WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

14 December 2018

Ms J.M. Freeman, MLA
Education and Health Standing Committee
Legislative Assembly Western Australia
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005
By email: laehsc@parliament.wa.gov.au

Dear Ms Freeman,

RE: FOLLOW UP ITEMS FROM HEARING

In response to your letter dated 23 November 2018, please find enclosed the following requested documentation:

- Information from the Primary Health Network needs assessment in relation to type 2 diabetes (transcript page 2) – see attachment.
- Information on the relevant HealthPathways (transcript page 4), including those related to diet management being trialled in PHNs in other states (transcript page 5) – see attachment.
- Information on the care plans in relation to obesity (transcript page 4) – see attachment.
- Contact information for the Commonwealth agencies with responsibility for chronic diseases prevention (transcript page 9) – contact details are as follows:

  Tiali Goodchild (Branch Head for Preventative Health Policy).
  Email: Tiali.Goodchild@health.gov.au.

If you require any further information, please contact my Executive Assistant

Yours sincerely,

Chris Kane
General Manager, Strategy and Health Planning

Diabetes Prevalence:

Regional and Rural Communities:

Diabetes prevalence in regional and rural areas is not higher than either state or national rates, however, avoidable deaths from diabetes is significantly higher than WA and Australian rates in Country WA with particularly high rates in the East Pilbara, Kimberley and Midwest.

Risk factors for diabetes including obesity, being overweight and low exercise levels are also significantly higher in Country WA. Note data for risk factors has been suppressed in some regions due to small population sizes.

Eleven Potentially preventable hospitalization hotspots for diabetes complications have been identified in Country regions. Derby – West Kimberley had hospitalizations for diabetes complications at 4.1 times over the state average while Halls Creek had hospitalization for diabetes complications at 3.4 times the state average.

Diabetes prevalence, avoidable deaths and risk factors in Country WA

Area	Diabetes Mellitus (aged 18+ years)	Avoidable Mortality Diabetes ASR per 100,000	Low exercise levels ASR per 100	Overweight (but not obese) ASR per 100		Obese ASR per 100	
				Male	Female	Male	Female
Albany	5.2	4.9	69.5†‡	37.8	30.8‡	27.7†	28.2†
Augusta-Margaret River-Busselton	4.6	3.7	63.2	37.8	30.7‡	26.7†	26.9†
Bunbury	5.4	6.6	66.6†	37.2	30.4‡	29.8†‡	30.3†‡
East Pilbara	-	26.5*†‡	-	-	-	-	-
Esperance	5.1	12.2	-	-	-	-	-
Gascoyne	-	NA	-	-	-	-	-
Goldfields	5.5	17†‡	-	-	-	-	-
Kimberley	-	42.8*†‡	-	-	-	-	-
Manjimup	5.6	5.6	71.0†‡	38.0	31.4‡	29.2†	29.7†‡
Midwest	5.7	10.7†‡	67.7†	36.9	30.5‡	30.1†‡	30.5†‡
West Pilbara	-	13.1	-	-	-	-	-
Wheatbelt – North	5.0	6.4	70.4†‡	37.7	31.2‡	31.3*†‡	32*†‡
Wheatbelt – South	5.0	9.4	72.7*†‡	37.2	30.8‡	29.3†	30†‡

* Statistically significantly higher compared to PHN rate.

† Statistically significantly higher compared to Western Australian rate.

‡ Statistically significantly higher compared to Australian rate.

Metropolitan Areas with high rates of diabetes and risk factors:

Diabetes prevalence was significantly higher than WA and Australian rates in Belmont-Victoria Park, Canning, Cockburn, Fremantle, Gosnells, Kwinana, Swan, Stirling and Wanneroo. Avoidable deaths from diabetes were not higher than WA and Australian rates except in Belmont-Victoria Park.

Risk factors for diabetes including obesity, being overweight and low exercise levels are also significantly higher in many metropolitan areas. With particularly high rates of obesity in both males and females in South Metropolitan Perth.

Four Potentially preventable hospitalization hotspots for diabetes complications have been identified in South Metropolitan Perth and six in North Metropolitan Perth. Midland-Guildford has hospitalizations for diabetes complications at 2.5 times the state rate and Clarkson at 2.2 times the state rate.

Diabetes prevalence, avoidable deaths and risk factors South Metropolitan Perth

Area	Diabetes Mellitus (aged 18+ years)	Avoidable Mortality Diabetes ASR per 100,000	Low exercise levels ASR per 100	Overweight (but not obese) ASR per 100		Obese ASR per 100	
				Male	Female	Male	Female
Armadale	5.6	7.3	66*†	42.5†	31.1*†‡	28.4*†	28.3*†‡
Belmont-Victoria Park	5.9‡	12.2*†‡	61.1	41.2	28.9	21.4	21.5
Canning	6.1†‡	5.0	62.6	40.7	28.8	19.6	19.7
Cockburn	5.9‡	5.1	65.7†	42.1	30.3‡	25.5*†	25.4*†
Fremantle	5.8‡	3.6	57.5	42.6	29.4	18.8	18.8
Gosnells	6.2*†‡	6.1	66.8*†	41.9	30.1‡	25.4*†	25.3*†
Kwinana	6.3*†‡	11.6	64.9	43.5†	31.2‡	30*†‡	30.7*†‡
Mandurah	5.4	5.1	64.1	42.9†	30.4‡	28.1*†	28.1*†
Melville	4.7	2.4	58.4	42.7†	30.2‡	17.3	17.5
Rockingham	5.2	4.1	63.9	42.9†	30.6‡	28*†	28*†
Serpentine-Jarrahdale	4.9	NA	62.7	43.6†	31.6‡	25.7*†	26*†
South Perth	4.7	4.5	54.1	40.8	28.9	16.7	16.9

Statistically significantly higher compared to PHN rate.

† Statistically significantly higher compared to Western Australian rate.

‡ Statistically significantly higher compared to Australian rate.

Diabetes prevalence, avoidable deaths and risk factors North Metropolitan Perth

Area	Diabetes Mellitus (aged 18+ years)	Avoidable Mortality Diabetes ASR per 100,000	Low exercise levels ASR per 100	Overweight (but not obese) ASR per 100		Obese ASR per 100	
				Male	Female	Male	Female
Bayswater - Bassendean	5.6	7.5	62.2	42.3	29.8‡	21.5	21.5
Cottesloe - Claremont	4.5	3.0	48.6	42.2	29.2	13.1	13.5
Joondalup	4.7	2.2	59.7	42.5†	30.3‡	22.1	22.1
Kalamunda	4.9	3.7	62.0	42.0	30.9‡	25*	25*
Mundaring	5.1	3.5	61.4	42.4	30.8‡	23.4	23.6
Perth City	5.5	7.3	56.2	39.3	27.2	16.2	16.2
Stirling	6†‡	4.6	60.7	42.0	29.5	20.7	20.8
Swan	6.3*†‡	5.5	65.9*†	42.6†	31.1*†‡	27.0*†	26.9*†
Wanneroo	6.3*†‡	6.1	66.7*†	41.8	30‡	28.8*†	28.7*†‡

Statistically significantly higher compared to PHN rate.

† Statistically significantly higher compared to Western Australian rate.

