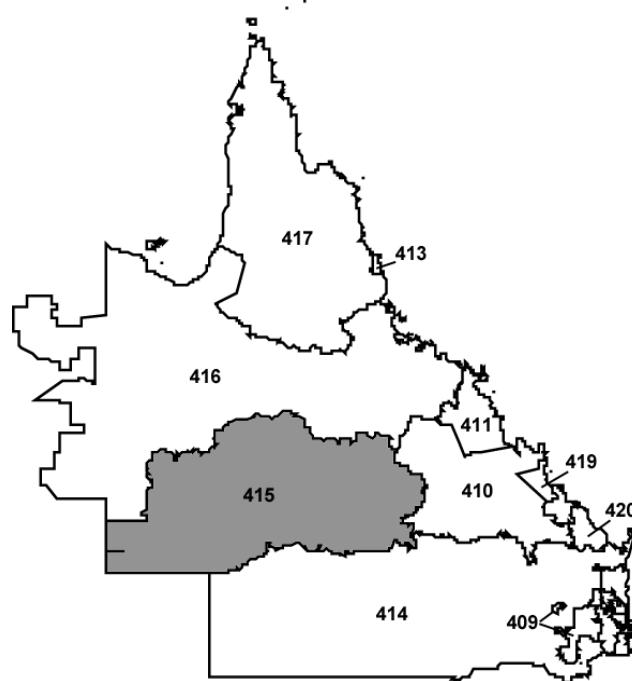
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- What resource materials do you provide to practices?

 - GP upskilling,
 - Practice staff upskilling,
 - Increase access to allied health professionals (MAHS).

Division Contact Person/
Program Co-ordinator

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Central West Queensland Rural DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	19,071	
■ Aboriginal or Torres Strait Islander	1109	5.8%
■ Speaks language other than English at home	299	1.6%
■ RRMA classification ¹		
5: Other rural	4844	25.4%
6: Remote centre	1163	6.1%
7: Other remote	13,064	68.5%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1000	8.0%
■ High blood pressure ⁴	3834	30.5%
■ High blood cholesterol ⁵	6512	51.8%
■ Obese or overweight ⁶	7688	61.2%
■ Physical inactivity ⁷	5475	43.6%
■ Smoking ⁸	2416	19.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

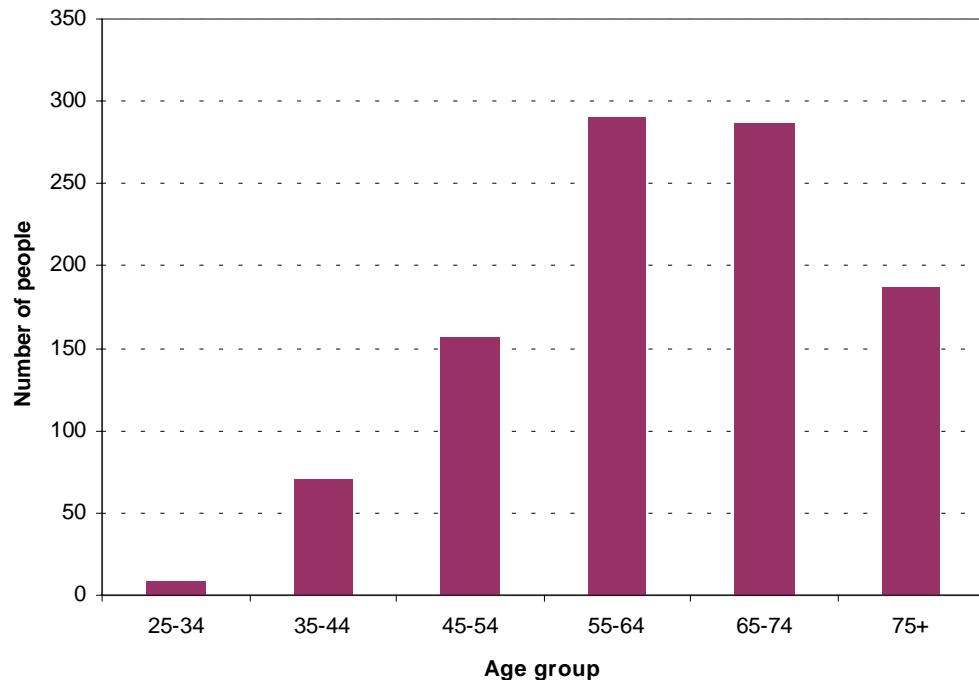
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

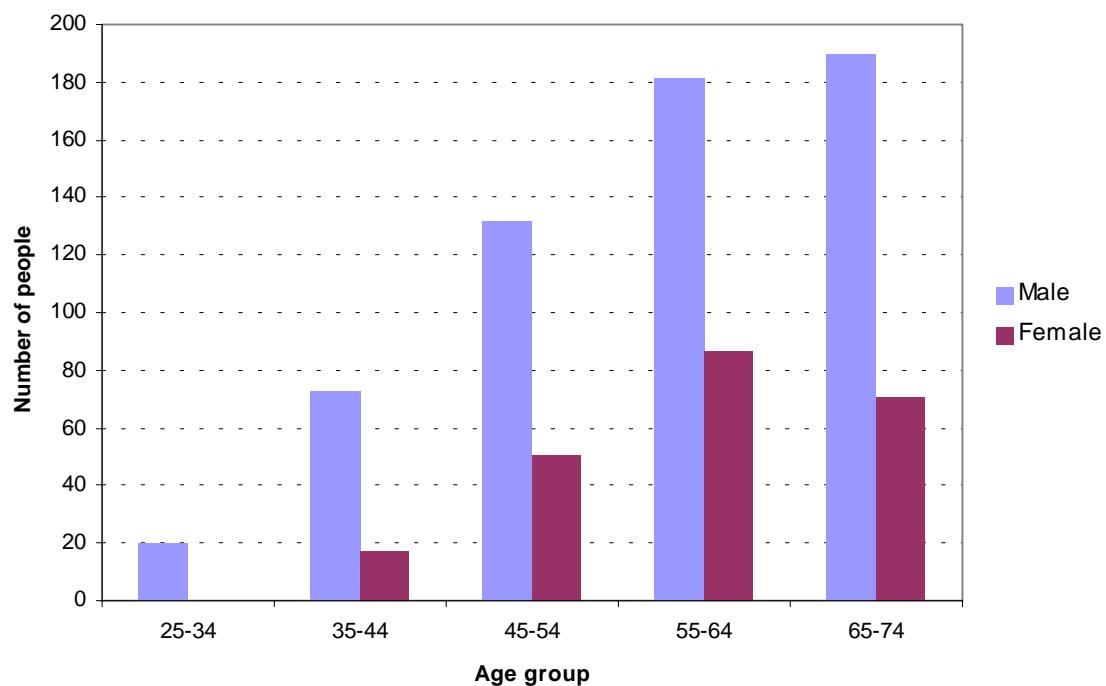
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



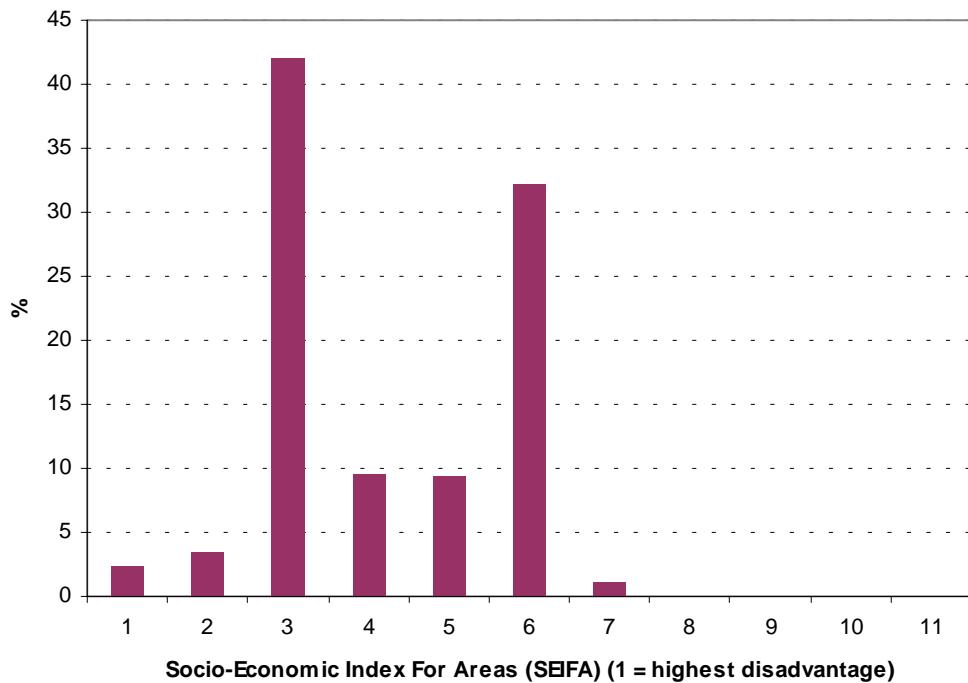
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

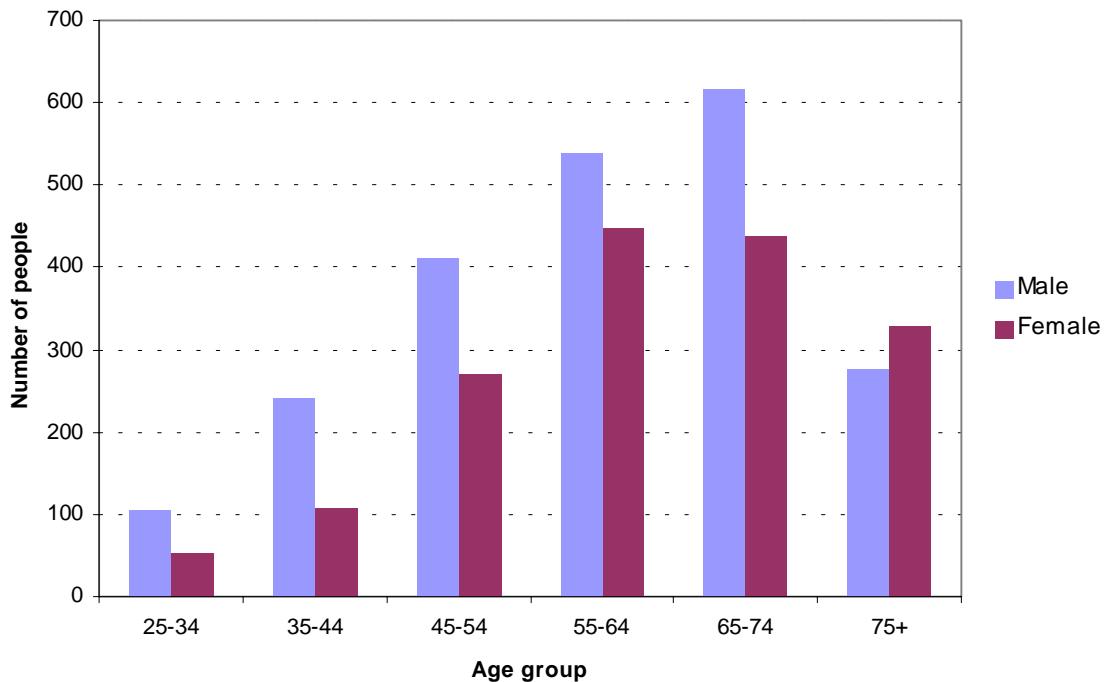
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

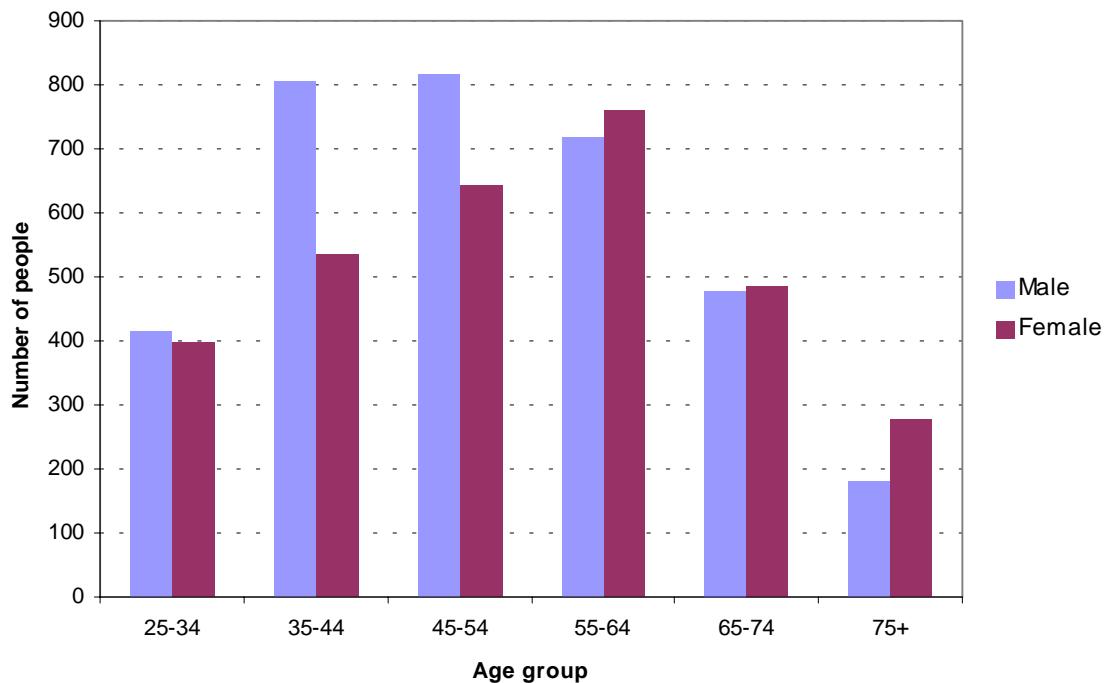
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



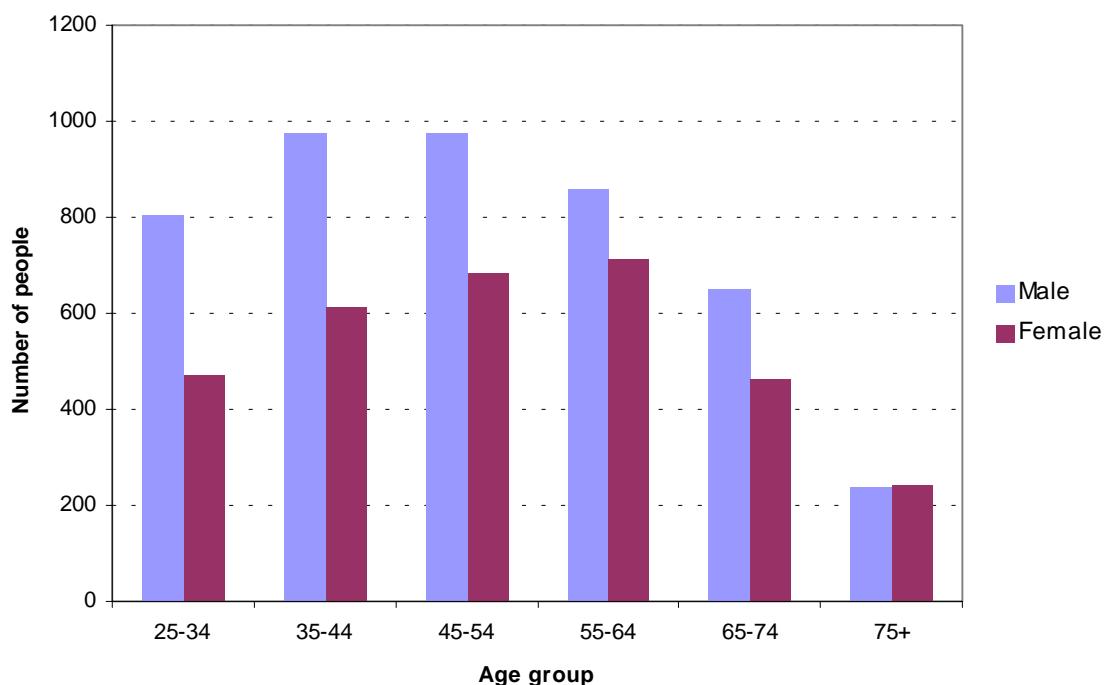
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



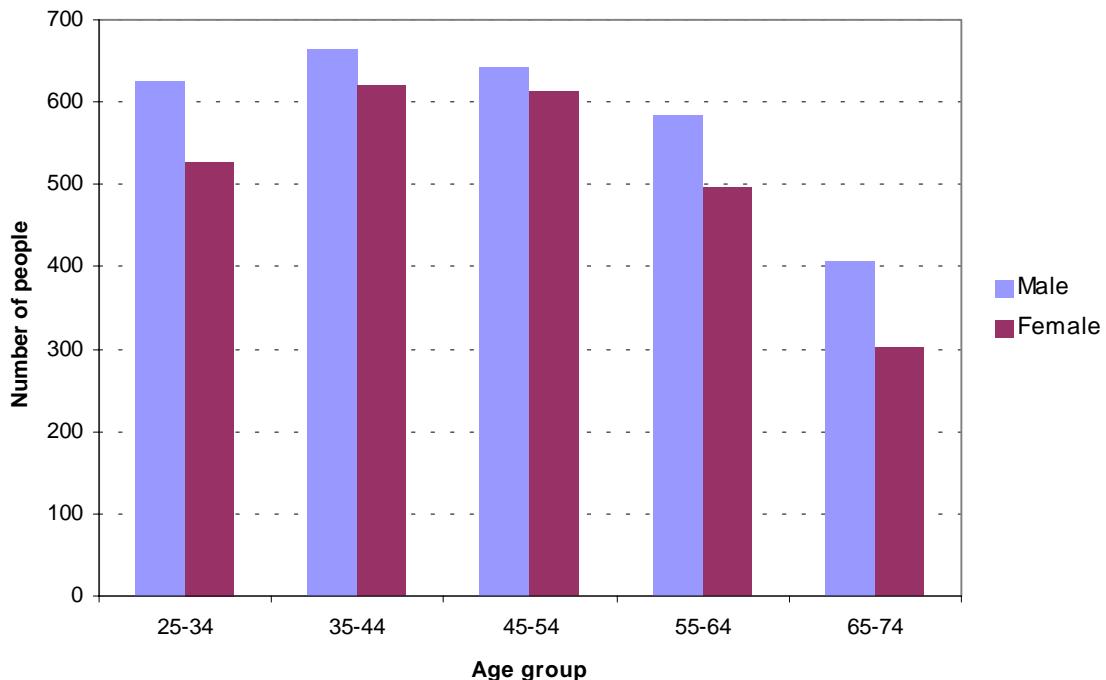
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



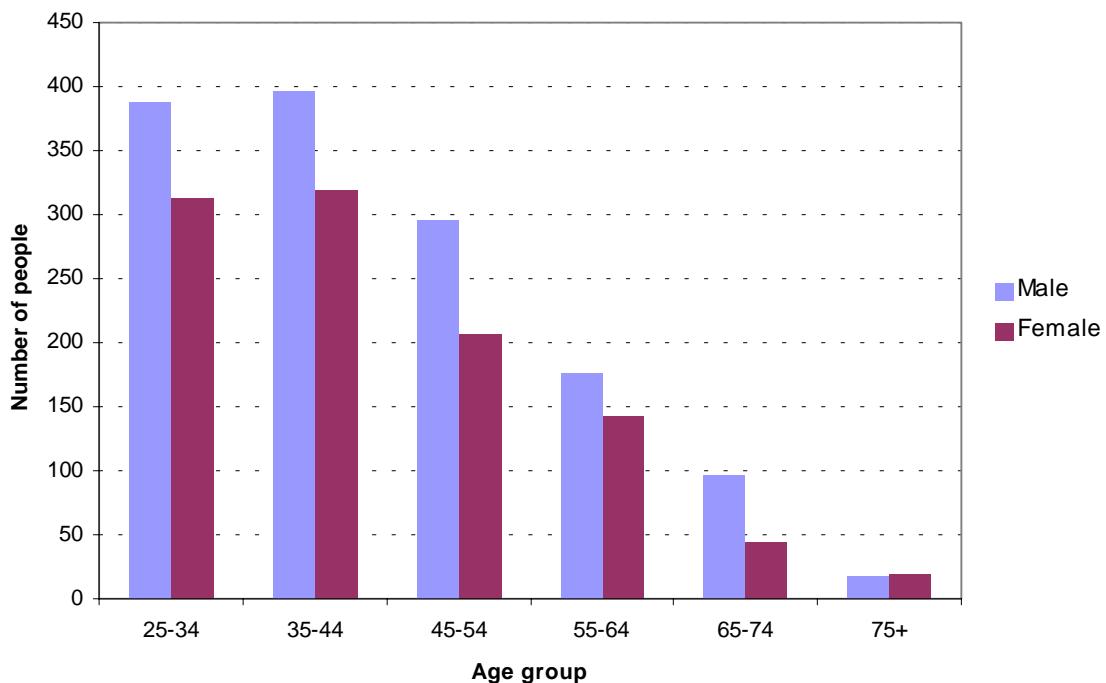
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 12 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Visiting part-time diabetes educator – 0.2,
 - Three part-time diabetes resource nurses (DRN) – 0.6,
 - Podiatrist – 1 FTE,
 - Dietitian – 1 FTE,
 - Visiting ophthalmologist.

- What services are needed but are not available in your Division area?
 - More diabetes educator time,
 - More podiatry services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1992	1993	1994	1995
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1996	1997	1998	1999
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2000	2001	2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Diabetes educator visits six times per year, provides supervision care of DRNs and training, based in Brisbane,
 - Individual patient consults plus distance management if difficult insulin regimes,
 - Ongoing support supplied by DRNs located throughout the Division.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Providing diabetes support to GPs and communities of Tambo, Blackall, Alpha, Barcaldine, Longreach and Winton. Also Birdsville and Bailia, Jindah and Windarai.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Staff recruitment.

- What future plans do you have for diabetes management in your Division?
 - Build on present services,
 - Collect data.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Advertising of the available services,
 - Communication amongst all allied health services,
 - Demand GP support.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Resource nurses and members of Australian Diabetes Educators Association (ADEA) and Diabetes Australia (Queensland) (DAQ).
 - Use of diabetes educator based in Brisbane.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Diabetes Resource Centre – Victoria,
 - Diabetes Australia – Queensland.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.

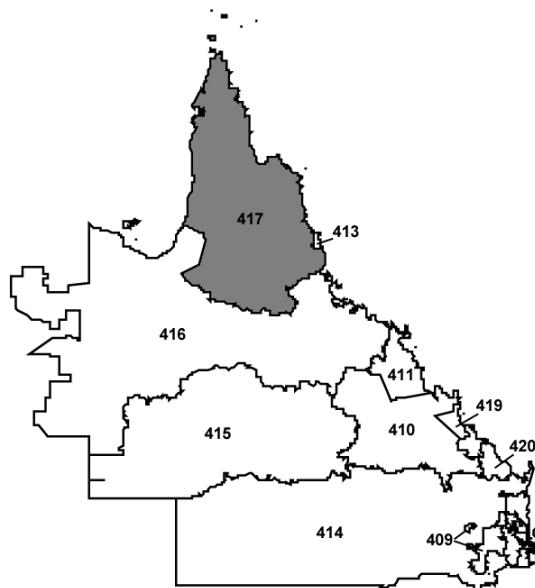
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.

- What resource materials do you provide to practices? N/A.

Division Contact Person/
Program Co-ordinator

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Far North Queensland DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	104,649	
■ Aboriginal or Torres Strait Islander	20,313	19.4%
■ Speaks language other than English at home	14,484	13.8%
■ RRMA classification ¹		
5: Other rural	69,382	66.3%
6: Remote centre	23,755	22.7%
7: Other remote	11,511	11.0%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5419	8.0%
■ High blood pressure ⁴	20,687	30.4%
■ High blood cholesterol ⁵	35,328	51.9%
■ Obese or overweight ⁶	41,456	60.9%
■ Physical inactivity ⁷	29,486	43.3%
■ Smoking ⁸	13,049	19.2%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

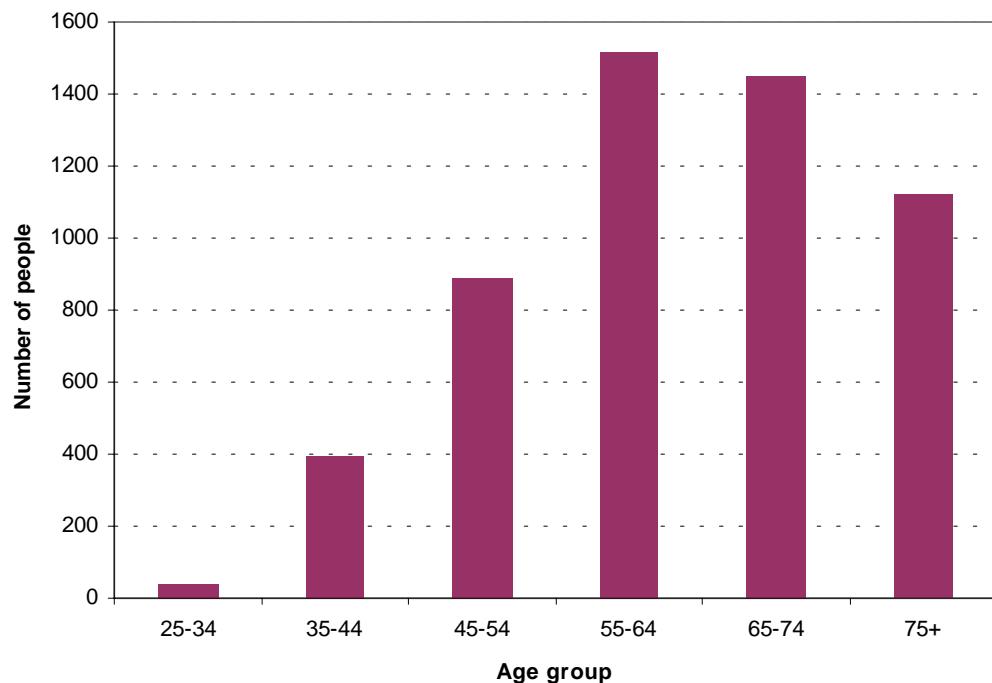
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

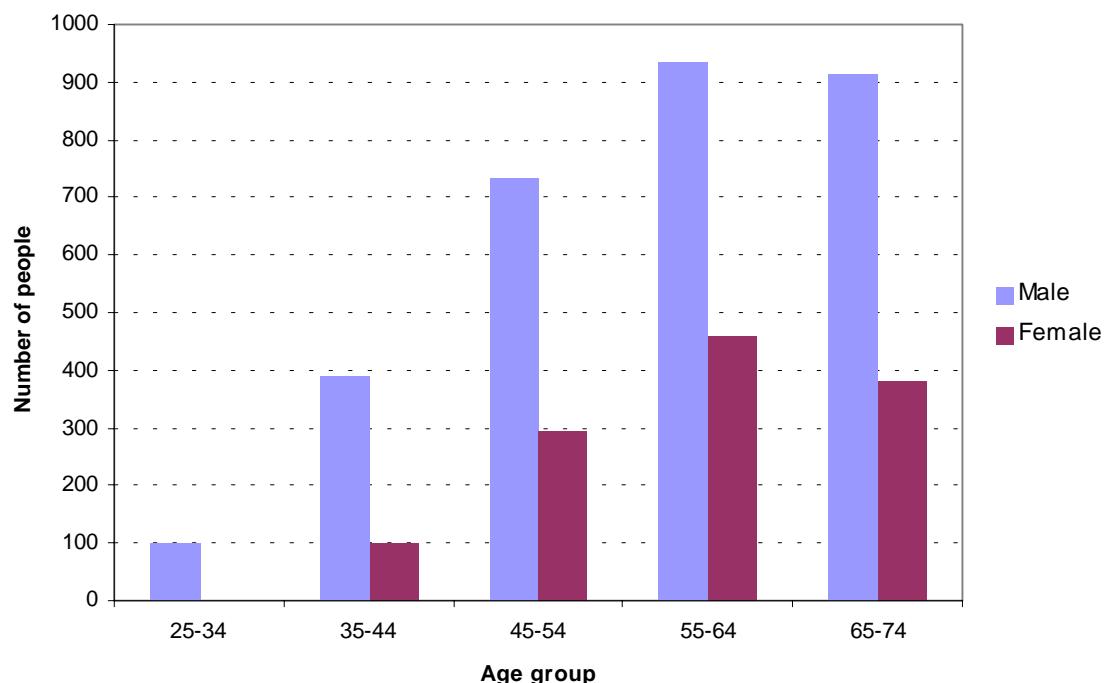
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



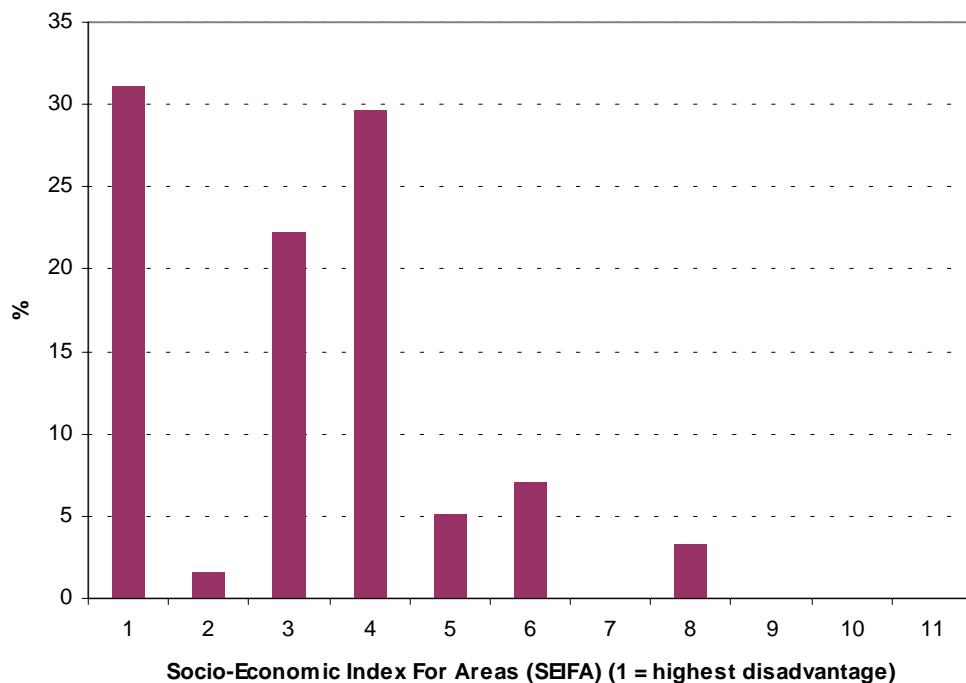
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

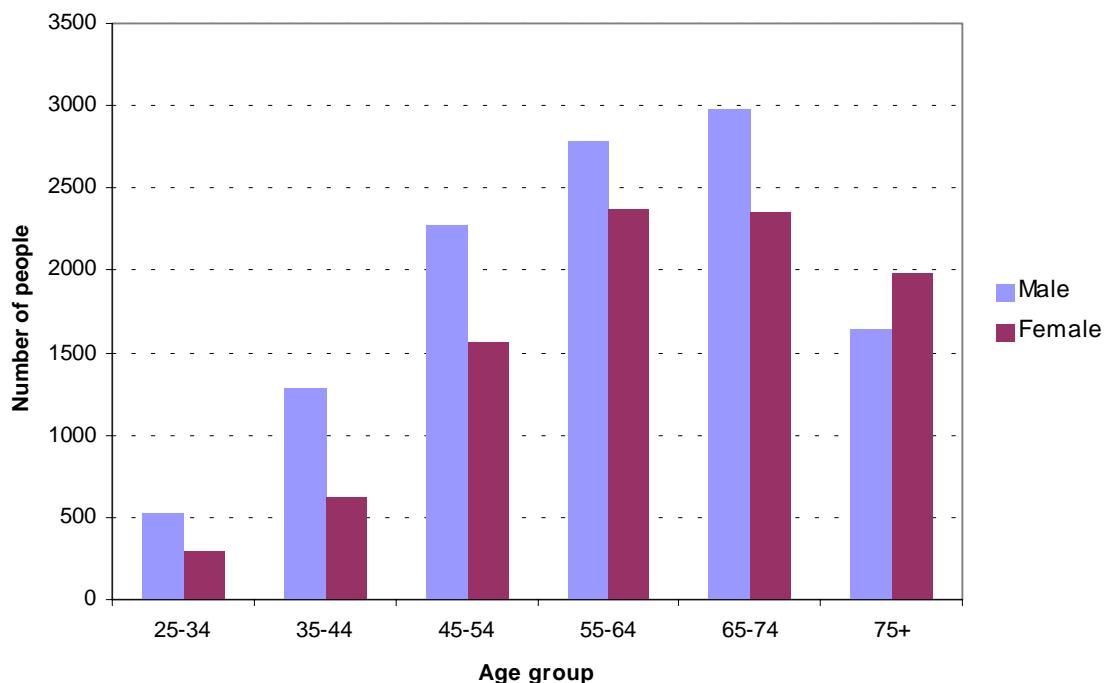
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

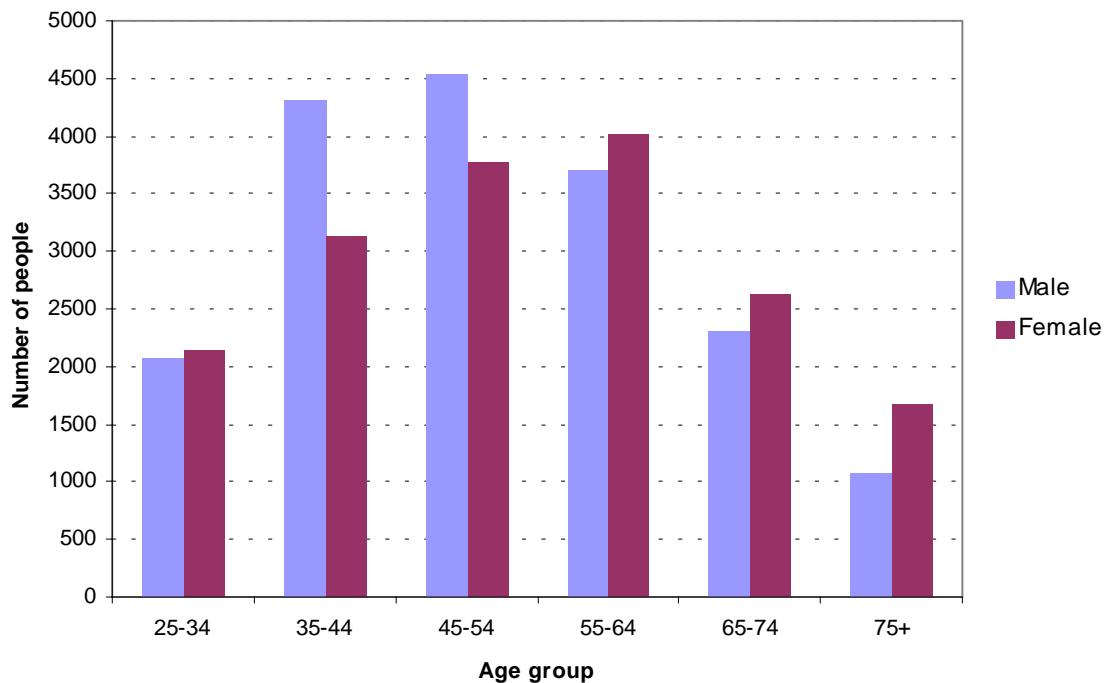
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



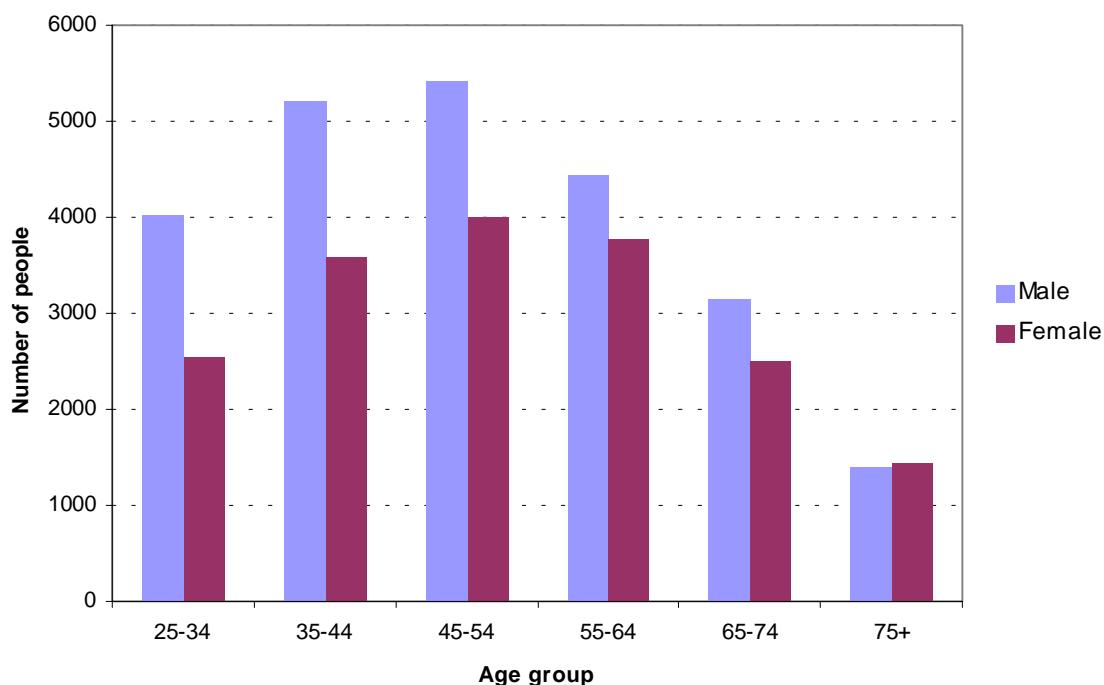
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



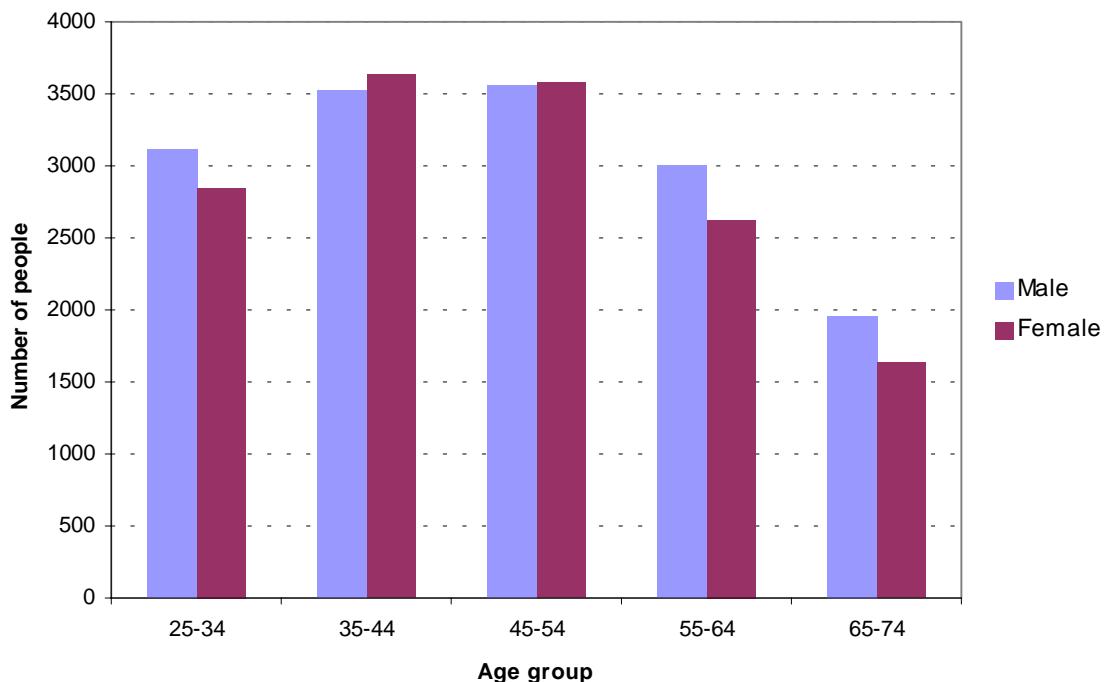
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



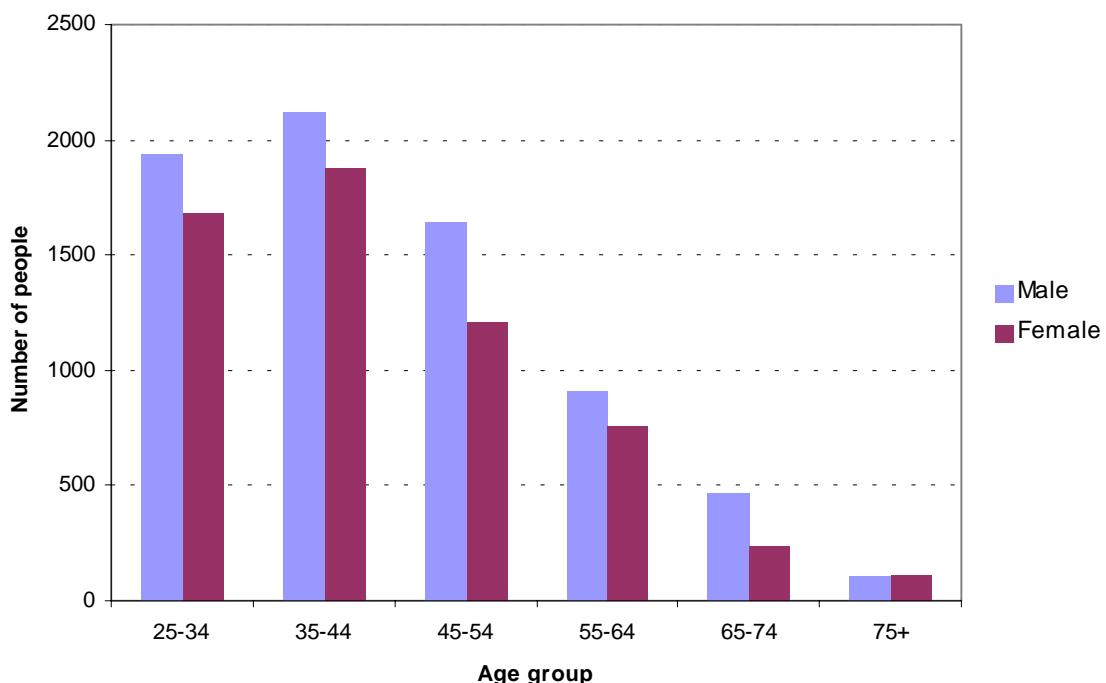
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 113 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes education – Innisfail Tully (neighbouring Division Babinda),
 - Mossman, Port Douglas, Etheridge Shire, Mareeba, Atherton, Kuranda,
 - Dietitian – as above, excluding Babinda,
 - Podiatry – as above, excluding Babinda and Etheridge Shire,
 - GP diabetes clinic in Kuranda once per month – multidisciplinary.

- What services are needed but are not available in your Division area?
 - Podiatry to Mossman Gorge – Aboriginal and Torres Strait Islander (ATSI),
 - Dietitian to Mossman Gorge (ATSI),
 - Diabetes educators to Mt Garnet, Ravenshoe, Malanda, Weipa, and the Cape.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Individual diabetes educator consultations in GPs surgeries,
 - Group sessions as needed,
 - Home visits,
 - Support groups,
 - Royal Flying Doctor Service (RFDS) model (remote clinics),
 - Referral to dietitian and podiatrist as necessary.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Recall systems,
 - Setting up a clinic in Mossman Gorge,
 - Collaboration with RFDS to service Etheridge Shire,
 - Integration into More Allied Health Services (MAHS) program,
 - Established podiatry and dietitian,
 - Long term (5-6 years) provision of diabetes education services.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Remote locations cost a lot more to service,
 - The occasional GPs who do not want to be a part of the program,
 - Integration of services with Queensland Health,
 - Need further MAHS funding to fully integrate diabetes educators.
- What future plans do you have for diabetes management in your Division?
 - Accessing other areas on Tablelands, ie Ravenshoe, Malanda, and Herberton,
 - Visit other areas with RFDS.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Doctors must be interested in participating,
 - Education for staff involved – mandatory,
 - Need to be willing to have health professionals use their surgeries,
 - Computerised surgeries help.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Commencing Health - Diabetic working parties, teleconferences, health workers, Diabetic Action Groups, Diabetes Centre.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Videos, booklets, hand-outs from pharmaceutical companies, local GPs, and health professional presentations and talks addressed to groups,
 - Equipment from Division, eg digital camera, VCR.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Web site,
 - Brochure,
 - Support groups,
 - Teleconferences with other health professionals.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Better diabetes section in Medical Director – software (more automated, more user friendly),
 - Further MAHS funding,
 - Financial modelling for surgeries/GPs considering change to regular diabetic clinics (team approach),
 - Have a working model, need assistance to develop exportably financial model.

- What resource materials do you provide to practices?
 - Booklets,
 - Handouts,
 - Brochures.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Outpatients Cardiac Rehab Phase II and III,
 - Outpatient physician clinic,
 - Stress testing,
 - Cardiac rehab staff availability for case conferences on demand,
 - CVD clinics at one GP surgery - cardiac rehab staff involved.

- What services are needed but are not available in your Division area?
 - Outpatient Cardiac Rehab in Division Centres (especially Mareeba, Mossman & remote),
 - ATSI specific programs/staff,
 - Higher profile in general practice,
 - Improved primary health focus,
 - CVD specific public and private specialist clinics,
 - Support for two rural physicians in the area.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Outpatients six week Phase II Program, including exercise and information, utilising allied health workers,
 - Phase III weekly walking program,
 - Commencing education on demand.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Its ongoing existence,
 - Support participant and their family's recovery to health and well being,
 - Liaising with other health professionals,
 - National Heart Week activities.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - It could be better with more time allocation,
 - Commitment to funding (either More Allied Health Services (MAHS) or Queensland Health).

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What future plans do you have for CVD management in your Division? | <ul style="list-style-type: none">• Continuation, sustainability,• Lobby for funding. |
| <ul style="list-style-type: none">▪ Based on your experience, what advice would you give to a Division planning or implementing a CVD program? | Identify area of greatest need. |
| <ul style="list-style-type: none">▪ What type of strategic alliances or linkages do you have with external organisations and how have you developed them? | <ul style="list-style-type: none">• Cardiac rehab staff committee members of Queensland Cardiac Rehab Association – (QCRA), Australian Cardiac Rehab Association (ACRA),• Quarterly Queensland Cardiac Coordinators teleconference,• Atherton Cardiac Support Group,• Pharmaceutical companies assistance – resource provision. |

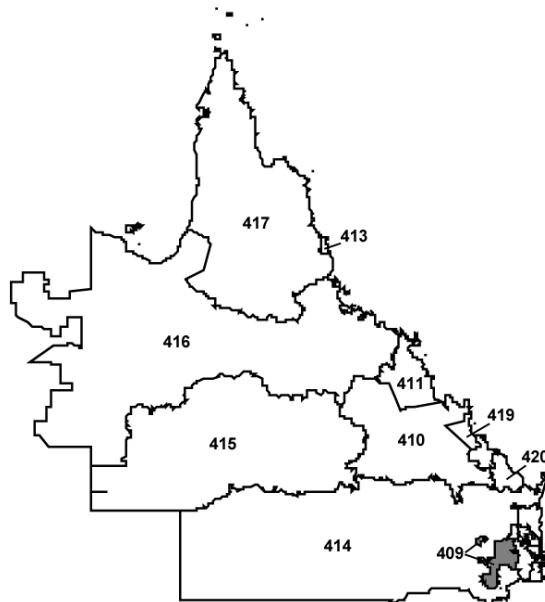
Division Resources

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)? | <ul style="list-style-type: none">• National Heart Foundation literature,• Cardio Pulmonary Resuscitation (CPR) 2000 Video,• Eating for Health St Andrew's,• Type 2 and Coronary Heart Disease (resource). |
| <ul style="list-style-type: none">▪ What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? | N/A. |
| <ul style="list-style-type: none">▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? | <ul style="list-style-type: none">• Further MAHS funding,• Assistance to look at exportable model (including financial) of having cardiac clinics (multidisciplinary) in general practice (we have one surgery doing this successfully). |
| <ul style="list-style-type: none">▪ What resource materials do you provide to practices? | <ul style="list-style-type: none">• National Heart Foundation Guidelines,• Program information,• Latest development. |

Division Contact Person/
Program Co-ordinator

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GP Connections (Toowoomba and District DGP)



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	141,391	
■ Aboriginal or Torres Strait Islander	3629	2.6%
■ Speaks language other than English at home	3629	2.6%
■ RRMA classification ¹		
3: Large rural	91,763	64.9%
5: Other rural	49,628	35.1%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7029	8.1%
■ High blood pressure ⁴	26,588	30.6%
■ High blood cholesterol ⁵	44,831	51.6%
■ Obese or overweight ⁶	52,235	60.1%
■ Physical inactivity ⁷	36,576	42.1%
■ Smoking ⁸	16,486	19.0%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

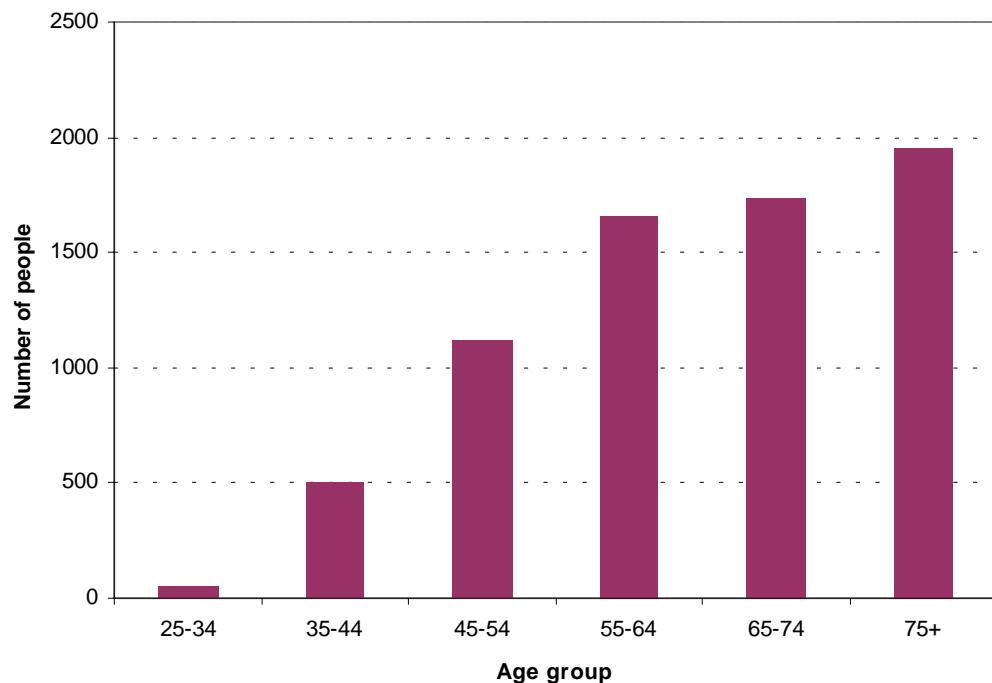
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

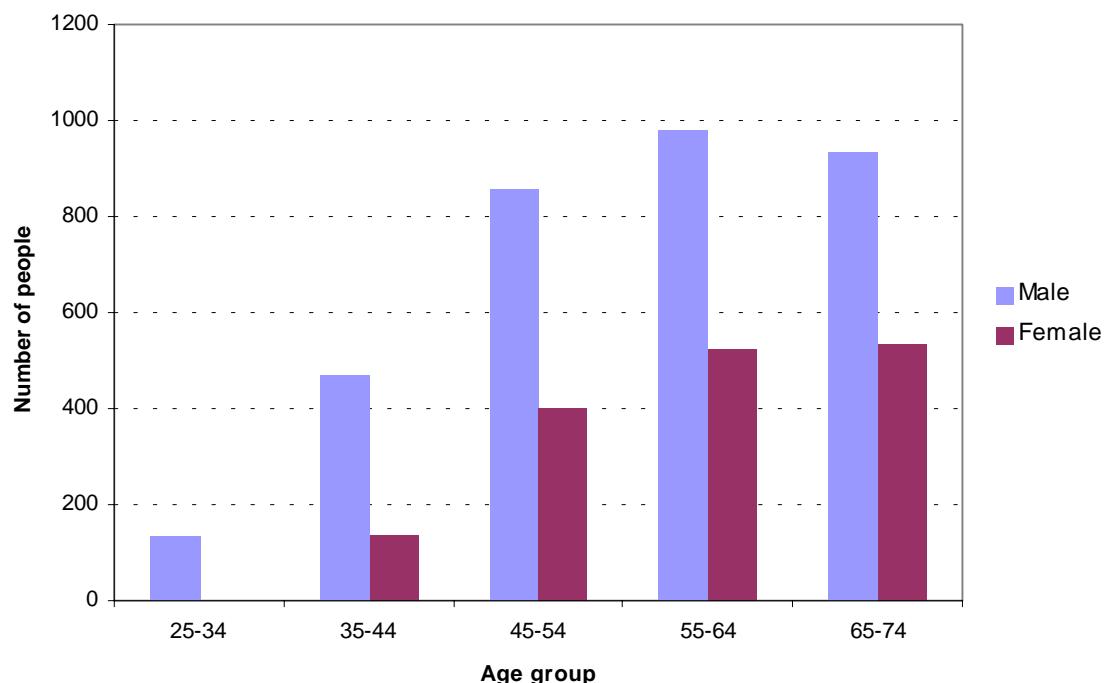
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



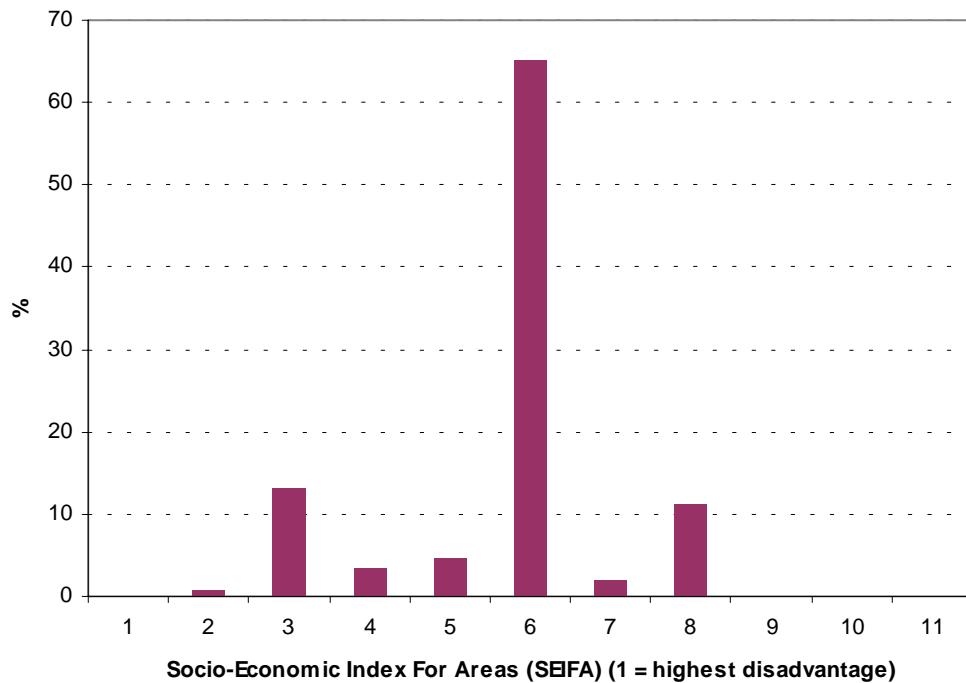
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

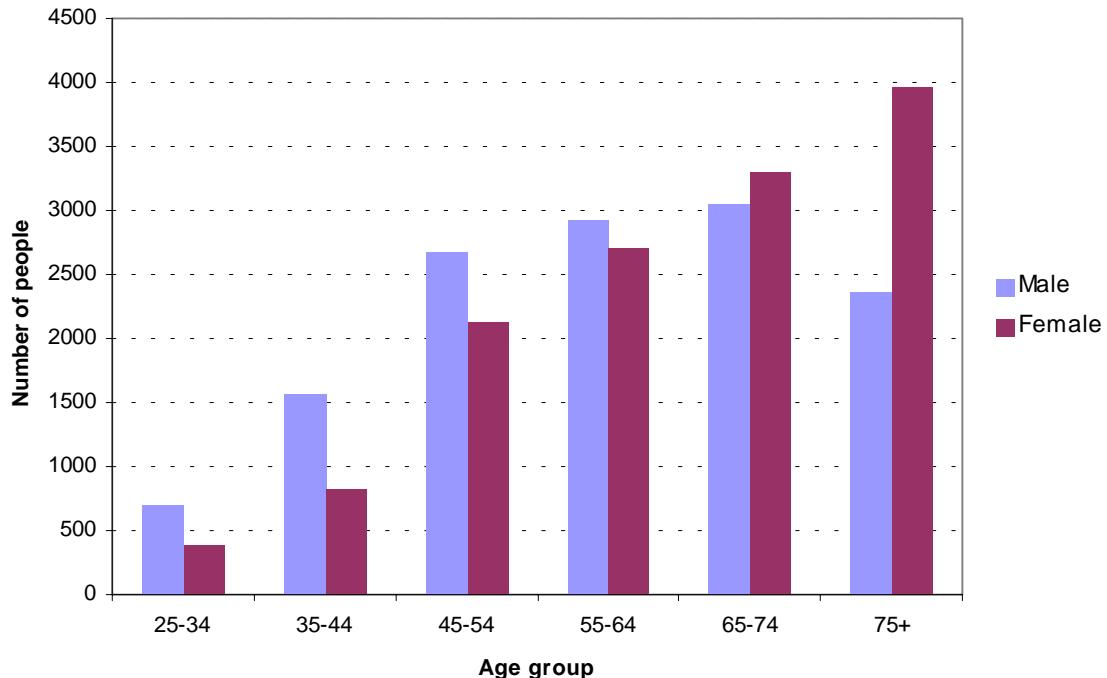
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

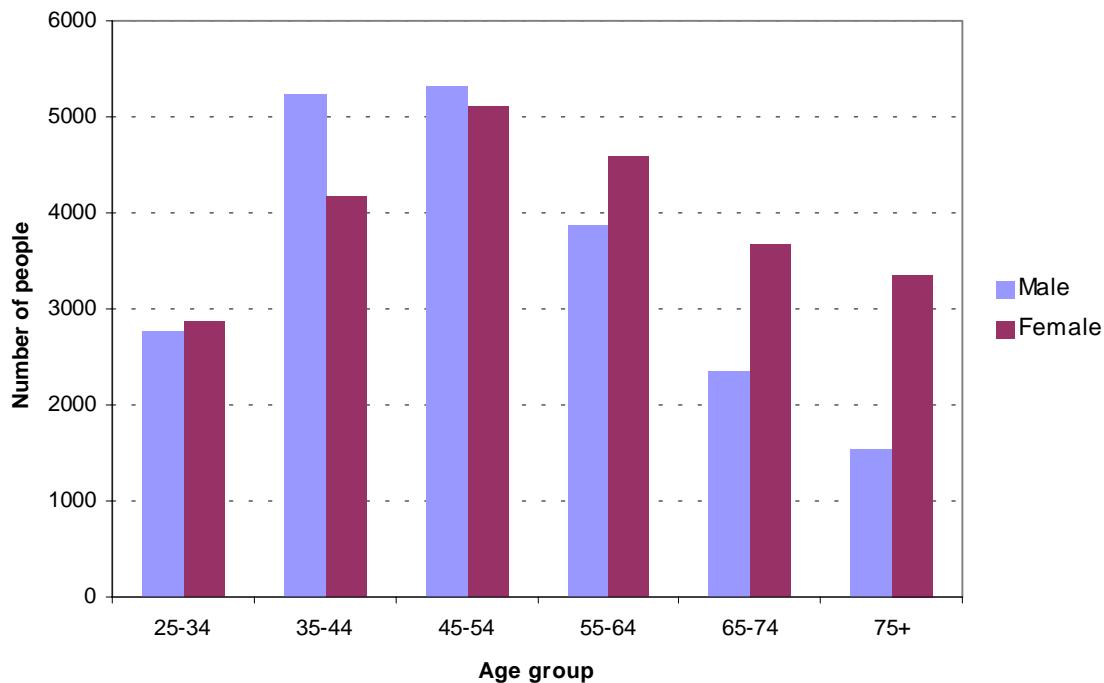
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



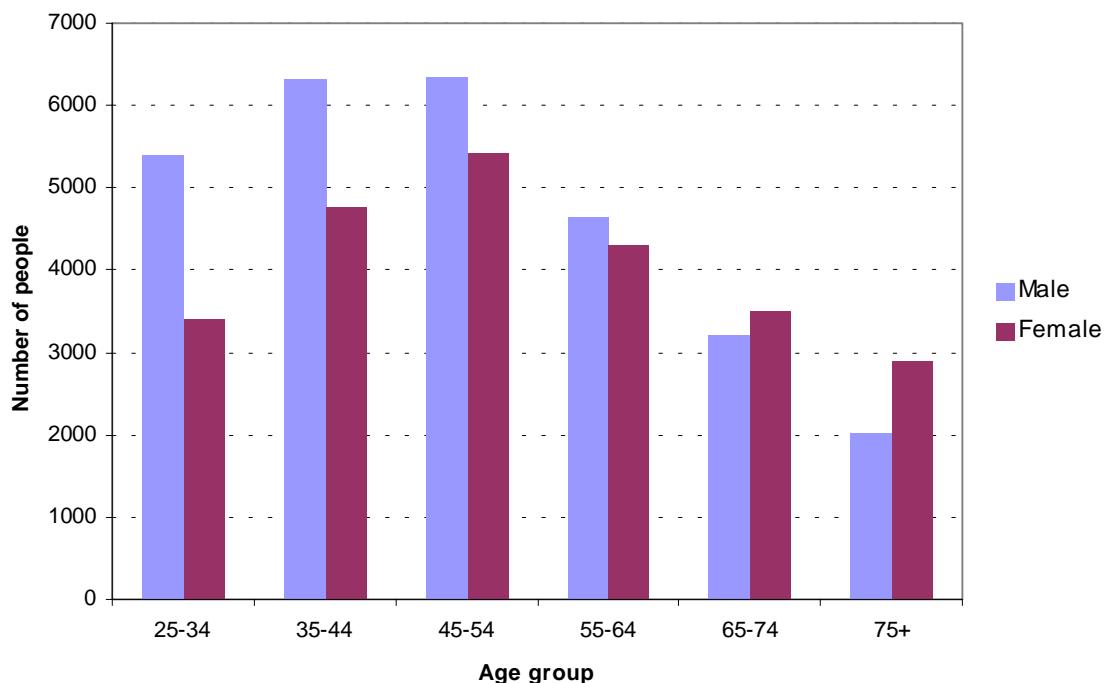
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



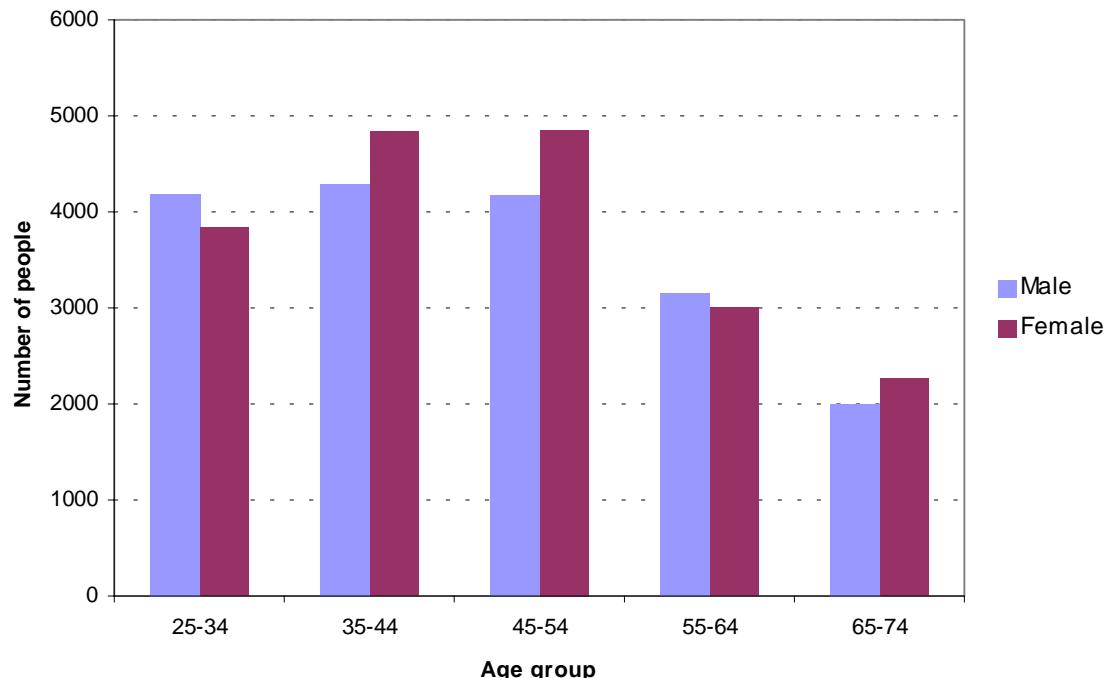
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



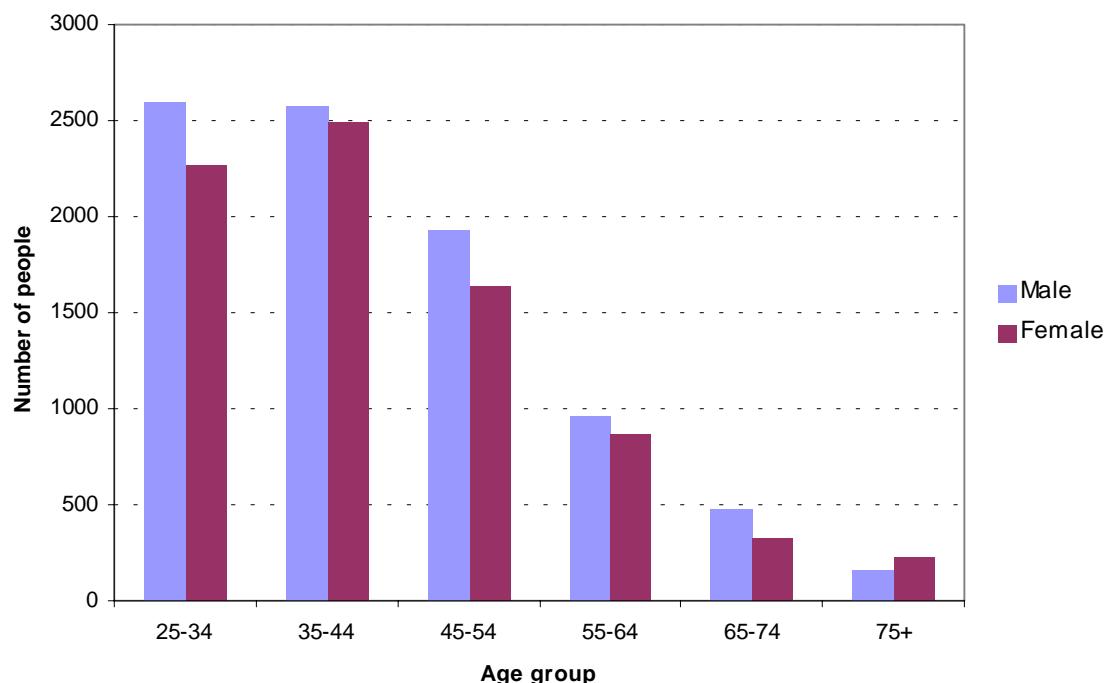
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 132 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - GPs,
 - Two diabetes educators,
 - One specialist physician with an interest in diabetes,
 - Six podiatrists with an interest in diabetes,
 - Two dietitians.

Plus

- Diabetic clinic,
- Specialist,
- Registrar,
- Educator,
- Podiatrist (fully booked).

- What services are needed but are not available in your Division area?

More diabetic educators and an improved public system.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?

- Diabetic network meets regularly with interested allied health professionals,
- Diabetes upskilling for practice nurses.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Education evening.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Time and money.

- What future plans do you have for diabetes management in your Division?

More upskilling for practice nurses.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives? Practice nurses and good clean databases.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them? Practice nurses and good clean databases.

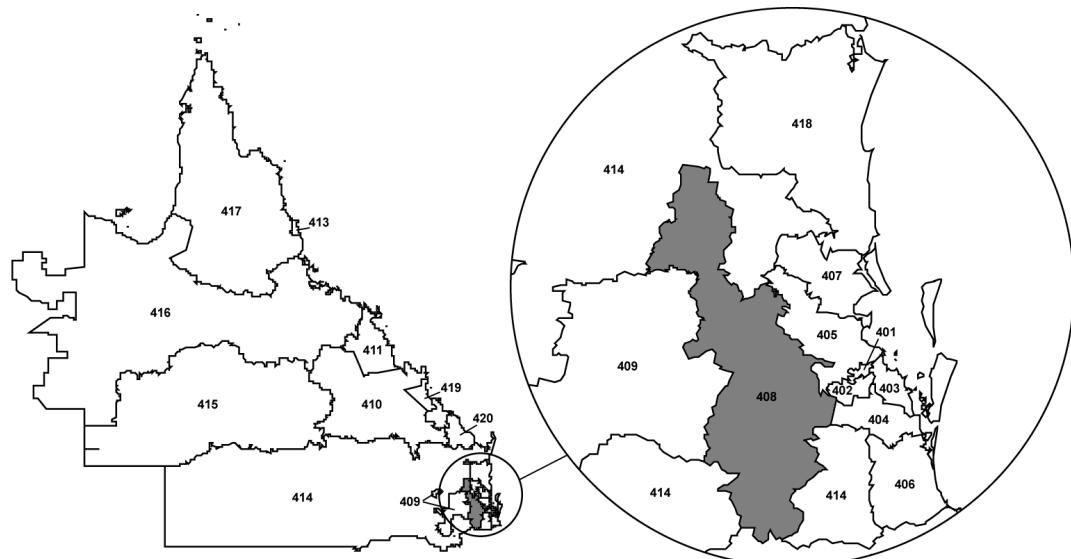
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)? At present we do not utilise any diabetes resources.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Nutrition manual,
 - Diabetes educational session resource video.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - More user friendly systems,
 - Pathology recall tools.
- What resource materials do you provide to practices? Guidelines for practice staff.

Division Contact Person/
Program Co-ordinator

Name: Fairlie McIllwraith
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Fax: 07 4633 0829
Email: fmcillwraith@tddgp.com.au

Ipswich and West Moreton DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	165,036	
■ Aboriginal or Torres Strait Islander	4695	2.8%
■ Speaks language other than English at home	8686	5.3%
■ RRMA classification ¹		
1: Capital city	129,223	78.3%
5: Other rural	35,813	21.7%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7449	7.4%
■ High blood pressure ⁴	28,690	28.3%
■ High blood cholesterol ⁵	51,527	50.8%
■ Obese or overweight ⁶	60,614	59.8%
■ Physical inactivity ⁷	43,693	43.1%
■ Smoking ⁸	19,967	19.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

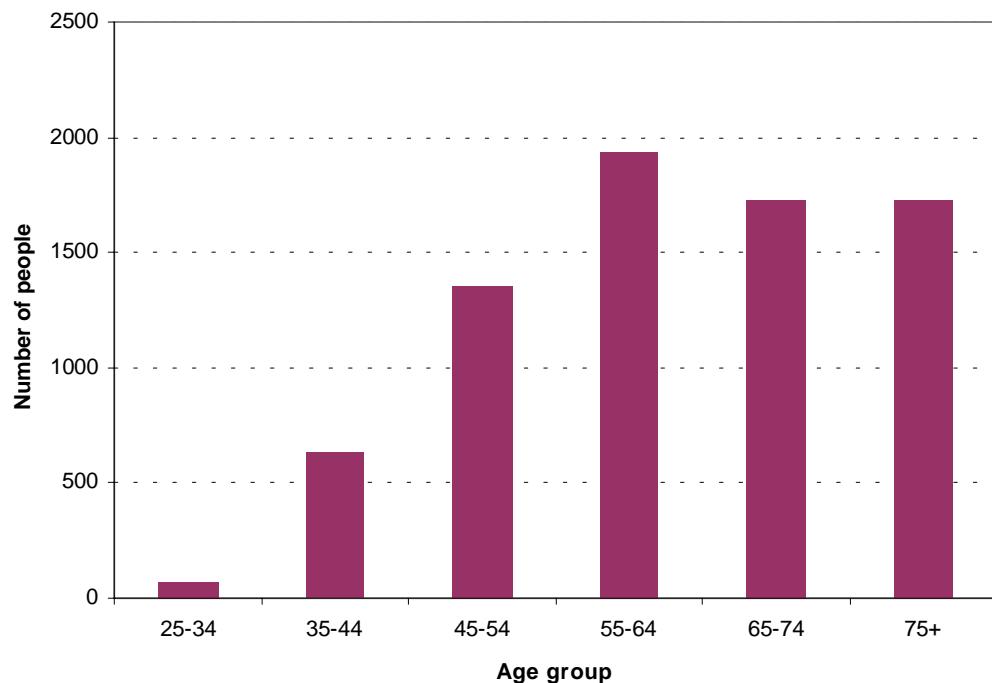
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

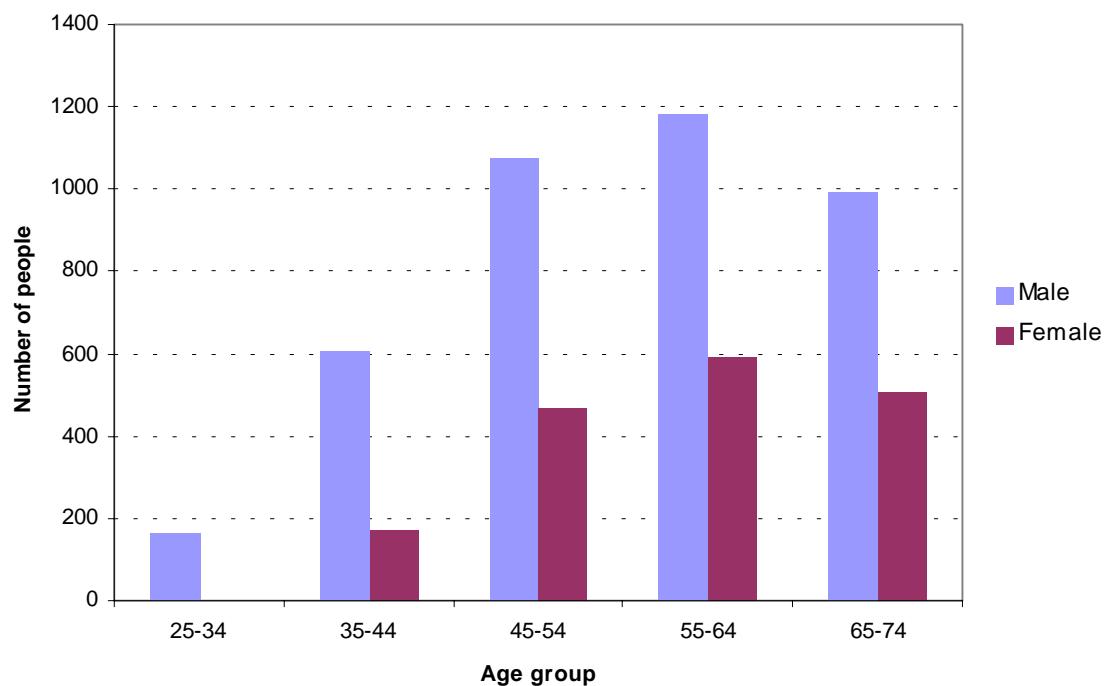
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



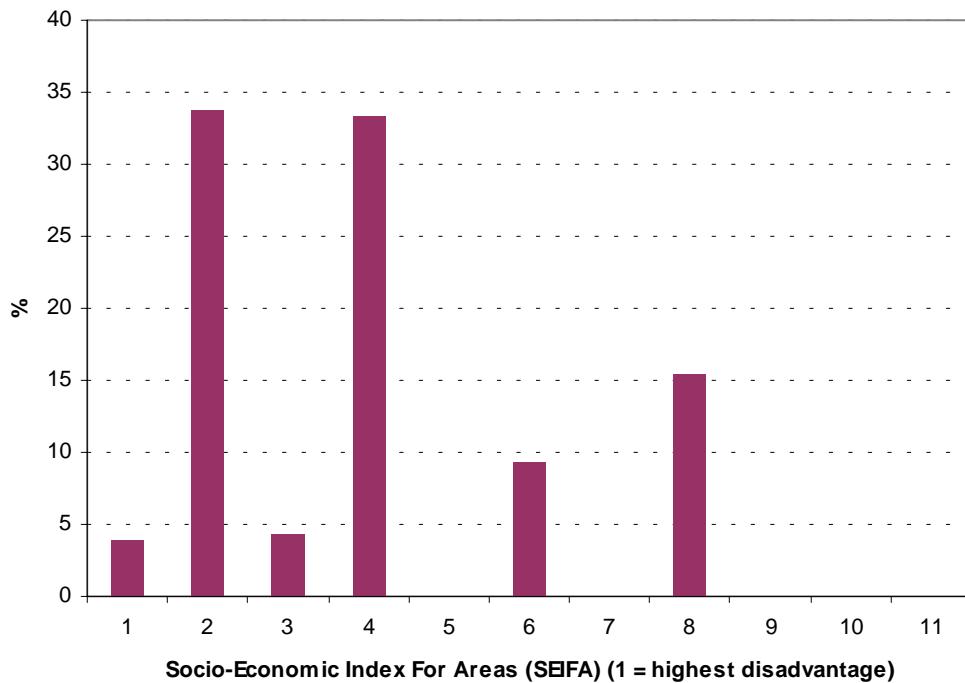
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

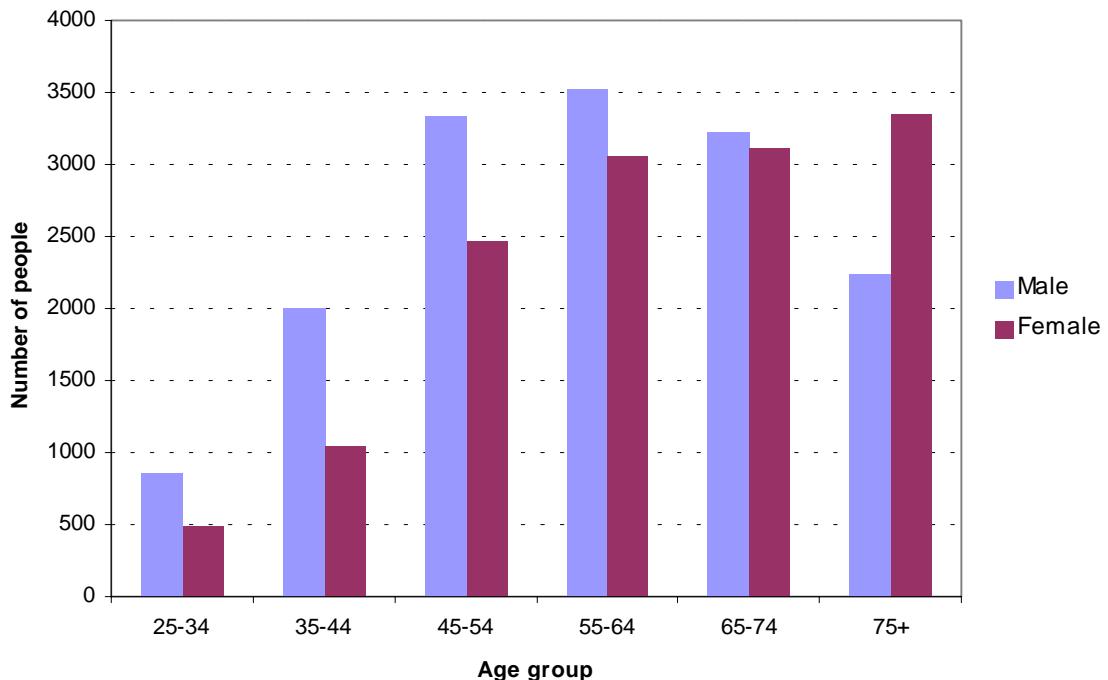
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

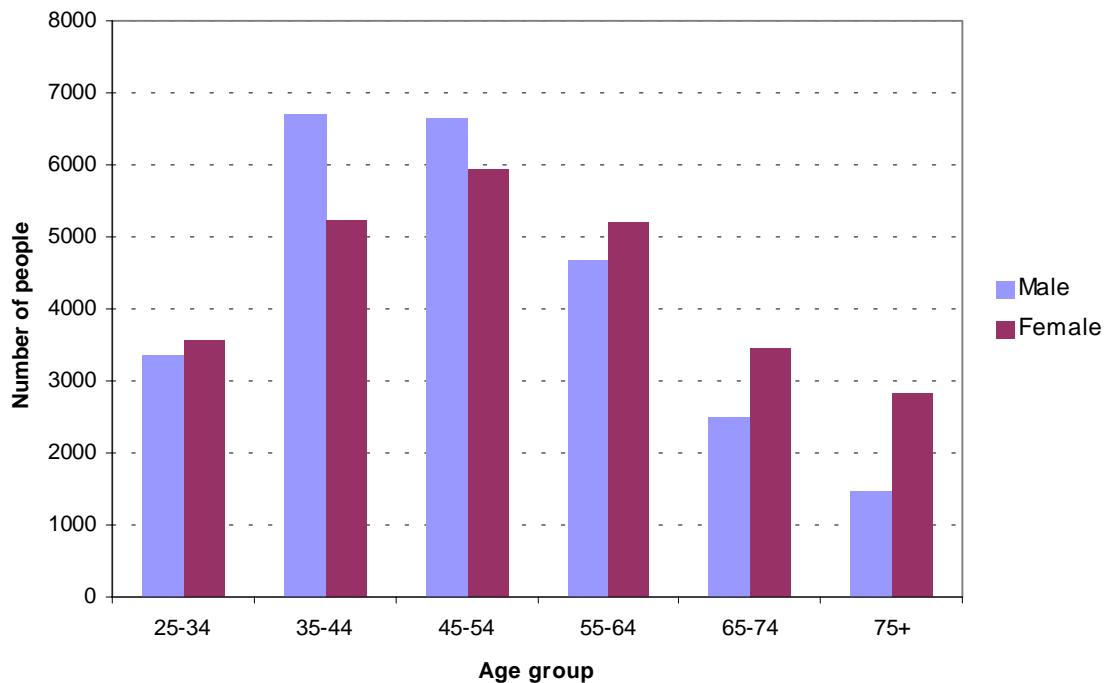
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



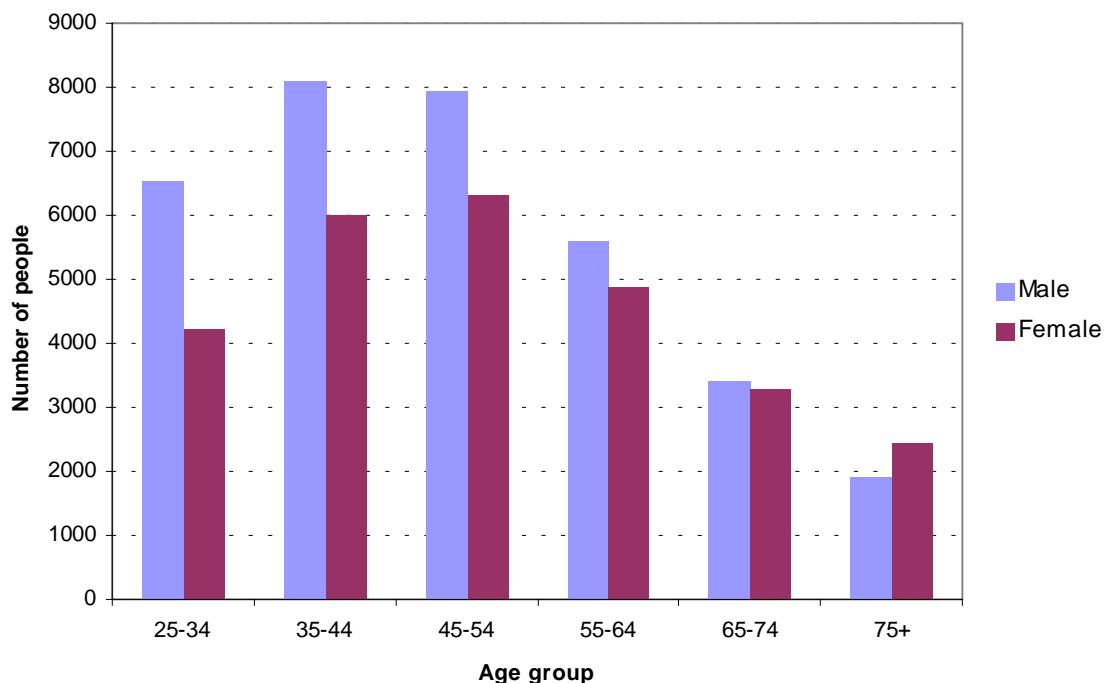
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



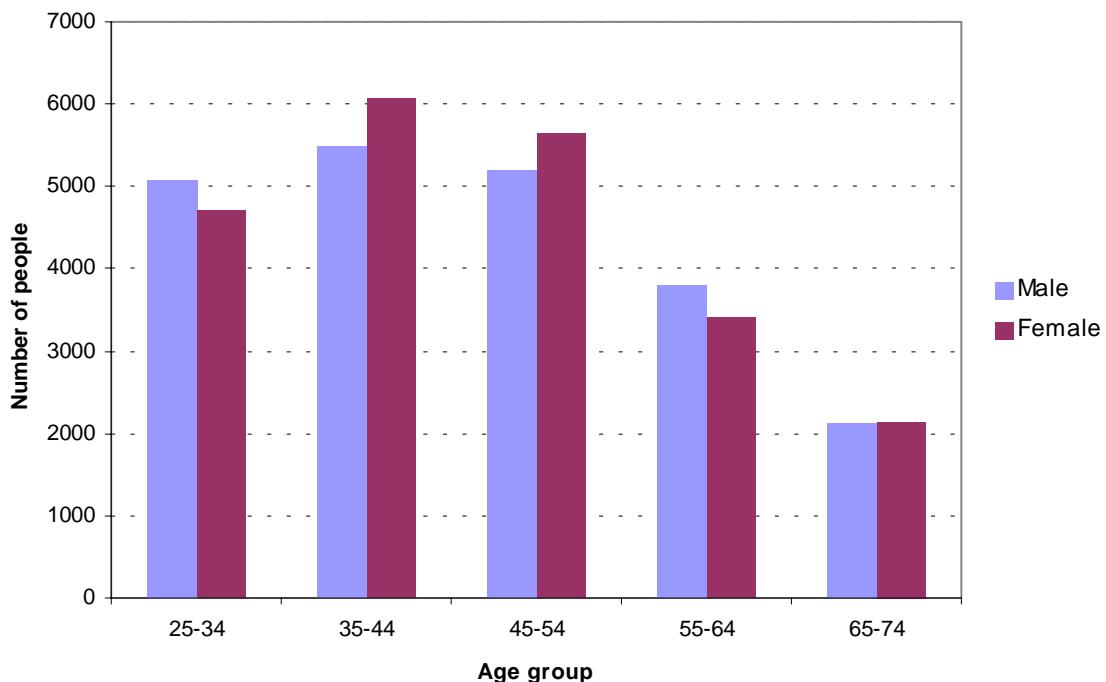
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



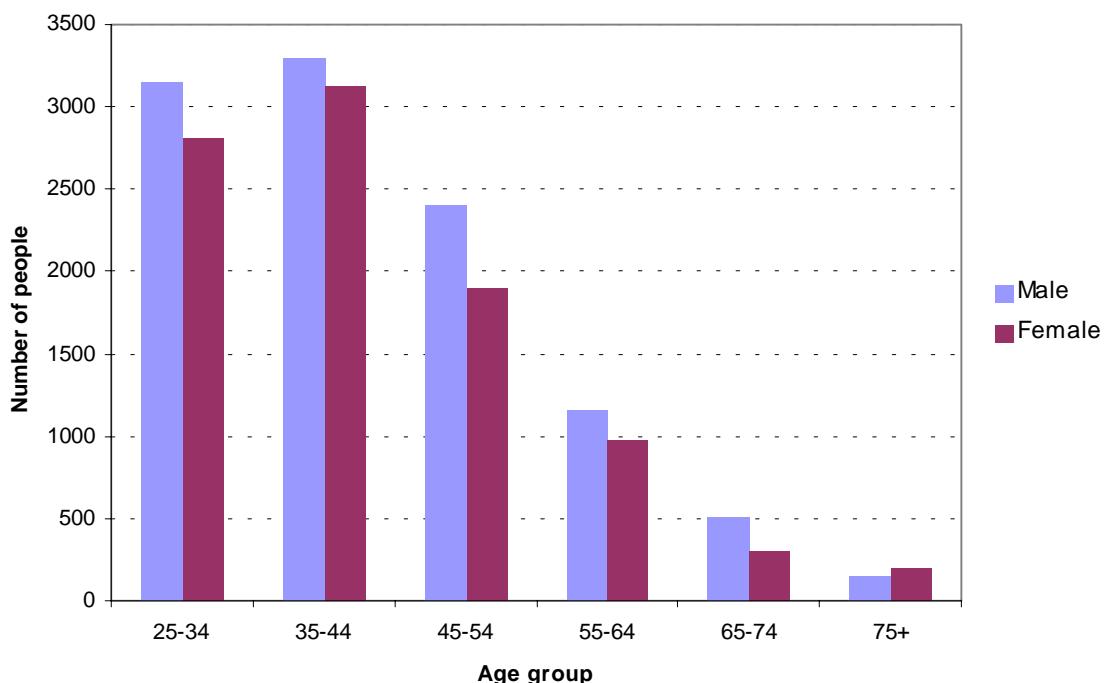
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 135 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Outpatients Clinic and Inpatient Services at Ipswich Hospital,
 - Conventional services by GPs,
 - Podiatrist Home and Community Care (HACC) Services/Community Health Dietitian Rural Service via More Allied Health Services (MAHS),
 - Private dietitians/podiatrists/diabetes educator,
 - Public and private ophthalmologists.

