How do you measure up

Australian Better Health Initiative
A joint Australian, State and Territory government initiative.

Case Study: Chronic Disease Prevention and Management and the "Measure Up" Campaign

Case study - Diana

Diane is a **46 year old** mother who works part-time. Diane has made an appointment to see her practice nurse for her regular pap smear. She has seen the 'Measure Up' campaign advertisements on the television and after measuring her waist, feels she may be at risk. She eats fruit and vegetables daily, however rarely undertakes any physical activity. Diane is a non-smoker.

The practice nurse takes Diane's pap smear and during the same consult, measures her blood pressure. Diane's blood pressure is 140/ 95, her height is 1.74m and her weight is 85kg (BMI =28). She has no history of high blood sugar levels; however her father does have type 2 diabetes.

Some suggestions for the next steps….

1. The practice nurse identifies that Diane may be at risk of developing a chronic disease due to her current lifestyle and family history. The practice nurse can discuss with Diane her risk of developing type 2 diabetes and suggests Diane complete the Australian Type 2 Diabetes Risk Assessment* (AUSDRISK) tool. This tool will indicate the risk of Diane developing type 2 diabetes within the next five years.

The column on the left indicates the outcomes of Diane's assessment against the AUSDRISK tool.

As Diane has a waist circumference of more than 100cm, this gives her a "**High Risk**" score on the AUSDRISK tool. Diane has seen the Measure Up campaign, she has a basic awareness of the correlation between waist measurement and risk of chronic disease.

2. The practice nurse can discuss the results of the AUSDRISK tool with Diane. If Diane is ready to make some changes to her lifestyle, the following tools are available to support Diane, the practice nurse and the GP in this process:

AUSDRISK TOOL

Age
2 points
Gender
0 points
Ethnicity
0 points
Diet
0 points
Exercise
2 points
Family History
3 points
Blood Pressure
2 points
Waist (cm)
7 points

SCORE =16

- **MBS item 713 (the Type 2 Diabetes Risk Evaluation)** this item allows a GP to assess the factors contributing to Diane's high risk score and consider referring Diane to a **Lifestyle Modification Program** run through the local **Division of General Practice.**
- **MBS item 717 (the 45-49 year old health check)** to assist in the prevention and early detection of chronic disease and support Diane to make healthy lifestyle changes. Diane can also be referred to a **Lifestyle Modification Program** under an item 717 as she has a high risk score on the **AUSDRISK.**
- **Lifescripts Resource Kit** to support the GP in providing lifestyle modification advice.
- **www.australia.gov.au/MeasureUp** website has further information and helpful tips to support change.
- Contact the local **Division of General Practice** who can provide a list of local services and referral pathways to support Diane in taking actions to reduce her risk.

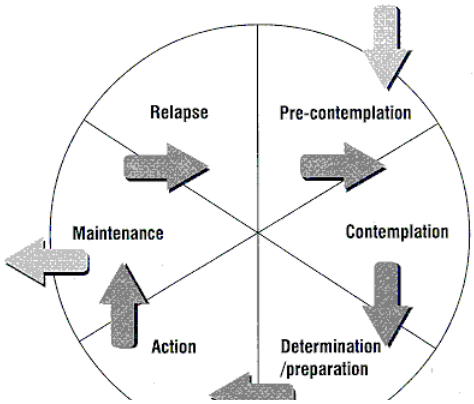
*AUSDRISK tool is available to download from:
www.health.gov.au/epc by clicking on "Type 2 Diabetes Risk Evaluation"
Here you will find the PDF:
"Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)"

Utilising the 5A's to Support Preventative Activities in General Practice

ASK and ASSESS

Body mass index (BMI) and adult waist circumference should be measured every 2 years for those patients who appear over or underweight. Weight alone may be used to monitor the patient at follow up. Blood pressure should be measured on all patients over the age of 18 years.

Assess the patient's readiness to change - the patient's motivation to lose weight should be assessed to better target advice. **The Stages of Change Model** can be used as a guide to assist in this assessment.



Stages of Change Model

ADVICE and ASSIST

Advice should be tailored to the degree of overweight. Patients who are overweight or obese should be offered individual education and skills training.

The **Lifescripts Resource Kit** provides General Practice with the tools to complete an individual assessment and provide tailored advice.

What dietary advice should be provided?
Reduce total energy intake over time. This should involve reduced fat, high sugar drinks and food. The size of food portions should be reduced.

What physical activity should be recommended?
Any increase consistent with the patient's medical condition should be encouraged. This should start with moderate physical activity.

What should the goals for weight loss in adults be?
The goals should be to achieve a sustainable weight reduction (1–4 kg per month in the short term, 10% of initial body weight in the long term).

ARRANGE

People suffering from obesity should have long term contact with, and support from health professionals. Multidisciplinary care from appropriate services or an allied health professional such as a dietician is recommended, especially in complex cases and in patients with morbid obesity.

Eligible patients should be offered a referral to an accredited **Lifestyle Modification Program** under item 713, item 717 or item 710. Contact your local division for more information.

FOLLOW UP

Patients should be reviewed after 2–3 months to help increase the chance of sustaining lifestyle changes over the long term. The practice information system can generate reminders or lists of patients overdue for follow up.

Emphasis at follow up should be on sustained change in diet (and physical activity) rather than on repeatedly measuring weight (unless otherwise indicated for specific diseases such as diabetes). Relapse and weight gain are common.

The 5A's form part of the RACGP SNAP Guidelines. The above information has been adapted from the Guidelines.