‡ Statistically significantly higher compared to Australian rate.

Children and adolescents:

Wanneroo has significantly higher rates of children that were overweight or obese while Armadale, Gosnells, kwinana and Rockingham had high rates of obese children. The prevalence of overweight children was significantly higher in Canning, Gosnells, Belmont-Victoria Park, Bayswater-bassendean, Joondalup and Stirling. Children in Country WA did not have a high prevalence of overweight or obese children.

Risk factors for children aged 2 to 17 years in Perth South PHN by SA3, (ASR per 100), modelled estimates (2014 to 2015).

Area	Children 2-17 years					
	Overweight (but not obese)			Obese		
	Male	Female	All children	Male	Female	All children
Armadale	22.6‡	14.9	18.6	7.9*†‡	8*†	7.7*†
Belmont-Victoria Park	27.3*†‡	17.5*†‡	22*†‡	6.4	6.3	6.1
Canning	25.7*†‡	19*†‡	22.2*†‡	5.8	6.0	5.7
Cockburn	23.4‡	16.4	19.7‡	6.3	6.3	6.1
Fremantle	20.0	15.0	17.5	4.8	4.8	4.6
Gosnells	24†‡	16.8†	20.2†‡	7.2*†‡	7.3*†	7*†
Kwinana	22.8‡	15.0	18.7	8.7*†‡	8.9*†	8.5*†‡
Mandurah	19.2	14.2	16.6	6.9†	7†	6.7†
Melville	21.8‡	14.8	18.1	4.2	4.4	4.2
Rockingham	22.8‡	15.3	18.9	7.3*†‡	7.4*†	7.1*†
Serpentine-Jarrahdale	20.6	14.3	17.2	6.4	6.4	6.1
South Perth	19.5	15.2	17.4	4.7	4.8	4.6

Risk factors for children aged 2 to 17 years (ASR per 100) in Perth North PHN by SA3, from 2014 to 2015.

Area	Children 2-17 years					
	Overweight (but not obese)			Obese		
	Male	Female	All children	Male	Female	All children
Bayswater - Bassendean	23.3‡	16.2	19.6‡	5.8	5.8	5.6
Cottesloe - Claremont	19.7	13.6	16.5	3.7	3.8	3.6
Joondalup	23.6‡	16.6†	19.9†‡	4.7	4.9	4.6
Kalamunda	21.9‡	15.2	18.4	5.5	5.7	5.4
Mundaring	21.8‡	15.5	18.5	5.7	5.9	5.6
Perth City	21.5	14.4	17.8	4.8	4.7	4.6
Stirling	23.2‡	16.5†	19.7‡	5.7	5.8	5.5
Swan	22.2‡	15.6	18.8	6.9*†	7.1*†	6.8*†
Wanneroo	24.8*†‡	17.1*†‡	20.8*†‡	7.4*†‡	7.5*†	7.2*†

Risk factors for children aged 2 to 17 years (ASR per 100) in Country WA PHN by SA3, from 2014 to 2015.

Area	Children 2-17 years					
	Overweight (but not obese)			Obese		
	Male	Female	All children	Male	Female	All children
Albany	21.4	15.6	18.4	5.9	6.0	5.7
Augusta-Margaret River-Busselton	19.0	13.9	16.3	5.4	5.6	5.3
Bunbury	21.5‡	14.9	18.0	6.5	6.6	6.3
East Pilbara	-	-	-	-	-	-
Esperance	-	-	-	-	-	-
Gascoyne	-	-	-	-	-	-
Goldfields	-	-	-	-	-	-
Kimberley	-	-	-	-	-	-
Manjimup	21.7	15.4	18.4	5.7	5.9	5.6
Midwest	20.5	15.0	17.6	6.6	7.0†	6.5
West Pilbara	-	-	-	-	-	-
Wheatbelt – North	22‡	14.9	18.2	6.2	6.4	6.0
Wheatbelt – South	22.0	16.0	18.8	6.0	6.0	5.7

WAPHA Submission – HealthPathways WA

Context of Submission

The WA Primary Health Alliance (WAPHA) attended a Committee Hearing on 21 November 2018, where witness Chris Kane (General Manager, Strategy and Health Planning) mentioned the HealthPathways WA project, and committed to providing more information on the platform. The HealthPathways WA platform was also raised in the *Evidence by Mrs Sophie McGough (Health Services Operations Manager, Diabetes WA) on 10/10/2018*. WAPHA would like to address the concerns raised in Mrs McGough's testimony and provide the Committee with a greater understanding of the platform and how it can be utilised by General Practitioners (GPs) and other health professionals to assist with the lifestyle and preventative aspects of diabetes and pre-diabetes, as well as the medical management.

Background

HealthPathways is an online tool to support General Practitioners (GPs), practice nurses, and other health professionals in the assessment, management and referral decisions of patients. HealthPathways is designed and written for use at the point of care, most commonly this will be in a consultation setting within a general practice. Each pathway consists of clear and concise steps for assessing and managing a patient with a particular symptom or condition in the local health system. The aim of the tool is to enable a more seamless, effective and complete patient journey by combining clinical and health service information, educational opportunities, and access to relevant medical evidence in one place.

The HealthPathways platform was initially developed by the Canterbury District Health Board in New Zealand, in 2008. Since then, over 40 instances of HealthPathways are being implemented throughout Australia and New Zealand. In Western Australia, the HealthPathways project commenced in 2013, and has been primarily funded through the WA Primary Health Alliance (WAPHA) since 1 July 2015. To date, 450 pathways have been localised. These pathways are a combination of clinical management, referral information, and other useful resource information for GPs.

The clinical content in HealthPathways is written by local GPs in conjunction with local specialist physicians, or other local health professionals as is relevant to each pathway. The platform requires users to enter login details, which are only shared with health professionals certified by the Australian Health Practitioner Regulation Agency (AHPRA).

Funding and support for HealthPathways WA

The HealthPathways WA project is supported by the WA health system. In September 2015, WAPHA and the WA health system signed the *Partnership Agreement between WA Department of Health, Health Service Providers and WA Primary Health Alliance to Develop HealthPathways for Western Australia* [the Partnership Agreement]. It was recognised that there is an opportunity for all signatory parties to work in partnership to improve integration between primary, secondary and tertiary care. The partnership focuses on the development and ongoing review of pathways, and on monitoring and facilitating the uptake and utilisation of HealthPathways WA. The Partnership Agreement sets out the roles and responsibilities for all parties in developing pathways and increasing engagement with the platform.

WA DoH also provide a financial contribution to the HealthPathways WA project through a grant funding agreement. This agreement commenced 19 June 2015, and expires on 31 December 2018. A

procurement process is currently underway to secure further funding through a service level agreement.

HealthPathways Structure

A pathway summarises local agreement between primary and specialist health professionals in a region about assessing and managing a particular symptom or condition at the point of care. Each pathway consists of standard sections, broken into steps; these include assessment, management request, and patient information sections. An explanation of each of these sections is available at Appendix 1. Pathways are designed to be read at a glance and therefore kept as succinct as possible. They include embedded drop-boxes where supplementary information may be useful, which can be expanded by the user. Screenshots of an example pathway are shown in Appendix 2.