- What services are needed but are not available in your Division area?

Public services especially community health are over stretched. District education program planned with Ipswich West Moreton DGP (IWDGP) cooperation but yet to be implemented.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Division no longer has diabetes program, does not have a chronic disease register or CARDIAB. Our philosophy is to encourage and support these functions at practice level, eg. Promote Enhanced Primary Care (EPC) Practice Nurses.

Division Perspective

- What have been the major achievements or highlights of your program so far?

N/A.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for diabetes management in your Division?

Continue down our current path of general practice support, which includes practice staff and nurses as well as GPs.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Commonwealth initiatives, EPC support and encouragement from the Division.

Cooperation with Diabetes Service to establish district-wide education for patients with newly diagnosed or difficult to control diabetes.
Presentations to local diabetes support group.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- What resource materials do you provide to practices?

N/A.

N/A.

No.

Royal Australasian College of General Practitioners (RACGP) diabetes record, management flow diagram, Enhanced Primary Care (EPC) details and updates.

Division Contact Person/
Program Co-ordinator

Name: Ms Soraya Arrage
Phone: 07 3813 7000
Fax: 07 3812 1403
Email: s.arrage@iwmdgp.org.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - General medical specialists at district hospital and in private practice,
 - Brisbane private cardiologist visits weekly,
 - Cardiac Rehab Service and Rural Rehab Service joint funded and managed by District Health Service and Ipswich and West Moreton Division of General Practice (IWMDGP),
 - Coronary Care Unit (CCU) available at district hospital and Intensive Care Unit (ICU) at local private hospital.

- What services are needed but are not available in your Division area?
None.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
There is no Division-wide CVD program now as the focus of Division activity has been the support of general practice, however, the Division has been involved in co-management of the West Moreton Cardiovascular Disease Project (WESTCOP) since 1996.

Division Perspective

- What have been the major achievements or highlights of your program so far?
WESTCOP has followed course of patients admitted to local hospitals with proven myocardial infarction (MI) through inpatient stay and up to eighteen months post discharge project to end December 2002. Data currently being analysed. GP contact and data collection by them, post discharge.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
No.

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">■ What future plans do you have for CVD management in your Division? | Continue as now. |
| <ul style="list-style-type: none">■ Based on your experience, what advice would you give to a Division planning or implementing a CVD program? | <ul style="list-style-type: none">• Promote best practice,• Support GPs and practice staff,• Identify and promote best resources,• Identify and provide, if necessary, educational needs. |
| <ul style="list-style-type: none">■ What type of strategic alliances or linkages do you have with external organisations and how have you developed them? | <ul style="list-style-type: none">• Close linkage with local branch Heart Support Australia,• Close linkage with District Health Service through co-management of cardiac rehab service. |

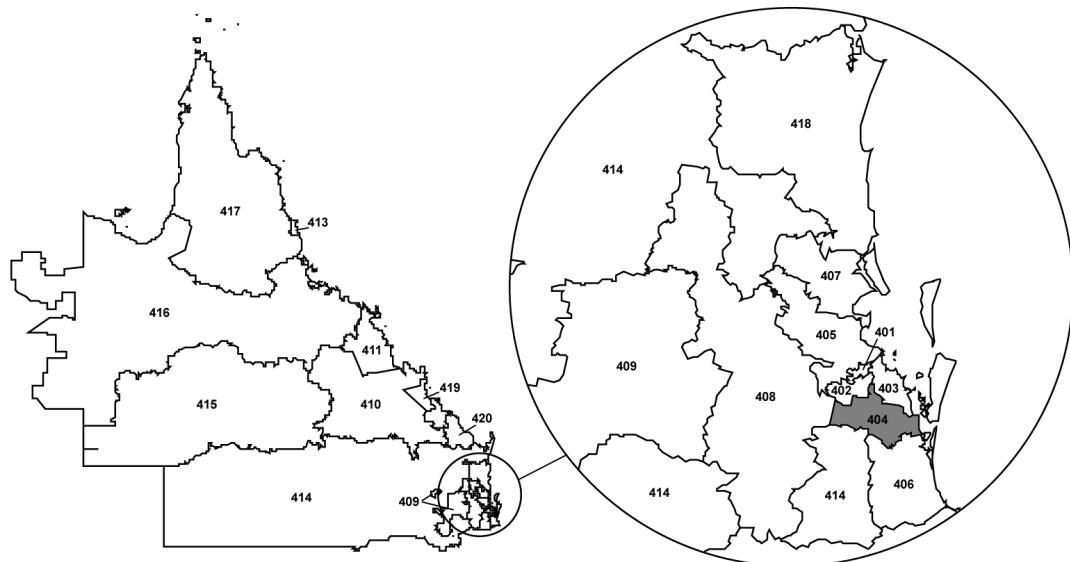
Division Resources

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">■ What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)? | Nil. |
| <ul style="list-style-type: none">■ What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? | Rural Cardiac Rehab Patient Education Book. |
| <ul style="list-style-type: none">■ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? | No. |
| <ul style="list-style-type: none">■ What resource materials do you provide to practices? | <ul style="list-style-type: none">• Enhanced Primary Care (EPC) education & support,• Best Practice guidelines. |

Division Contact Person/
Program Co-ordinator

Name: Ms Soraya Arrage
Phone: 07 3813 7000
Fax: 07 3812 1403
Email: s.arrage@iwmddgp.org.au

Logan Area DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	251,567	
■ Aboriginal or Torres Strait Islander	5407	2.1%
■ Speaks language other than English at home	26,703	10.6%
■ RRMA classification ¹		
1: Capital City	251,567	100.0%
■ SEIFA category containing population median: ²	6	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9402	6.3%
■ High blood pressure ⁴	37,297	25.1%
■ High blood cholesterol ⁵	74,034	49.7%
■ Obese or overweight ⁶	88,048	59.2%
■ Physical inactivity ⁷	66,161	44.5%
■ Smoking ⁸	30,721	20.6%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

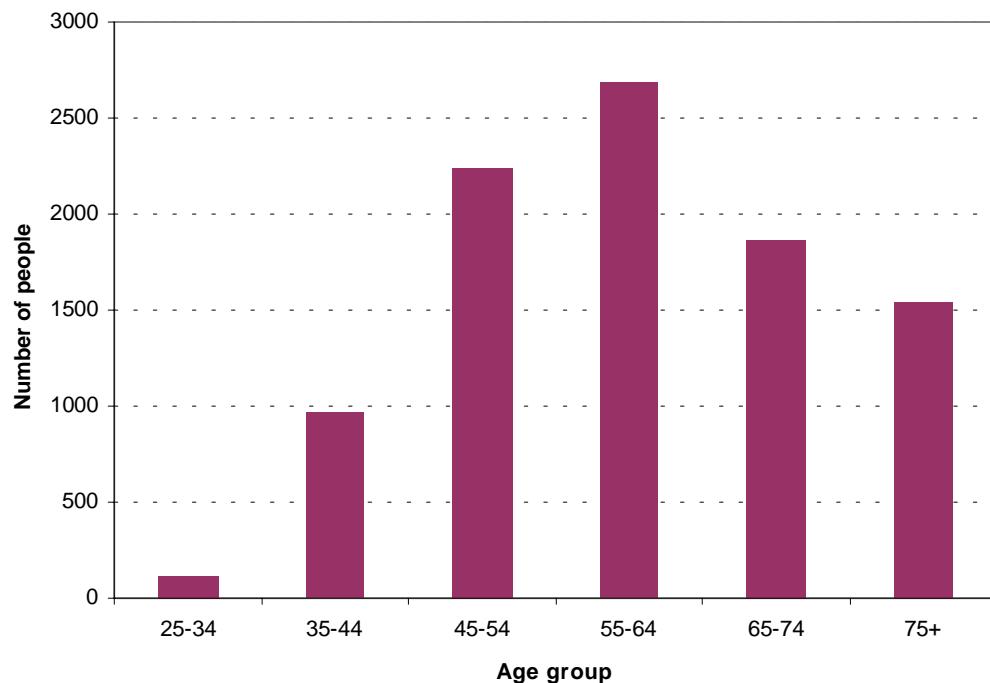
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

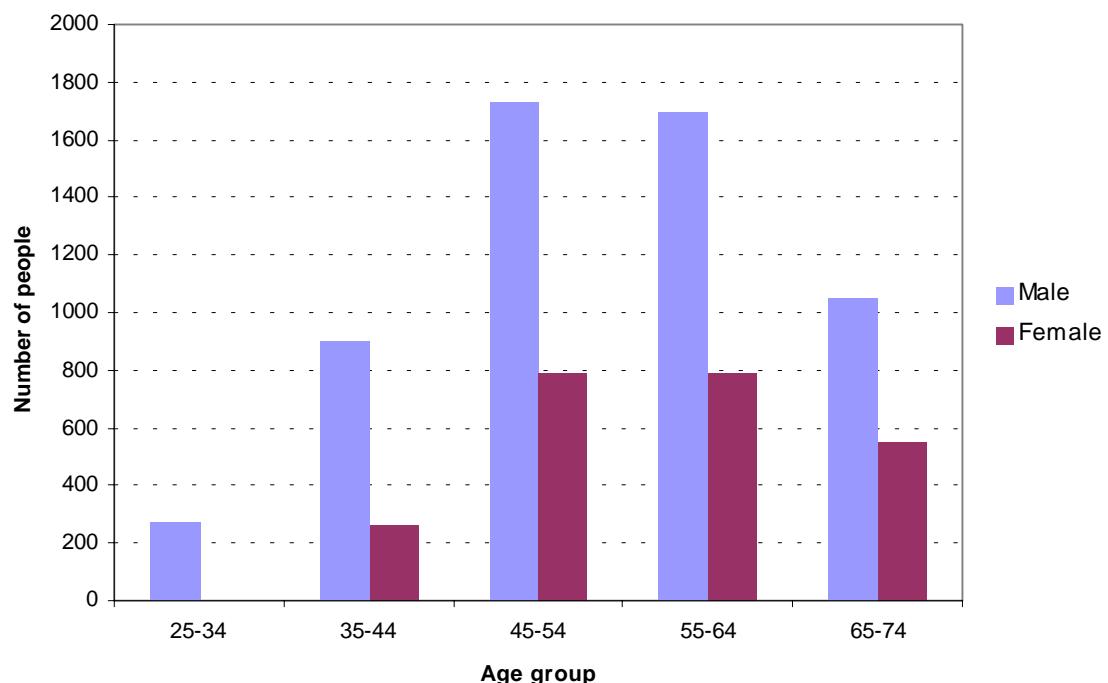
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



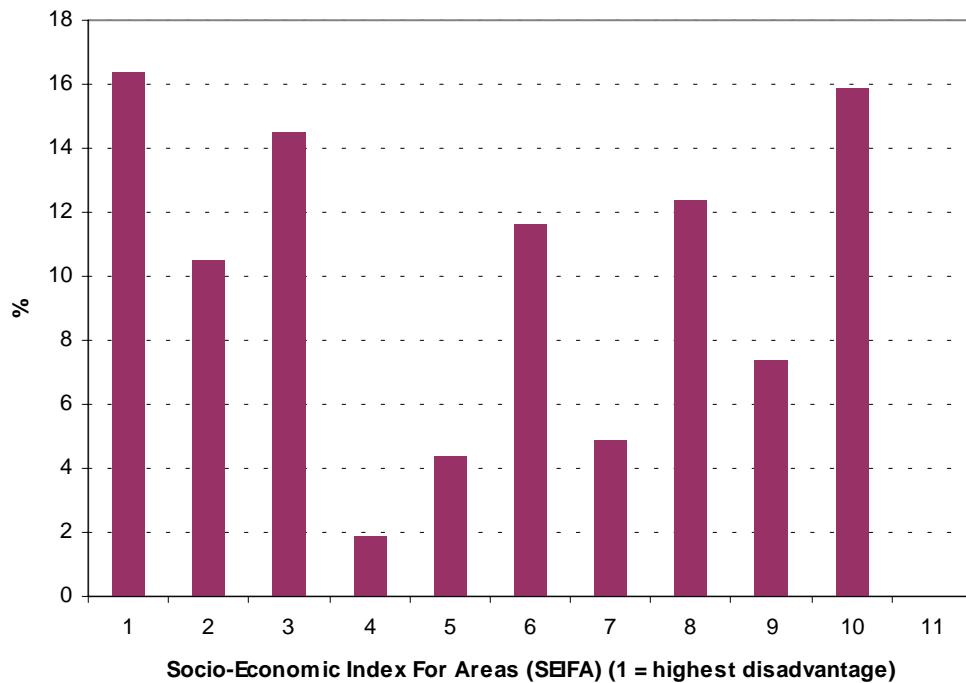
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

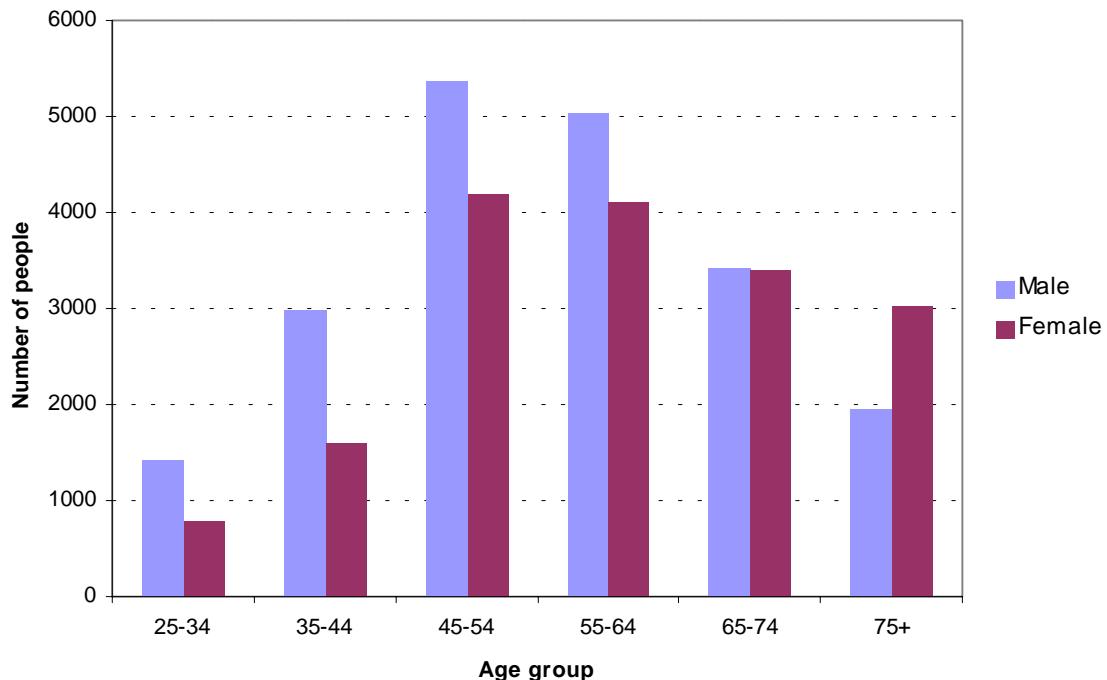
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

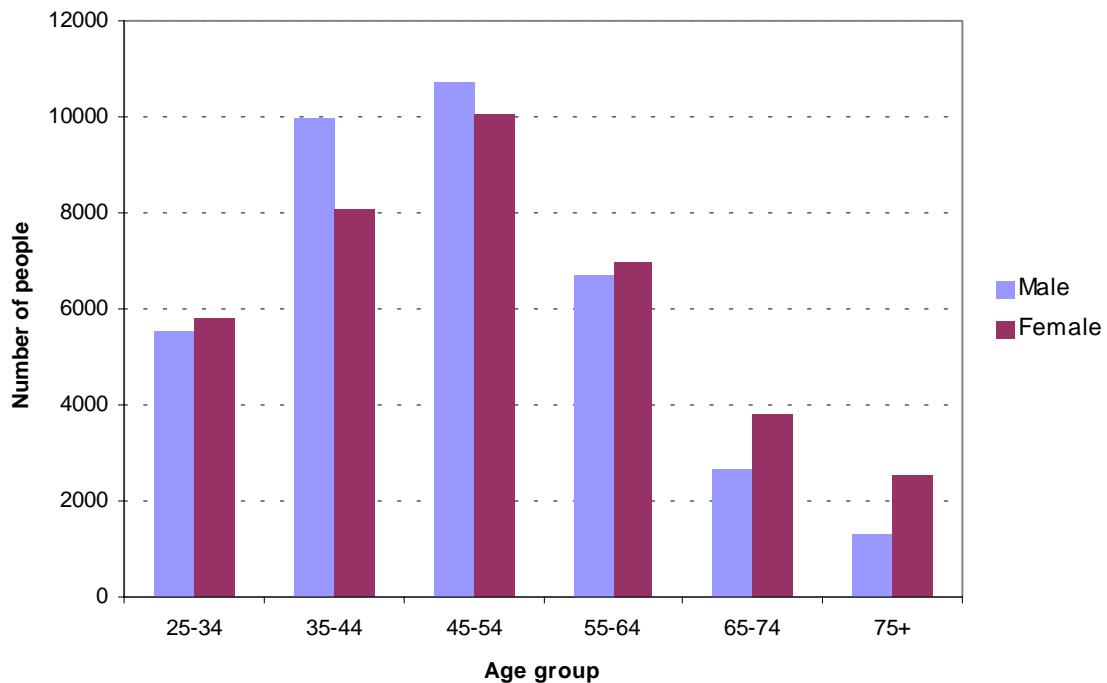
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



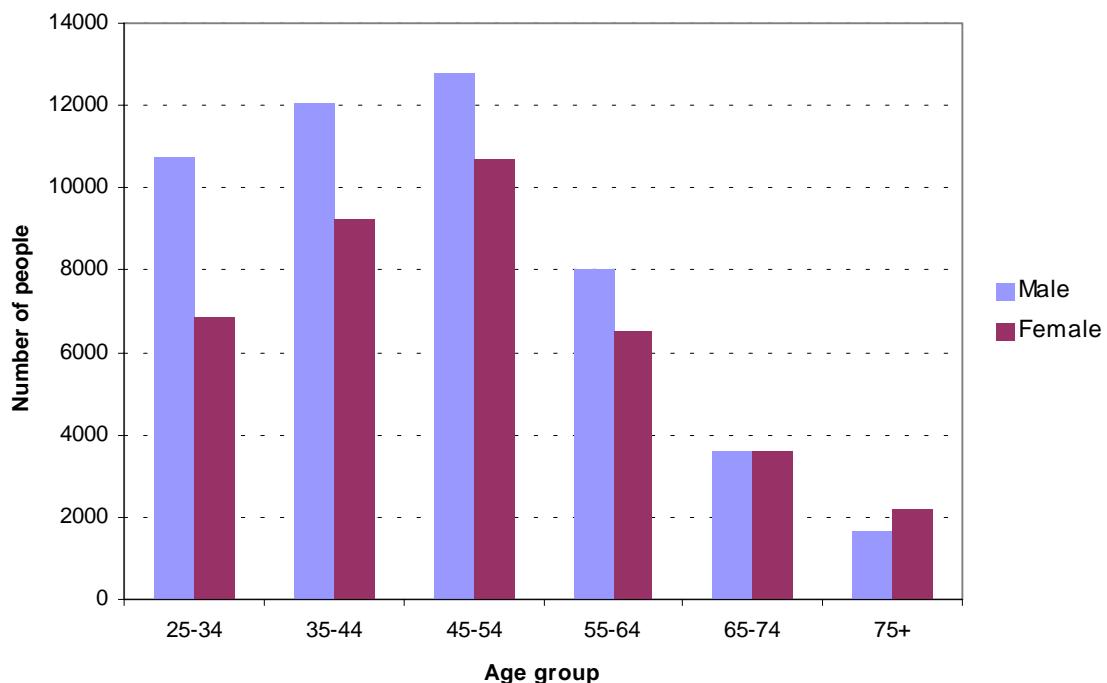
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



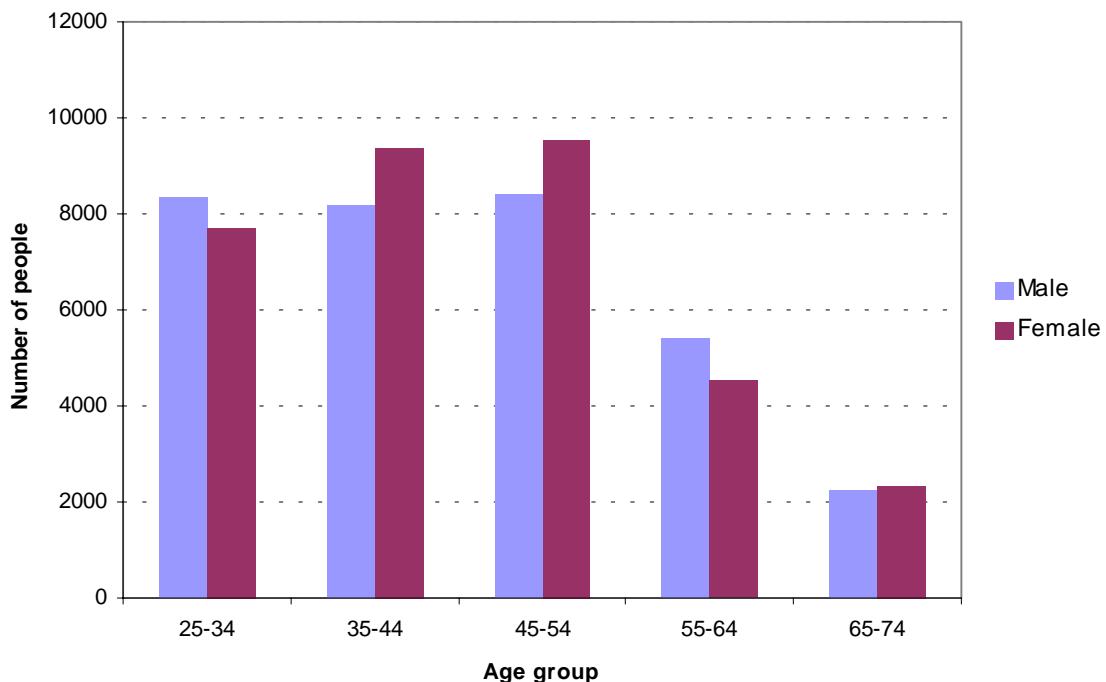
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



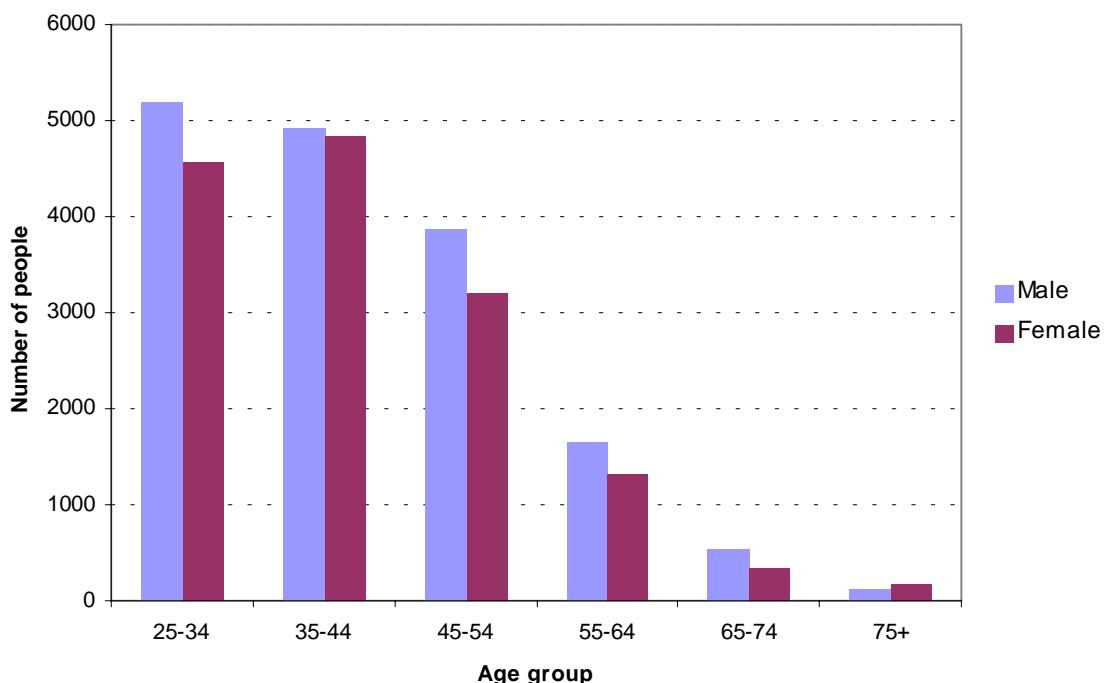
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

▪ Number of GPs working in the Division area:	Total	257
-----------------------------------------------	-------	-----

Division Comments

- Do you have any comments about the nature of the population in your area?

Logan Division is located in one of the fastest growth corridors in Australia and is situated between Brisbane and the Gold Coast in South East Queensland. In broad terms, the population tends to be younger than the national average, more transient, and the population have a relatively low socio-economic status. It is estimated up to 25% of people in the region do not have a regular GP, making clinical follow up difficult. Although two-thirds of the area is rural, the RRMA classification of the Division is 1 (capital city), preventing the Division accessing incentives and assistance schemes normally available to rural areas (such as MAHS and practice nurse incentives). In addition, the number of GPs in the area has declined by 20 over the last 6 years, whilst the population has grown by more than 40,000. Adding further to the workforce problem is the fact that the patients in the Logan area see their doctor 15% more often than the Queensland average. All diabetes in the area as shown in these profiles an underestimate of the true picture.

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Logan Hospital diabetes clinic,
 - Diabetes Australia (Queensland) Diabetes Clinic (Logan Outlet) – Logan City Council,
 - Community health (Logan and Beenleigh) nurses.

- What services are needed but are not available in your Division area?

Specific clinics for Indigenous and Pacific (South Sea) Islander populations (poor screening rates = undiagnosed patients).

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - GP upskilling program,
 - Development of “General Practice Complication Screening & Education Modules for Non-Pregnant Adults with Diabetes”,
 - Development of other resources,
 - Improving referrals and communication between hospital and GP.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Development of modules and corresponding CME events.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Uptake limited to a few GPs (only those interested).

- What future plans do you have for diabetes management in your Division?

Improving integration between Logan Hospital and GPs. Targeting diabetes in the first instance as sound systems already in place, ie clinic.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Interest is high,
 - Diabetes 12-month cycle of care is easier to implement.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Logan Hospital, Community Health – strengthened by recent funding through National Health Development Fund (NHDF) allocation (GP integration project).

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

N/A.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

GP education and screening modules.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

- What resource materials do you provide to practices?

Community contacts.

Division Contact Person/
Program Co-ordinator

Name: Mrs Tracey Varney
Phone: 07 3290 3733
Fax: 07 3290 3144
Email: admin@ladgp.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Cardiac Rehab Program – Logan Hospital (public).
- What services are needed but are not available in your Division area?

N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002
- Please describe your CVD program including any changes that occurred over time?

Eight-week cardiac rehab program. Originally developed, operated and managed by the Division. Progressively changed format where Logan Area Division of General Practice (LADGP) was responsible for admin and management. GP input into program. Logan Hospital responsible for Allied Health input. As of 1 July 2002 program now fully operated and managed at Logan Hospital. LADGP responsible for GP links only.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Incorporation of Enhanced Primary Care (EPC) care planning into program.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.
- What future plans do you have for CVD management in your Division?

Unsure at this stage. Continue with education, ensure GP links remain with program.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

N/A.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Logan Hospital. Commenced with a Memorandum of Understanding (MOU) where LADGP and Logan Hospital shared the operation of the program. Program (clinical services) now fully operational at the hospital.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

Division developed care plan.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

As above.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

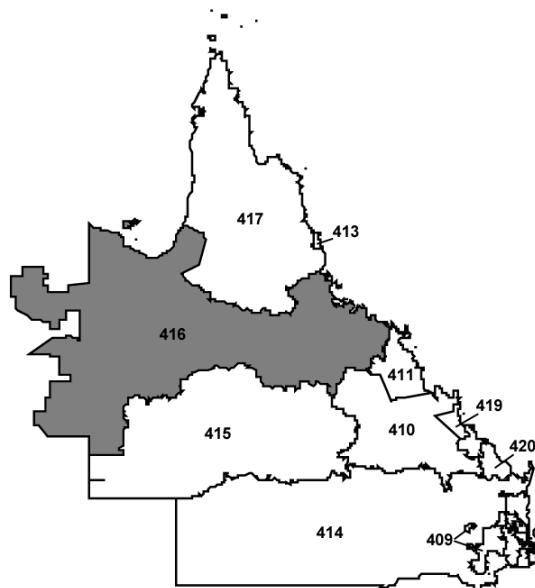
N/A.
- What resource materials do you provide to practices?

Referral contacts, care plans, EPC guidelines/flow charts.

Division Contact Person/
Program Co-ordinator

Name: Margaret Diefenbach/Robyn O'Rourke
Phone: 07 3290 3733
Fax: 07 3290 3144
Email: admin@ladgp.com.au

Northern Queensland Rural DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	101,470	
■ Aboriginal or Torres Strait Islander	12,092	11.9%
■ Speaks language other than English at home	5414	5.3%
■ RRMA classification ¹		
5: Other rural	53,069	52.3%
6: Remote centre	36,631	36.1%
7: Other remote	11,771	11.6%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5173	7.8%
■ High blood pressure ⁴	19,900	30.1%
■ High blood cholesterol ⁵	34,038	51.5%
■ Obese or overweight ⁶	40,339	61.1%
■ Physical inactivity ⁷	28,599	43.3%
■ Smoking ⁸	12,810	19.4%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

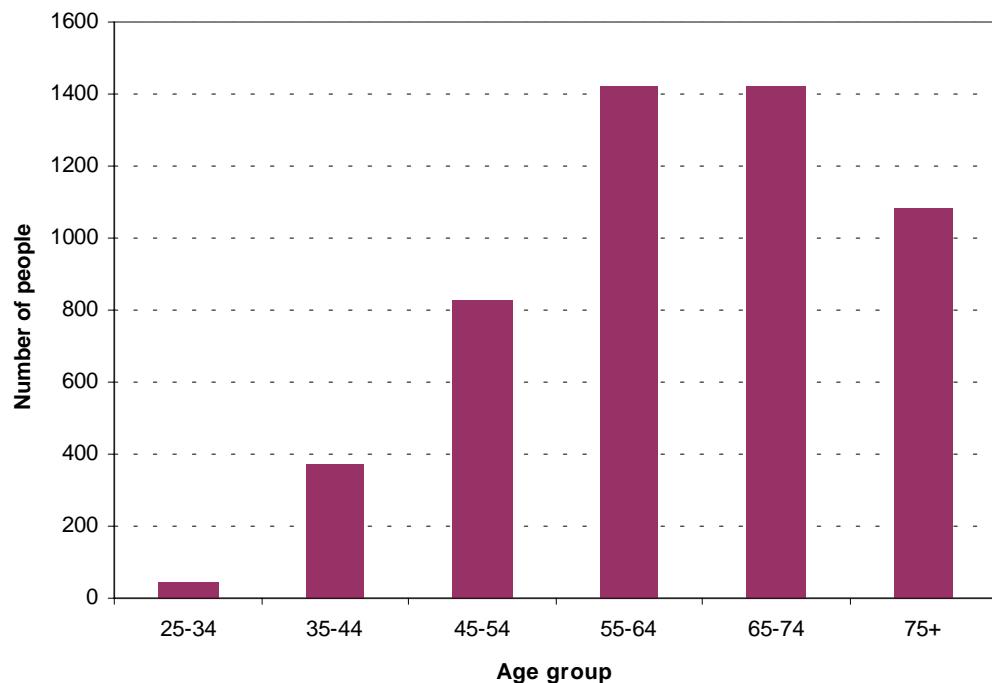
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

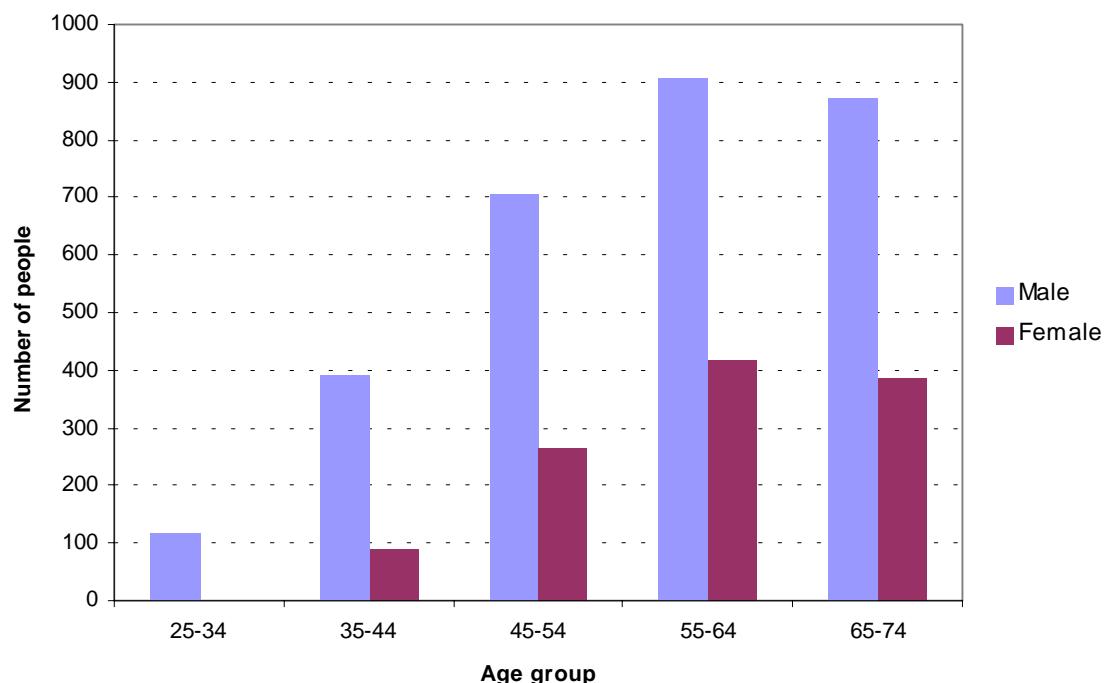
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



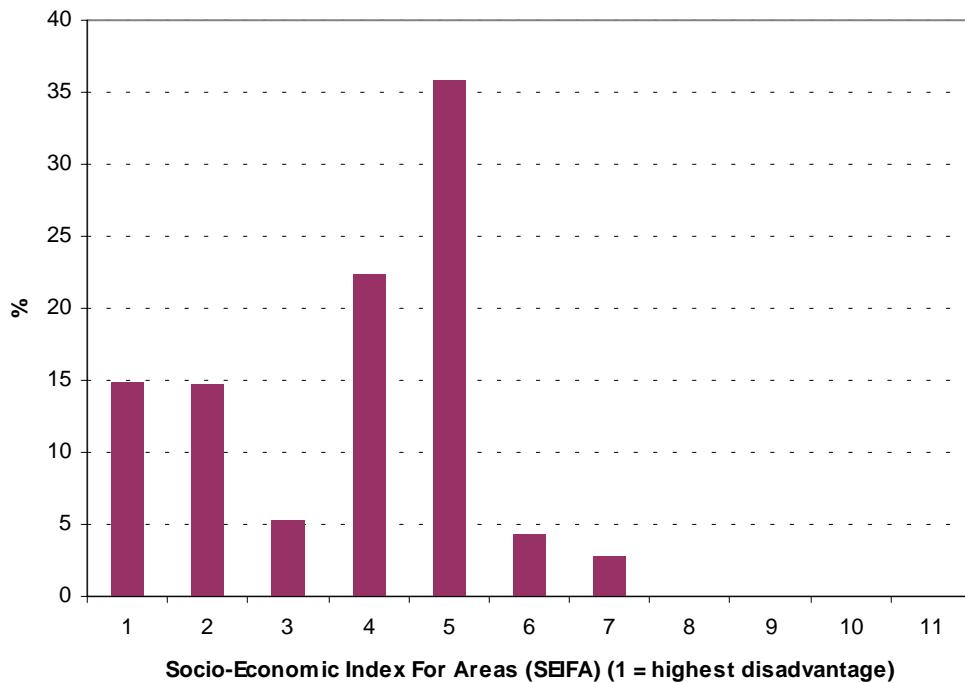
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

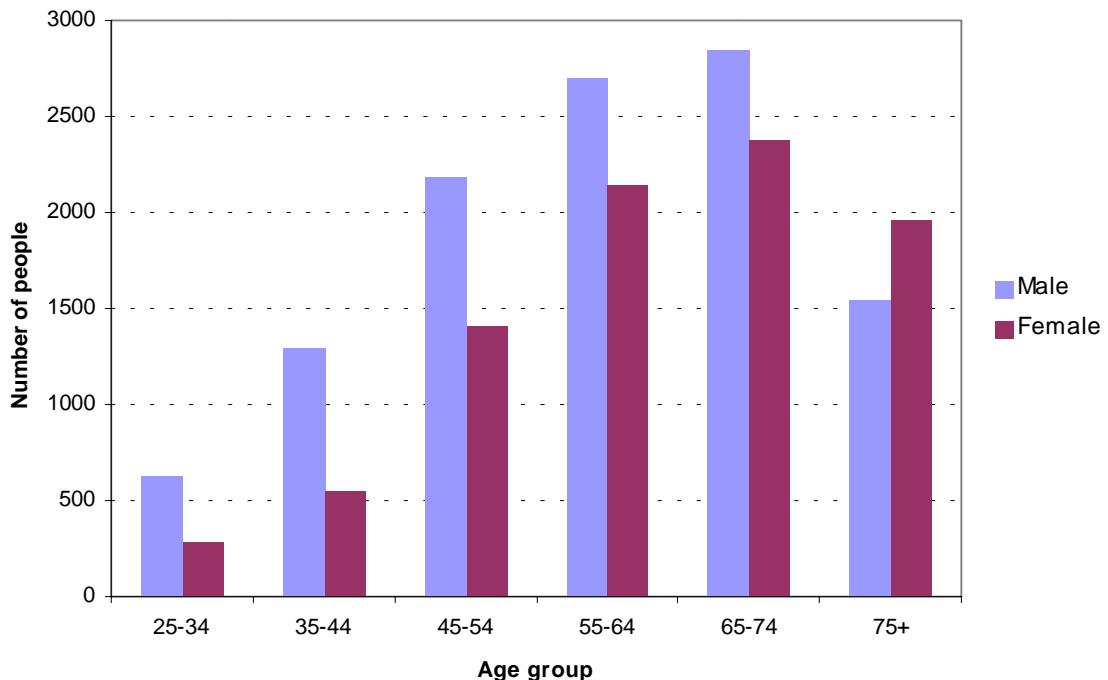
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

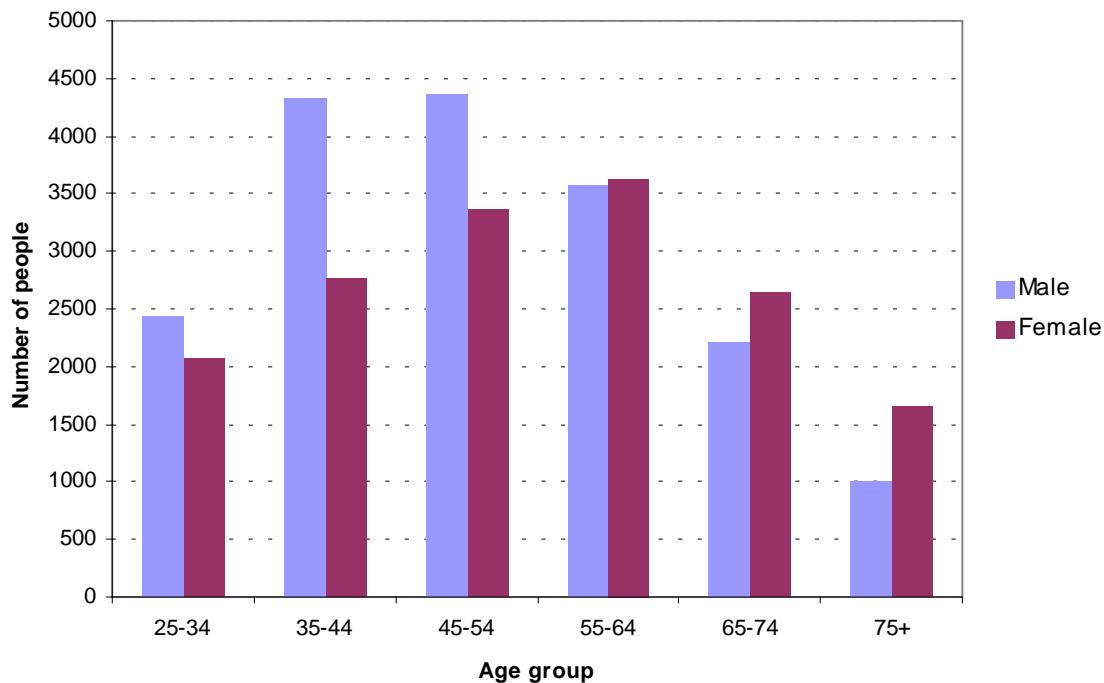
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



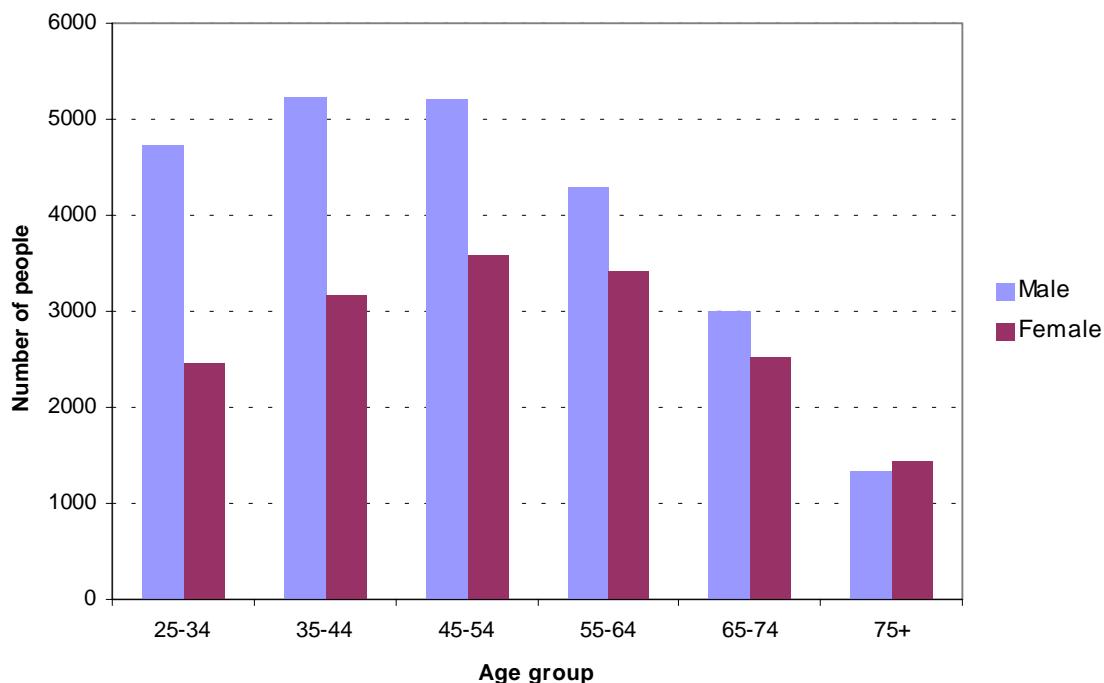
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



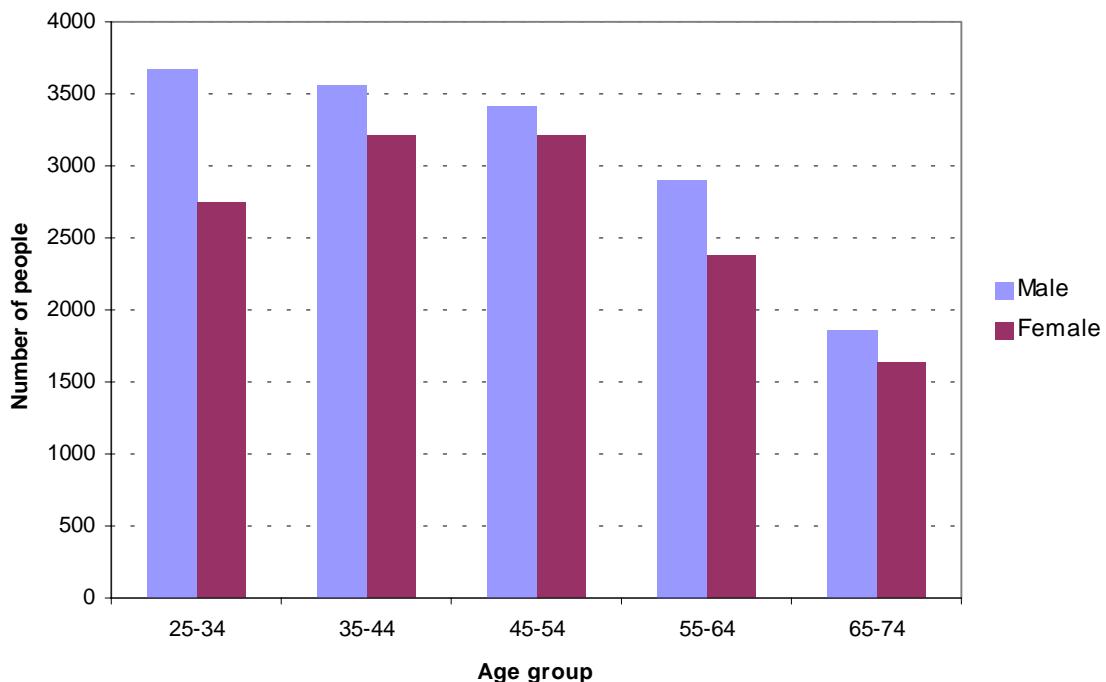
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



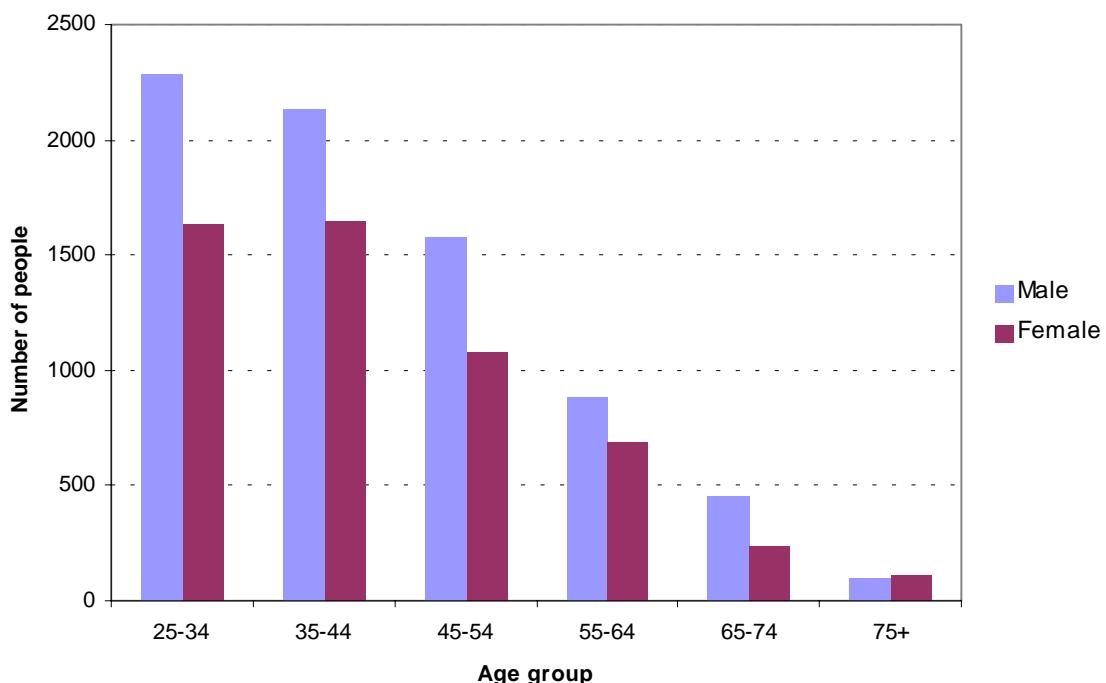
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 83 |
|-----------------------------------------------|-------|----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Division employs three diabetes educators (2.2 FTE), one Aboriginal Health Worker and two (1.5 FTE) psychologists and has service contracts with private podiatrists, dieticians – More Allied Health Services (MAHS),
 - Division employs two dietitians, one podiatrist, two physiotherapists, two occupational therapists, two psychologists – Regional Health Service, Mt Isa,
 - Queensland Health Services Palm Island with full diabetes team – one day per month,
 - Sporadic services elsewhere throughout Divisional area,
 - Division funds MAHS another day per month.

- What services are needed but are not available in your Division area?
 - Ophthalmology,
 - Diabetes educators in North West of area (Mt Isa & Gulf),
 - Dedicated Aboriginal Health Workers.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time? N/A.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Clinical audits of all identified patients with diabetes in 85% of practices (including an Aboriginal Medical Services – AMS, and Royal Flying Doctor Service - RFDS). Approximately 1200 patients in initial and 1100 patients in follow-up audits. Practice nurse training in diabetes management – all nurses trained – two went on to become Diabetes Educators – now employed by Divisions. Use of MAHS funds to employ three diabetes educators and service contracts with podiatrists, dietitians, occupational therapists, physiotherapists and psychologists.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Almost complete absence of Queensland Health Allied Health Services. No GPs in three large Indigenous communities, where Queensland Health has not welcomed Division program.
- What future plans do you have for diabetes management in your Division?

Division has just become National Diabetes Supply Scheme Sub Agency – implementing this over next 6 months. At least 1 further clinical audit. Increased role in Indigenous communities – recent approval from Queensland Health Chronic Disease Self Management training.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

In our Division, the critical barrier was an almost complete lack of access to allied health professionals. As that barrier is overcome, uptake has greatly increased. However, the other critical factor has been the development of practice-specific IMIT and practice management systems to facilitate uptake.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Queensland Health – strong alliance with Diabetes Centre in Townsville. Three years ago they accepted request to allow practice nurses to attend nurse diabetes training. They now mentor and greatly support Division, diabetes educator and nurses. Diabetes Australia Queensland – networking – now a National Diabetes Supply Scheme (NDSS) sub-agency. University of New South Wales, Centre for GP Integration Studies (CGPIS) – collaborative research and evaluation projects.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

RACGP Diabetes Management in General Practice.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Developed very little. Have modified other resources.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? No.

- What resource materials do you provide to practices? As diabetes educators operate in all practices, they provide whatever resources are required. Good support from Diabetes Australia Queensland, drug companies.

Division Contact Person/
Program Co-ordinator

Name: Ross Nable
Phone: 07 4725 8868
Fax: 07 4725 5122
Email: rossn.nqrdfp@bigpond.com

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - The Townsville Hospital: Phase 2 – eight week program. Phase 3 – weekly program at Fit for Life Gym,
 - Mater Private Hospital: Phase 2 – eight week program and one week information sessions,
 - Charters Towers: Phase 2 – six week program,
 - Huhenden and Richmond programs run by Charters Towers (two day workshops),
 - Mt Isa: Four week Phase 2 program.

- What services are needed but are not available in your Division area?
 - Indigenous health workers require training/resources to deliver programs within remote areas,
 - GP/home-based programs for remote areas.

CVD Program Description

- In which years did you have a CVD project or program operating:

- Please describe your CVD program including any changes that occurred over time?

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

Cardiac Outreach Program commenced 1997. Clients referred by cardiac educators/unit nurses/GPs. Initial education by Outreach Coordinator (information package sent if in remote area). Baseline health data collected and client's GP notified. Follow-up at 2, 6, and 12 months. Newsletter, information and letter for GP sent to client. Client to see GP and progressive data sent to Outreach Coordinator. Clients able to contact coordinator for information or support. The Outreach Program was designed to support clients with limited or no access to other rehab programs.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Support for clients living in remote areas/or those unable to access other cardiac rehab programs.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What future plans do you have for CVD management in your Division? N/A.
▪ Based on your experience, what advice would you give to a Division planning or implementing a CVD program? Implement a community-based approach.
▪ What type of strategic alliances or linkages do you have with external organisations and how have you developed them? <ul style="list-style-type: none">• Strong links with all cardiac hospital staff within Divisional boundaries – sharing of resources and inclusion in planning,• National Heart Foundation – involvement at a local level. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

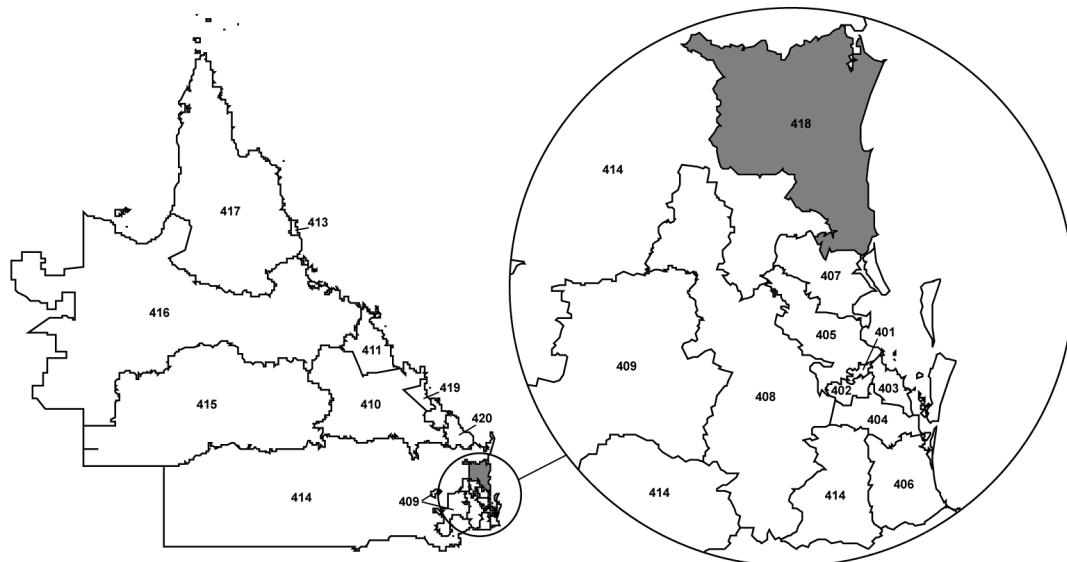
Division Resources

- | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">▪ What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)? <ul style="list-style-type: none">• National Heart Foundation resources,• Commonwealth health resource material.
▪ What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions? Healthy Heart Guide – Information package developed by Division.
▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
▪ What resource materials do you provide to practices? N/A. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Division Contact Person/
Program Co-ordinator

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Email: rossn.nqrdfp@bigpond.com

Sunshine Coast DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	279,370	
■ Aboriginal or Torres Strait Islander	3384	1.2%
■ Speaks language other than English at home	8853	3.2%
■ RRMA classification ¹		
3: Large rural	117,335	42.0%
4: Small rural	84,090	30.1%
5: Other rural	77,944	27.9%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	17,727	9.2%
■ High blood pressure ⁴	65,729	34.3%
■ High blood cholesterol ⁵	102,389	53.4%
■ Obese or overweight ⁶	117,733	61.4%
■ Physical inactivity ⁷	79,989	41.7%
■ Smoking ⁸	34,240	17.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

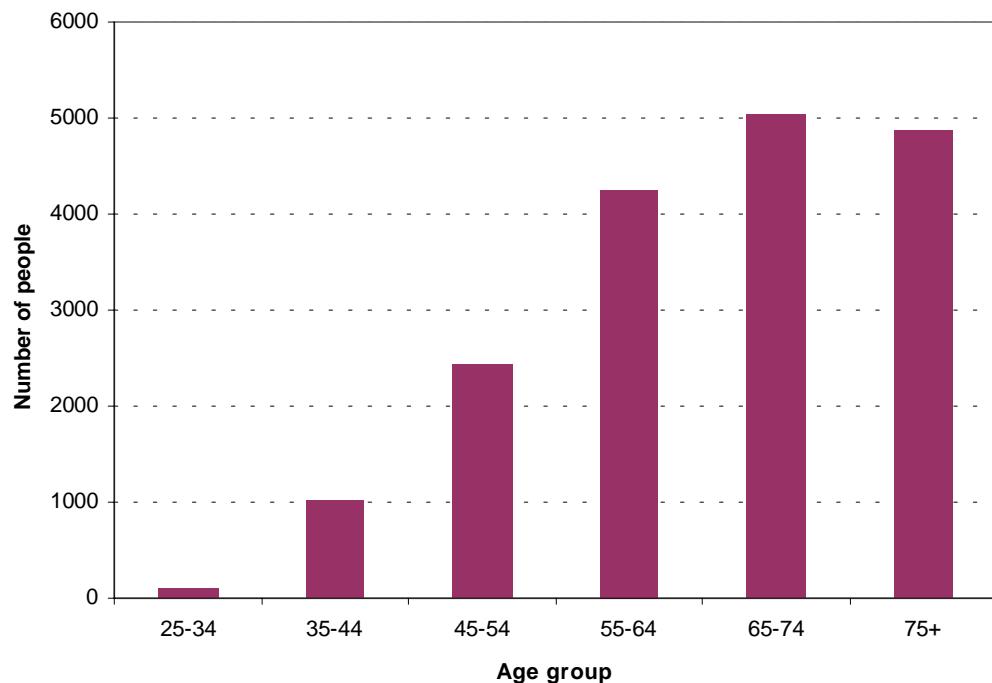
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

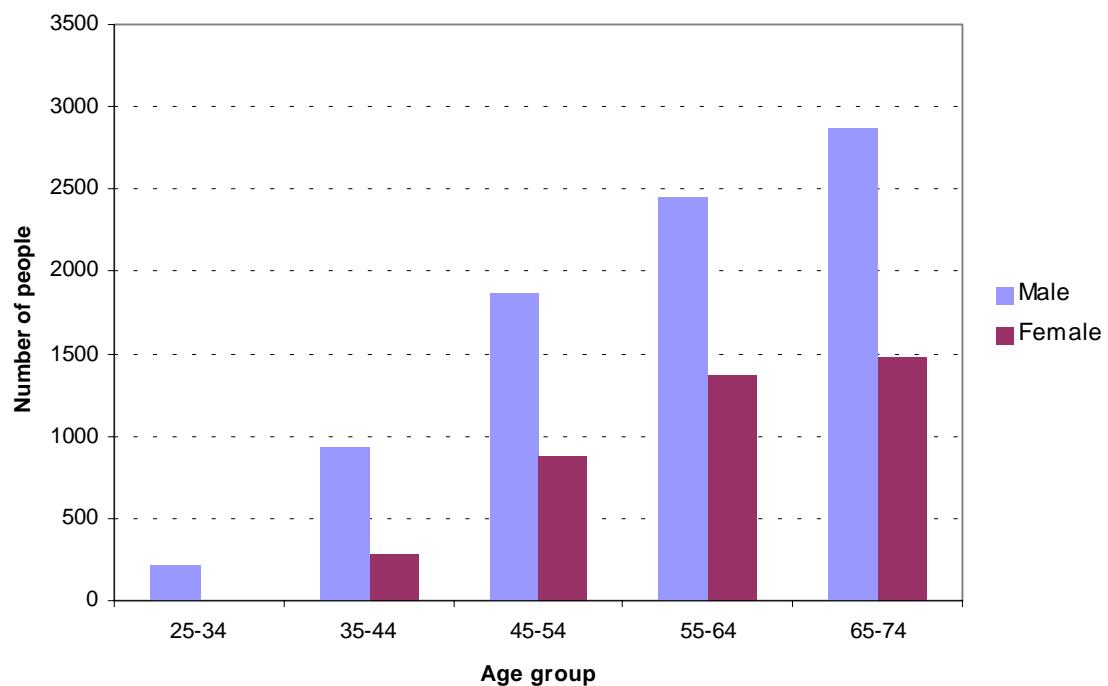
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



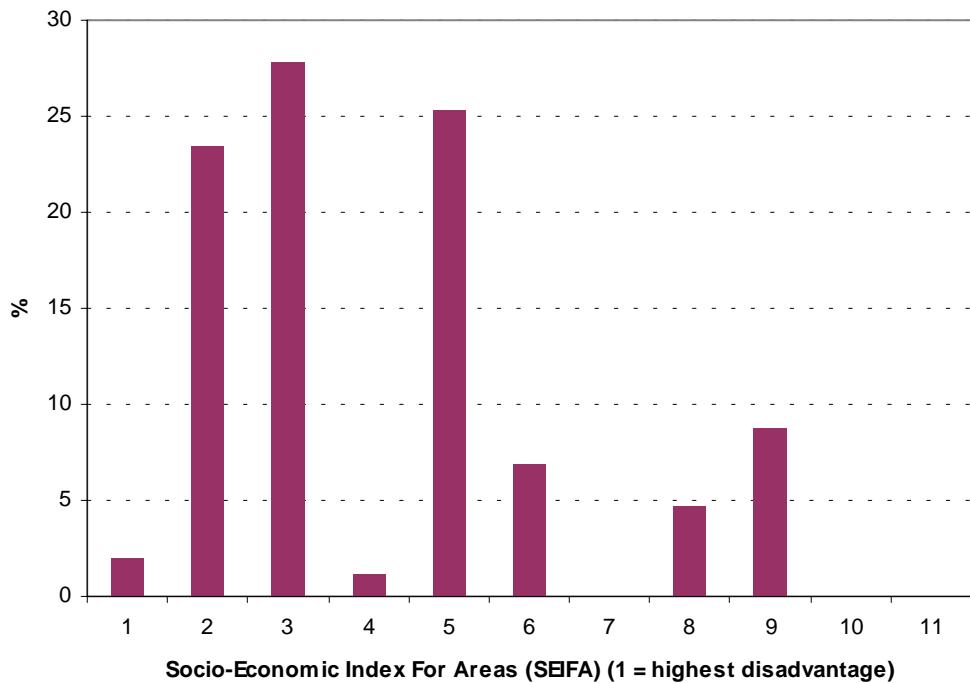
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

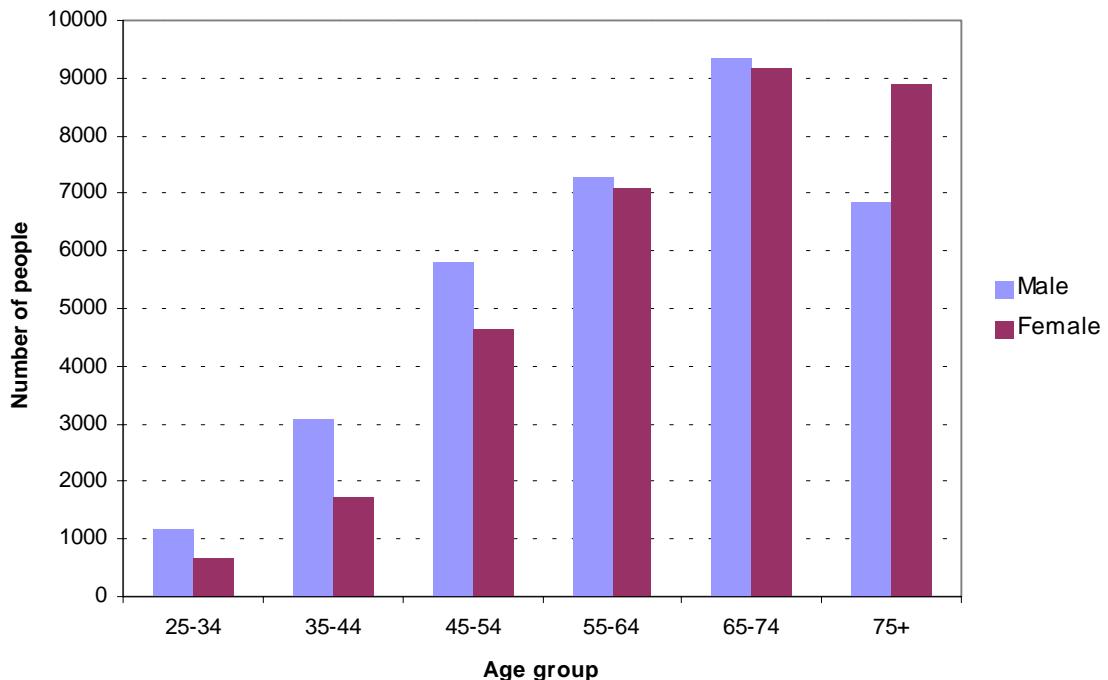
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

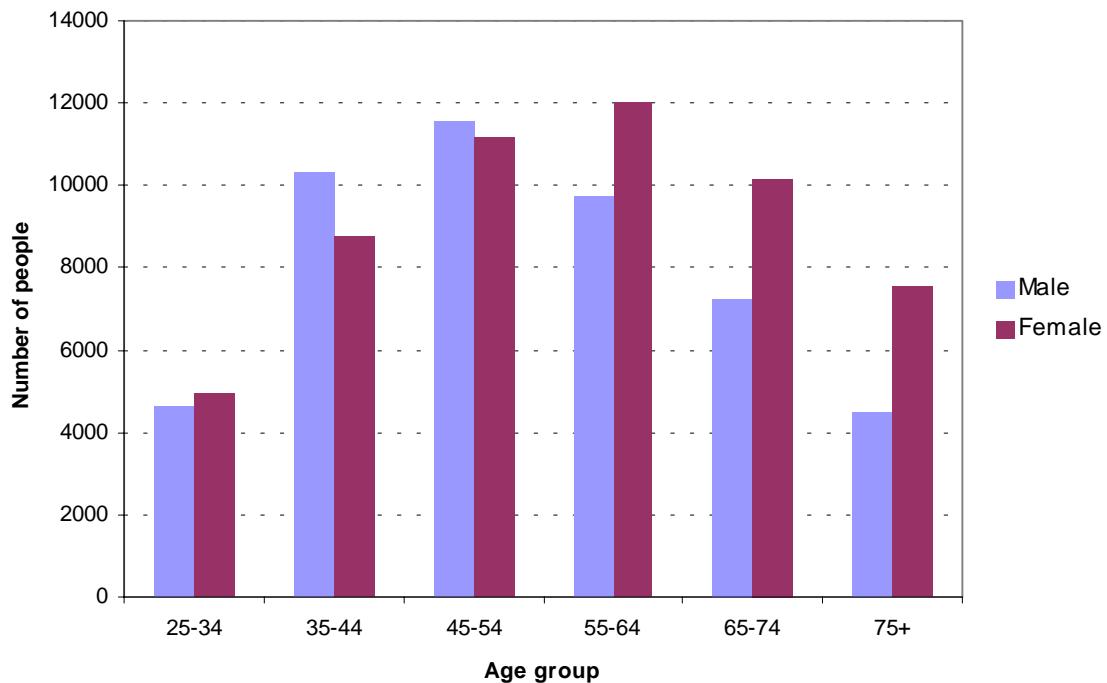
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



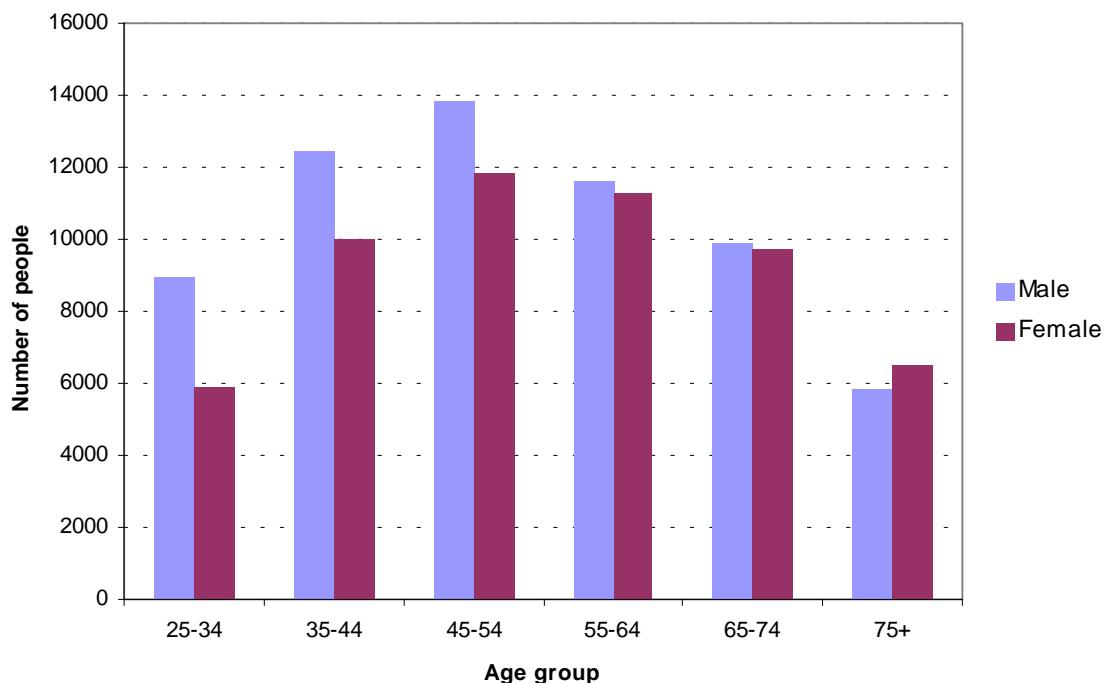
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



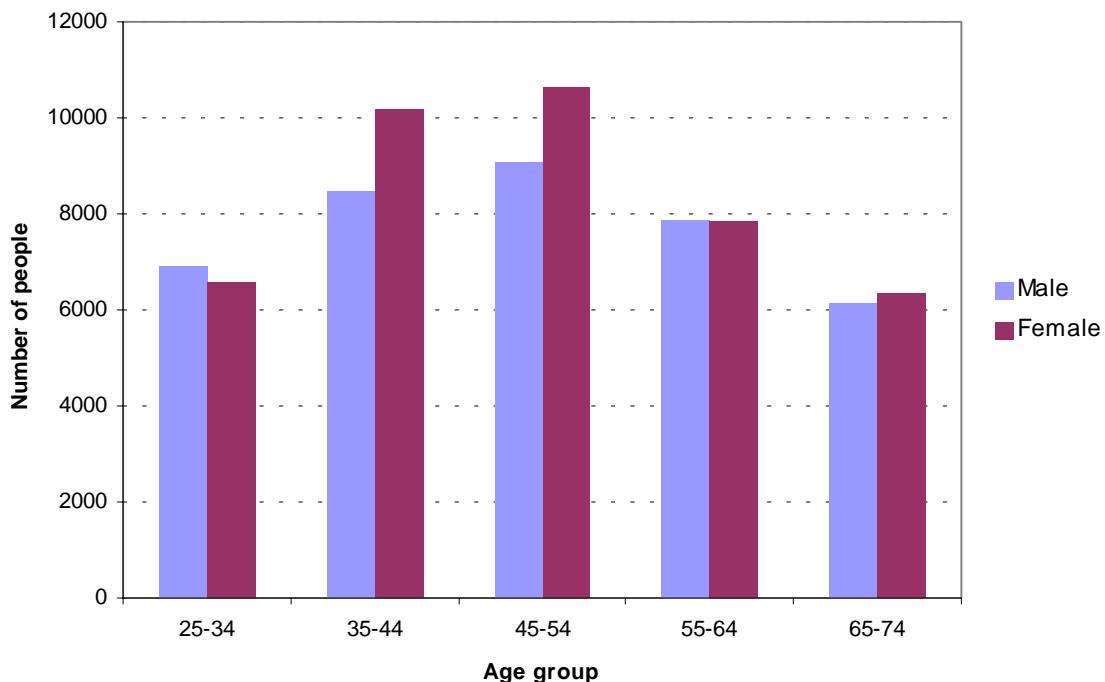
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



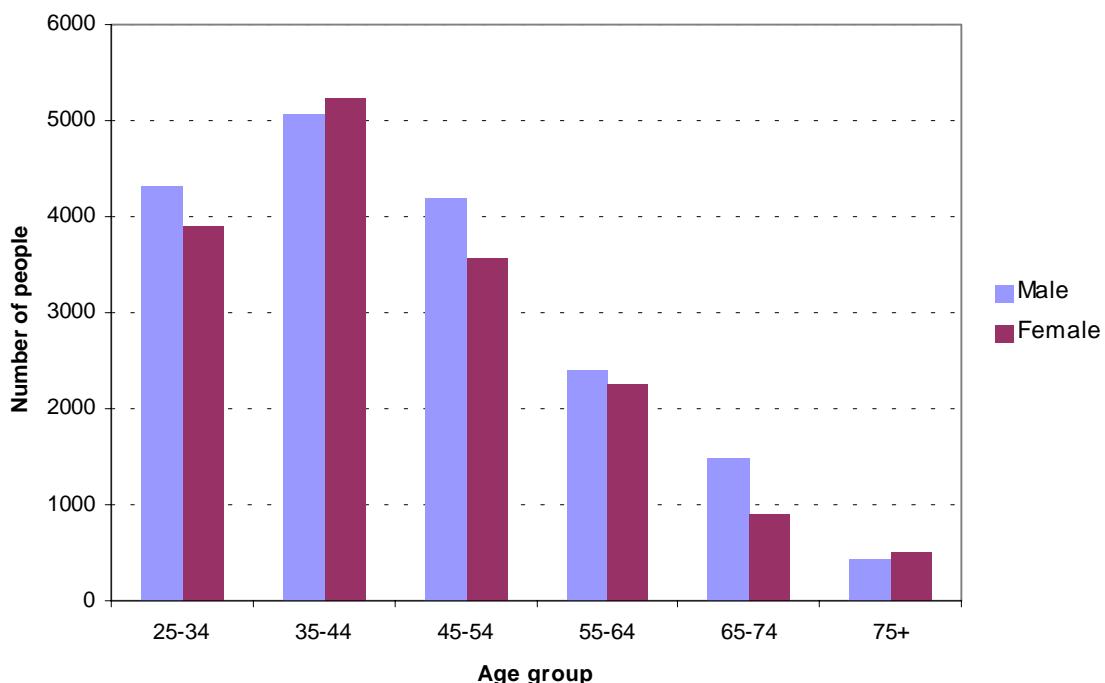
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 322 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Centre at Nambour, offering diabetes nurse educator and dietitian,
 - Diabetes Centre at Gympie, offering limited services, diabetes nurse educator and dietitian.

- What services are needed but are not available in your Division area?
 - Leg ulcer clinic (not only, mainly for diabetes),
 - Awareness activities for the community on the risk factors for diabetes,
 - Awareness activities for GPs on the services available.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995

 - 1996
 - 1997
 - 1998
 - 1999

 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?
 - Division funds Queensland Health, to provide diabetes nurse educator to work in general practice,
 - Support for Lighten Up to a Healthy Lifestyle program, a weight management and lifestyle program conducted by Queensland Health.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Greater use of care plans by GPs,
 - Increased appreciation of role of diabetes educators.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for diabetes management in your Division?

Active Script project has been developed over the last six months and will be piloted soon.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Having a practice manager,
 - Having a practice nurse,
 - Practices with systems in place.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Service agreements with the two District Health Services within the area of the Division, for the provision of services described earlier,
 - Informal but very successful partnership with Public Health Unit and other agencies for Active Script.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

N/A.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Active Script resources, when complete, if approved by partners in the project.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

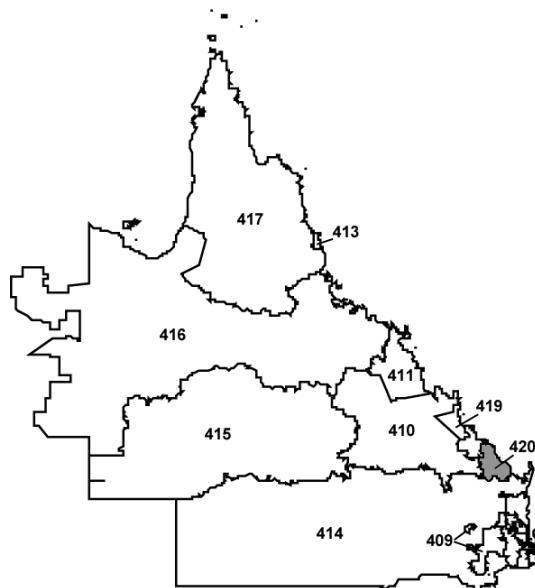
- What resource materials do you provide to practices?

Until now, we have provided videos, pamphlets, posters, and CD-ROMs with templates and referral forms, but no plan to continue these, as the time consumed has been misappropriate to identified benefits. Will continue distribution of Diabetes Record Card and selected other resources.

Division Contact Person/
Program Co-ordinator

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Wide Bay DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	155,548	
■ Aboriginal or Torres Strait Islander	4080	2.6%
■ Speaks language other than English at home	3919	2.5%
■ RRMA classification ¹		
3: Large rural	125,527	80.7%
5: Other rural	30,021	19.3%
■ SEIFA category containing population median: ²	2	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	9999	9.5%
■ High blood pressure ⁴	36,999	35.1%
■ High blood cholesterol ⁵	56,754	53.8%
■ Obese or overweight ⁶	65,227	61.8%
■ Physical inactivity ⁷	44,062	41.8%
■ Smoking ⁸	18,622	17.7%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

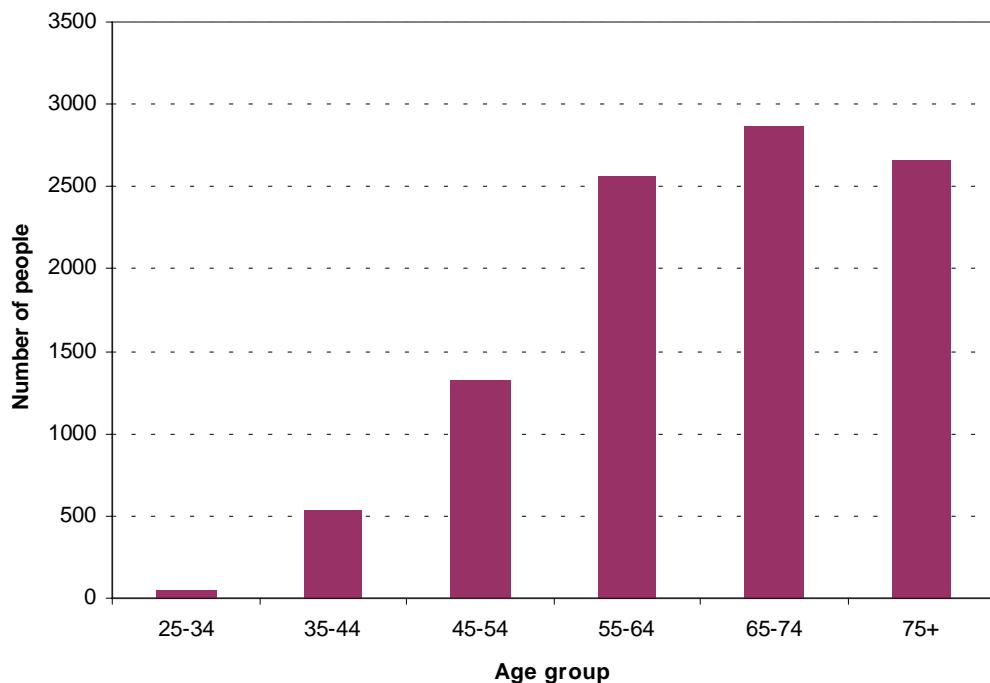
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

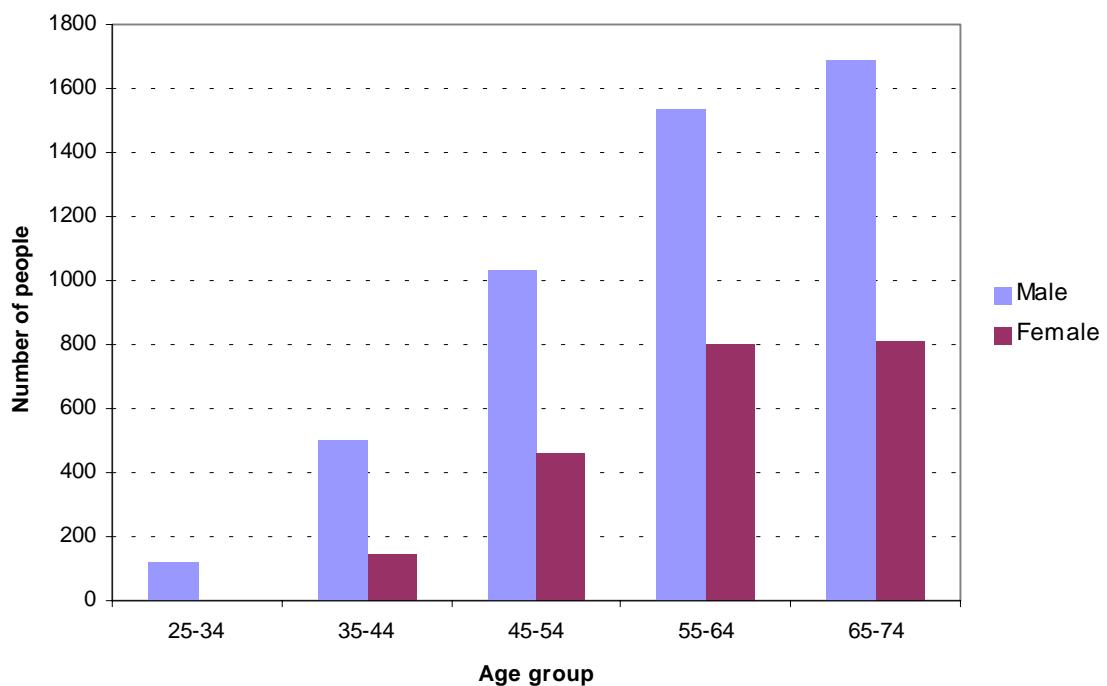
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



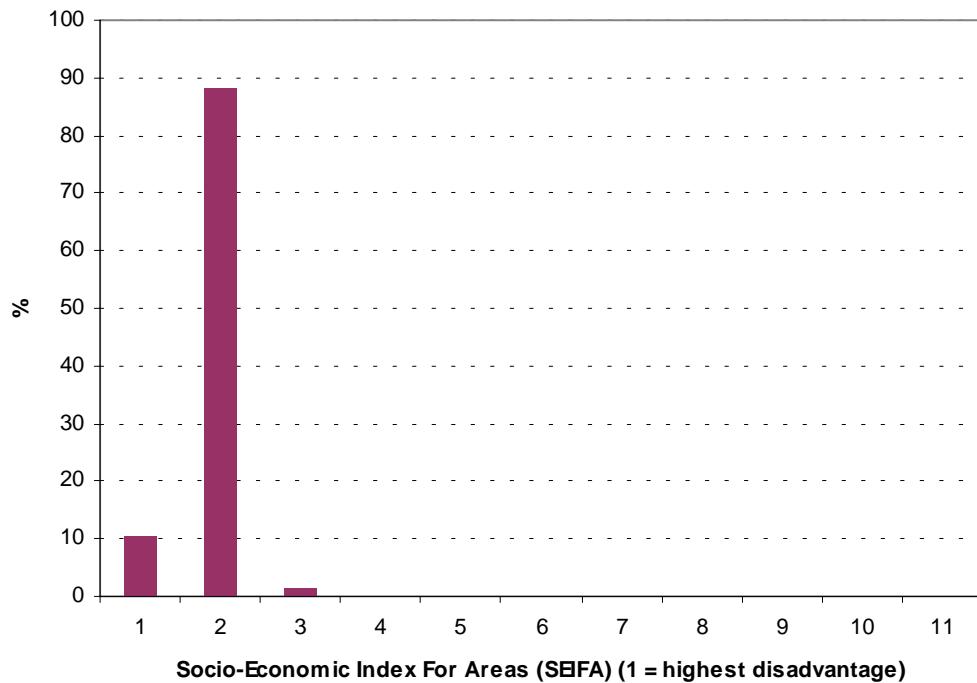
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

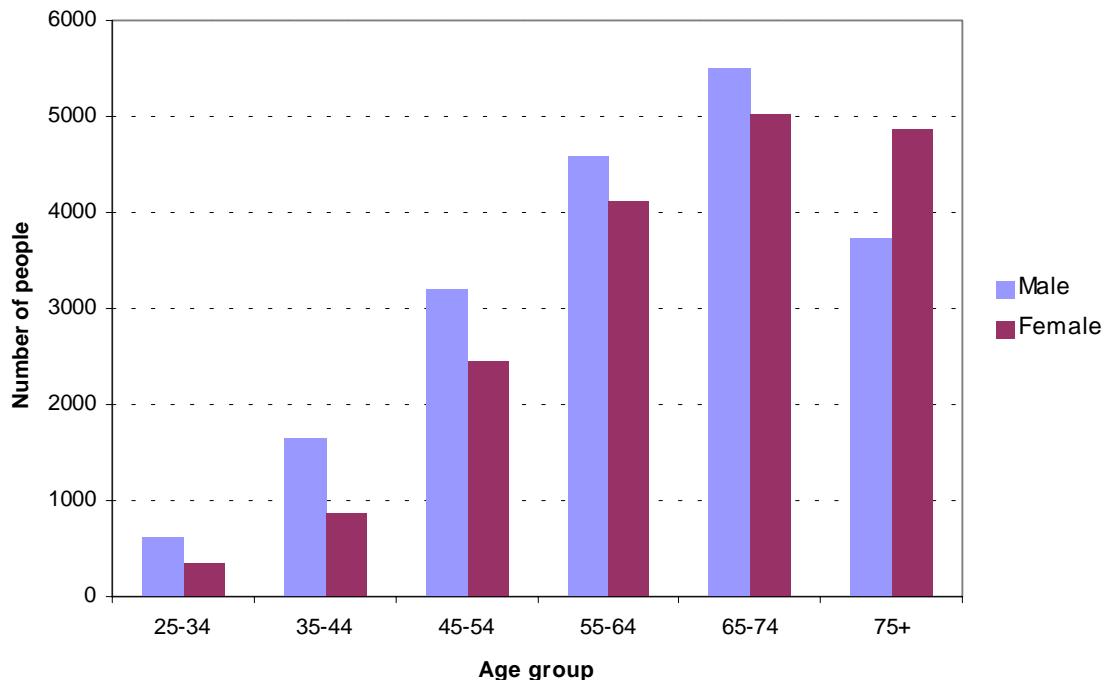
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

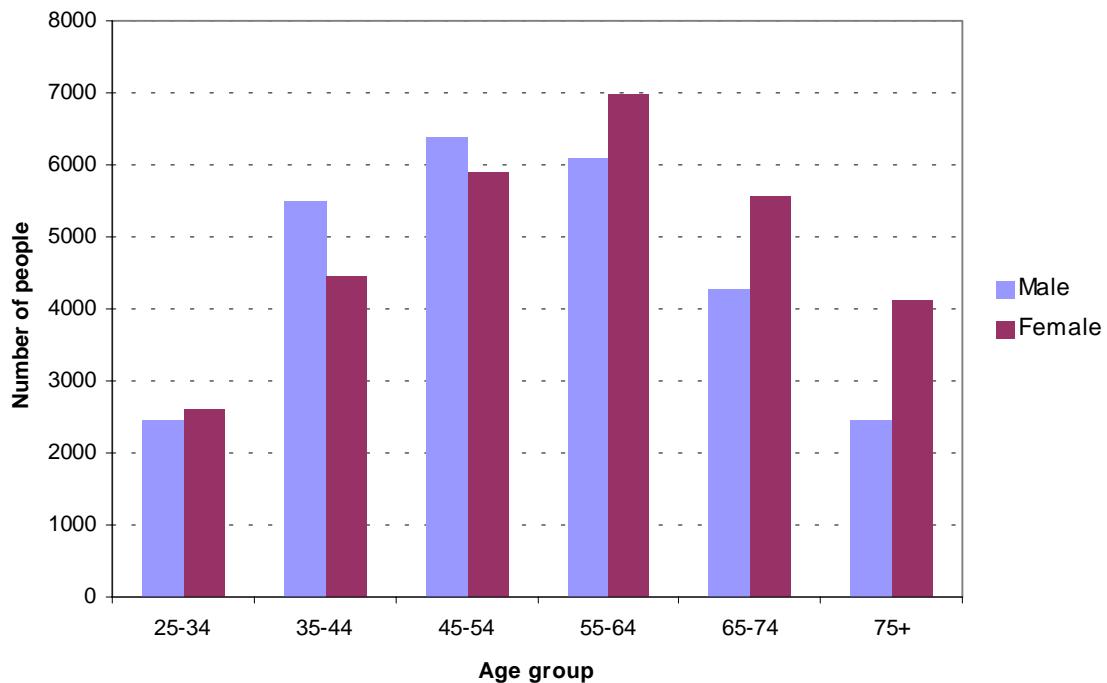
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



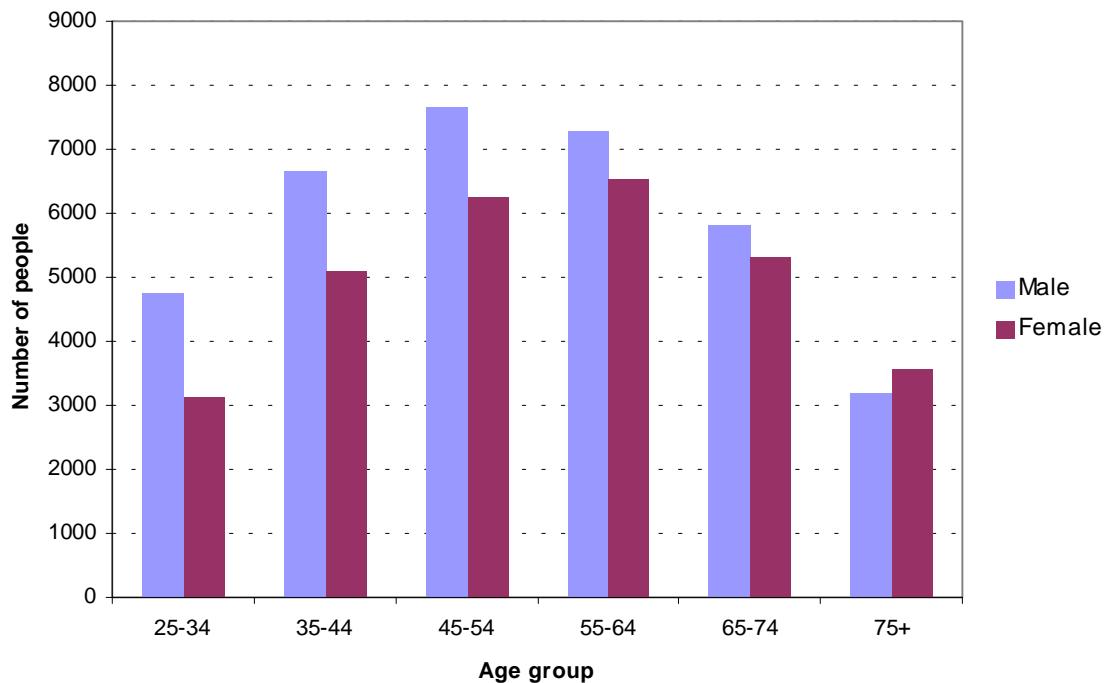
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



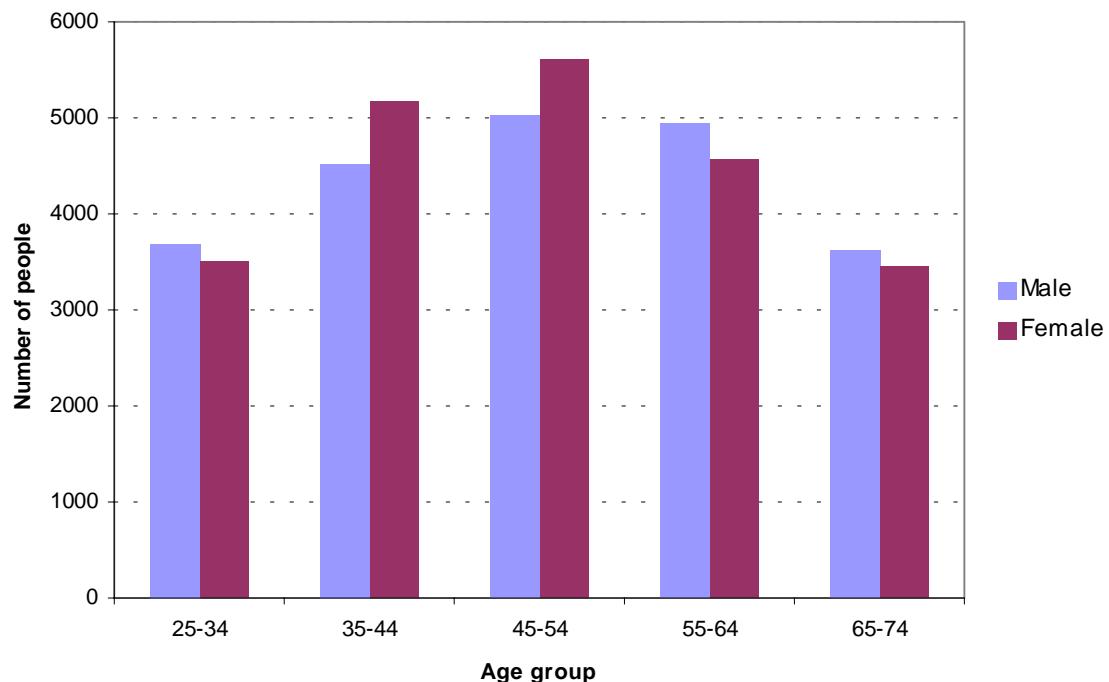
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



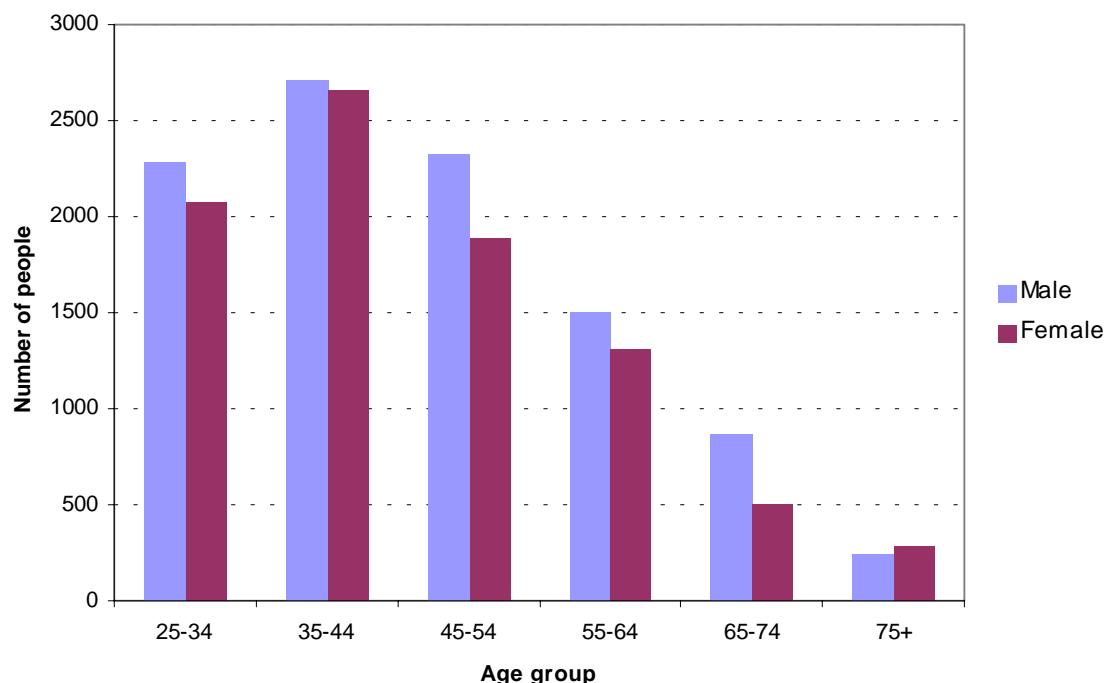
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 152 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - One private diabetes educator – Bundaberg,
 - One hospital diabetes educator – Bundaberg,
 - One More Allied Health Service (MAHS) diabetes educator,
 - Two private podiatrists – Bundaberg,
 - One MAHS podiatrist,
 - One private dietitian – Bundaberg,
 - One hospital dietitian shared for MAHS program.

