Government of **Western Australia**
Department of **Health**

# Evaluation of the Healthy Lifestyle Program (2016 - 2019)

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# Contents



# 1. Executive Overview

The evaluation of the Healthy Lifestyle Program (HLP) 2016-2019 report was prepared by Dr Michael Rosenburg in September 2019, this is a summary of that report.

The HLP commenced as a pilot program in 2008 as a participant-centered support program providing practical support for people who were recently diagnosed, or at risk of developing diabetes or cardiovascular disease delivered through four Medicare Local sites (previously Divisions of General Practice) across the Perth metropolitan area.

In 2012 the program expanded to Fremantle and Mandurah areas and focussed on people at risk and newly diagnosed with type 2 diabetes, coronary heart disease and chronic kidney disease. In 2015, the program was re-launched as the Healthy Lifestyle Program (HLP) with the delivery of services contracted to the two primary health service organisations that were successful at the tender. These services offer a lifestyle intervention to community members at risk of heart disease and type II diabetes, as well secondary prevention and chronic pain management across the Perth metropolitan area. Each primary health service organisation offers services tailored to their business and participant needs. There is no cap of the number of services accessed by participants in the HLP. On average participants access 2.5 sessions per year across the program. This evaluation presents findings on the program's clinical, social return on investment and sustainability options between January 2016 and June 2019.

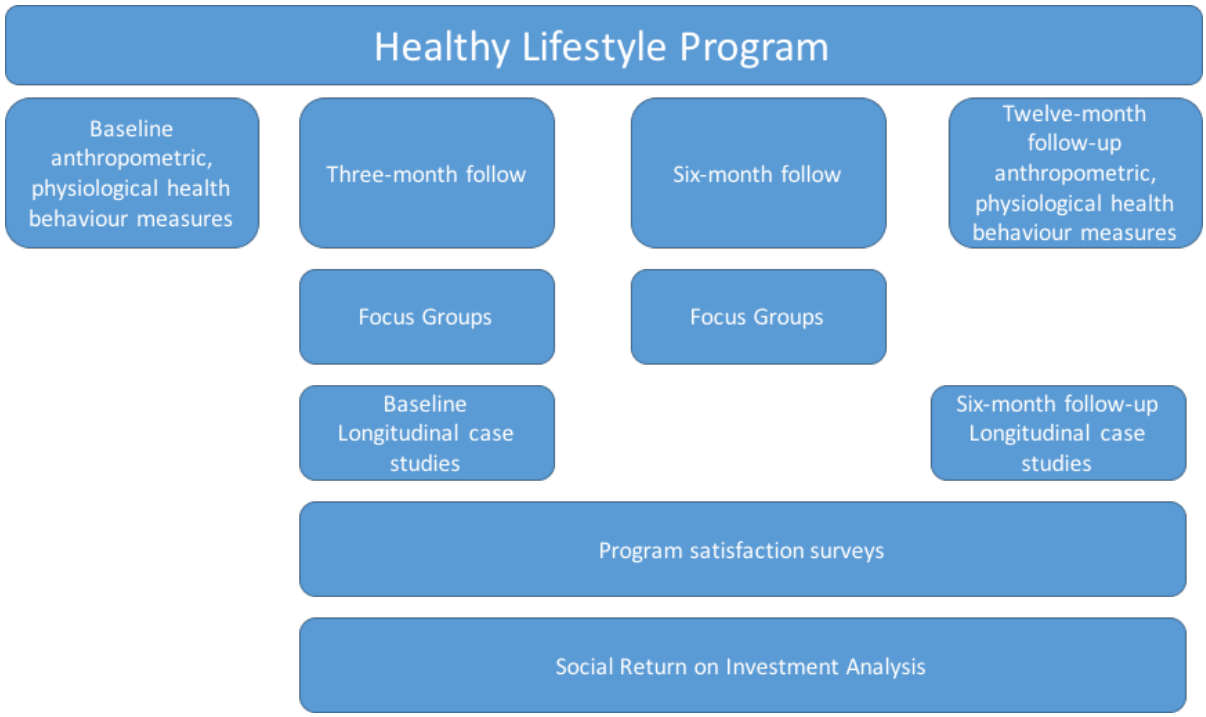
The current agreement consolidates the program and builds on intervention strengths as identified in the previous evaluation findings. The current contract includes participant assessment of need, care planning, facilitation of access to required services and participant follow-up whilst keeping the participant and GP central to care.

## 1.1 Evaluation Methods

The overall evaluation of the HLP comprised several components measuring the delivery and impact of the program over the 5 year duration of the funding (Figure 1).