The concern raised by Mrs McGough was that the diabetes content on HealthPathways WA, "is too buried and all over the place" and "if you try to work out the pathway, it is a clinical pathway, not a services pathway". The structure and design of each pathway is created by GPs to ensure that information is presented in a way that is logical to other GPs accessing the information. Therefore, it commences with the clinical information, and links off to the specific referral information, based on clinical need.

These referral pages list similar services together, so that the GP can determine which service will best suit their patients' needs e.g. based on location or cost. The types of services listed include public and private hospitals, allied health, and community-based services. HealthPathways is independent, and therefore does not preference a service offered by one provider over another. A WAPHA staff member contacts all providers before listing them on a request page, to ensure that the service provided is appropriate for that stage in the patient's journey, and to ensure accuracy of the service details.

Pathway Development Process

Each pathway undergoes a robust development process. The pathways contain reliable information through genuine engagement from health professionals and representatives across the state. Detail on WAPHA's pathway development processes and governance processes are available in Appendices 3 and 4. Conducting Working Groups with local GPs, and having a local GP as the Clinical Editor ensures that the pathway content is useful and relevant to this target audience.

Through the Partnership Agreement development between WAPHA and the WA health system, the pathway development process was defined.

Diabetes and Lifestyle and Preventative Care Pathways

The diabetes and lifestyle and preventative care streams of pathways are pertinent to this inquiry. These pathways were progressively published on HealthPathways WA during 2015 and 2016. All the pathways are evidence-informed, reflect local reality, and aim to preserve clinical autonomy and patient choice. For example, the diabetes pathways are underpinned by the Royal Australian College of General Practitioners (RACGP) diabetes guidelines, as well as evidence from other credible organisations and journal publications.

In the adult diabetes stream there are currently 23 clinical pathways and 9 pages of service information within this stream, which cover type 1 diabetes, pre-diabetes, type 2 diabetes, and gestational diabetes. Appendix 5 provides an overview of all the available diabetes pathways and service information.

As well as information specific to diabetes, HealthPathways WA also has a stream of pathways focused on 'Lifestyle and Preventative Care'. There are 9 clinical pathways and 6 pages with service

information, that are relevant to managing lifestyle factors associated with diabetes. Appendix 6 lists the pathways that are relevant to healthy eating, physical activity, and weight management.

In addition to development and review by HealthPathways Clinical Editors, these pathways were developed with input received from: endocrinologists, dietitians, diabetes educators, podiatrists, exercise physiologists, vascular surgeons, optometrists, nephrologists, nurse practitioners, and Diabetes WA. The health professionals involved in developing each pathway are shown in Appendices 5 and 6.

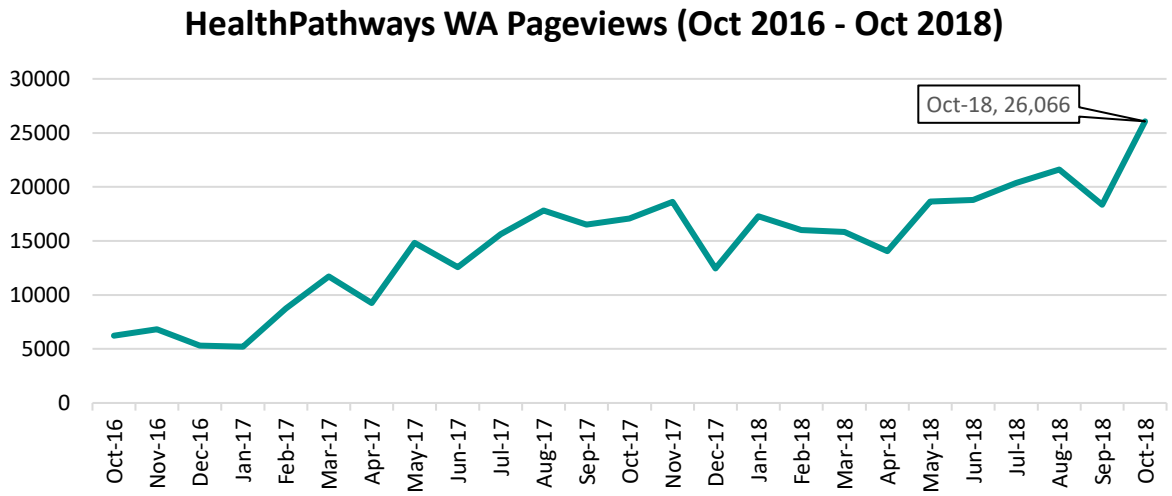
As these pathways combine the assessment, management and referral information for managing these conditions all in one place, they are a useful resource for GPs or other health professionals to quickly locate the information they need to assist their patients.

All pathways are formally reviewed every three years to ensure the content remains up-to-date and relevant to a GP audience. These pathways are scheduled for review in 2019. WAPHA will be working closely with the WA Health Service Providers (HSPs) and relevant clinicians in this process. In between the formal review cycles, partial updates are made to pathways on an as-needed basis. To date, there have been 70 updates made to the diabetes stream, and 31 to the Lifestyle and Preventative Care stream. A significant proportion of these updates were related to changes in service information.

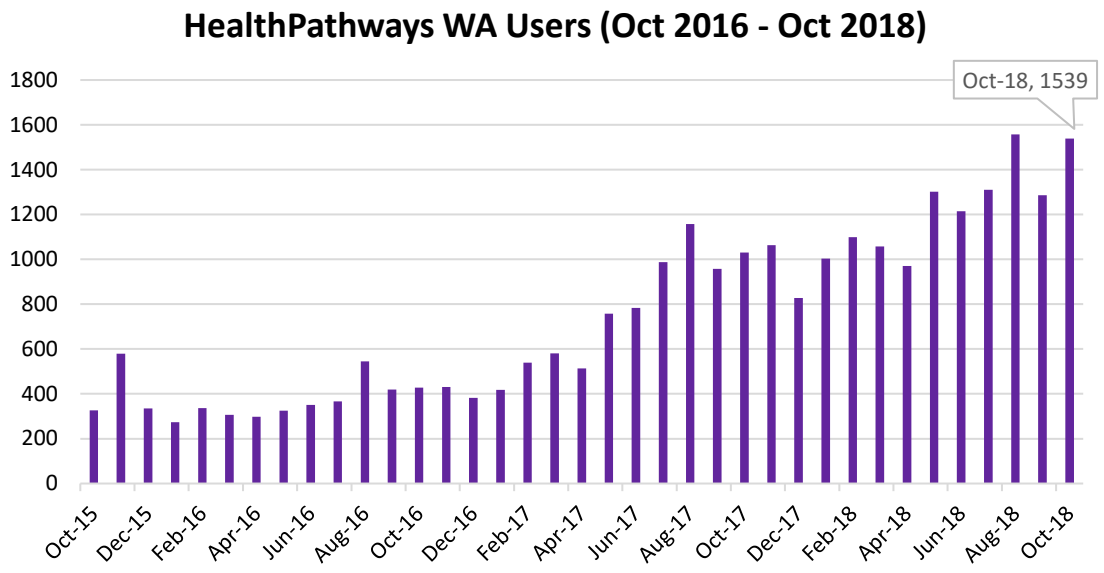
Utilisation of HealthPathways WA

The uptake of HealthPathways WA has been continuously increasing since the platform was launched in October 2015. Graph 1 (below), shows the number of pageviews per month from October 2016 – October 2018. Graph 2 (below), shows the number of users accessing HealthPathways each month from October 2016 – October 2018.