- What services are needed but are not available in your Division area?
 - More allied health services.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

Diabetes program – includes Diabetes Outreach Team, (diabetes educator, dietitian, podiatrist), that visit rural areas once per fortnight – part of MAHS program. Team contracted from Queensland Health and Blue Care. Receives referrals from GPs. Also Divisional support to GPs for Diabetes Care Pathways soon to commence.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Getting the Outreach team off the ground.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Finding the allied health service providers to participate (scarce),
 - Finding venue to practice out of,
 - Encouraging GPs to refer.

- What future plans do you have for diabetes management in your Division?
 - Continuance of Outreach team,
 - Working with GPs in the practice with improving care for diabetic population from register through to referral and care planning.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- Ability to adapt to new situations,
- Readiness to trial new ways of doing things,
- Team approach to the running of the practice,
- Willingness to seek help from the Division.

Partnership with Queensland Health identified need for Outreach Diabetes Team. Queensland Health had vested interest as they came from their local Diabetics Outcome Group. Partnership with Blue Care, which assists them in delivering care to their target group. Local private providers in diabetes have been involved in MAHS as GPs in town see clients from MAHS eligible postcodes and refer to town service if suits the client.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

- What resource materials do you provide to practices?

Nil developed by this Division.

Not sure.

Just commencing planning for this, therefore have not provided much to practices to date.
Information only on Diabetes Initiative: National Prescribing Services Resources, Diabetes Pathway.

Division Contact Person/
Program Co-ordinator

Name: Ngaire McRae
Phone: 07 4151 0814
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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Bundaberg and surrounds
 - “Heart Start” Cardiac Rehab and Secondary Prevention Program,
 - Cornish Walking Program Fraser Coast,
 - Hospital cardiac rehab program,
 - Bundaberg (private) – cardiac nuclear diagnostic medicine.

- What services are needed but are not available in your Division area?

Specialists in cardiology.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The Division allocates funds annually and is represented on the board of the Bundaberg Health Promotions Association, which care-takes “Heart Start” – a Bundaberg wide cardiac rehabilitation and disease prevention program. The Division, therefore, works closely with the Director of Heart Start to improve GP referrals and education and support. The Division is also undertaking a major physical activity project that will enhance Heart Start.

Division Perspective

- What have been the major achievements or highlights of your program so far?

The Division has been involved with an award winning Men’s Health exercise at the major regional agricultural show where GPs worked on site to consult high risk men about their heart risk.
Worked with Men’s Tune Up and Heart Start. Won award with local show as well as Heart Foundation.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Financial.

- What future plans do you have for CVD management in your Division?
 - Continue to assist cardiac rehab and referral systems,
 - Implement major physical activity strategy.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Not sure.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Alliances with all hospitals (public and private) in Bundaberg via Heart Start and our position on board of Bundaberg Health Promotions. Alliances commencing for physical activity project with local fitness centres and other health professionals.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

Once again, the Division does not provide direct service delivery, therefore, resources are service providers domain in Heart Start.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Nil developed by this Division.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

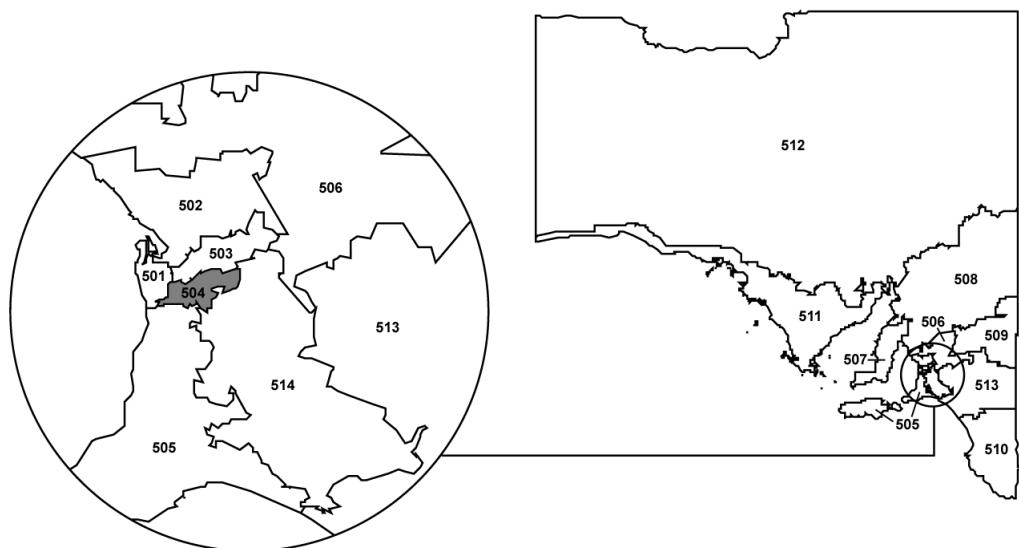
Have not encountered this as just commencing.
- What resource materials do you provide to practices?

National Prescribing Service Resources.

Division Contact Person/
Program Co-ordinator

Name: Ngaire McRae
Phone: 07 4151 0814
Fax: 07 4151 0794
Email: ihs@bundaberggp.org.au

Adelaide Central and Eastern DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	175,454	
■ Aboriginal or Torres Strait Islander	821	0.5%
■ Speaks language other than English at home	33,282	19.0%
■ RRMA classification ¹		
1: Capital city	175,454	100.0%
■ SEIFA category containing population median: ²	10	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,009	8.9%
■ High blood pressure ⁴	40,931	33.2%
■ High blood cholesterol ⁵	64,428	52.2%
■ Obese or overweight ⁶	74,477	60.4%
■ Physical inactivity ⁷	49,763	40.3%
■ Smoking ⁸	22,432	18.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

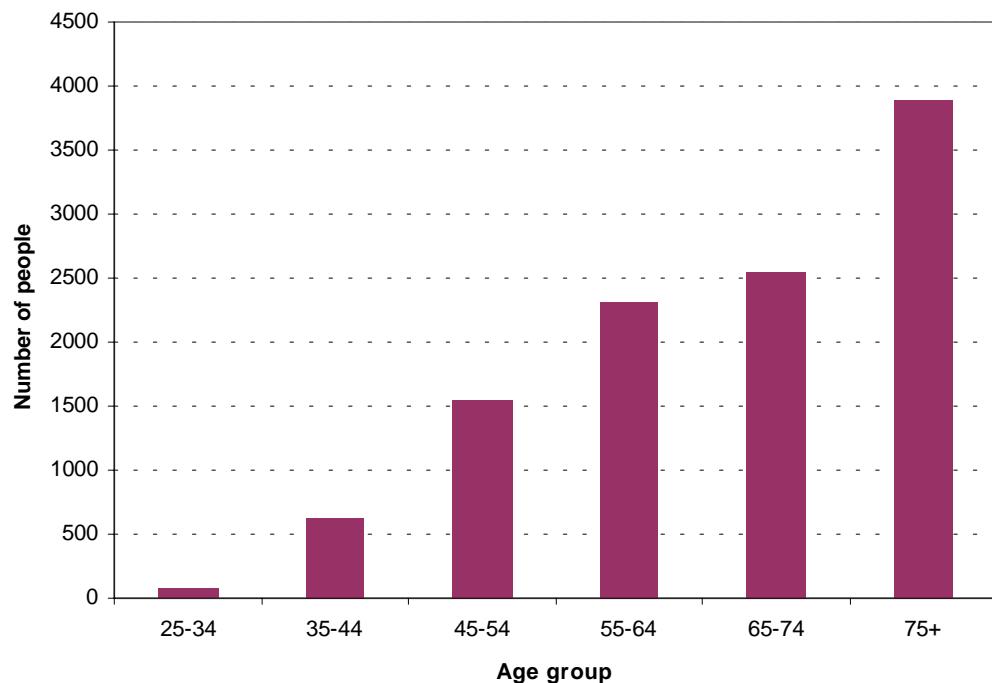
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

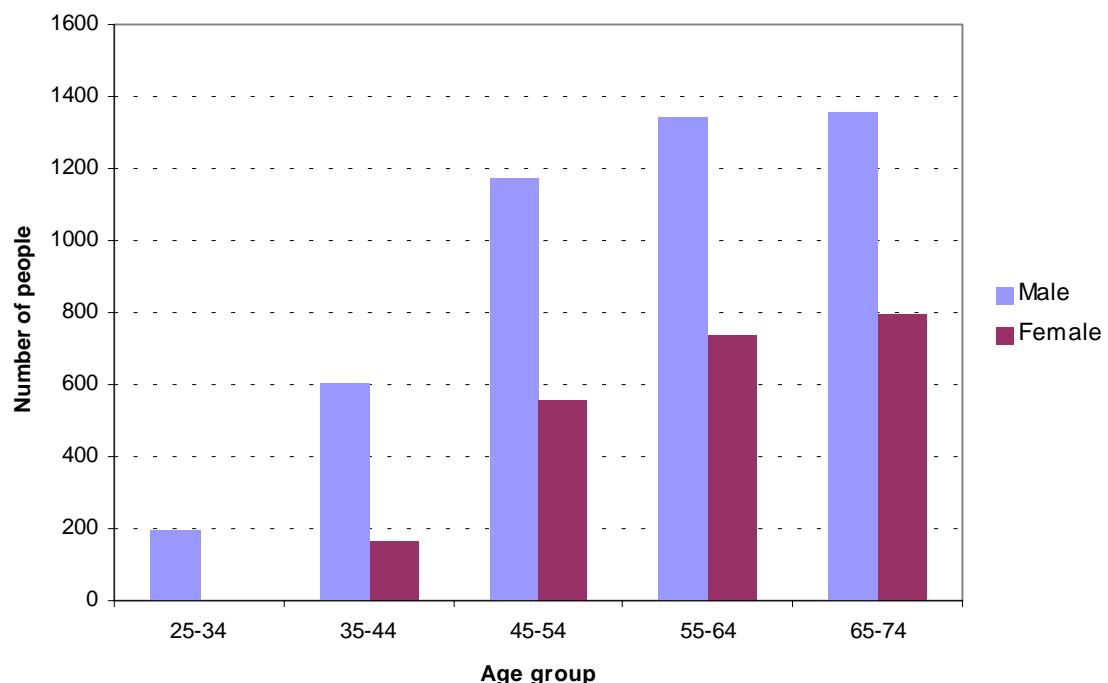
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



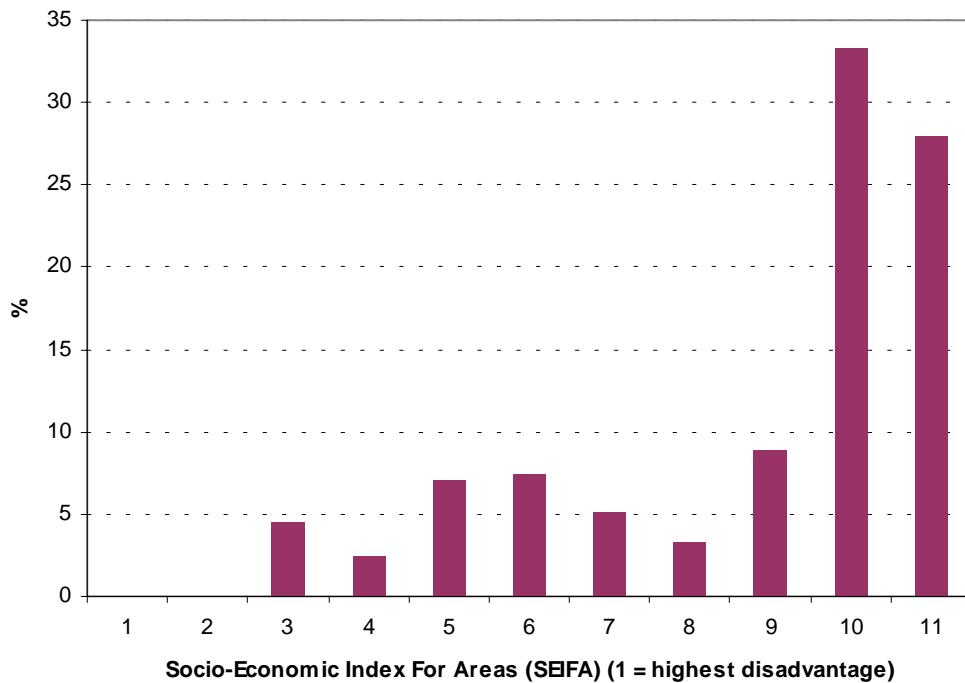
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

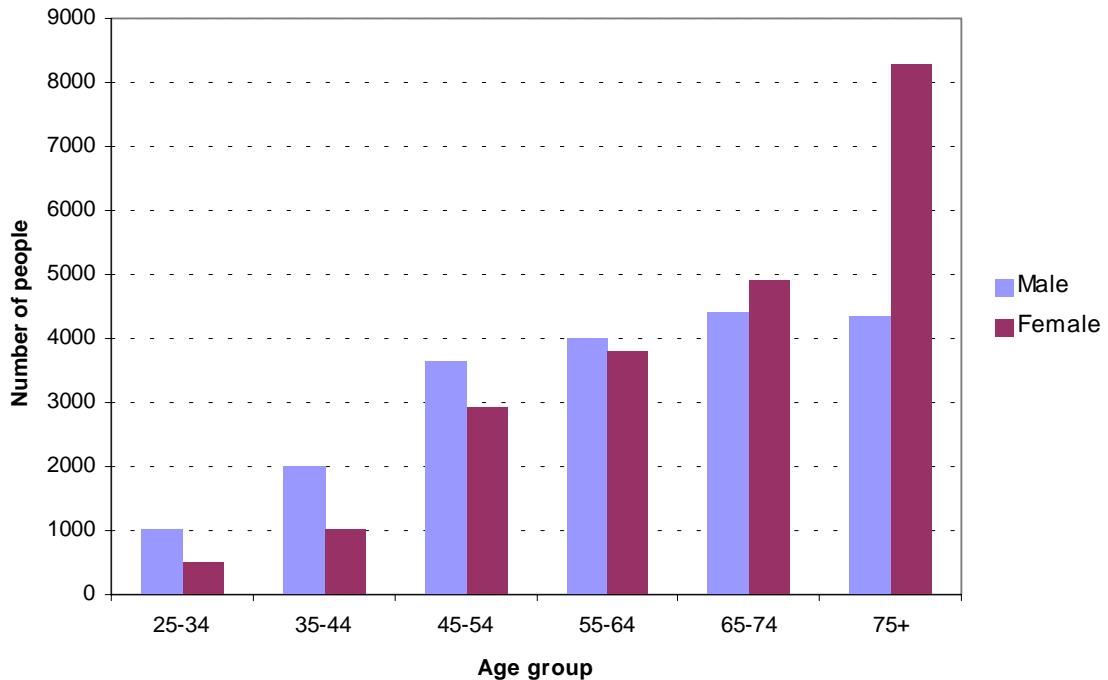
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

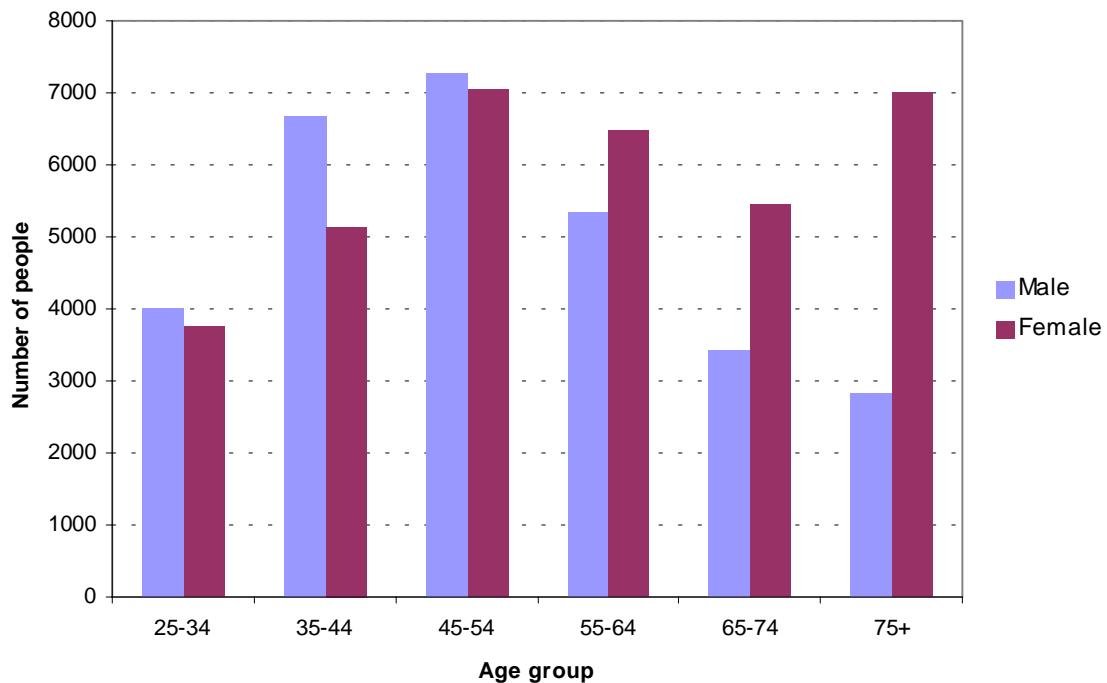
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



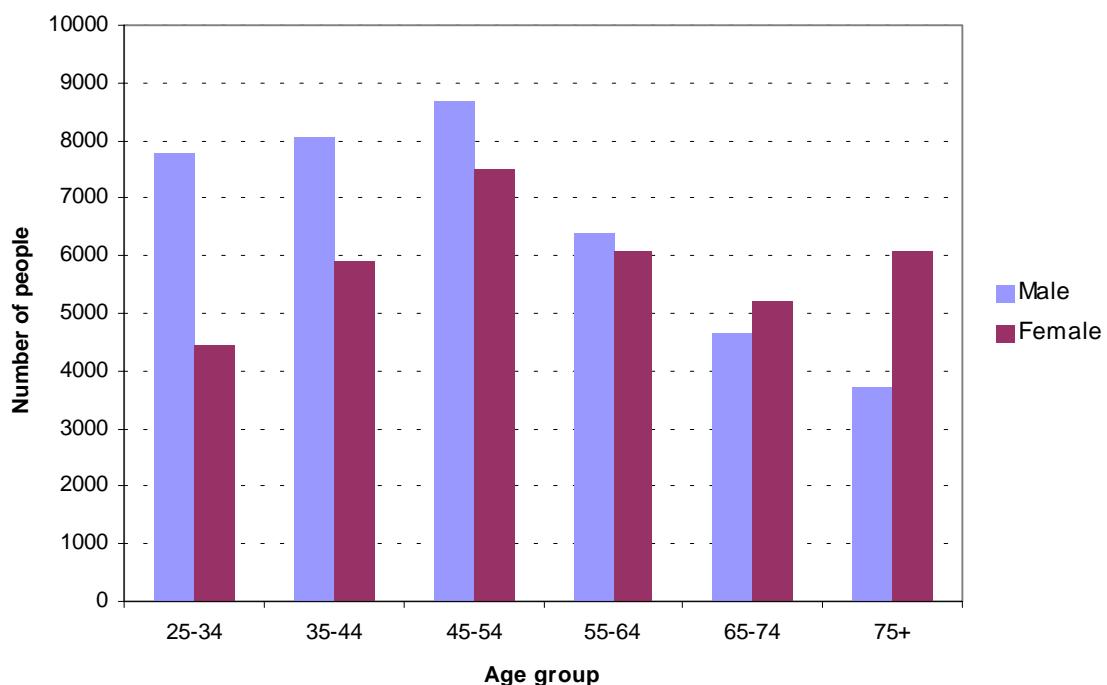
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



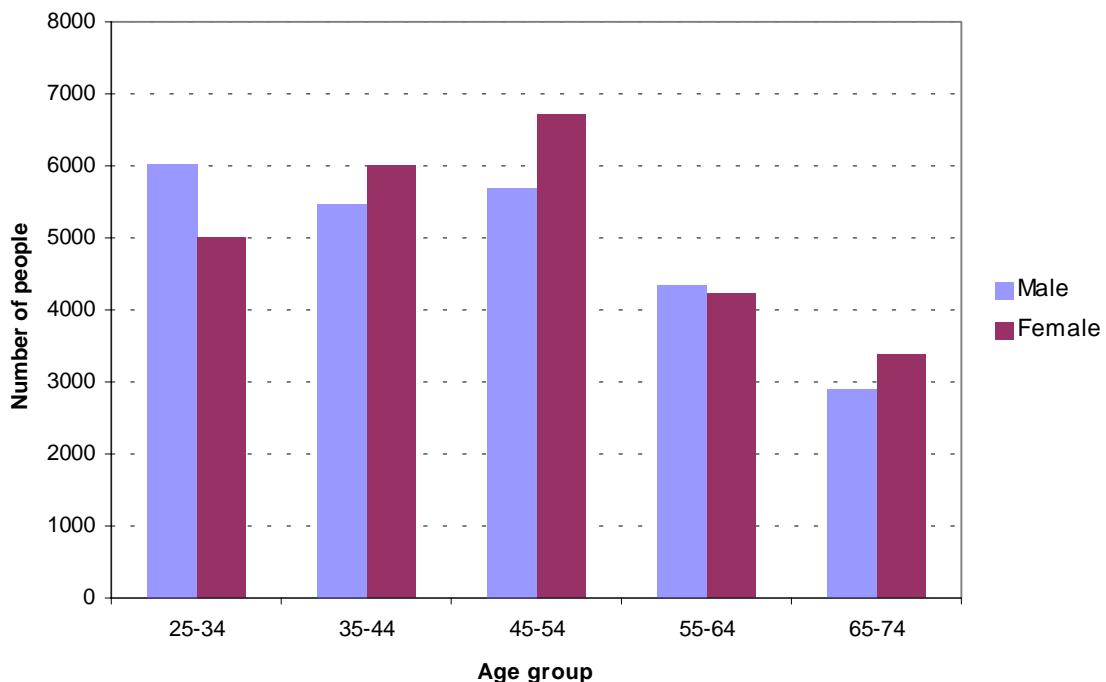
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



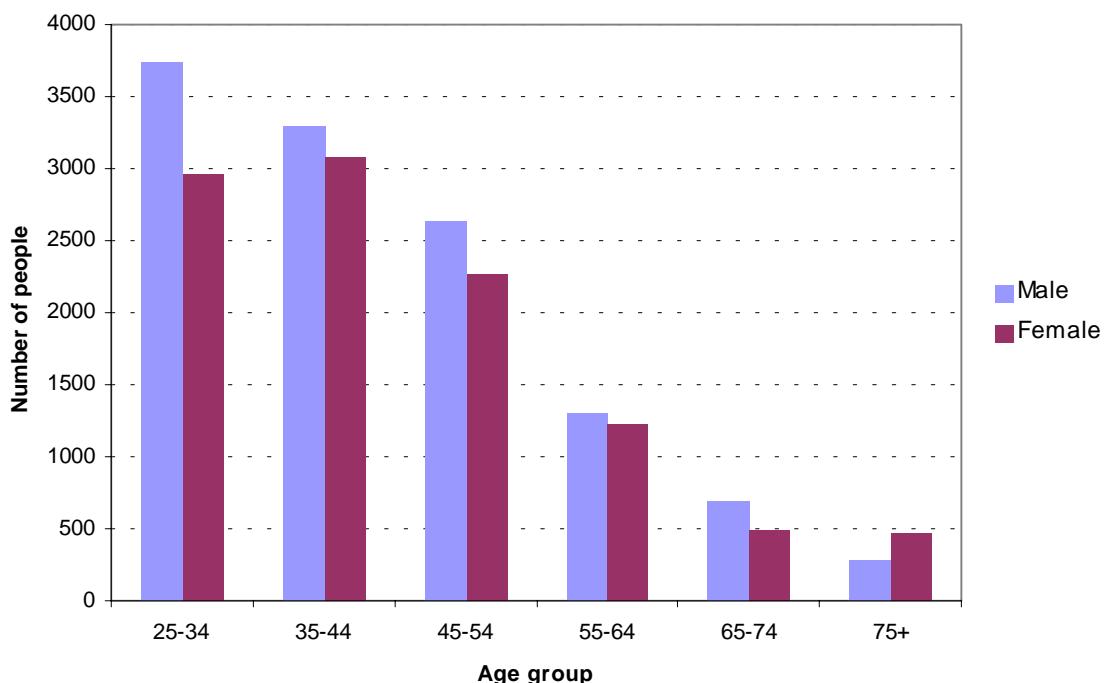
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 359 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Royal Adelaide Hospital Diabetes Centre – public,
 - Burnside Hospital Diabetes Centre – private.

- What services are needed but are not available in your Division area?

Community Diabetes Centre with all relevant allied health services (diabetes educators, dietitians, podiatrist).

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Program includes:

 - Initial visit by Program Coordinator and GP Advisor (remunerated),
 - Specialist and allied health visits to practices (endocrinologist, dietitian, podiatrist),
 - One-off attachments to diabetes clinic at Royal Adelaide Hospital,
 - Assistance with diabetes register and recalls, Service Incentive Program (SIP), Practice Incentive Program (PIP) etc, and diabetes review and assessment tests.

Program has changed significantly. Diabetes Clinic with GP attachments has closed and we have been helping GP practices implement change by assisting with registers and recalls for diabetes review appointments.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The visit of an endocrinologist to each practice to discuss management issues has been extremely popular,
 - Audits pre and post program have shown significant changes in GP management of patients with diabetes, eg 36% increase in foot examinations performed,
 - To June 2002, 36 GPs have joined the program and 569 patients audited.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Funding limits number of GPs joining program,
 - Practice staff have difficulty finding time to implement recall systems.
- What future plans do you have for diabetes management in your Division?
 - Audits no longer to be performed by GPs as government funded PIP and SIP provide incentives for implementation of same processes we initiated,
 - Money saved (GPs were paid to do audits) is now being used to provide GPs with education sessions from a dietitian and podiatrist. Psychologist to be included later.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Individual and group dynamics are the keys to whether these programs work or not,
 - The GPs and all practice staff need to communicate effectively with each other regarding systems and processes.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Royal Adelaide Hospital (RAH) Diabetes Centre and endocrinologists – developed over time and strengthened by continued efforts from Program Coordinator and Program GP Advisor,
 - Adelaide Central Community Health Service (ACCHS) – Dietitian and nutritionist keen to remain involved with combined RAH, Division, ACCHS patient education courses (coordinated by the Division) for Italian speaking diabetes patients and a course for patients with impaired glucose tolerance.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - We encourage use of the diabetes record tool on Medical Director, which assists with an accurate register and claiming of Practice Incentive Program (PIP) and Service Incentive Program (SIP),
 - We will provide (if required) a Division designed twelve monthly and three monthly

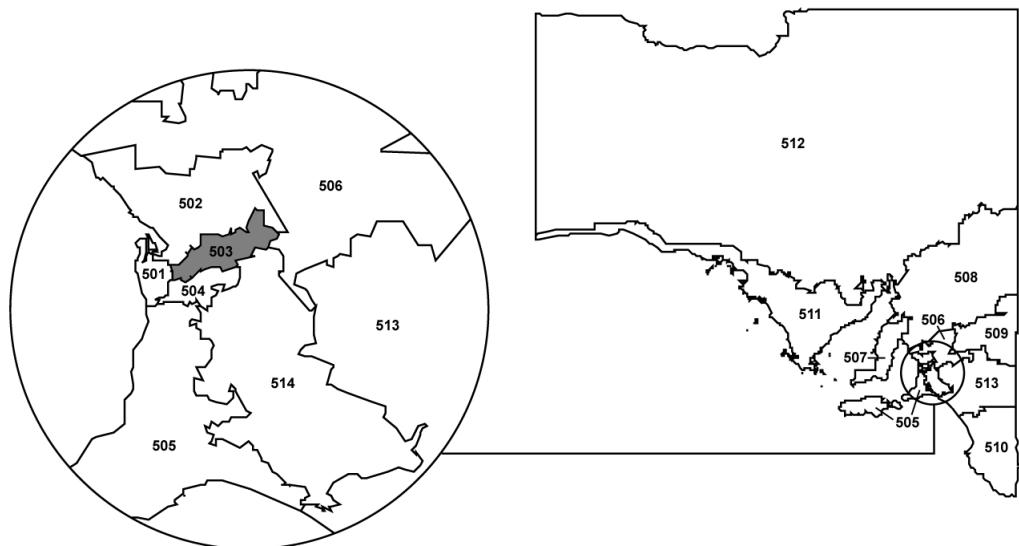
- printed review sheet,
- Podiatrist and dietitian provide up to date guidelines for the GPs.

▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?	N/A.
▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?	N/A.
▪ What resource materials do you provide to practices?	As above, plus documentation on PIP and SIP diabetes related item numbers and how to use the Medical Director tools.

Division Contact Person/
Program Co-ordinator

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Adelaide North East DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	194,661	
■ Aboriginal or Torres Strait Islander	2020	1.0%
■ Speaks language other than English at home	26,640	13.7%
■ RRMA classification ¹		
1: Capital city	191,741	98.5%
5: Other rural	2920	1.5%
■ SEIFA category containing population median: ²	8	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	10,259	7.9%
■ High blood pressure ⁴	39,027	30.0%
■ High blood cholesterol ⁵	66,850	51.4%
■ Obese or overweight ⁶	78,226	60.1%
■ Physical inactivity ⁷	55,242	42.4%
■ Smoking ⁸	24,941	19.2%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

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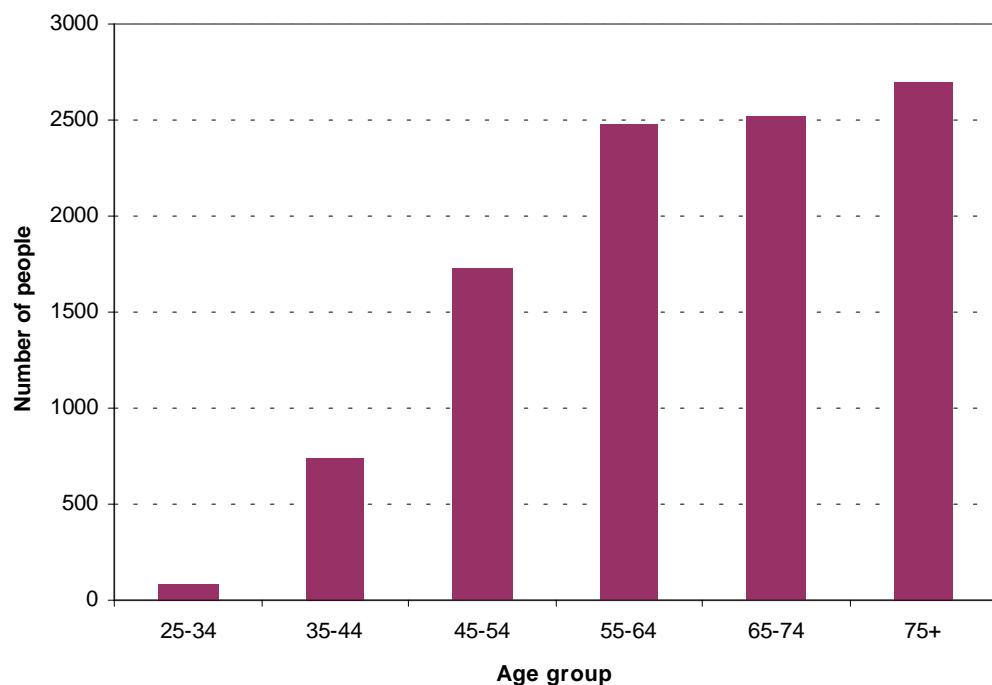
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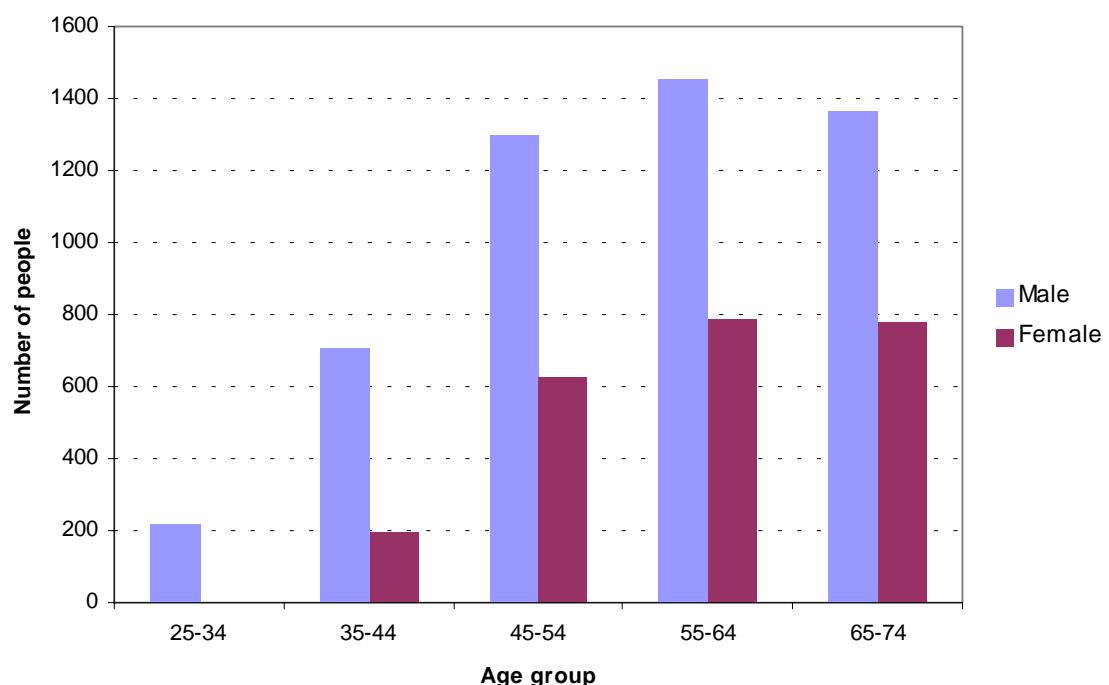
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



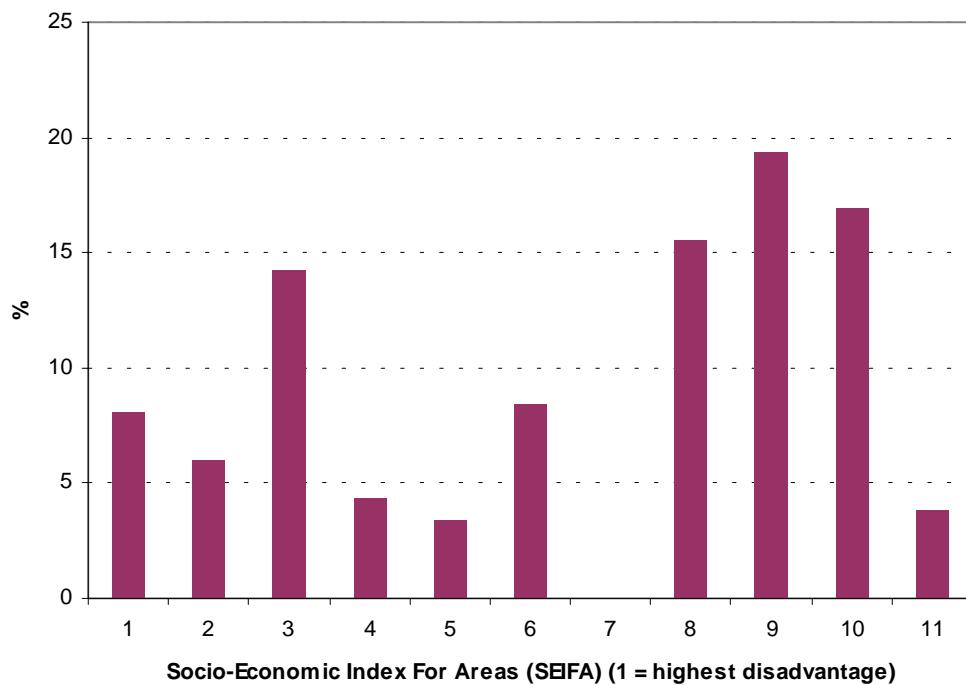
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

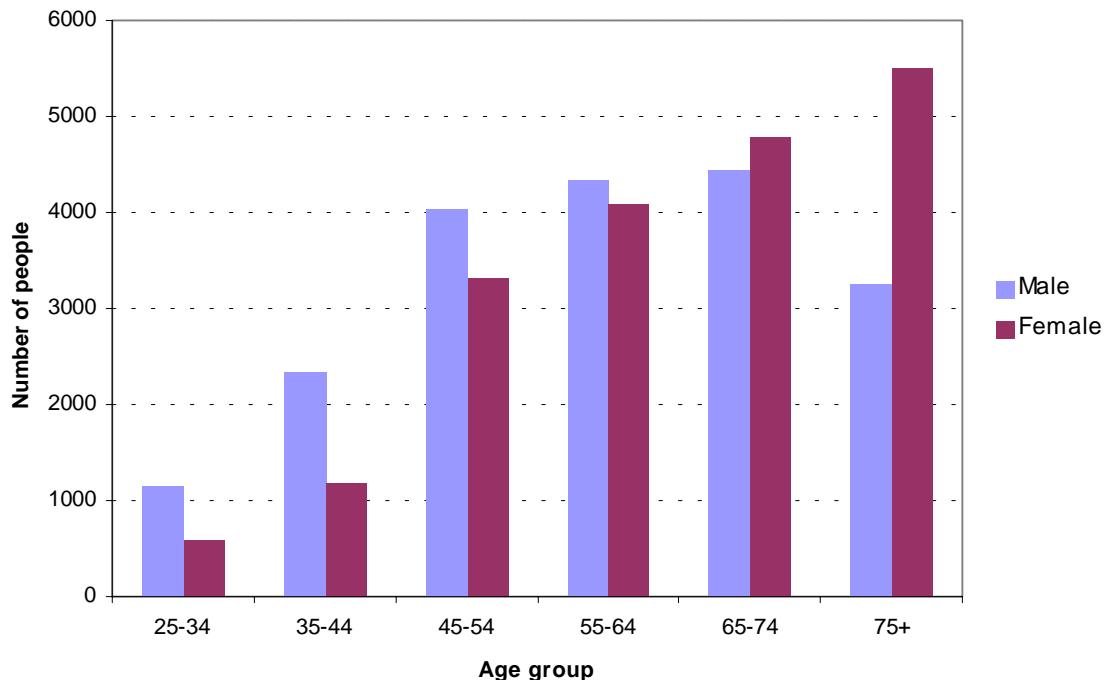
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

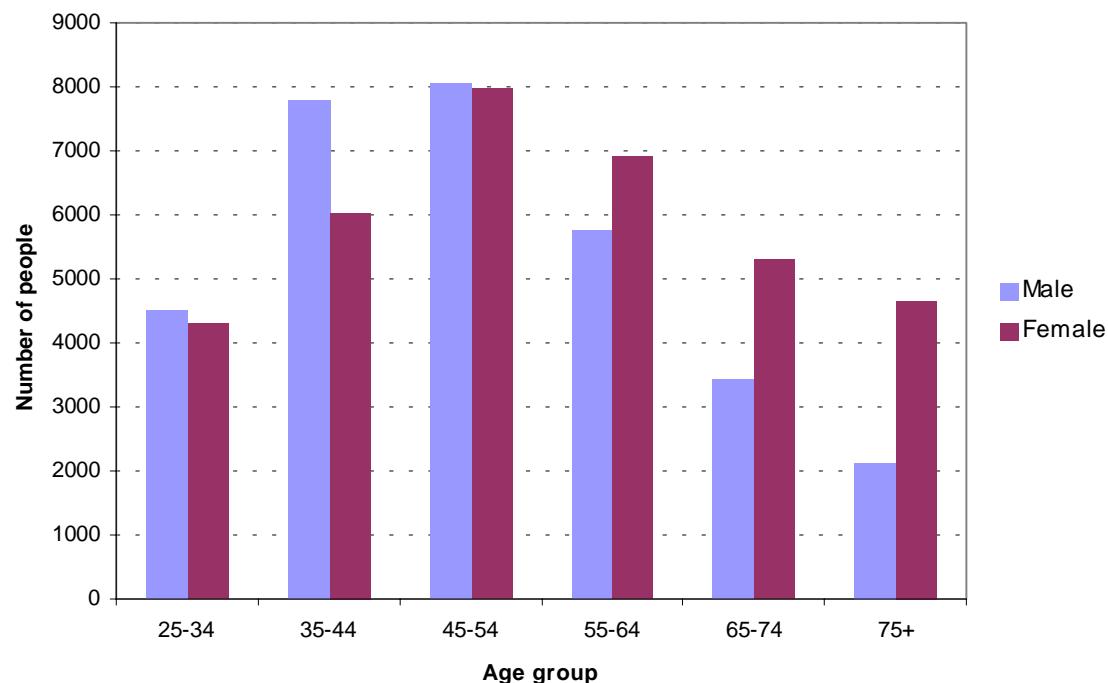
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



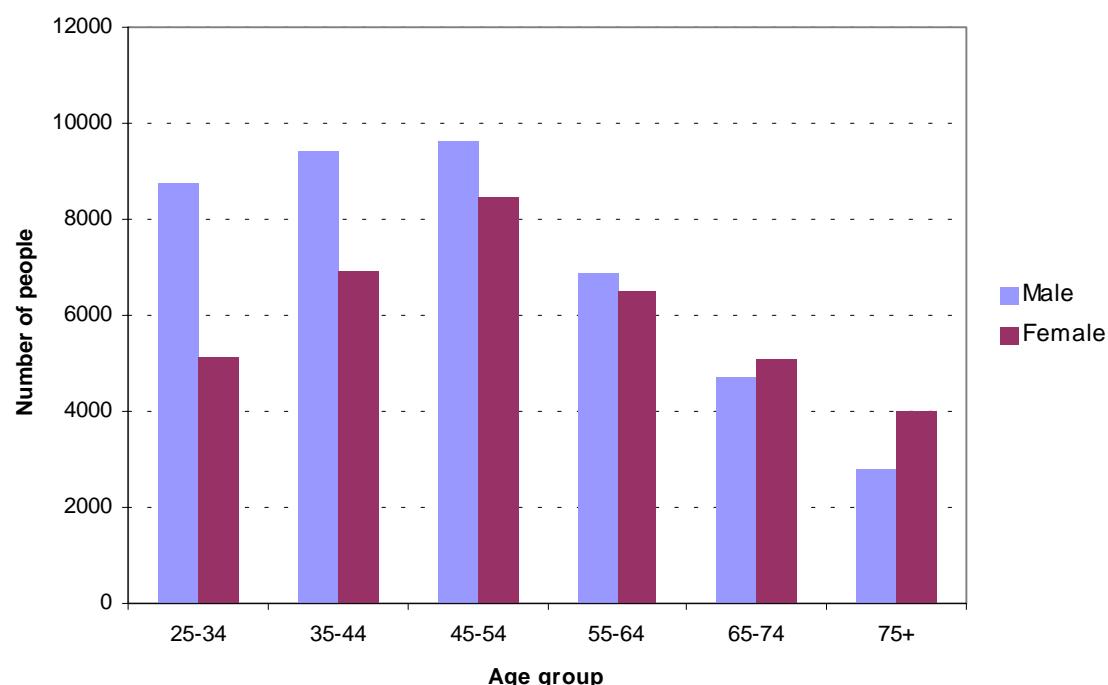
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



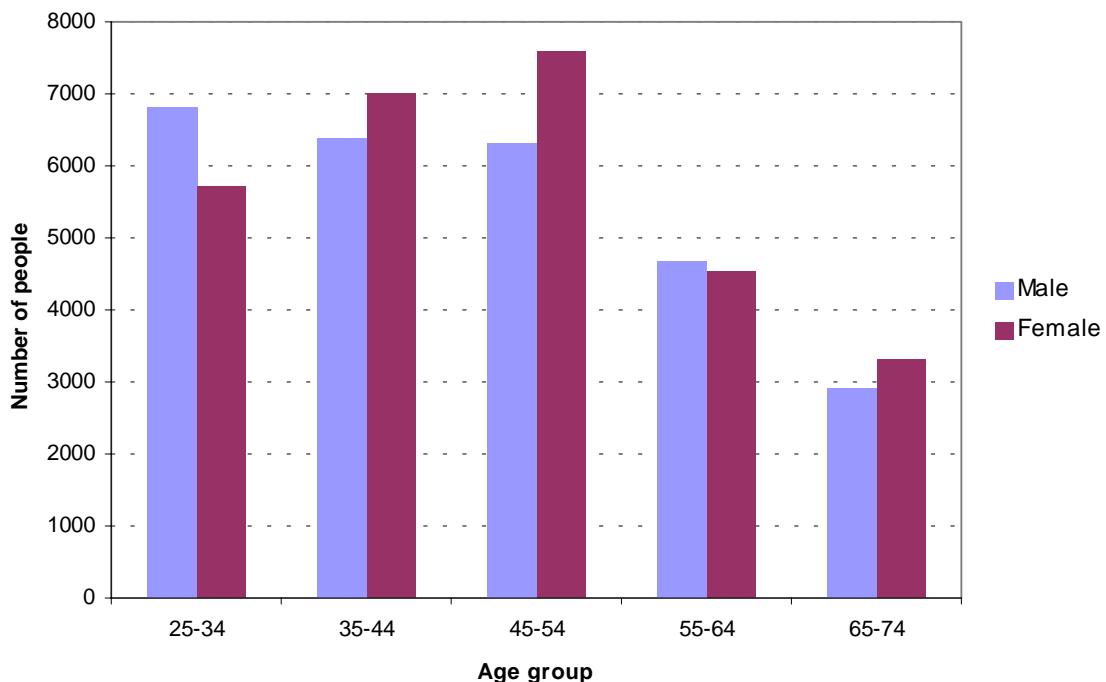
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



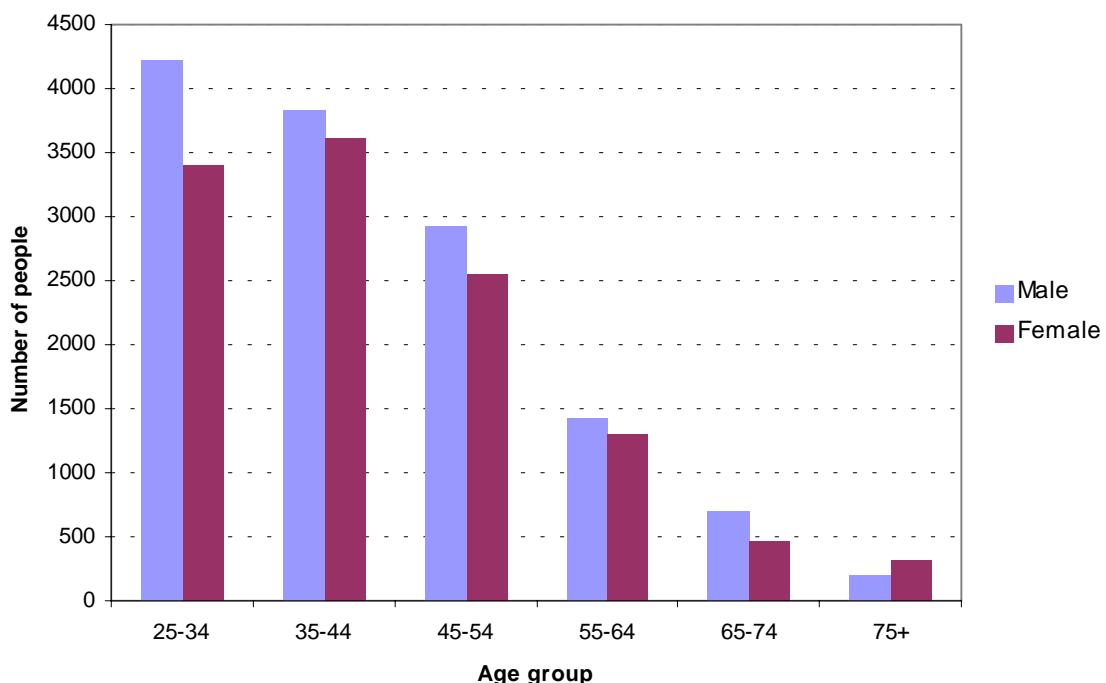
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- Number of GPs working in the Division area: Total 229

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - The Division provides resources of a dietitian and nurse educator,
 - Diabetes mini-clinics were running up until December 2001, incorporating the services of the Division's dietitian and nurse educator,
 - The local public hospital provides dietitian and nurse educator sessions. They hold introductory sessions and outpatient clinics,
 - The Community Health Service provides support groups and dietitian services,
 - The Division provides discussion/support groups held regularly.

- What services are needed but are not available in your Division area?
 - Public podiatry services are inadequate,
 - Dietitian and nurse educator services are also inadequate.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input checked="" type="checkbox"/> 1992	<input checked="" type="checkbox"/> 1993	<input checked="" type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - The Division supported practices to operate multidisciplinary mini-clinics up until December 2001. There were eight general practices running mini-clinics by the time this ended, and involved the services of the Division's nurse educator, dietitian and podiatrist. The services for the dietitian and nurse educator were originally subsidised, however, a co-payment had to be introduced by the end of 1997, due to changes in funding. The practices involved in the mini-clinics were committed to providing services to people with diabetes for a prescribed number of sessions per week/month,
 - The Division provides support to practice nurses through regular education/information sessions. Diabetes practice nurse lunches are held every two months, and a different speaker attends each lunch to speak about diabetes,
 - The services of a diabetes nurse educator and dietitian are offered by the Division. Two

locations were initially running, which has now amalgamated into the one central location, and patients can be referred by their general practitioner. Services are offered fortnightly and a small co-payment is applied to each service,

- Supermarket Tours are conducted by the dietitian to inform attendees about making more informed choices when it comes to purchasing food,
- Discussion groups are held to offer support to diabetics and their families. A guest speaker attends the monthly meetings to provide a range of information,
- GP education sessions are held throughout the year to encourage general practitioners to adopt consensus guidelines,
- Disease Register and Recall system – facilitation of this program continues, with the number of participants increasing each year, and a clinical audit process is linked to the register and recall system, offered CPD points to participating general practitioners. The register reports clinical outcomes over time.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The introduction of multidisciplinary mini-clinics within general practice have proven to provide effective treatment for diabetes with markedly improved clinical outcomes compared with “usual” care,
 - The development of a local diabetes/CVD Register and Recall System, reporting long-term outcomes – has been showcased at numerous state-wide forums,
 - Clinical Attachment Program for general practitioners.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Time management for general practitioners seems difficult as national processes such as computerisation and incentive programs consume a lot of their time,
 - Co-payments for allied health services have caused a decline in the utilisation of these services,
 - Practice restructuring required in implementing ongoing patient management programs.

- What future plans do you have for diabetes management in your Division?
 - Encourage best practice clinical management guidelines – for example, promoting access to evidence based medicine,
 - Promote quality data entry – classification of disease in medical records,
 - Promote multidisciplinary care planning as a management tool,
 - Provision of education/training to general practitioners and practice nurses to help increase the quality of care for their patients,
 - Encourage and educate diabetics in self-management of their illness via support/discussion groups.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Having the administrative capacity to implement new systems, eg. more complex appointment systems, protocol information, follow-up and tracking systems, etc,
 - Quality data collection – allows for effective recall systems, and accurate reporting,
 - Informed practice staff (admin, nursing and GP) – they need to have a good understanding of requirements and processes,
 - Practice nurses – employed for sessional work if a practice does not employ them on a regular basis – to assist in the uptake of initiatives by satisfying some of the clinical and administrative requirements,
 - Setting up and running programs – ie, diabetic clinics, asthma clinics,
 - Access to allied health professionals – preferably on site,
 - Utilisation of Division services/support – through education/training, queries, etc.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Diabetes SA – exchange of information materials – promotion of campaigns, etc,
 - SBOs – support from SA Division of General Practice Inc (SADI) in relation to policy,
 - Pharmaceutical Companies – participation in education/training of GPs, practice staff/nurses – providing educational information, sponsorship,
 - Podiatrists/Dietitians/Educators – participation in education/training of GPs, practice staff/nurses,

- Australian Kidney Foundation – exchange of information, participation in education/training of GPs, practice staff/nurses,
- Royal College of Nursing – provision of reading material on nursing in general practice,
- Royal College of General Practitioners – information on policies, government regulations, etc,
- Modbury Public Hospital – support in program development and clinical attachments,
- HIC – GP requirements on incentive implementation,
- SA Department of Health – involvement in strategic planning for diabetes services.

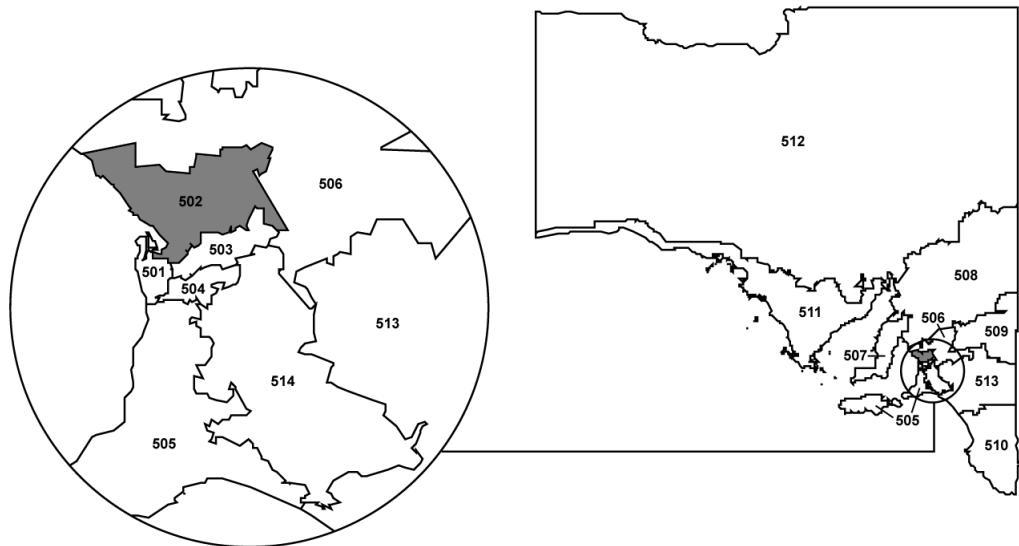
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Diabetes SA, Diabetes Australia – Diabetes Management Guidelines booklets,
 - Royal College of General Practitioners,
 - SBO's (SADI),
 - Australian Kidney Foundation – web site,
 - Various web sites.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Practice Incentive Program Kit,
 - Diabetes Management in General Practice guidelines,
 - Patient Diabetes Diary,
 - Flow chart examples on how to utilise diabetes incentive items,
 - Templates for clinical software – for collection of data.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? N/A.

Division Contact Person/
Program Co-ordinator

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Adelaide Northern DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	176,711	
■ Aboriginal or Torres Strait Islander	3138	1.8%
■ Speaks language other than English at home	21,021	11.9%
■ RRMA classification ¹		
1: Capital city	169,996	96.2%
5: Other rural	6715	3.8%
■ SEIFA category containing population median: ²	1	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7834	7.2%
■ High blood pressure ⁴	30,375	27.8%
■ High blood cholesterol ⁵	55,101	50.5%
■ Obese or overweight ⁶	65,122	59.7%
■ Physical inactivity ⁷	47,269	43.3%
■ Smoking ⁸	21,709	19.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

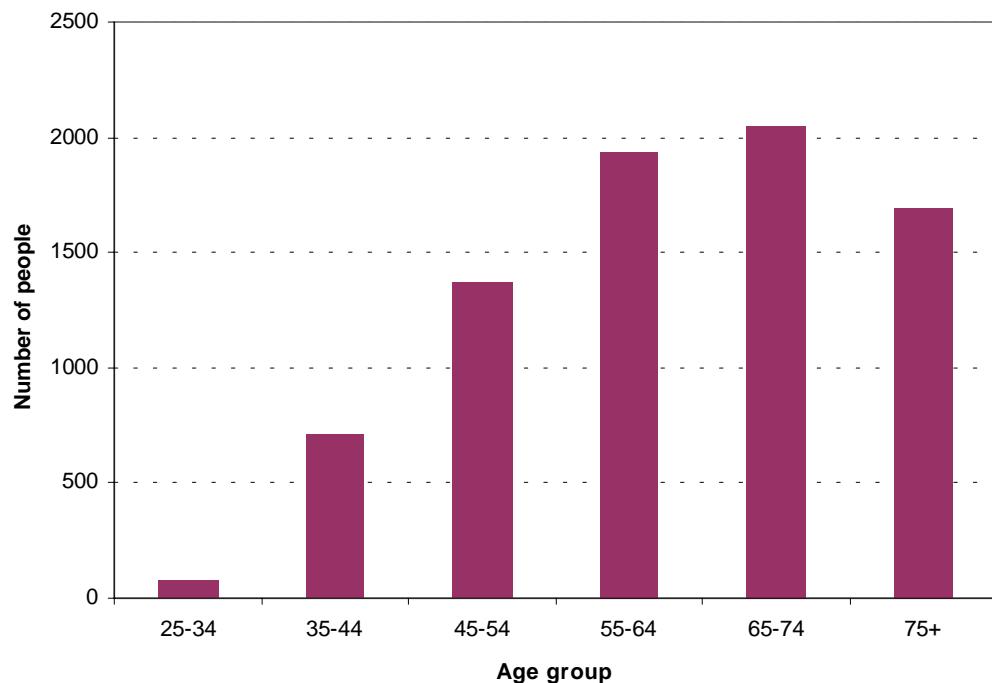
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

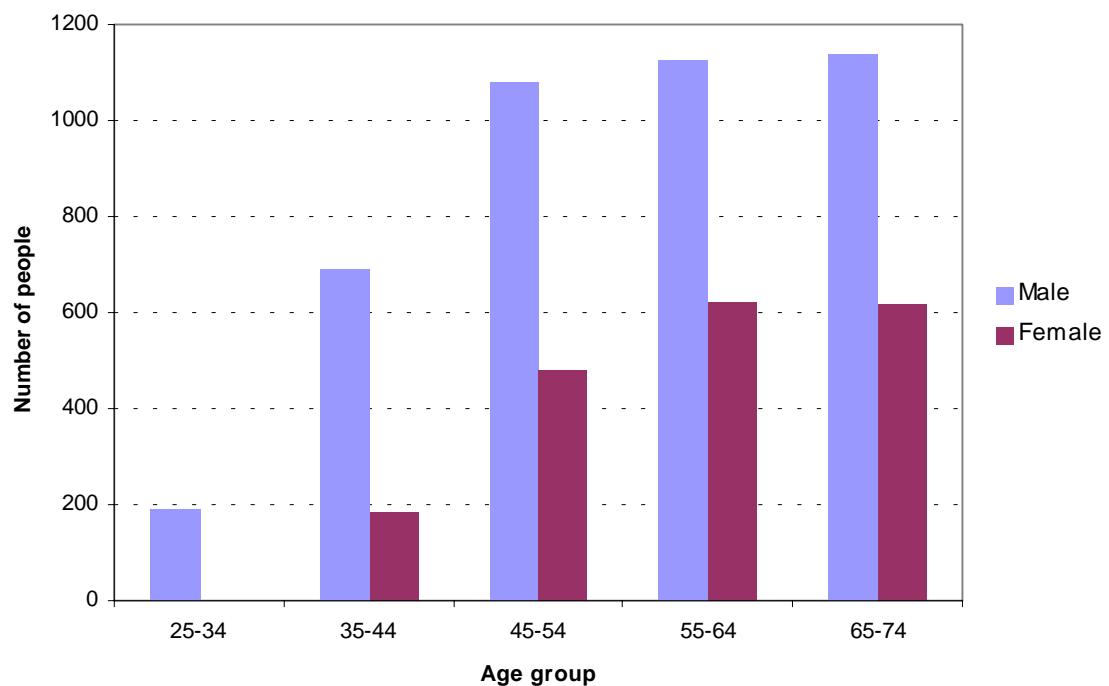
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



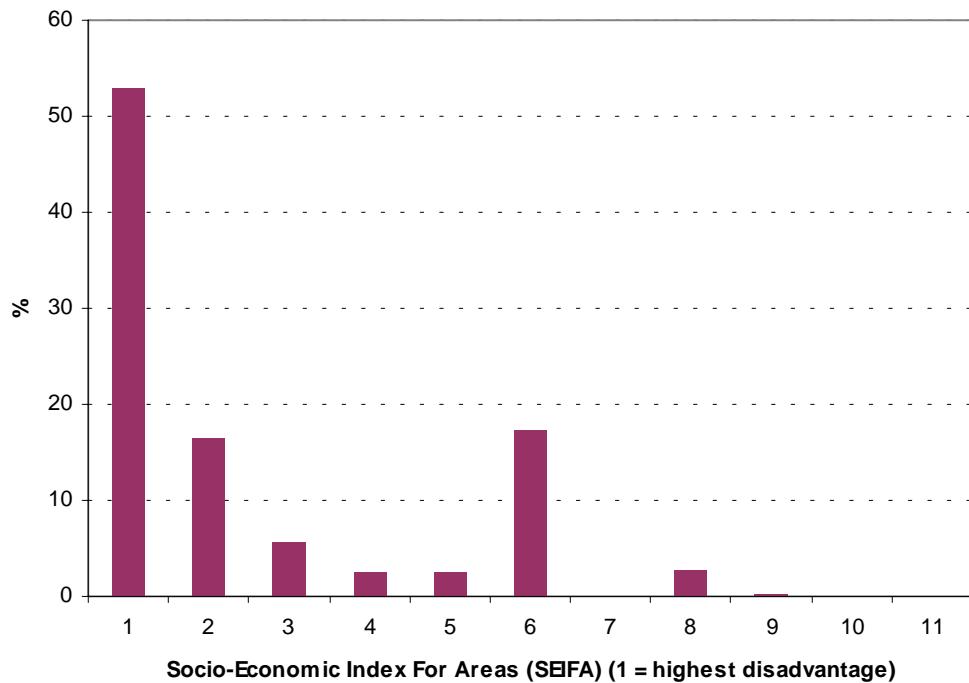
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

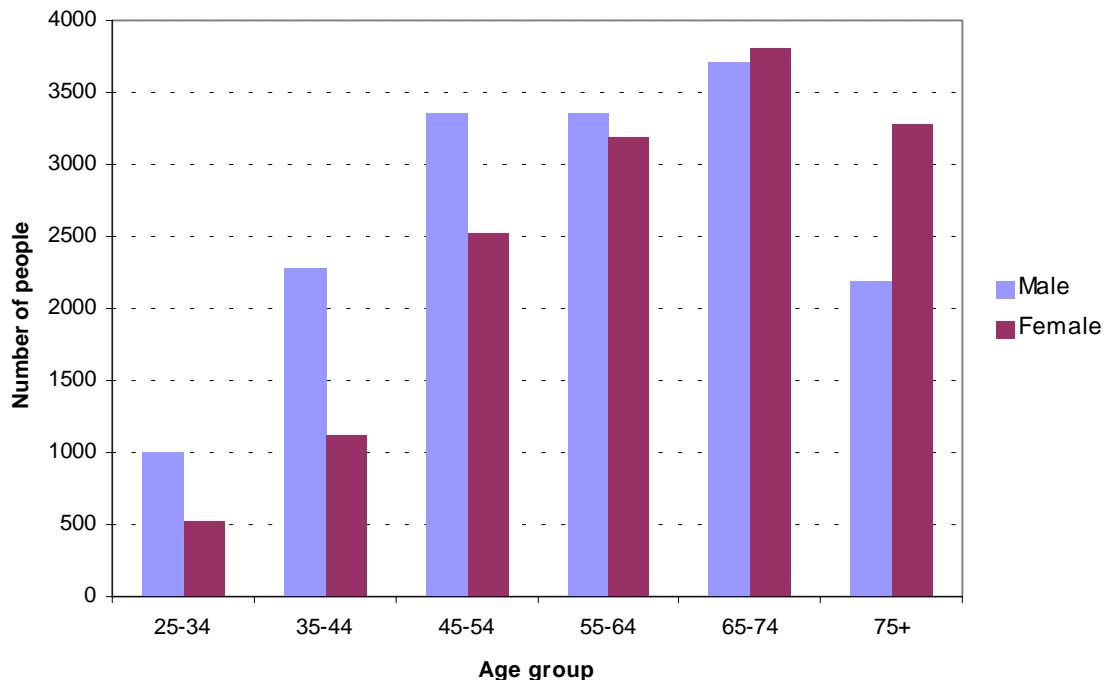
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

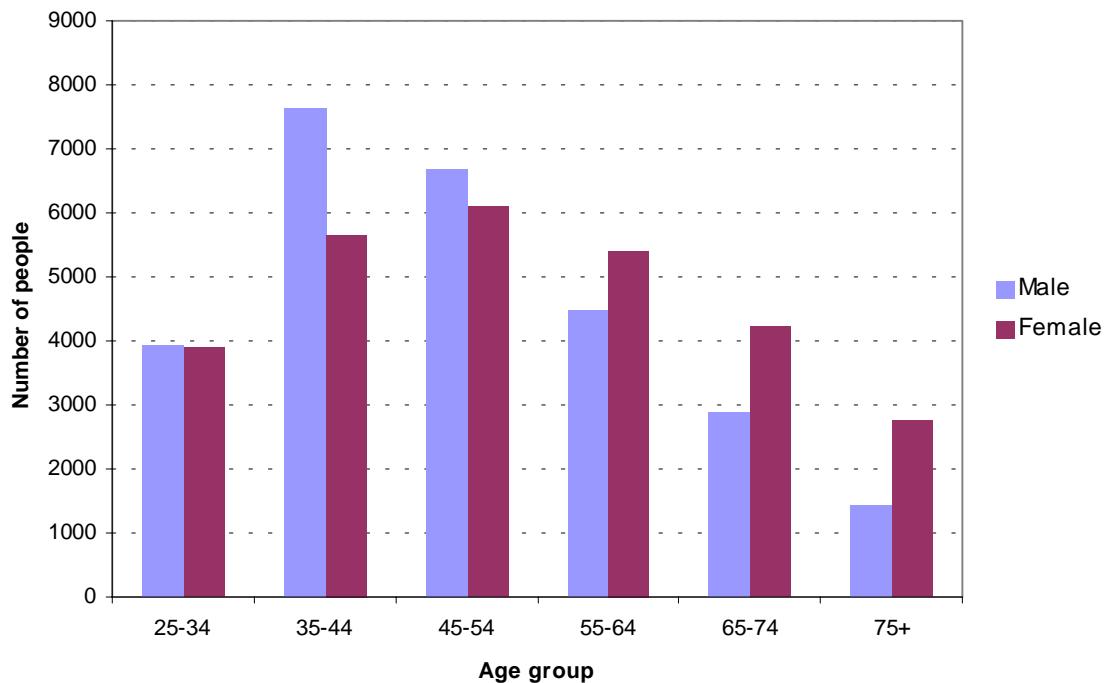
Key Descriptors of Division Population

Figure 4: Estimated prevalence of high blood pressure by age and sex



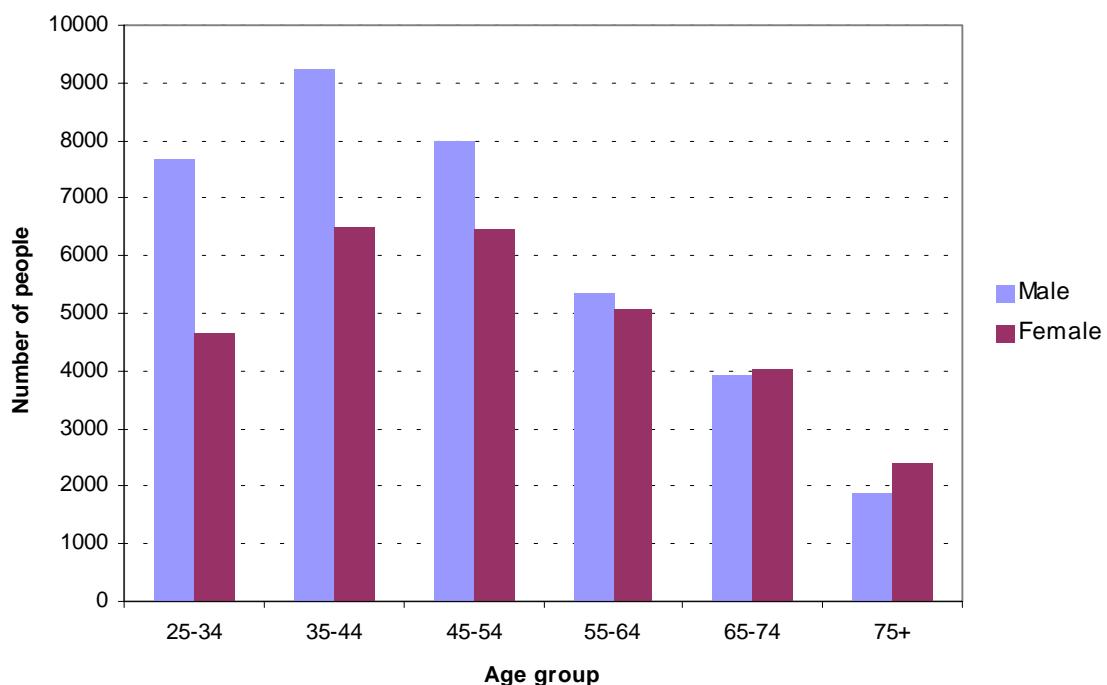
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



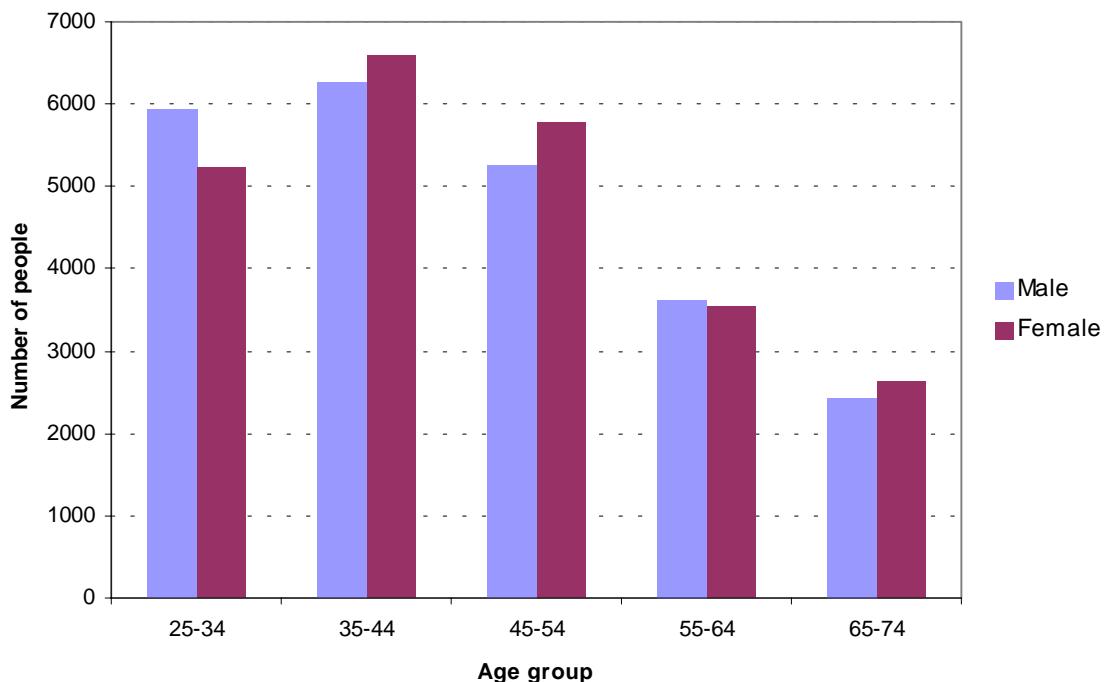
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



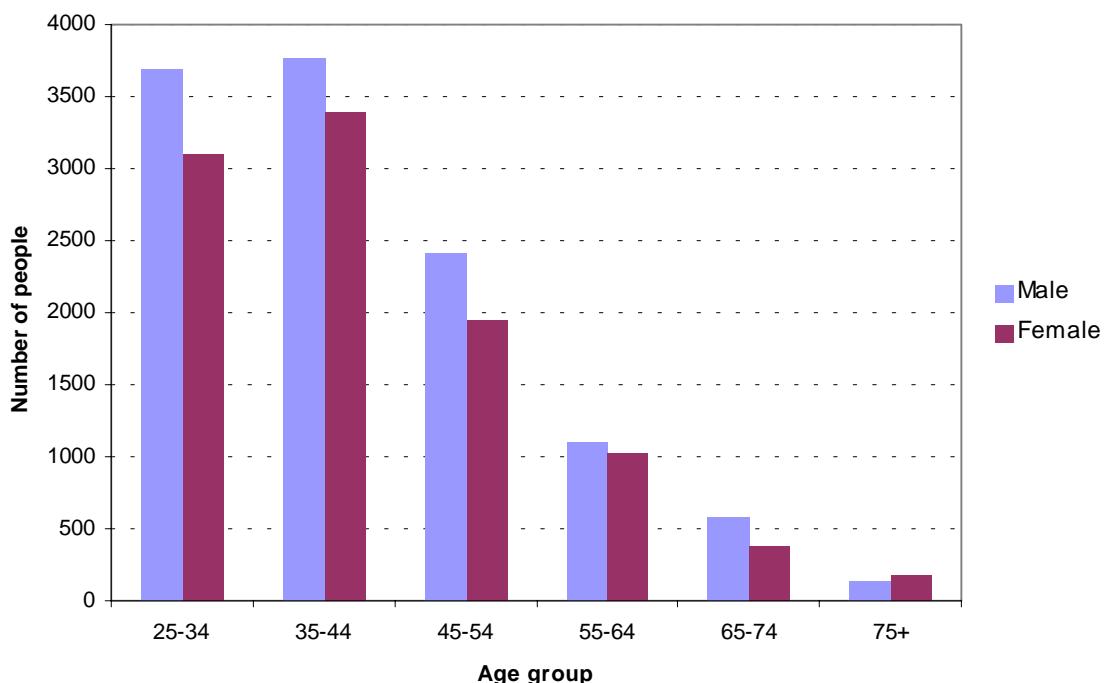
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 176 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Lyell McEwin Health Service (LMHS) Diabetes Centre,
 - Gawler Health Service.

- What services are needed but are not available in your Division area?

Cheap podiatry for those under 60 years.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Provide education for GPs/practices and tools/materials to assist likes of care planning (and diabetes management generally).

Division Perspective

- What have been the major achievements or highlights of your program so far?

Established steering group of local health providers.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Limited funding and time (especially GPs),
 - Ongoing development of tools (new guidelines, medical director, diabetes training),
 - Changing services available or criteria,
 - HIC incentives guidelines and GP confidence.

- What future plans do you have for diabetes management in your Division?

Maintain steering group including continuing to provide education (GP and practice nurses) and seek funding.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Motivations/interest,
 - GP register recall protocols and trained staff,
 - Educated/knowledge,
 - Adequately staffed (numbers and trained).

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
- Steering group initiated in May 2001 and meet every 6 – 8 weeks. Representatives from GP, LMHS endocrinology and Diabetes Centre, Gawler Health Service Diabetes Centre, Northern Metropolitan Community Health, RDNS, Northern Domiciliary Care Muna Paiendi and Diabetes North Support Group.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP above,
 - DATIS diabetes guide,
 - Managing type 2 diabetes in South Australia (release August 2002).
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Diabetes care plan checklist (different formats),
 - And other area specific resources,
 - Register recall manuals.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.
- What resource materials do you provide to practices?

Those listed above developed by us.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Lyell McEwin Public Hospital – new referrals through emergency to Northern Cardiology Services at Central Districts Private Hospital,
 - Growing vascular services on a weekly basis – three physicians,
 - Home stroke program,
 - Endocrinology services.

- What services are needed but are not available in your Division area?
 - No haematology complex; general physicians refer on,
 - No ophthalmology services,
 - Public transport system means people requiring hospital need to use two buses to get to the hospital.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Division project,
 - Collaborative project between Adelaide Northern Division of General Practice (ANDGP) and local Aboriginal Community Health organisation (Muna Paiendi),
 - Aim is to build relationships between Aboriginal health workers and GPs and improve heart health skills of Aboriginal health workers as first contact service providers.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Healthy Heart Workshop – an interactive skills exchange between GPs and Aboriginal health workers, identified people and families with heart disease who are willing to tell their stories (interactive therapy) and which can be used as tools for helping other Aboriginal people newly diagnosed with CVD.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Heavy workload of GPs and Aboriginal health workers in this area and seasonal difficulties (winter),
 - Lack of knowledge of the role of Aboriginal health workers,
 - Cultural awareness GPs and practice staff,
 - Lack of capacity to bring GP and health workers together at a mutually suitable time.
- What future plans do you have for CVD management in your Division?
 - Further collaborative activities to develop relationships between GPs and Aboriginal health workers,
 - Development of a suitable model for improving health of Aboriginal community,
 - More education and training for health workers in CVD,
 - Peer education model for improving heart health in Aboriginal community,
 - Further work in modifying risks related to heart health – lifestyle factors.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Get to know the people working in Aboriginal Health,
 - Develop a service agreement – develop good relationships,
 - Mentor Aboriginal people who are interested in working in Aboriginal Health,
 - Set achievable time frames – developmental nature of the work,
 - Make sure activities also develop cultural awareness and that services/programs are culturally appropriate.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Memorandum of Understanding – Adelaide Northern Division of General Practice (ANDGP) and Muna Paiendi,
 - Develop strong networks – attend functions and events,
 - Develop networks and relationships with other relevant organisations who may be outside the area. In our case, Aboriginal Controlled Community Health Organisation (ACCHO) Nunkanwarrin Yunti provides Outreach services in our Divisional area.

Division Resources

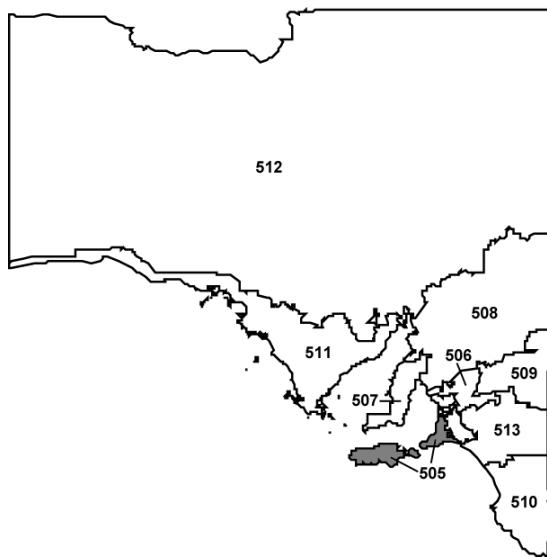
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation (NHF) representative on our advisory group,
 - Culturally appropriate video and resource package,
 - Support to National Heart Foundation's (NHF) training package for Aboriginal health workers,
 - Use of culturally appropriate QUIT smoking resources,
 - Develop own local resources – promotional brochure, hand held record stories.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Need to negotiate use of stories with the local community,
 - Program management plan and out times for heart health workshop,
 - Evaluation plan.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Looking at the need for an “at risk” register not just to identify or monitor CVD but one that provides a checklist of risks for the GP to incorporate at primary and secondary levels of prevention that can be used as prevention tools.
- What resource materials do you provide to practices?
 - Resource manual for Enhanced Primary Care (EPC) incentives,
 - Flowchart to track overall EPC incentives, what is available and when, for Quality Use of Medicines (QUM), diabetes, asthma and cervical screening. Have available, dyslipidaemia resources from National Prescribing Service (NPS).

