

NSW Get Healthy Information and Coaching Service[®]

The first five years 2009 - 2013



Health





“

“We do a lot more as a family now, especially with the kids... I am not embarrassed to get into a swimming costume, I feel more comfortable.”

WENDY



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SECTION ONE: BACKGROUND

In February 2009, the NSW Ministry of Health launched the NSW Get Healthy Information and Coaching Service® (GHS; www.gethealthynsw.com.au), as a key initiative under the Australian Better Health Initiative¹ and the National Partnership Agreement on Preventive Health².

The GHS is a free telephone-based service supporting NSW adults to make sustained improvements in healthy eating, physical activity and achieving or maintaining a healthy weight. Since its introduction, the Service has been expanded to be offered to a number of other jurisdictions across Australia.

The GHS targets those adults in the community most at need, due to their risk of chronic disease and seeks population level reach to maximise its public health impact.

Priority groups include



Aboriginal
people



Culturally & linguistically
diverse communities



people from
low socio-economic
areas



and those living in
remote, rural & regional
areas
of NSW



people at risk of
diabetes



ELIZABETH'S Get Healthy Story

Having gone through breast cancer and losing her mother 3 months before, Elizabeth found she had become an emotional eater. Also suffering from different ailments like ulcers and nausea Elizabeth decided when she could no longer do up her trousers, it was time to change.

"Going through chemotherapy, my diet wasn't very good and the treatment did some weird things to me."

Leading a fairly inactive life and indulging in the wrong foods prior to the program, Elizabeth often experienced bad reflux and aches and pains throughout her body. Since joining the program she has lost 6 kilograms and leads a much healthier lifestyle with her husband.

Elizabeth enjoys cooking healthier meals and is trying to get her husband to eat more fish by cooking salmon at least once a week. She also encourages him to step outside and go for a walk. Since completing the program Elizabeth does not suffer from bad reflux anymore, her general aches and pains have improved and she is more mobile around the house.

During the first 5 years from 2009 to 2013 the GHS was provided by Medibank Health Solutions on behalf of the NSW Ministry of Health and from 2014 the service will be provided by Healthways Australia.

1.1 Get Healthy Service levels of service

The GHS includes two levels of service³:

1. **6 month coaching program:** Includes 10 individually-tailored calls provided by university qualified health coaches based on behaviour change/self-regulation principles designed to assist with goal setting, maintaining motivation, overcoming barriers and making sustainable lifestyle changes⁴. Coaching calls are provided on a tapered schedule, with a higher intensity of calls occurring in the first twelve weeks of the program to promote initiation of behaviour change, and less frequent calls during the latter fourteen weeks to promote maintenance and prevent relapse⁵. Printed support materials are also provided. Participants can cease coaching at any time during the 6 month program and can also re-enrol in the program after completing the six months.
2. **Information-only:** Provides an evidence-based printed information package on healthy eating, physical activity, and achieving or maintaining a healthy weight, consistent with the Australian Guide to Healthy Eating⁶ and National Physical Activity Guidelines^{7,8}. In addition to the package, a one-off information and advice session on these topics is available to participants at the time of the call.

1.2 Get Healthy Service medical clearance

Callers enrolling in the coaching program undergo medical screening via a telephone survey, and callers with any issue of potential concern are referred to their General Practitioner (GP) to obtain medical clearance before coaching can commence. In May 2012, the medical screening process was revised to exclude

breastfeeding and recent hospitalisation as an indicator for GP clearance, in order to facilitate a greater number of participants joining the coaching program without requiring GP clearance.

1.3 Get Healthy Service enrolment and recruitment

Adults aged 18 years and older can enrol in the GHS using a free call phone number or via the website. Potential participants are recruited to the Service via two primary methods:

1. **Self-referral:** Mass media and local promotions
2. **Secondary and other referral:** General practitioner and other health care providers' referral and direct marketing to targeted households that includes a letter of introduction to the Service.