Graph 1: The number of pageviews to HealthPathways WA each month between October 2016 to October 2018.

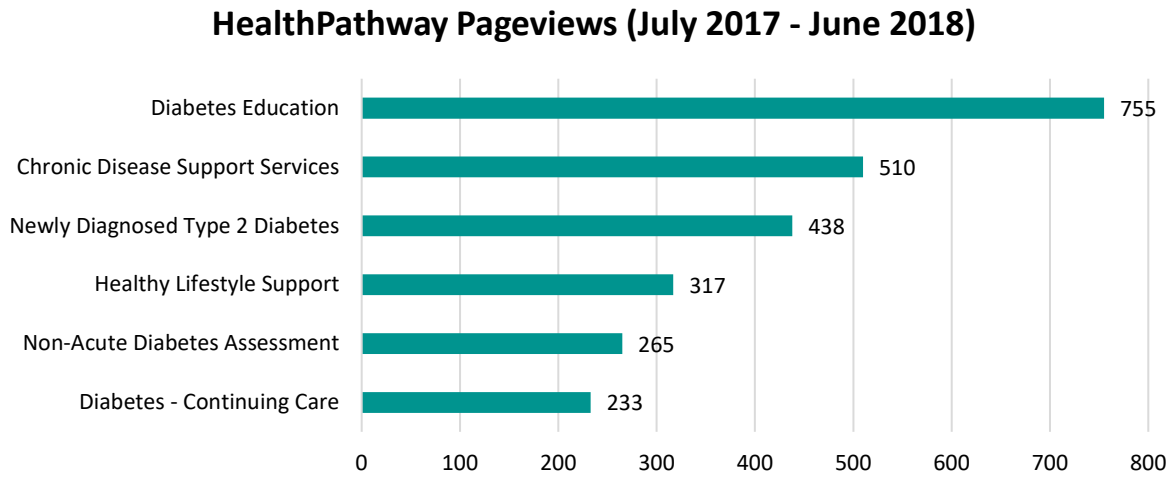


Graph 2: The number of users to HealthPathways WA on a monthly basis between October 2016 to October 2018.



In relation to the diabetes pathways, Graph 3 shows the number of times several of the more popular pathways were accessed in financial year 2017-2018. In total, the diabetes pathways and relevant lifestyle and preventative care pathways were viewed 6804 times in that financial year. This represents 3.42% of total pageviews to HealthPathways in financial year 2017-2018.

Graph 3: Pageviews to several diabetes and lifestyle and preventative care pathways between July 2017 and June 2018.



To ensure the uptake and use of HealthPathways WA continues to increase, WAPHA utilizes the following strategies:

- Working with the HSPs and WA Department of Health (WA DoH) to develop pathways which directly support their system changes projects, such as changes in criteria for GP referral to public hospitals.
- Education events are held on published pathway streams, in conjunction with metropolitan public hospitals and HSPs. These events are RACGP accredited and provide GPs with 40 Category 1 Continuing Professional Development (CPD) points.
- Attending as a stall-holder at GP-centered conferences and events, and providing demonstrations of the platform.

- Educating individual GPs and GP practices through demonstrations provided by WAPHA's Practice Support staff.

For 2019, WAPHA is in discussion with Diabetes WA to collaborate on a GP education event on type 2 diabetes management. As the pathways are reviewed in 2019, WAPHA will also work with the HSPs to encourage appropriate primary care management of type 2 diabetes, prior to referral for public hospital clinician input.

Appendix 1: HealthPathways elements

Assessment section: A succinct list of steps that users would take (or consider taking), to: diagnose a patient who has or may have the pathway condition, and/or evaluate the severity of the pathway condition.

Management section: A succinct list of steps users would take (or consider taking) to care for a patient with the pathway condition including:

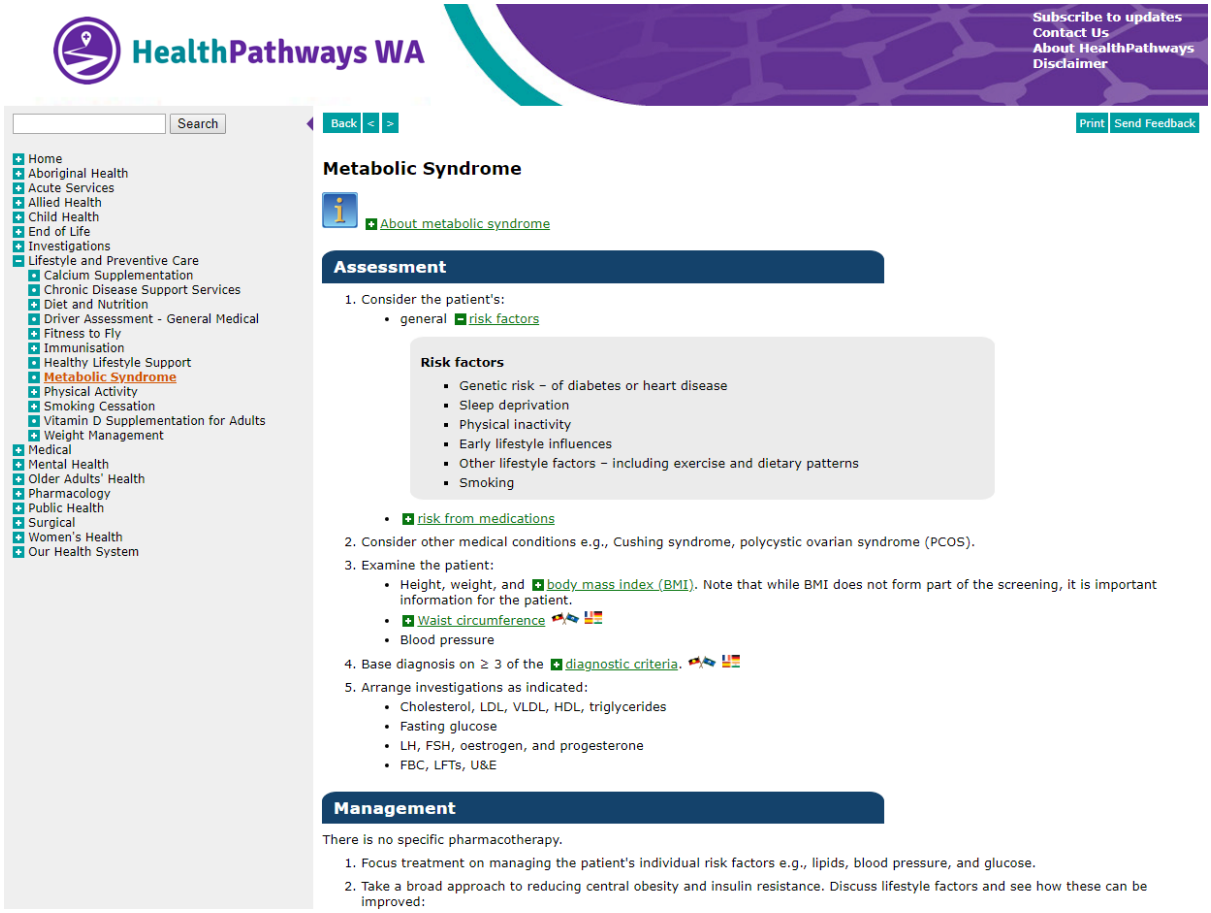
- How to manage any red flags (the most serious clinical risks that are easily missed)
- How to manage any particular groups of patients e.g. patients older than 55 years with mild symptoms
- All investigations the user would consider or use to manage a patient with the pathway condition, once they've finished assessing the patient.
- All further health services users would request or consider requesting to manage the patient.