Division Contact Person/
Program Co-ordinator

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Adelaide Southern DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	329,018	
■ Aboriginal or Torres Strait Islander	2387	0.7%
■ Speaks language other than English at home	24,813	7.5%
■ RRMA classification ¹		
1: Capital city	304,013	92.4%
5: Other rural	20,728	6.3%
7: Other remote	4277	1.3%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	19,097	8.6%
■ High blood pressure ⁴	71,501	32.3%
■ High blood cholesterol ⁵	115,994	52.4%
■ Obese or overweight ⁶	134,071	60.6%
■ Physical inactivity ⁷	91,566	41.4%
■ Smoking ⁸	40,782	18.4%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

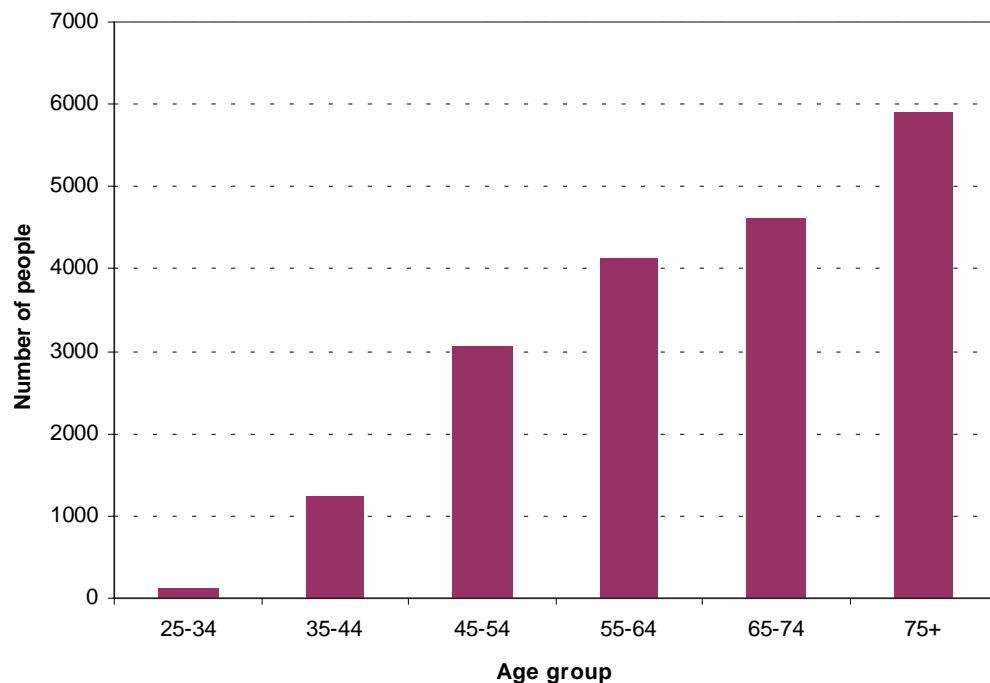
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7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

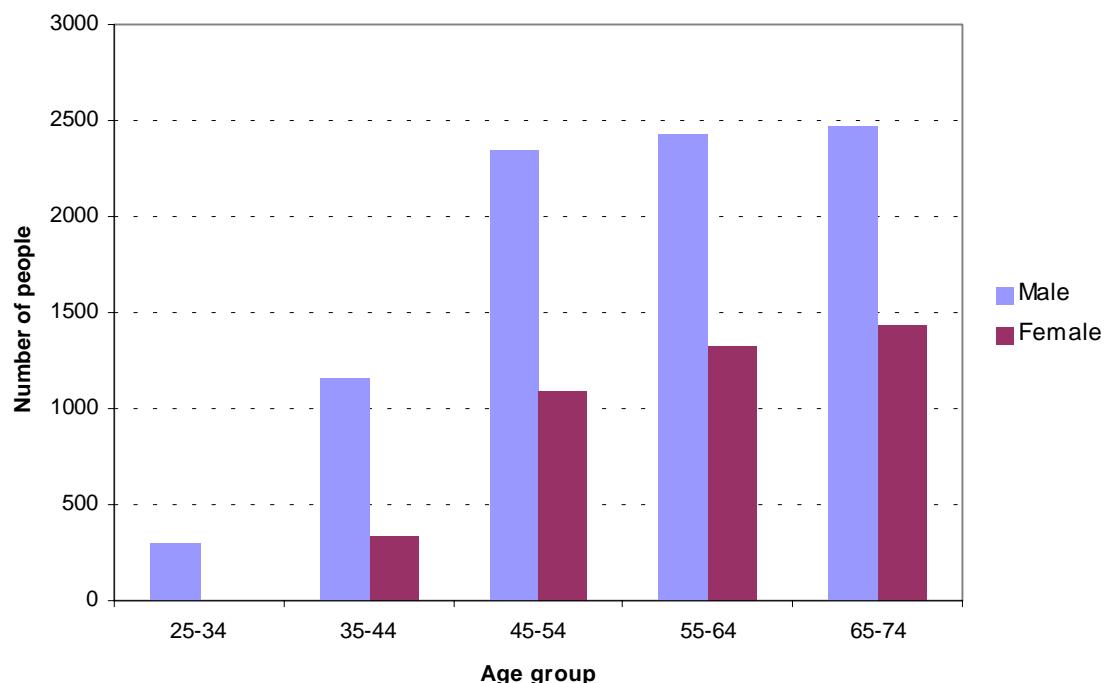
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



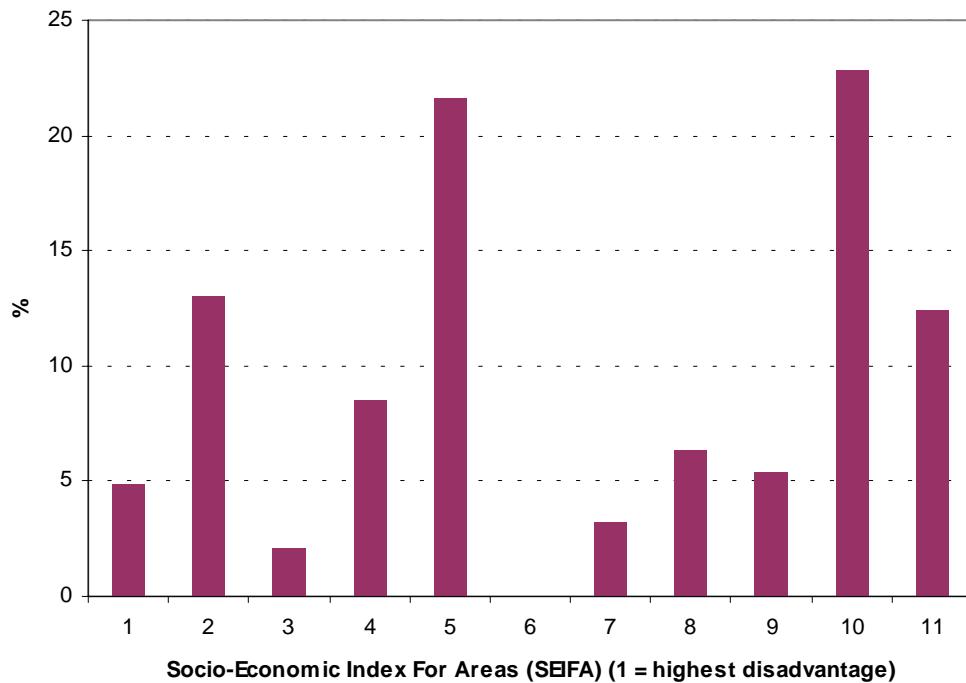
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

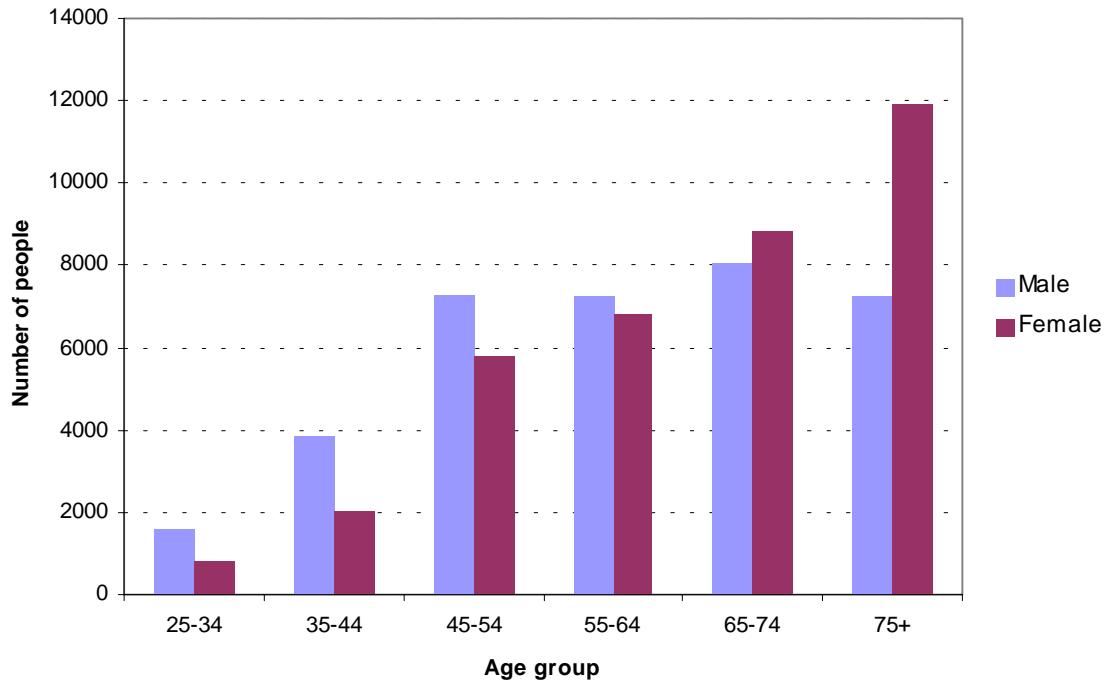
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

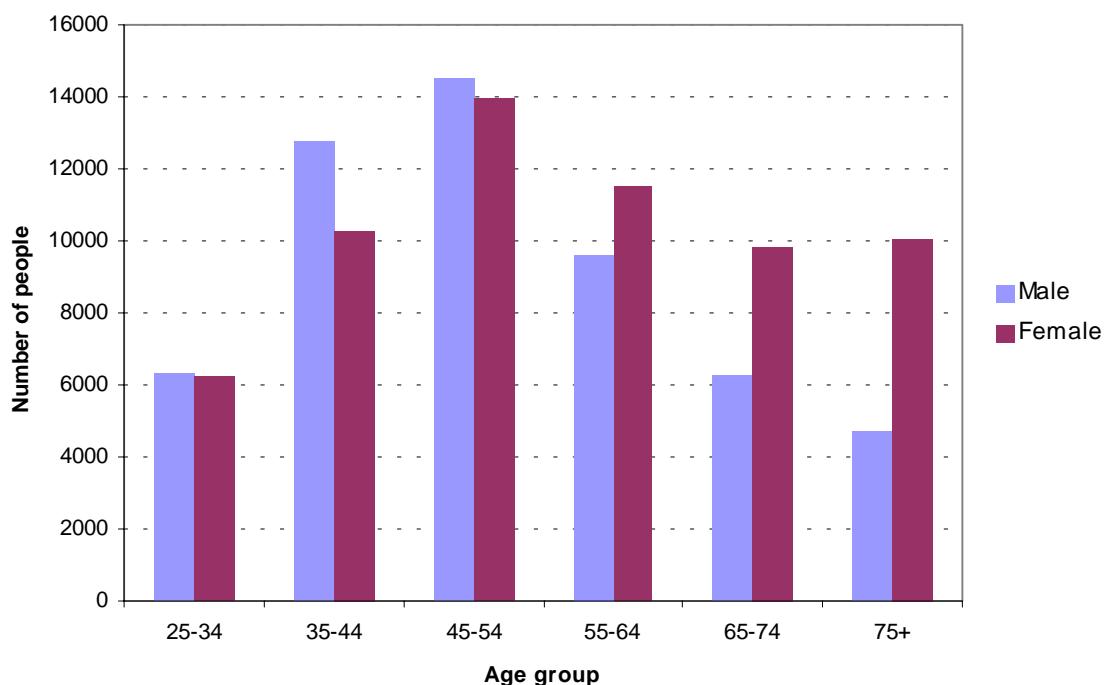
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



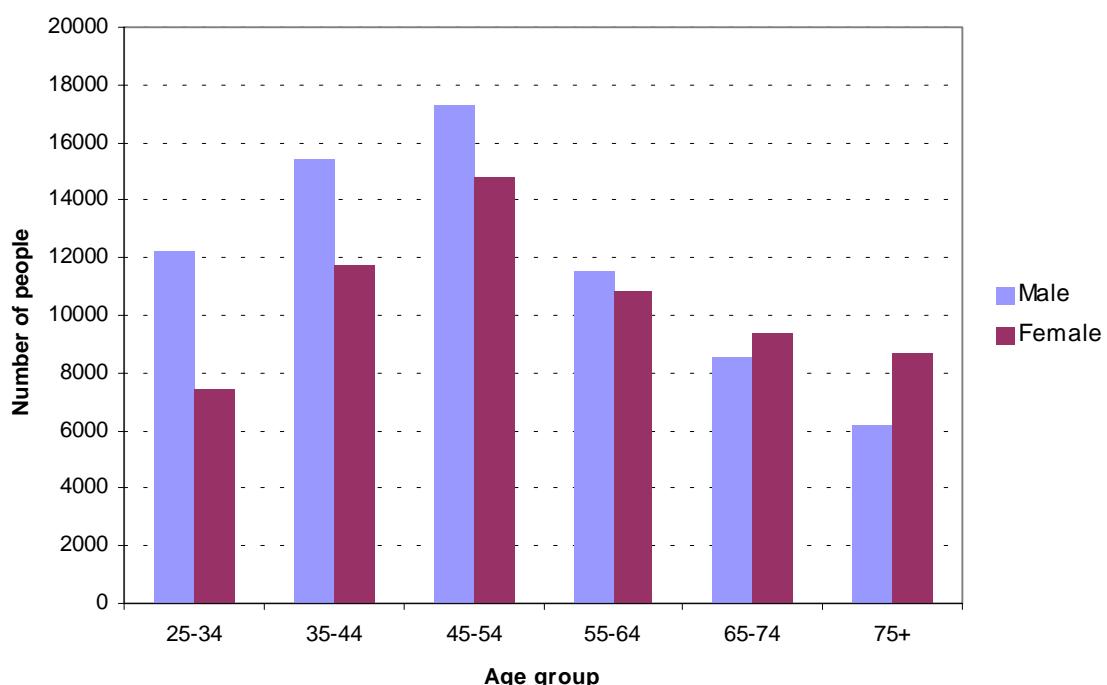
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



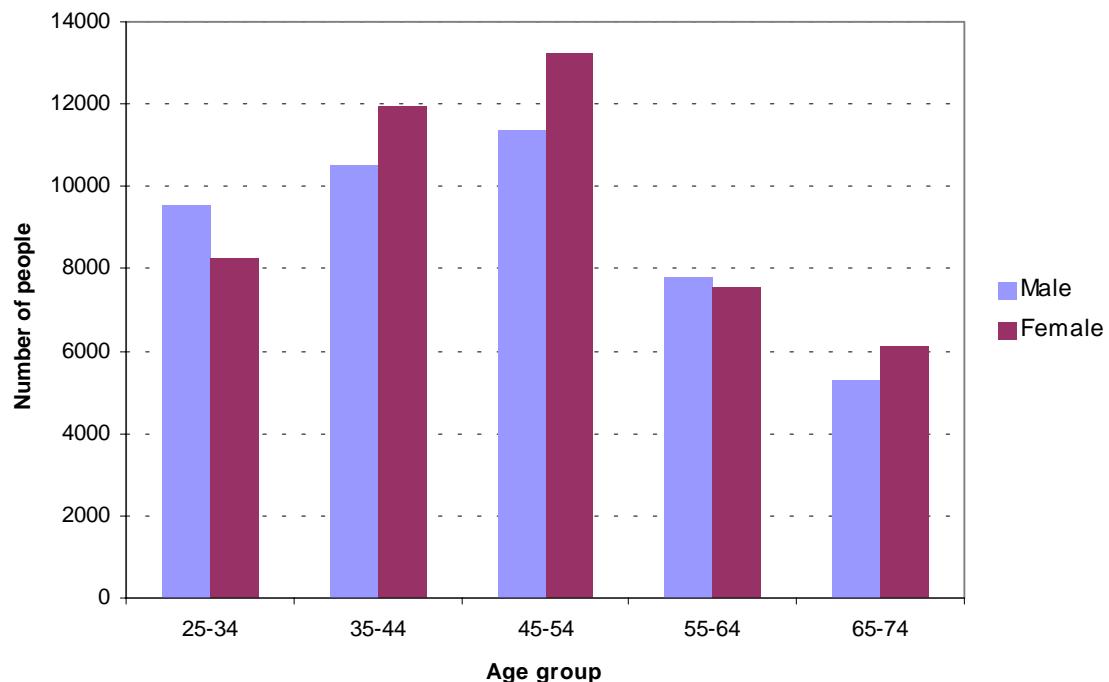
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



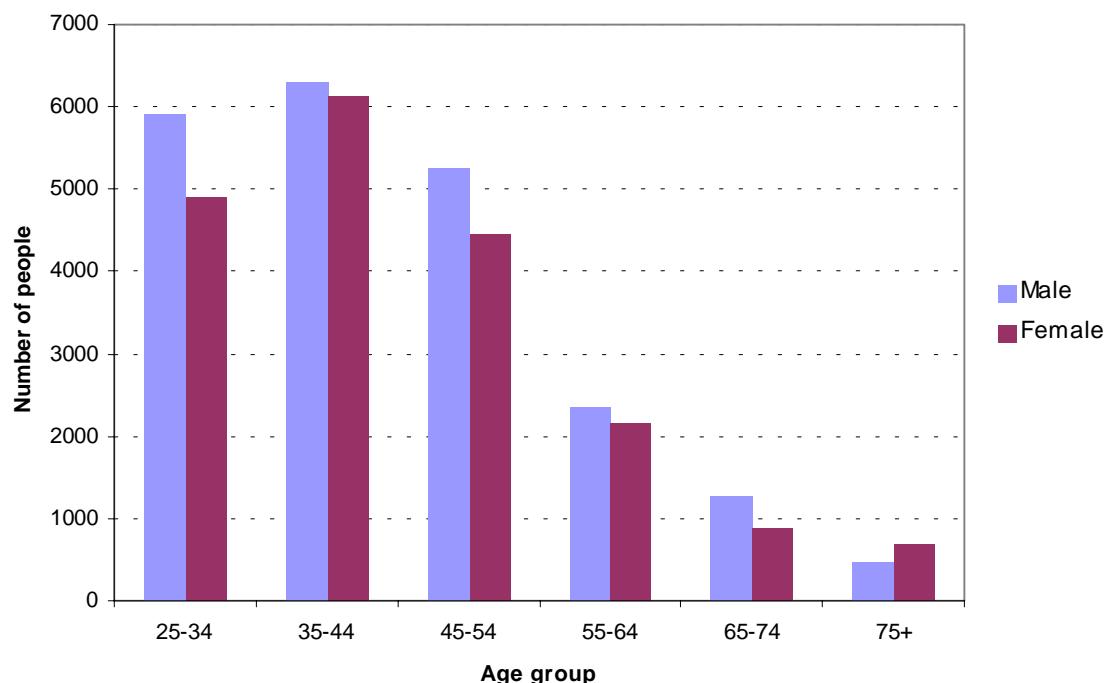
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 394 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Two public hospitals have a diabetes outpatients clinic, which provide endocrinology, dietetics, podiatry and diabetes nurse educators,
 - Public and private podiatry,
 - Public and private dietitians,
 - Public and private diabetes nurse educators,
 - Public and private renal physicians,
 - Public and private ophthalmology/optometry.

- What services are needed but are not available in your Division area?

While services are available there are long waiting times for public podiatry appointments (especially foot screening), and similarly with individual appointments with a diabetes nurse educator located in the public hospital.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Southern Division of General Practice, (SDGP), Diabetes Program is staffed by a GP advisor (3.5hrs/week), a full-time program coordinator, and a full-time diabetes nurse educator.

The aim of the program is to support and extend GPs' knowledge in effectively managing diabetes. The model of systematic structured care involving a multidisciplinary team is expected to improve population health outcomes.

GPs are assisted to establish a diabetes register, recall patients for regular clinical reviews following evidence-based clinical management guidelines, and use their medical software for these purposes wherever possible. The diabetes educator visits practices, consults individually with patients, and provides written reports back to the patient's GP. Continuing Professional Development (CPD) evenings are held regularly, and clinical attachments to the diabetes outpatients units at Repatriation Hospital and Flinders Medical Centre are available. The diabetes program is advised by a committee

comprising of four GPs, the diabetes educator, a representative from Diabetes South Australia, two consumers and the program coordinator.

For the past three years, approximately sixty GPs have actively participated in the SDGP Diabetes Program, and have utilised the CARDIAB database held by the Division for patient recall and audit purposes. The diabetes program ceased to collect clinical data from GPs actively participating in the program in March 2002. The introduction of the Chronic Disease Initiatives (CDI) changed the focus of the program to be inclusive of all GPs in the Division (approximately 390).

With the introduction of the Chronic Disease Initiatives (CDI) in November 2001, GPs have been actively encouraged to develop a register of their diabetes patients and an active recall system to promote systematic management of diabetes.

Program staff have conducted practice visits in response to the introduction of the CDI. Visits have covered issues relating to setting up registers and recalls, utilising the diabetes assessment on Medical Director, completing the Diabetes Annual Cycle of Care, and claiming the Service Incentive Payment, and changes to care planning.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Thirty-nine GPs have completed a ten-week clinical attachment with a public hospital diabetes outpatient's clinic. This attachment provides GPs with a comprehensive overview of diabetes care and exposes GPs to patients with a variety of complications and management issues. Over the ten-week period, GPs spend time with all members of the multidisciplinary team (diabetes nurse educator, dietitian, podiatrist, ophthalmologist and endocrinologist),
 - The diabetes nurse educator provides a comprehensive education session for patients of GPs practicing within the boundaries of the Division. Each patient is seen individually at the practice where they attend, for 1.5 hours. GPs receive a written report,
 - CPD sessions are well attended by GPs and diabetes nurse educators,
 - GP advisor is actively sought for participation

in State and National forums regarding diabetes management in general practice.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

The greatest limitation is the size of the Division. With approximately 400 members and 90 practice nurses, it is quite a task to ensure that GPs have the support and resources they require to undertake systematic care of their diabetes patients.

- What future plans do you have for diabetes management in your Division?

- A clinical pathway for diabetes has been developed by SA Division of General Practice Inc in partnership with the Department of Human Services. This publication “Managing Type 2 Diabetes in South Australia – Screening, Diagnosis and Management in General Practice” will be distributed to all GPs in the SDGP both in desk top version and a CDROM,
- We will continue to support GPs and their practice staff with practice-based activities, including the establishment of effective recall, case detection and management systems.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

- Good practice-based systems,
- Common philosophy amongst GP and practice staff to embrace systematic care,
- Support from the Division to assist them with problems they may encounter,
- Timely dissemination of information to clarify requirements or changes as they occur.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

- Flinders Medical Centre,
- Noarlunga Health Services,
- Repatriation General Hospital,
- Diabetes South Australia,
- Department of Human Services,
- South Australian Divisions Inc.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- NSW Health Department Consensus Guidelines for the Clinical Management of Diabetes Mellitus in Adults,
- Royal Australian College of General Practitioners (RACGP) – Diabetes Management in General Practice 2001,
- Diabetes Manual – Diabetes Centre, Queen

Elizabeth Hospital, Adelaide,

- Patient education resources developed by Diabetes Australia,
 - Patient education resources developed by Diabetes Centre, Queen Elizabeth Hospital, Adelaide,
 - Patient education resources developed by the International Diabetes Institute.
-

▪ What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Diabetes management review sheet (covering two years) and complying with the requirements for the “Annual Cycle of Care”.

▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

No.

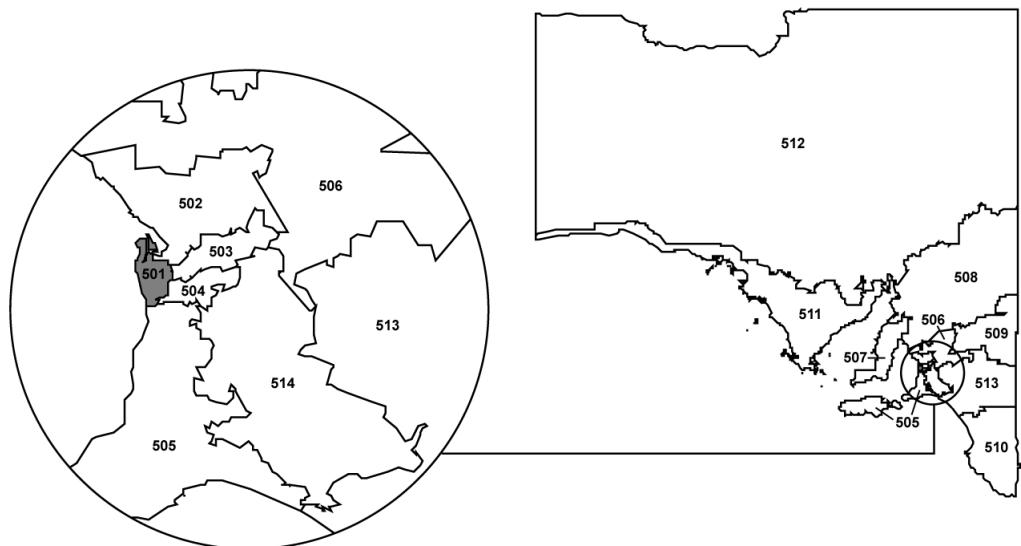
▪ What resource materials do you provide to practices?

- Current clinical guidelines,
- Clinical management forms (diabetes management review sheet),
- Information on setting up register and recall systems in their practice,
- SDGP employs a diabetes educator who is available to see patients of GPs in the Division,
- The diabetes educator also provides expert advice to GPs regarding the management of their patients with diabetes.

Division Contact Person/
Program Co-ordinator

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Adelaide Western DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	210,508	
■ Aboriginal or Torres Strait Islander	2935	1.4%
■ Speaks language other than English at home	50,441	24.0%
■ RRMA classification ¹		
1: Capital city	210,508	100.0%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	13,319	9.0%
■ High blood pressure ⁴	49,584	33.4%
■ High blood cholesterol ⁵	77,464	52.1%
■ Obese or overweight ⁶	89,818	60.4%
■ Physical inactivity ⁷	59,974	40.4%
■ Smoking ⁸	27,008	18.2%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

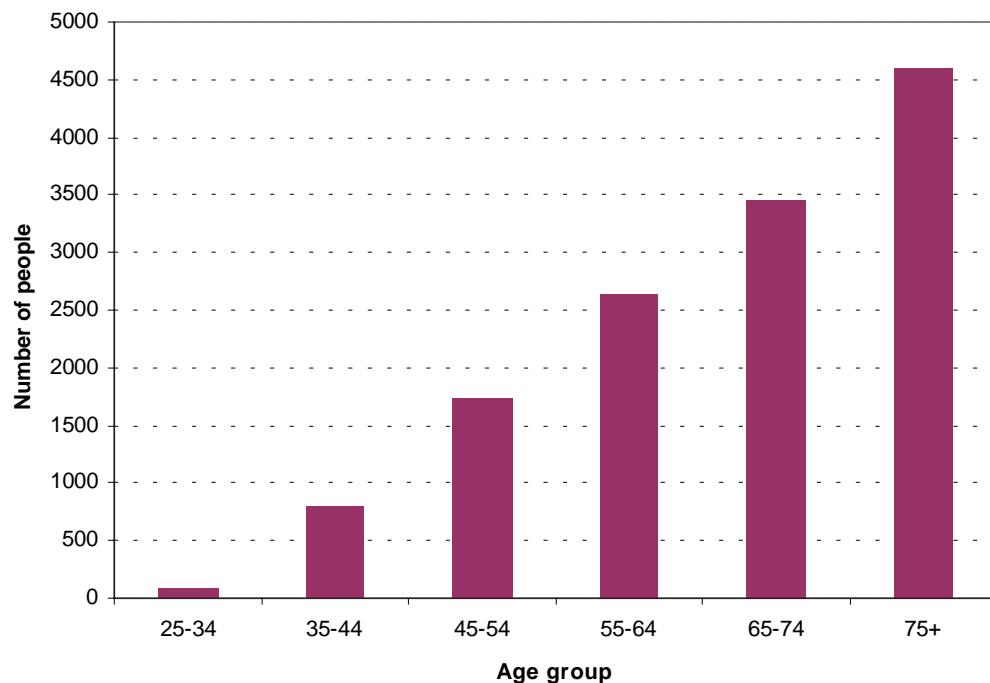
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

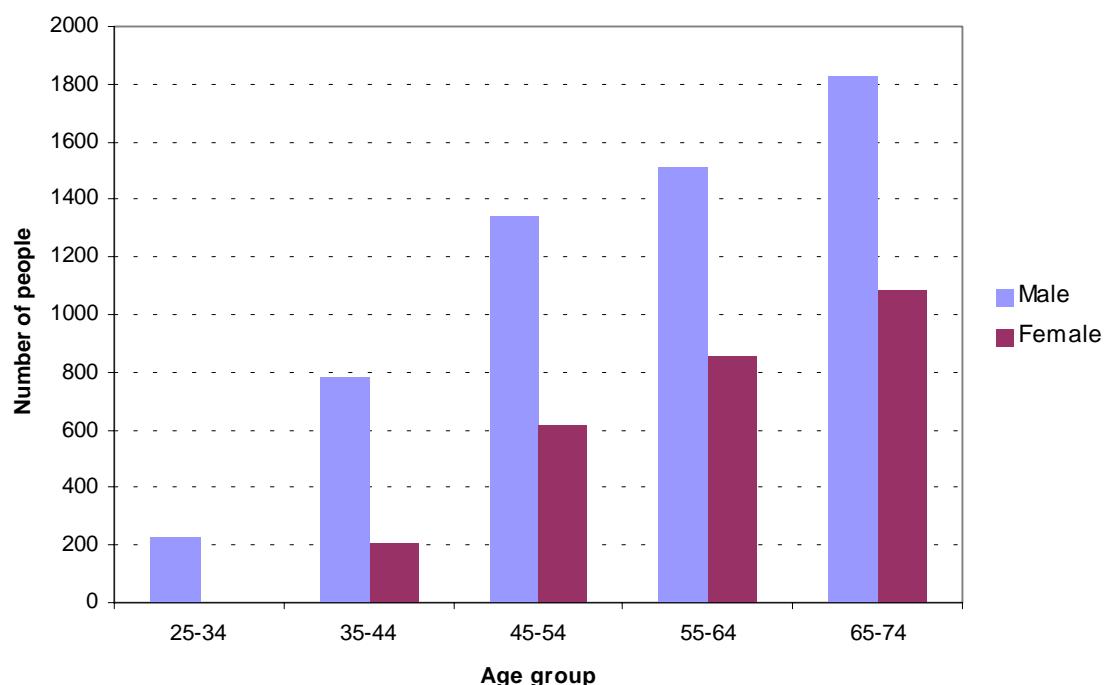
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



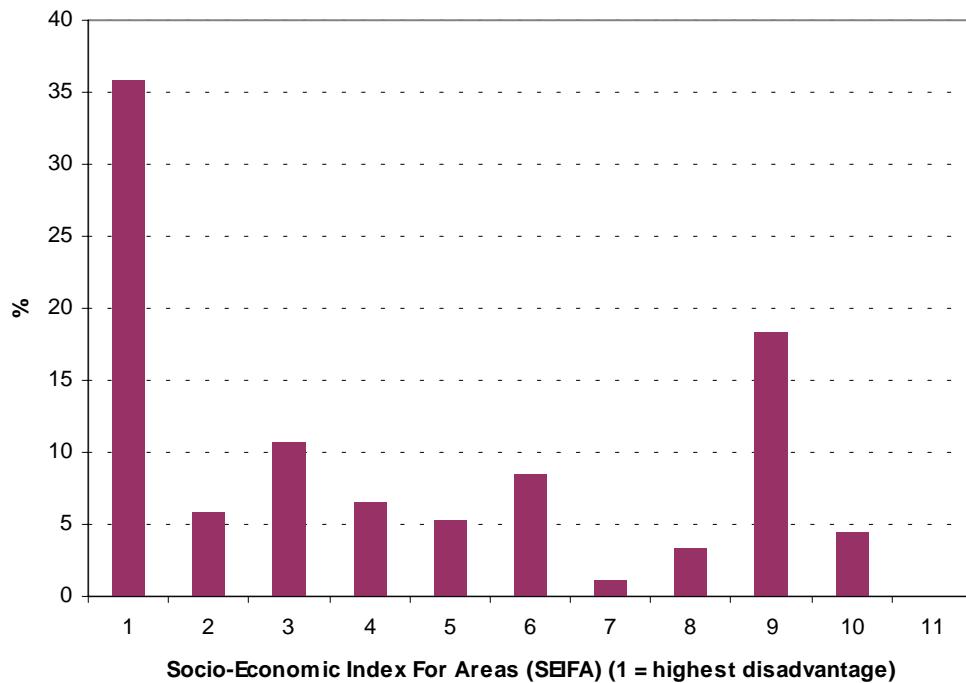
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

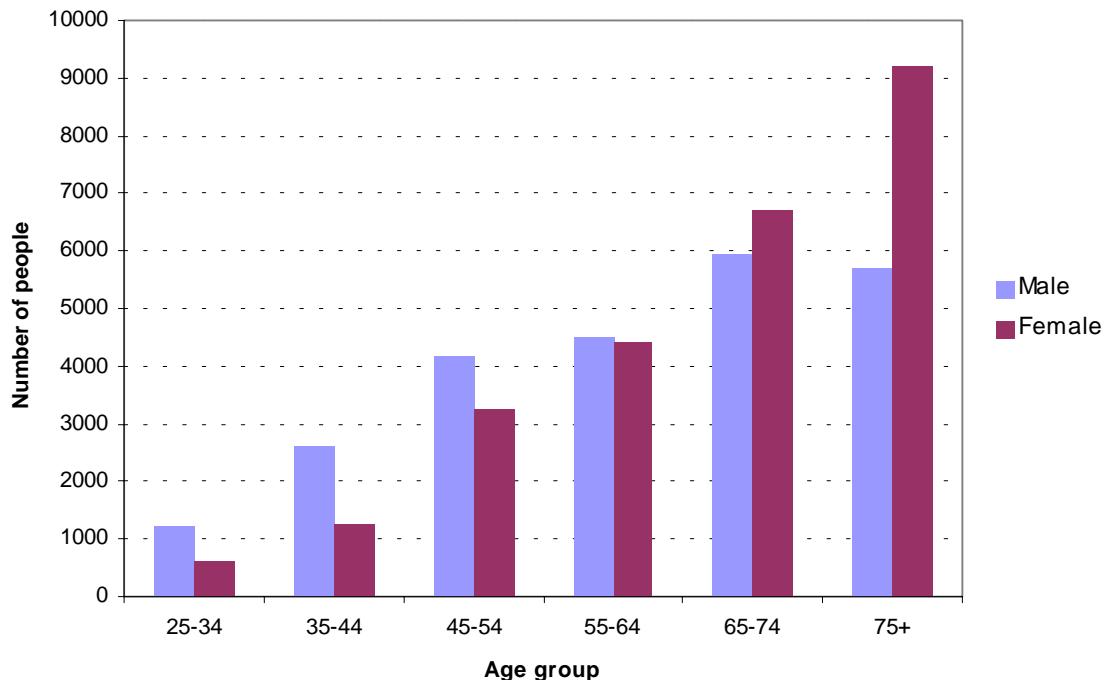
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

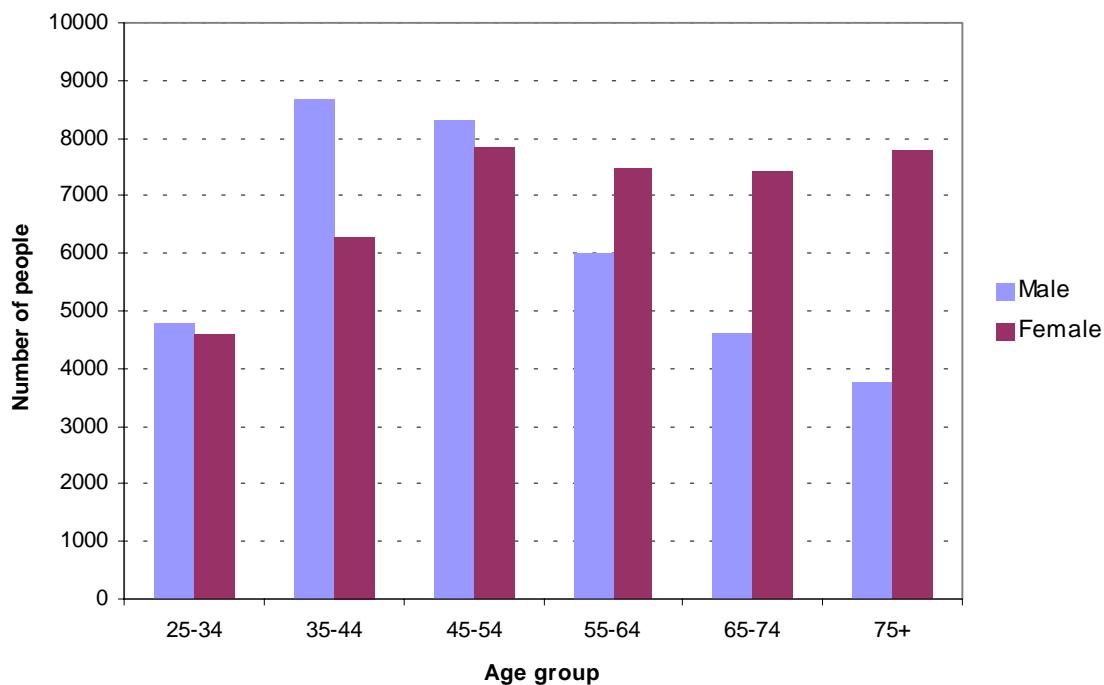
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



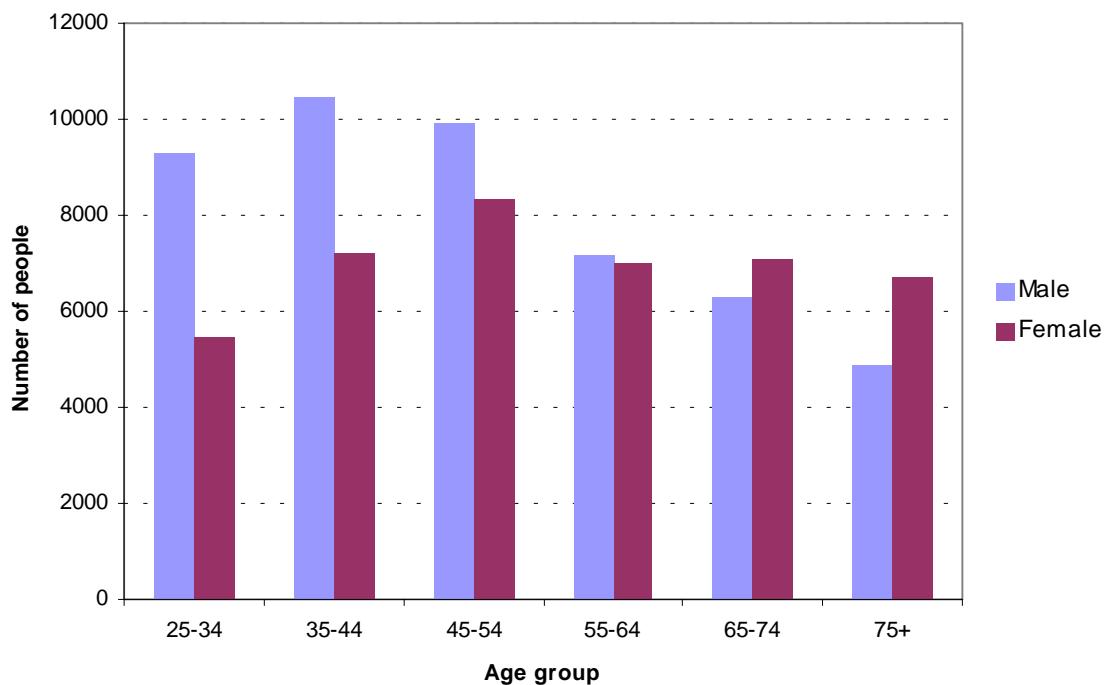
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



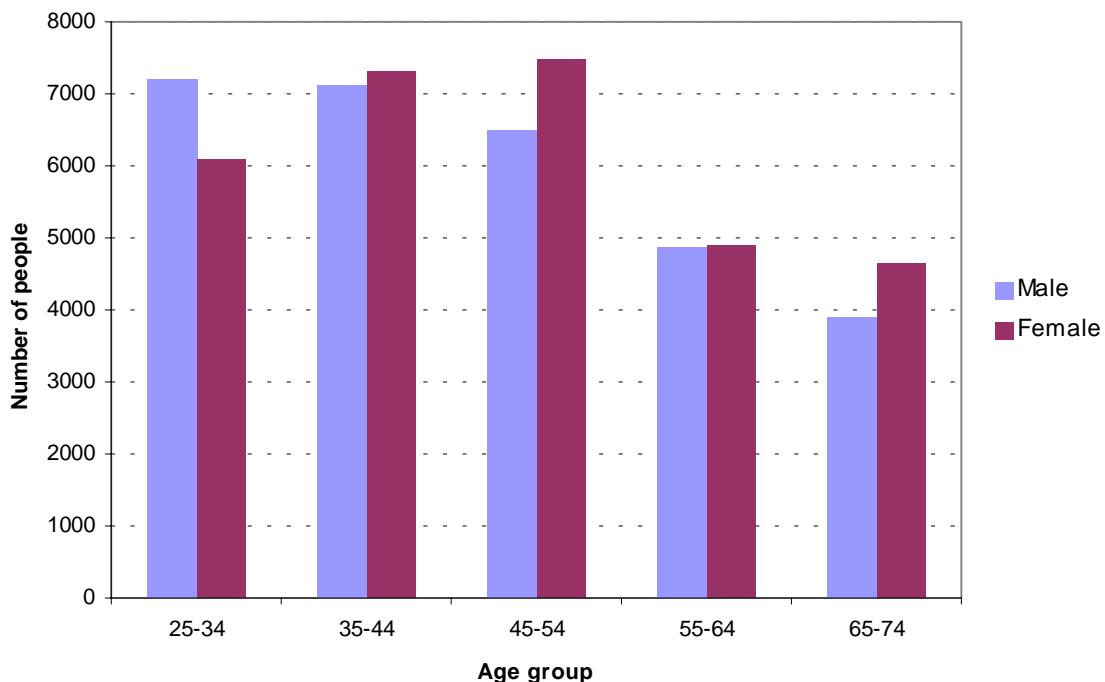
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



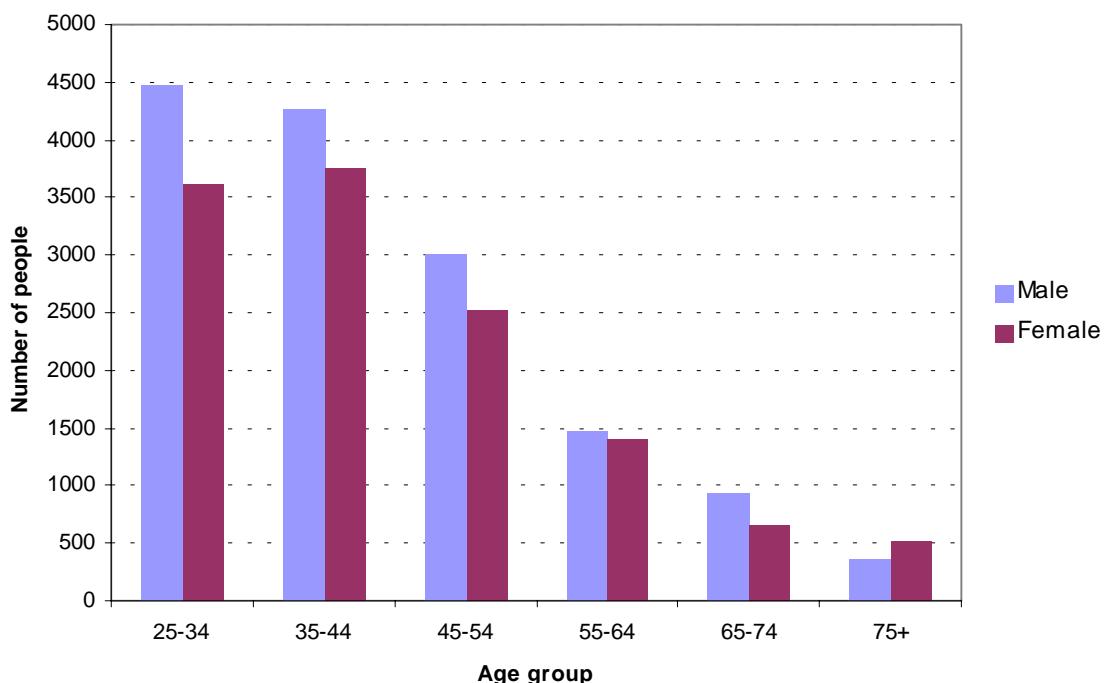
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 284 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - The Queen Elizabeth Hospital – Diabetes Centre, five educators, one dietitian,
 - Medical assessment clinic and review,
 - Diabetes outpatients clinic,
 - Funky feet workshop with podiatrist,
 - Diabetes Australia,
 - Two private hospitals – three educators, two dietitians, podiatrist,
 - Community centres – two podiatrists, two dietitians, Aboriginal health workers,
 - GAP WEST – GP assisted care planning clinics for the Western Division,
 - Division educator.

- What services are needed but are not available in your Division area?
 - Still no diabetes educator at the community centre,
 - Diabetes community support group,
 - Impaired glucose tolerance education group,
 - Need to strengthen links with community and council.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

1993 – 1997: Service provision with a team of three educators, one dietitian and one podiatrist and GP program manager. Team provided individual education (home-based) and group education at community centres.

1998 – 1999: Outcomes Based Funding (OBF) and funding to diabetes program saw shift from service provision to assisting GPs in diabetes management with introduction of a systems of diabetes care and clinical audit over six month period and establishment of diabetes mini-clinics in GP surgeries for assessment of diabetes patients.

2000-2002 GAP WEST program established. Program staff assisting GPs with new enhanced primary care items through diabetes mini-clinics for

assessment/education and planning services.

Establishment of Diabetes West health promotion pathway with key agencies and GP and consumer regularly updating communication tools and monitoring gaps in services and responding to consumer six-monthly consultation.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Continuation of diabetes miniclinics,
 - Developing early action CVD/diabetes pathway with links to cardiac rehabilitation,
 - IT/IM work in partnership to assist GPs with register/recall and templates to assist GPs with care planning,
 - GAP WEST – GP assisted care planning.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Lack of sufficient resources.

- What future plans do you have for diabetes management in your Division?
 - Develop a community-based diabetes support group,
 - Establish stronger links with community centres and the local council. Set up impaired glucose tolerance education sessions in the community,
 - Employ a dietitian and podiatrist to work on a sessional basis to assist with development of care plans.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

N/A.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Established a steering committee for Diabetes West health promotion pathway. All the key agencies involved. Six-monthly community consultations to address gaps in services and to supply new information to consumers and health professionals. Monthly clinical meeting at The Queen Elizabeth Hospital to meet with all educators, dietitians from the West and update information. Three-monthly diabetes educators meeting at South Australia Divisions Inc (SADI) to share information with other Divisions.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP diabetes management in general practice,
 - Diabetes West resources – generic referral form, self record booklet,
 - Diabetes Australia – education material,
 - The Queen Elizabeth Hospital (TQEH) Diabetes Centre fact sheet,
 - Diabetes in the family – poster and flyers.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Multicultural Video in Italian and Greek (healthy eating, monitoring exercise),
 - Diabetes self record book,
 - Templates for Medical Director for care planning,
 - Diabetes flow sheet for management by GPs.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.
- What resource materials do you provide to practices?
 - Templates for care planning,
 - Notification letters for service providers for care planning,
 - Diabetes Type 2 management guidelines – flip chart and web site,
 - Diabetes Australia education material,
 - TQEH diabetes centre fact sheets,
 - Diabetes in the family – poster and flyers,
 - Diabetes West resources,
 - RACGP diabetes management in general practice.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Public – The Queen Elizabeth Hospital Cardiac Unit Rehabilitation six-week course, Rehabilitation Risk Assessment and Self-management Home Program.

Private – Ashford Hospital Cardiac Unit and Rehabilitation.

Adelaide Western Division of General Practice (AWDGP) and The Queen Elizabeth Hospital (TQEH) have launched a Western Adelaide Branch of Heart Support.

- What services are needed but are not available in your Division area?

N/A.

CVD Program Description

- In which years did you have a CVD project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your CVD program including any changes that occurred over time?

- 1999 – Cardiovascular project, Information Screening Packs to all GPs,
- 2001 – Developing self-management model and pathway for cardiac care from TQEH to GP to care plan to community support.

Division Perspective

- What have been the major achievements or highlights of your program so far?

- Establishment of Heart Support Branch,
- Database developed,
- Training of GPs for care planning.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

N/A.

- What future plans do you have for CVD management in your Division?

- Continue to program and integrate,
- Develop Heart Support branch to include walking groups.

- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - Build upon existing links,
 - A sound understanding of theoretical framework and what you're trying to achieve,
 - Consult with key stakeholders.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Diabetes West Pathway was developed in 1998. Key organisations meet bi-monthly and consult with consumers at a six-monthly forum. This established network has enhanced communication between the Queen Elizabeth Hospital, GPs, consumers and the Community/Council services.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - National Heart Foundation resources and TQEH developed material,
 - Heart Support – Australia.

- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - CVD care plan template for Medical Director,
 - CVD hand-held care plan booklet.

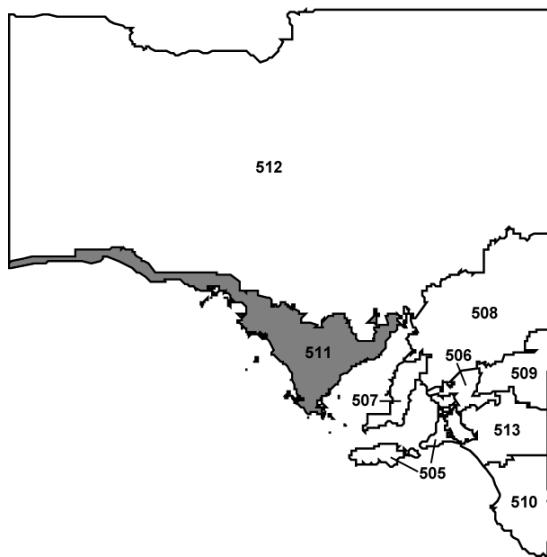
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.

- What resource materials do you provide to practices?
 - CVD care plan template,
 - Heart Support brochures,
 - Referral criteria and forms for Cardiac Rehabilitation at TQEH.

Division Contact Person/
Program Co-ordinator

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Eyre Peninsula DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	54,810	
■ Aboriginal or Torres Strait Islander	2473	4.5%
■ Speaks language other than English at home	2207	4.0%
■ RRMA classification ¹		
3: Large rural	23,349	42.6%
4: Small rural	13,100	23.9%
5: Other rural	9592	17.5%
7: Other remote	8824	16.1%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2888	8.1%
■ High blood pressure ⁴	10,997	30.7%
■ High blood cholesterol ⁵	18,561	51.8%
■ Obese or overweight ⁶	21,761	60.7%
■ Physical inactivity ⁷	15,215	42.5%
■ Smoking ⁸	6848	19.1%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999–2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

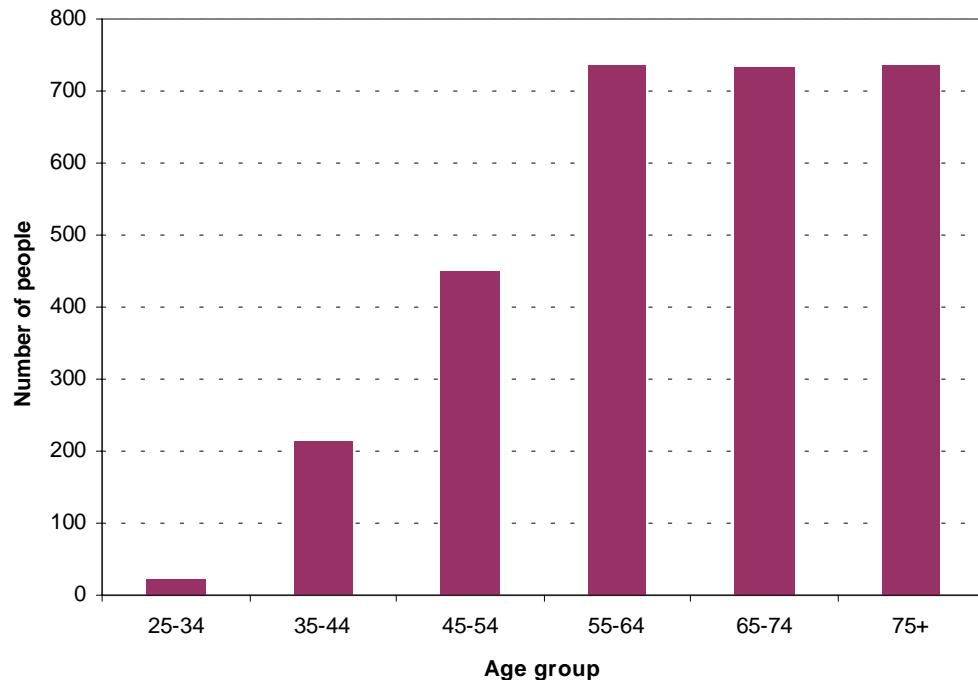
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

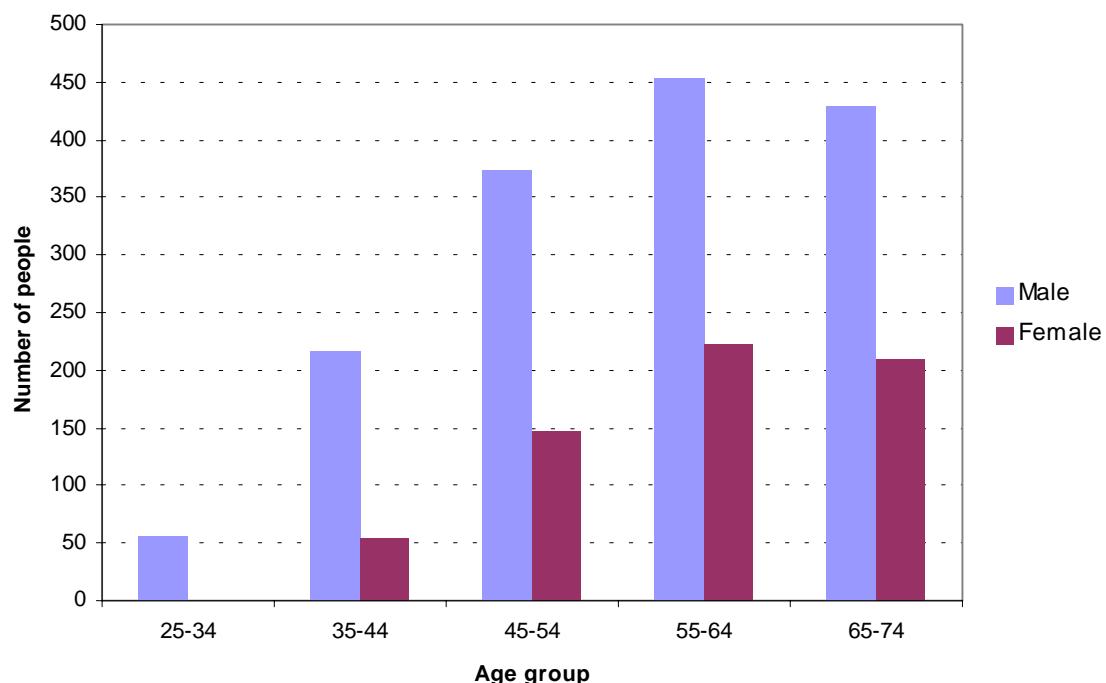
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



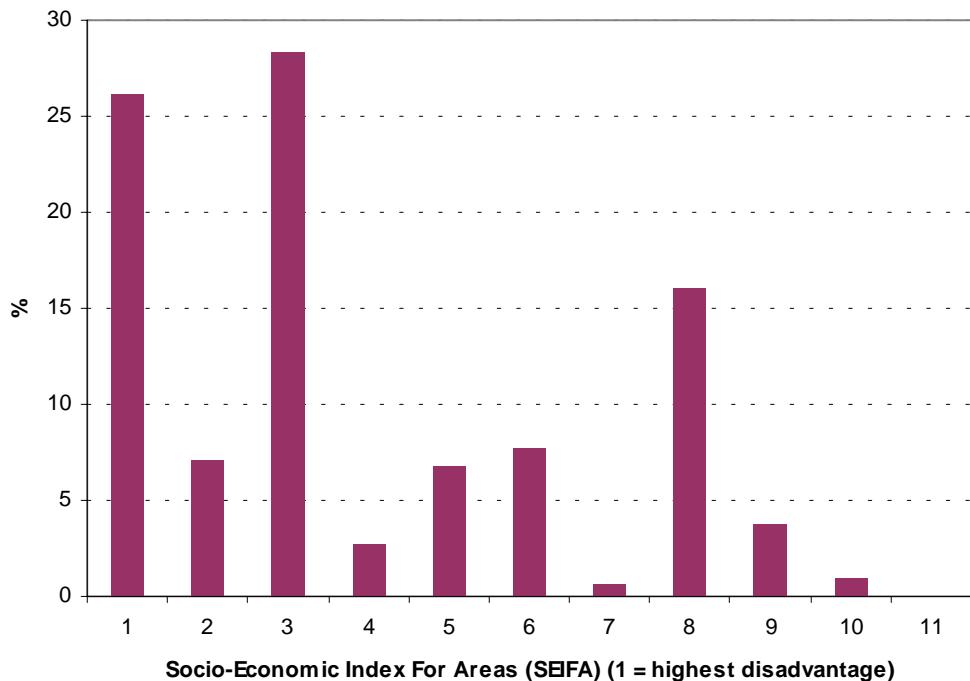
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

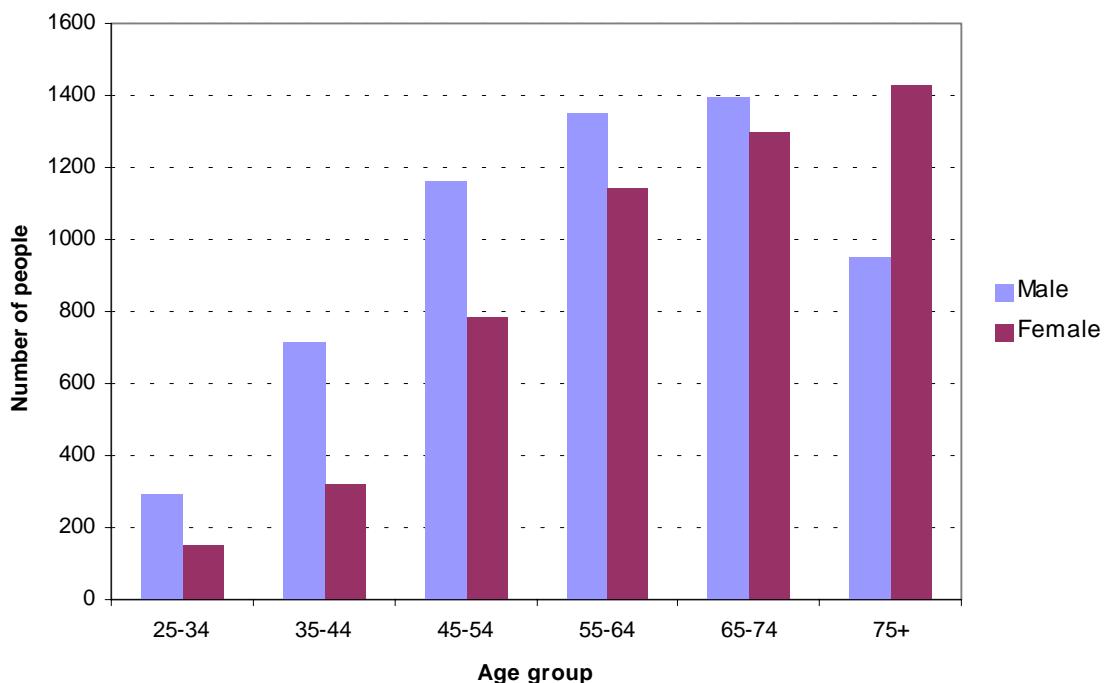
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

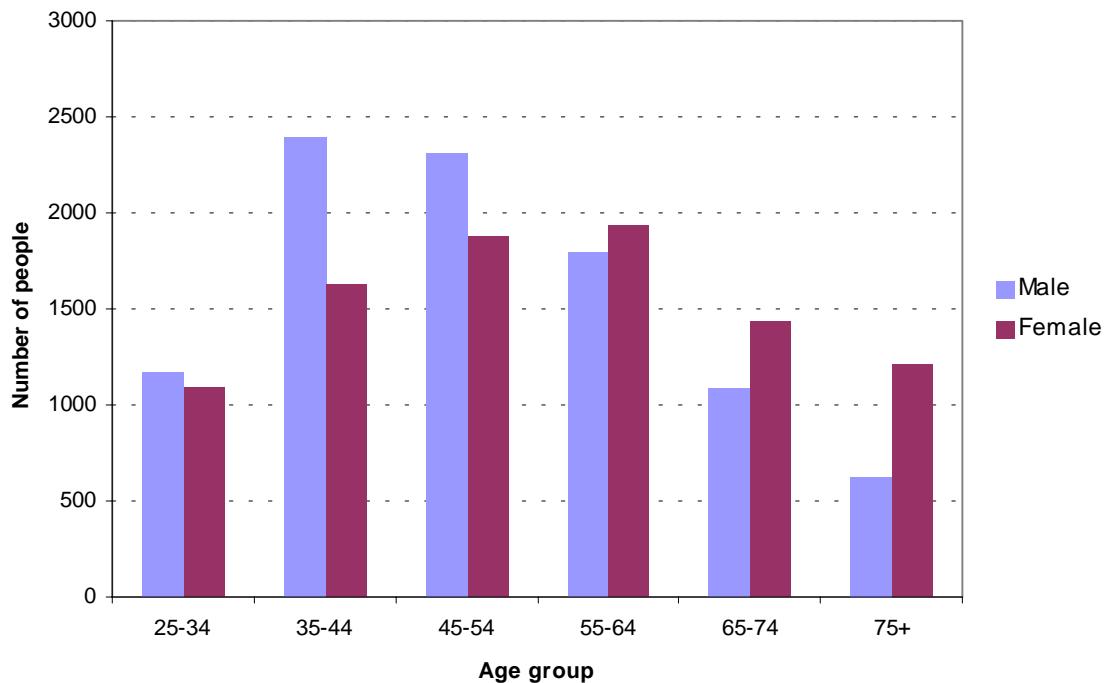
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



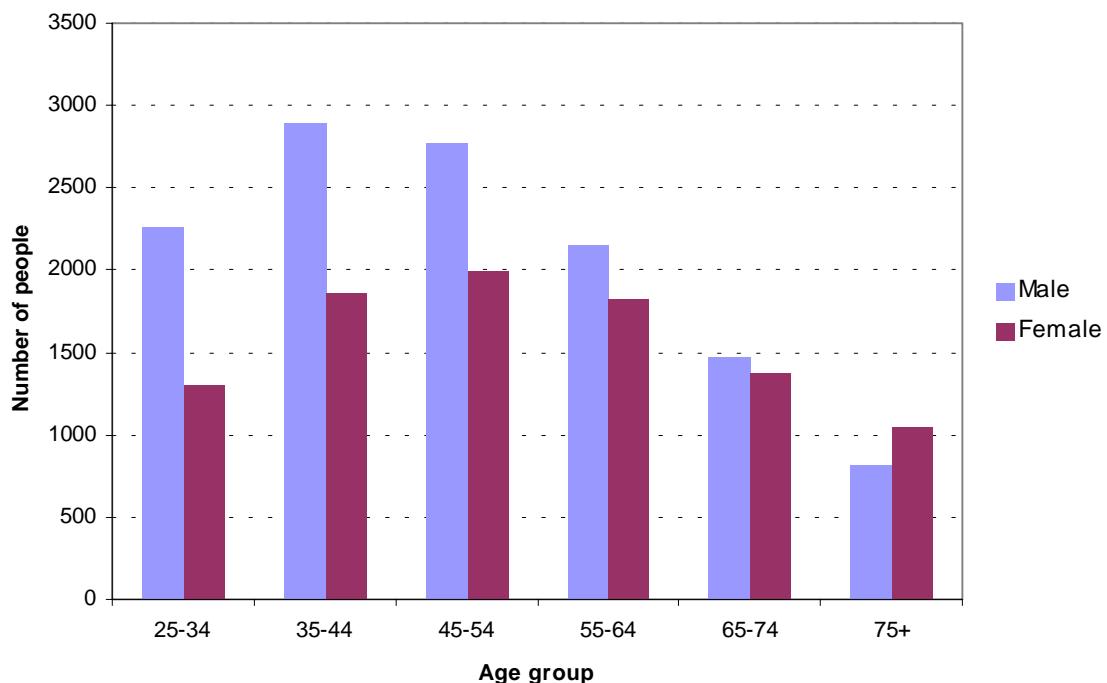
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



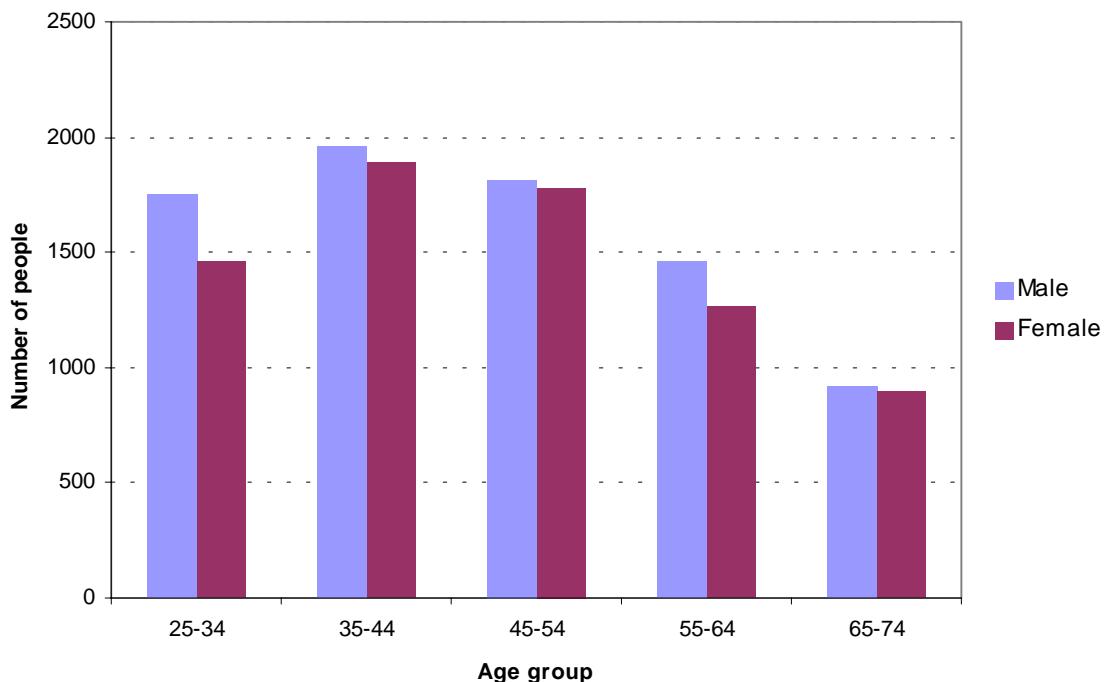
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



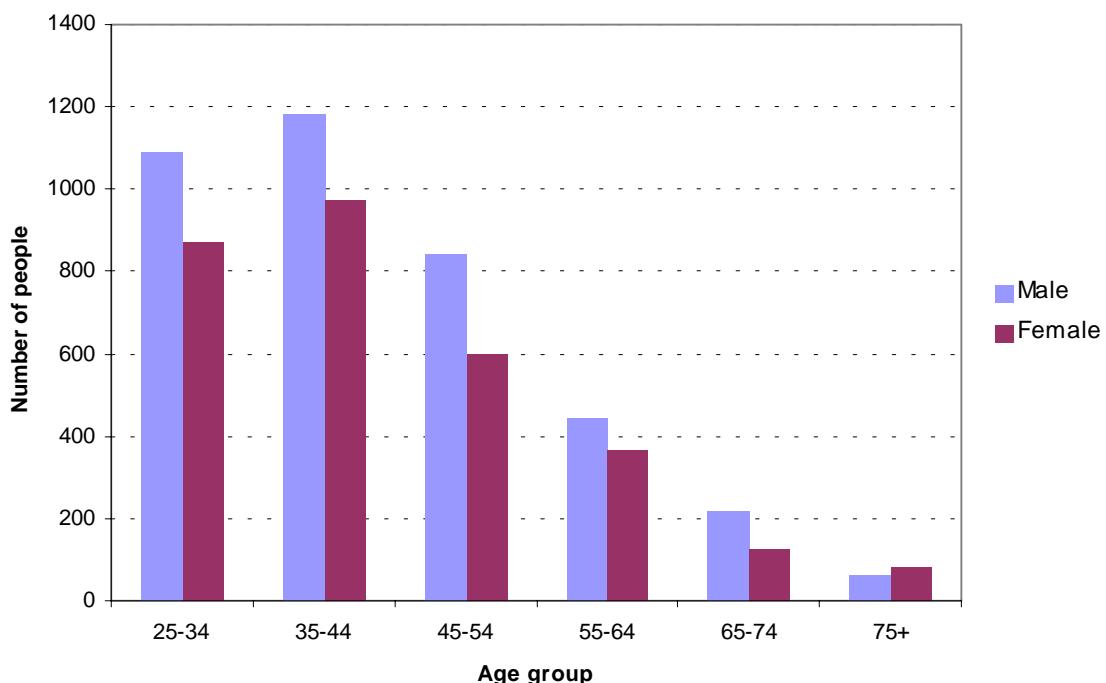
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 45 |
|-----------------------------------------------|-------|----|

Division Comments

- | | |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| ▪ Do you have any comments about the nature of the population in your area? | The population is spread over greater than 72,000 square kilometres, which gives the second lowest population density in South Australia. |
| | There are five Aboriginal communities in our region. |
| | The main industries are crop and sheep farming, fishing and aquaculture. |

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes clinic in Port Lincoln only,
 - There are 13 diabetes educators located in 11 locations with most working one day a week in that role. The approximate full time equivalents (FTE) are:
 - Port Lincoln 2.5
 - Whyalla 1.0
 - Rural 1.4

Totalling approximately 5 FTE

- What services are needed but are not available in your Division area?

More allied health.

We have 13 diabetes educators and 3.4 FTE dietitians for 60,000 people.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?

Reduction in input of diabetes clinic increased management by GPs using care plans and Enhanced Primary Care (EPC).

Division Perspective

- What have been the major achievements or highlights of your program so far?

Use of EPC item numbers. Most GPs now using these and incorporating diabetes in chronic disease programs.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

No.

- What future plans do you have for diabetes management in your Division?

Continue to reduce diabetes clinic and development of GP registers and management (this is more sustainable and our long term goal).

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives? Division support ++.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - South Australian Diabetes Strategy Group (SA government),
 - South Australian Divisions Incorporated (SADI) network.

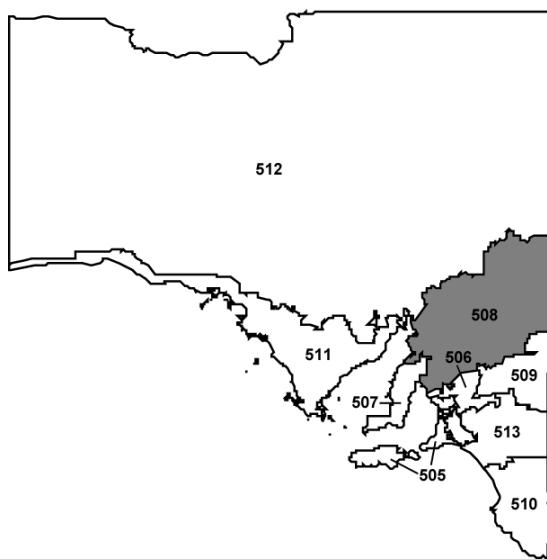
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)? None.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? We have developed a clinical pathway at SADI, which has gone to every GP in SA; it is an electronic and paper version. We are also developing a web site.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? If you can help with funding our wide area network (WAN) then we can link all the practices!
- What resource materials do you provide to practices?
 - EPC support to develop care plans,
 - Eyre Care electronic version.

Division Contact Person/
Program Co-ordinator

Name: Ms Sylvia Dansie
Phone: 08 8682 5599
Fax: 08 8682 5590
Email: sdansie@epdgp.org.au

Mid North Rural SA DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	45,015	
■ Aboriginal or Torres Strait Islander	683	1.5%
■ Speaks language other than English at home	1159	2.6%
■ RRMA classification ¹		
4: Small rural	15,075	33.5%
5: Other rural	29,170	64.8%
7: Other remote	765	1.7%
■ SEIFA category containing population median: ²	4	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2785	9.1%
■ High blood pressure ⁴	10,383	34.0%
■ High blood cholesterol ⁵	16,333	53.4%
■ Obese or overweight ⁶	18,817	61.5%
■ Physical inactivity ⁷	12,715	41.6%
■ Smoking ⁸	5520	18.1%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

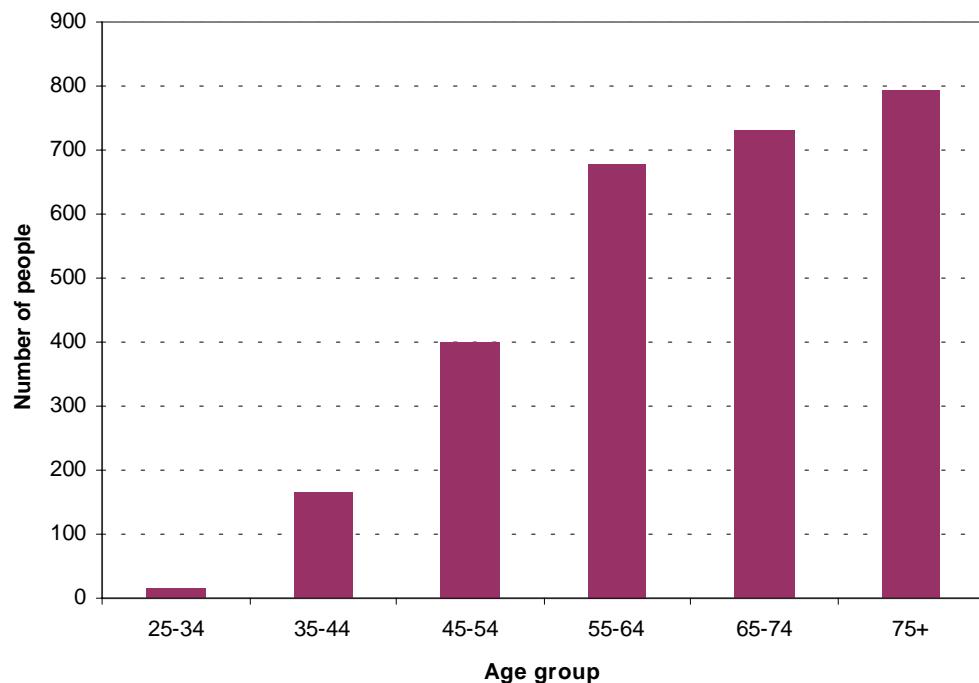
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

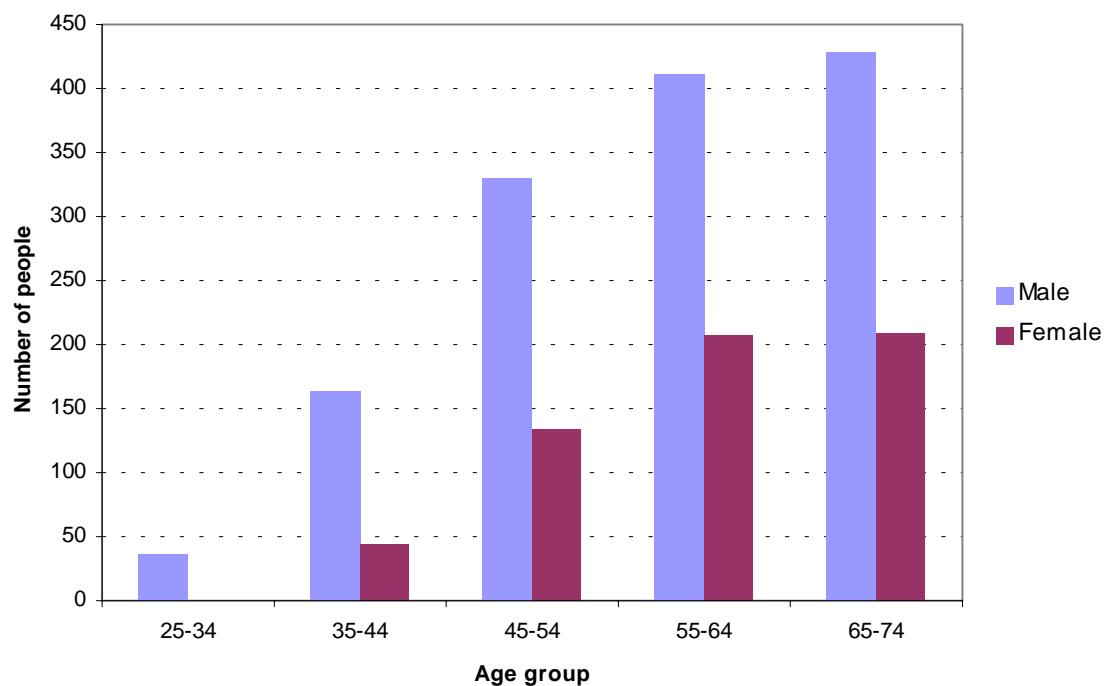
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



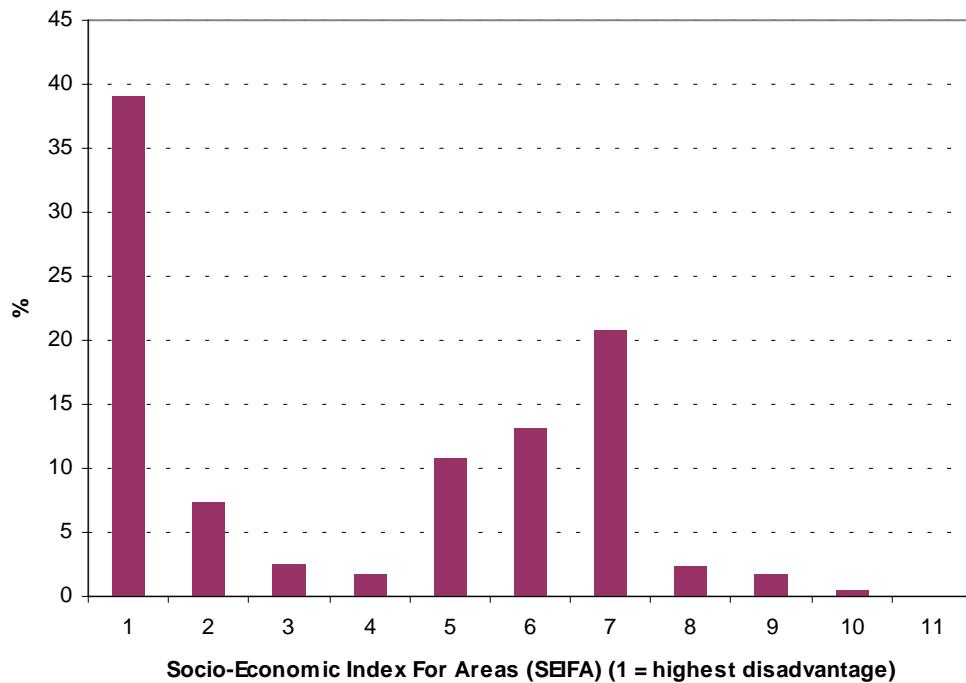
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

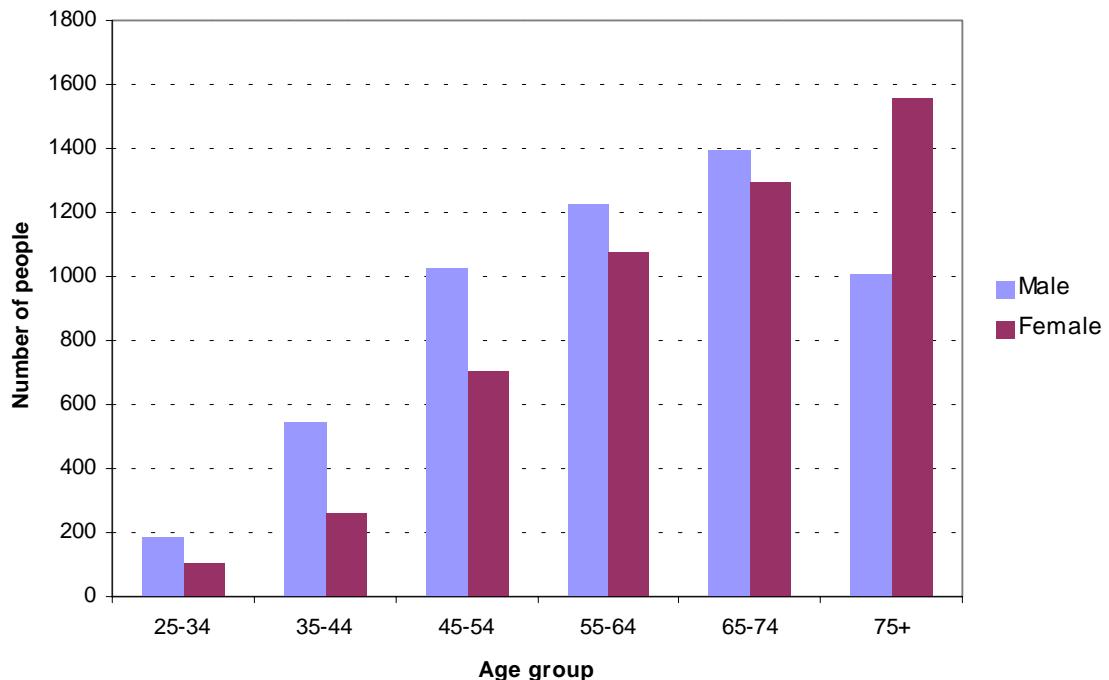
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

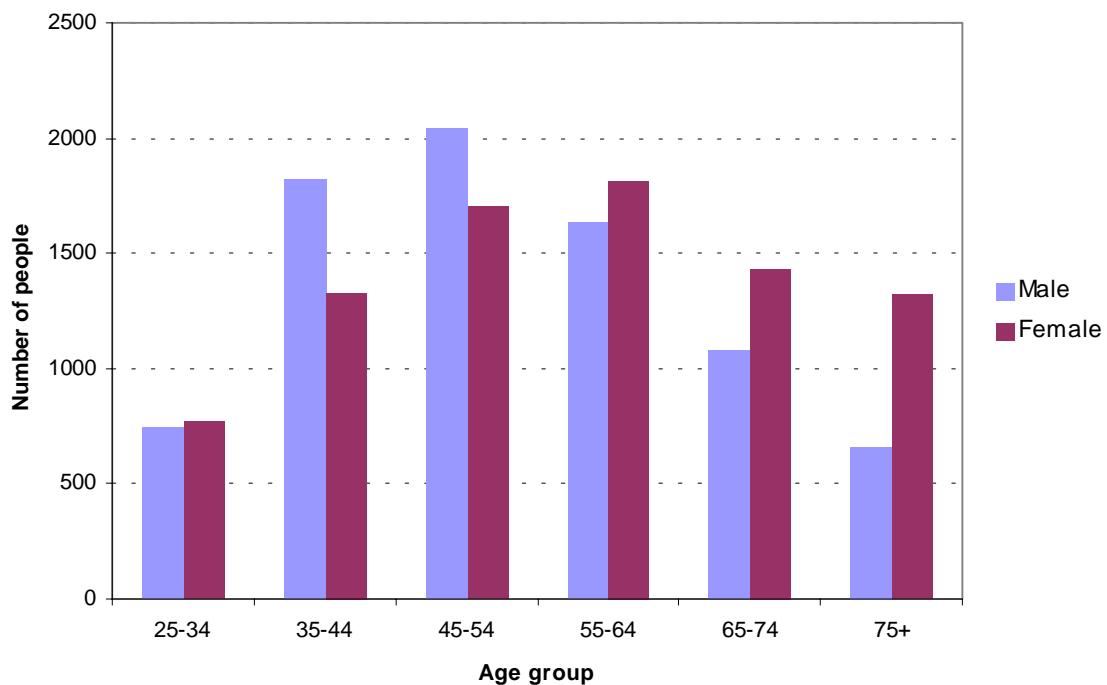
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



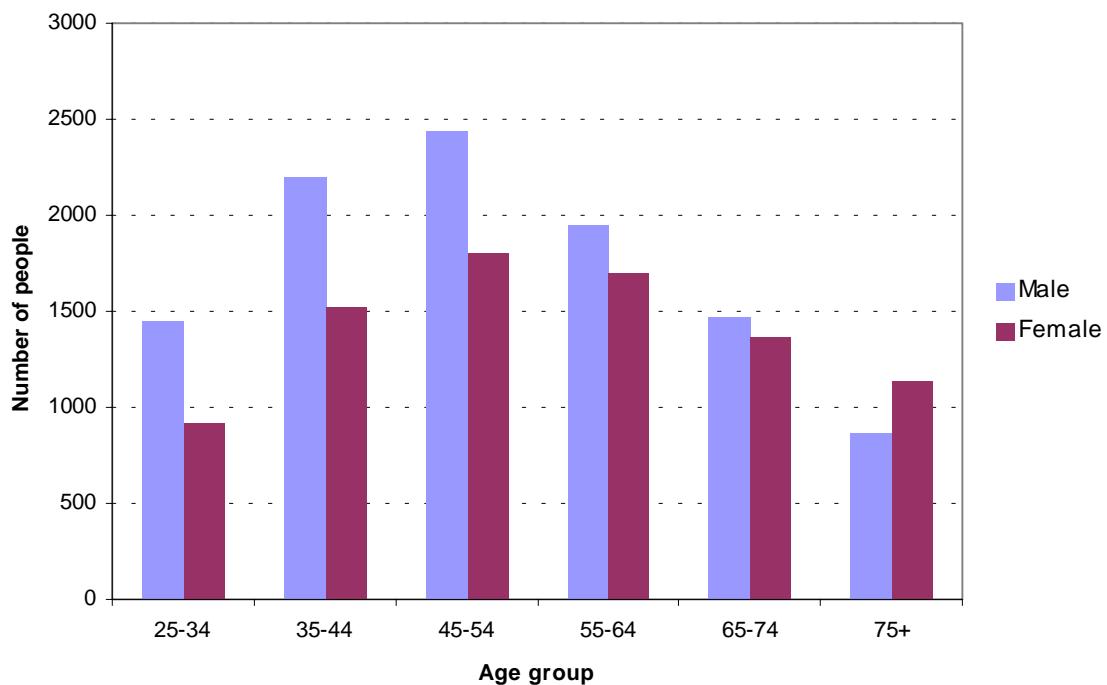
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



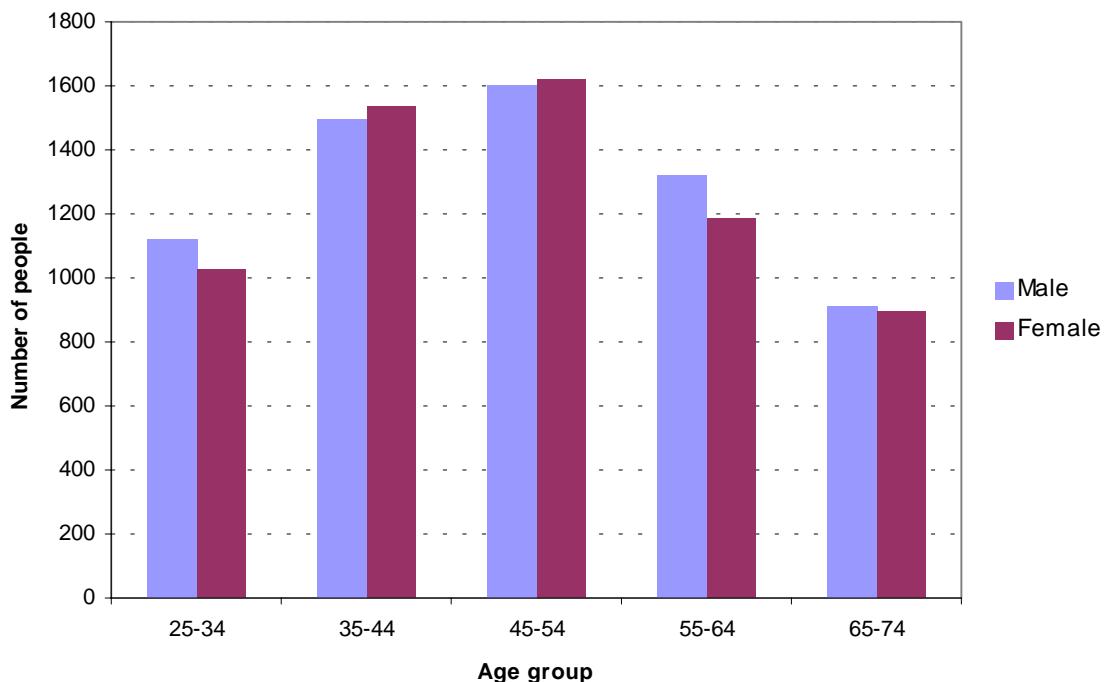
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



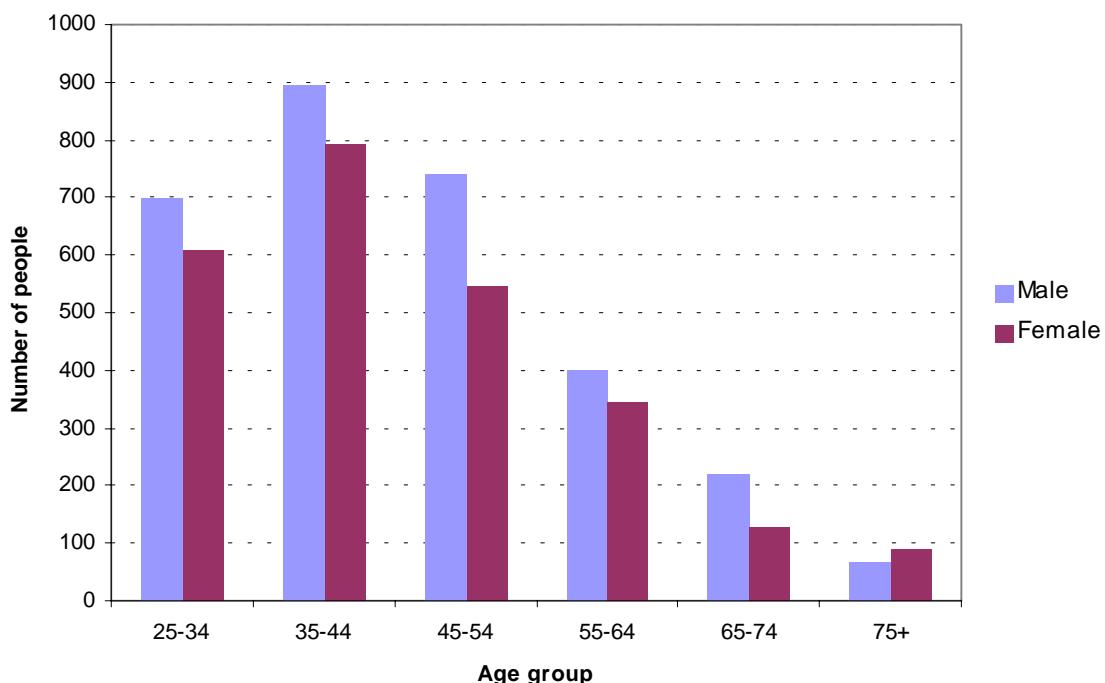
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 42 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes nurse educators available at both Community Health Centres,
 - Diabetes nurse educator working in one general practice (0.1 FTE),
 - Wakefield Health funds 0.2 FTEs for each health service in Wakefield Health region = 2 health services in our Division area.

- What services are needed but are not available in your Division area?
 - Diabetes nurse educators,
 - Dietitians,
 - Podiatrists.

These services are available, but with limited availability.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input checked="" type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

We do not have a specific diabetes program, however, we do employ nine Primary Health Care Nurses for nine general practices within our Division, a number of which either focus on or include diabetes health assessments as part of their role.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Increased number of Diabetes Health Assessments being conducted.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Lack of funding.

- What future plans do you have for diabetes management in your Division?

Continue to support Primary Health Care Nurses to upskill in Diabetes Management (Quarterly training sessions held on various topics).

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives? Availability/use of practice nurse.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them? N/A.

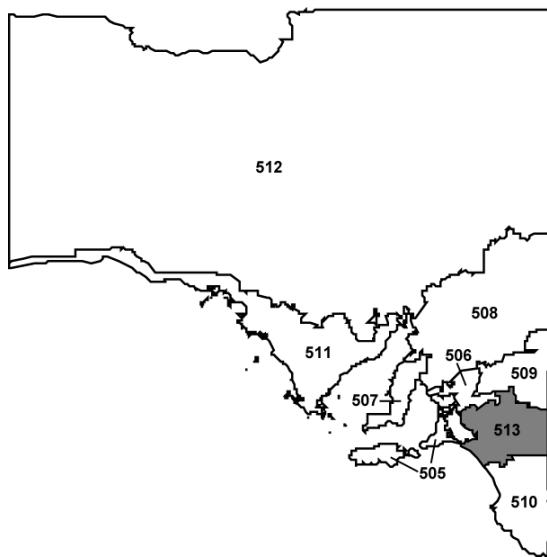
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)? N/A.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? Resource outlining register and recall systems available.
- What resource materials do you provide to practices? General info.

