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| DecorativeDiabetes prevention  16450 |
| Outcome objective: Victorians are healthy and well  Output group: Public Health  Output: Health advancement |

# 1. Service Objective

Diabetes prevention seeks to contribute to halting the rise in diabetes prevalence. There is a target contained within the Victorian Public Health and Wellbeing Outcomes Framework.

# 2. Description of the service

To undertake primary and secondary prevention initiatives aimed at reducing the number of people in the Victorian community developing type 2 diabetes and cardiovascular disease.

# 3. Client group

The client group this activity is targeted at Victorians with modifiable risk factors of chronic disease. In 2018-19 the eligibility for the Life! program includes Victorian adults (18 years or over) with one or more of the following:

* AUSDRISK score ≥ 12 and BMI ≥ 25 or Absolute CVD risk of ≥ 10% when referred by a GP clinic.[[1]](#footnote-1)
* Have previously been diagnosed with:
  + impaired glucose tolerance (by FPG, OGTT or HbA1c)
  + polycystic ovary syndrome
  + gestational diabetes
  + familial hypercholesterolemia
  + moderate or severe chronic kidney disease (persistent proteinuria or eGFR <45 mL/min/1.73 m2)
  + total serum cholesterol > 7.5mmol/L
  + systolic BP of ≥ 180mmHg or diastolic BP of ≥ 110mmHg.
  + cardiovascular disease (including myocardial infarction, angina and angioplasty)
  + \*NB The Absolute CVD Risk Calculator will only be performed by GPs for patients 45 years of age or over (35 for Aboriginal and Torres Strait Islander people).

# 4. Obligations specific to this activity

In addition to the obligations listed in the Service Agreement, organisations funded to deliver this activity must comply with the following:

## 4a. Registration and Accreditation

* Compliance with obligations in the Service Agreement.

## 4b. Program requirements and other policy guidelines

* [The Victorian Public Health and Wellbeing plan](https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan)

<https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan>

* Service delivery requirements document developed and agreed to by the department and Diabetes Victoria.

# 5. Performance

Funding is subject to achieving the performance targets specified in Schedule 2 of the Service Agreement. Performance is measured as follows:

## Key performance measure 1: Report against agreed objectives

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| Aim/objective | The performance measure provides data on actual participation in program delivery for the Life! program. |
| Target | The performance measure target is provided in the Service Agreement |
| Type of count | Cumulative  Non-cumulative |
| Counting rule | BP3 – health advancement - 5,616 – the number of participants completing the Life! diabetes and cardiovascular disease prevention program. This is a direct measure of program throughput. |
| Data source(s) collection | Quarterly reporting of actual participant data or as otherwise specified e.g. project specific data. |
| Definition of terms | The measure for completing the Life! program is agreed as group course session one or telephone health coaching initial call.  In accordance with the Policy and Funding Guidelines, funding will be recalled for participant target not met. |

# 6. Data collection

The reporting requirements for this service are:

| Data collection name | Data system | Data set | Reporting cycle |
| --- | --- | --- | --- |
| Salesforce CRM | Cloud-base CRM | *Life!* program data including participant minimum data set, participant and workforce profiles, invoicing etc | Monthly, quarterly and annually |
| Project specific data collection – 12 month session pilot | Excel spreadsheet | 12 month session pilot for Group course and THC participants | Monthly, quarterly |
| Project specific data collection – priority engagement BHC/ Life! webpage | Google analytics- dashboard | Life! on Better Health Channel – Life! participants | Ad hoc. |

Life! program participants are working to reach five lifestyle modification goals:

1. Decrease weight by five per cent
2. Decrease the amount of total fat; no more than 30 per cent of energy from fat

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1. Decrease the amount of saturated fat; no more than 10 per cent of energy from saturated fat
2. Increase the amount of fibre; aim for at least 30 grams every day
3. Decrease the amount of sodium (salt) consumed; no more than 2300mg of sodium (about 6g) per day.

1. 45 years or more (or ≥ 35 years and of Aboriginal and/or Torres Strait Islander descent) and have an Absolute Risk score of ≥10% when referred by a General Practice clinic. [↑](#footnote-ref-1)