Request section: Any assessment, treatment, or other service that the user might request from a third party to manage a patient with the pathway condition, and the clinical criteria of each option, i.e. when each is medically appropriate. This section includes links to information on individual providers and how to refer to those services.

For health professionals: A selective list of links to useful information, primarily aimed at clinicians, about the pathway condition, its assessment, or its management. These could be links to: education, further information, or protocols and procedures.

For patients: a short list of the most relevant resources that a user might give to a patient who has the pathway condition. Resources provide accessible information about the pathway condition itself, how it's likely to be assessed and managed, and anything the patient or their carer might need to do. This allows users to easily locate good quality patient resources that are relevant to give to a patient during a consultation, as part of assessing or managing that condition. These are generally sourced from peak bodies and consumer groups, or are government developed consumer resources.

Appendix 2: Pathway Example – Metabolic Syndrome



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  - Healthy Lifestyle Support
  - Metabolic Syndrome
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  - Vitamin D Supplementation for Adults
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Metabolic Syndrome

About metabolic syndrome

Assessment

1. Consider the patient's:
   - general – risk factors

     Risk factors
     - Genetic risk – of diabetes or heart disease
     - Sleep deprivation
     - Physical inactivity
     - Early lifestyle influences
     - Other lifestyle factors – including exercise and dietary patterns
     - Smoking

   - risk from medications
2. Consider other medical conditions e.g., Cushing syndrome, polycystic ovarian syndrome (PCOS).
3. Examine the patient:
   - Height, weight, and body mass index (BMI). Note that while BMI does not form part of the screening, it is important information for the patient.
   - Waist circumference
   - Blood pressure
4. Base diagnosis on ≥ 3 of the diagnostic criteria.
5. Arrange investigations as indicated:
   - Cholesterol, LDL, VLDL, HDL, triglycerides
   - Fasting glucose
   - LH, FSH, oestrogen, and progesterone
   - FBC, LFTs, U&E

Management

There is no specific pharmacotherapy.

1. Focus treatment on managing the patient's individual risk factors e.g., lipids, blood pressure, and glucose.
2. Take a broad approach to reducing central obesity and insulin resistance. Discuss lifestyle factors and see how these can be improved:
   - aerobic exercise – see Physical Activity.
   - weight loss – see Weight Management – Overweight Adults.
   - smoking cessation – see Smoking Cessation.
   - reducing alcohol – see Alcohol Intervention.
   - dietary change – see Healthy Eating.
3. Consider if the patient would benefit from a structured lifestyle support program.
4. Review medications.

Request

- Consider referral to a lifestyle support program.
- If appropriate to help with improving lifestyle factors, refer to a community exercise program.

Information

For health professionals

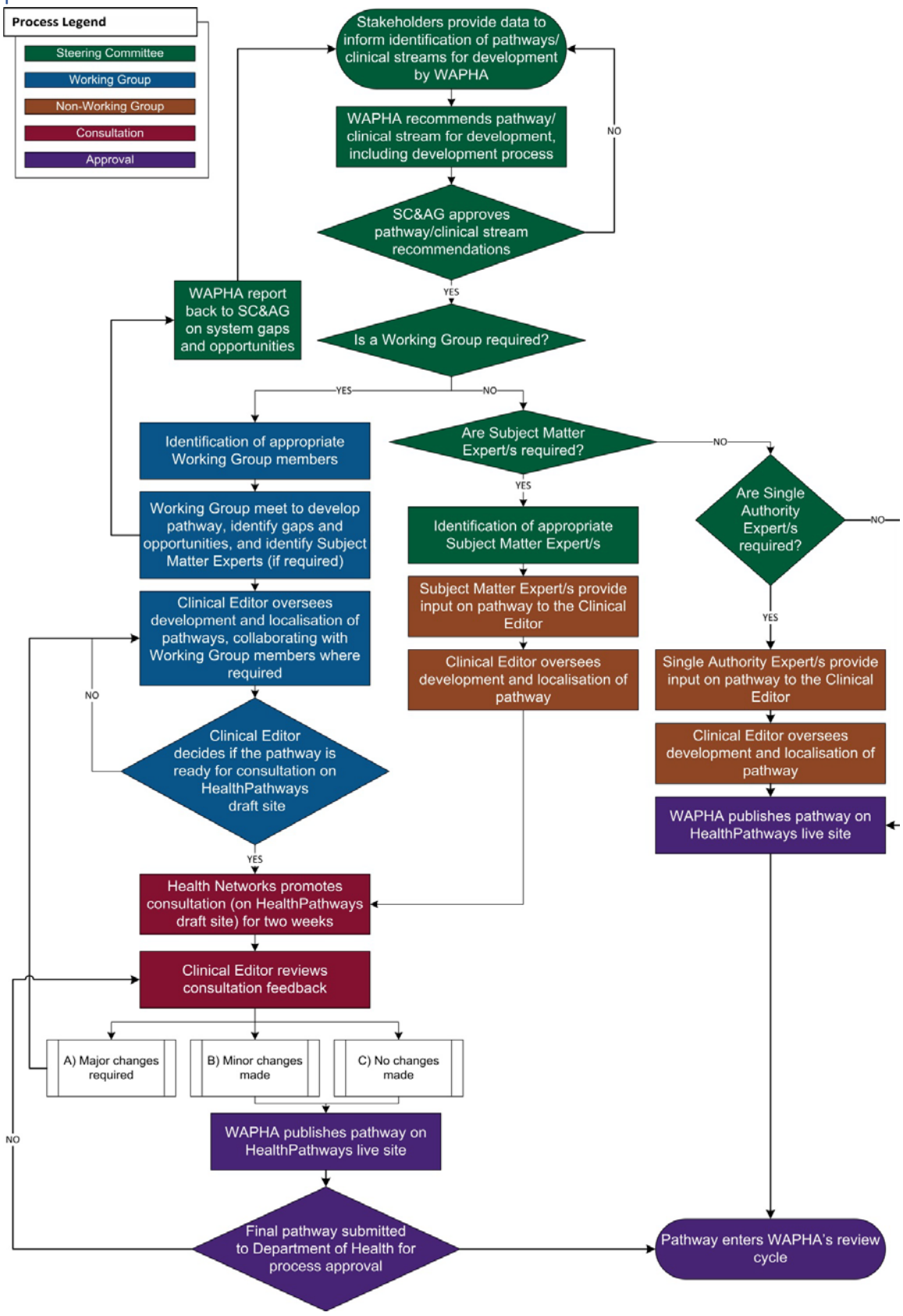
- Australian Family Physician – The Metabolic Syndrome
- University of Western Australia School of Psychiatry and Clinical Neuroscience – Clinical Guidelines for the Physical Care of Mental Health Consumers

For patients

MyDr – Metabolic Syndrome

Sources

Appendix 3: Coordination of pathway development and approval processes



Appendix 4: Key development processes for clinical pathways

The integration of the processes listed below are shown in Appendix 3.