Division Contact Person/
Program Co-ordinator

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Murray Mallee DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	29,965	
■ Aboriginal or Torres Strait Islander	1052	3.5%
■ Speaks language other than English at home	966	3.2%
■ RRMA classification ¹		
4: Small rural	16,720	55.8%
5: Other rural	13,245	44.2%
■ SEIFA category containing population median: ²	1	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1752	8.7%
■ High blood pressure ⁴	6578	32.7%
■ High blood cholesterol ⁵	10,611	52.7%
■ Obese or overweight ⁶	12,341	61.3%
■ Physical inactivity ⁷	8459	42.0%
■ Smoking ⁸	3721	18.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

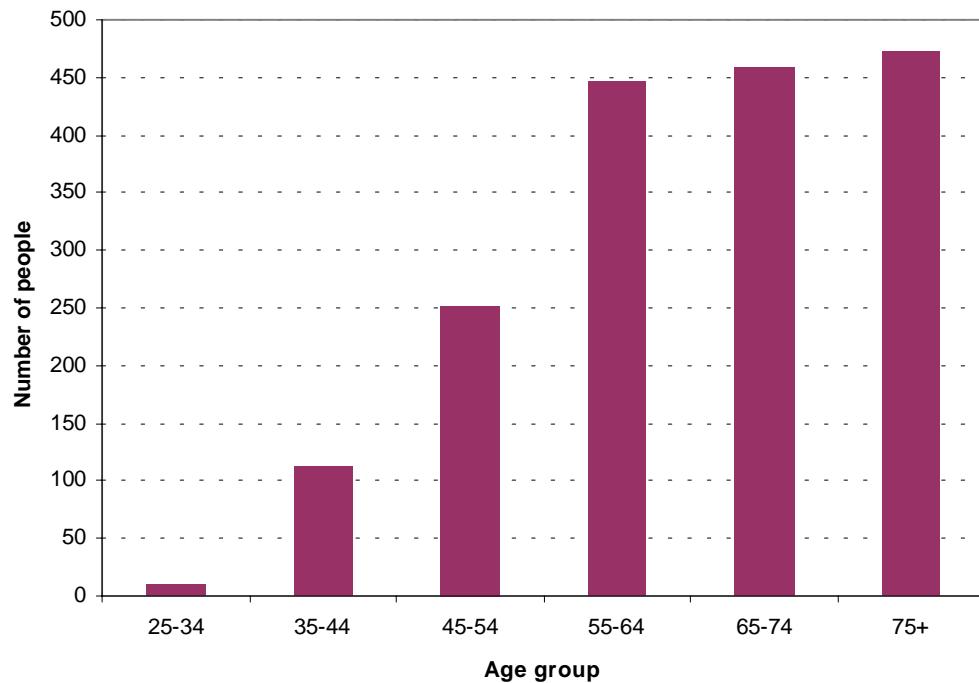
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

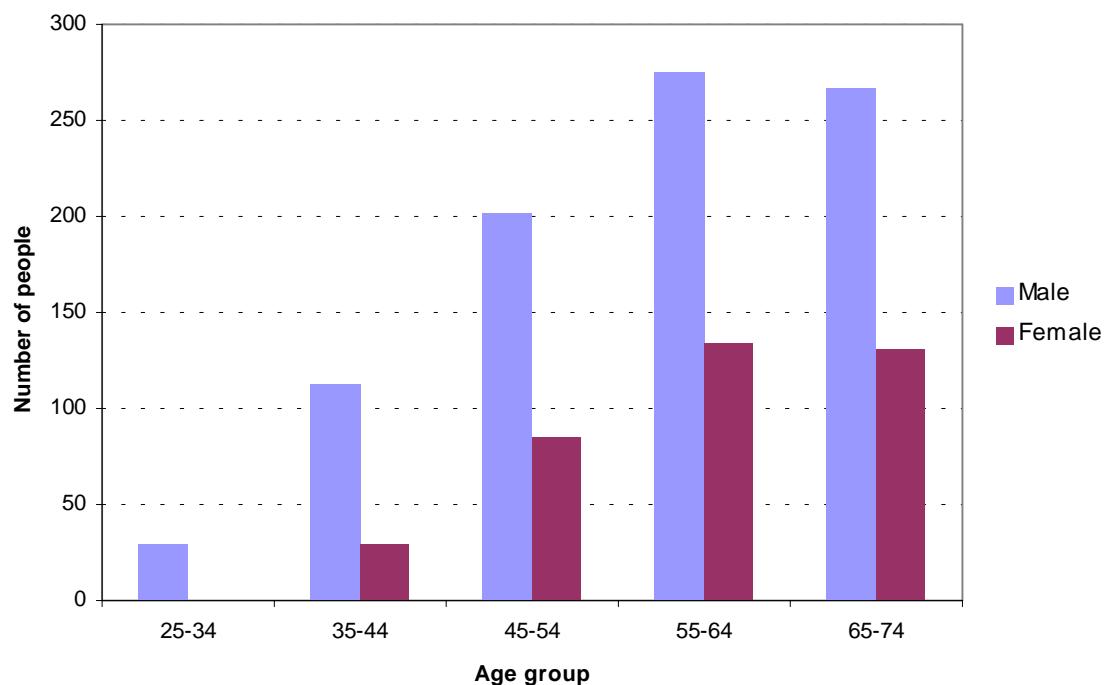
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



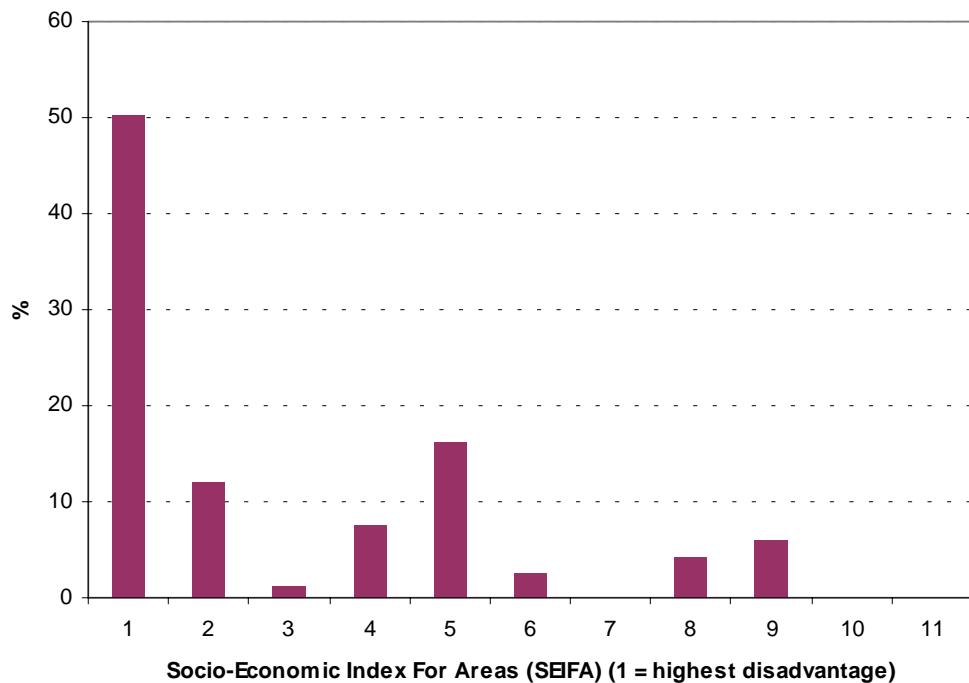
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

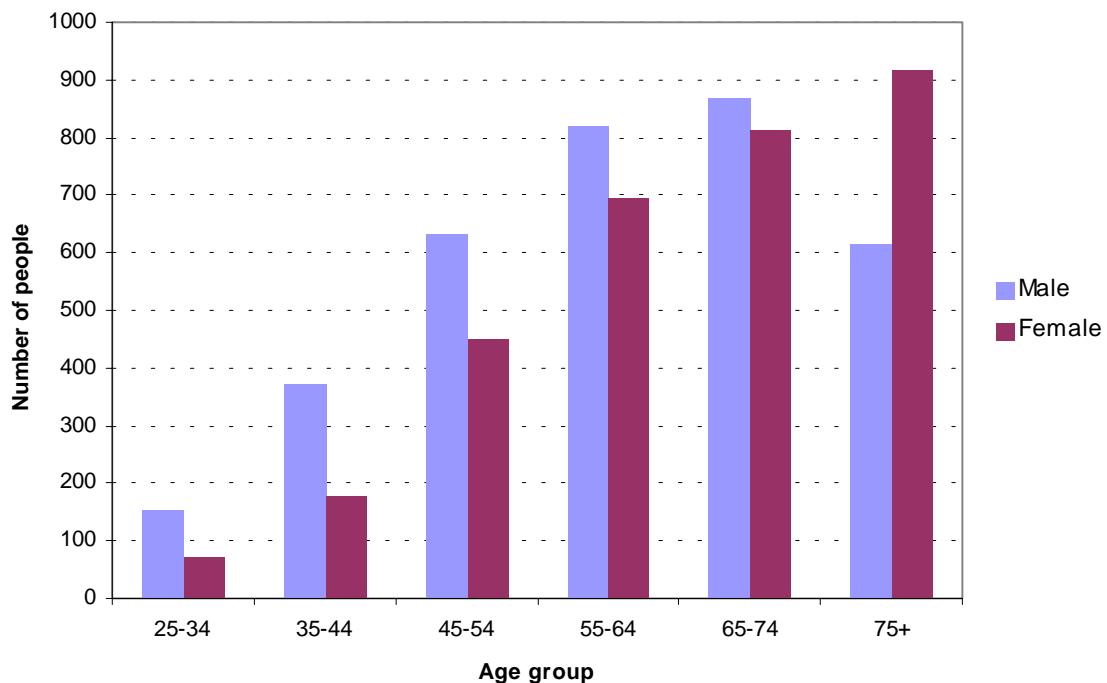
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

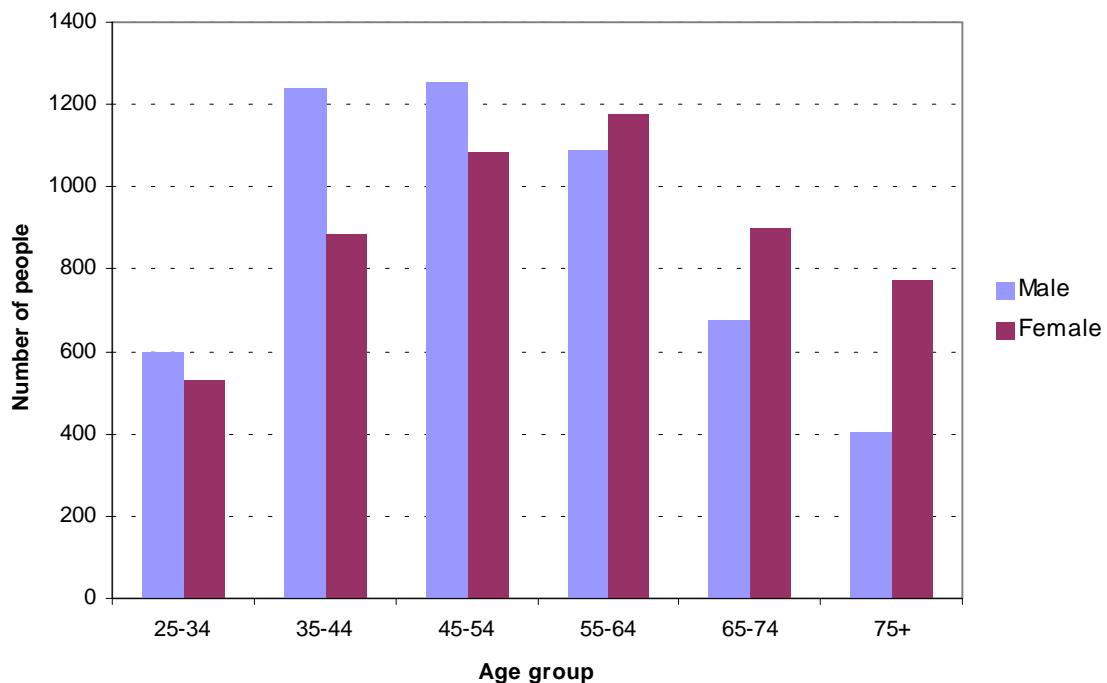
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



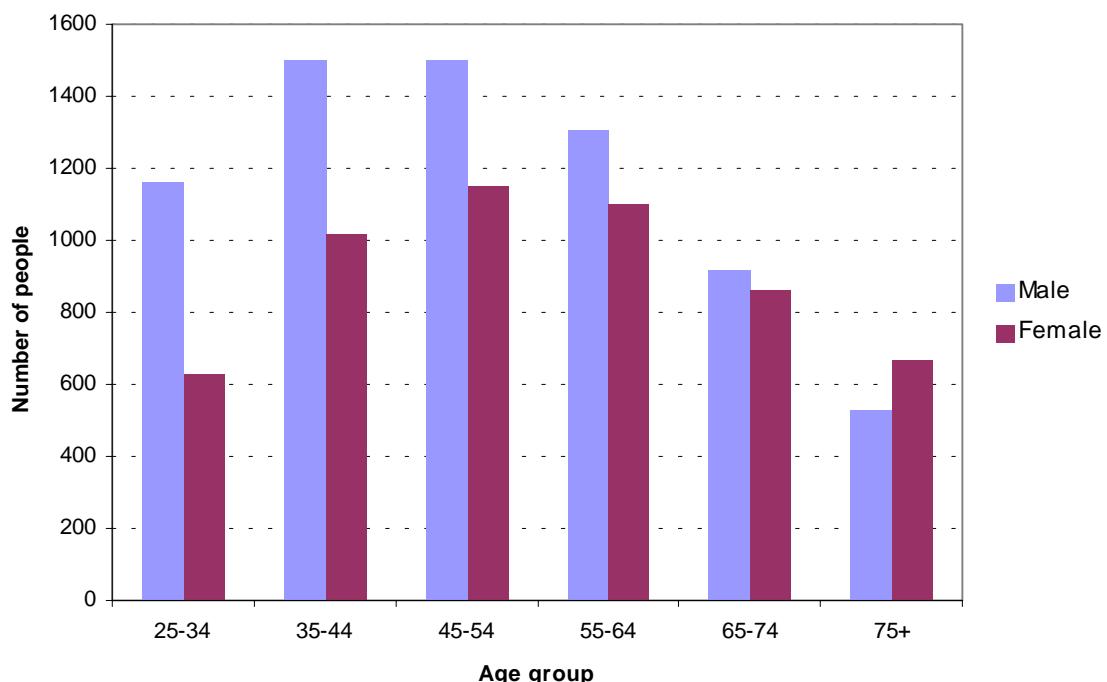
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



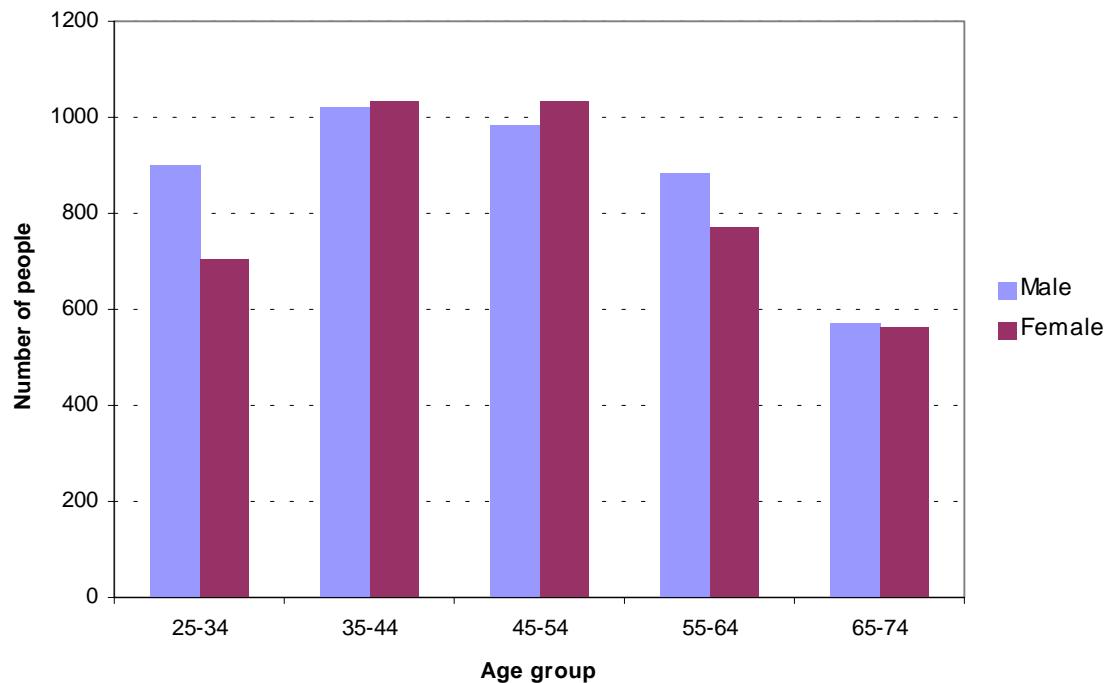
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



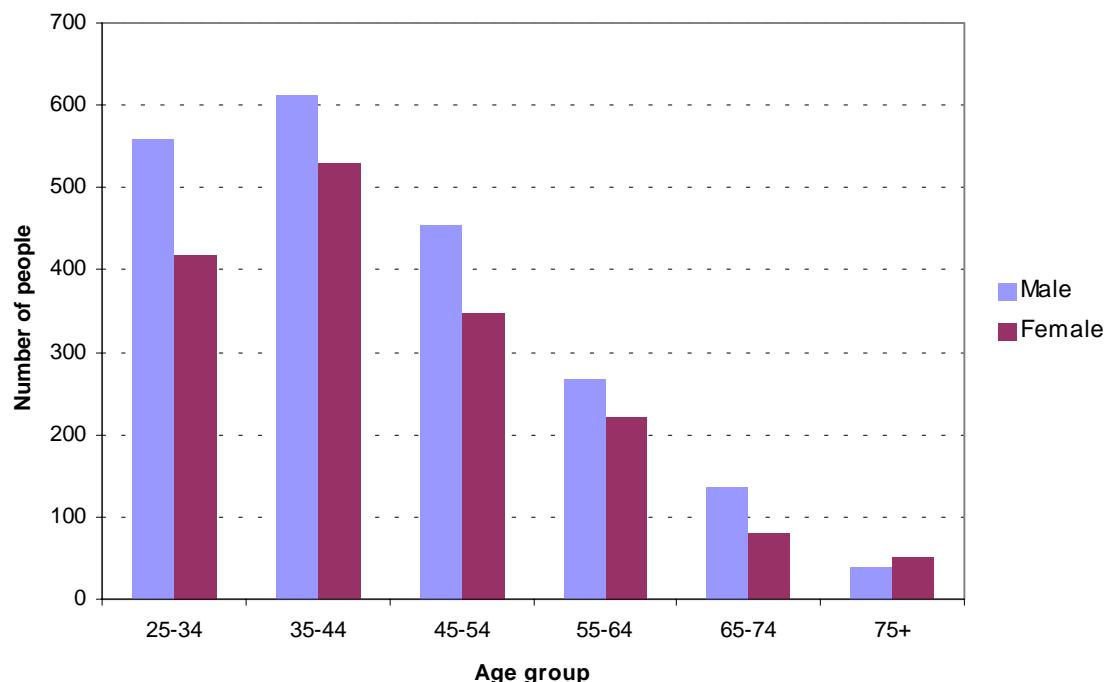
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 28 |
|-----------------------------------------------|-------|----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Public

- Murray Mallee Community Health Service (services not specifically for diabetes except for coordinator and diabetes nurse educator):
 - Regional diabetes coordinator,
 - Diabetes nurse educator,
 - Podiatry,
 - Dietitian.

Private

- Podiatry,
- Visiting endocrinologist.

Public services are located in regional centre with visiting services to other towns with practice/hospital.

- What services are needed but are not available in your Division area?

Difficulty in recruiting podiatry, but currently okay.

The Regional Health Service has committed a minimum level of diabetes services (to provide a minimum level of services to 4% of the population) as identified in the Regional Integrated Diabetes Plan. These services are used to capacity.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

- The Hills Mallee Southern Integrated Diabetes Program offers Diabetes Review Clinics to patients diagnosed for longer than 12 months. The diabetes nurse educator, podiatrist, dietitian and GP provide clinics in the practices with patients seeing all service providers in the one visit. Referrals to clinics are made by GPs. Following each session the four service providers meet to discuss each patient and to document a care plan for the following 12 months.

- Allied health services are funded by the Regional Health Service, and GPs are funded through Medicare for patient contact and the EPC Care Planning item number for care planning meeting.

Division Perspective

- What have been the major achievements or highlights of your program so far?

All practices are involved with the review clinics. To date, 433 individual patients are on the database from a population of less than 30,000. This was the first integrated care program of the Division and a positive working relationship has been established between the Regional Health Service and general practice.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

A minimum level of service has been provided by the Regional Health Service, but the demand is much higher. Only those most at risk are able to be accepted by review clinics. We would like to be able to target those at risk, but current resources (which are higher than most other areas in SA) do not allow this.
- What future plans do you have for diabetes management in your Division?

The Division is promoting use of the diabetes cycle of care for all people with diabetes and review clinics for those most at risk.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Simple referral and recording systems in place when program commenced – excessive paperwork is strongly resented by practices,
 - Ongoing support from both the regional coordinator and Divisional staff for GPs and practice staff has been essential.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - The Integrated Diabetes program was developed collaboratively with the Regional Health Service and is therefore more sustainable than programs with Divisional contract funding.
 - The Division facilitates a Health Partnerships Forum, which focuses on areas where improved collaboration between general practice and the wider health system will improve population health outcomes. The Diabetes program was the first program undertaken.

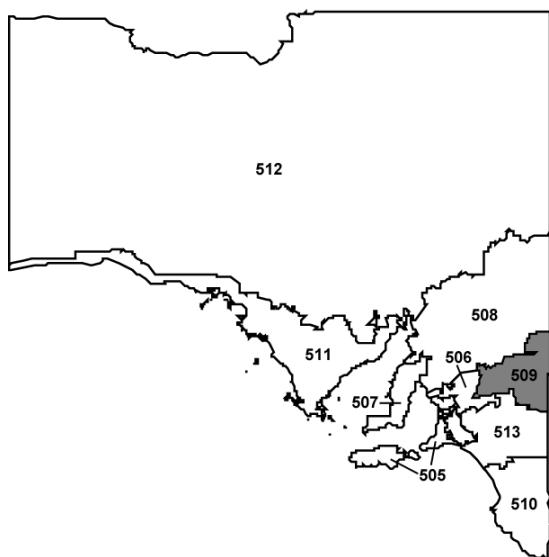
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)? RACGP Guidelines.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? Diabetes Patient Held Record.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? No.
- What resource materials do you provide to practices?
 - Referral forms,
 - Patient Held Records,
 - RACGP guidelines.

**Division Contact Person/
Program Co-ordinator**

Name: Chris McRae
Phone: 08 8531 1303
Fax: 08 8531 1427
Email: cmcrae@lm.net.au

Riverland DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	34,655	
■ Aboriginal or Torres Strait Islander	797	2.3%
■ Speaks language other than English at home	3081	8.9%
■ RRMA classification ¹		
5: Other rural	34,378	99.2%
7: Other remote	277	0.8%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1963	8.4%
■ High blood pressure ⁴	7421	31.9%
■ High blood cholesterol ⁵	12,163	52.3%
■ Obese or overweight ⁶	14,205	61.1%
■ Physical inactivity ⁷	9777	42.1%
■ Smoking ⁸	4355	18.7%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

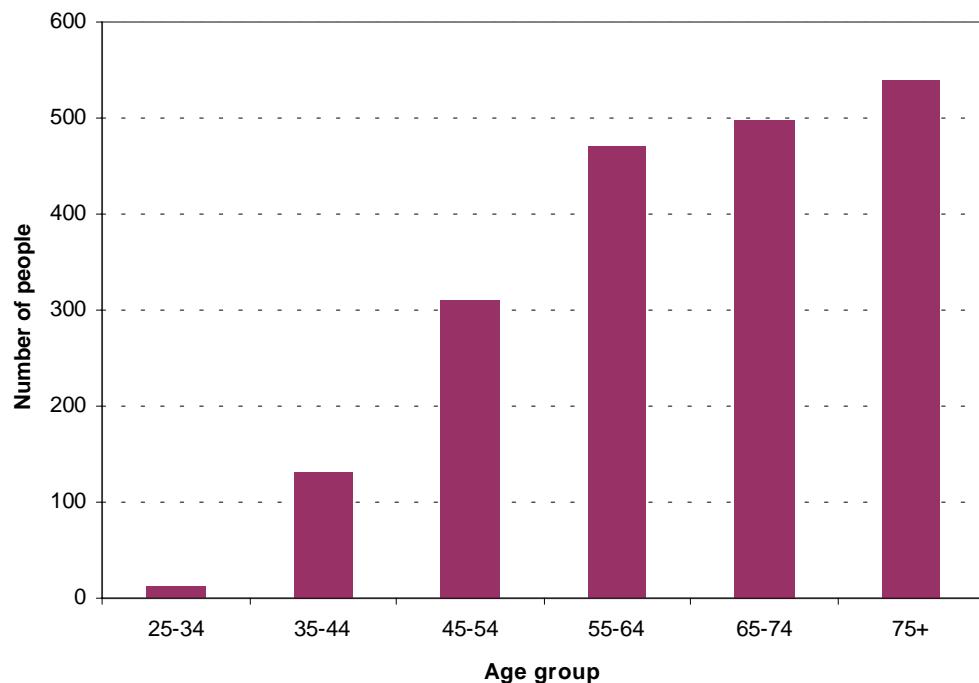
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

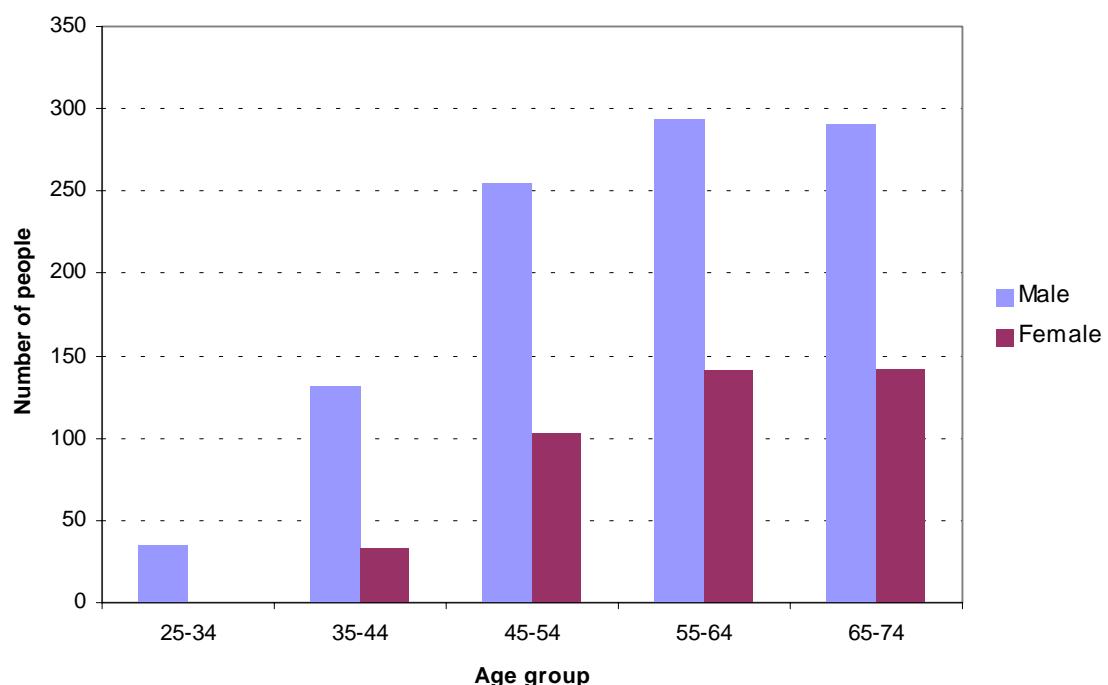
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



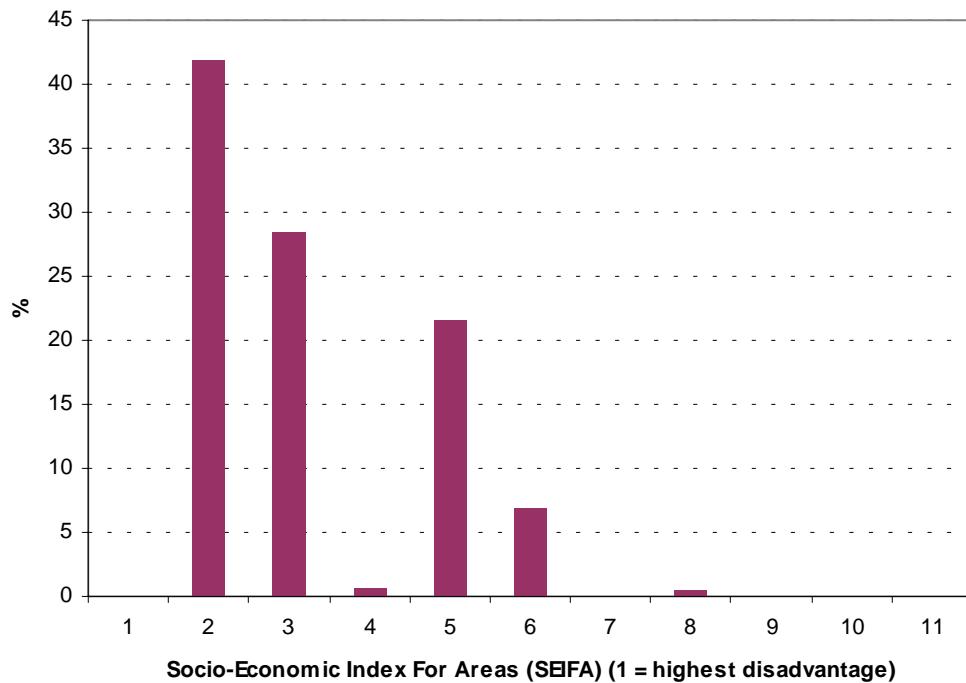
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

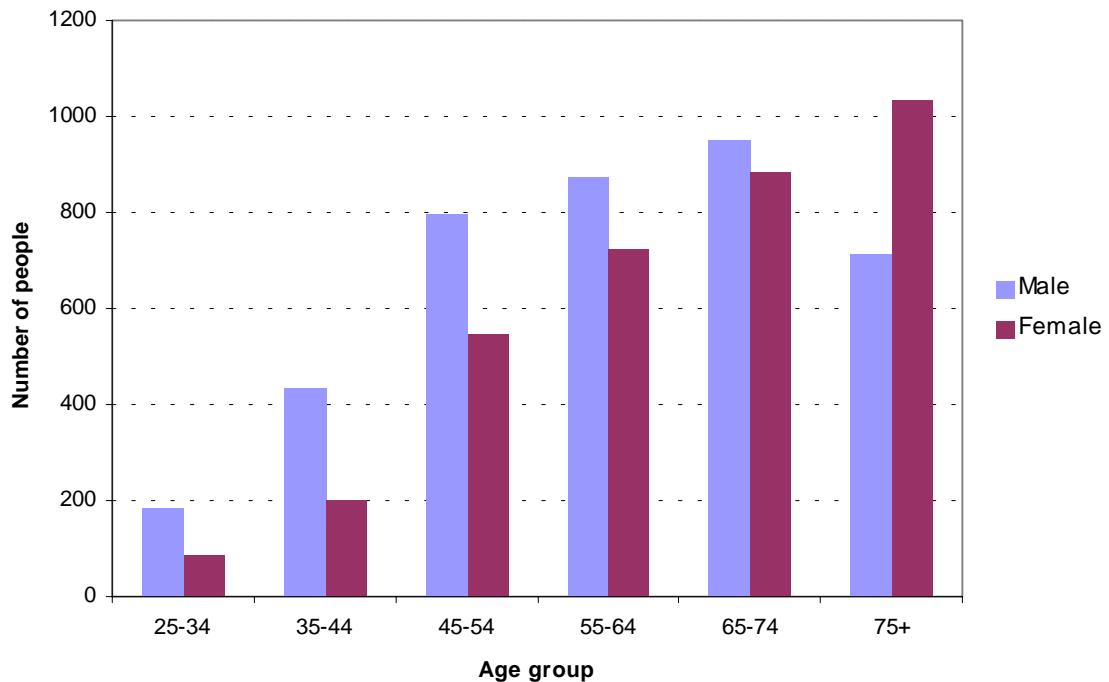
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

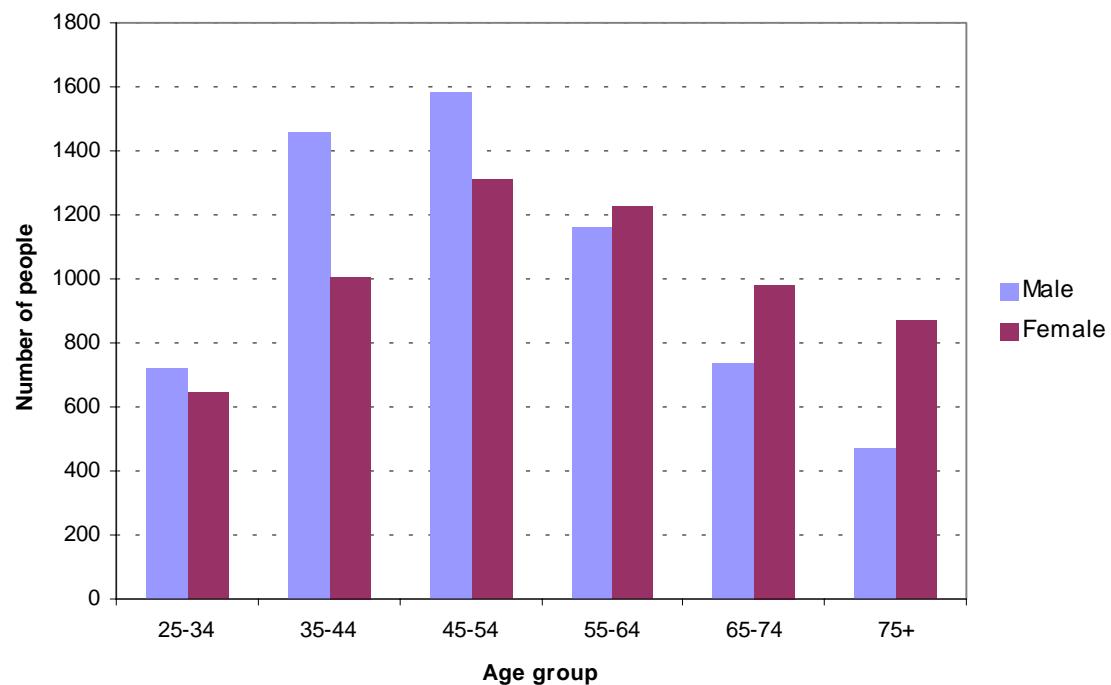
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



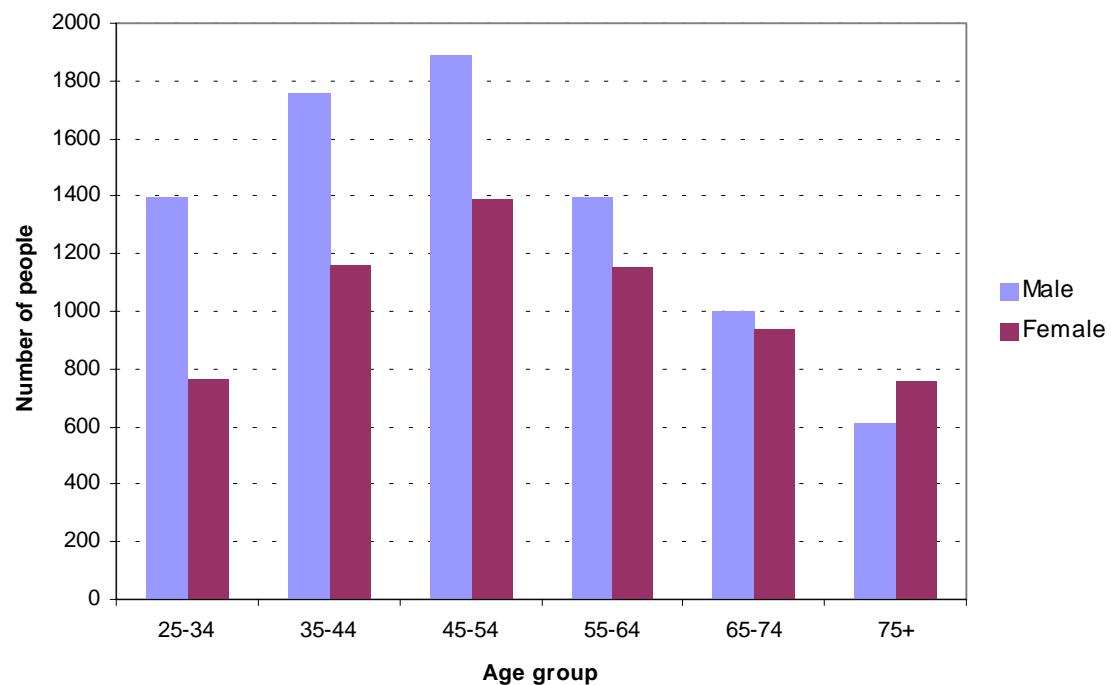
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



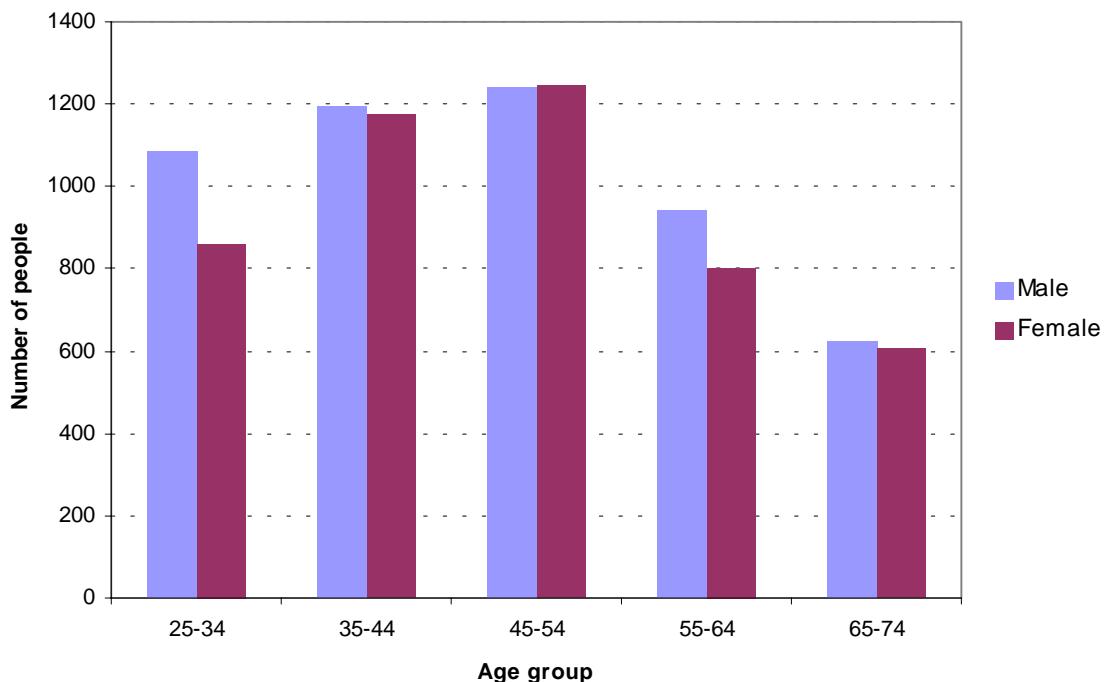
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



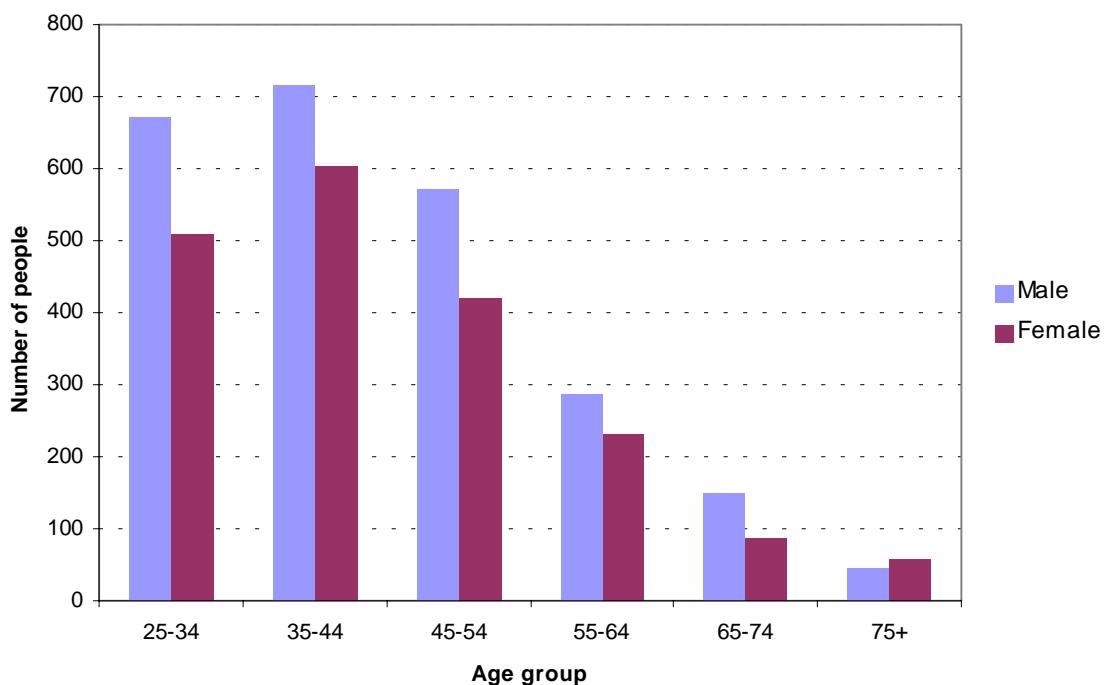
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 34 |
|-----------------------------------------------|-------|----|

Division Comments

- | | |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ▪ Do you have any comments about the nature of the population in your area? | <ul style="list-style-type: none">• Ageing population,• Large transient population,• Large Culturally and Linguistically Diverse (CALD) groups. |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes educator – Riverland Regional Health Services (RRHS),
 - Five practice nurses – one in each clinic,
 - Dietitians – two,
 - Podiatrists,
 - Aboriginal health workers.
- What services are needed but are not available in your Division area?

In accordance with RRHS Diabetes Project Final Report, the services reported by consumers, and stakeholders were: shortfalls in diabetes professional staffing levels, therefore, hard to get appointments, information, etc; staff pushed for time and did not have the time to spend with patients.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002
- Please describe your diabetes program including any changes that occurred over time?

Our program offers care for patients and recall systems. Through practice nurses, clinics are run weekly. From the database in each clinic, data can be extracted on local and regional levels to produce “Diabetes Picture” and demographics.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Re-inputting clinical data after it was revamped last year – 2001. Being able to go out to clinics and searching the database to produce de-identified “pictures” of diabetics in the Riverland.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Yes – inputting the data – very slow. Practice nurses do not have the time,
 - Acceptance by GPs to run a separate database, which does not integrate with Medical Director.
- What future plans do you have for diabetes management in your Division?

Chronic Disease Initiatives (CDI) will assist GPs and practice nurses to improve population health outcomes for Type 1 and 2 diabetics.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

The practice nurses and CDI Project Officer is contributing in the way of education and training. Practice Incentive Program (PIP) and Service Incentive Payment (SIP) are an attraction, but not the main reward. Support by Division to practice nurses – aid in taking the “load” off GPs and sharing the work.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Gerard – Aboriginal Health Clinic,
 - Field Days – Health promotions to consumers,
 - Riverland Community Health Services – diabetes educators/podiatrists/dietitians,
 - Practice nurses – financial support by Division,
 - Regional Health Planning Group.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

Diabetes database.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

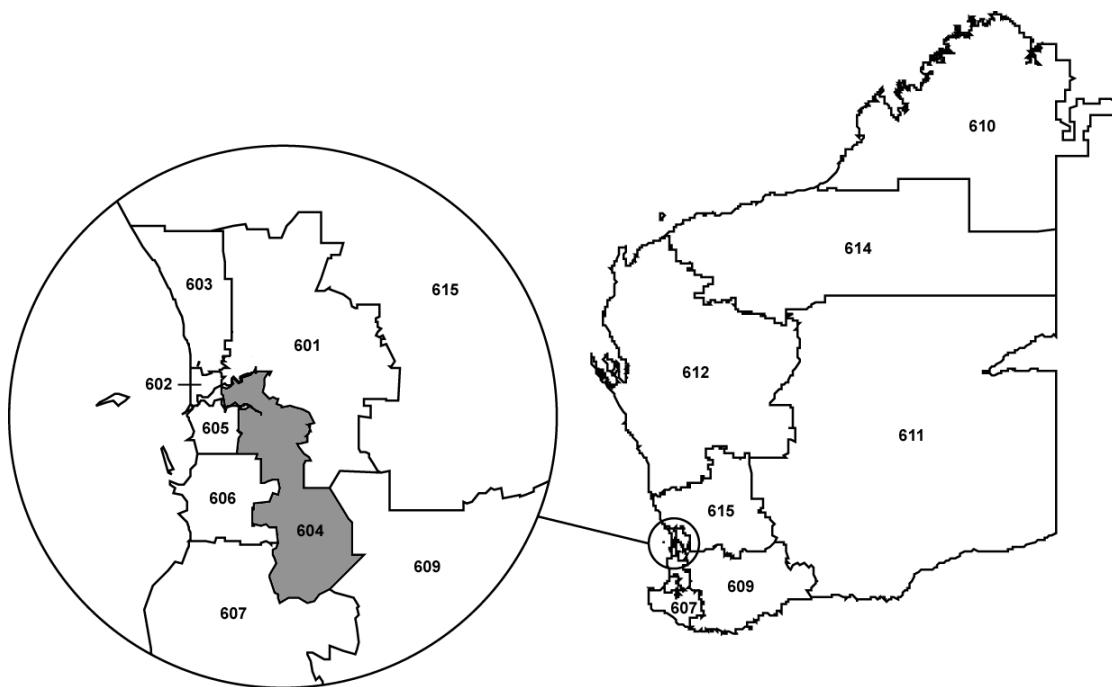
Reports from diabetes database – de-identified.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Up to date information/resources, eg recall system, guidelines.
- What resource materials do you provide to practices?
 - Diabetic Nurse Review Forms (client details, etc),
 - Resource booklets for hand-outs to clients, eg “Impaired glucose intolerance”, “The food you eat”, Diabetes Record Books, etc.

Division Contact Person/
Program Co-ordinator

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Canning DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	269,839	
■ Aboriginal or Torres Strait Islander	5912	2.2%
■ Speaks language other than English at home	36,043	13.4%
■ RRMA classification ¹		
1: Capital city	269,839	100.0%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	12,851	7.5%
■ High blood pressure ⁴	49,337	28.8%
■ High blood cholesterol ⁵	86,874	50.7%
■ Obese or overweight ⁶	102,256	59.7%
■ Physical inactivity ⁷	72,860	42.5%
■ Smoking ⁸	33,476	19.5%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

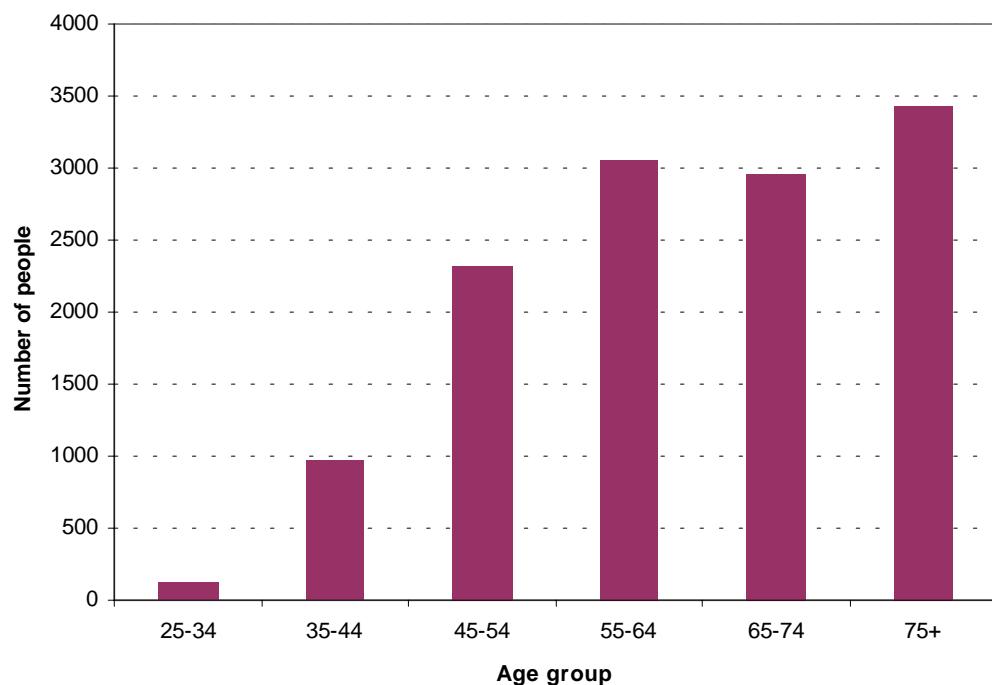
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

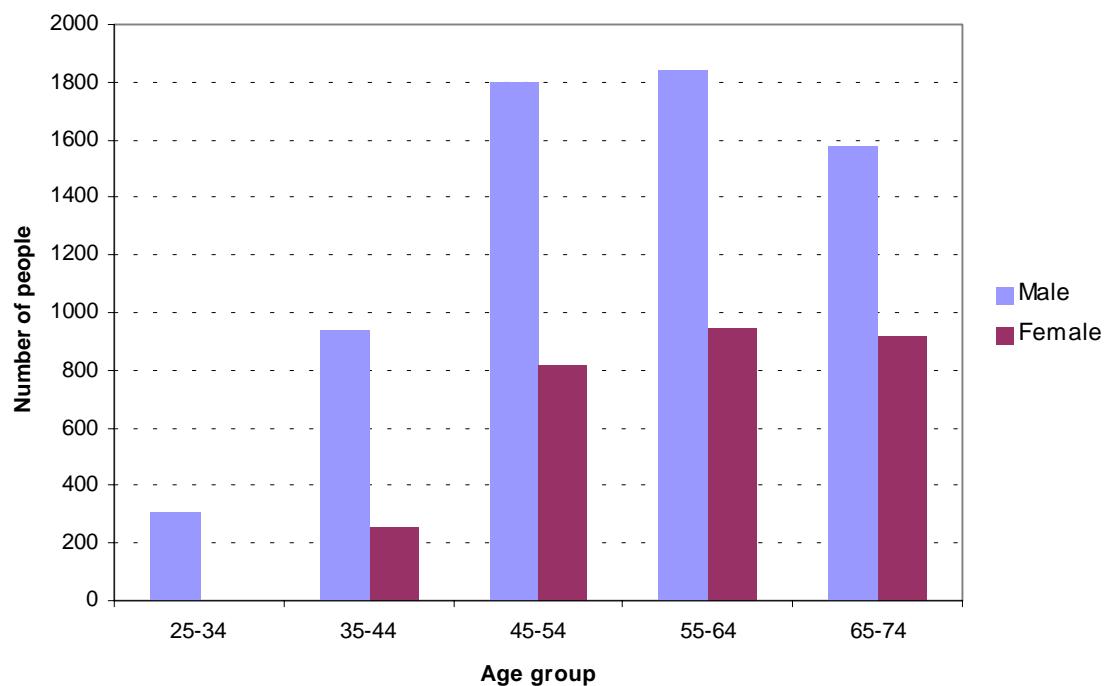
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



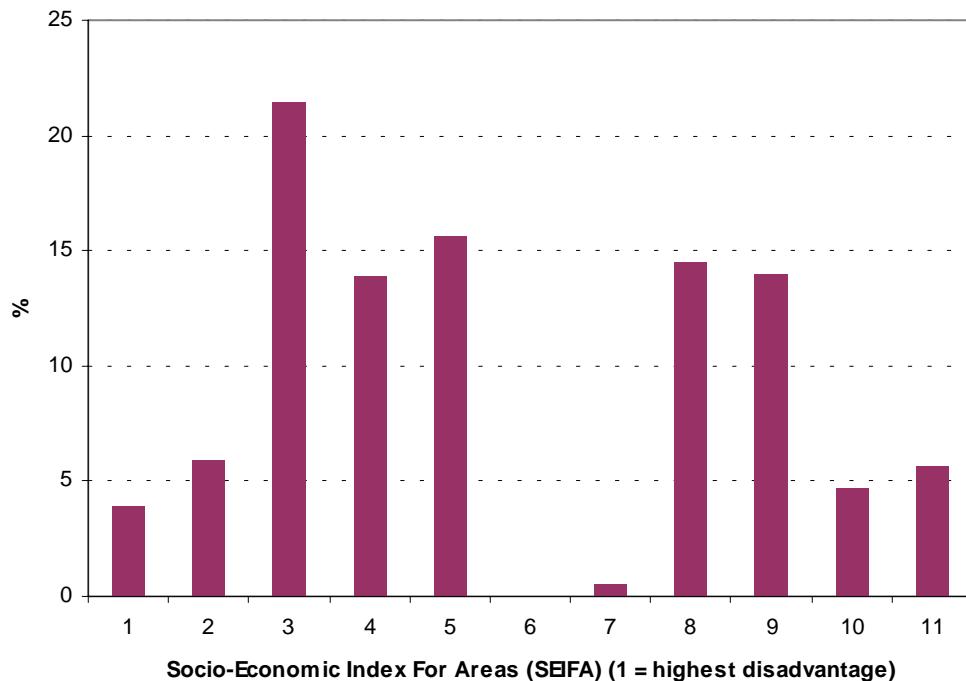
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

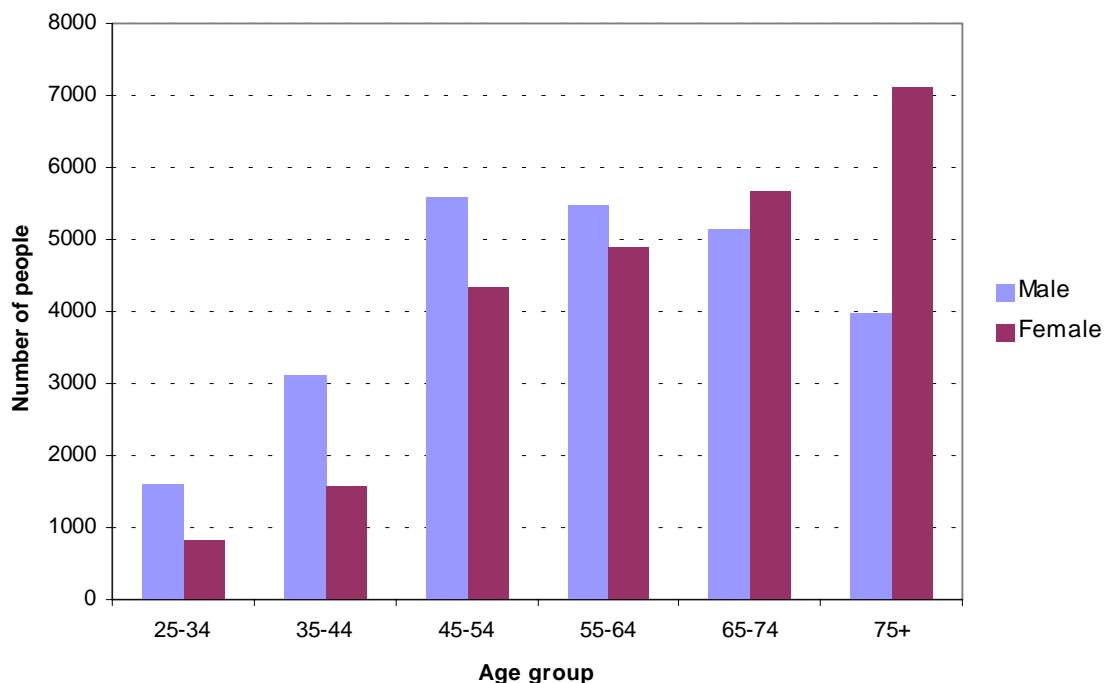
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

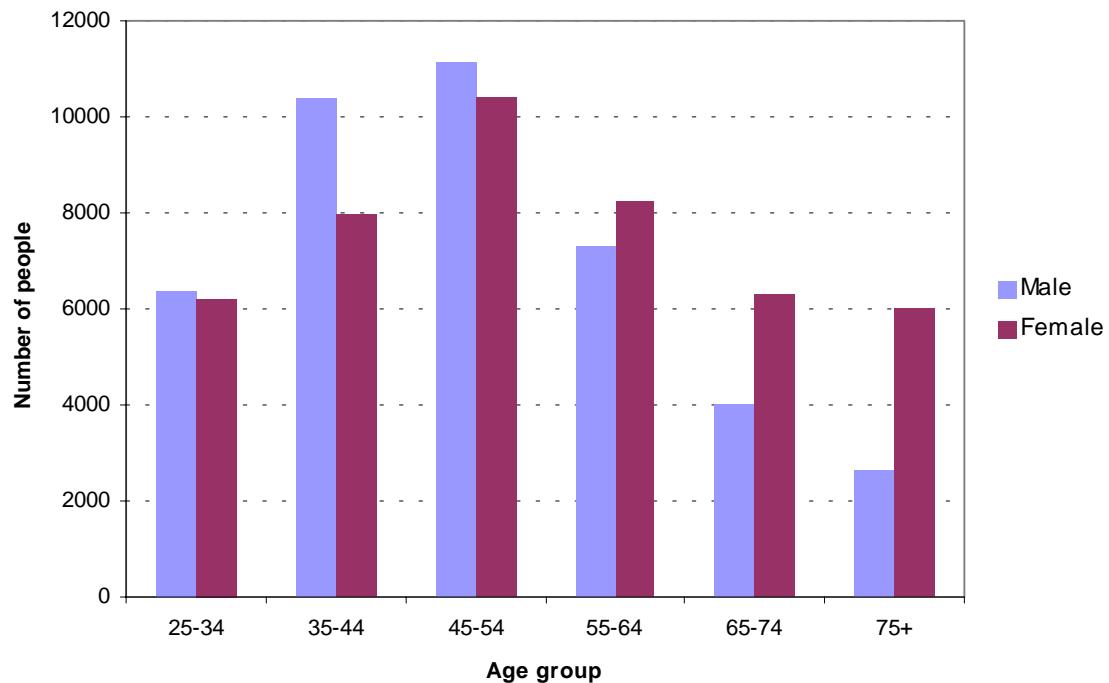
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



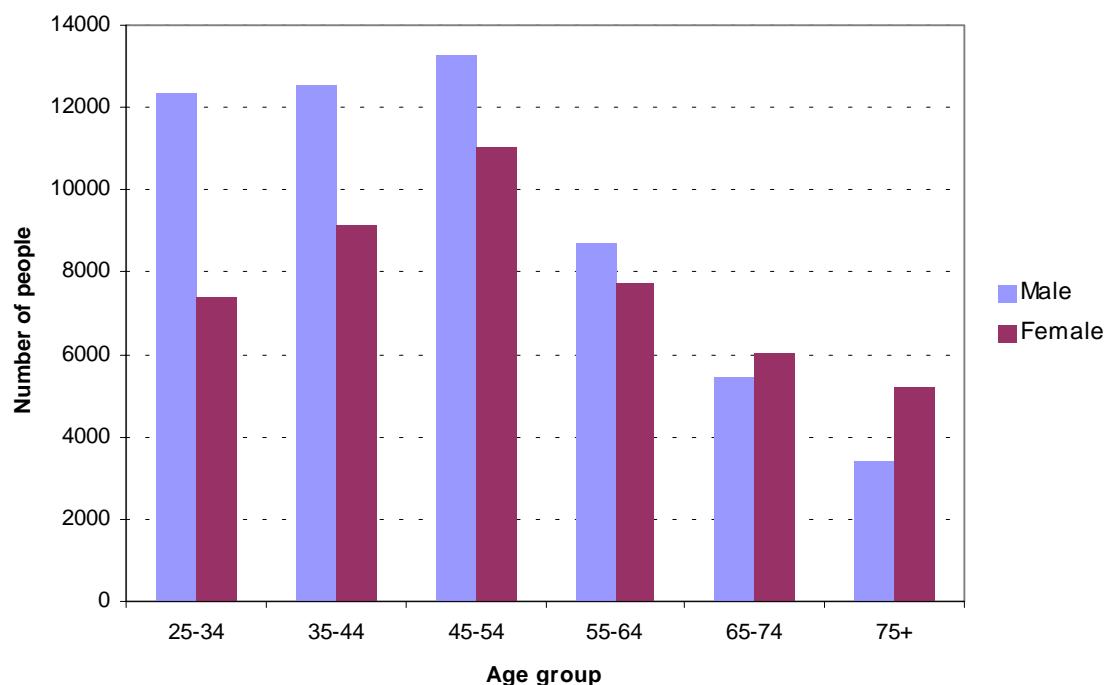
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



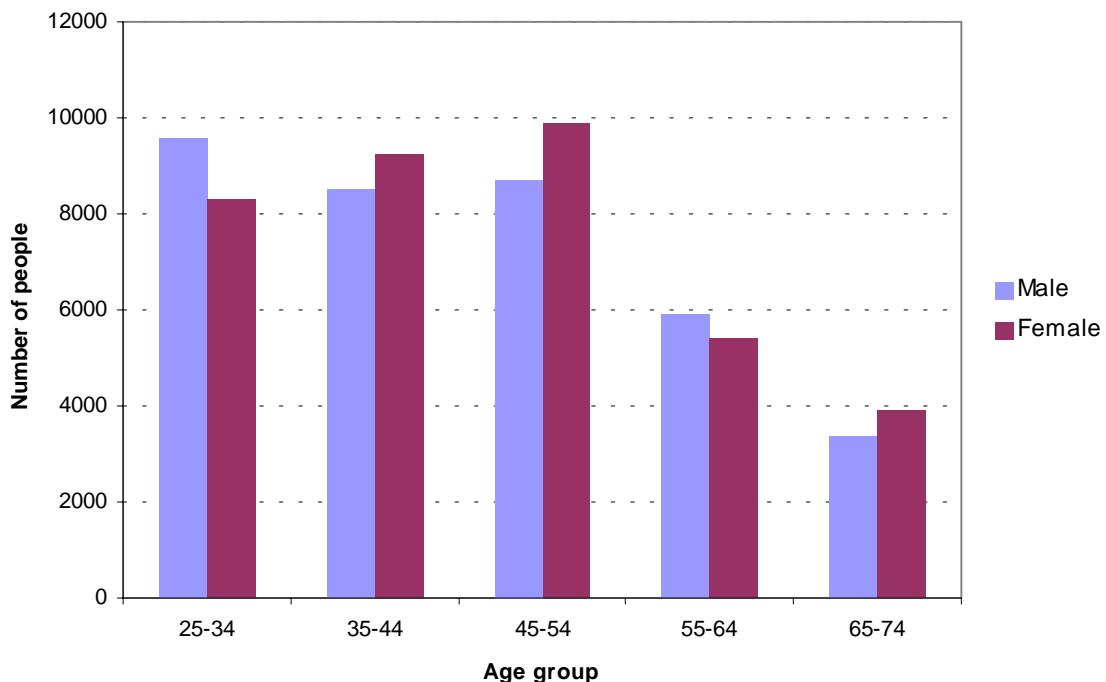
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



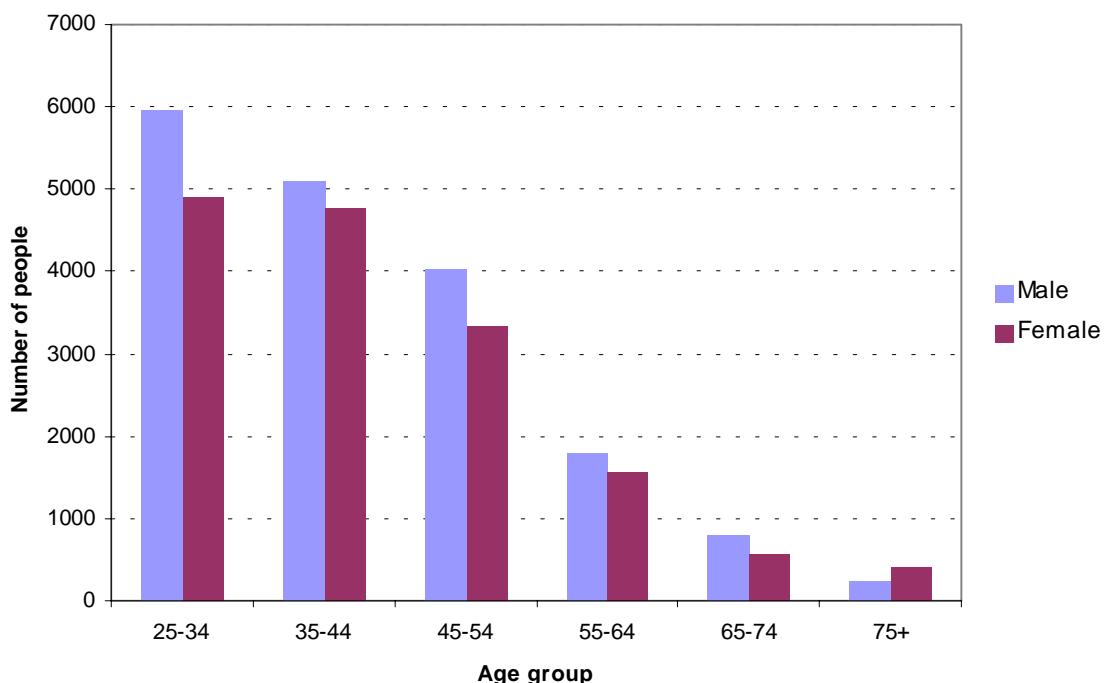
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 269 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Group and individual education at two sites,
 - Limited secondary care for podiatry and dietetics at two sites,
 - Secondary complications clinic at Bentley Hospital, (to commence mid to late 2003),
 - A number of private podiatrists, dietitians and optometrists – screening and education.

- What services are needed but are not available in your Division area?
 - Aboriginal and bi-cultural health workers with diabetes knowledge and skills,
 - Secondary complications clinic in Armadale (southern) region,
 - Additional prevention and screening services at primary care sites (ie general practice).

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?

The Integrated Diabetes Care Program is based at Canning Division and aims to integrate and enhance diabetes services in the Perth South-East metropolitan region.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Improved co-ordination and integration of diabetes services,
 - Variety of opportunities for upskilling health professionals in diabetes management, eg upskilling practice nurses in foot screening,
 - Strategies addressing the Aboriginal populations needs,
 - Trialling foot screening clinics in practices with supervision from Area Health Service podiatrist.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Time limitations to address so many areas of need.

- What future plans do you have for diabetes management in your Division?
 - Provision of primary diabetes services in general practice, eg foot screening clinics,
 - Continued education in diabetes management for GPs, practice nurses, Aboriginal health workers,
 - Formalise referral procedures between GPs and secondary complications clinic at Bentley Hospital,
 - Multidisciplinary team meetings with GPs and Area Health Service's diabetes teams (case study format).
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Involvement and commitment of all practice staff,
 - IT support from Division,
 - Practice Incentive Payment (PIP) and Enhanced Primary Care (EPC) support from Division,
 - Register and recall systems,
 - A dedicated program officer in diabetes to liaise with practices.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Local service providers are represented on the Integrated Diabetes Care steering committee which meets on a bi-monthly basis,
 - The Canning Division involves local organisations in strategic planning for the Division.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice guidelines,
 - Resources developed by the Division, eg local service provider lists (public and private), care plan development guide, foot screening checklist,
 - National Diabetes Supply Scheme (NDSS) forms and patient resources from Diabetes Australia.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Care plan development guide,
 - Foot screening checklist.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? See above.

Division Contact Person/
Program Co-ordinator

Name: Trina Langton
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Email: trina@canningdivision.com.au

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Group education and exercise programs in the community,
 - Cardiac rehab program based at a tertiary hospital,
 - Private and public physiotherapists and private dietitians.

- What services are needed but are not available in your Division area?

Cardiac rehab services for culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander people.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input checked="" type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The HeartBeat Program is a collaborative program between Canning Division of General Practice and Royal Perth Hospital. HeartBeat is GP-led and offers a range of community-based rehab options.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Gaps in services in the community have been identified by the program resulting in the establishment of new services,
 - Improved communication between Royal Perth Hospital and GPs,
 - Peer support groups,
 - Education and exercise classes operating at two sites.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Marketing of the program to GPs and the community,
 - Referral from Royal Perth Hospital to the community program – territorial professional issues.

- What future plans do you have for CVD management in your Division?
 - To expand the services currently offered by the program,
 - Integrate existing programs with HeartBeat,
 - Increase the number of sites for education and exercise classes operating within the Division,
 - Broaden the scope of the classes to include other chronic conditions.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
 - To conduct a needs assessment prior to the implementation of new services,
 - To ensure local service providers are represented on the program.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Local service providers have been involved since the program commenced. Regular steering committees are held with Division staff and local service providers.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

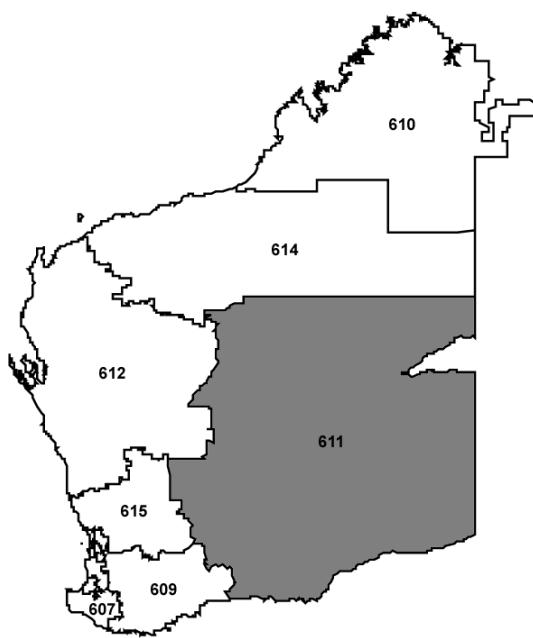
Resources from the National Heart Foundation, Heartline and Heart Support Australia.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Care plan development guide,
 - Patient record cards,
 - Copy of program content for education classes.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.
- What resource materials do you provide to practices?
 - Care plan development guide,
 - Cardiac care service provider details,
 - Guide to risk reduction for patients with/or “at risk” of CVD.

Division Contact Person/
Program Co-ordinator

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Phone: 08 9458 0523
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Email: N/A

Eastern Goldfields Medical DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	57,828	
■ Aboriginal or Torres Strait Islander	5492	9.5%
■ Speaks language other than English at home	3911	6.8%
■ RRMA classification ¹		
6: Remote centre	39,959	69.1%
7: Other remote	17,869	30.9%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1987	5.5%
■ High blood pressure ⁴	8301	22.8%
■ High blood cholesterol ⁵	17,470	48.0%
■ Obese or overweight ⁶	21,561	59.2%
■ Physical inactivity ⁷	16,158	44.4%
■ Smoking ⁸	7948	21.8%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

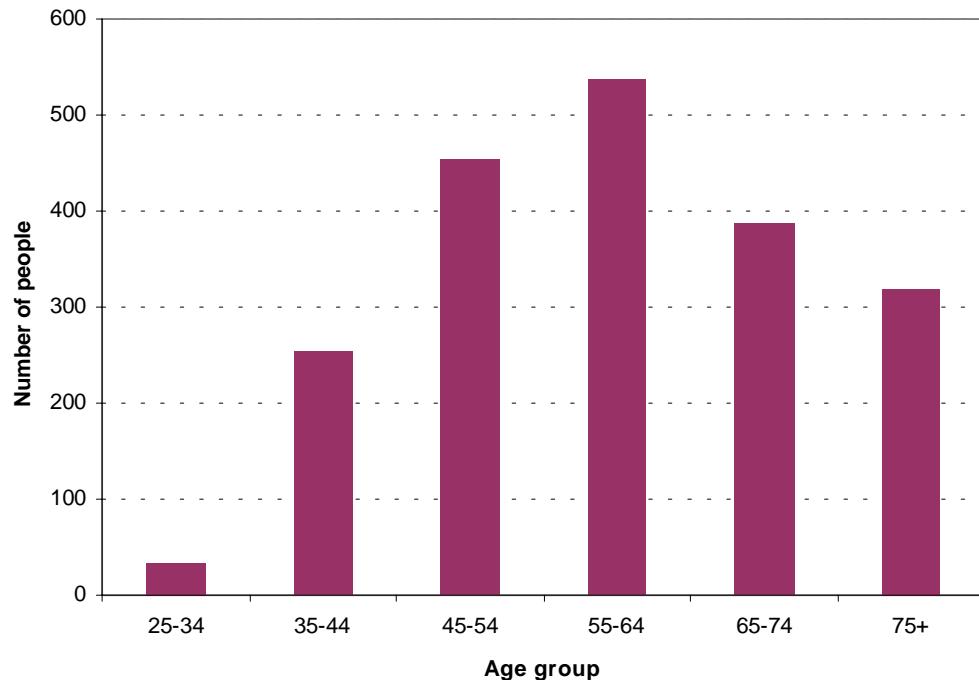
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

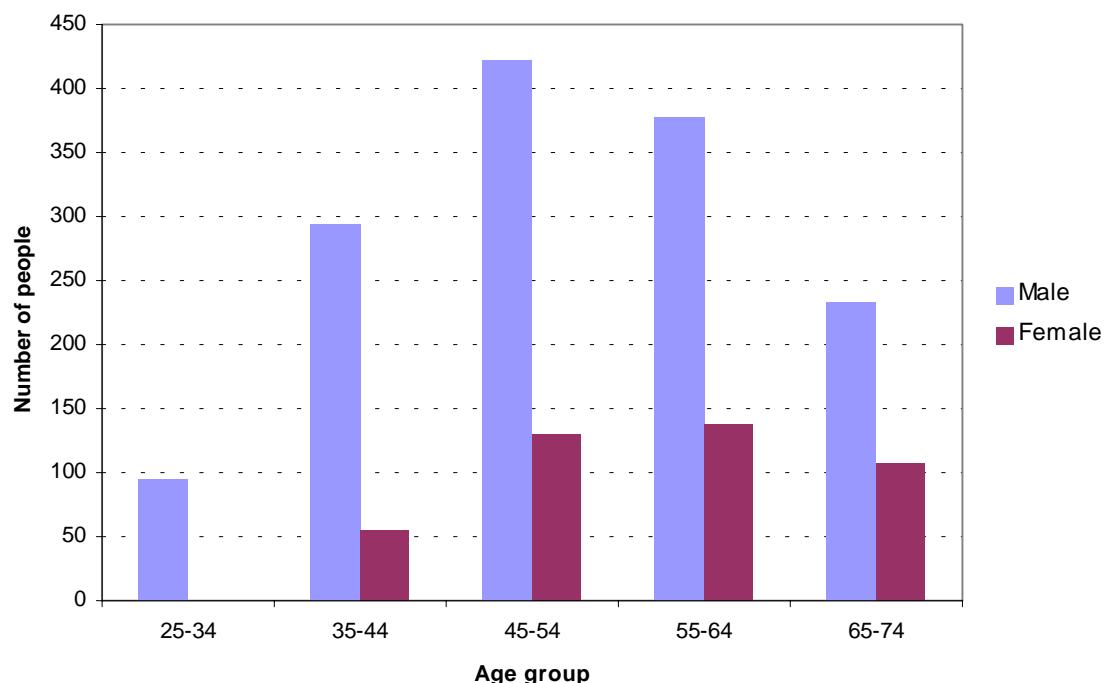
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



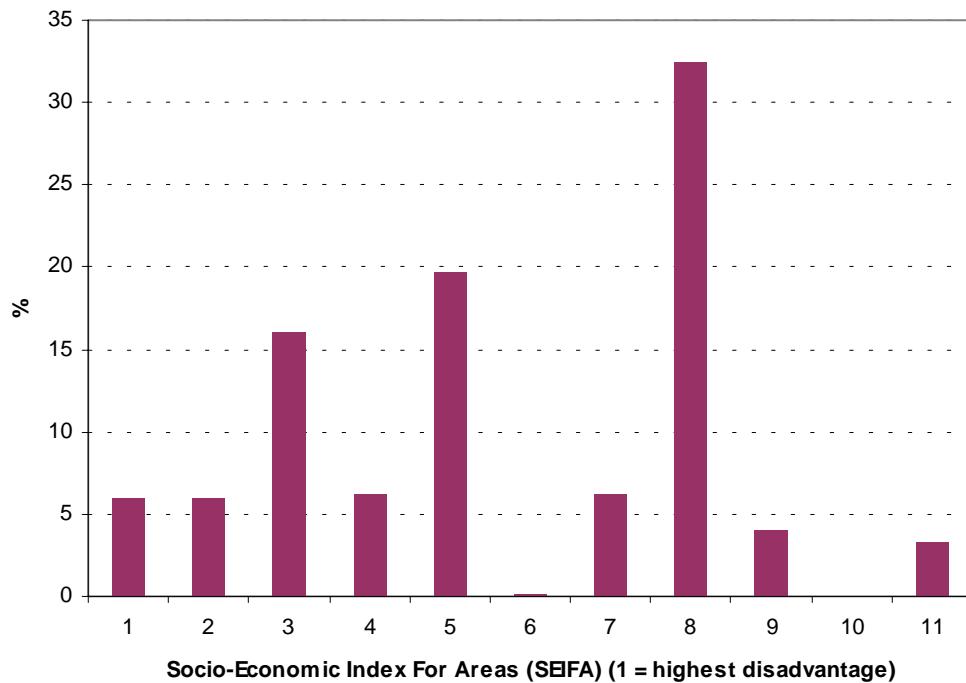
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

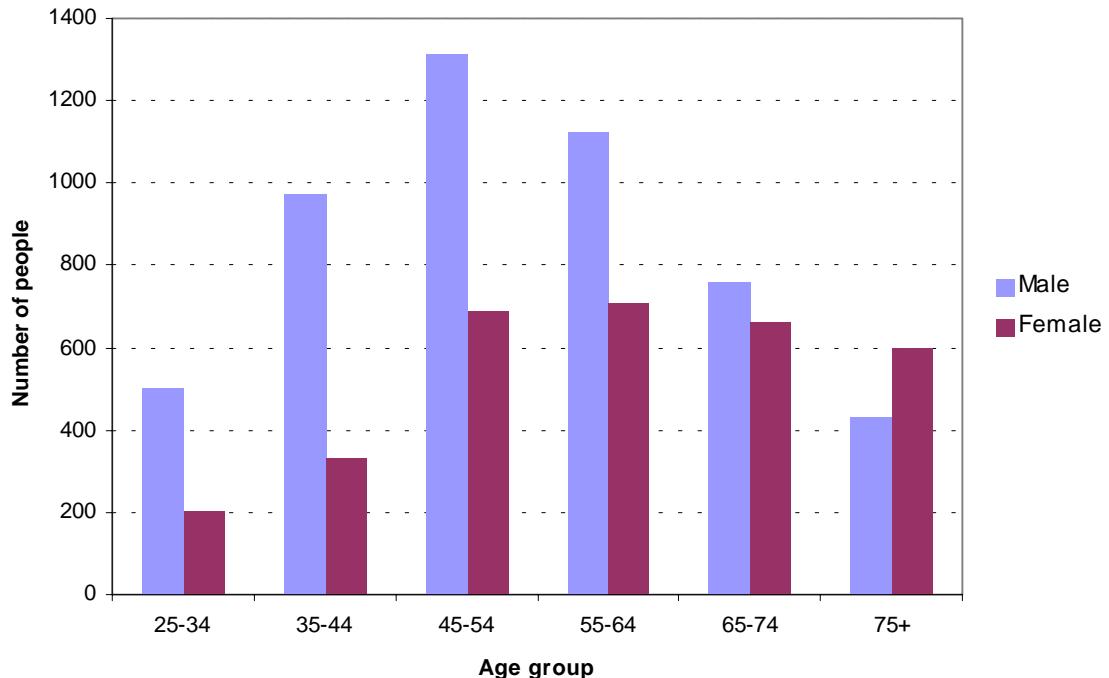
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

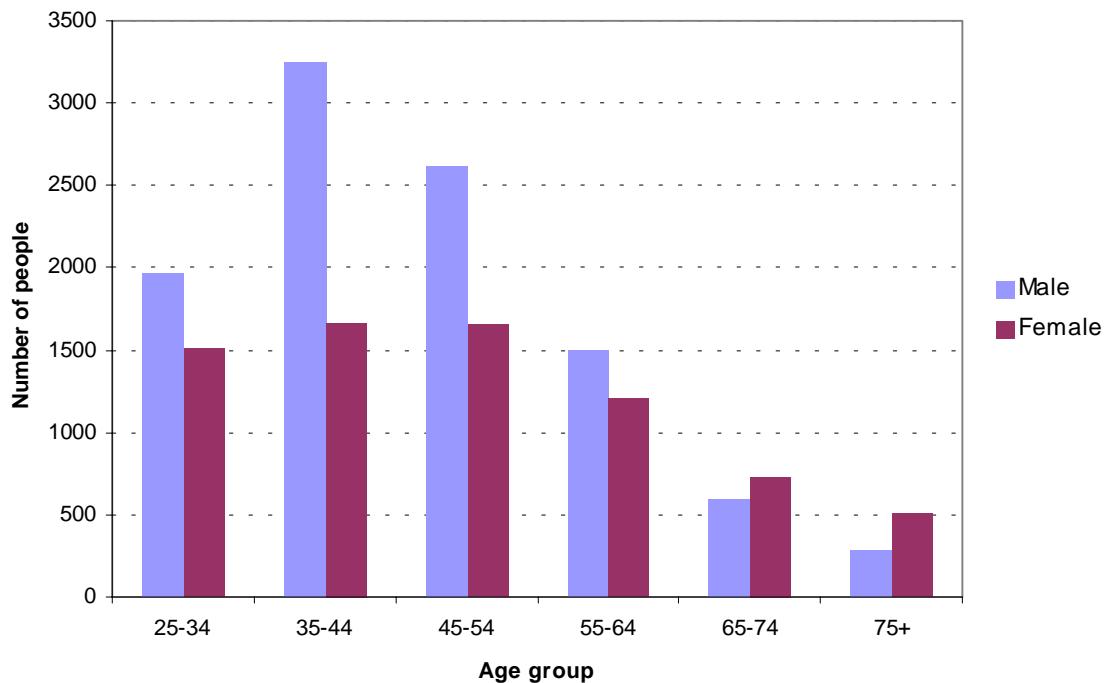
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



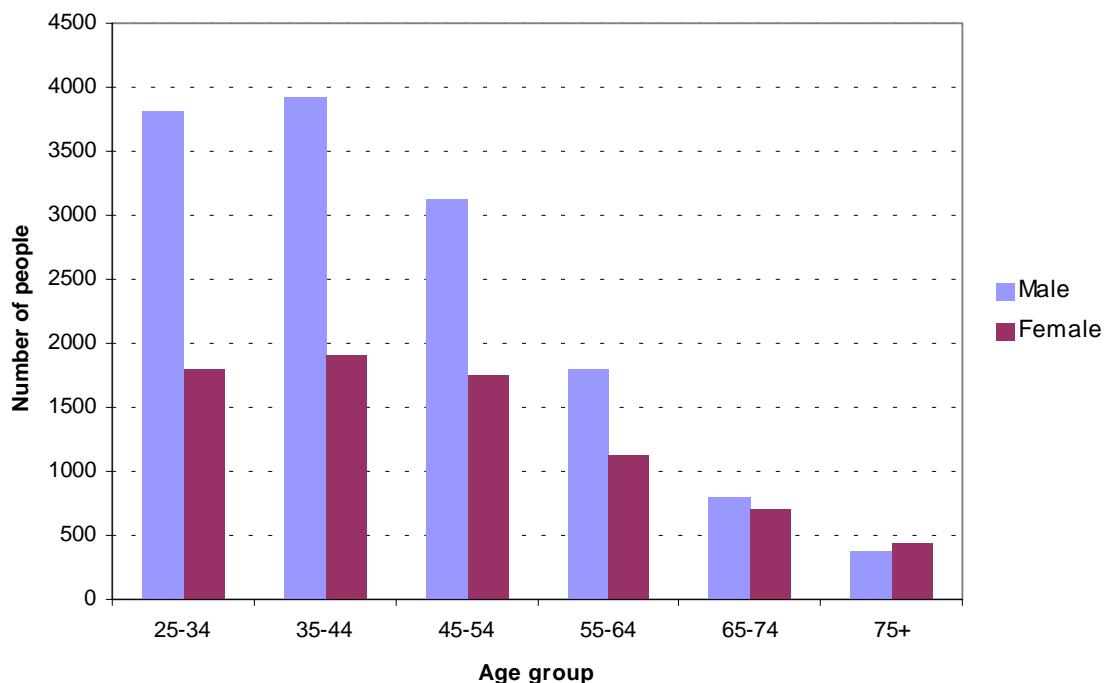
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



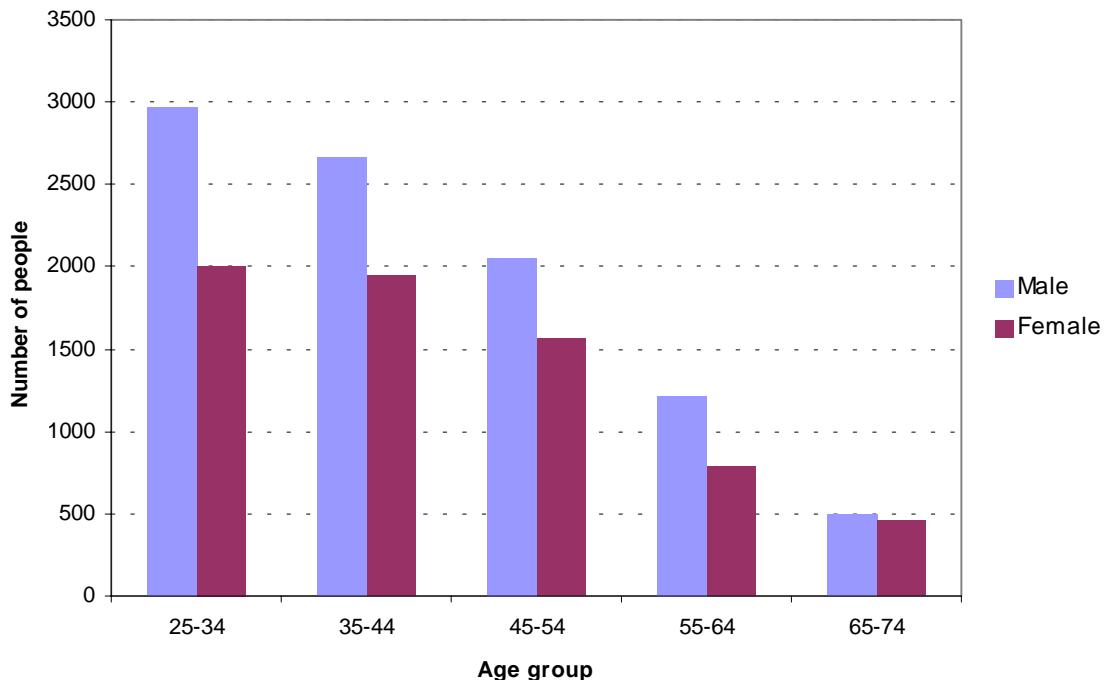
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



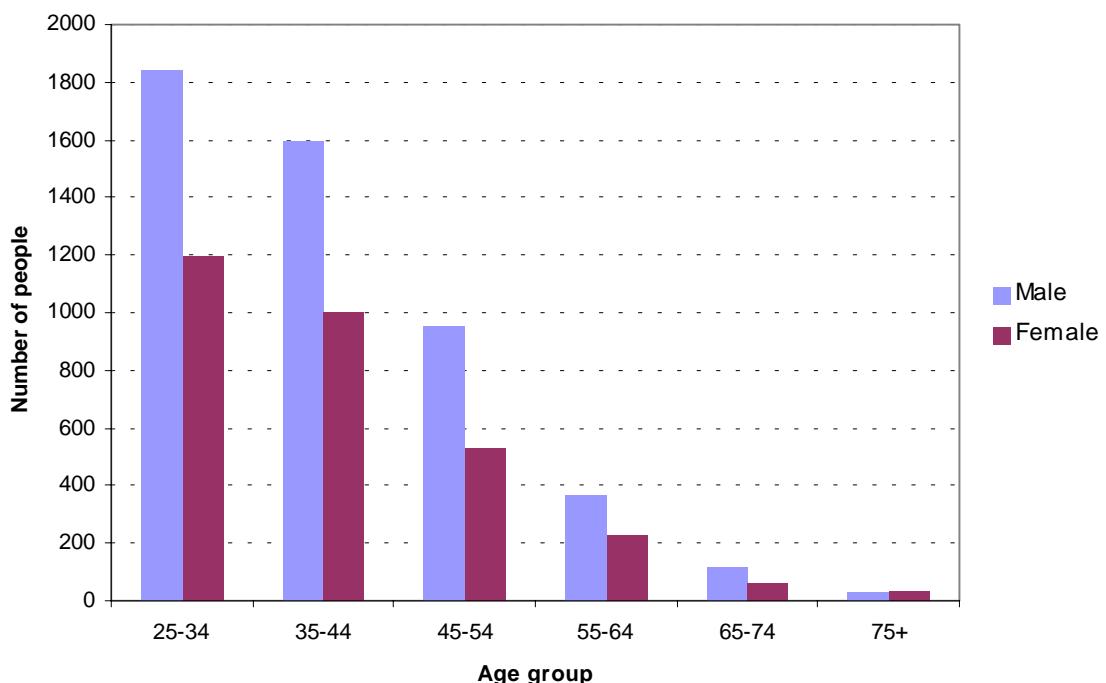
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

▪ Number of GPs working in the Division area:	Total	47
-----------------------------------------------	-------	----

Division Comments

- Do you have any comments about the nature of the population in your area?
- Kalgoorlie and Northern Goldfields;
- Mining area,
 - Transient population,
 - Long working hours,
 - Difficulty in recruiting and retaining health professionals,
 - Fringe dwelling and community based Aboriginal population.
- Esperance and the Southern Goldfields;
- Agricultural community,
 - Long working hours,
 - Self-employed,
 - Large elderly population.

CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Take Heart Program – Six week program which is open to individuals who have had or are at risk of a cardiac event,
 - Part time CVD coordinator (Division),
 - Physiotherapist, dietitian and occupational therapist – public services, which contribute to the Take Heart Program,
 - Psychologist (Division) also contributes to Take Heart Program,
 - Three Phase Cardiac Rehabilitation and Secondary Prevention Program:
 - Phase 1: In-patient support and education for clients and their families,
 - Phase 2: Five week lifestyle education program,
 - Phase 3: Twelve month follow-up and support, which offers the opportunity to collect data on lifestyle modification patterns,
 - Community based “Graduates Exercise Program” and “Wednesday Walkers”. These initiatives are designed to support graduates of the rehabilitation program in their efforts to maintain a desired level of physical activity while providing the opportunity to maintain and expand social and support networks,
 - Southern Goldfields Branch of Heart Support Australia. Formed by graduates of the rehabilitation program, this group offers community support and a hospital visiting service for clients with CVD and their families.

- What services are needed but are not available in your Division area?
 - A psychologist available to public patients for ongoing support.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?

The CVD program was created to provide a rehabilitation and secondary prevention service. This has been enlarged to offer primary prevention and health promotion in the community setting.

Division Perspective

- What have been the major achievements or highlights of your program so far?
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
- What future plans do you have for CVD management in your Division?
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

As public awareness of the Take Heart program increases we are seeing a growing number of self-referrals to the program.

Reluctance of GPs to refer their patients to the program. This may stem from an ownership issue or may simply be a case of “forgetting”.

- Expansion of primary prevention and health promotion role,
- Establishment of a “Graduates” exercise program for participants of Take Heart Program,
- Establishment of branch of Heart Support Australia.

Involve GPs at the outset; gather their ideas; nurture their support for the program; promote the program in the public arena – if their Doctor does not refer them, they can refer themselves.

Support network with other CVD coordinators and educators. This has been built through membership of Western Australia Cardiac Rehabilitation Association (WACRA), attendance at educational meetings, and visiting other programs in action.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?

- National Heart Foundation written and video material,
- Heart Research Centre handouts,
- Some drug company material, eg dietary handbooks, and cholesterol information.

- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?

Take Heart Handbook – a 62-page book written to accompany the program.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

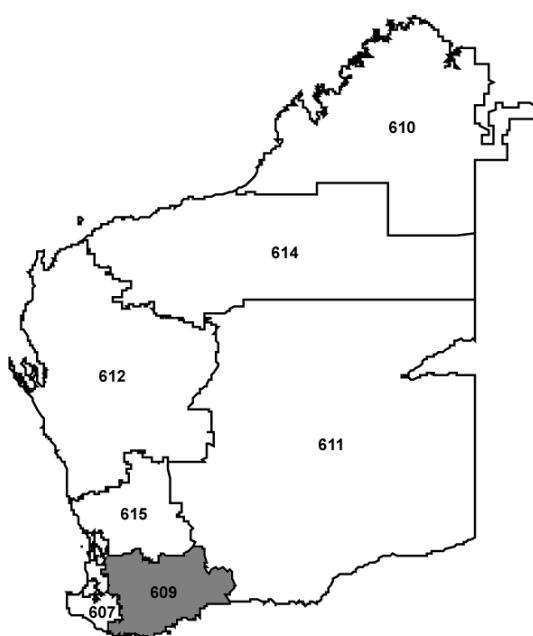
Would like to develop a hand held record.
- What resource materials do you provide to practices?

None as yet, but a “patient package” for patients with CVD is on the drawing board.

Division Contact Person/
Program Co-ordinator

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Great Southern WA DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	70,171	
■ Aboriginal or Torres Strait Islander	2525	3.6%
■ Speaks language other than English at home	2287	3.3%
■ RRMA classification ¹		
4: Small rural	27,297	38.9%
5: Other rural	30,103	42.9%
7: Other remote	12,701	18.1%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	3634	8.0%
■ High blood pressure ⁴	13,834	30.4%
■ High blood cholesterol ⁵	23,625	51.9%
■ Obese or overweight ⁶	27,609	60.7%
■ Physical inactivity ⁷	19,411	42.7%
■ Smoking ⁸	8707	19.1%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

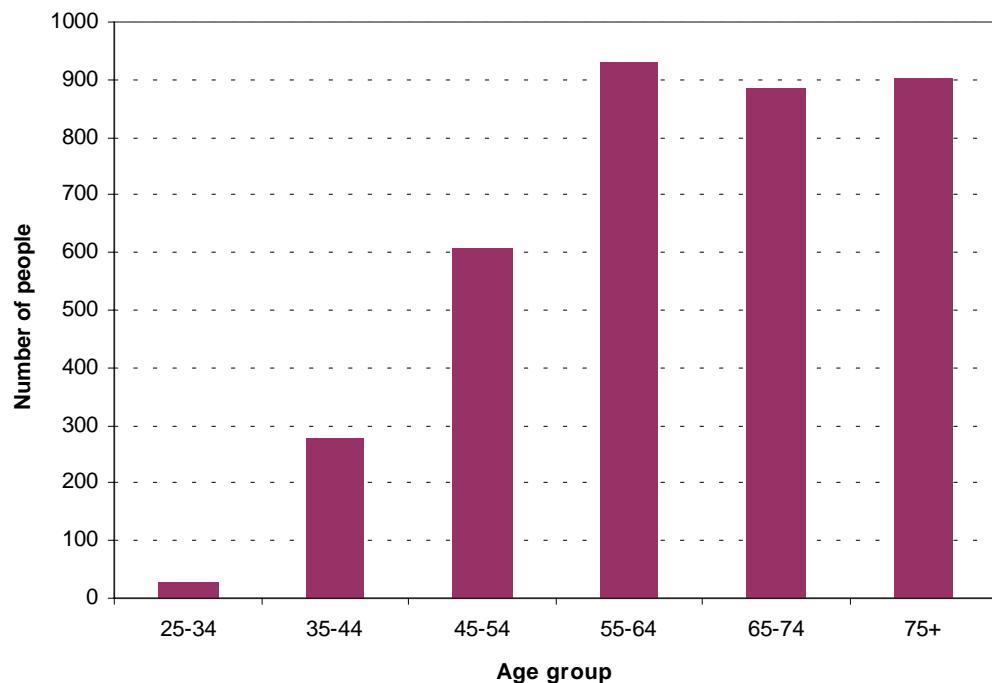
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

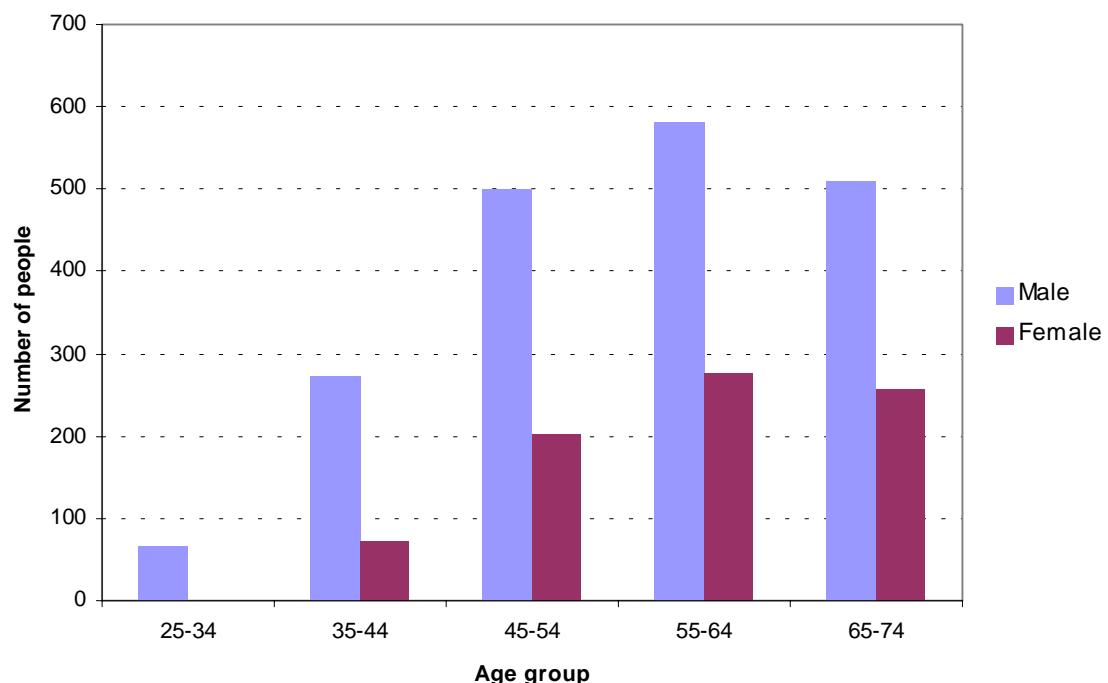
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



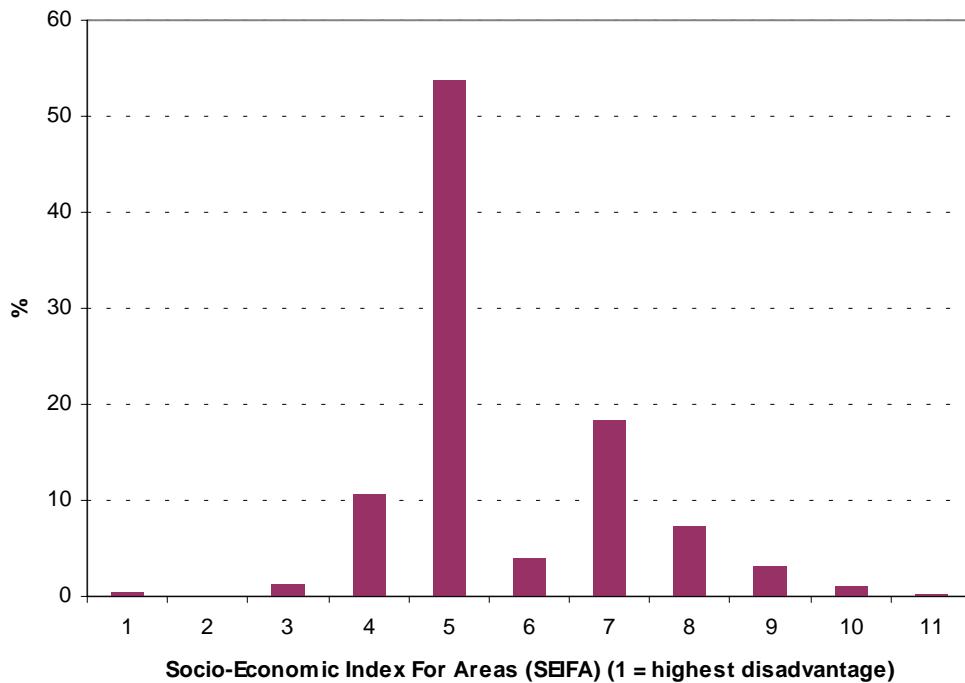
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

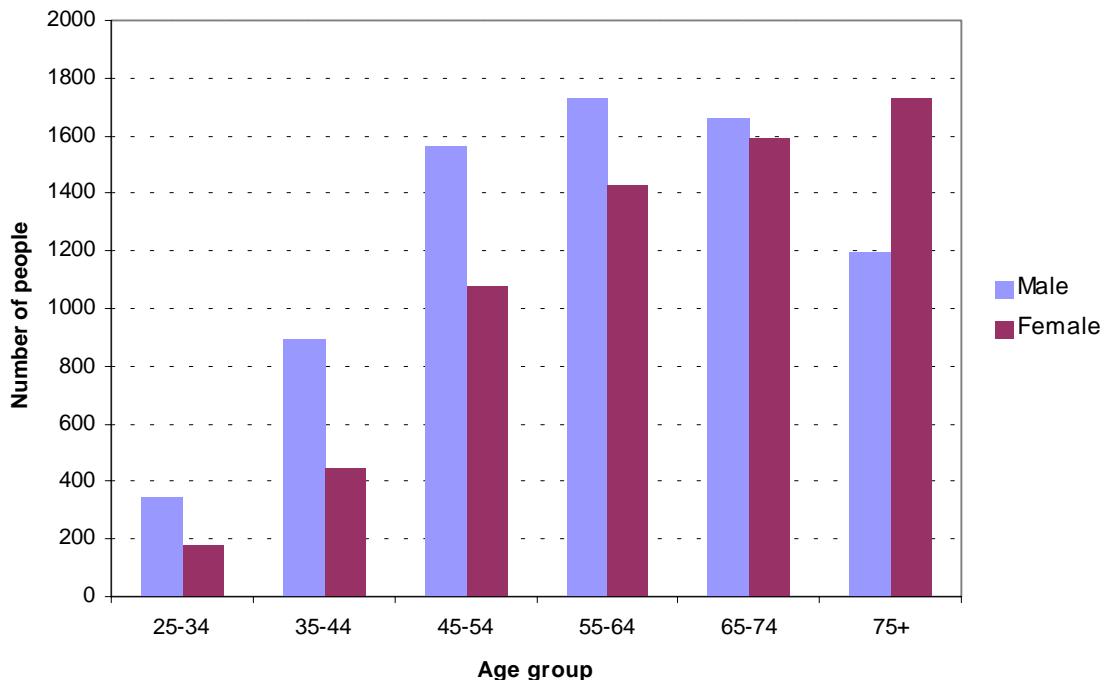
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

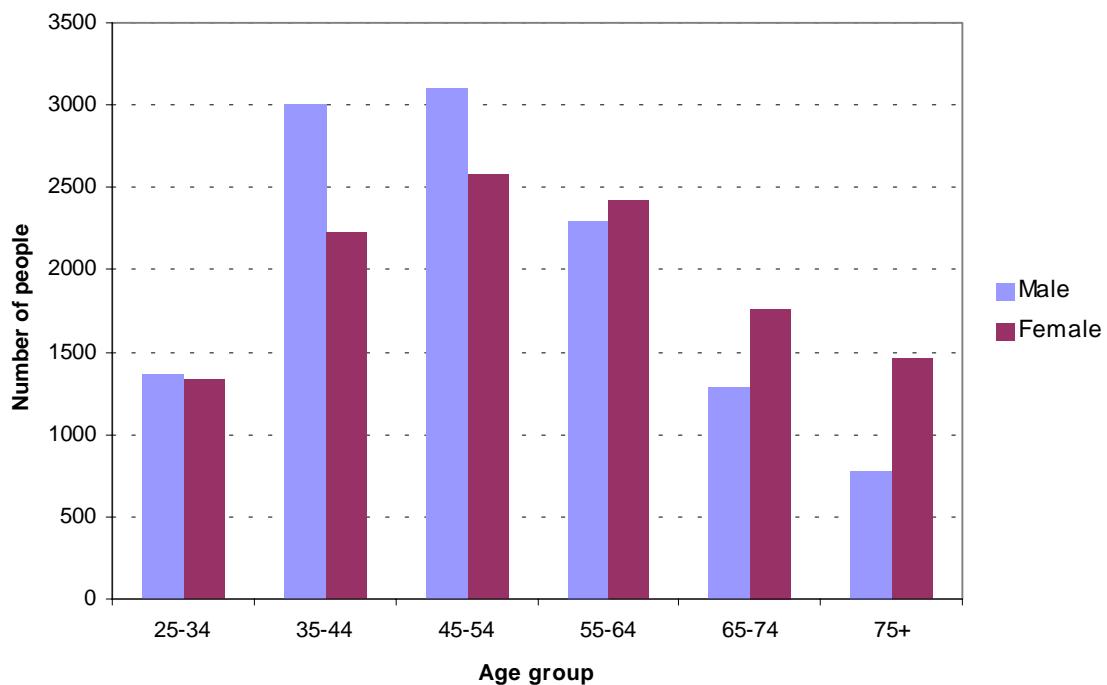
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



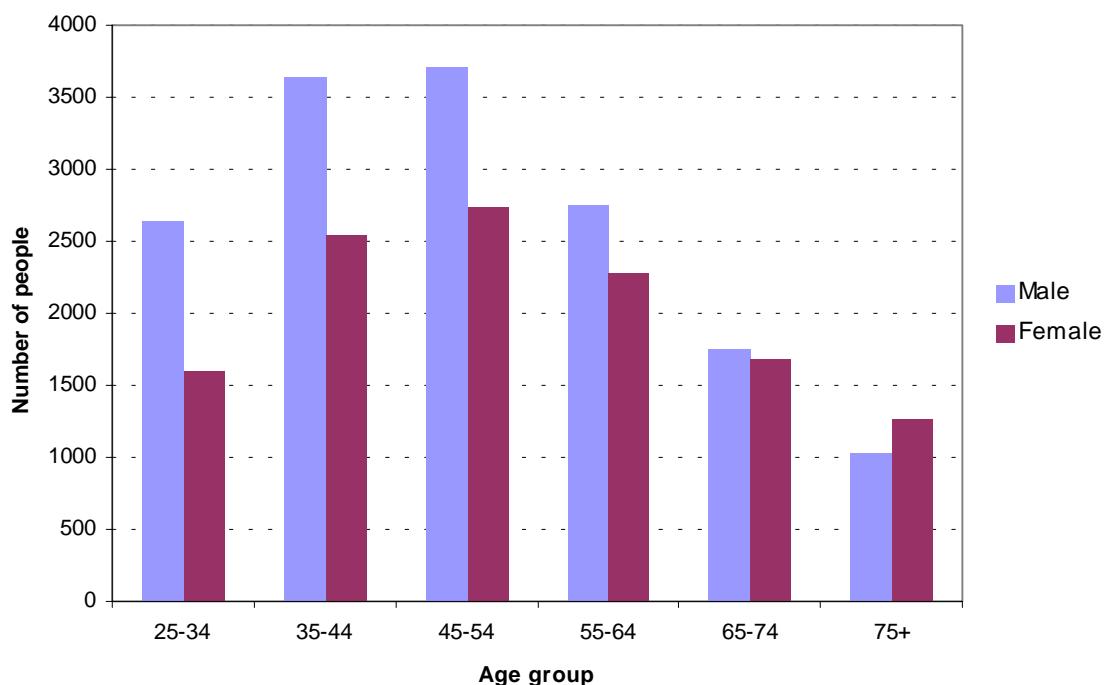
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



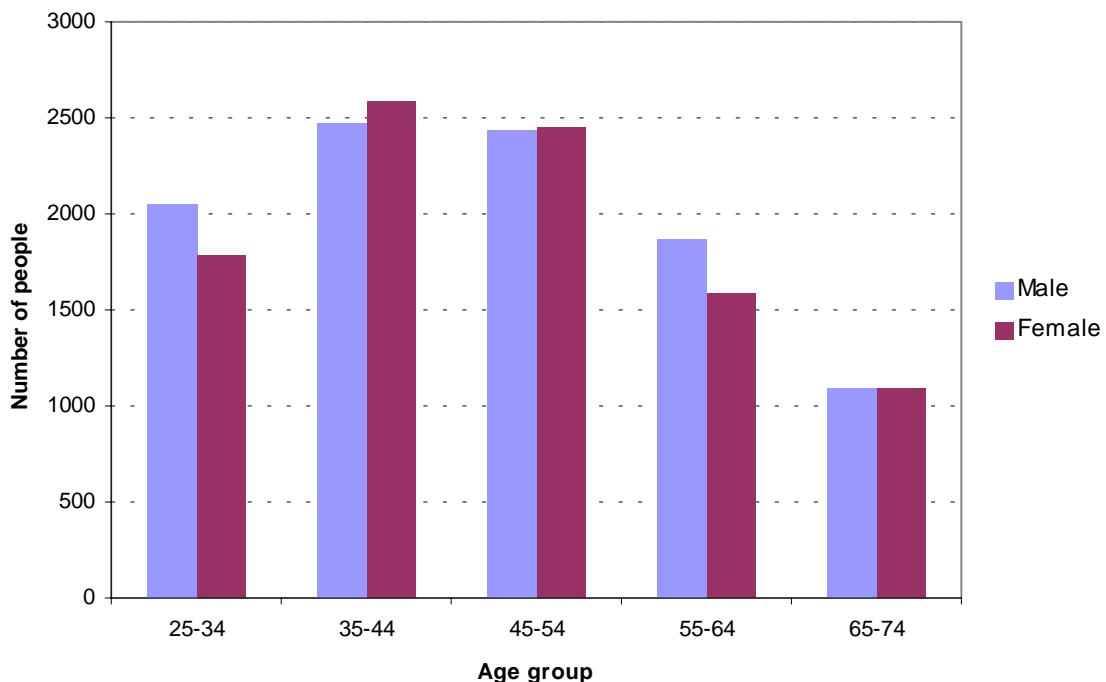
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



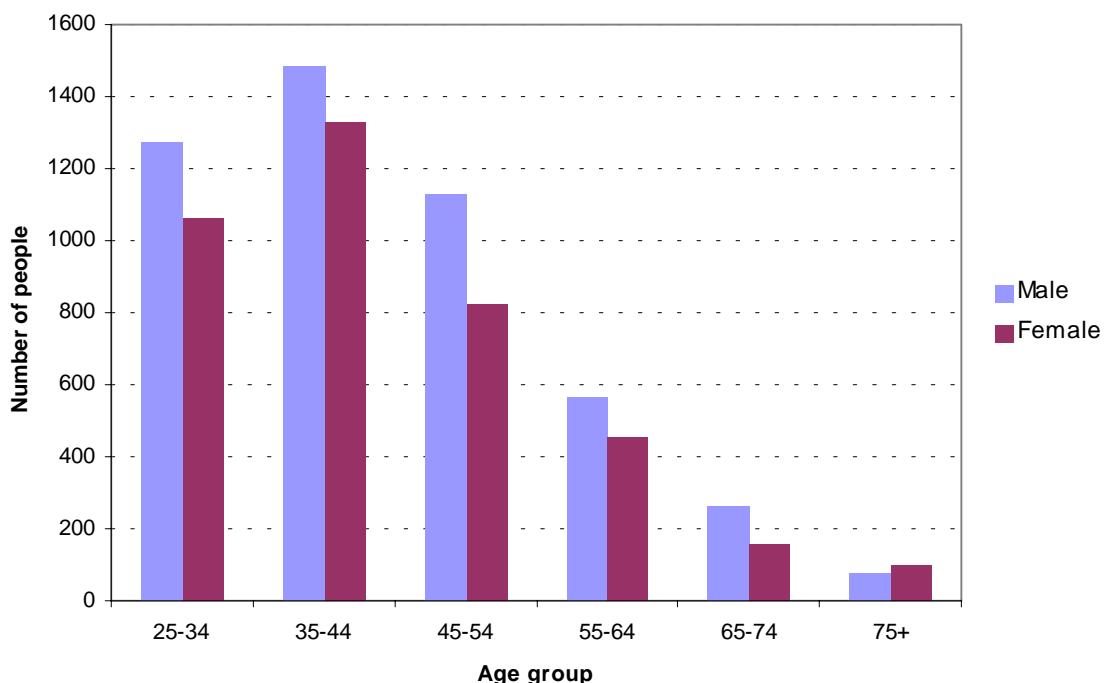
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 56 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Great Southern Integrated Diabetes Care Program provides:

- One-on-one diabetes education in the GP surgery,
- Group education in the community,
- Aboriginal and Torres Strait Islander (ATSI) focused program,
- CARDIAB register and recall system,
- Silver Chain Nursing Association,
- Family Futures.

-
- What services are needed but are not available in your Division area?

Increased patient education and support to aged care, facilities and staff.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

We provide a practice-based service across the Great Southern Region, mainly focusing on type 2 diabetes. Integrated notes are a key factor in this process, both the diabetes educator and dietitian use the practice notes, either paper or electronic. Referrals are from general practitioners.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Engaging GPs and provision of service in GP practices has increased the number of patients receiving education.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Regular management and steering group meetings have facilitated implementation and minimal barriers have occurred.

- What future plans do you have for diabetes management in your Division?

To address the main gap in the area of aged care facilities.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
- Familiarisation of GPs and practice managers in new initiatives,
- Recruitment of more practice nurses by individual practices,
- Ongoing support from Great Southern Division of General Practice (GSDGP).

-
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

The Division is in partnership with key stakeholders, including local health services, Silver Chain and local hospitals to develop and coordinate a systematic approach to diabetes and cardiovascular care. The key has been communication and persistence over time in conjunction with several other programs in the region.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

- Australian Diabetes Educators Association including web site,
- Diabetes Australia, including web site.

Because we are part of an integrated program, the network of stakeholders share information and resources minimising the necessity for frequent contact with State Based Organisations.

-
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

We have previously provided resources on request to other organisations:

- Patient Information on The Cardio Risk Program brochure,
- Diabetes Management book,
- Patient held record,
- The Cardio Risk program,
- Information for use by practice staff,
- Information for GPs,
- Cardio Risk Program (Resource File),
- Care plan.

-
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

N/A.

- What resource materials do you provide to practices?
- The Cardio Risk Program – Resource manual for use by practice staff,
- Updates to practice staff on new initiatives.

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?
 - Albany – hospital-based program,
 - Narrogin, Mt Barker and Denmark – community-based group education/exercise program,
 - Katanning – home-based education program.

- What services are needed but are not available in your Division area?
 - Community-based program in Albany.

CVD Program Description

- In which years did you have a CVD project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input checked="" type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your CVD program including any changes that occurred over time?
 - Narrogin – five week community-based group exercise/education program twice weekly with 3, 6 and 12 month Phase 3 follow-up,
 - Albany – ran two x five week programs as above in 2001. Now hospital-based program in Albany,
 - Mt Barker – six week community-based exercise/education program x twice weekly with 3, 6, and 12 month changes that have occurred over time,
 - Denmark – has developed from a four week program once weekly, gradually to a five week community-based group exercise/education program twice weekly with 3, 6, and 12 month Phase 3 follow-up.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Increasing the programs in Mt Barker and Denmark to more accurately reflect best practice guidelines.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Funding limitations,
 - In Albany there is some resistance from health providers to work together.

- What future plans do you have for CVD management in your Division?
 - Increase coordinator hours in Mt Barker and Denmark,
 - Seek to work with local hospital staff to provide a joint, flexible, Phase 3 program.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Work with allied health and health providers to develop a program from the beginning.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Networking with Heart Foundation – visit from State Secondary Prevention Manager,
 - Plans to further develop networks.

Division Resources

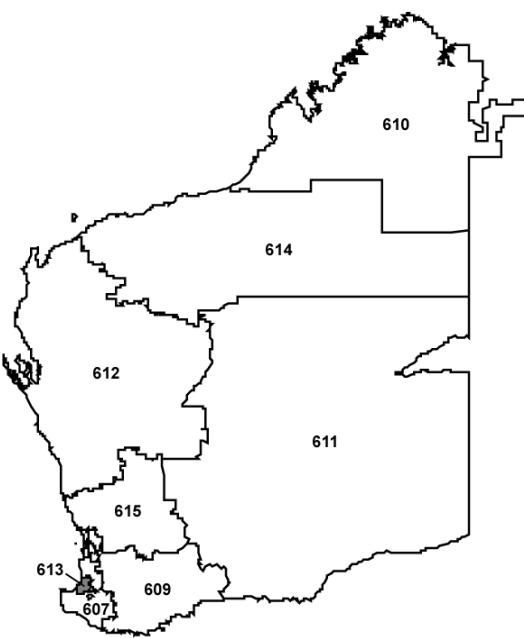
- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
 - Patient held record cards,
 - Client Information files,
 - National Best Practice Guidelines for Cardiac Rehabilitation and Secondary Prevention.
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Client Information files/Patient Resource file,
 - CVD Program GP Resource Kit – including Referral and Assessment Forms,
 - Care plans,
 - Data Collection Form,
 - Consent Forms.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Database that complies with outcomes required by Department of Health.
- What resource materials do you provide to practices?
 - Care Plan templates,
 - CVD Program GP Resource Kit.

Division Contact Person/
Program Co-ordinator

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Greater Bunbury DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	59,085	
■ Aboriginal or Torres Strait Islander	1414	2.4%
■ Speaks language other than English at home	2448	4.1%
■ RRMA classification ¹		
4: Small rural	45,259	76.6%
5: Other rural	13,826	23.4%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	2629	7.2%
■ High blood pressure ⁴	10,178	27.8%
■ High blood cholesterol ⁵	18,537	50.7%
■ Obese or overweight ⁶	21,846	59.7%
■ Physical inactivity ⁷	15,783	43.1%
■ Smoking ⁸	7267	19.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

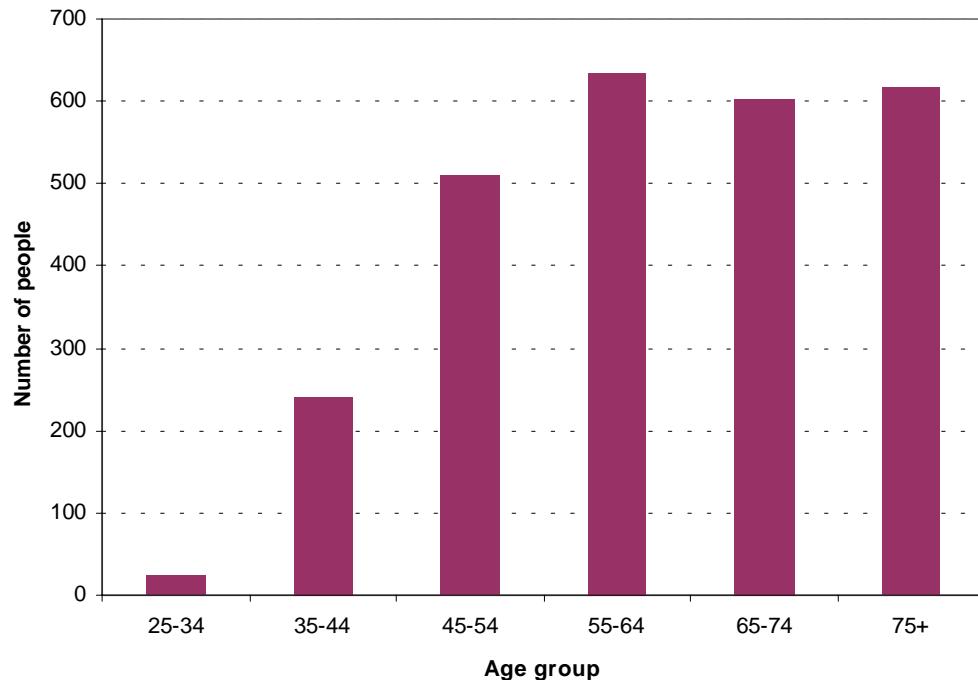
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

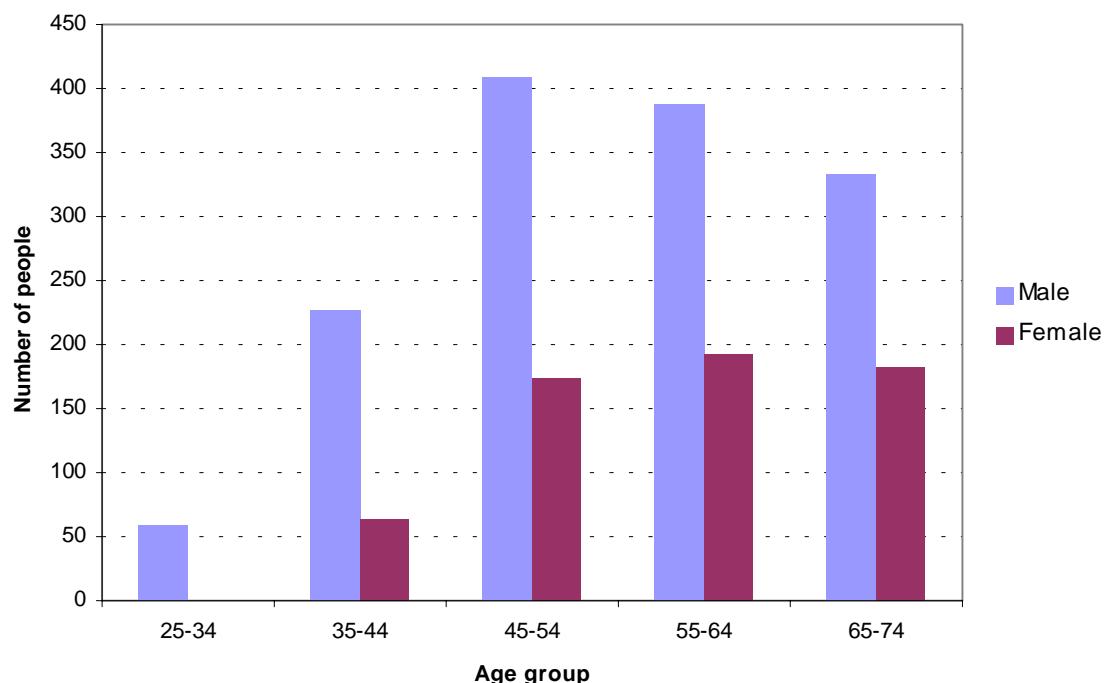
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



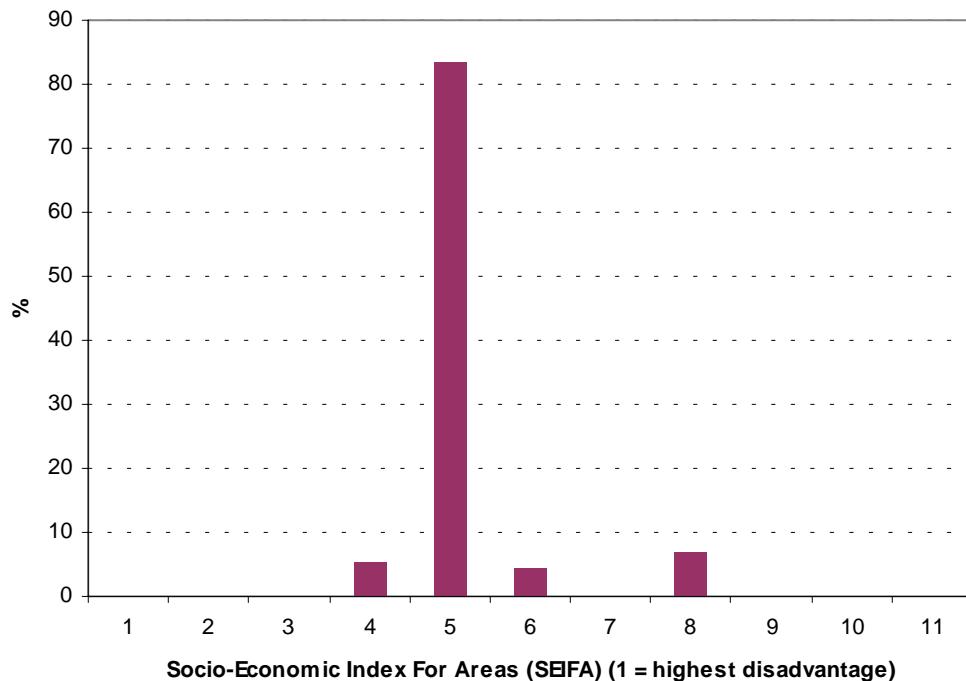
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

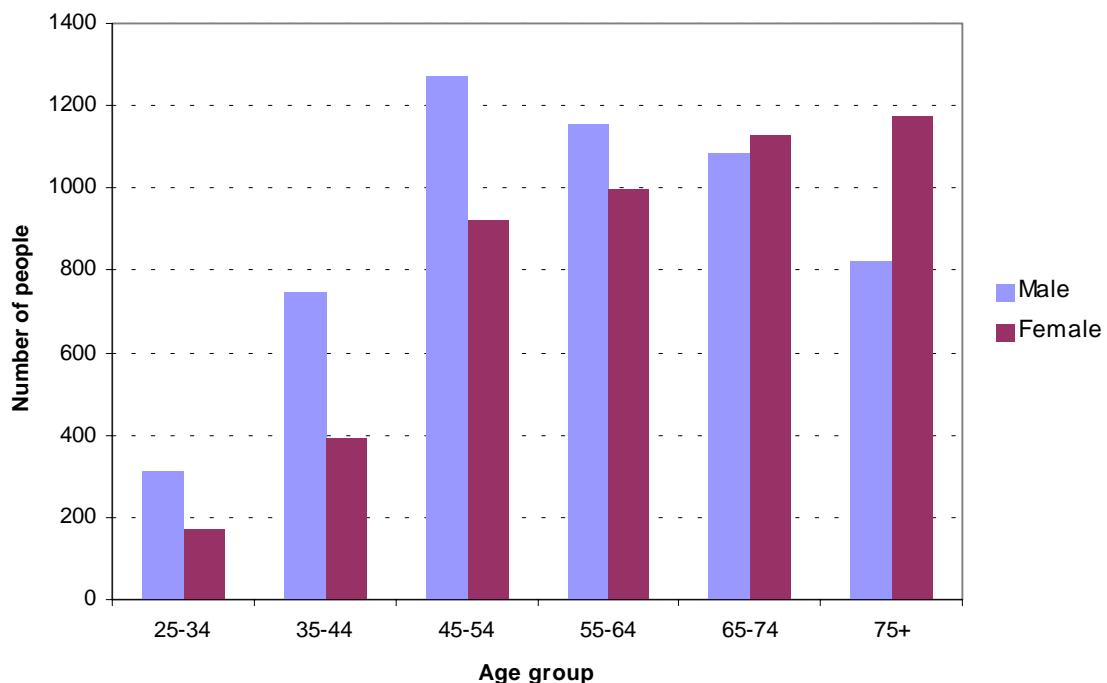
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

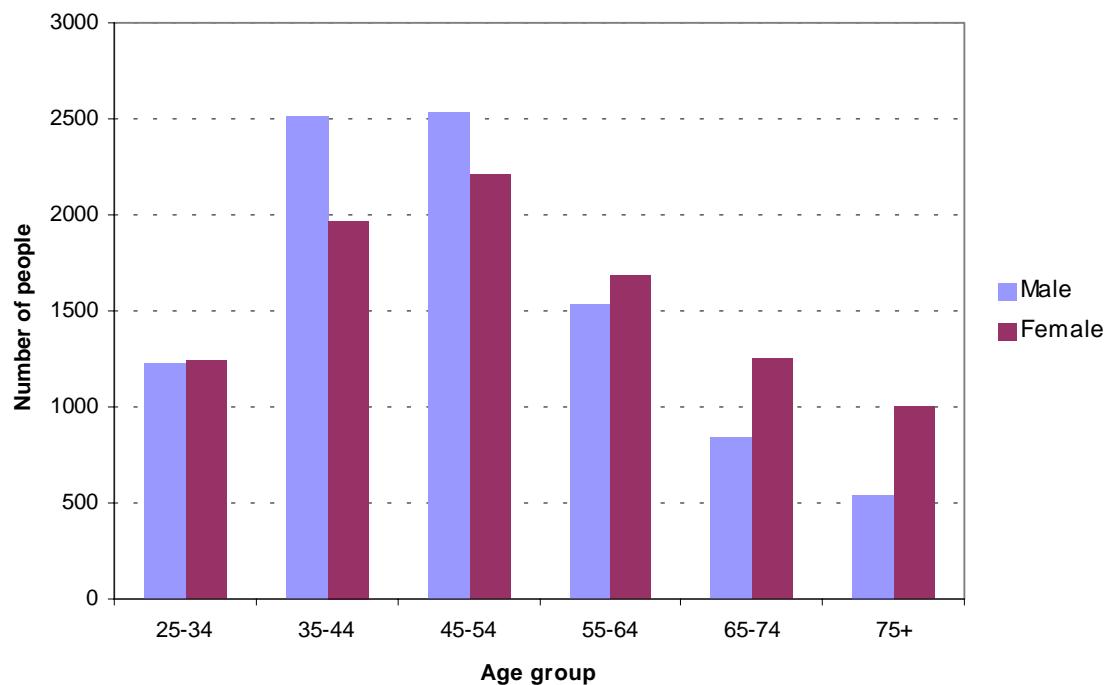
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



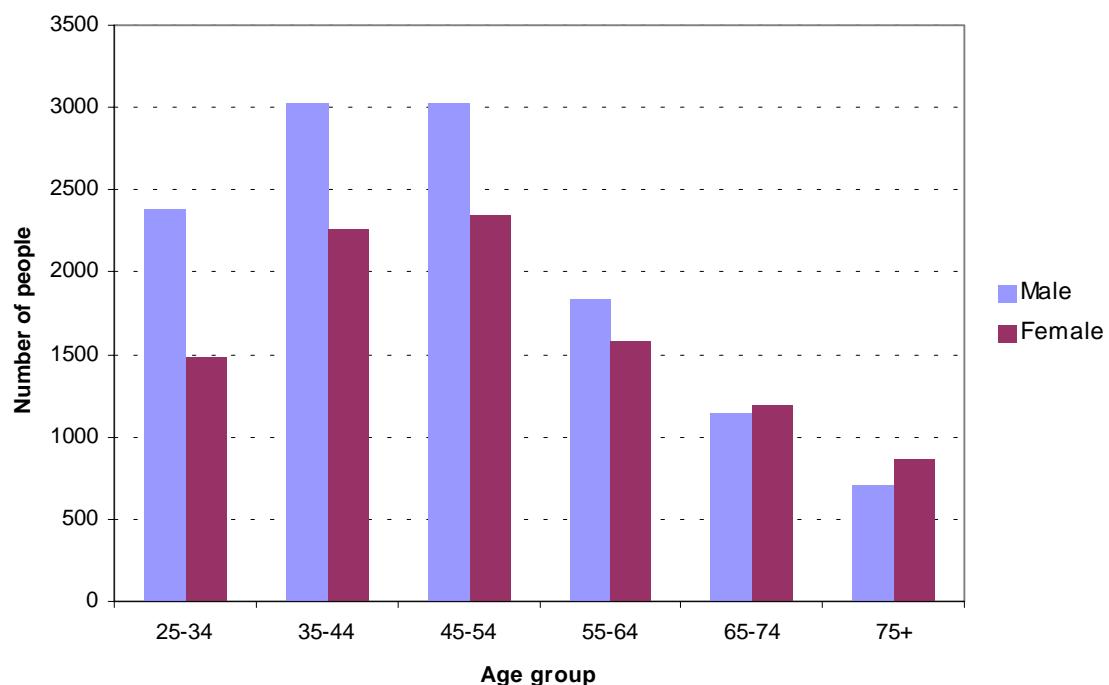
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



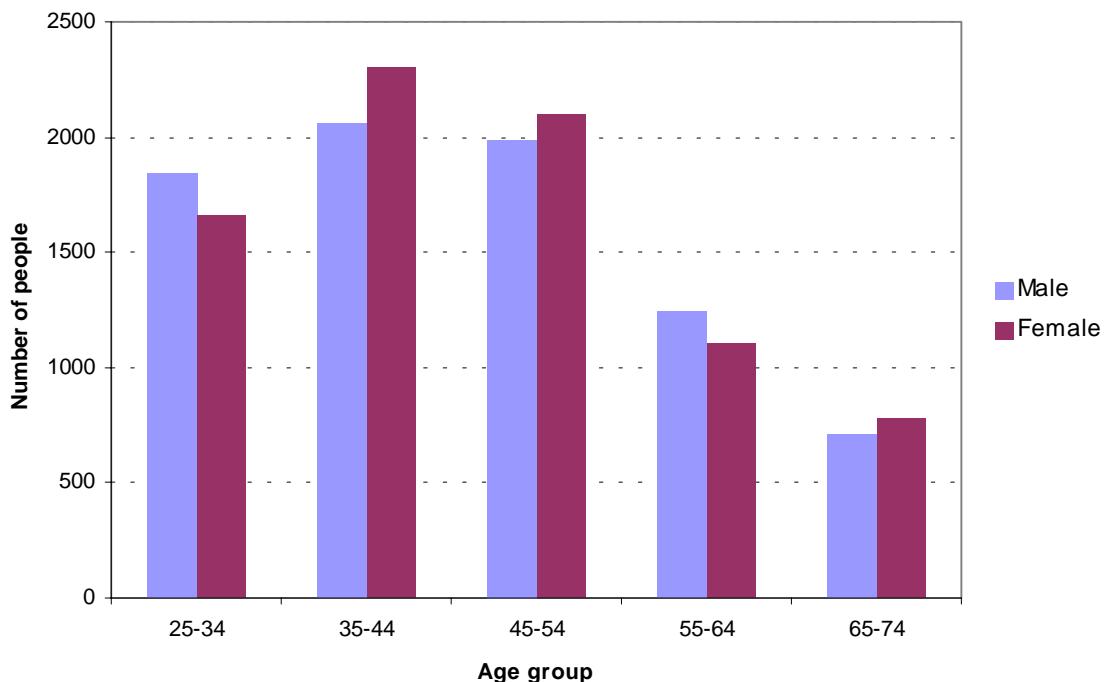
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



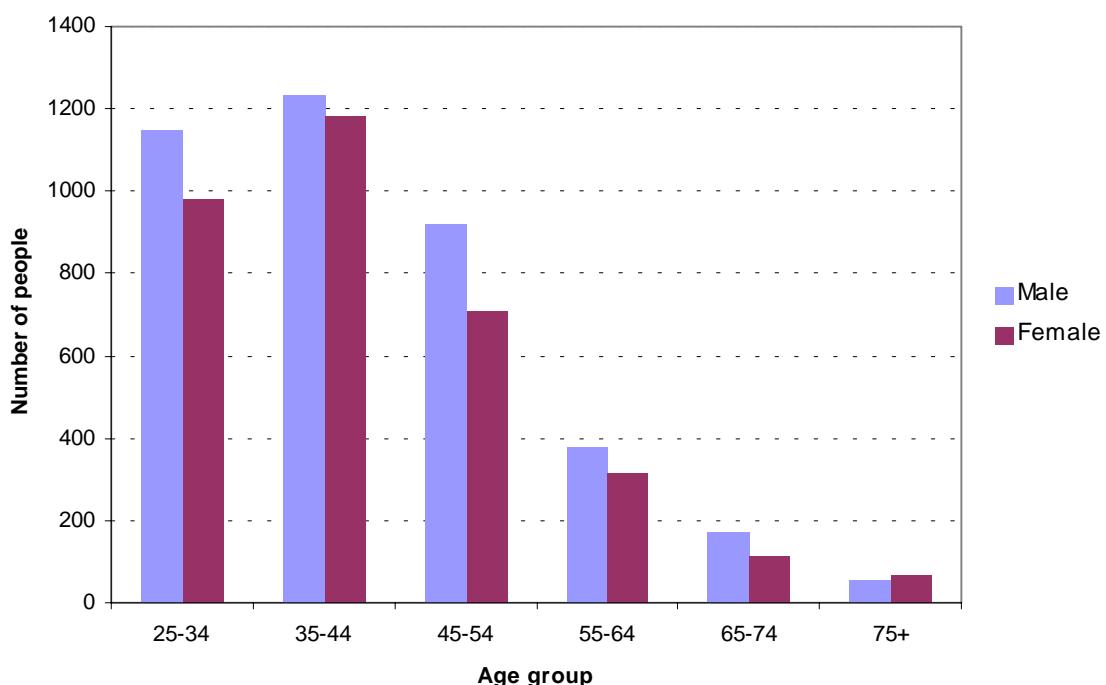
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|----|
| ▪ Number of GPs working in
the Division area: | Total | 41 |
|--------------------------------------------------|-------|----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Integrated Diabetes Care Pilot Program,
 - Primary Health Service Outpatient Diabetic Service,
 - Visiting Princess Margaret Hospital diabetic team every six weeks,
 - Inpatient Diabetic Service,
 - General Practice based diabetic nurse educator.

- What services are needed but are not available in your Division area?
 - Increased diabetic services for general practice,
 - After hours provision of diabetic services to the community “at risk”.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input checked="" type="checkbox"/>	1999
<input checked="" type="checkbox"/>	2000	<input checked="" type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?

Integrated diabetes care program aims to identify service gaps in the South West region of WA, and provide funding to address these services. Also provide funding to five health services to be channelled into provision of diabetes services.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Increased services to the region,
 - Increased accessibility of trained staff to deliver current up-to-date services,
 - Increased networking between professionals.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

No.

- What future plans do you have for diabetes management in your Division?

Provision of a diabetes nurse educator into general practice who can be accessed by all Division GPs. Services to take place in general practice.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Availability of “space” (rooms) for service provision,
 - A good understanding of how to “take up” initiatives,
 - A commitment by GPs to learn how to use the software.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Relationships with other service providers need to be built upon – in early stages currently.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

All of the above, national based resources, consumer input.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

None developed by the Division alone, although a patient hand held record is currently being trialled in Vasse Leewin Health Service area.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

Funding!
We will need to investigate other avenues of funding next year as the state based funding will probably cease.

- What resource materials do you provide to practices?

We distribute whatever we are asked to distribute to our GP membership (updated clinical guidelines, etc).

Division Contact Person/
Program Co-ordinator

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CARDIOVASCULAR DISEASE PROGRAM

Services

- What CVD services are available in your Division area?

Cardiac Rehabilitation Program.
- What services are needed but are not available in your Division area?

Expansion of the above program to cater for out of hours.

CVD Program Description

- In which years did you have a CVD project or program operating:

 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002
- Please describe your CVD program including any changes that occurred over time?

Provision of outpatient based cardiac rehab health education and exercise, six-week program.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Participants enjoy the program with a support group growing all the time.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Lack of funding.
- What future plans do you have for CVD management in your Division?

None at this stage – although, next year we will be reviewing the situation, as we will receive continued funding in the next financial year.
- Based on your experience, what advice would you give to a Division planning or implementing a CVD program?

Developing partnerships with other service providers.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Started quarterly meetings with Health Service Managers to better facilitate transfer of information between stakeholders and plan for future service delivery.

Division Resources

- What CVD resources do you frequently utilise to help implement your programs (eg. National Heart Foundation or state based resources)?
- What CVD resources developed by your Division would you be willing to share with or provide access to for other Divisions?
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
- What resource materials do you provide to practices?

All of the above, national, consumer representation.

We have not developed resources ourselves except for a small patient held record book.

Increased funding.

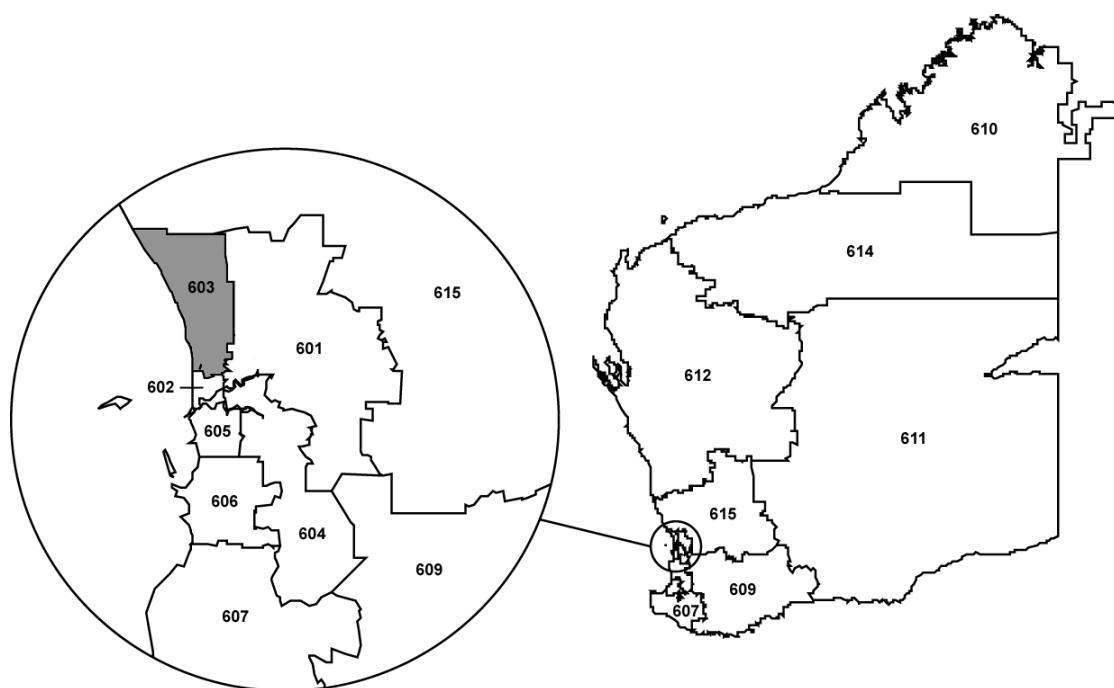
We will be reviewing plans for next year on how the Division can sustain a service to our GPs as funding will probably cease from the State.

We provide resources to practices as we are requested to do so.

Division Contact Person/
Program Co-ordinator

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Osborne DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	328,443	
■ Aboriginal or Torres Strait Islander	3861	1.2%
■ Speaks language other than English at home	46,536	14.2%
■ RRMA classification ¹		
1: Capital city	328,443	100.0%
■ SEIFA category containing population median: ²	9	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	14,680	7.1%
■ High blood pressure ⁴	56,929	27.5%
■ High blood cholesterol ⁵	105,035	50.7%
■ Obese or overweight ⁶	123,619	59.6%
■ Physical inactivity ⁷	90,221	43.5%
■ Smoking ⁸	41,257	19.9%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999–2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

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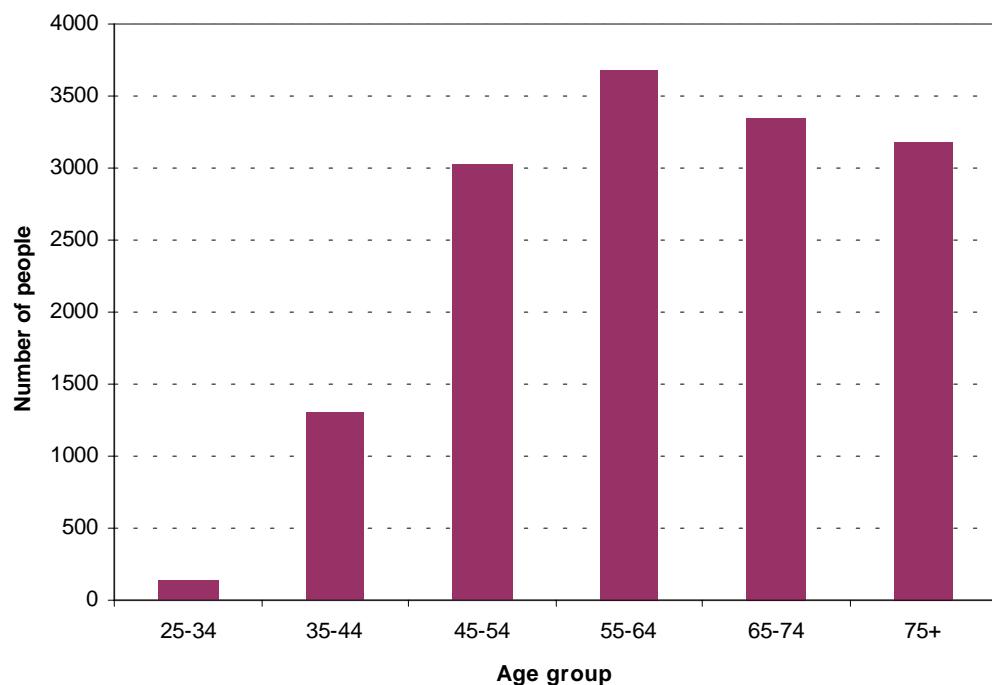
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8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

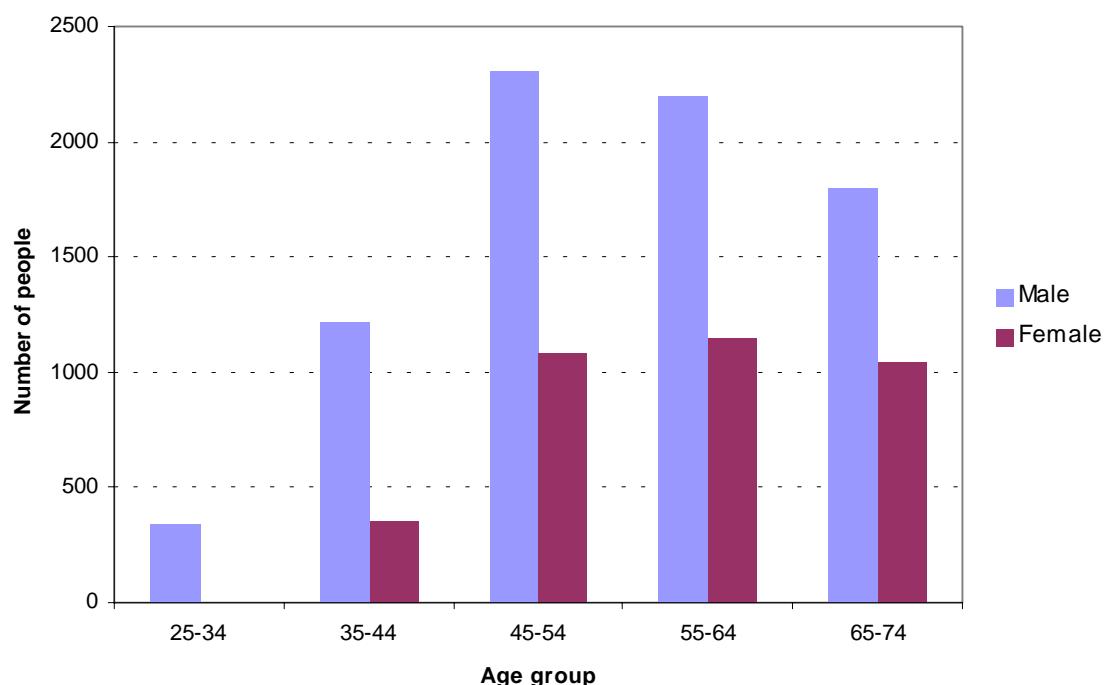
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



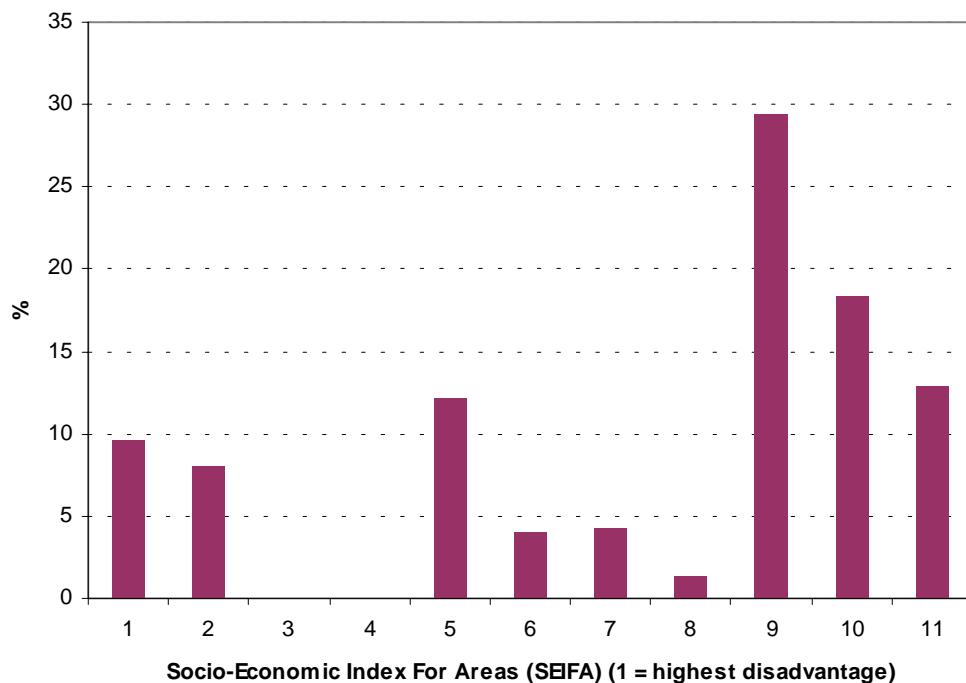
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

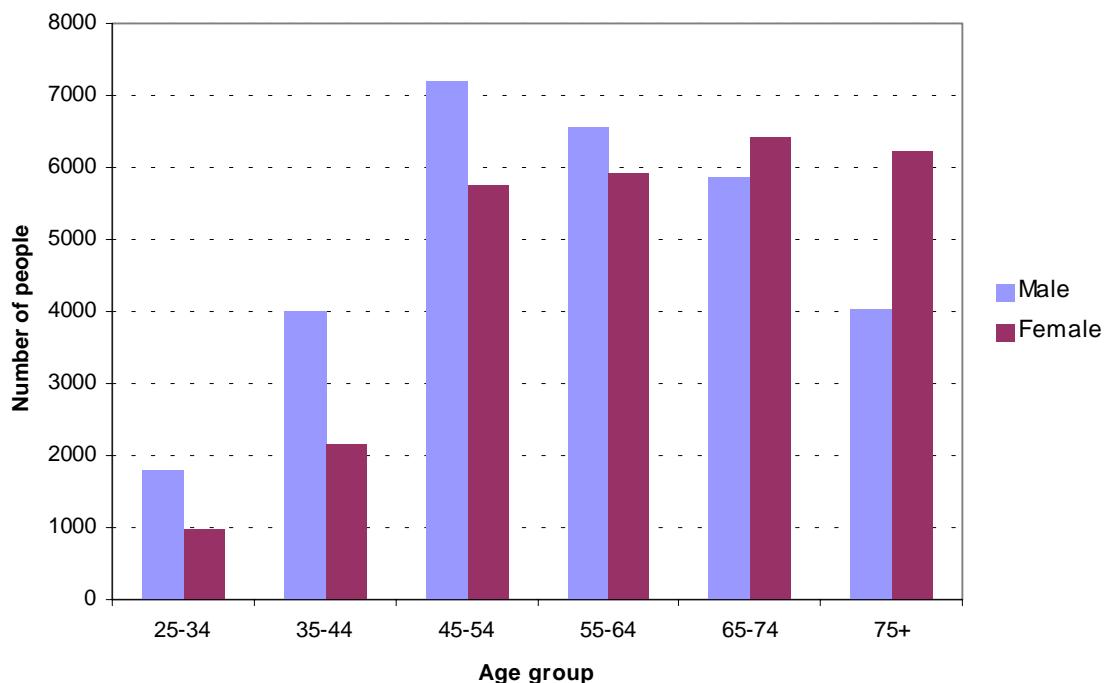
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

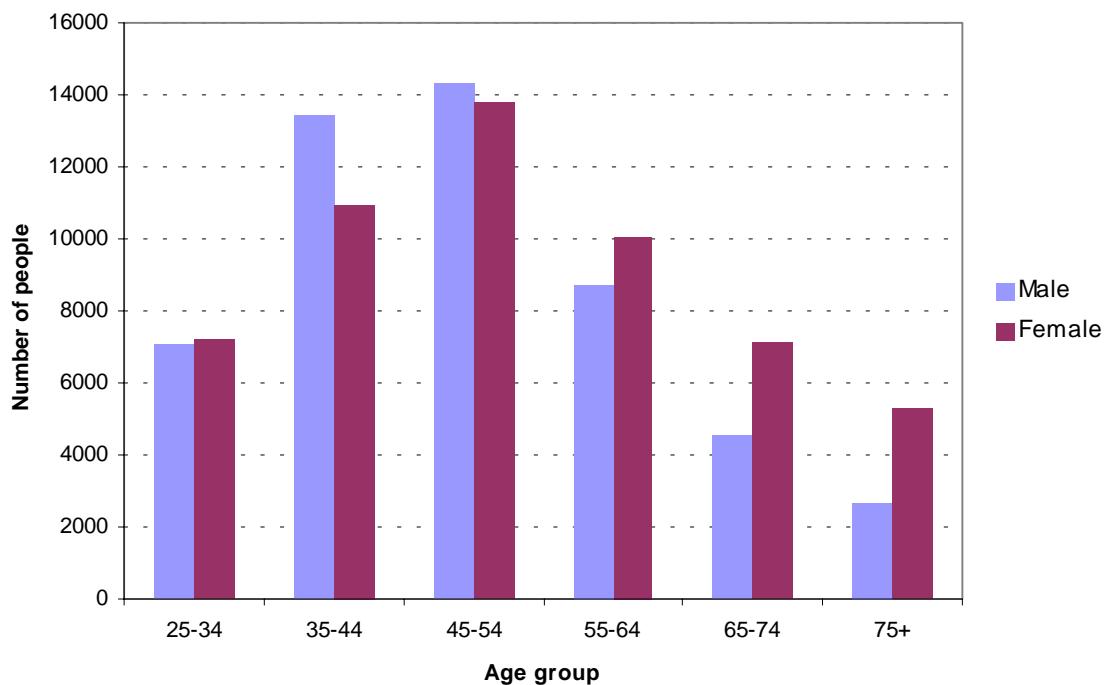
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



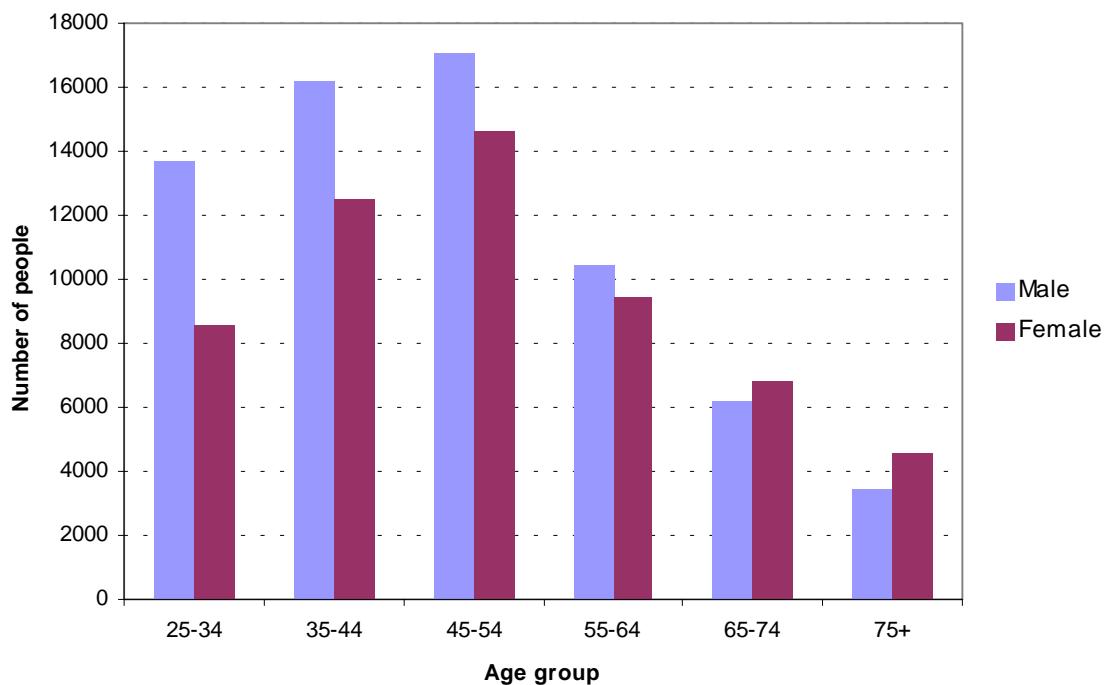
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



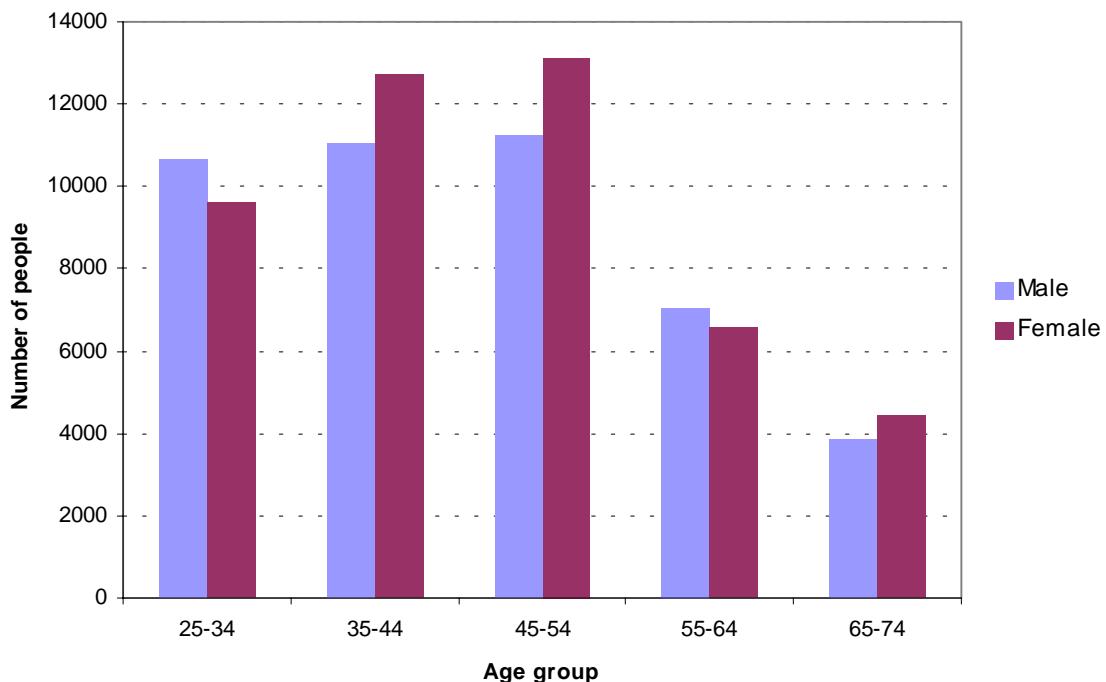
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



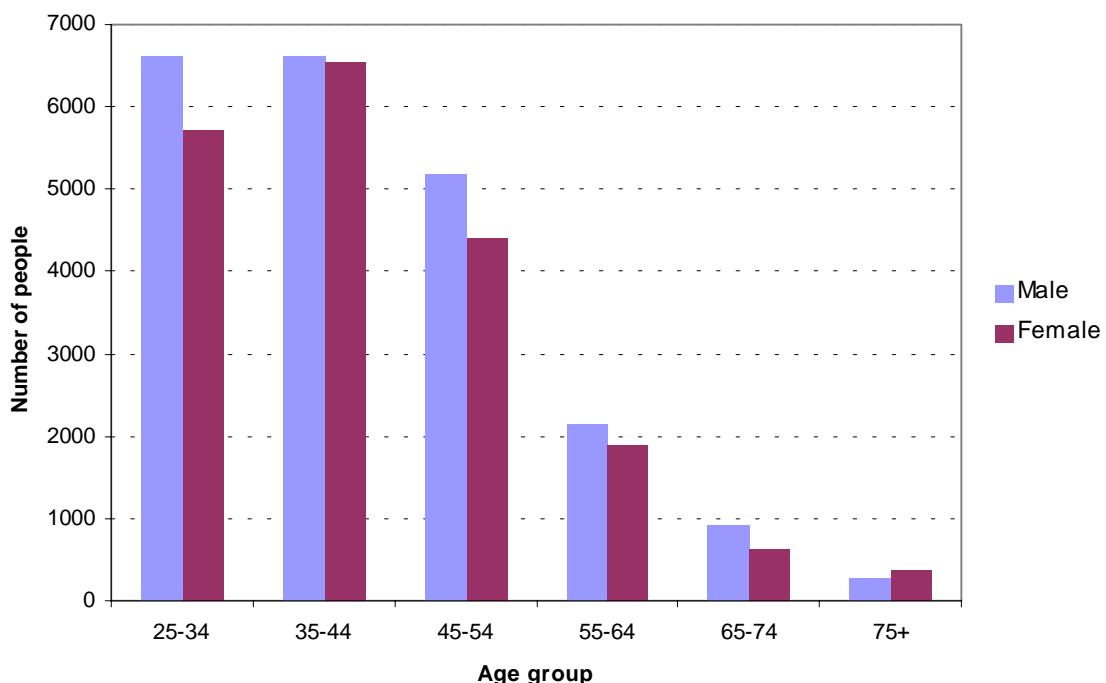
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 411 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Public:

- North Metropolitan Health Service (NMHS) – patient diabetes education,
- Sir Charles Gairdner Hospital – Department of Endocrinology & Diabetes.

Private:

- Dietitian.

- What services are needed but are not available in your Division area?

Currently there is a three-month waiting period for patients to have diabetes education (for newly diagnosed type 2 patients) in the north metropolitan area of Perth. Early in 2002 a collaborative team of diabetes stakeholders put together a business case (under the Department of Health and Ageing [DOHA] Diabetes Program Plan 2002 – 2004) to focus on integrated diabetes care, encompassing the Division, the North Metropolitan Health Service (NMHS), Osborne Park Hospital and Sir Charles Gairdner Hospital. Some of the recommendations have already been implemented. The business case included (amongst other things) the following recommendations:

- Firstly, the appointment of a Regional Diabetes Coordinator and the establishment of a Regional Diabetes Steering Committee, to oversee the integrated care program,
- Secondly, the increasing of resources such as endocrinology registrars (and more sessions for consultants); diabetes nurse educators; podiatrists; dietitians; diabetes dedicated physiotherapists; an Aboriginal and bi-cultural health worker; and a physical activity program coordinator,
- The NMHS will continue to work in collaboration with the Division who, in turn, will continue to focus on diabetes as a priority area; including the maintenance of the diabetes register, support of collaborative partnerships between GPs and other key stakeholders and increasing upskilling opportunities for practice nurses, leading to more communication within the “team” and better integration of care for the patient. The idea is to minimize the fragmentation of services through better review

and planning to ensure better (and more equitable) access for all people with/or at risk of diabetes.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input checked="" type="checkbox"/> 1998	<input checked="" type="checkbox"/> 1999
<input checked="" type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?

- Various diabetes seminars and lectures to GPs and practice nurses; either Division-developed or promoted by the Division,
- Community talks to various consumer groups such as:
 - Elderly,
 - Vietnamese,
 - Chinese,
 - Italian,
 - Spanish,
 - Diabetics.
- Maintenance of the Diabetes Management in General Practice Program (this program includes management guidelines for type 2 diabetes, consent form for patient inclusion on the diabetes database, and a management review sheet (covers patient management for 2 years),
- Maintenance of the diabetes database (register/recall system developed in-house). This included providing payments to participating GPs up until June 30 2002,
- Provision of type 2 diabetes kits for patients (provided free to GPs for distribution). The kits were recently expanded to include more information on nutrition, physical activity and a medication record,
- Development and launch of diabetes brochures (sets of six or eight covering nutrition, risk factors etc) and posters in Italian, Croatian and Vietnamese.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - The development and printing of the brochures in Croatian, Italian and Vietnamese. These were produced with wide consultation and took into account cultural sensitivities. They were launched officially by a representative of the State Health Minister and have been popular all around Australia,
 - The patient kits which GPs and patients alike find really informative.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Budget constraints: Particularly in the development of the brochures in other languages, posting and initial printing. There is no further budget to allow us to produce more as an ongoing free resource for our GP members and local communities.

- What future plans do you have for diabetes management in your Division?
 - Continue previous long-term activities,
 - Coordinate upskilling sessions for practice nurses on diabetes,
 - Continue forwarding updated information to GPs on the management of diabetes,
 - Work collaboratively with the integrated diabetes care team (as identified above).

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - A need in the Division,
 - People willing to put in the time and effort,
 - Budget and alternative sources of funding,
 - Available knowledge and information,
 - Access to financial incentives – some practices not accredited.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Development/participation in stakeholder meetings,
 - Collaborative planning for practice nurse diabetes upskilling,
 - Plan to lead to more open communication and integration of care,
 - Mainly NMHS.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
- Diabetes Kits (2002 version) include:
 - Diabetes Diary – produced in partnership with the Perth and Hills Division of General Practice,
 - Personal medical card – produced by Osborne Division of General Practice (ODGP),
 - Personal medication list plastic wallet – produced by ODGP,
 - “Helping you to better manage your Diabetes” – pamphlet produced by ODGP,
 - “The Australian Guide to Health Eating – Background Information for Consumers” – booklet developed as part of a project undertaken for the Commonwealth Department of Health and Family Services,
 - “National Physical Activity Guidelines for Australians” – brochure by Active Australia and Commonwealth Department of Health and Ageing,
 - Patient Information Sheets for type 2 diabetes – produced by ODGP,
 - “Why you need a GP” - pamphlet produced by ODGP,
 - “Getting Started” – booklet produced by Active Australia,
 - “The Australian Guide to Healthy Eating – Summary Information” - pamphlet produced as part of a project undertaken for the Commonwealth Department of Health and Family Services,
 - “Be Well – Know your BGL” – posters and “scratchy” cards produced by Diabetes Australia,
 - “Diabetes Management in General Practice 2001 – Revised Edition” – management guidelines booklet produced by Diabetes Australia and The Royal Australian College of General Practitioners,
 - Diabetes fact sheets – produced by Diabetes Australia Western Australia,
 - Diabetes Management in the general care setting – nurses upskilling course – developed by the National Association of Diabetes Centres,
 - Posters and brochures in Croatian, Italian and Vietnamese – produced by ODGP.

- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - As above,
 - Diabetes Diary (in partnership with Perth and Hills Division),
 - Personal medication card and plastic wallet,
 - “Why you need a GP”,
 - Vietnamese, Croatian, and Italian brochures and posters.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?

See answer provided under section: “What services are needed but are not currently available in the Division area?”

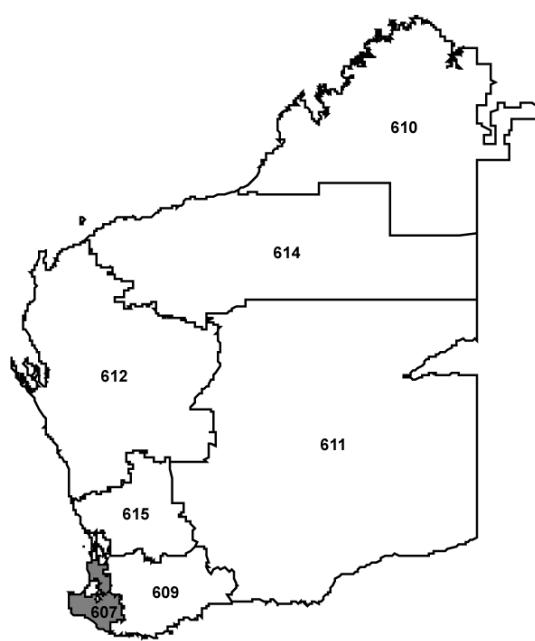
- What resource materials do you provide to practices?

See above under Division resources.

Division Contact Person/
Program Co-ordinator

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Email: kateh@odgp.com.au

Peel South West DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	119,933	
■ Aboriginal or Torres Strait Islander	1977	1.6%
■ Speaks language other than English at home	3864	3.2%
■ RRMA classification ¹		
4: Small rural	46,054	38.4%
5: Other rural	73,878	61.6%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	6692	8.5%
■ High blood pressure ⁴	25,198	32.1%
■ High blood cholesterol ⁵	41,253	52.5%
■ Obese or overweight ⁶	47,897	60.9%
■ Physical inactivity ⁷	33,311	42.4%
■ Smoking ⁸	14,610	18.6%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

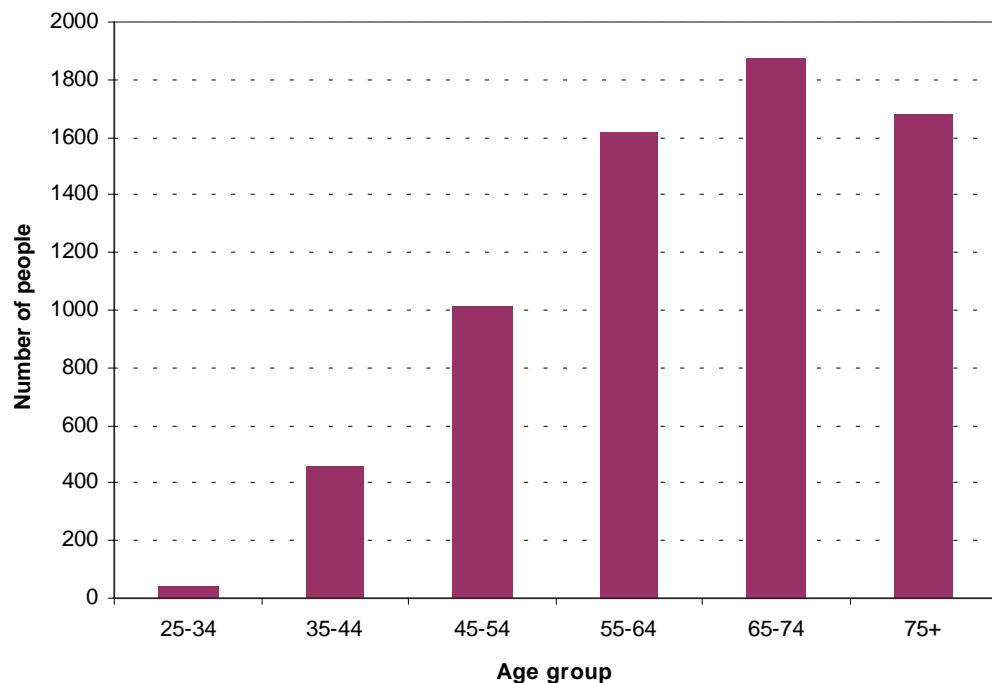
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

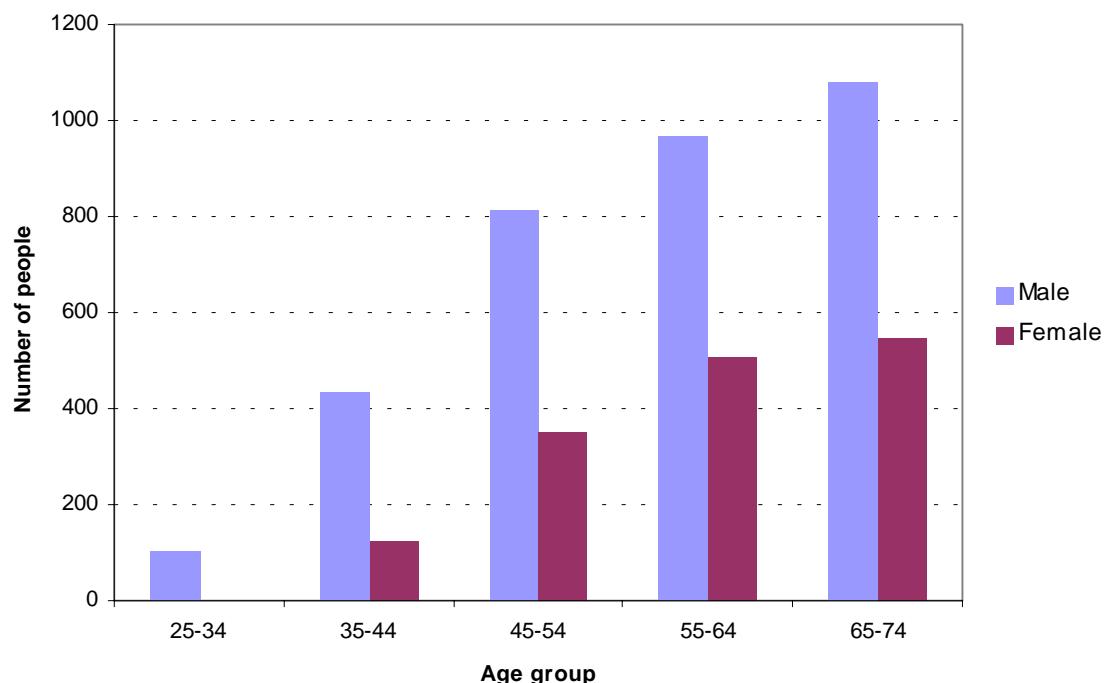
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



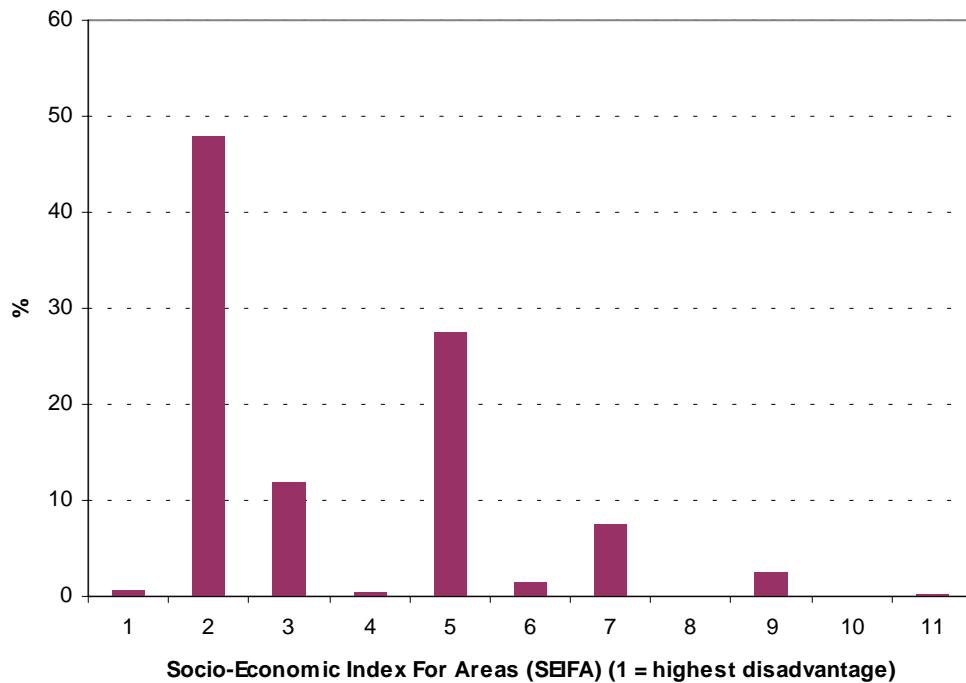
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

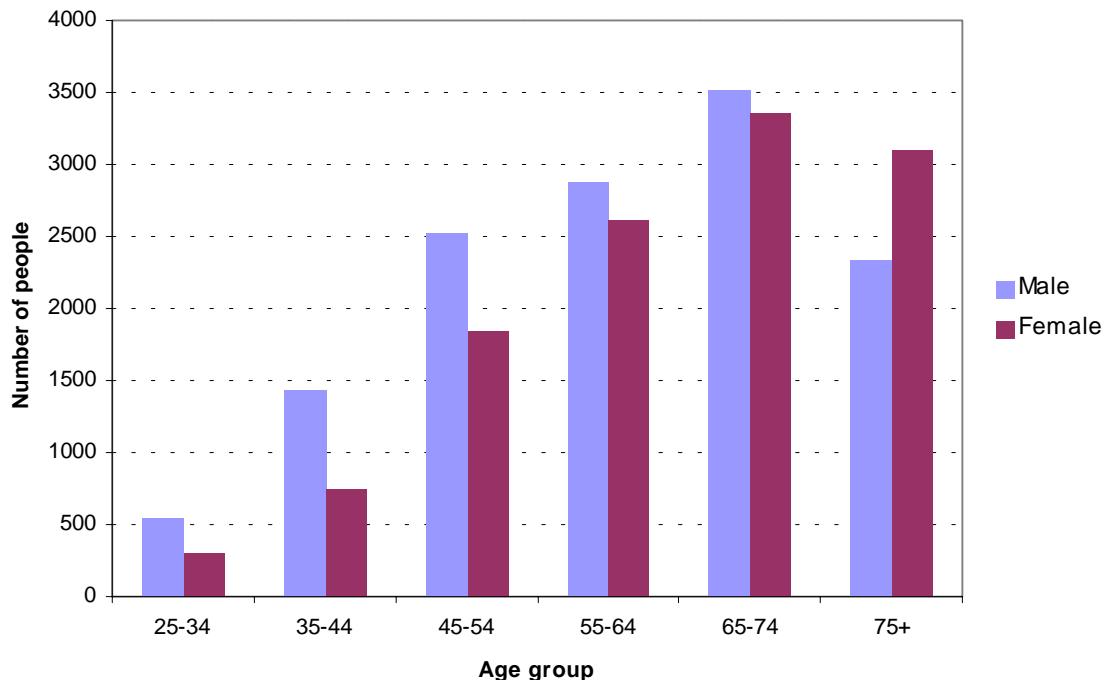
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

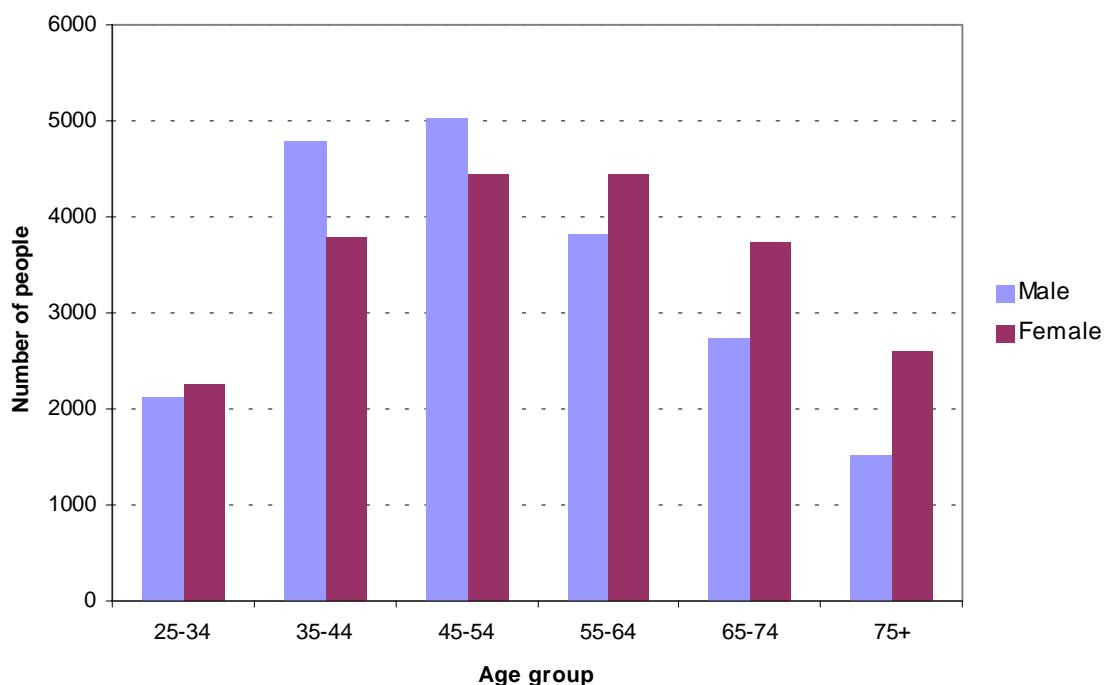
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



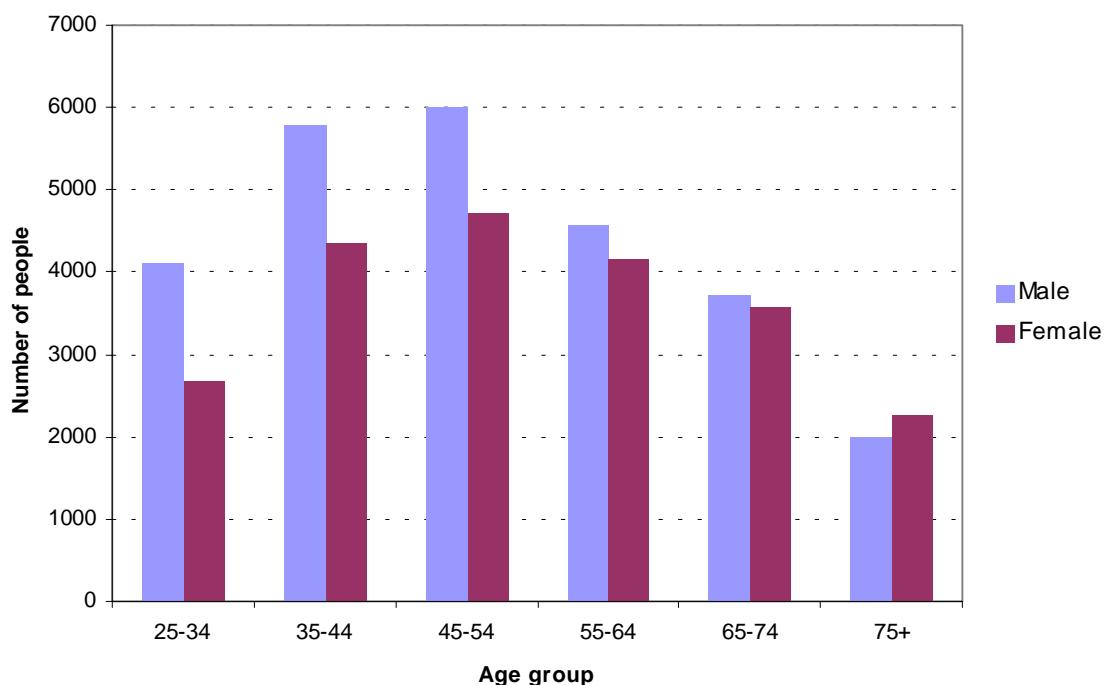
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



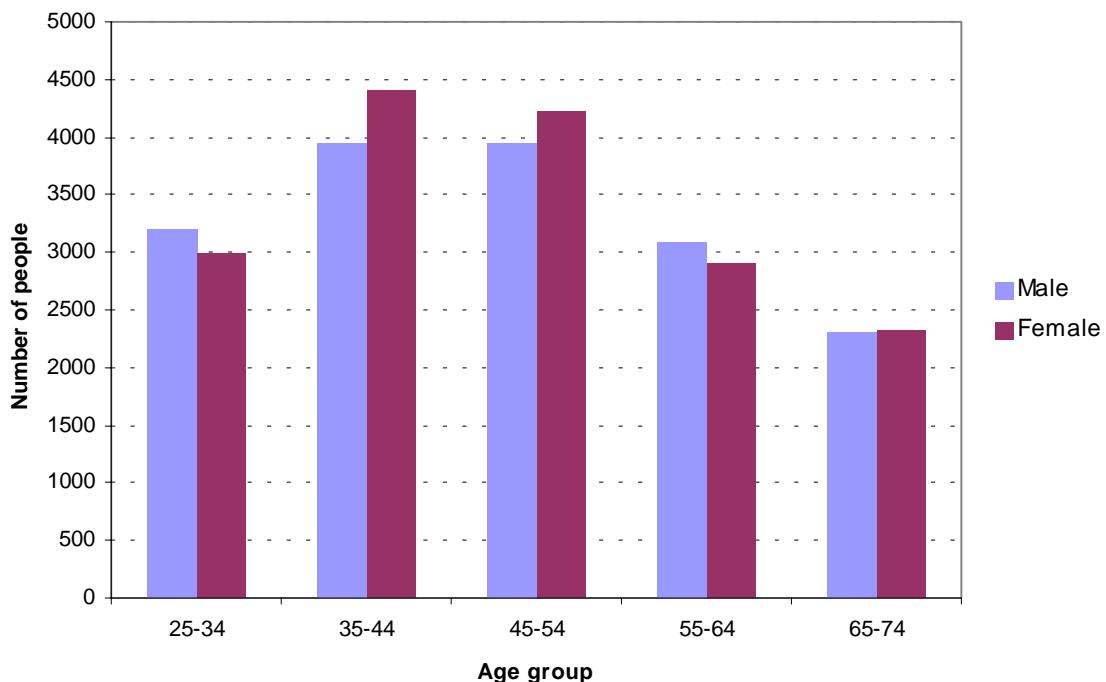
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



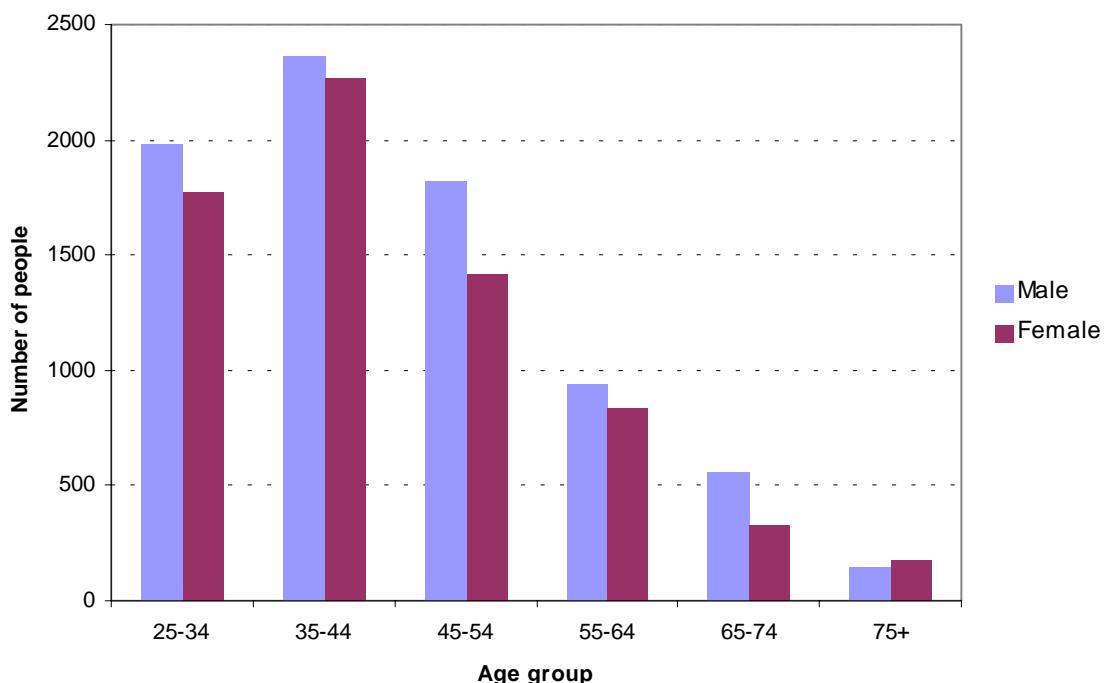
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 130 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Division miniclinics in doctors practices

Private:

Silver Chain

- group programs/individual clinics,
- limited availability in country areas.