Figure 1 shows how the main components of the evaluation were designed to measure the delivery and impact of the HLP. The evaluation of HLP involved the collection of data by both the HLP project team, and external evaluator.

***Figure 1:*** *Overview of HLP evaluation*




1. ***A qualitative investigation to understand the HLPs impact on participant health and wellbeing.***

A series of focus groups and interviews were held with HLP participants, stakeholders and general practitioners to generate feedback about the Program.

2. ***Sustainability of the HLP***

This included qualitative investigations of the service providers, income and expenditure. Interviews with stakeholders and exploration of potentially sustainable models.

3. ***Clinical Data 2016 - 2019***

Participants that enrolled in the HLP completed a baseline and 12-month follow-up health assessment (Anthropometric, physiological, attitudinal and behavioural). Depending upon the primary health service organization, a 3 and 6-month interim health assessment was also conducted.

4. ***Longitudinal Case study***

Longitudinal case studies of participants' journey through HLP were conducted to explore the participant experience and stakeholder and general practitioner program satisfaction surveys.

5. ***Social Return on Investment***

The purpose of the project was to explore longer term sustainability models for the HLP program and the potential longer term commitment of the DoH and Service Providers.

# 2. Results

## 2.1 A qualitative investigation to understand the HLP's impact on participant health and wellbeing.

The following recommendations for the HLP are highlighted below:

- It is recommended that the HLP continues to offer services determined by each primary health service organisation , as overall patient experiences are similarly positive. This approach is the most likely to result in sustainable ongoing service provision.
- The HLP is unique and provides a valuable service to people most at risk of continuing unhealthy lifestyles and the subsequent health related consequences. It is recommended that working towards sustainable models of care provision for the HLP is a priority. This includes both public, private and user-pays funding options.
- There exist a small number of patients for which the HLP does not appear to appeal or benefit. It is recommended that providing a mechanism for these participants to express their views could be created, as well as care pathways that provide early exit and alternative strategies for these participants. This should not penalise the patient or service provider, but free resources that can be directed towards participants that will benefit most from the Program.
- It is also recommended that extended follow-up opportunities be explored to help increase the beneficial effects of the Program. This may include periodic assessments, or group gatherings, that may require additional funding, and can potentially reduce any decay back to unhealthy lifestyles.

## 2.2 Sustainability of the Western Australian Health Lifestyle Program

The following recommendations regarding sustainability of the HLP are highlighted below.

- Clarify that the primary target audience intended to receive HLP funding, and whether prevention and/or management of chronic disease is the priority.
- Determination of the number of participants or services to be offered through the HLP, and the role of MBS funding within the program.
- In consultation with service providers, determine the most suitable delivery model, from those presented, to achieve program goals. It is also recommended that the DoH consider how to direct HLP funds towards primary prevention and MBS funds towards secondary prevention.
- In consultation with service providers, develop sustainability objectives and strategies to support development of a sustainable HLP within an agreeable timeframe.

## 2.3 HLP Clinical Data 2016 - 2019

A wide range of data were collected on each participant by the HLP. Broadly these related to participant program interaction, anthropometric, biomedical, and health related attitudinal and behaviour measures. The combined HLP participant database contained details for 5484 people who had contact with the program from January 2016 to May 2019.

- The majority of HLP participants were over 40 years of age, with about one third over the age of 65 years.

- Participants recruited into HLP were observed to be at risk of chronic health conditions, with almost all having elevated BMI, HBA1C, and Triglyceride levels, however, HLP participants were more commonly observed to have healthy blood cholesterol, HDL and LDL measures.
- Approximatively 80 per cent of participants recorded baseline measures, around 40 percent had at least one measurement at 3 months with approximately 1 in 10 participants not completing the 12 month follow-up assessment. Rolling recruitment may partly explain the lag in follow-up measures though further investigation is warranted. Despite the small number of follow-up assessments participants were similar on most key variables, suggesting no systematic reason for loss to follow-up in the HLP.
- Overall data suggests that people who initiated and remained engaged with the program for at least a 3 month period, had a positive healthy lifestyle change in anthropometric, clinical markers and health related behaviours occurred.

## 2.4 HLP Longitudinal Case Study

Between June 2017 and Jun 2019, 200 HLP participants were randomly selected and invited to participate in a baseline and follow-up telephone survey six months apart. A total of 182 HLP participants completed the baseline survey (92 per cent) with 133 participating in the follow-up survey (73 per cent).