GP Clinical Editor

A GP Clinical Editor, appointed by WAPHA, oversees the pathway localisation and development process. The Clinical Editor either writes a new pathway, or localises an existing pathway from another HealthPathways region. Pathways are developed in line with state and national clinical care guidelines, and consider the metropolitan and regional interface, and the needs of disadvantaged groups.

Working Groups

A Working Group is held when the development of a new stream of pathways commences, or when issues arise in the development of a pathway which requires health professionals and representatives from across the state to resolve and agree upon a solution. These Working Groups generally consist of: GPs, specialists, nurses, allied health, and relevant peak bodies or non-government organisations (NGO's). When a Working Group is held to initiate the development of a new stream of pathways, the Working Group identifies any issues in the current assessment, management or referral of those patients, and agree upon priority pathways for development within the stream. Several Working Groups may be held throughout the development process; the decision to hold a Working Group is at the discretion of the Clinical Editor.

Subject Matter Experts (SMEs)

SMEs are typically medical specialists; their role is to review the clinical content of pathways and provide feedback to the GP Clinical Editor. For some pathways there are multiple SMEs, and depending on the content of the pathway, the SME may be a nurse or an allied health professional. WAPHA works with HSPs to identify appropriate SMEs.

Single Authority Experts (SAEs)

SAEs are utilised instead of SMEs when:

- there are clear national or state guidelines related to the pathway;
- there exists an area of WA Department of Health with appropriate expertise and authority to sign-off on the pathway; or
- there is only one recognised expert in the field.

Guidance is sought from the HealthPathways WA Steering Committee & Advisory Group, which consists of representatives for WA Department of Health (WA DoH) and each Health Service Provider (HSP), on whether the identified SAE is appropriate. Pathways signed-off by SAEs do not undergo pathway consultation.

Pathway consultation

The current consultation process is conducted in conjunction with WA Health Networks, WA DoH. The pathway consultation periods are communicated via WA Health Networks to a database of WA DoH and HSP stakeholders, and individual Health Networks are also invited to provide feedback. The consultation is conducted on the HealthPathways WA Draft site, to enable users to see the layout and functionality of the pathways as well as the clinical content. All feedback provided in the consultation process is considered by the GP Clinical Editor, and changes are made as appropriate at the Clinical Editor's discretion.

Feedback on published pathways

In between a pathway being published and the pathway being formally reviewed, users of HealthPathways WA can submit feedback on published pathways at any time. This feedback is triaged by a clinician who escalates any relevant clinical feedback to the Clinical Editor. WAPHA maintains a register of all feedback received and actions taken. This process ensures that any changes in guidelines or clinical practice are communicated to the HealthPathways WA Team, and appropriate updates can be made.

Scheduled Review Process

Pathways enter the review cycle two years after publication, in order for the review to be completed within a three-year period. Feedback received on the published pathway and clinical guidelines are reviewed by the Clinical Editor, in consultation with a SME, where required. Where major clinical changes are made to the content, the pathway follows the existing consultation process for newly localised pathways. Minor changes are published without consultation. The reviewing GP Clinical Editor determines whether the clinical changes are major or minor.

Appendix 5: HealthPathways WA Diabetes Pathway Stream

Clinical pathways

Pathway Title	Subject Matter Expert and Pathway Reviewers	Content
Screening and Detection of Diabetes and Pre-diabetes	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes information who to screen, the investigations required and links to other useful pathways.
Pre-diabetes (IFG and IGT)	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes information on performing investigations for pre-diabetes, and appropriate management based on the result. Request section provides links to relevant education and support programs.
Pre-pregnancy Planning for Type 1 and Type 2 Diabetes	• Dr Emily Gianatti, Consultant Endocrinologist and Endocrine Lead of the Diabetes in Pregnancy Service, Fiona Stanley Hospital • Mark Shah, Nurse Practitioner – Diabetes, Perth Children's Hospital, and Co-Lead - Diabetes and Endocrine Health Network	Contains important management considerations for patients with existing diabetes who are planning to become pregnant. The request section outlines when to refer to appropriate diabetes in pregnancy services with links to relevant referral information.
Gestational Diabetes	• Dr Emily Gianatti, Consultant Endocrinologist and Endocrine Lead of the Diabetes in Pregnancy Service, Fiona Stanley Hospital	Includes the investigations and diagnostic criteria for gestational diabetes, and appropriate management strategies, with links to other useful pathways and referral information.
Newly Diagnosed Type 1 Diabetes - Adults	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Mark Shah, Nurse Practitioner – Diabetes, Perth Children's Hospital, and Co-Lead - Diabetes and Endocrine Health Network	Covers how to assess for type 1 diabetes and referral to specialist management, with links to pages of relevant services.

Newly Diagnosed Type 2 Diabetes	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Mark Shah, Nurse Practitioner – Diabetes, Perth Children's Hospital, and Co-Lead - Diabetes and Endocrine Health Network • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Assessment covers checking for red flags and considerations of secondary causes and rare genetic forms of diabetes. Management is extensive, and provides guidance on management to provide at initial appointments and follow-up appointments. There are links to other relevant pathways and pages with referral information.
Diabetes Medication Management	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes links to resources pages covering the major classes of hypoglycaemic agents, and the algorithm for lowering glucose in type 2 diabetes.
Glycaemic Control for Type 2 Diabetes	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Mandy Chan, Dietitian and Credentialed Diabetes Educator • Mark Shah, Nurse Practitioner – Diabetes, Perth Children's Hospital, and Co-Lead - Diabetes and Endocrine Health Network	Includes information on the four measures of glycaemic control. Assessment covers measuring HbA1C, determining a target HbA1c for each patient, and self-monitoring of blood glucose. Management covers ongoing monitoring, and lifestyle and medication considerations, with links to referral information as required.
Initiating and Titrating Insulin	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Dr Ashley Makepeace, Endocrinologist, Fiona Stanley Hospital and Fremantle Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Covers starting insulin in adults with type 2 diabetes.
Needle Phobia	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes information on assessing and strategies to overcome needle phobia.

Diabetes – Continuing Care	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes information on ongoing general practice diabetes management, and when to consider different diabetes services with links to relevant pages with service listings.
Diabetes Cycle of Care	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital	Includes information on the Diabetes Australia/RACGP recommended Cycle of Care for patients with Type 2 diabetes, and the minimum requirements to attract a Service Incentive Payments (SIP).
Diabetes Dietary Information	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Cathy Latino, Senior Dietician, Endocrinology Department, Fiona Stanley Hospital • Keely O'Keeffe, Diabetes Project Officer and Dietician, One Healthy Community • Mandy Chan, Dietitian and Credentialed Diabetes Educator • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes management information on considerations of healthy eating. Request section includes links to pages to find a dietitian or diabetes education.
Self-Monitoring Blood Glucose (SMBG)	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Dr Ashley Makepeace, Endocrinologist, Fiona Stanley Hospital and Fremantle Hospital • Mandy Chan, Dietitian and Credentialed Diabetes Educator • Mark Shah, Nurse Practitioner – Diabetes, Perth Children's Hospital, and Co-Lead - Diabetes and Endocrine Health Network	Includes information to guide GPs to enable patients to self-monitor their blood glucose levels. Request section includes consideration for diabetes education and specialist assessment.