1.4 Get Healthy Service modules and additional components

GHS Aboriginal program: In November 2012, an enhancement to the GHS for Aboriginal people commenced. All Aboriginal participants receive Aboriginal-specific resources and three extra coaching calls in the first half of the program. The program was developed following formative research and focus testing with GHS Aboriginal participants, Aboriginal adults and Aboriginal Health organisations.

Type 2 Diabetes Prevention Module: In July 2013, the GHS launched a type 2 Diabetes Prevention Module to address the high burden of disease from this chronic disease. All GHS coaching participants aged over 40 years and all Aboriginal participants are screened using the AUSDRISK tool⁹ and if their score is 12 or over they are allocated to this module. Participants in this module also receive three extra coaching calls focussed on individual risk for type 2 diabetes at the start of the program. This module is based on the Sydney Diabetes Prevention Program¹⁰, an effective face-to-face program for type 2 diabetes prevention.

Since the introduction of the **Type 2 Diabetes** Prevention Module on **1 July 2013**, there have been

937 adults allocated to this module following screening using the **AUSDRISK tool**





“

“My husband eats a lot better, not a lot of junk, but if he indulges I can say no and not let it worry me which makes me feel better in myself.”

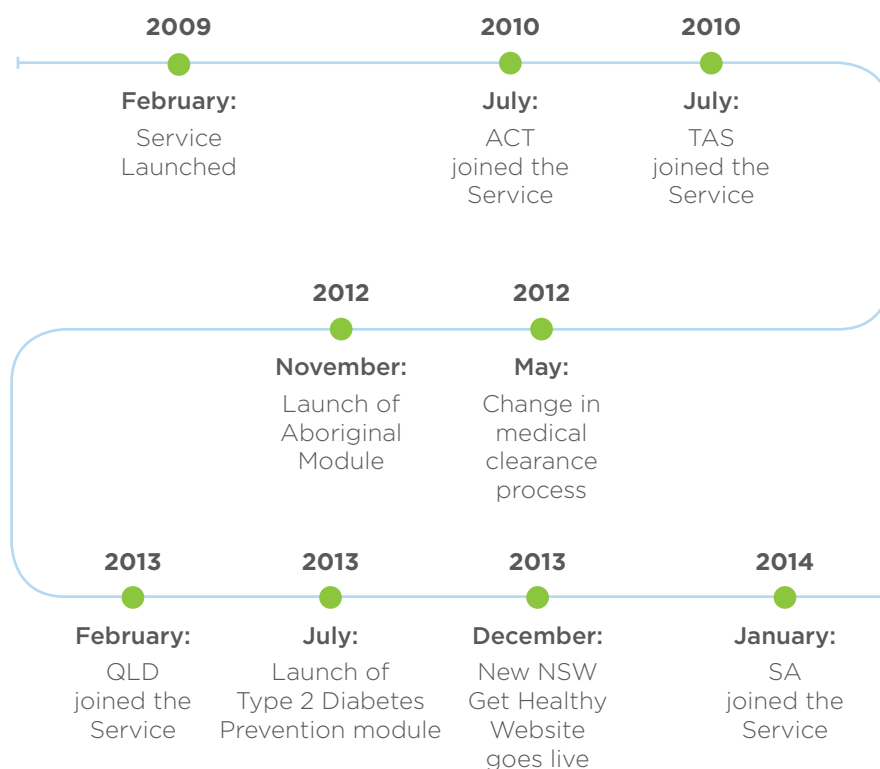
ELIZABETH

1.5 GHS evaluation framework

The evidence base from systematic reviews has confirmed that telephone-based interventions are effective in increasing physical activity, improving nutrition and reducing weight in the short to medium term (three–six months) across different populations, in a range of settings, and using different intervention modalities^{11, 12}. The GHS provides a rare example of the translation of this research into population wide dissemination^{12, 13}. Accordingly, the primary goals of the GHS evaluation framework are to assess the process of implementation, the reach and the impact of GHS¹⁴. This involves collecting information regarding GHS promotional activities, its delivery and reach (process evaluation), and participant outcomes (impact evaluation) using a pre-test and post-test design (collecting self-report information at baseline, three months and six months) to assess change in health and behaviour-related outcomes³.