Public:

- Regional Hospital and Health Services – diabetes teams, eg educator, dietitian, podiatrist, physiotherapist, pharmacy, etc.

- What services are needed but are not available in your Division area?

- Aboriginal health workers for diabetes education in certain regional areas,
- After hours clinics for working clients.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

- 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

- Continuing Professional Development (CPD) events for GPs and allied health workers focusing on diabetes have been conducted at least annually in both health service regions,
- Nineteen diabetes miniclinics set up over last 18 months, in areas perceived to have a shortage of diabetes education services. These involve the employment of a diabetes educator to operate within doctors' practices educating newly diagnosed diabetics and Impaired Glucose Tolerance (IGT) clients and re-educating previously diagnosed diabetics,
- Enhanced Primary Care (EPC) planning and case conferencing education was offered to all GPs over the last 12 months specifically with regard to diabetic patients. This education was offered and taken up either on an individual basis or in a group setting, involving other relevant health workers,
- A review and update of diabetes literature available in doctors' practices was undertaken in the last 12 months to ensure information for

patients was easily understandable,

- Public screening for diabetes risk has been conducted at the local shopping centre on an annual basis for the last two years.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Referral of patients with IGT for education prior to miniclinics. Existing services reported that these patients were not being referred,
 - Substantial decrease and in some case elimination of waiting lists for education,
 - Collaboration between doctors and allied health workers.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Insufficient funding to cover number of clinics required especially after hours,
 - Conflict between service providers with regard to collaborating on delivery of diabetes services,
 - Conflict of interest with regard to clients attending a clinic in another doctors' practice/ability for one practice to accommodate clients from other GPs.
- What future plans do you have for diabetes management in your Division?
 - To continue in a similar manner for the next 12 months, incorporating a review of the miniclinics and whether or not there are any other gaps in education anywhere else in the Division,
 - To further develop and consolidate relationships with other stakeholders.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?

External factors would primarily relate to education about the chronic disease initiatives for both GPs and staff. Internal factors would include staff availability and support regarding maintenance of registers and recall systems, and GP motivation towards initiatives.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Member of management committee of South West Integrated Diabetes Care Program (IDCP). Attend meetings of diabetes teams in all primary health services areas. All key stakeholders in the area of diabetes are represented in the IDCP management committee. This has been a major contributing factor to the alliances developed between individual stakeholders and the group as a whole.

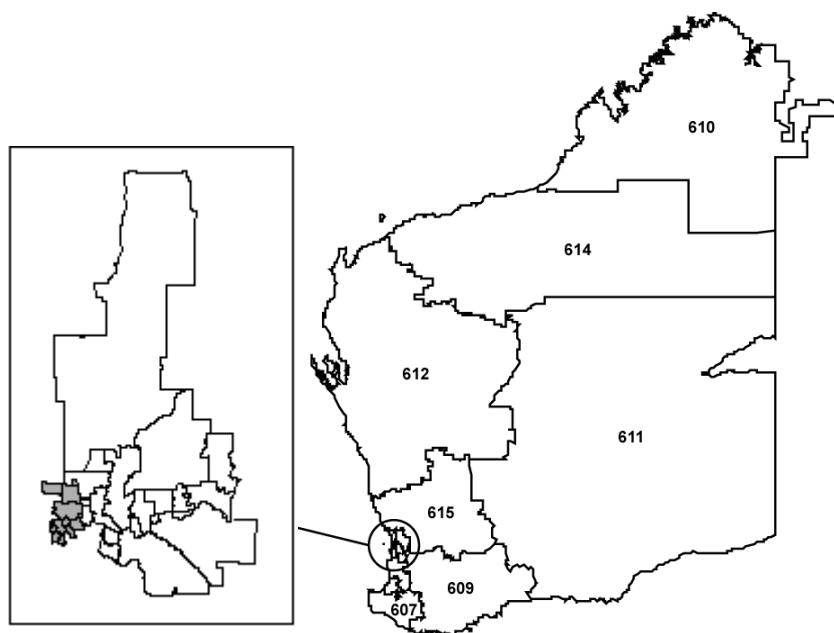
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Diabetes Australia WA (DAWA) – patient brochures and literature,
 - Royal Australian College of General Practitioners (RACGP) diabetes management in general practice,
 - Australian Diabetes Education Association pharmacist,
 - Diabetes Australia agents.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? Database – register
- What resource materials do you provide to practices? DAWA – brochures and literature

Division Contact Person/
Program Co-ordinator

Name: Sue Hoddinott
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Email: sueh@pswdgp.com.au

Perth and Hills DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	297,014	
■ Aboriginal or Torres Strait Islander	5511	1.9%
■ Speaks language other than English at home	45,232	15.2%
■ RRMA classification ¹		
1: Capital city	297,014	100.0%
■ SEIFA category containing population median: ²	8	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	14,389	7.4%
■ High blood pressure ⁴	55,371	28.6%
■ High blood cholesterol ⁵	98,372	50.8%
■ Obese or overweight ⁶	115,792	59.8%
■ Physical inactivity ⁷	82,920	42.8%
■ Smoking ⁸	37,996	19.6%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

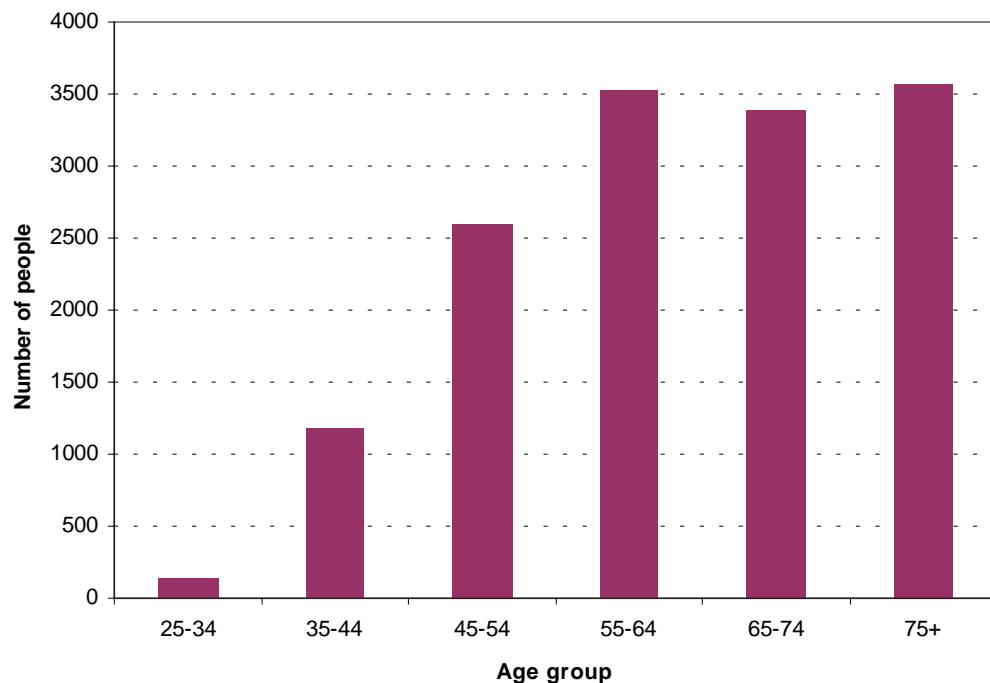
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

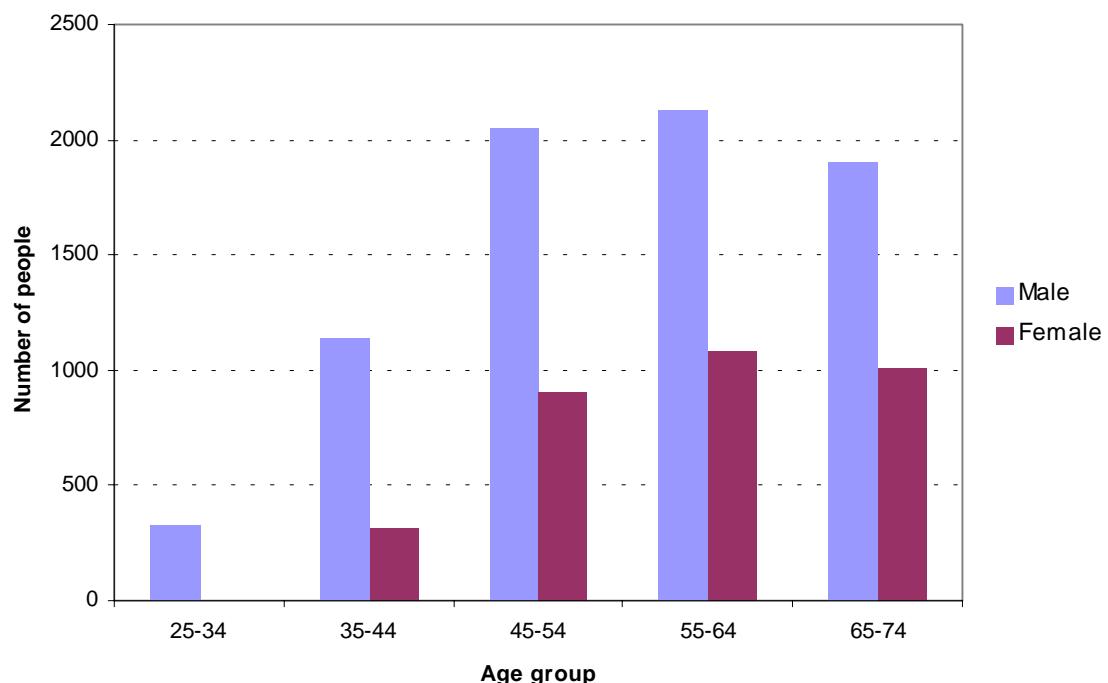
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



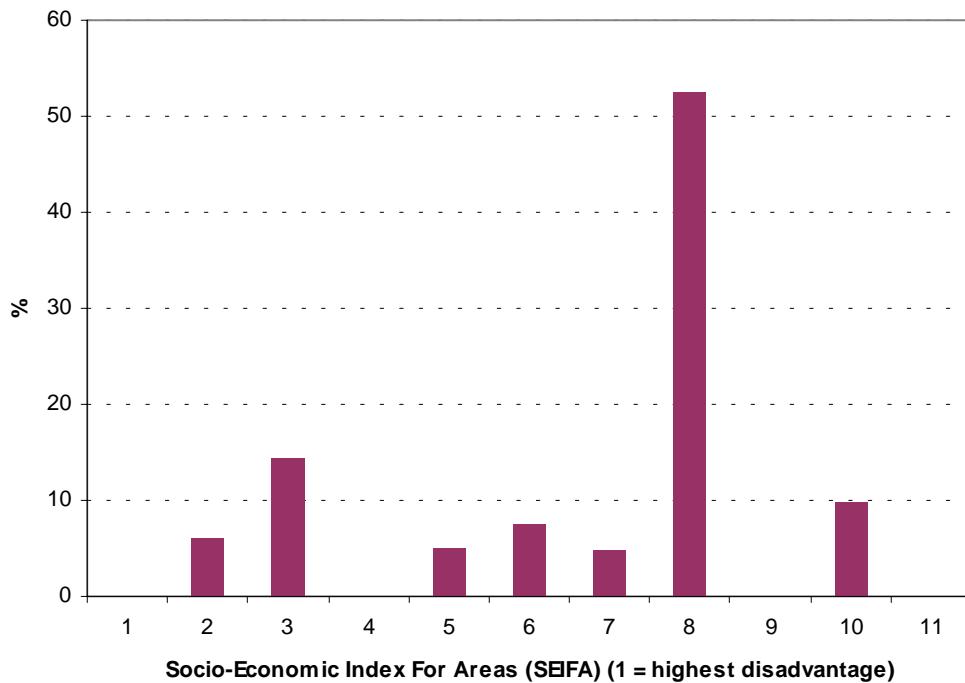
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

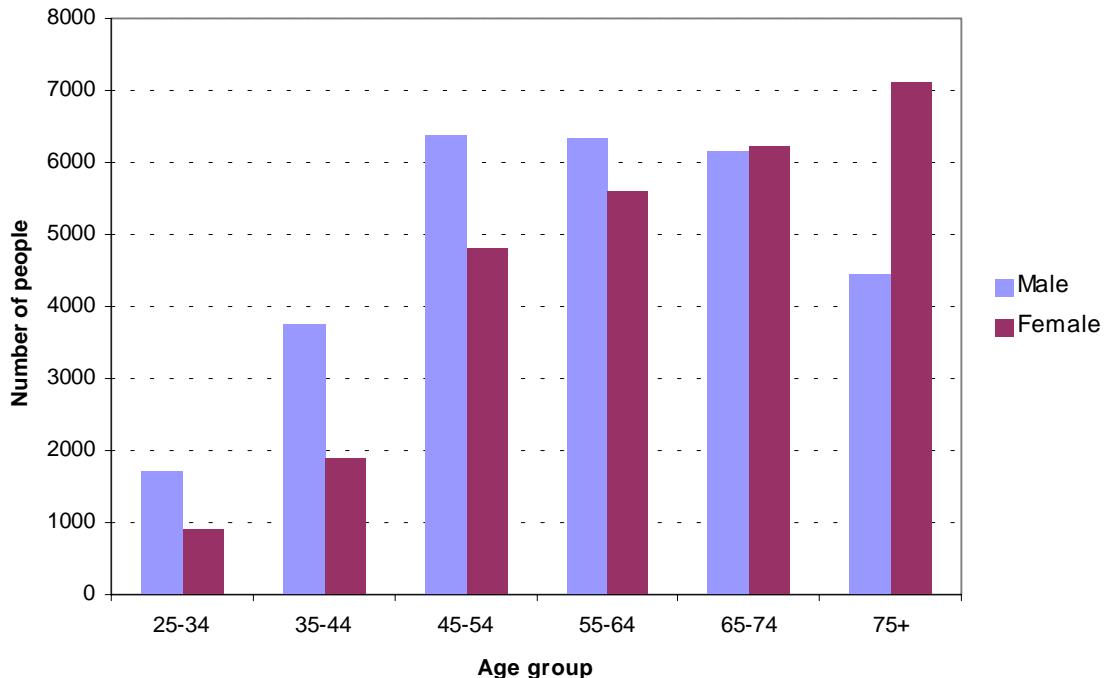
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

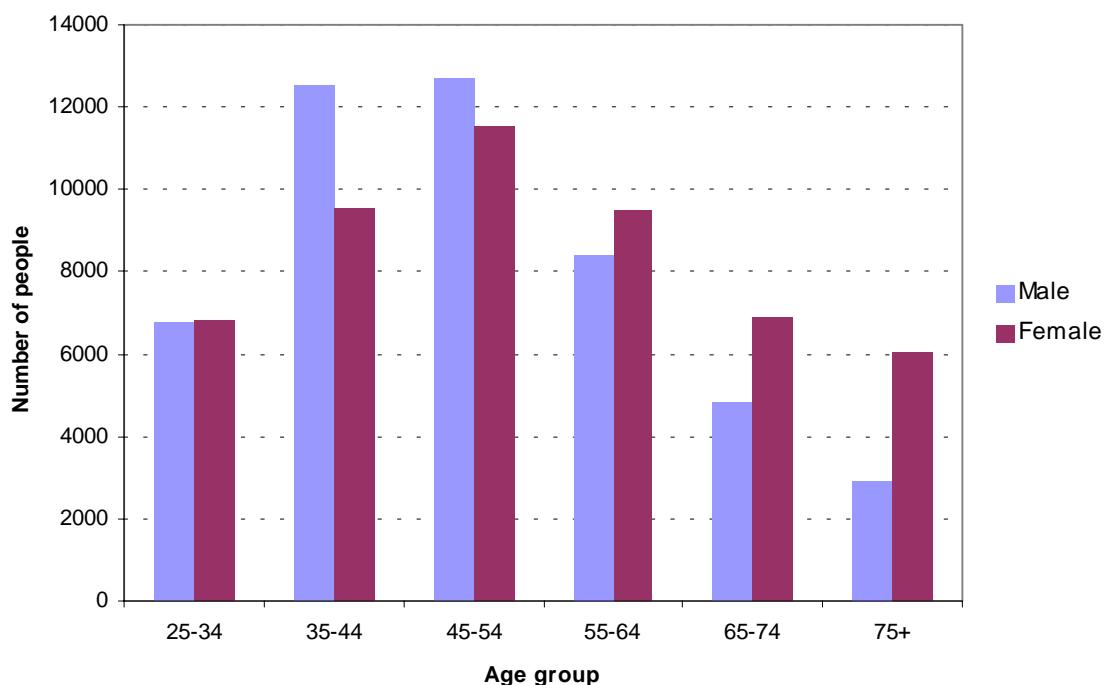
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



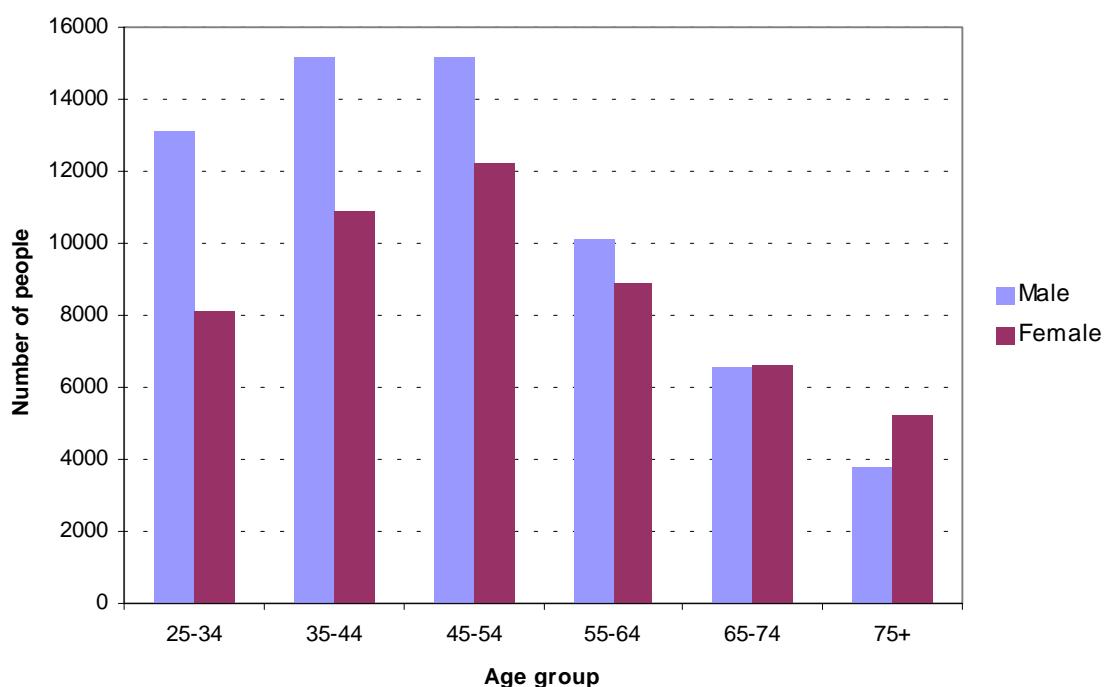
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



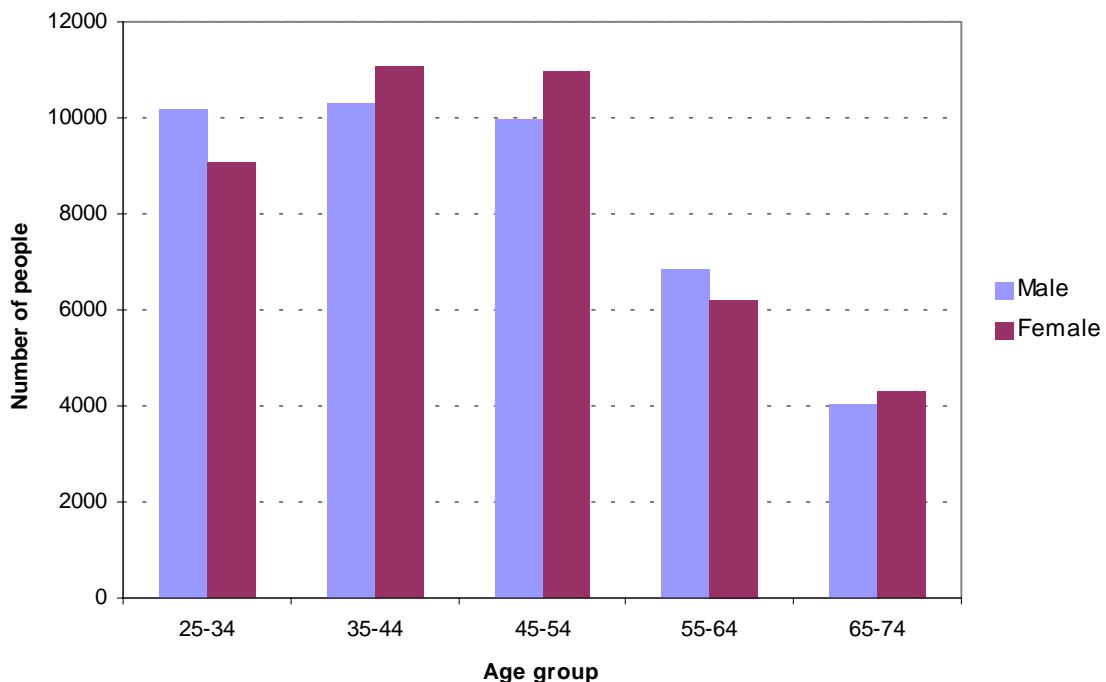
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



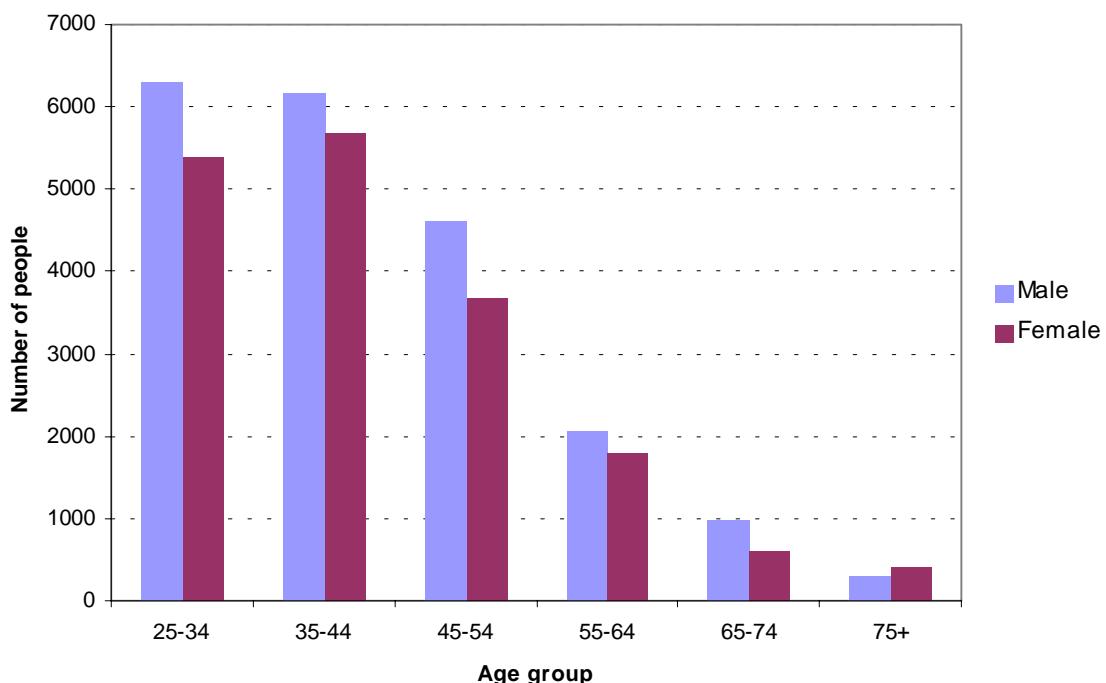
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 322 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Group education (combined State Health and Division),
 - CARDIAB database (Division),
 - Podiatry Clinic (State Health & Division),
 - GP education (Division),
 - Impaired glucose program (Division),
 - Practice nurse training in diabetes (combined State Health and Division).

- What services are needed but are not available in your Division area?
 - House most services, just need more sessions etc,
 - Resources and groups for culturally and linguistically diverse (CALD) people.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 - 1992
 - 1993
 - 1994
 - 1995
 - 1996
 - 1997
 - 1998
 - 1999
 - 2000
 - 2001
 - 2002

- Please describe your diabetes program including any changes that occurred over time?
 - CARDIAB register and recall, including gestational diabetes,
 - Impaired Glucose Tolerance (IGT)/Impaired Fasting Glucose (IFG) register and recall and patient education,
 - Information and help with Practice Incentive Program (PIP), Service Incentive Program (SIP) and care plans and assistance with practices setting up their own register and recall for diabetes,
 - Miniclinic – patient education and podiatry,
 - Practice nurse.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Providing patient education and podiatry services – mini clinic,
 - Development of impaired glucose tolerance program.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of time,
 - GPs find paperwork with CARDIAB too time consuming.

- What future plans do you have for diabetes management in your Division?
 - To promote CARDIAB to the Swan GPs,
 - Further assist computerised GPs to use diabetes,
 - Component of their software, Practice Incentive Program (PIP), Service Incentive Program (SIP) and Chronic Disease Initiatives (CDI),
 - Further training for practice nurses,
 - Explore possibility of education and resources for Chinese community.

- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Better understanding by GPs of requirements and benefits from CDI through information sessions conducted by Division,
 - Assistance with setting up the register and recall in practice.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - East Metro Population Health Unit – practice nurse, training, patient education,
 - Diabetes Australia – WA,
 - Australian Diabetes Educators Association.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice,
 - Living with Diabetes patient education program,
 - National Training programs for nurses and allied health professionals,
 - Diabetes Australia – WA patient information resources,
 - East Metro Population Health gestational diabetes resources.

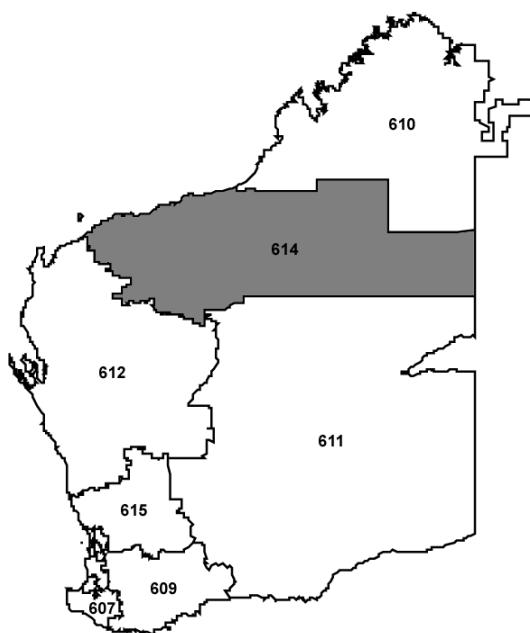
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Patient home monitoring diaries,
 - “Are You Too Sugar”; brochure targeting undiagnosed,
 - Desktop guidelines.

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| <ul style="list-style-type: none">▪ Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?▪ What resource materials do you provide to practices? | N/A. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
-
- Diabetes Management in General Practice guidelines,
 - Condensed laminated desktop guideline,
 - Information sheets on PIP, SIP, care plans and CDI,
 - Referral forms for Impaired Glucose program and patient education,
 - Information sheets on CARDIAB and practice based register and recall.

Division Contact Person/
Program Co-ordinator

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Pilbara DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	41,616	
■ Aboriginal or Torres Strait Islander	5551	13.3%
■ Speaks language other than English at home	3952	9.5%
■ RRMA classification ¹		
6: Remote centre	33,917	81.5%
7: Other remote	7699	18.5%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	1326	5.1%
■ High blood pressure ⁴	5666	21.6%
■ High blood cholesterol ⁵	12,546	47.9%
■ Obese or overweight ⁶	15,528	59.3%
■ Physical inactivity ⁷	11,846	45.3%
■ Smoking ⁸	5820	22.2%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

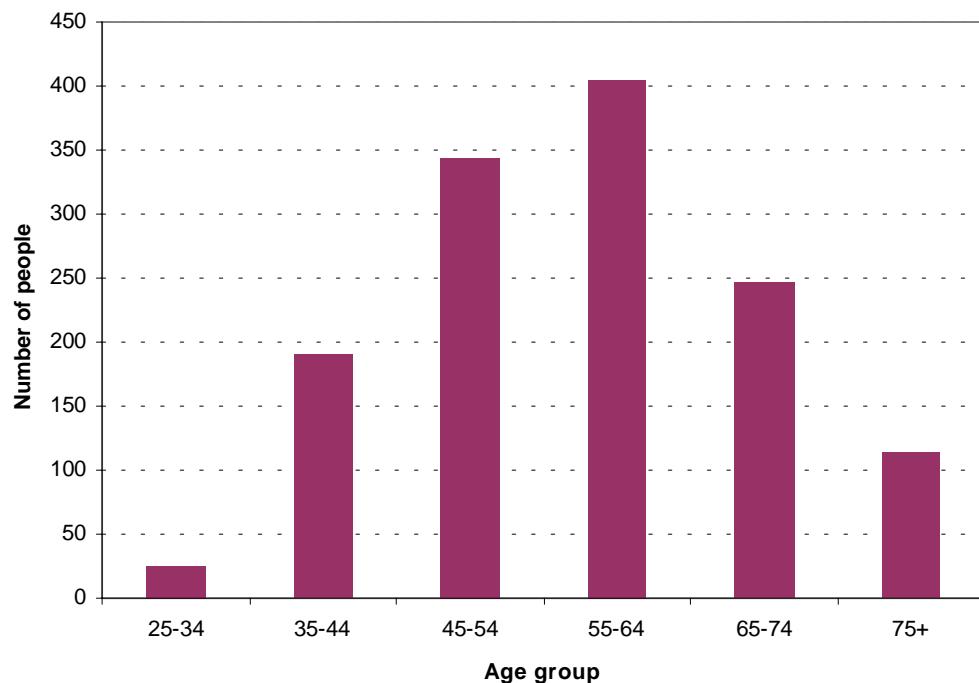
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

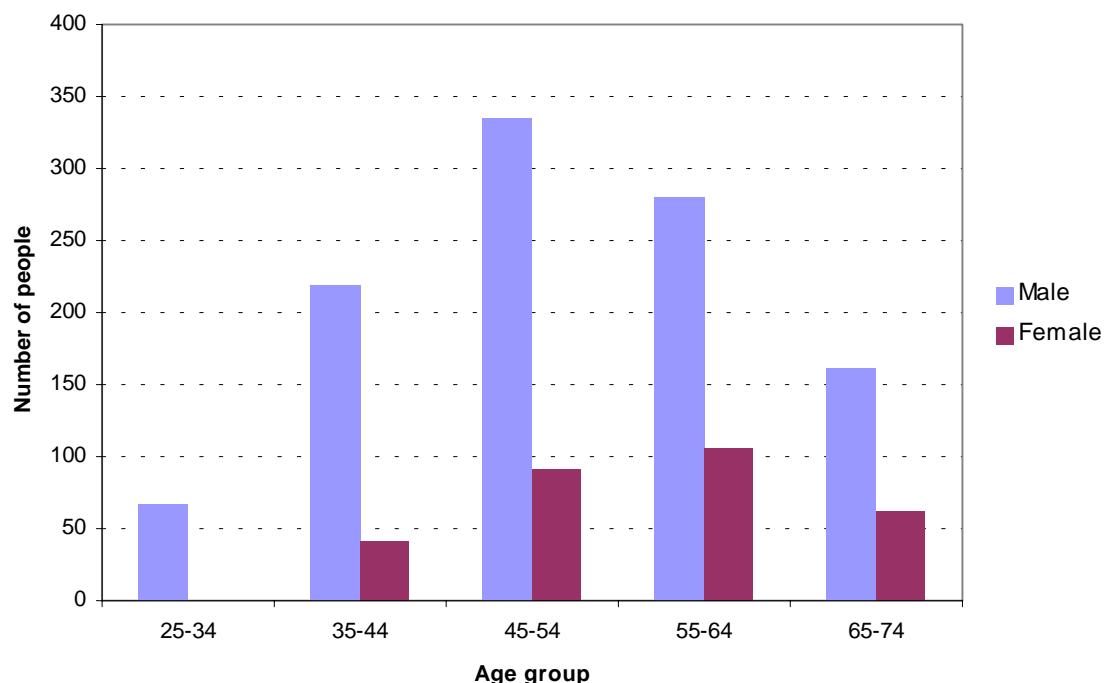
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



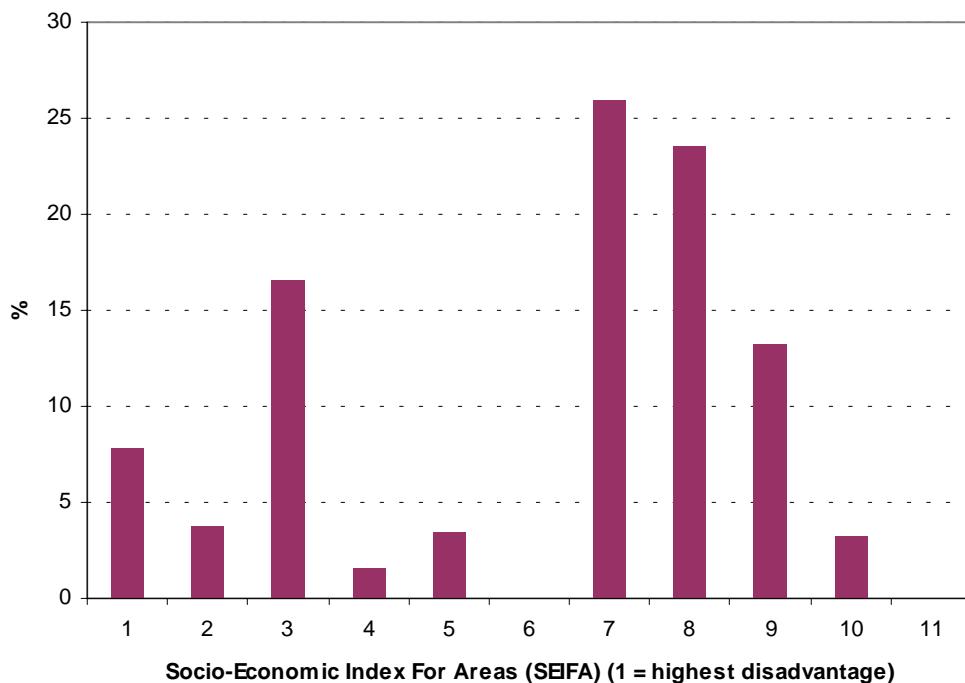
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

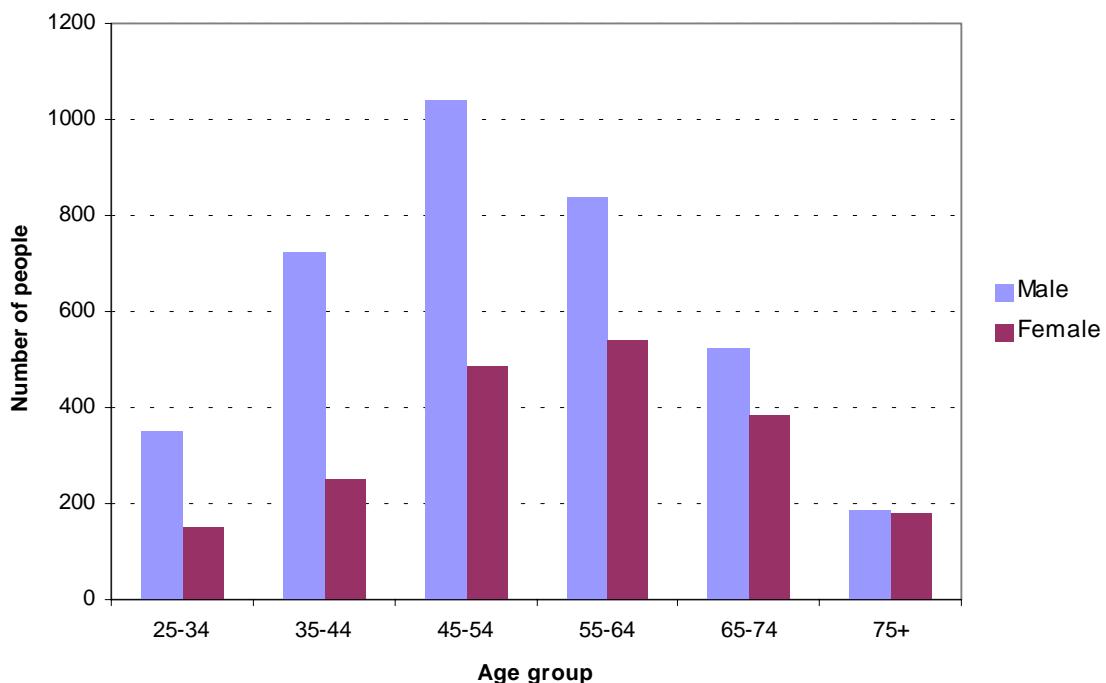
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

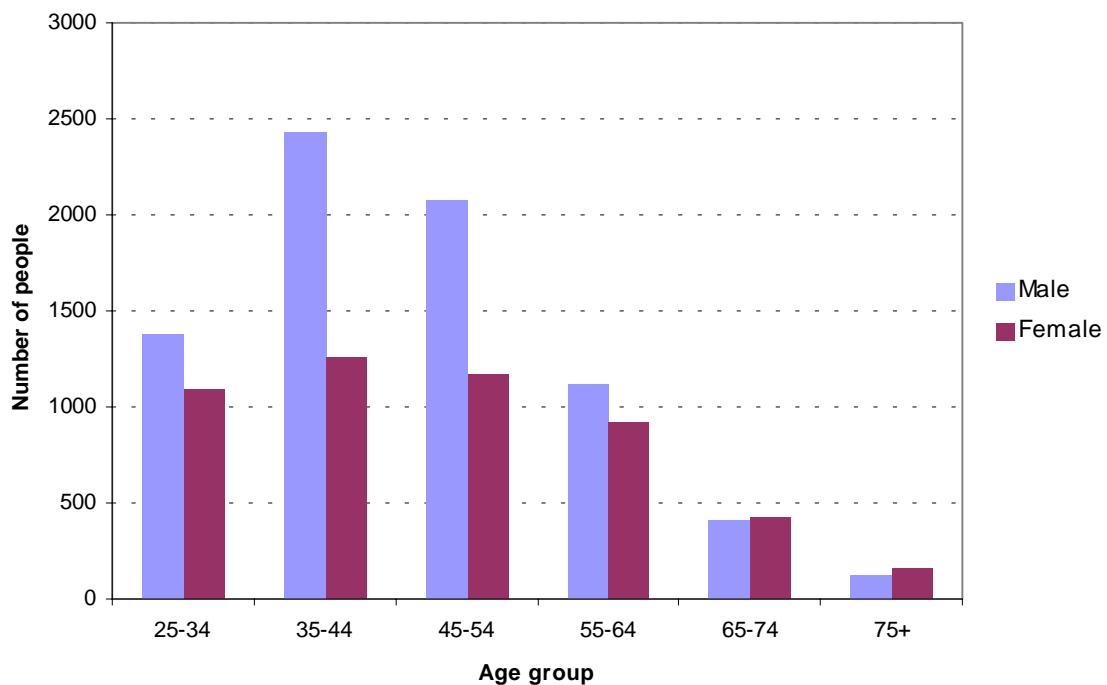
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



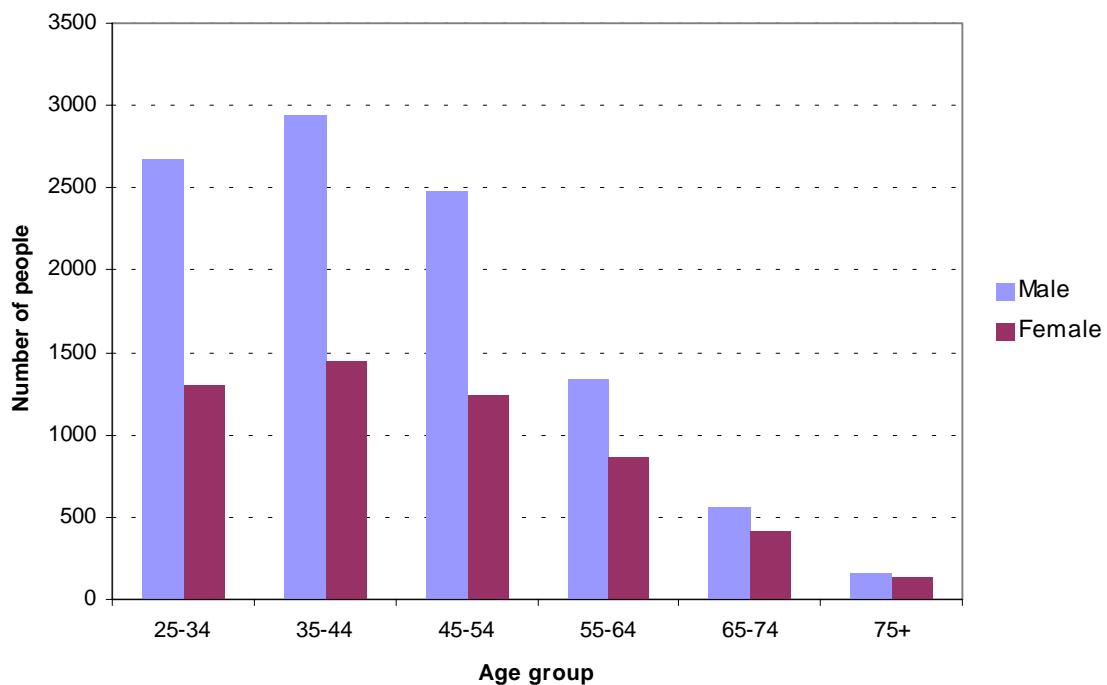
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



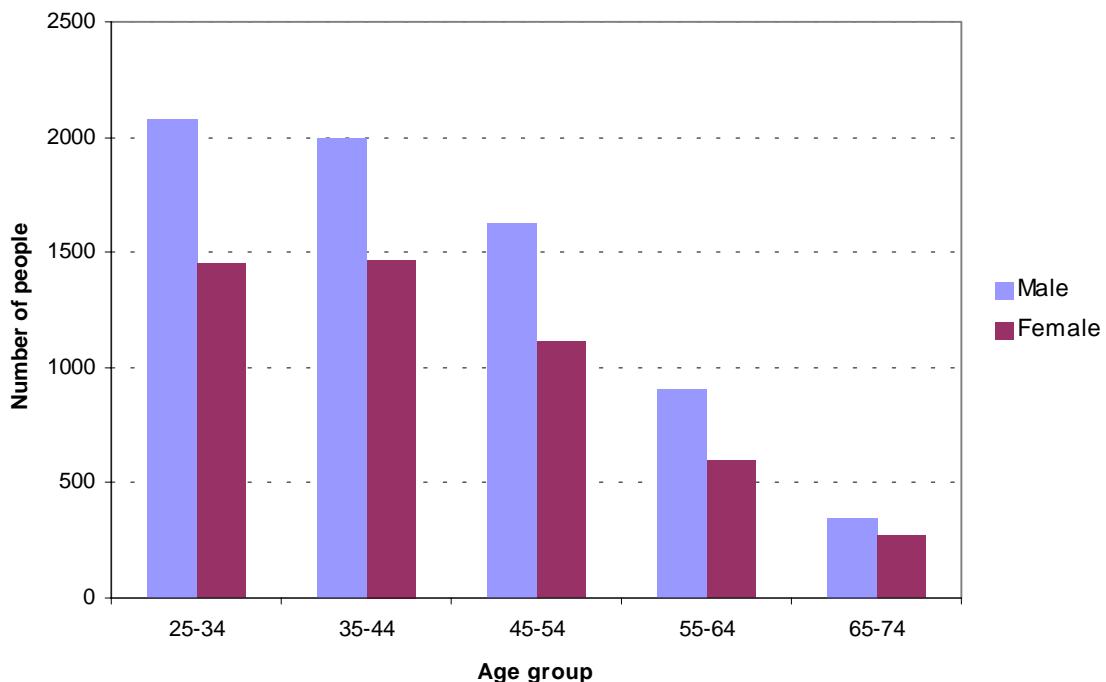
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



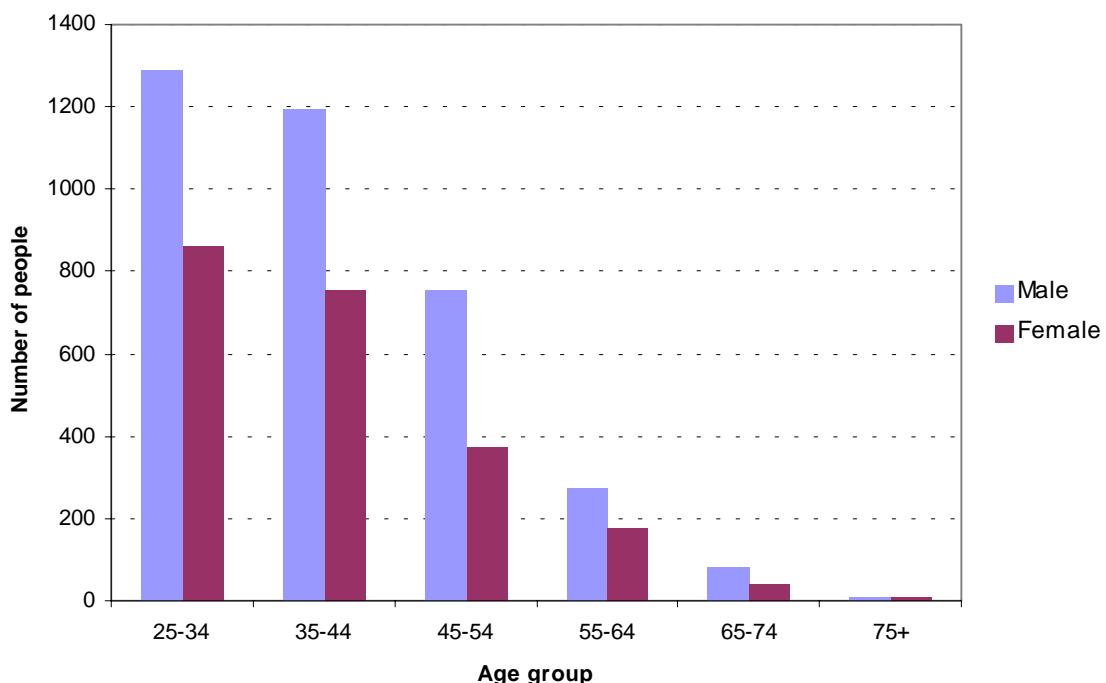
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|----|
| ▪ Number of GPs working in the Division area: | Total | 30 |
|-----------------------------------------------|-------|----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - One FTE non-credentialed diabetes nurse educator in Port Hedland at Community Health,
 - 0.2 FTE credentialed diabetes nurse educator with More Allied Health Services (MAHS) funding in Karratha, providing service to Tom Price and Paraburadoo and Wakathuni and Bellary Springs,
 - 0.3 FTE podiatry using MAHS funding in all Pilbara towns and communities (17 sites).

- What services are needed but are not available in your Division area?
 - Full time credentialed diabetes educator for Newman and Tom Price,
 - Full time credentialed diabetes educator for Karratha, Dampier, Roebourne and Wickham,
 - Full time credentialed diabetes educator for Port Hedland and surrounding communities,
 - Dietitian for Port Hedland and surrounding communities,
 - Dietitian for Karratha and surrounding communities and towns,
 - Full time coordinator for chronic diseases in the Pilbara.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/>	1992	<input type="checkbox"/>	1993	<input type="checkbox"/>	1994	<input type="checkbox"/>	1995
<input type="checkbox"/>	1996	<input type="checkbox"/>	1997	<input type="checkbox"/>	1998	<input type="checkbox"/>	1999
<input type="checkbox"/>	2000	<input type="checkbox"/>	2001	<input checked="" type="checkbox"/>	2002		

- Please describe your diabetes program including any changes that occurred over time?
 - Diabetes Clinical Audit in General Practice – 14 Pilbara GPs participated, 2000,
 - Diabetes CME over a weekend – 25 GPs, 1 podiatrist, 2 practice nurses, 2001,
 - One FTE credentialed diabetes nurse in General Practice Pilot August 2001 – August 2002 in four towns, very successful, tripartite funding local health service, Division and Aboriginal Medical Service,
 - 0.2 FTE diabetes service by credentialed diabetes nurse educator to GP patients via video-conferencing weekly and bi-monthly personal contact visits,

- Diabetes upskilling to hospital and practice nurses, nine modules over five-weeks, part-funded by Diabetes Australia Western Australia and part-funded and wholly facilitated by Pilbara Division of General Practice (PDGP). Very successful May/June 2002.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Increased GP awareness of importance of recall and reminder systems,
 - Increased GP awareness of best practice,
 - Increased networking of local service providers with endocrinology team from Princess Margaret Hospital for Children in Perth,
 - Increased local services for people diagnosed with diabetes.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - Lack of funding in State Health or Aboriginal Health for positions specifically addressing diabetes,
 - Lack of human resources, only one credentialed diabetes educator in the area, and no Aboriginal health workers credentialed or skilled in diabetes care and management,
 - No dietitians employed by the State Health system in the West Pilbara,
 - Dietitian employed by State Health in the East Pilbara not for clinical purposes,
 - Difficulty sharing data between health services.
- What future plans do you have for diabetes management in your Division?
 - Include diabetes in a Pilbara-wide plan that will look at chronic disease management and services under a Regional Health Service (RHS) Commonwealth grant (if we are successful),
 - Assist GPs with good data integrity and management,
 - Work with State Health, Aboriginal Medical Services and people diagnosed with diabetes to share patient data where patient management overlaps systems.
- What would you say are the contributing factors (both internal and external) for practices that are successful in
 - Registered nurse in practice,
 - IM/IT expertise available locally to assist with ongoing hardware and software problems,

taking up chronic disease initiatives?

- Availability of allied health personnel on a regular and frequent and known basis,
- The chronic disease must be a real issue for that population,
- The population must be accustomed to an appointment basis for interaction with GPs.

- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

We have a formal alliance with the local State Health service and the local Aboriginal Medical Service to provide diabetes education to the community, which was developed after an initial push by the Division. This is a big problem for our community. There was a credentialed and skilled allied health person in the area who was under-utilised. A general practice, local hospital and community health staff, local Aboriginal Medical Service GPs and Aboriginal health workers are concerned about the issue.

We have a less formal alliance with Diabetes Australia Western Australia who think of us every time there is a state-wide diabetes forum, or some state-wide education and training, or the opportunity exists to deliver some local education and training. This alliance came about because we employed an overseas-accredited diabetes nurse educator in 2001-2002 and as part of her one-week orientation and network building in Perth, I took her to meet staff at DAWA. It was further helped because we took up their initial offer to facilitate training in diabetes for generalist nurses when no local health services came forward to take up the offer.

We have formal alliances with three podiatrists who provide services to patients under the More Allied Health Service.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?

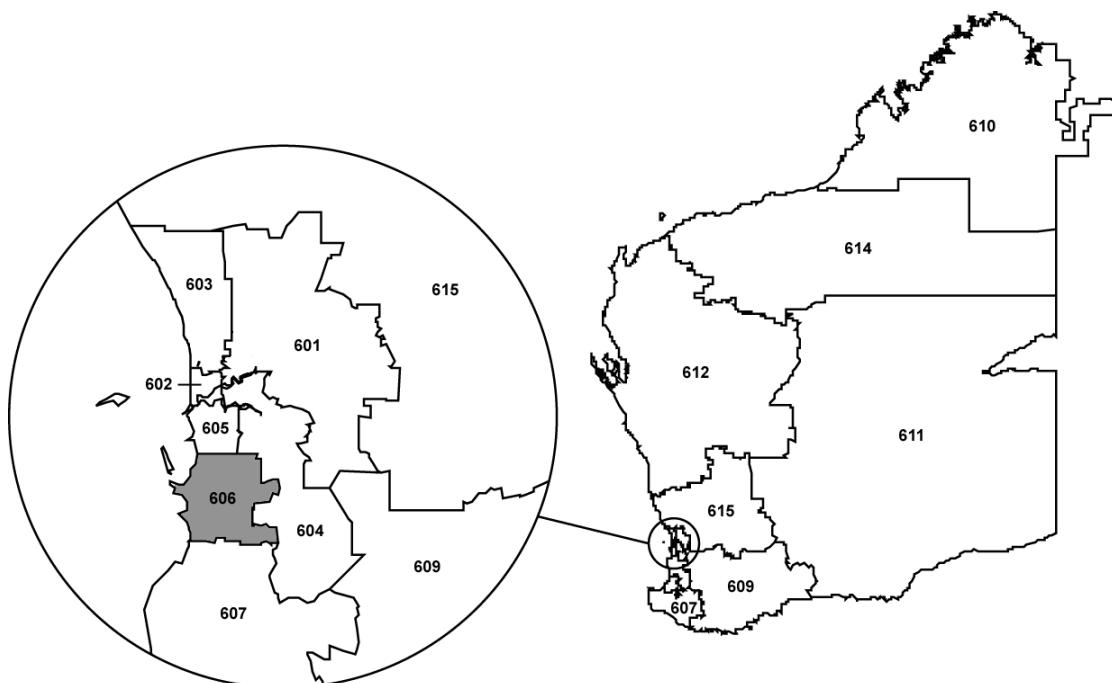
- CAMIT pro database (a software program for the management, analysis and documentation of diabetes patient data),
- Diabetes Management in General Practice (RACGP and DA),
- An indigenous tool showing good tucker, sourced from Diabetes Australia NT,
- Kidney disease handbook, sourced from Royal Perth Hospital,

- Database that records clinical data and also workload data,
 - Referral forms for referrals from GPs and from hospitals,
 - An electronic referral form for Medical Director,
 - A consent form for patient to opt in or out.
-
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Database that records clinical data and also workload data but this is quite unsophisticated,
 - Referral forms for referrals from GPs and from hospitals,
 - An electronic referral form for Medical Director,
 - A consent form for patient to opt in or out.
-
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
 - What resource materials do you provide to practices?
 - Diabetes Management in General Practice (RACGP and DA),
 - An electronic referral form for Medical Director.

Division Contact Person/
Program Co-ordinator

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Rockingham Kwinana DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	94,797	
■ Aboriginal or Torres Strait Islander	1817	1.9%
■ Speaks language other than English at home	4304	4.5%
■ RRMA classification ¹		
1: Capital city	94,797	100.0%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	4334	7.4%
■ High blood pressure ⁴	16,696	28.5%
■ High blood cholesterol ⁵	29,741	50.8%
■ Obese or overweight ⁶	35,050	59.8%
■ Physical inactivity ⁷	25,298	43.2%
■ Smoking ⁸	11,524	19.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

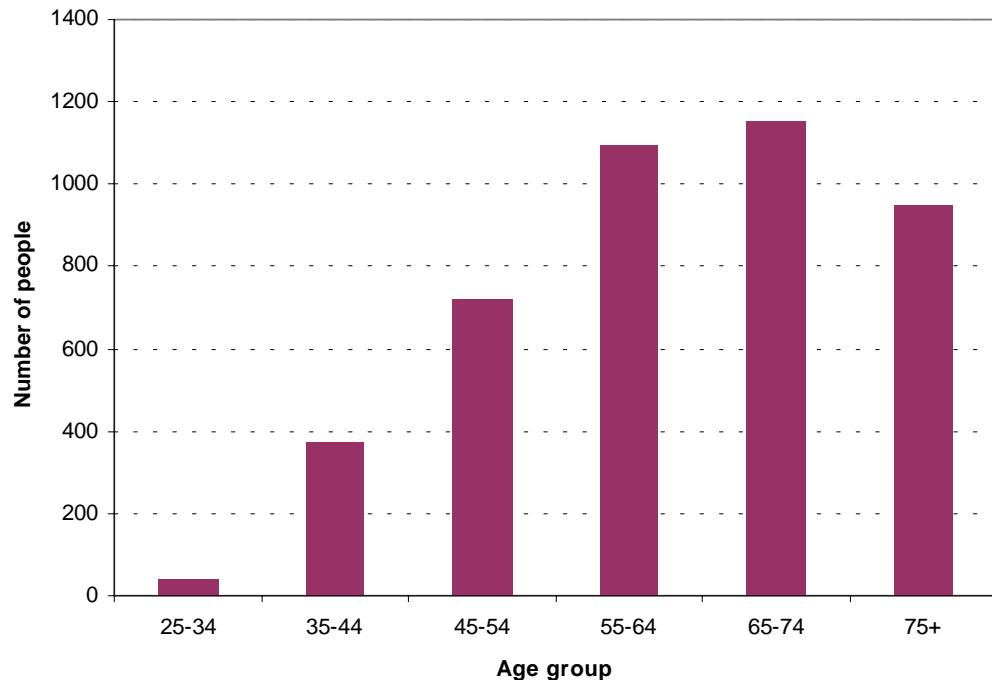
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

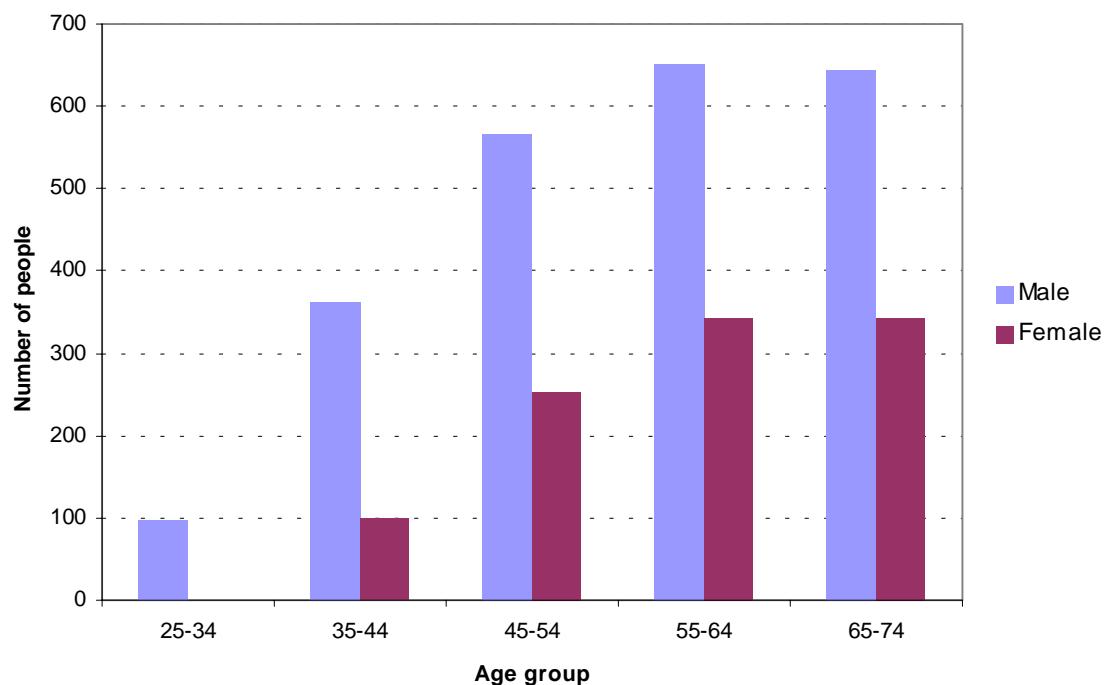
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



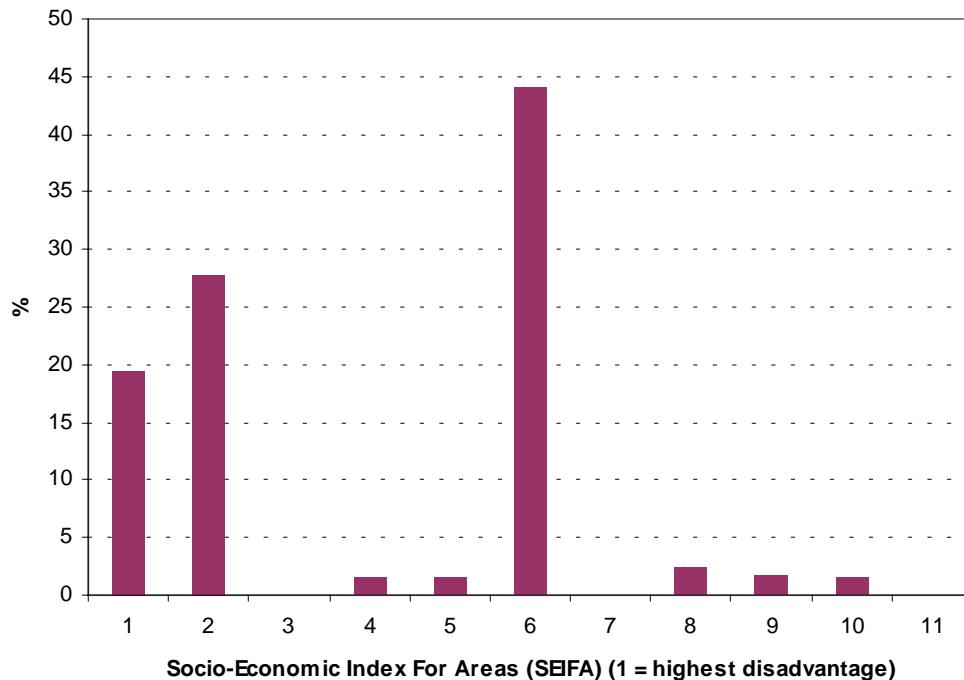
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

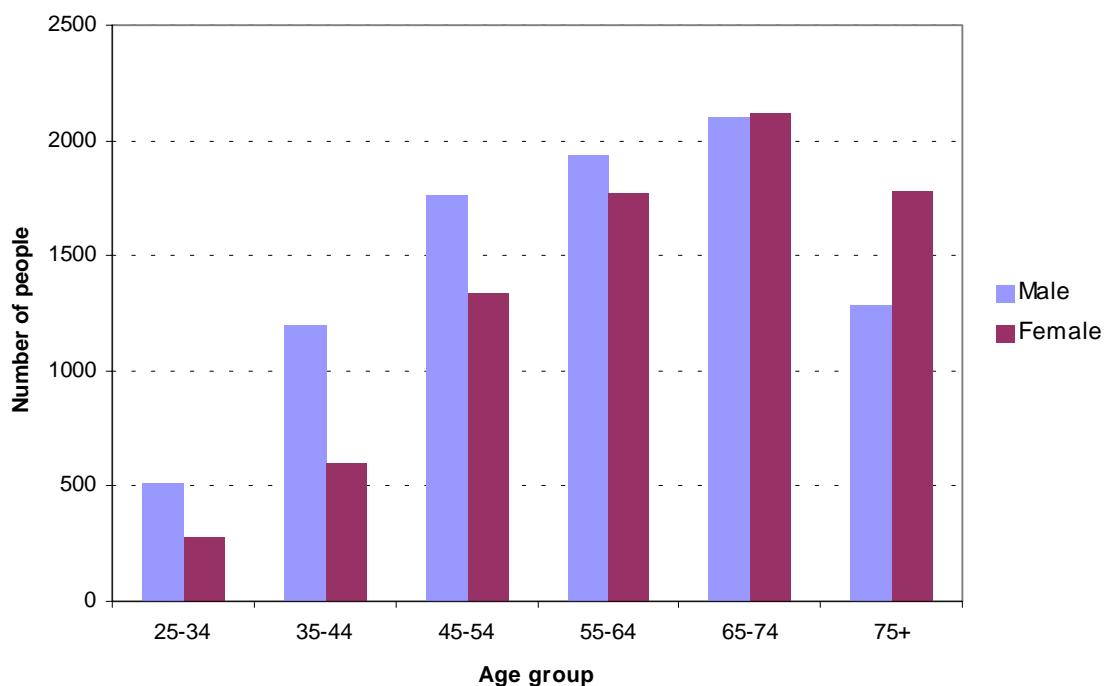
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

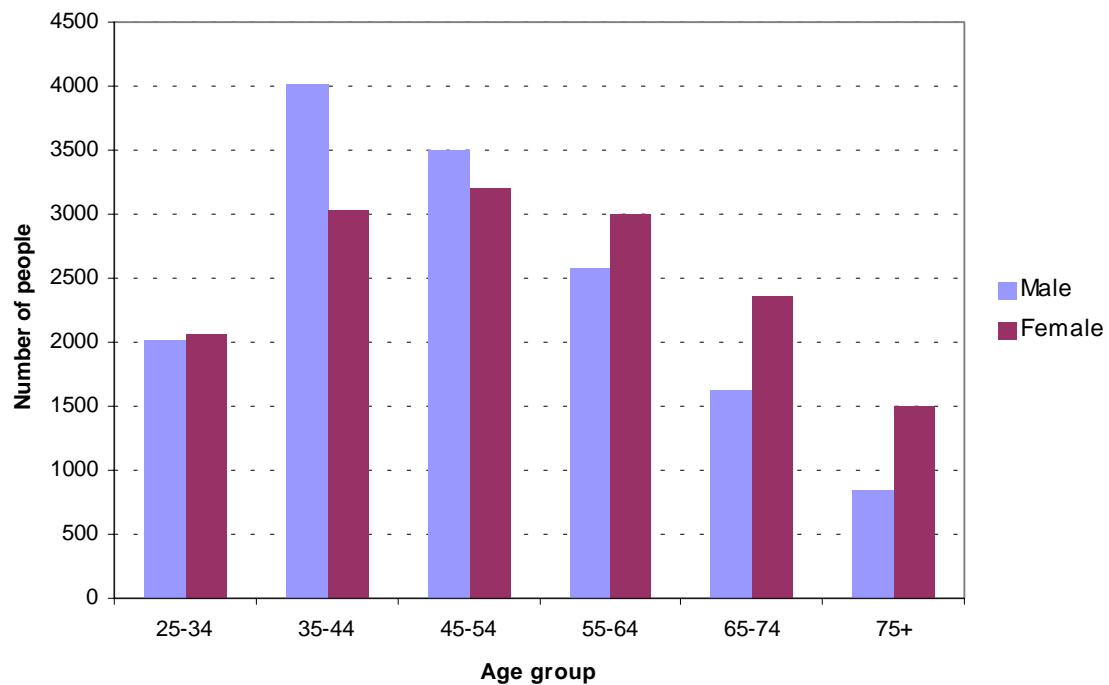
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



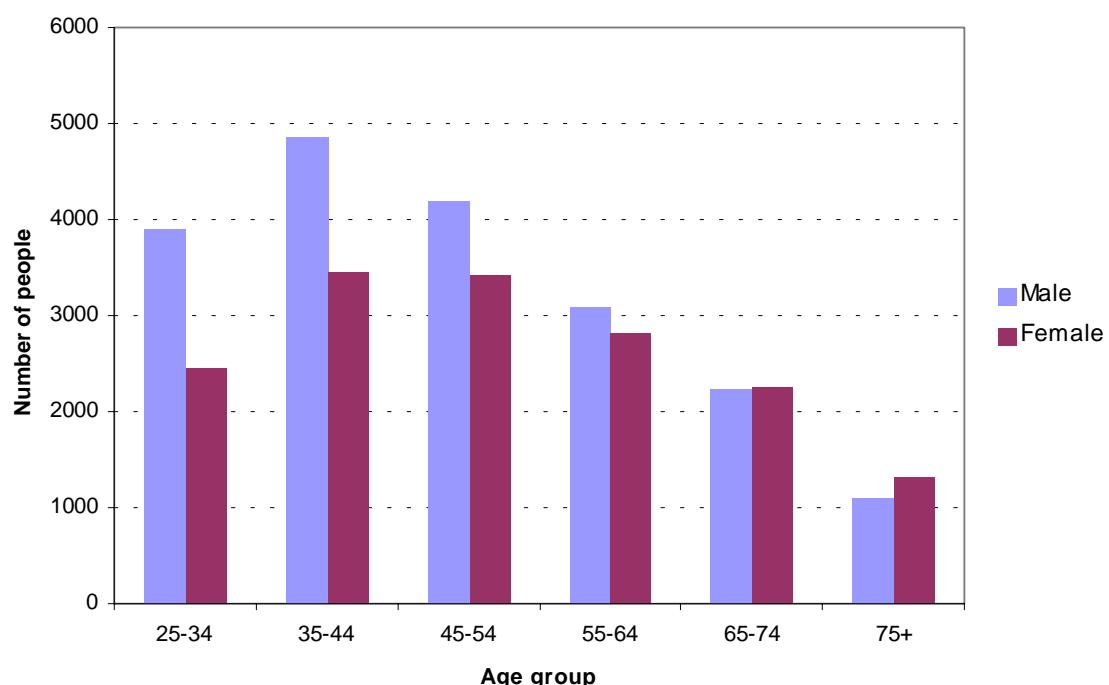
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



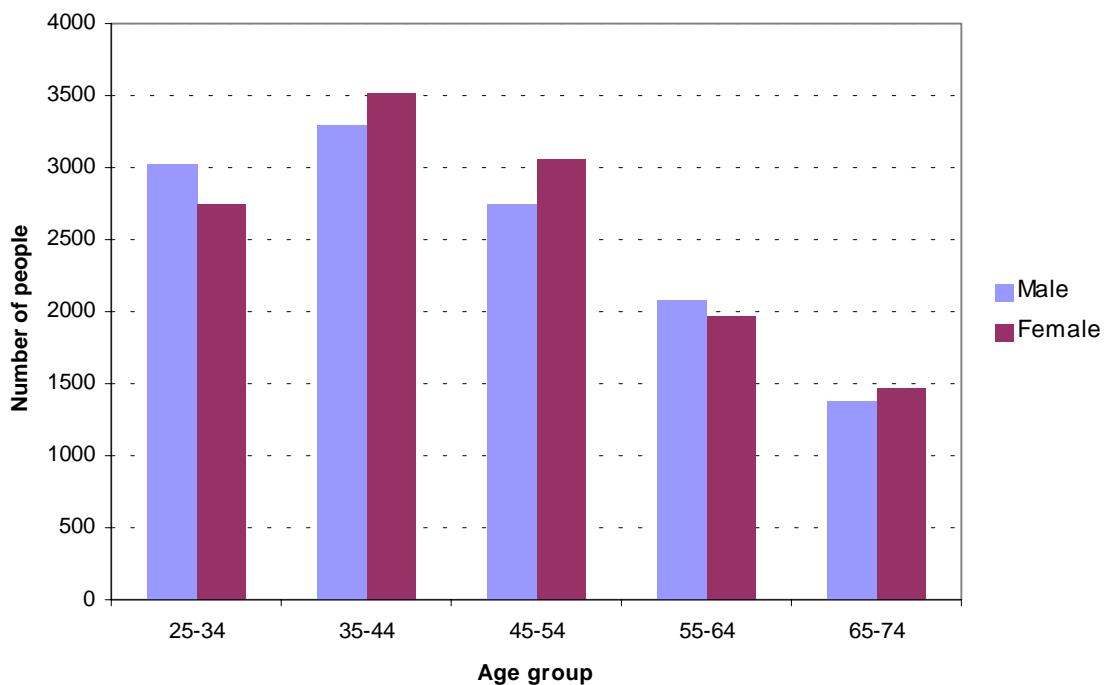
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



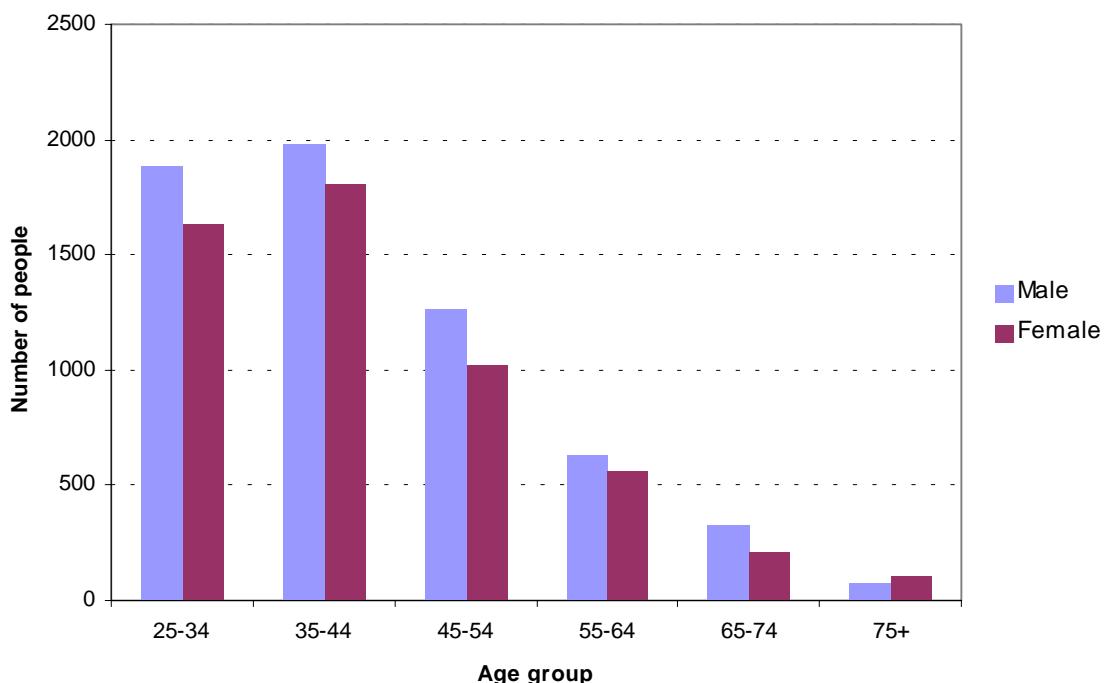
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- Number of GPs working in the Division area: Total 75

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Public Sector

- Diabetic education resources and services,
- One-to-one program and group sessions,
- Diabetic team consultation – physiotherapist, dietitian, podiatrist, diabetic nurse educator and visiting physician,
- Two national supply agencies – Rockingham/Kwinana.

Private Sector

- One dietitian,
- Five podiatrists,
- Four major surgeries/diabetic clinics.

-
- What services are needed but are not available in your Division area?

- More diabetic nurse educators for patients to access,
- More diabetic programs under government system.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

- 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

- Sessions: One-to-one or group held at central locations under umbrella of Community Health,
- Changes: Diabetic nurse educator (DNE) visits most major practices in the discussion where the DNE holds sessions.

Division Perspective

- What have been the major achievements or highlights of your program so far?

Closer working relationships with GPs where DNE visits practice to hold sessions.

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Limitations: Lack of human resources and funding to meet community need.

- What future plans do you have for diabetes management in your Division?
 - Continue GP upskilling program – GPs attend a four hour one-on-one session with diabetic team,
 - Strive for a more coordinated service for patients between GPs and community health services.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Community Health and Rockingham-Kwinana DGP work closely to achieve best patient outcomes. This alliance allowed the diabetic nurse educator and major practices to form a partnership and conduct sessions with these practices.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Drug companies,
 - Diabetes Australia (WA and National).
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

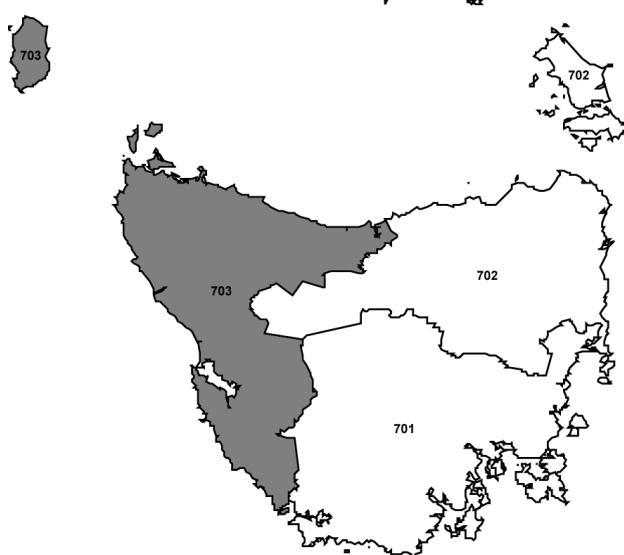
GP upskilling program.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - NEED – easy access to quick/simple screening prompted on regular basis,
 - Information systems to assist practices with register and recall – current programs only automate half the process,
 - Human Resource to:
 1. Facilitate clinical screening,
 2. Health promotion/risk areas,
 3. Screening for complications.

- What resource materials do you provide to practices?
 - Diabetic management check lists,
 - Service Directory,
 - RACGP Diabetes Management in General Practice.