	• Rohan Gay, General Practitioner, Walter Road East General Practitioners	
Eye Disease Screening in Diabetes	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Dr Carol Holden, Senior Research Fellow – Indigenous Eye Health Group, University of Melbourne • Michael Doyle, Optometrist, Bassendean Optical • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Provides guidance on who to screen and assess for diabetic eye disease, and how to manage and follow-up. Includes considerations for referral to optometry and ophthalmology.
Foot Screening in Diabetes	• Cara Westphal, Head of Department – Podiatry, Royal Perth Hospital • Dr Emma Hamilton, Consultant Endocrinologist, Fiona Stanley Hospital & Royal Perth Hospital • Jessica Harrison, Podiatrist, Royal Perth Hospital • Joanna Scheepers, Senior Podiatrist, North Metropolitan Health Service – Public Health and Ambulatory Care • Professor Paul Norman, Vascular Surgeon, Fremantle Hospital	Contains information on assessing a patient's foot health, and their appropriate risk category for ongoing management. Includes links to referral options based on the clinical need of the patient.
Renal Disease Screening in Diabetes	• Dr Hemant Kulkarni, Nephrologist, Royal Perth Hospital, and Co-Lead – Renal Health Network • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Covers assessment for and management of diabetic renal disease. Request section considers when to refer the patient for specialist assessments.
Elective Procedures and Diabetes	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Describes the management of patients with diabetes who are having procedures requiring fasting and sedation.

Older Patients with Diabetes	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	Includes information on assessment and management of diabetes in older patients with links to other pathways. Request section provides guidance on when to consider specialist assessments, aged care assessments, care coordination.
Hypoglycaemia	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Mandy Chan, Dietitian and Credentialed Diabetes Educator • Rohan Gay, General Practitioner, Walter Road East General Practitioners	How to assess and manage hypoglycaemia, with links to relevant service information.
Driver Assessment - Diabetes	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Rohan Gay, General Practitioner, Walter Road East General Practitioners	How to assess fitness to drive, management in relation to driving following hypoglycaemic events, and when to consider specialist review, with links to relevant services.
Insulin Education by Practice Nurse	• Dr Gerry Fegan, Head of Department – Endocrinology, Fiona Stanley Hospital • Mandy Chan, Dietitian and Credentialed Diabetes Educator • Rohan Gay, General Practitioner, Walter Road East General Practitioners	A pathway targeted at practice nurses to assist them with providing ongoing education on insulin to patients.
Insulin Pump Breakdown and Troubleshooting	• Dr Brett Sillars, Consultant Endocrinologist, Fiona Stanley Hospital • Mandy Chan, Dietitian and Credentialed Diabetes Educator	Covers patient assessment following an insulin pump breakdown and patient management while their insulin pump is unavailable, with links to pages with service information.

Service information [known as 'request' pages]

Pathway Title	**Content**
Acute Diabetes Assessment (seen within 7 days)	Lists public hospitals who are able to provide specialist management to patients with diabetes within 7 days.

Non-acute Diabetes Assessment (seen within 30 days to 1 year)	Lists public hospitals who are able to provide specialist management to patients with diabetes.
Diabetes Advice	Provides contact numbers for public hospitals who can provide specialist advice on diabetes management to GPs.
Diabetes Education	Lists providers that offer a credentialed diabetes educator service.
Hospital-based Diabetes Education	Lists diabetes education services at public hospitals, for complex or high-risk patients, or patients with gestational diabetes.
Diabetes in Pregnancy Services	Lists endocrinology services for pregnant patients with diabetes.
Multidisciplinary Foot Ulcer Team (MDFUT)	Lists public hospital foot ulcer clinics where a variety of allied health and specialists are involved in the patients care and treatment.
Comprehensive Foot Assessment	Lists public podiatry clinics and links out for private podiatry options.
National Diabetes Services Scheme (NDSS)	Provides information on how to register patients on the NDSS.

Appendix 6: HealthPathways WA Lifestyle and Preventative Care Pathway Stream

Clinical Pathways relevant to the inquiry

Pathway Title	Subject Matter Expert Involvement	Content
Healthy Eating	• Charlene Grosse, Manager Dietetics & Social Work, St John of God Subiaco Hospital	Includes guidance on assessing patients current dietary habits, and management to improve diet, including links to pages with appropriate services.
Nutrition Supplements	• Charlene Grosse, Manager Dietetics & Social Work, St John of God Subiaco Hospital • Deanne Beare, Dietician, 360 Health and Community	Provides general information on nutrition supplements, particularly oral nutrition supplements.
Metabolic Syndrome	• Krysten Blackford, Project Officer – Collaboration for Evidence, Research and Impact in Public Health	Includes information on how to diagnose and assess metabolic syndrome, with appropriate management options and links to pages with appropriate services.
Physical Activity - Adults	• Andrew Maiorana, Physiotherapist, South Metropolitan Health Service • Hazel Mountford, Physiotherapist, Sir Charles Gairdner Hospital • Sarah Amesz, A/Allied Health Professional Lead – Physiotherapy, Fiona Stanley Hospital	Includes information on assessing patient's suitability for physical activity and current physical activity levels. Outlines management information to encourage physical activity in patients, and options for referral to external programs.
Salt Intake	• Charlene Grosse, Manager Dietetics & Social Work, St John of God Subiaco Hospital • Deanne Beare, Dietician, 360 Health and Community	Contains information on assessing patients current dietary salt intake, and how to manage this.
Smoking Cessation	• Amy Hunter, Policy Officer, Tobacco Policy Team • Lorena Chapman, Make Smoking History Project Officer	Guidance to assess patients current smoking status, and willingness to change. Management involves brief interventions, pharmacotherapy, and specific management for high risk groups, with links to relevant service information.
Nicotine Replacement Therapy (NRT)	• Amy Hunter, Policy Officer, Tobacco Policy Team • Lorena Chapman, Make Smoking History Project Officer	Resource page on nicotine replacement therapy.

	• Dr Revle Bangor-Jones, Medical Advisory, WA Department of Health	
Weight Management – Overweight Adults	• Charlene Grosse, Manager Dietetics & Social Work, St John of God Subiaco Hospital	Contains information on assessing the patients weight history, lifestyle, risk factors and barriers to change. Management covers treatment options, behavioural strategies, and goal setting, for weight loss. Includes options for referral for weight loss support.
Overweight Older Adults	• Jillian Abraham, Senior Policy Officer, Obesity and Physical Activity and Nutrition, Chronic Disease Prevention Directorate, WA Department of Health	Similar to the 'Weight Management – Overweight Adults' pathway (above), but tailored to older adults.