- Results of survey showed small positive changes in participants health behaviour, social, emotional and mental wellbeing. Results also suggest greater adherence to medication amongst HLP participants.
- The most common referral pathway to enrol in the HLP was through the GP.
- The majority of HLP participants made small changes across a large number of areas, when accumulated showed a positive overall effect. Most HLP participants did not currently smoke or drink alcohol, with little influence of the HLP on these behaviours over the 6 month period.
- Majority of HLP participants did visit a dietician during the six month follow-up period. Relatively minor changes were self-reported including increased consumption of fruit. There was no change noted in fast food consumption from baseline to follow-up with the HLP participants.

## 2.5 Social Return on Investment

The following recommendations for the HLP are highlighted below.

- HLP has evolved into a mostly individual tailored primary and secondary prevention service, with two revenue funding streams. Sustainability of the HLP may involve the continuation of the overall service, or aspects that offer the greatest return.
- A decision on the proportion of primary and secondary prevention participants that are funded from the DoH portion of the HLP funding is required.
- The majority of HLP participants are the most at risk population group. In the longer term there may be increasingly greater consideration for the type of participant that is enrolled in HLP. Decisions on the key target group should include an assessment of alternative service options for community members.
- The current HLP model relies on two service providers to deliver all the services. There may be merit in devolving the program funding directly to general practices where the majority of patients already visit.

- The need for the program within the community exceeds the funding available for the HLP. Any growth in the program is likely to occur through the ability to raise additional revenue through the MBS or fee-for-service models. Alternatives through sponsorship, or other government funding may also be possible.
- An optimal investment point is required to ensure that HLP funding is transparently directed towards the intended target group.
- Technology based solutions may increase the management, monitoring and outcome of HLP participants. Consideration around the investment in complimentary solutions to aid sustainability of the program is warranted.

# 3. Program Effectiveness

Overall, evidence from multiple evaluations have consistently shown the benefits of the HLP to community members, service providers and the public purse. The clinical data from the HLP provides evidence that changes in participants BMI and health behaviours continue to improve significantly across multiple iterations of the program. In addition to the direct health benefits of the program, focus group findings provide evidence of broader social and emotional support derived from the HLP that support participants change their lifestyles and extend the benefits of the program.

The effectiveness of the HLP has resulted in many community members accessing services and changing their lifestyles that had not happened previously and was potentially unlikely to have occurred. If participants maintained engagement in the HLP they were likely to accrue significant positive health benefits, with benefits observed amongst participants that remained engaged for as little as three months. Participants who remained engaged for a six month period would appear to accrue the greatest benefit, but they also seem to leave the program after that point and there is no further data on the sustainability of their lifestyle changes.

The economic benefits of the HLP have been shown to provide an overall benefit to the Department of Health and potential saving to the public purse. The most recent evidence is from an SROI analysis showing that in addition to the economic cost-effectiveness of the program there is a measurable social value generated. The SROI revealed that many of the mental wellbeing and social activities captured in participant focus groups materialised into measurable changes that when assigned a financial proxy suggest that for every dollar invested approximately $3.70 is returned in social value.

When SROI assumptions (client numbers, lifestyle change decay, attribution to the HLP) were tested, the social returns remained positive. The SROI analysis suggests the HLP is a robust intervention in terms of the direct health benefits from lifestyle changes, but also pastoral care and support that generate social and mental wellbeing that has historically been difficult to capture and value.

Considering the economic and social value generated from the HLP it remained beyond the scope of the evaluation to separate individual component of the HLP into contributing factors. As such, it is not possible to surmise the contribution of any clinical service or individual versus group approach delivered by the HLP. The tailored nature of the program with resources available to each service provider and the needs of participants is considered in totality. Nonetheless, one component of the HLP that remains constant in the program, is the clinical care coordinator. Focus group feedback from participants, the sustainability options available, and the clinical data all identify the coordinator position as central to any positive HLP outcome.

## 3.3 The HLP Target Group

The recruitment of HLP participants and their progression through the program is central to the observed and potential benefits of the program. It is also the most challenging aspect of the

current HLP iteration, with less than 15% of participants recording a 12 month follow-up assessment and even fewer completing a full assessment, including blood related risk markers where risk factor profiles can be more definitively determined. It is possible that participants returned to the care of their GP prior to completing the 12 month follow-up, as that is the likely referral pathway into the program, although this information is currently unavailable.