Division Contact Person/
Program Co-ordinator

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North West Tasmania DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	102,134	
■ Aboriginal or Torres Strait Islander	5033	4.9%
■ Speaks language other than English at home	1623	1.6%
■ RRMA classification ¹		
4: Small rural	53,416	52.3%
5: Other rural	46,267	45.3%
7: Other remote	2451	2.4%
■ SEIFA category containing population median: ²	3	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5543	8.3%
■ High blood pressure ⁴	20,932	31.3%
■ High blood cholesterol ⁵	34,894	52.2%
■ Obese or overweight ⁶	36,909	55.2%
■ Physical inactivity ⁷	28,262	42.2%
■ Smoking ⁸	12,583	18.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

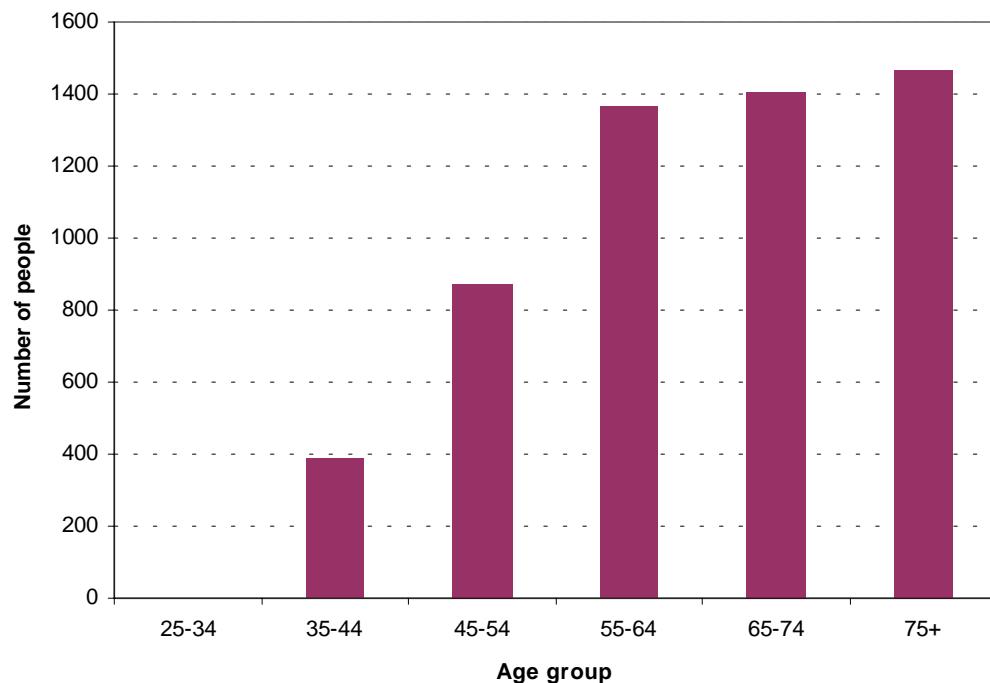
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

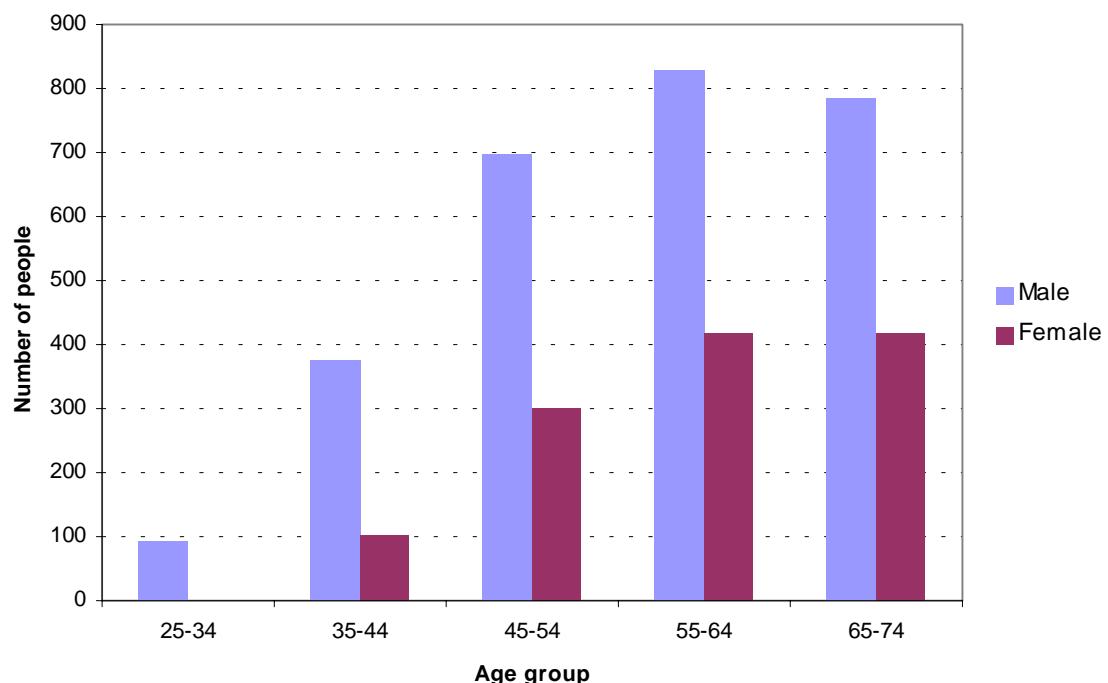
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



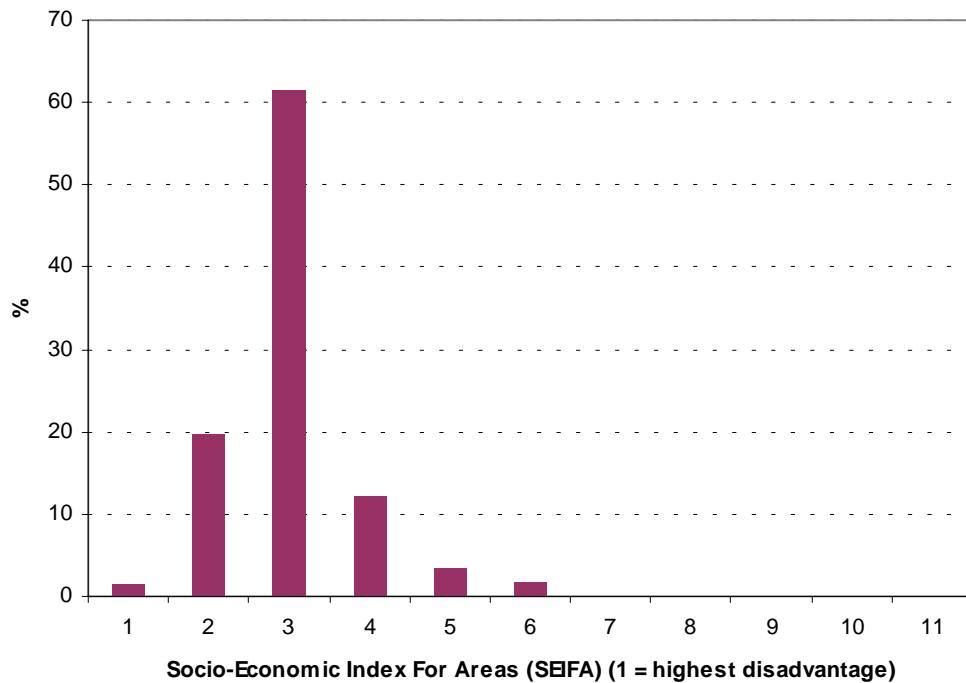
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

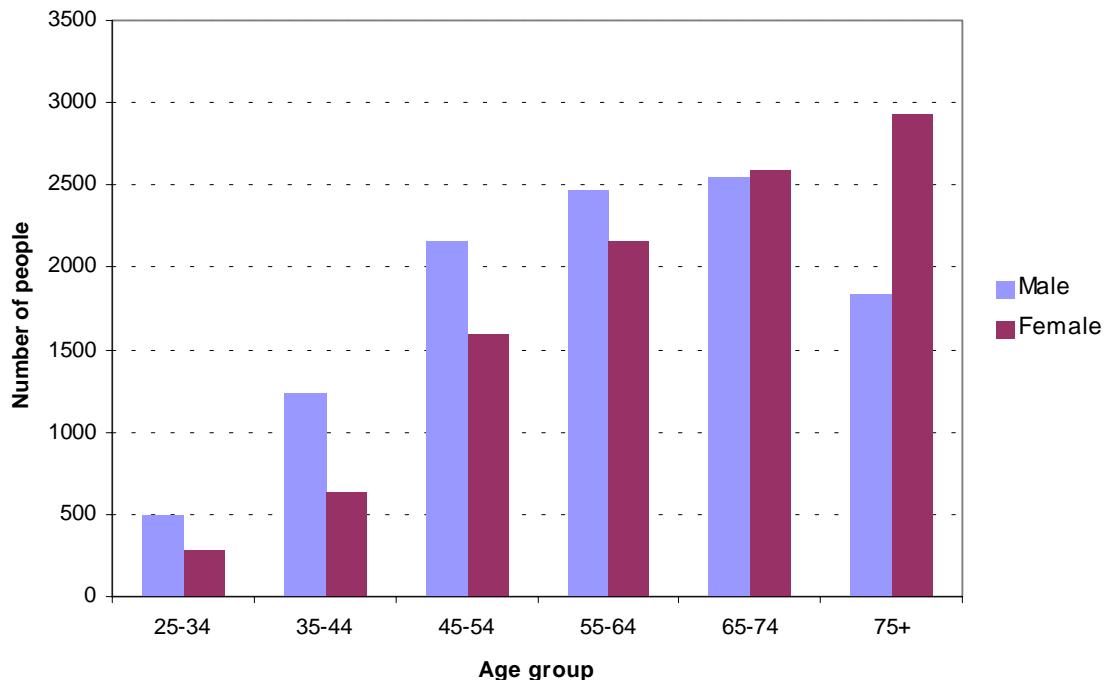
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

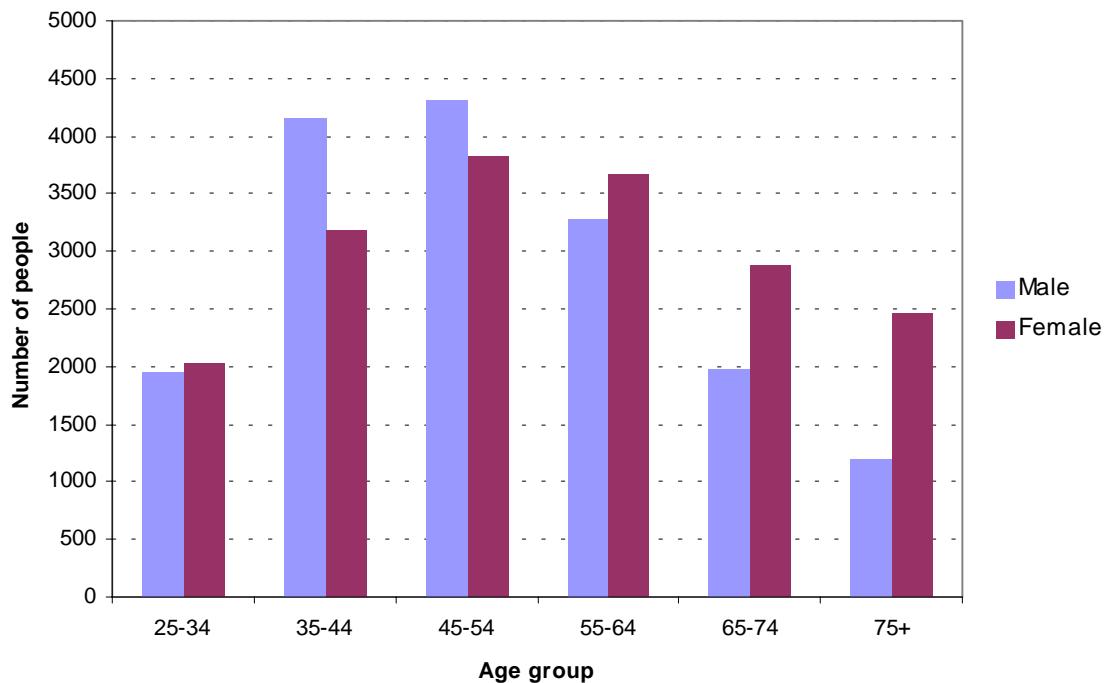
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



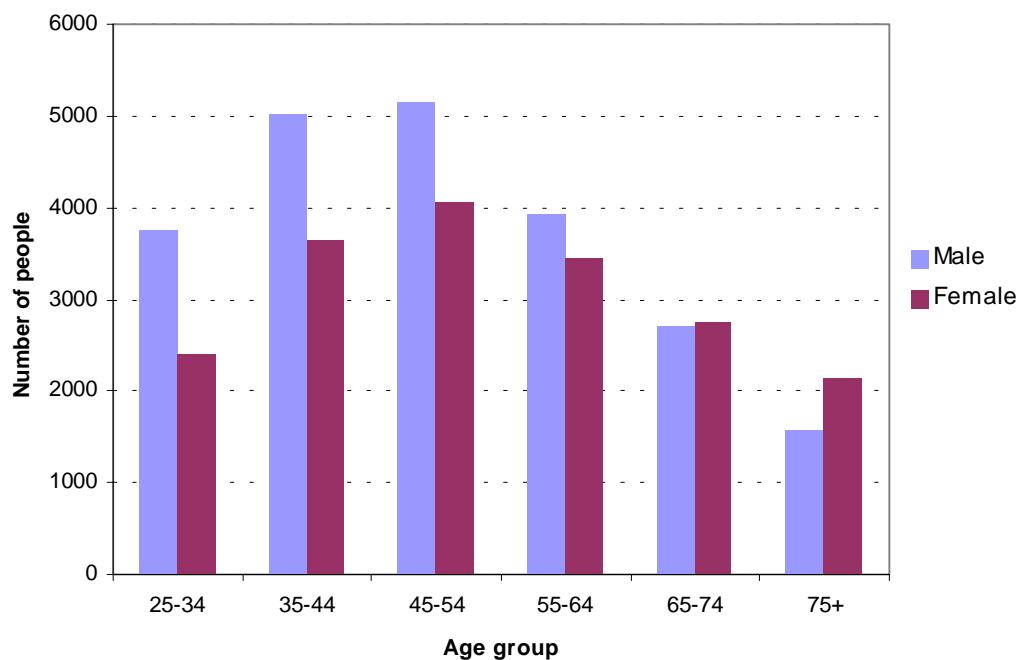
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



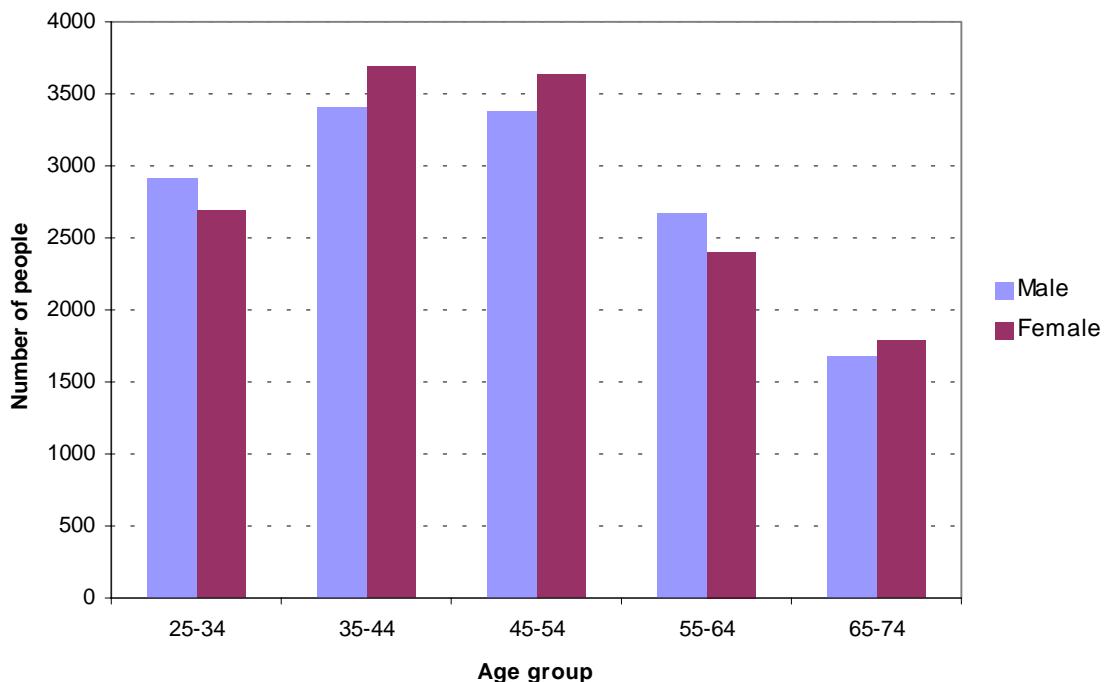
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



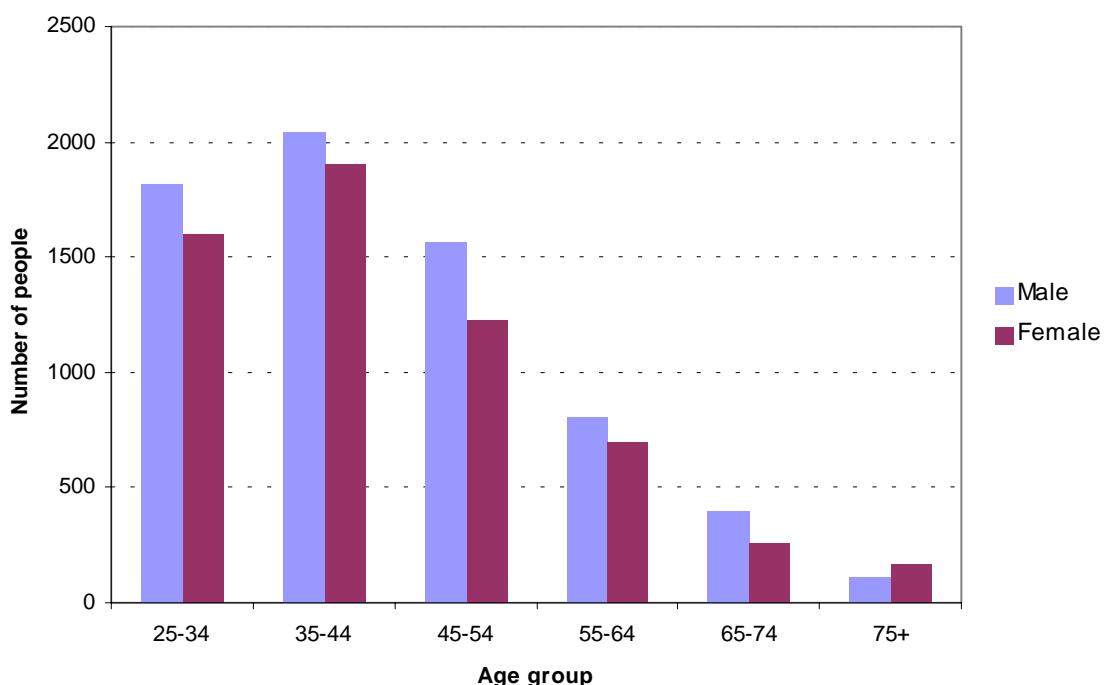
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 101 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?

Two diabetes education centres with diabetes physician, diabetes educator and podiatrist; two sites – Devonport and Burnie. Diabetes educator on a twelve-month contract – More Allied Health Services (MAHS) – January 2003.
- What services are needed but are not available in your Division area?

• More services to remote rural areas,
• Diabetes dietitian to remote rural areas,
• Endocrinologist services,
• Podiatrist to remote rural areas.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

Establishment of sound communication pathways with key diabetes stakeholders and diabetes service providers to enhance services to the region. The Division has been providing GP assistance in establishing a systematic approach to diabetes care.

Division Perspective

- What have been the major achievements or highlights of your program so far?

• Education opportunities in relation to diabetes,
• Provide advice in the collection of data for the management and recall of diabetes patients,
• Establishment of a Diabetes Reference Group within the Division.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:

• Bureaucracy of diabetes progress at national level,
• GP resistance to provide time and data to Divisions,
• Limitation of services provided by Diabetes Centre (access of distance),
• Funding limitations to the Division diabetes educator under the MAHS funding agreement.

- What future plans do you have for diabetes management in your Division?
 - Continued diabetes education opportunities for GPs,
 - One-on-one training in the use of clinical software to manage a patient with diabetes,
 - Funding for diabetes educator after January 2003.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GPs time and space,
 - Implementation of acceptance/practice care plans.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - We have established a working relationship with Diabetes Australia, leveraging on their immense source of diabetes resource. This will better position the Division to deliver high quality information to GPs,
 - Involvement with the Key Leaders Meeting,
 - Australian Diabetes Education Association (ADEA),
 - Public diabetes services.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - Diabetes Australia (Tasmania) information handouts,
 - Royal Australian College of General Practice (RACGP) “Diabetes Management in General Practice”,
 - “Diabetes and You” (DA),
 - “Diabetes in the New Millennium”,
 - Diabetes Handbook of Management M Cohen.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

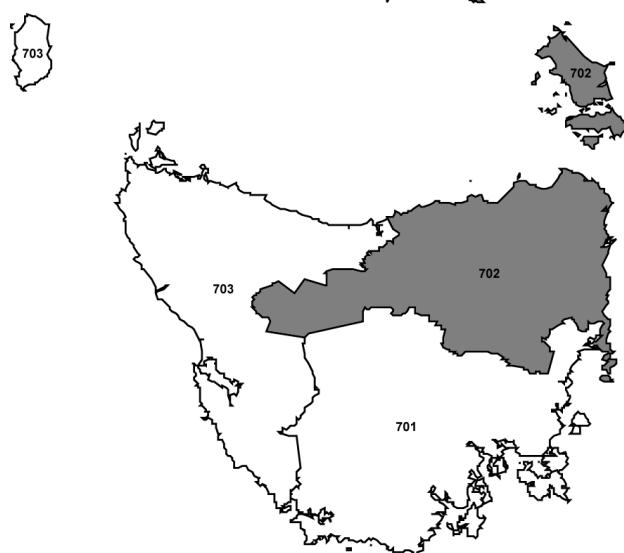
N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Standardised diabetes management guidelines (useful format),
 - Standardised complication screening format,
 - Shared Care booklet.

- What resource materials do you provide to practices?
- Information on diabetes recall and reminder system,
- Diabetes management,
- Practice Incentive Program (PIP) information (diabetes specific).

Division Contact Person/
Program Co-ordinator

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Northern Tasmania DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population *
■ Total population of the Division area	129,323	
■ Aboriginal or Torres Strait Islander	3205	2.5%
■ Speaks language other than English at home	3179	2.5%
■ RRMA classification ¹		
3: Large rural	81,991	63.4%
5: Other rural	46,427	35.9%
7: Other remote	905	0.7%
■ SEIFA category containing population median: ²	4	

* rounded to nearest 0.1%

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	7055	8.4%
■ High blood pressure ⁴	26,594	31.5%
■ High blood cholesterol ⁵	44,032	52.1%
■ Obese or overweight ⁶	51,121	60.5%
■ Physical inactivity ⁷	35,418	41.9%
■ Smoking ⁸	15,815	18.7%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

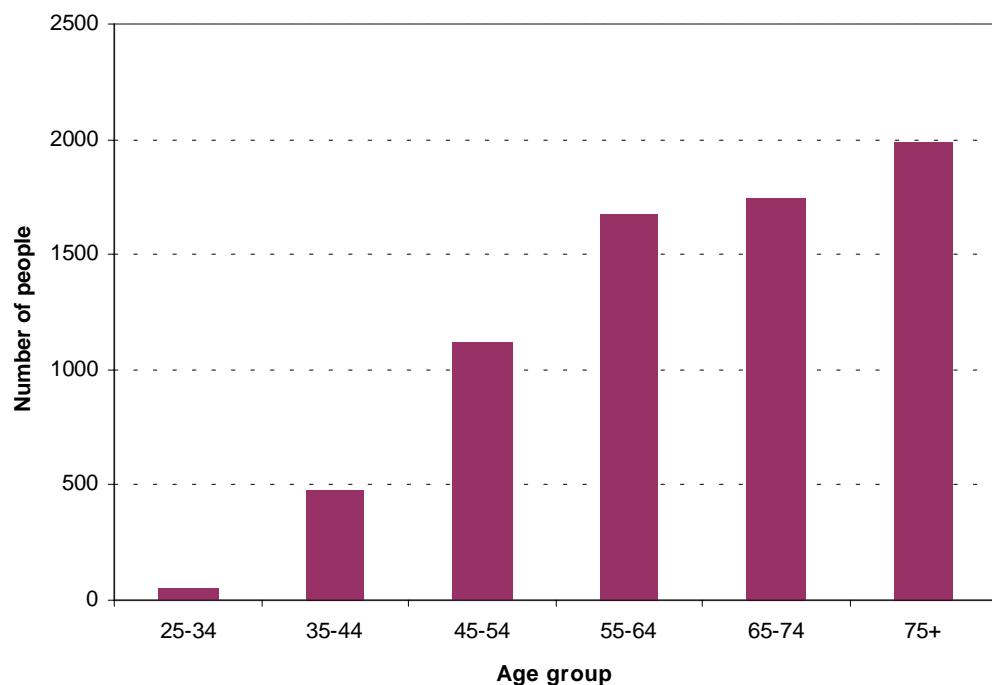
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

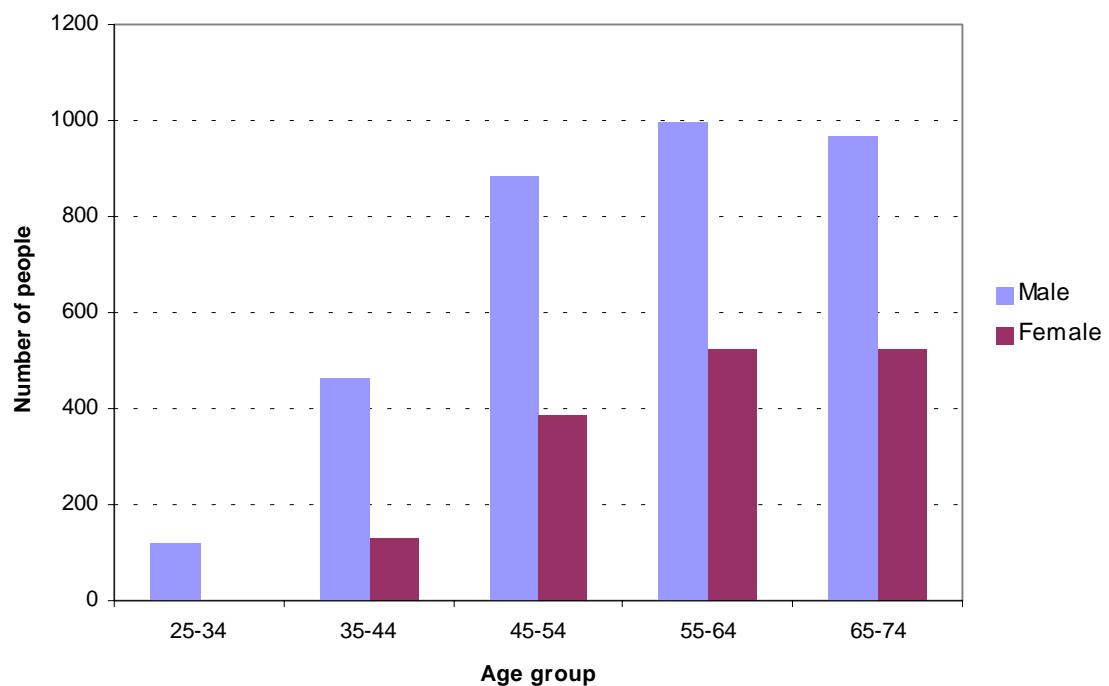
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



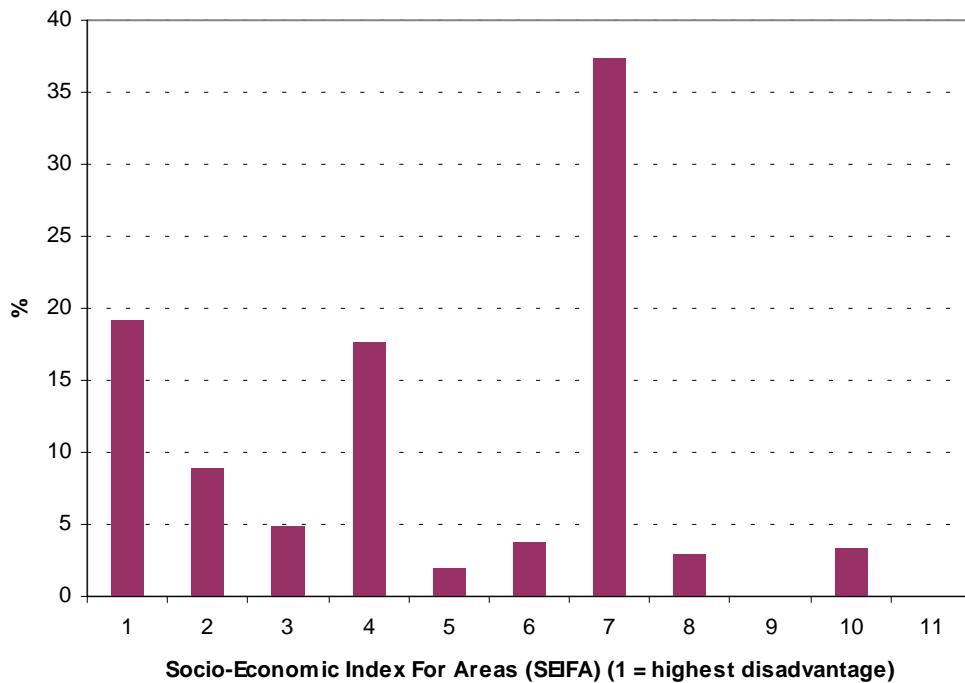
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

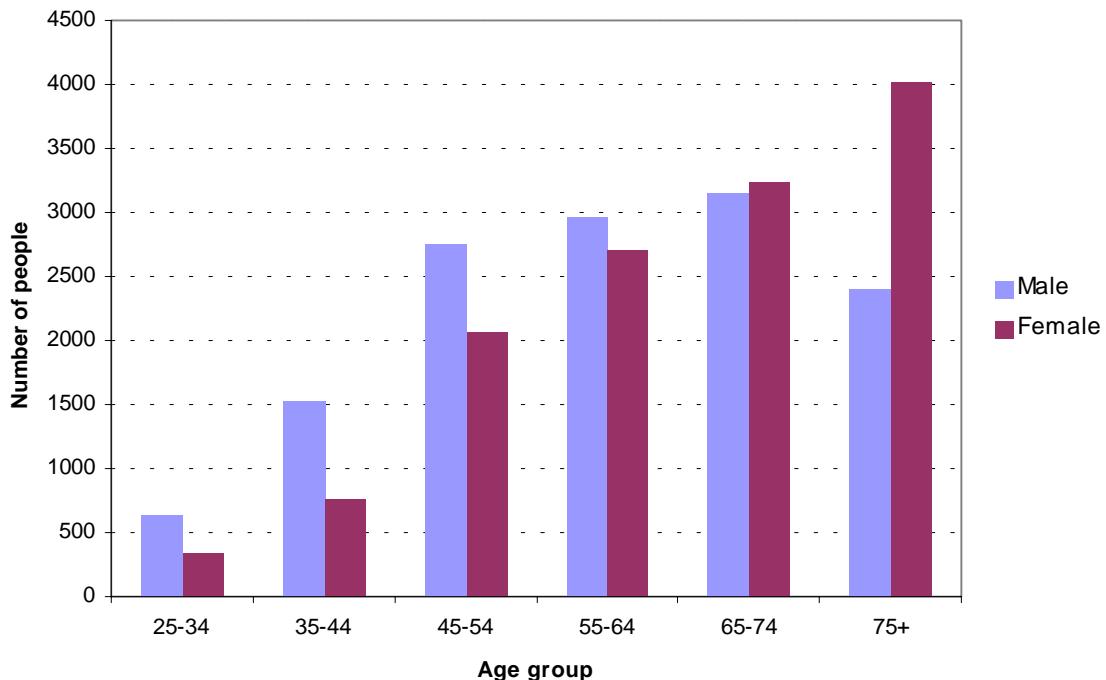
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

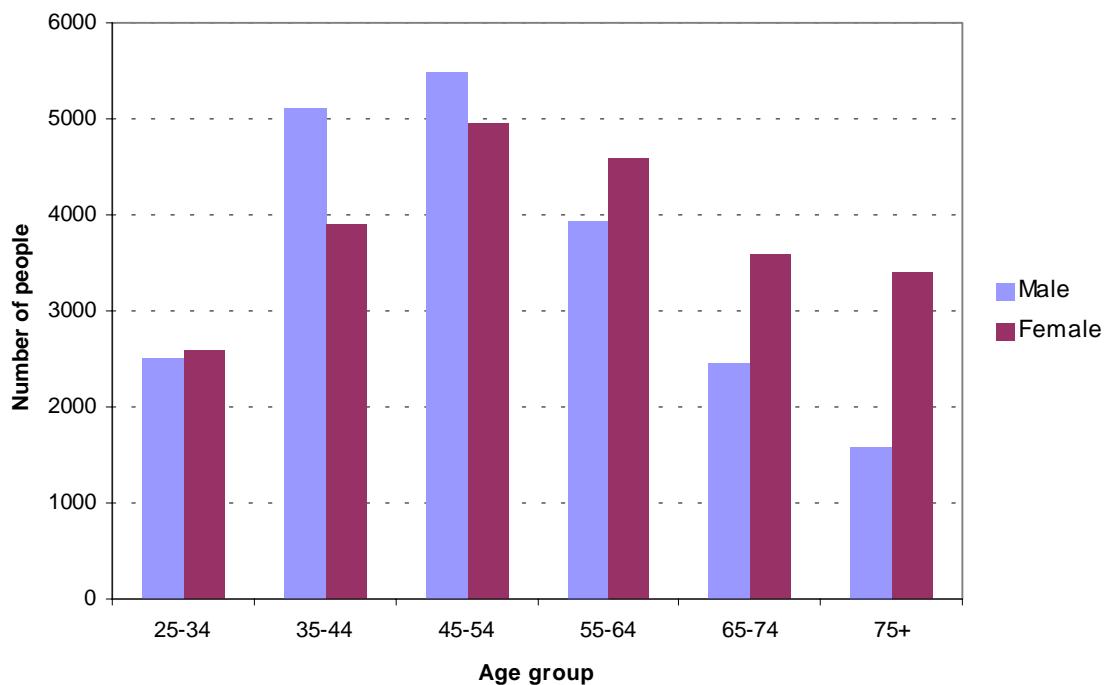
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



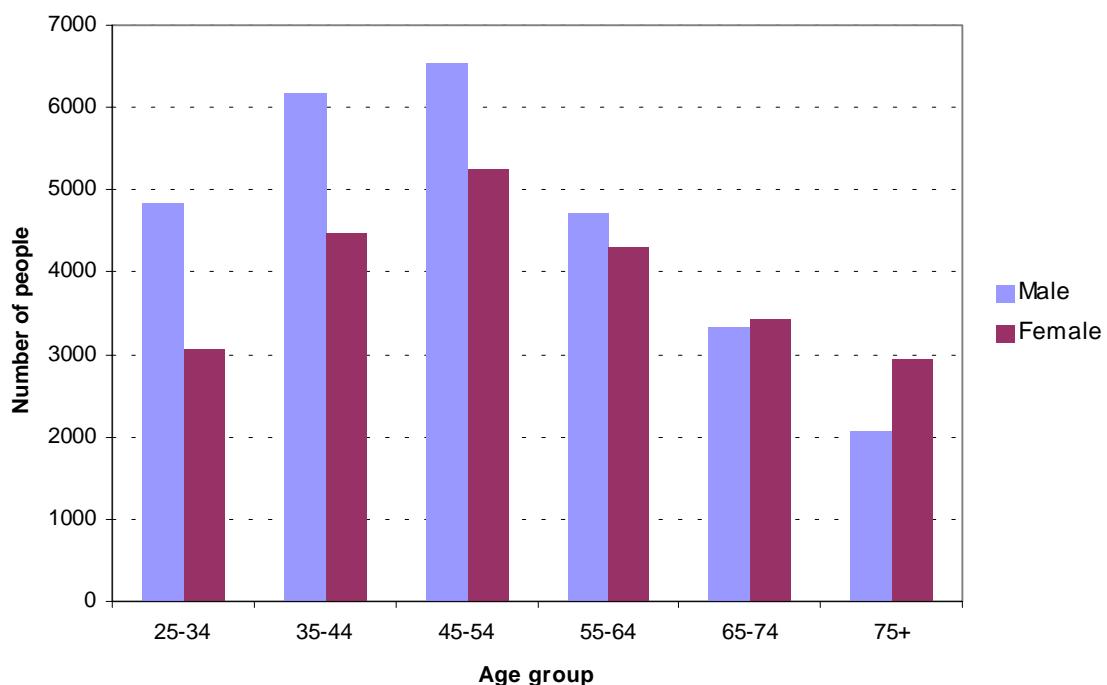
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



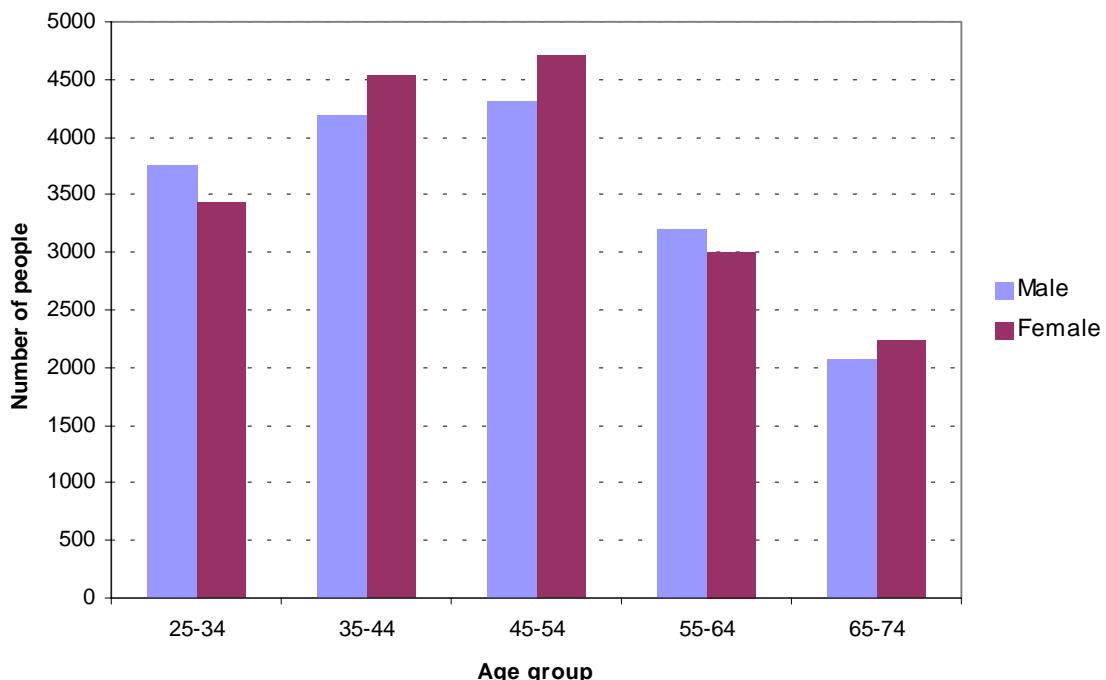
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



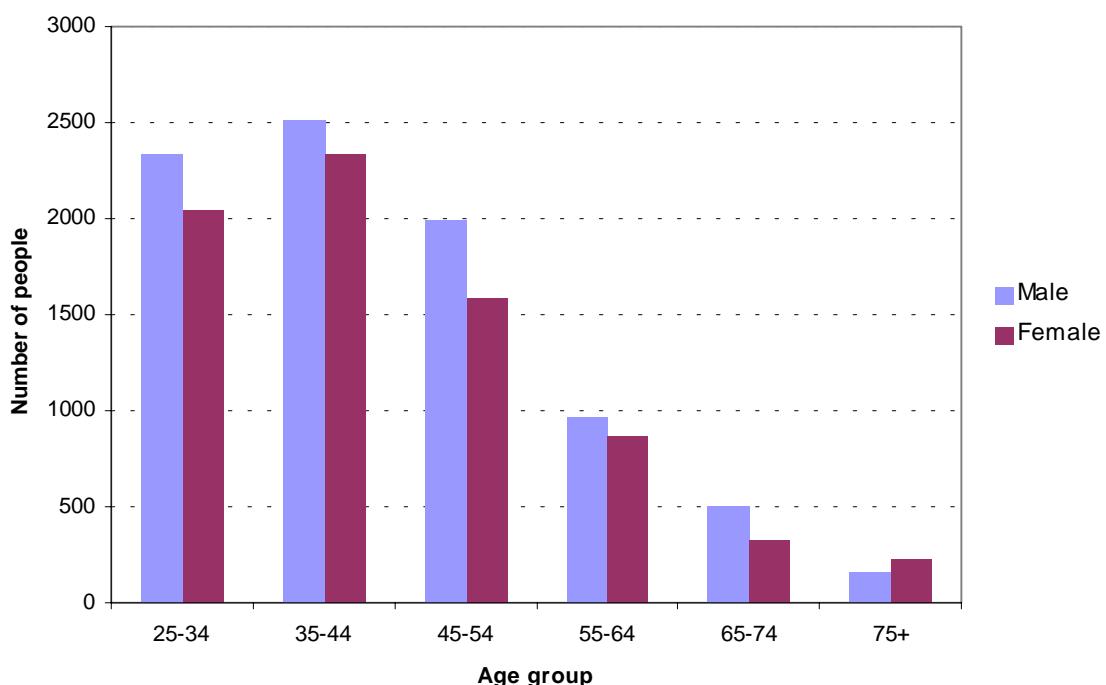
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 123 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Centre – Three diabetes educators, 0.5 podiatrist and part time endocrinologist,
 - One part time private endocrinologist,
 - One diabetes nurse educator – Diabetes Australia,
 - Six private podiatrists,
 - One part time private dietitian,
 - Two part time diabetes educators for rural practices,
 - Aboriginal Health Service.

- What services are needed but are not available in your Division area?
N/A.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:
 1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

The Divisions Diabetes Program began in 1997 and has evolved during the past 5 years. The resources developed have been evaluated and updated to reflect the changing environment in which GPs work.

The program includes

- Registration/Recall System (both paper-based and computer-based),
- Annual complications screening mechanism, including a form for recording the results of the complication screen. A copy of the deidentified form is sent to the Division whereby this information is entered onto a database. This allows the practice assessment cycle to operate and the Division is able to provide each practice and GP with valuable information about their patient population and its relationships to national and state averages and targets. This form has recently been revamped to include the recording of information necessary for the cycle of care as part of the HIC Service Incentive Payment (SIP),

- Co-operative Care Agreement with key stakeholders. As a result of the co-operative care agreement standardised referral and feedback forms have been developed,
- CPD sessions,
- Support for uptake of HIC Diabetes SIP,
- An annual month long screening blitz.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Signing of a Cooperative Care Agreement between key stakeholders,
 - Development and implementation of standardised referral and feedback forms.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - GP time,
 - Practice resources,
 - Competing incentives,
 - Divisional resources.
- What future plans do you have for diabetes management in your Division?
 - Further support GPs in the uptake of HIC Diabetes SIP and outcomes incentives,
 - Market the diabetes program to GPs to encourage participation from those GPs not involved,
 - To identify further issues for GPs in relation to diabetes management and develop/implement strategies to address identified issues.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - Practice resources (IT, personnel),
 - Developed systems with the practice.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Diabetes Australia,
 - Department Health and Human Services (State Health),
 - Diabetes Centre (State Health).

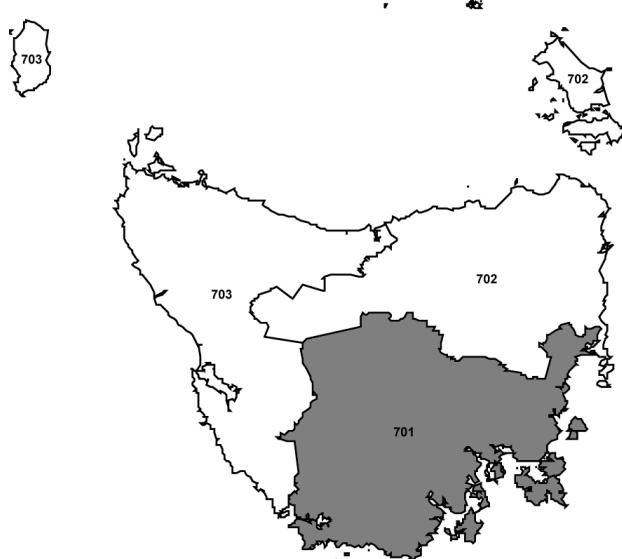
Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - We do promote “RACGP Diabetes Management in General Practice” and will be distributing the 2002 version to GPs,
 - A diabetes patient record form (annual half yearly complications screens, including yearly cycle of care for HIC SIP payments),
 - Register/Recall System.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions? N/A.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? ‘User friendly’ NHMRC Guidelines.
- What resource materials do you provide to practices? Information regarding SIP Incentives.

Division Contact Person/
Program Co-ordinator

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Email: dohalloran@gpnorth.com.au

Southern Tasmania DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	222,459	
■ Aboriginal or Torres Strait Islander	7528	3.4%
■ Speaks language other than English at home	9265	4.2%
■ RRMA classification ¹		
1: Capital city	195,319	87.8%
5: Other rural	27,140	12.2%
■ SEIFA category containing population median: ²	7	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	11,923	8.2%
■ High blood pressure ⁴	45,031	31.0%
■ High blood cholesterol ⁵	75,444	52.0%
■ Obese or overweight ⁶	87,624	60.4%
■ Physical inactivity ⁷	61,077	42.1%
■ Smoking ⁸	27,319	18.8%

¹ RRMA: Rural, Remote and Metropolitan Areas Classification

² SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

³ Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000AusDiab, 2001National Drug StrategyHousehold Survey, 2000 National Physical Activity survey:

⁴ Age and sex adjusted. High blood pressure defined as $>= 140/90$ mmHg or receiving medication

⁵ Age and sex adjusted. High blood cholesterol defined as $>= 5.5$ mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

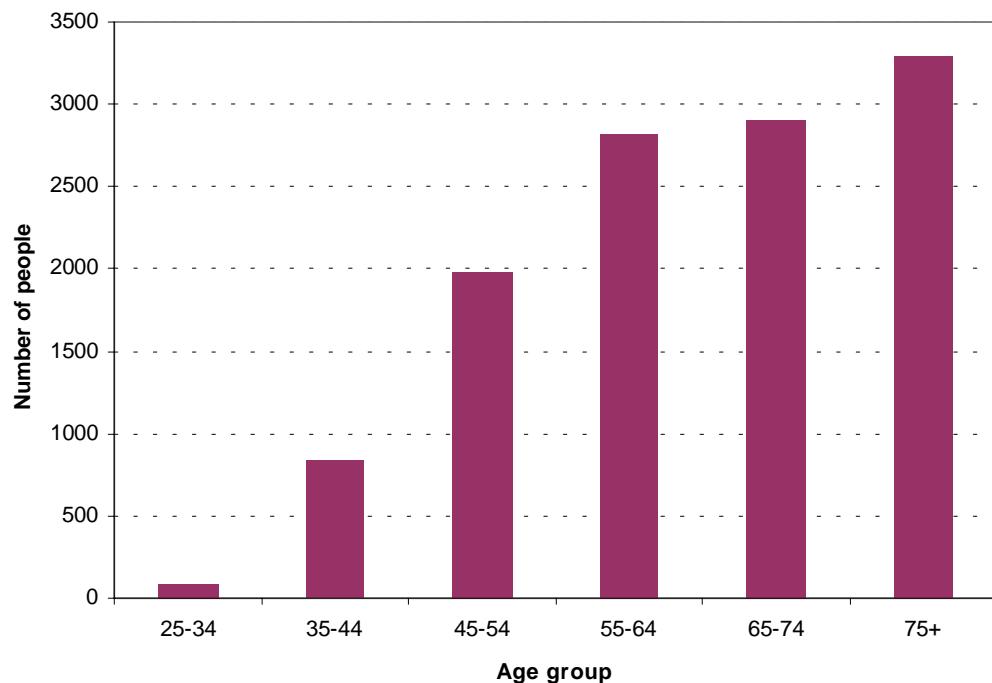
⁶ Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) $>= 25$

⁷ Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

⁸ Age and sex adjusted. Smoking defined as daily smoking of tobacco products

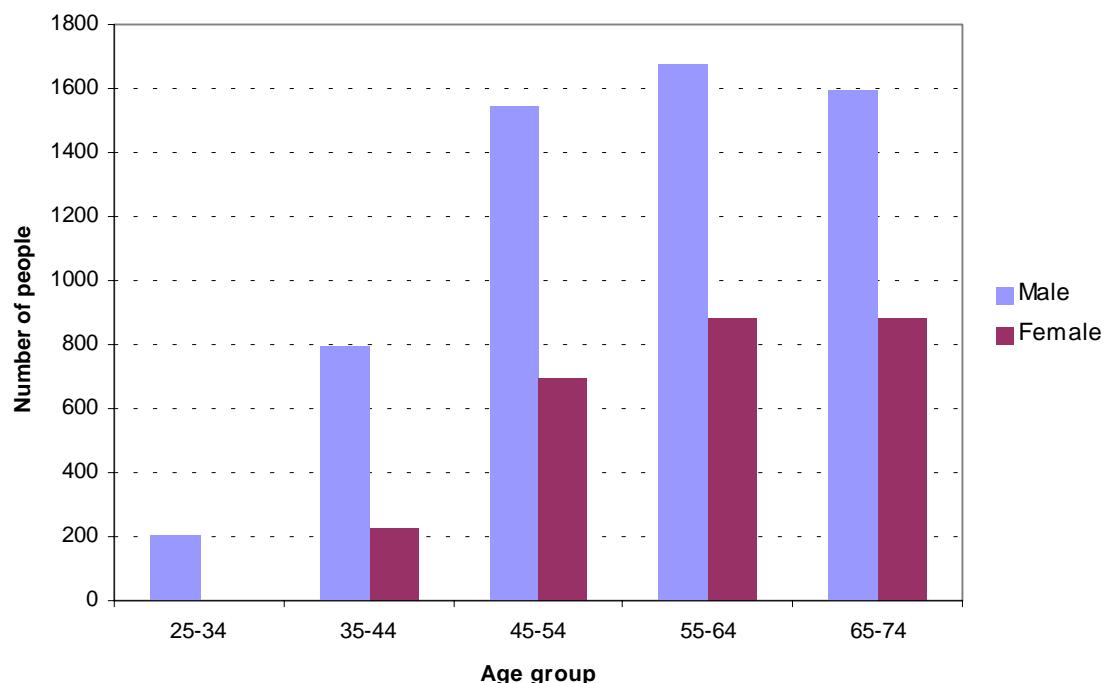
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



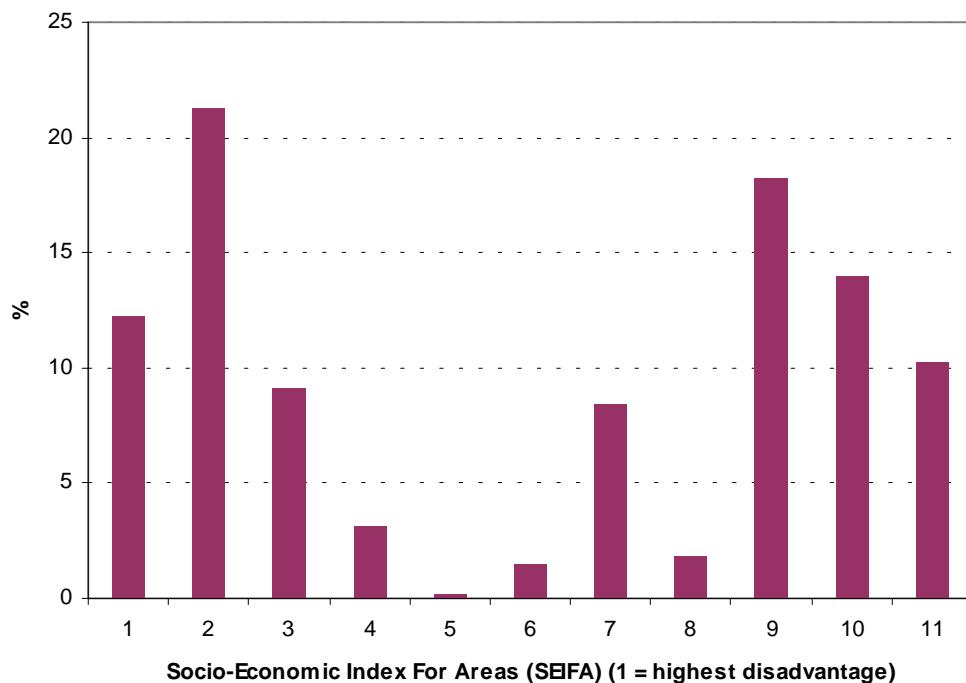
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

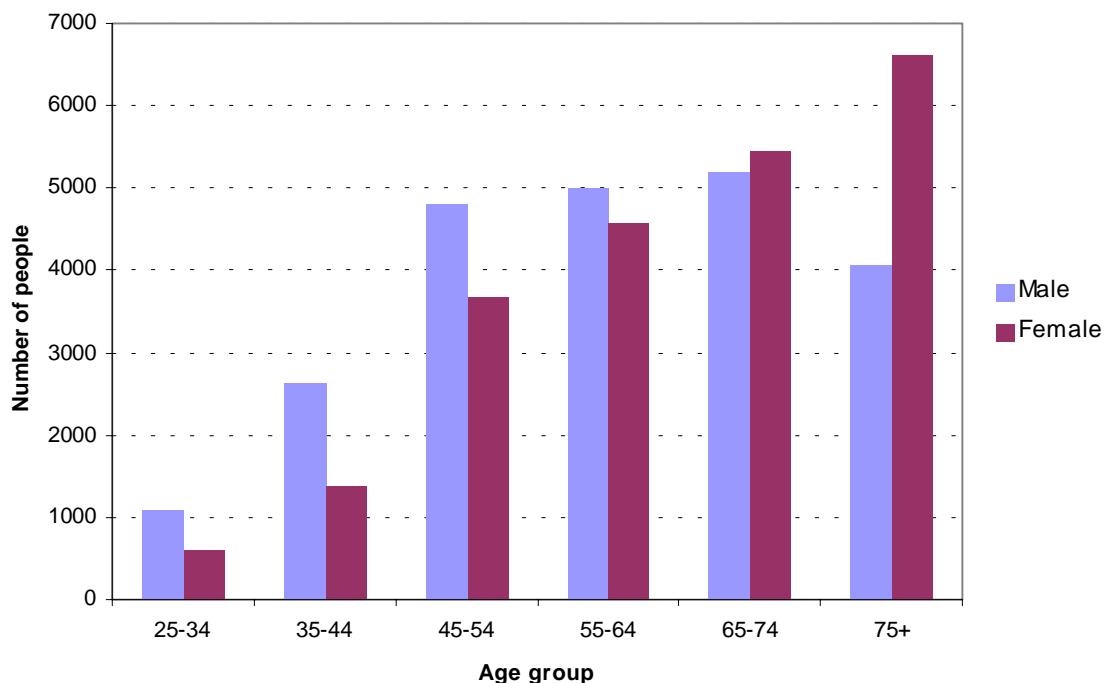
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

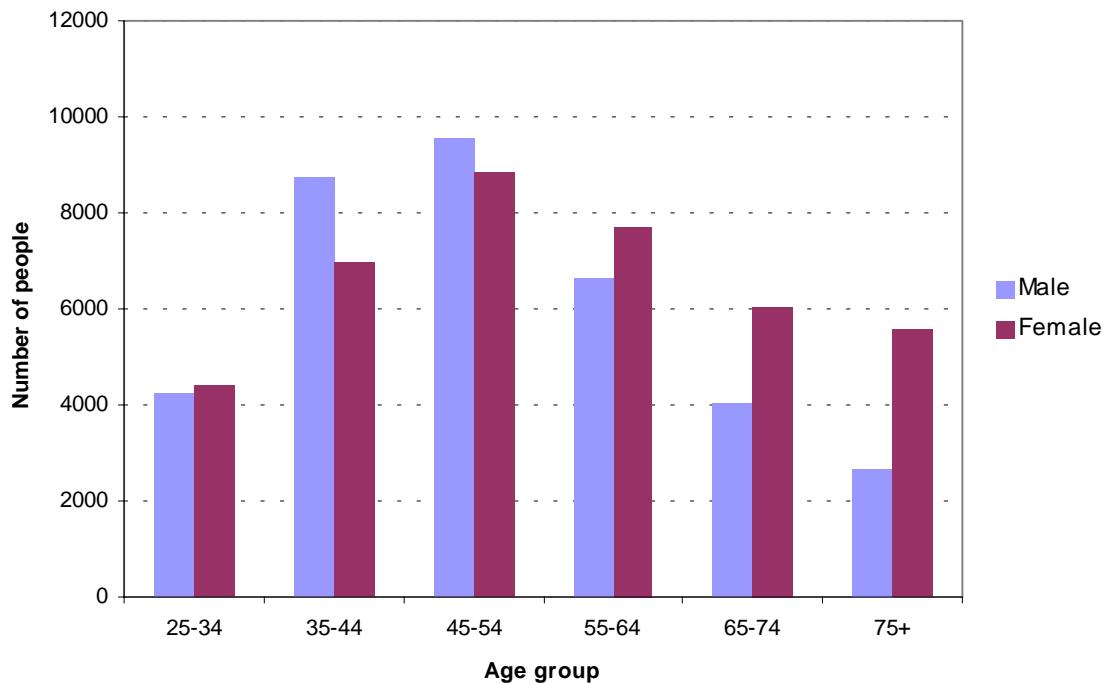
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



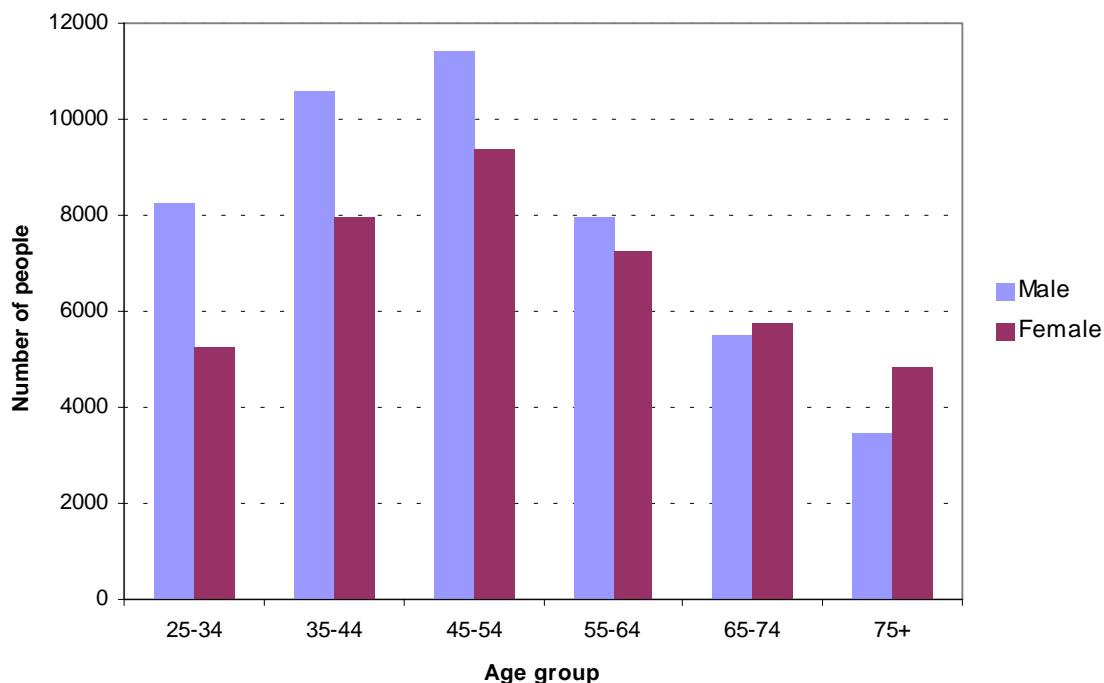
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



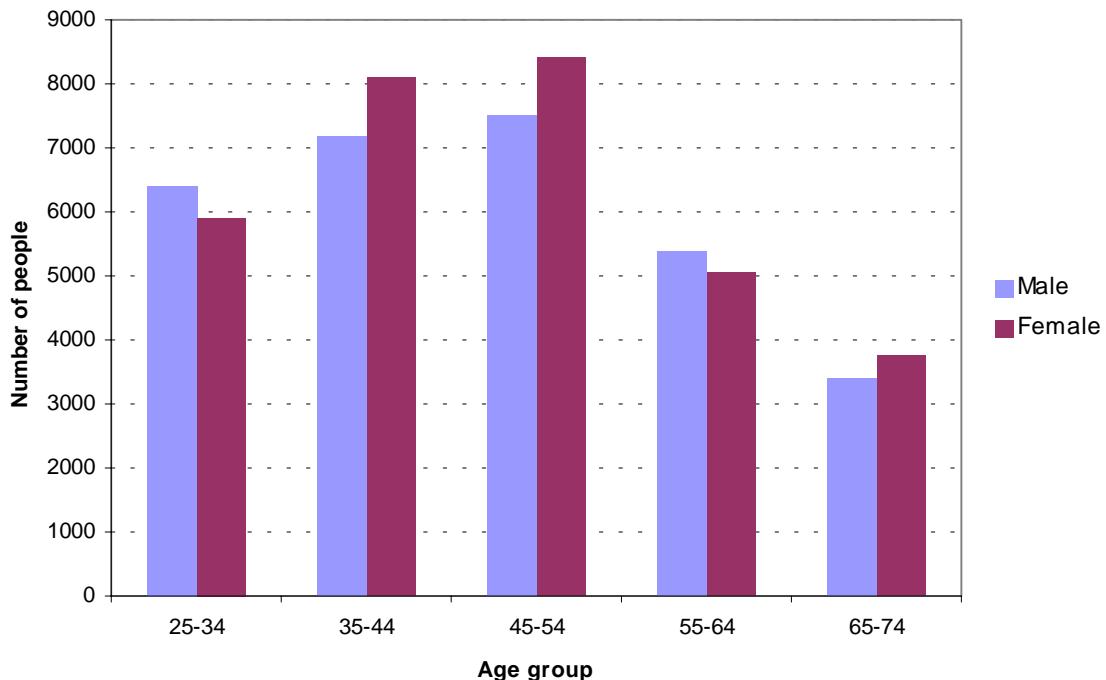
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



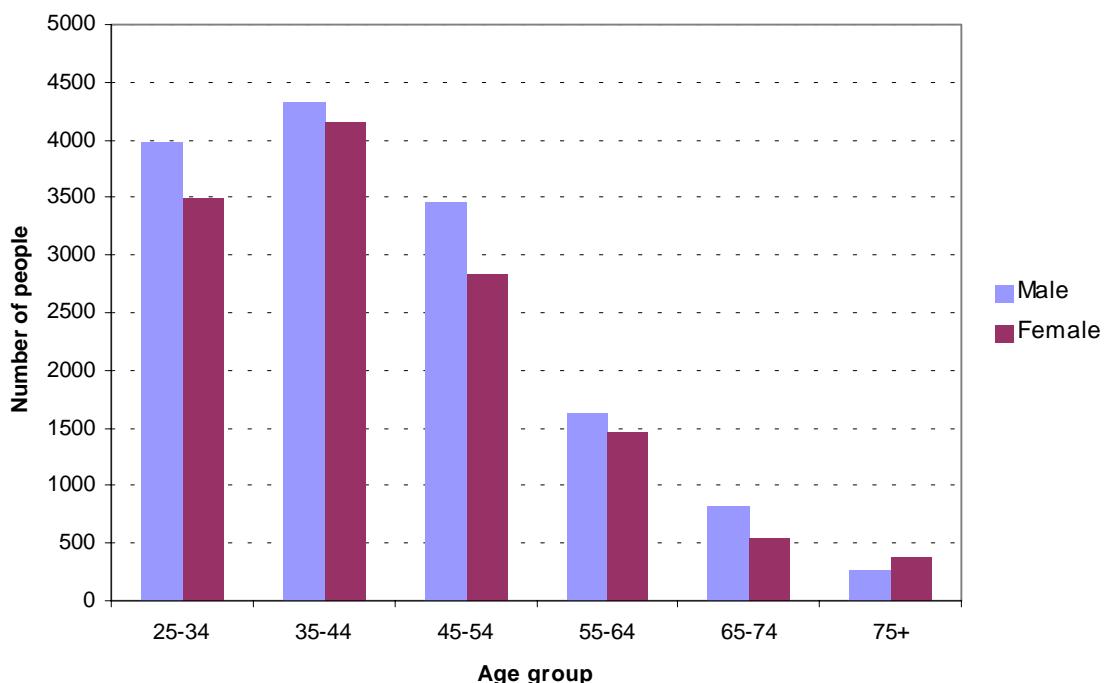
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|--------------------------------------------------|-------|-----|
| ▪ Number of GPs working in
the Division area: | Total | 291 |
|--------------------------------------------------|-------|-----|

Division Comments

- Do you have any comments
about the nature of the
population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes educator/clinic at Royal Hobart Hospital,
 - More Allied Health Services (MAHS) – diabetes educator 0.8/dietitian 0.4 to all rural practices,
 - Diabetes educators through Diabetes Australia,
 - One (private) diabetes educator.

- What services are needed but are not available in your Division area?

Shortage of diabetes educators (long waiting list for public services)

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

1992 1993 1994 1995
 1996 1997 1998 1999
 2000 2001 2002

- Please describe your diabetes program including any changes that occurred over time?

In past twelve months, much stronger focus on:

 - Small group GP education sessions, with endocrinologist/diabetes educator in attendance,
 - Practice support – assistance to establish recall/reminder, identify diabetes patients,
 - Provision of information (in variety of forms) re: clinical guidelines, Practice Incentive Payment (PIP) incentives, Enhanced Primary Care (EPC),
 - Through More Allied Health Services (MAHS) funding – provision of regular diabetes educator service to rural GP practices,
 - Collaboration with hospital re: referral/information between GPs and diabetes clinic.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - MAHS program in rural areas,
 - Focus on practice support (supported by development of population health manual).

- Are there any factors or barriers that have limited the implementation of your program? Please comment:

Lack of data regarding diabetes PIP uptake at a meaningful level (limiting opportunities to target).
- What future plans do you have for diabetes management in your Division?
 - In addition to the trend over the past twelve months, GP education (small group) practice support,
 - Continue to offer education at local level,
 - Target practice nurses for training,
 - Investigate opportunities for GP clinical attachment.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - GP “driver” at practice level,
 - Practice staff with skills/resources to develop the systems to support the uptake,
 - Critical role for Divisions in supporting the above,
 - Consumer education.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?

Strong links with endocrinologists, Royal Hobart Hospital (RHH) diabetes clinic, and Diabetes Australia (DA):

 - RHH/DA both have representation on Division reference group,
 - Endocrinologists/educators ongoing role in education,
 - Link with other Tasmanian Division/State Based Organisation.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP diabetes management booklet,
 - Developed PIP guide that links to above,
 - Division’s “Population Health Manual” – guide to setting up a diabetes education guide (rural practice),
 - EPC guide/sample care plans for diabetes patients,
 - Specific clinical information.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?

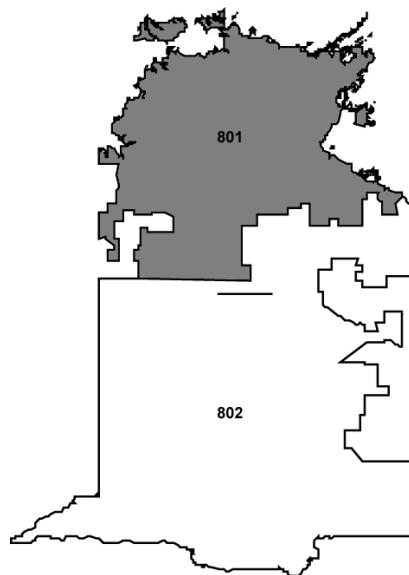
Population Health Manual – incorporates range of material.

- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines? N/A.
- What resource materials do you provide to practices? Refer top of page.

Division Contact Person/
Program Co-ordinator

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Top End DGP



Population demographics

Calculated from raw Australian Bureau of Statistics census data based on place of enumeration only

	Number	Percentage of Division Population
■ Total population of the Division area	153,403	
■ Aboriginal or Torres Strait Islander	33,920	22.1%
■ Speaks language other than English at home	33,094	21.6%
■ RRMA classification ¹		
1: Capital city	89,587	58.4%
5: Other rural	9818	6.4%
6: Remote centre	12,426	8.1%
7: Other remote	41,419	27.0%
■ SEIFA category containing population median: ²	5	

Estimated disease and risk factor prevalence

These figures assume that prevalence is same as that nationally

	Estimated number of adults in Division over 25 yrs	Percentage of Division population over 25 yrs
■ Diabetes ³	5186	5.5%
■ High blood pressure ⁴	21,351	22.8%
■ High blood cholesterol ⁵	45,257	48.4%
■ Obese or overweight ⁶	55,090	58.9%
■ Physical inactivity ⁷	42,196	45.1%
■ Smoking ⁸	20,140	21.5%

1 RRMA: Rural, Remote and Metropolitan Areas Classification

2 SEIFA index is divided into 11 categories. Category 1 is highest disadvantage, category 11 is lowest disadvantage. Area-based measure developed from 1996 Census and focuses on attributes such as low income, relatively lower educational attainment and high unemployment

3 Age adjusted. Calculated by multiplying the population aged 25+ years in the Division (2001 Census) by the expected prevalence of Type 2 diabetes in each 10 year age group from 25 – 34 (0.3%) up to 75+ years (23.6%) (Australian Diabetes, Obesity & Lifestyle Report, 2000)

From AIHW analysis of 1999-2000 AusDiab, 2001 National Drug Strategy Household Survey, 2000 National Physical Activity survey:

4 Age and sex adjusted. High blood pressure defined as $\geq 140/90$ mmHg or receiving medication

5 Age and sex adjusted. High blood cholesterol defined as ≥ 5.5 mmol/L (AIHW analysis of AusDiab, CVD 21, 2002)

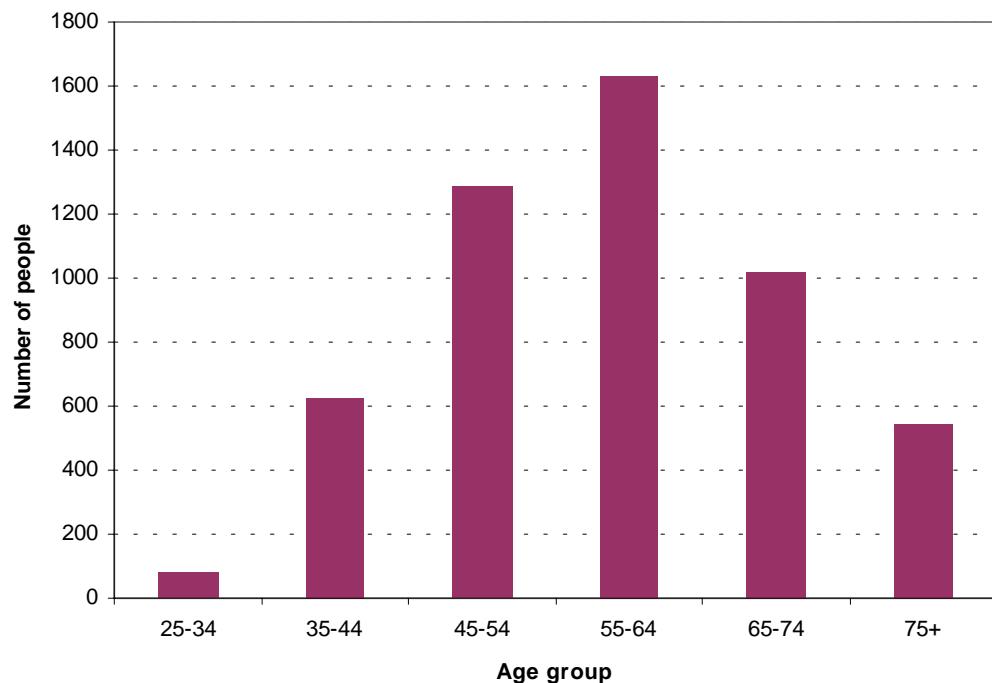
6 Age and sex adjusted. Obese or overweight defined as Body Mass Index (BMI) ≥ 25

7 Age and sex adjusted. Insufficient physical activity defined as less than 150 mins physical activity in the previous week

8 Age and sex adjusted. Smoking defined as daily smoking of tobacco products

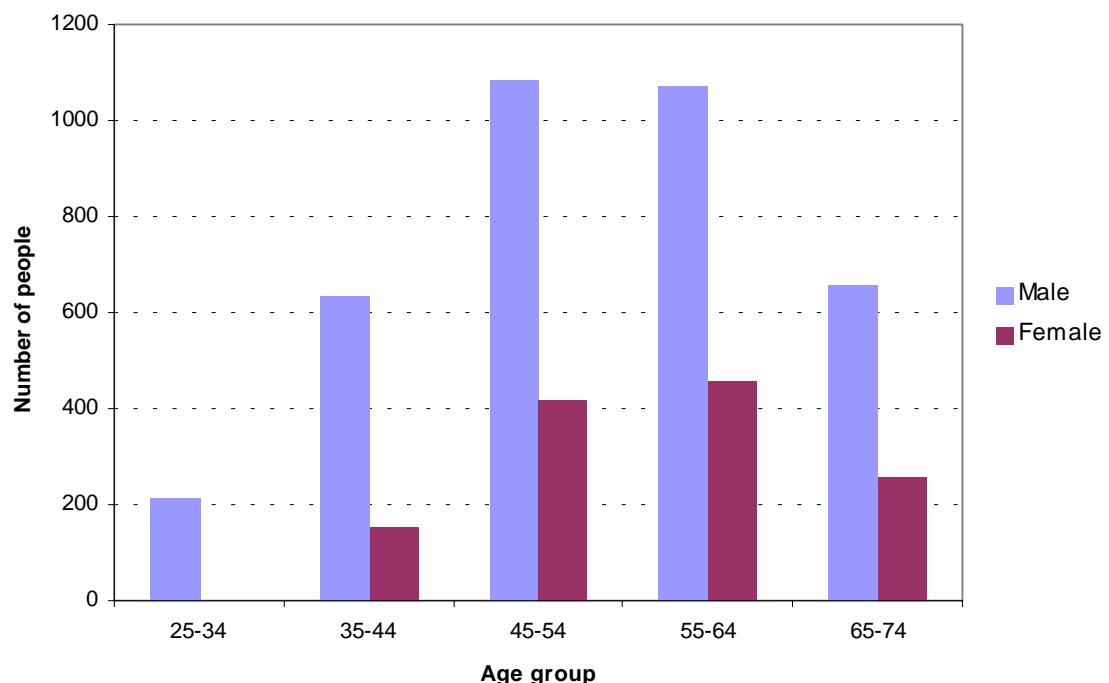
Key Descriptors of Division Population

Figure 1: Estimated number of adults with diabetes in the geographical area covered by the Division



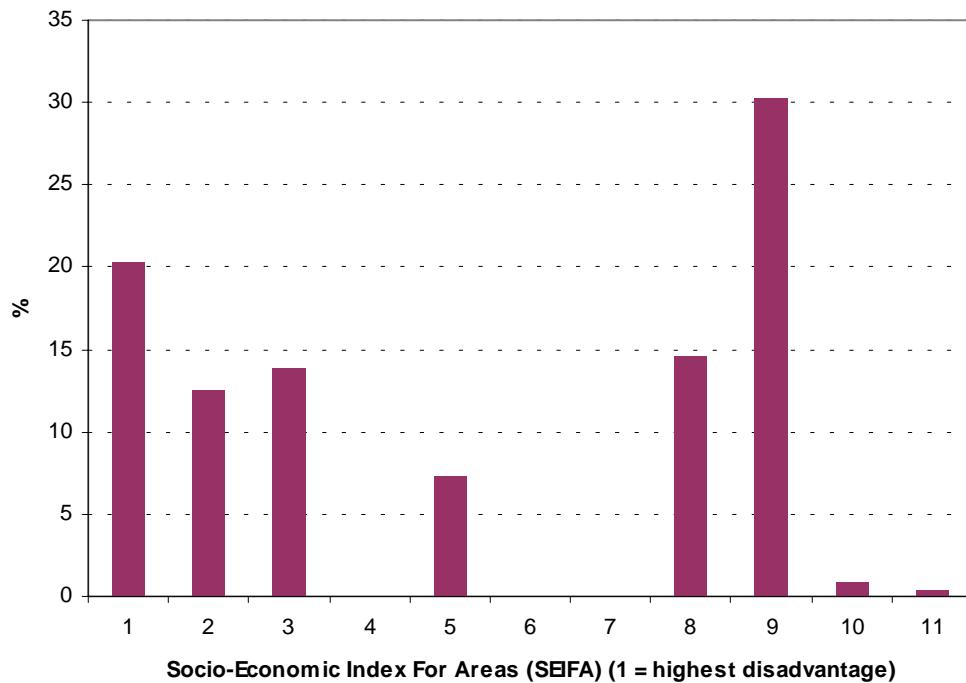
Prevalence rates from Australian Institute of Health and Welfare (AIHW) analysis of 1999-2000 AusDiab (Australian Diabetes, Obesity & Lifestyle Report, 2000), (AIHW – Mathur, 2002).

Figure 2: Estimated number of people (25-74 years) likely to suffer coronary heart disease event over the next ten years



The likelihood (based on the Framingham equation) over ten years of an occurrence of a CHD event (angina, acute myocardial infarction or CHD death) excluding stroke and peripheral vascular disease (AusDiab, 2000).

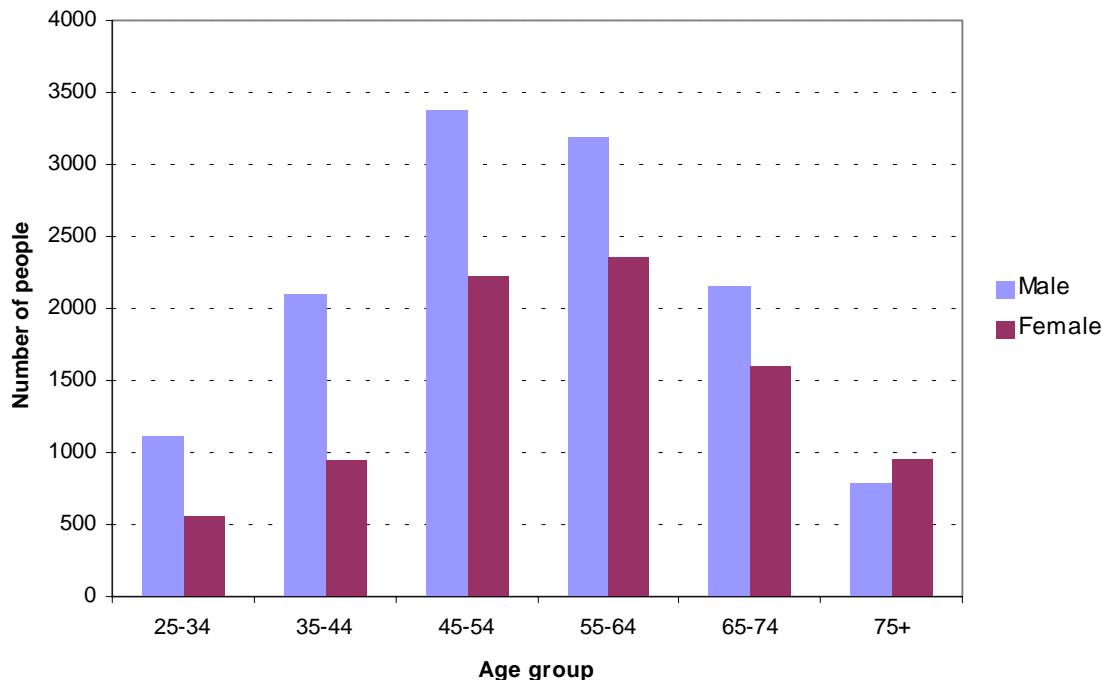
Figure 3: Proportion of the population in each of the Socio-Economic Index for Areas (SEIFA) groups



The SEIFA index is divided into 11 categories. It is an area based measure, developed from the 1996 census, focusing on attributes such as low income, relatively low educational attainment and high unemployment of a defined area (Comino E et al, 1999).

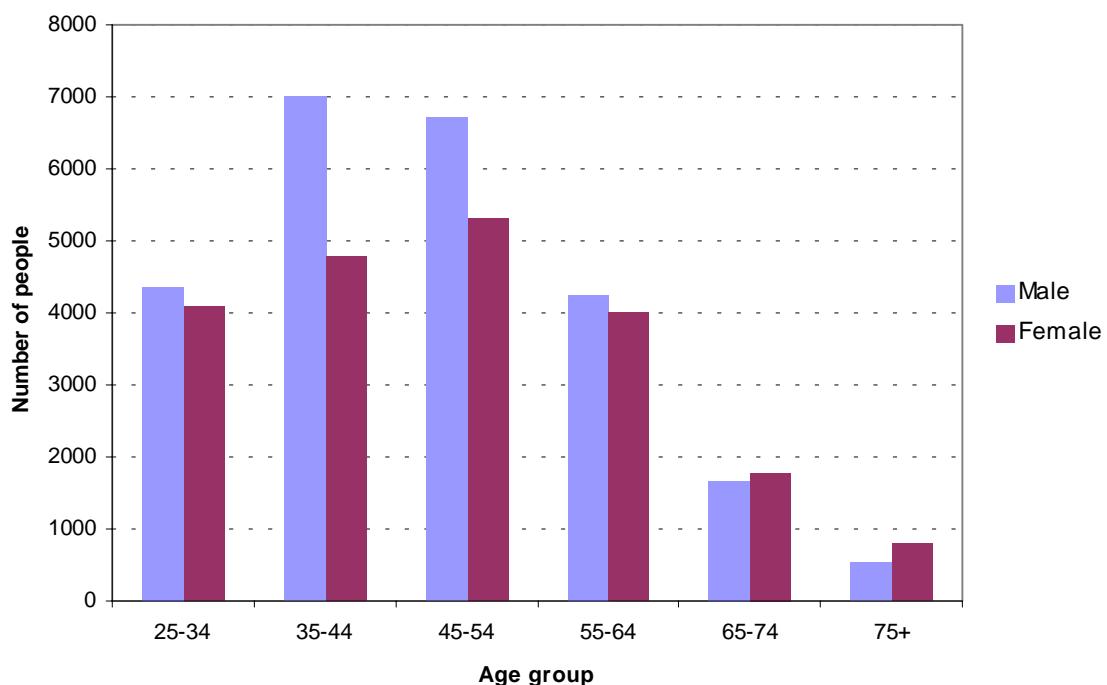
Estimated Risk Factor Prevalence

Figure 4: Estimated prevalence of high blood pressure by age and sex



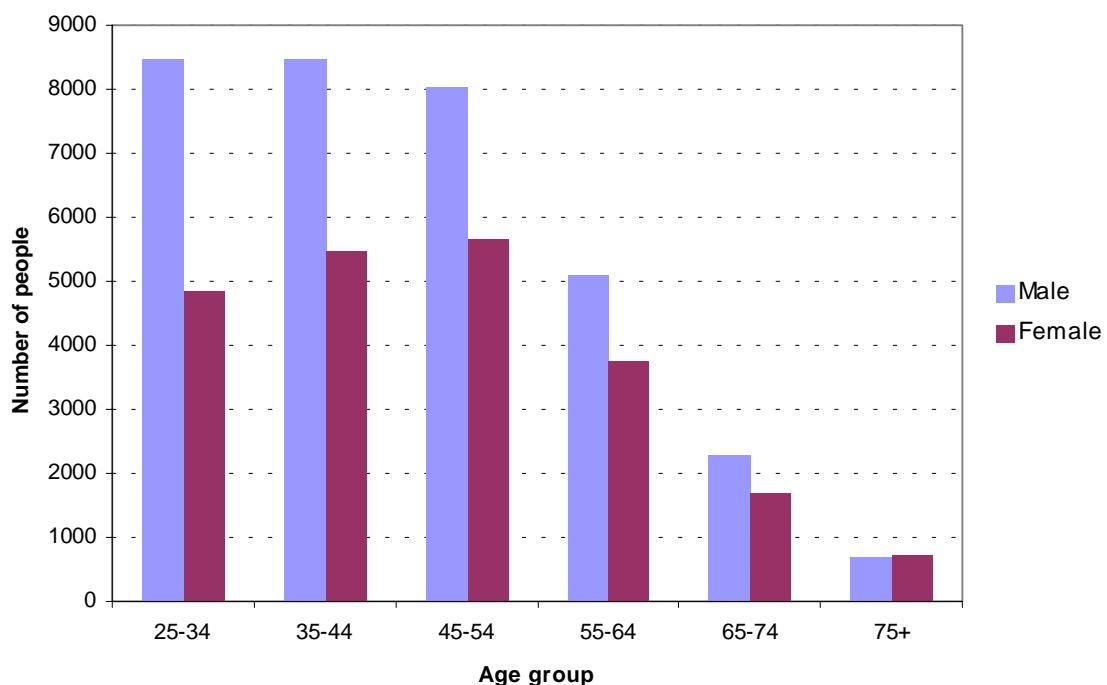
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood pressure is defined as $\geq 140/90$ mm Hg or receiving medication for high blood pressure. (AIHW – Mathur, 2002).

Figure 5: Estimated prevalence of high blood cholesterol by age and sex



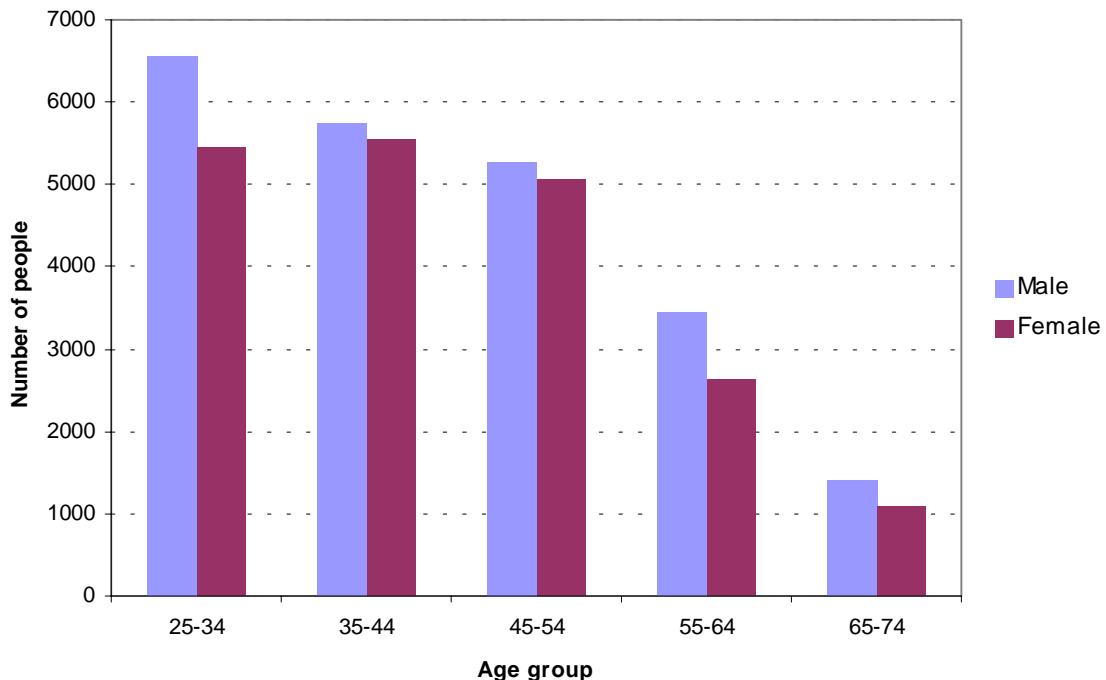
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. High blood cholesterol is defined as ≥ 5.5 mmol/L (AIHW – Mathur, 2002).

Figure 6: Estimated prevalence of overweight and obese people by age and sex



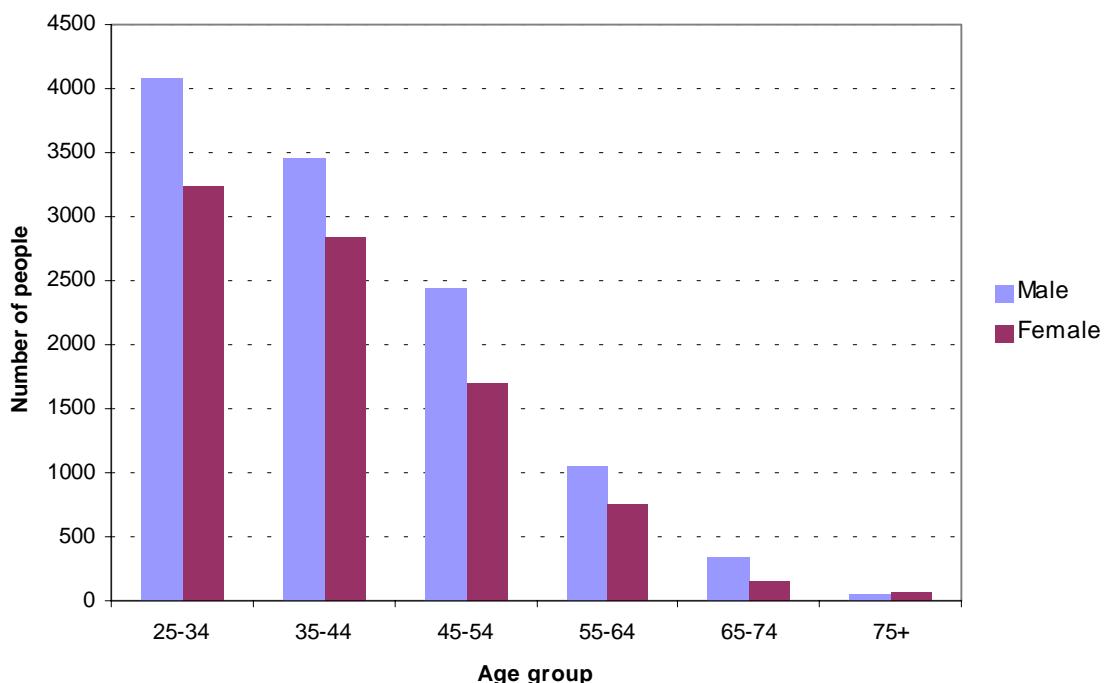
Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Overweight is defined as body mass index (BMI) ≥ 25 and obesity is defined as BMI ≥ 30 . (AIHW – Mathur, 2002).

Figure 7: Estimated prevalence of physical inactivity by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. Insufficient physical activity is defined as less than 150 minutes of physical activity for recreation or exercise (including walking for transport) in the previous week (AIHW – Mathur, 2002).

Figure 8: Estimated smoking prevalence by age and sex



Prevalence rates from Australian Institute of Health and Welfare analysis of 1999-2000 AusDiab; 2001 National Drug Strategy Household Survey; 2000 National Physical Activity Survey. The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars. Data are for 2001 (AIHW – Mathur, 2002).

GP Participation (as at 30.06.02)

- | | | |
|-----------------------------------------------|-------|-----|
| ▪ Number of GPs working in the Division area: | Total | 192 |
|-----------------------------------------------|-------|-----|

Division Comments

- Do you have any comments about the nature of the population in your area?

DIABETES PROGRAM

Services

- What diabetes services are available in your Division area?
 - Diabetes Australia with two educators,
 - Diabetes educator at the public hospital,
 - Two podiatrists, one high risk foot clinic at the public hospital,
 - One ophthalmologist, one endocrinologist,
 - Diabetes Project Officer, Top End Division of General Practice.

- What services are needed but are not available in your Division area?
Bilingual diabetes educators/health workers.

Diabetes Program Description

- In which years did you have a diabetes project or program operating:

<input type="checkbox"/> 1992	<input type="checkbox"/> 1993	<input type="checkbox"/> 1994	<input type="checkbox"/> 1995
<input type="checkbox"/> 1996	<input type="checkbox"/> 1997	<input type="checkbox"/> 1998	<input type="checkbox"/> 1999
<input type="checkbox"/> 2000	<input checked="" type="checkbox"/> 2001	<input checked="" type="checkbox"/> 2002	

- Please describe your diabetes program including any changes that occurred over time?
 - Survey of GPs to establish whether they had register and recall systems in place, and what assistance they would need, we then addressed that need,
 - Promoted the new MBS numbers for diabetes, and information on PIP and SIP and the outcome payment. Assisted GPs to set up registers and recall systems if they are paper based,
 - Education through three continuing professional development events, diabetes, cardiovascular and renal. A sexual dysfunction workshop, and the Nurses Forum. Provided resource materials to GPs, urban and remote. Facilitated care planning between Diabetes Australia, the Renal Unit and Healthy Living NT. This led to practice nurses being trained in the care plan process.

Division Perspective

- What have been the major achievements or highlights of your program so far?
 - Setting up registers and recall systems in paper based practices,
 - Facilitated the care plan process through Diabetes Australia, the Renal Unit, and Healthy Living NT,
 - Designing a referral form/annual assessment/care plan and hand held record.
- Are there any factors or barriers that have limited the implementation of your program? Please comment:
 - The shortage of GPs in the Top End, and the existing GPs' heavy workload,
 - The shortage of practice nurses in the Top End. Darwin being a capital city and not seen as remote can't access the practice nurse initiative,
 - The lack of bilingual educators and health workers,
 - The minimal payment for the MBS number for diabetes,
 - Lack of accredited practices, computerisation and finances,
 - The increased finances it needs to service remote isolated areas.
- What future plans do you have for diabetes management in your Division?
 - Training practice nurses to participate in the care plan process,
 - A practice nurse to assist practices that don't have a practice nurse to facilitate the care plan process,
 - A self-management program for patients.
- What would you say are the contributing factors (both internal and external) for practices that are successful in taking up chronic disease initiatives?
 - A computerised practice, with registers and recall in place,
 - A good practice nurse, with a good understanding of diabetes and the risk factors,
 - A good practice manager and reception staff.
- What type of strategic alliances or linkages do you have with external organisations and how have you developed them?
 - Weekly visits with Diabetes Australia (DANT) in the early stages of the program,
 - The monthly meetings of the chronic disease working party consisting of DANT, Department of Health and Community Services, GP representatives and the chronic disease network,

- Successfully working with DANT, the Heart Foundation and the Renal Unit to organise the three CPD events,
- Working with DANT and the chronic disease nurses with Health and Community Services to organise care planning and case conferencing in remote communities.

Division Resources

- What diabetes resources do you frequently utilise to help implement your programs (eg RACGP diabetes management in general practice guidelines, state based resources)?
 - RACGP Diabetes Management in General Practice,
 - DANT education material produced in the NT,
 - Management of Diabetic Retinopathy NHMRC Guideline.
- What diabetes resources developed by your Division would you be willing to share with or provide access to for other Divisions?
 - Annual assessment/referral/care plan/hand held summary,
 - Patient information on care plans and case conferencing,
 - GP information.
- Are there any resources that your Division needs but which are currently unavailable eg register recall systems, guidelines?
 - Hand held record,
 - Diabetic self-management tool.
- What resource materials do you provide to practices?
 - Annual assessment/referral/care plan/hand held summary
 - Patient information on care plans and case conferencing,
 - GP information on PIP, SIP and the outcome payment and the new MBS items,
 - Information on care plans and case conferencing,
 - RACGP Diabetes Management in General Practice book, diabetic retinopathy book,
 - Foot care packs, GFR calculators on request,
 - High risk foot stickers, referral forms to the high risk foot clinic,
 - Insulin titration referral forms to DANT.

Division Contact Person/
Program Co-ordinator

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