Service information [known as 'request' pages]

Pathway Title	**Content**
Chronic Disease Support Services	Services that would benefit complex chronic disease patients or those who cannot self-manage their condition.
Healthy Lifestyle Support	These programs focus on preventative health and may assist with chronic disease prevention or management.
Community Exercise Programs	Lists general exercise and activity programs in the community.
Child Exercise and Healthy Eating Programs	Programs designed specifically for children that provide exercise and healthy eating education.
Older Adults Exercise Programs	Lists exercise programs specifically for patients aged ≥ 50 years.
Smoking Cessation Programs	Lists programs designed to assist patients to quit smoking.

phn COUNTRY WA
An Australian Government Initiative

11 December 2018

Dear Chris,

Thank you for your enquiry regarding general practice support in the Midwest Region.

In the Midwest, WA Primary Health Alliance team member, Kathleen Slootmans undertakes the role of Primary Health Liaison Officer (PHL), and through this position provides equitable and extensive support to the GP practices throughout the regions. Kathleen has been involved in general practice in the Midwest for the past 20 years and is well respected by doctors, nurses and practice managers.

Kathleen's role supports general practice in quality data improvement, accreditation, immunisation advice, promoting the RACGP Standards for General Practices (5th Edition), the use of Medicare Billing Schedule item numbers and the use of good quality practice standards for chronic disease management. This role is consistent across country WA, with PHLs supporting practices to achieve high quality patient care and outcomes.

During the 2018 calendar year, it is estimated that Kathleen has provided 220 face-to face visits, and all 26 practices within the Midwest have benefited. These practices include the outlying towns of Carnarvon, Kalbarri, Northampton, Mullewa, Dongara, Three Springs, Morawa, Meekatharra, Carnamah and Perenjori. As you can appreciate, there are vast distances being travelled and to further support general practice, Kathleen provides regular contact both by phone and email correspondence. This significantly increases the level of engagement to the GPs and their staff.

Of these 26 practices, 52% are signed up to Comprehensive Primary Care (CPC), a WAPHA initiative which advocates enhanced patient access to comprehensive, coordinated, evidence-based, interdisciplinary care. CPC provides comprehensive support to practices to improve their outcomes across the Quadruple Aim. 81% of all practices in the Midwest share data with WAPHA and monthly reports are provided to the practice to overview their patient demographics.

The Midwest team is consistently receiving positive feedback with regards to the Primary Health Liaison service and the commissioned services in the region. If I refer to the WAPHA Annual Report 2017, there are quotes from local GPs regarding a commissioned chronic disease service:

"The Integrated Chronic Disease Care (ICDC) program has assisted my patients greatly as it has reduced their travelling time and cost significantly. I have been pleasantly surprised by the uptake by patients who have otherwise not engaged in these services previously. As a result, my patients have a greater understanding of their chronic health conditions and are better placed to improve their ongoing health." Dr Sasha Risinger, Three Springs Family Practice.

"The new service has been a breath of fresh air since it was introduced to the Carnarvon Medical Centre. This has improved the personalised care provided to our patients with chronic disease. It has certainly pushed us closer to addressing their full range of needs and supporting them to self-care." Dr Nnaemeka Eze, Carnarvon Medical Centre.

Kathleen, Midwest PHL, has also received additional comments from GPs in the region:

Dr Adebola Adeiye of Morawa Medical Centre is very happy with the ICDC service. His patients feel the same as they like having the service come to them, meaning there is no need to travel to Geraldton.

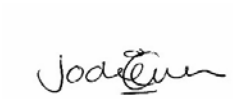
Dr Nalini Rao of Mullewa Medical Centre cannot talk more highly about the service and how it has assisted her and her patients suffering with a chronic condition, and she is a huge advocate for the program. It has truly assisted Nalini in providing good preventative healthcare to her more vulnerable Aboriginal patients. Nalini has also noted the financial rewards the practice has gained from having the service located within her practice.

ICDC services are delivered by local partner organisations to provide care coordination and allied health support to vulnerable and disadvantaged clients with chronic health conditions. These services operate in 'hot-spot'[1] areas across country WA.

The use of Telehealth is embedded into the ICDC program. Noting that WA Primary Health Alliance and WA Country Health Service jointly fund Diabetes WA and the Asthma Foundation for Telehealth services, which support all Country WA PHN locations. A Health Navigator service provided by Silver Chain, is also part of the ICDC program in the Wheatbelt, Great Southern and South West regions.

The role of the PHL, and the services commissioned by WAPHA in the Midwest region are highly endorsed by general practice, with Kathleen and the other Midwest WAPHA staff working to the top of their skill set every day to support all practices, their programs and clients in the region.

Yours sincerely,



Jodie Green
WA Primary Health Alliance
Country Operations Manager

[1] – Hot-spot areas identified in 'Lessons of Location' as areas with consistently higher rates of potentially preventable hospitalisations.

MEDIA RELEASE

Thursday 6 December 2018

NEW NATIONAL NUTRITION POLICY IS THE KEY FOR FUTURE HEALTH

The Dietitians Association of Australia (DAA) calls for a New National Nutrition Policy, to unlock practical solutions to many of the 22 recommendations handed down by the Select Committee into the Obesity Epidemic in Australia.

Robert Hunt, Chief Executive Officer (CEO) of DAA said, "dietitians across the country applaud the committee's recommendations. As the only professional body with skills in both nutrition and dietetics, DAA looks forward to being an essential member of the National Obesity Taskforce."

Written over 26 years ago, the National Nutrition Policy addresses the contribution of food and nutrition in reducing the rates of diet-related chronic disease, such as heart disease, obesity, Type 2 diabetes and cancer. Importantly, it integrates the impact food security has on nutrition, which considers food access and supply for our most vulnerable populations. This policy provides the framework to design national healthy living initiatives and ensures these are conducted in a co-ordinated way, that is relevant and culturally appropriate for both the current and future population.

DAA welcomes the recommendation to review the Australian Dietary Guidelines every five years, as a key element of the National Nutrition Policy, ensuring the dietary guidelines regularly evolve and provide public confidence in ways to undertake healthy eating.

Hunt also highlights the solution lies in empowering personal behaviour change. However, investing in programs such as the Medicare Chronic Disease Management scheme is imperative to ensure Australians are able to access adequate individualised support from Accredited Practising Dietitians.

"The recommendation for obesity to be included as a medical condition under the Medicare Chronic Disease Management Scheme is promising. However, within this scheme, Australian's are only provided five services per year to access 13 different allied health practitioners. Increasing the number of dietetics services that Australians can access under this scheme, including an option for telehealth services to boost access for rural and remote Australians, would be a step in the right direction," said Mr Hunt.

"The committee's recommendations are the first step to tackling the obesity epidemic and provide the practical solutions to future proof the health of all Australians. Having a current National Nutrition Policy and investing in strategies that support lifestyle change will further strengthen the impact of these recommendations, "Mr Hunt said.

Dietary interventions make a real difference, and Accredited Practising Dietitians are here to support Australians to live healthier lives.

ENDS

For further information or to organise an interview with Robert Hunt, contact Pattie King, Dietitians Association of Australia, on 0409 661 920.

Note to Editors: The Dietitians Association of Australia (DAA) is the professional body representing dietitians nationally. Accredited Practising Dietitian (APD) is the only national credential recognised by the Australian Government, Medicare, the Department of Veteran Affairs and most private health funds as the quality standard for nutrition and dietetics services in Australia. For more information visit **www.daa.asn.au.** For the Media section on the DAA website contains DAA's media releases and position on topical nutrition issues in the media.