This evaluation report presents data gathered from participants enrolled in the HLP between January 2016 and May 2019. A total of 5484 people were referred to the HLP. The typical participant in the HLP was over 40 years of age, with about one third over 65 years of age. The majority of participants who had contact with the program were referred to HLP services through their GP. Participants recruited into the HLP program were observed to be at risk of chronic health conditions, with elevated BMI, HBA1C and triglycerides, but with normal blood pressure, cholesterol, high-density lipoprotein (HDL) and low-density lipoprotein (LDL) markers. This risk factor profile suggests some intervention has already occurred, likely through prescription medication to mediate the negative effects of a poor lifestyle. Participants within the HLP were clearly in the at risk category, with the challenge remaining on whether they are the group who will benefit most from the program.

### 3.4 Sustainability of the Program

The HLP is offered as a tailored lifestyle program to participants referred typically through their GP. Depending on their service provider participants were provided an initial consultation to determine their requirements and scheduled services based upon their needs. Encouraged to move to a sustainable funding model, service providers have become more reliant on chronic disease management plans and team care arrangements. As a consequence, referrals through GPs dominate the referral pathway, and may potentially limit participants to people who have accessed a general practitioner and a consultation that included chronic disease prevention or management. Management Care Plans and Team Care arrangements allow access to public funds through the use of Medicare rebated items that can be used to bulk bill participants. As a consequence of the changes in the funding incentives, participants of the HLP remain at risk or are managing chronic disease but may be of greater capacity to access existing services. It remains unclear from the available data whether a shift in participant demographic has occurred. There does however appear to be a shift in the incentive for the service providers to modify their practice.

To deliver the HLP, service providers employed allied health providers and delivered services in house. This approach increased the number of participants that could be serviced with appropriate services and increased the likelihood of a sustainable program. One consequence of this approach was to potentially shift participants towards community members with greater capacity to access the services. Another consequence of the shift towards people on care plans is that initial appointments can become critical to program sustainability and the expense of ensuring adequate follow-up. It potentially favours people who are more self-motivated to attend appointments. The sustainability models presented in this evaluation suggests that the funding source influences the type of participant that can access the HLP and therefore the risk profile of those who may benefit.

There remains uncertainty on the merits of the current incentivise structure as a public purse investment. A number of potential sustainable options remain available to the service providers and Department of Health that could incentives service provision to different at risk populations.

However, the results of this evaluation highlight the difficulty in distinguishing between whether the primary target group is community members at risk of developing a chronic condition, or community members struggling to manage their chronic condition.

## 3.5 Conclusion

The primary purpose of an evaluation is to judge the value or worth of something. Equally important is that value is established by a standard or acceptable criteria. By most standards of acceptability in behaviour change interventions, the HLP has demonstrable health, social and economic value. The challenge for those funding and delivering the HLP is whether the community members who would benefit most from the HLP are able to access the service. The evidence from this and previous evaluation suggests that recruitment into the HLP does reach at risk populations, although the granularity of the at risk population may be too large. As the program has evolved, particularly embracing Medicare rebated services, the participants who accessed the HLP may be different from previous cohorts. It is likely that if the current approach continues, the HLP will offer more Medicare rebated services, partly underwritten by funding from the DoH and focus on management of chronic disease over their early intervention. Without DoH funding, the HLP is likely to end as a service, the consequences of which are hard to predict given how the program has evolved. The overall conclusion from the evaluation of the HLP is that positive gains in the health of at risk Western Australians has been made through the investment in the HLP over many years and these have been demonstrated through health, social and economic returns. Several recommendations are presented below to assist the Department of Health in future procurement planning.

## 3.6 Recommendations

- There remains social and economic value in supporting the HLP, although sustainability of the program is likely to require ongoing DoH support. It is recommended that a decision on the participant profile who can benefit most from lifestyle modification support is considered by the Department of Health. Consideration should be made of the balance between the risk profile of participants accessing services supported by Medicare rebated items and services offered through the DoH funding.
- It is recommended that the participant profile of HLP be revisited and clarification is required around the eligibility of participants into the HLP and definitions of “at risk” and “in need’ of the service. Consideration should be made in eligibility assessments in relation to propensity to access services, or another indicator of potential benefit beyond anthropometric and blood biomarkers.
- The proportion of HLP participants failing to complete follow-up assessments remains challenging. To ensure there exists a clear incentive to retain participants, it is recommended that funding based criteria are established around participant retention in addition to recruitment.
- It is recommended that the economic and social benefits of the HLP demonstrated through this evaluation are built upon in any future offerings of the HLP. This might include requiring measurable outcomes relating to the mental and social wellbeing as well as the existing clinical health measures.
- Finally, it is recommended that to maximise any future investment in the HLP, or similar programs the DoH targets its investment at community members at risk of developing a chronic disease, who are of high disadvantage and who enter the program without a GP referral, not those currently in a management care plan.

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