Figure 1: Overview of significant events for Get Healthy Service





SECTION TWO: REACH OF THE GET HEALTHY SERVICE

2.1 General GHS usage

GHS calls

Since its introduction on 23 February 2009 until 31 December 2013, the GHS has received in excess of 46,000 incoming calls, approximately 30,000 are from adults seeking information and support regarding healthy lifestyles, and of these calls nearly half of all callers then enrol in the coaching program.

From February 2009 to December 2013, approximately 25,000 (n=25,425) participants registered their interest in the GHS service. 93.0% (n=23,650) of participants consented for their information to be included for the purposes of evaluation, see below.

Since 2009, the GHS has averaged approximately



9,500
calls per year

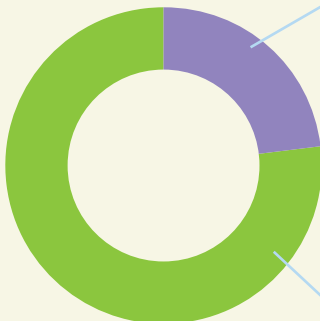


75,000
unique visits to
the **website**
per year

GHS Participants February 2009 - December 2013 23,650*

Information Only participants
5,483

23.2%



Coaching participants
18,167

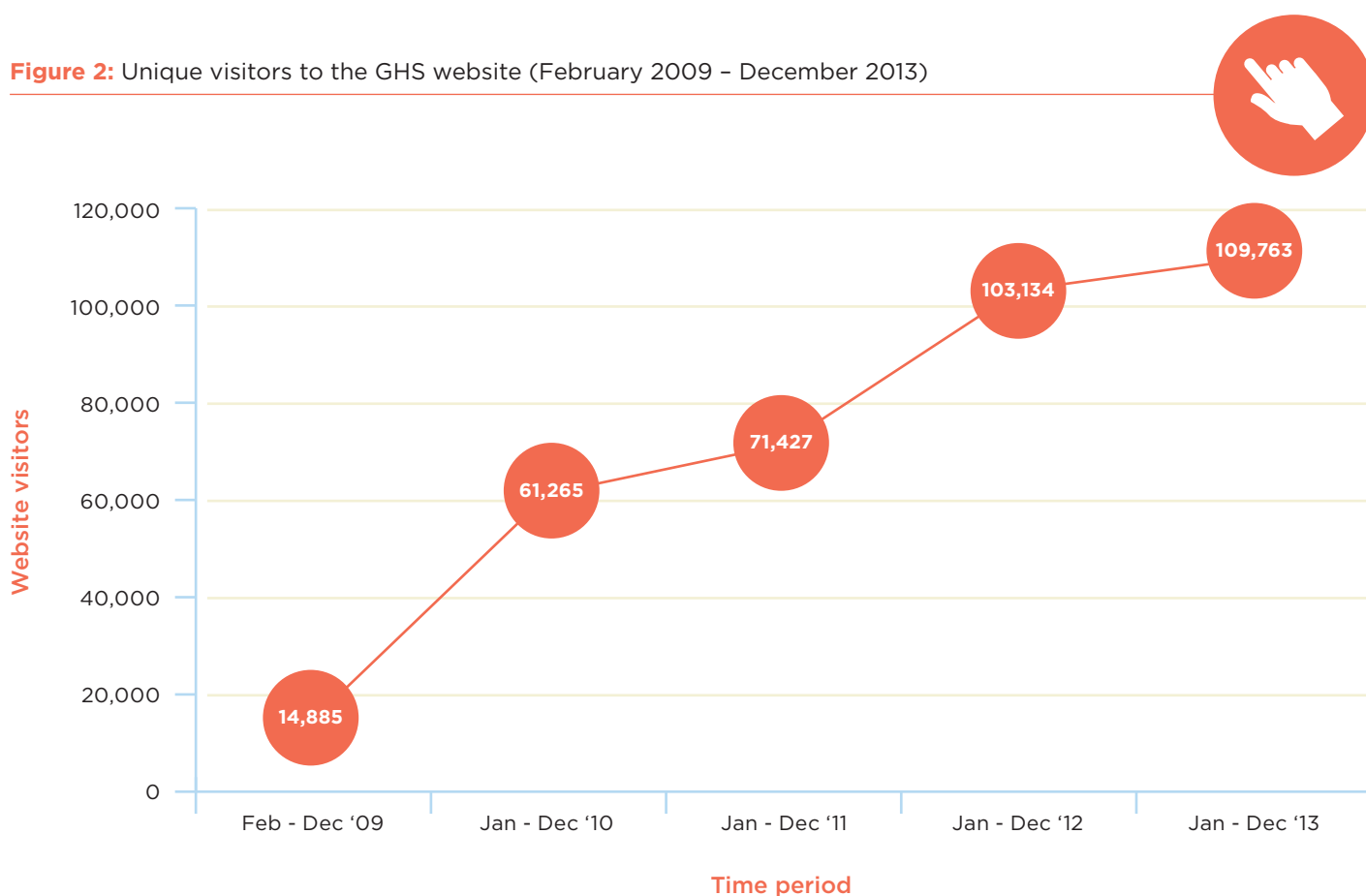
76.8%

* consenting participants only

GHS website usage

The total number of visits to the GHS website from February 2009 to December 2013 was 443,011; with 360,474 unique visitors to the site and an average of 77.8% of visitors being new visitors to the website. On average three GHS website pages were visited at each browsing session. The number of unique visitors to the website has steadily increased since the website was created in February 2009, with a 7.4 fold increase in visitors between 2009 and 2013 (Figure 2).

Figure 2: Unique visitors to the GHS website (February 2009 – December 2013)



2.2 Marketing and promotion of GHS

A number of marketing and promotional strategies have been used to encourage participation in the GHS, these have included:

1. **Mass media campaigns:** television (both GHS specific and advertisements with GHS branding at the conclusion of national campaigns), press, online and radio advertising and information distributed in letterboxes and subscription magazines. The GHS specific advertising during 2009-2013 included an educative style campaign providing information on what the GHS has to offer.
2. **Health professional partnerships:** direct referral and promotions through Local Health Districts; Medicare Locals; GP and other health professionals.

These include, partnership with Aboriginal Health and Medical Research Council for promotion and referrals from Aboriginal Community Controlled Health Services; partnership with Multicultural Health Communication Service to increase reach in culturally and linguistically diverse communities, and partnership with the Agency for Clinical Innovation to encourage referrals from the Aboriginal Knockout Health Challenge.

3. **Proactive marketing:** between August 2011 and June 2012 a proactive marketing strategy was used to promote the GHS to adults in targeted lower socio-economic areas. This involved the distribution of an introductory letter to households with a follow up phone call by the GHS inviting adults to join the service.

These combined marketing, promotion and partnership efforts have resulted in GHS participant numbers that have increased over time, except for in 2013 when there was a decline in numbers compared to the preceding three years, although there was a two fold increase in the proportion of health professional referrals (Table 1). The decline in 2013 was mainly due to mass media advertising only being utilised for half of the year.



**CULTURE
HEALTH
COMMUNITIES**








Many **participants** from the

Aboriginal Health Knockout Challenge

have enrolled in the GHS, as
support during the Challenge
or to help with **maintenance**
after the Challenge



Table 1: Number of GHS participants by referral source (February 2009 – December 2013)

	2009		2010		2011		2012		2013		ALL	
	n	%	n	%	n	%	n	%	n	%	n	%
 Mass media	1824	64.4	2269	54.9	3513	69.8	4813	62.5	2535	64.2	14954	63.2
 Health Professionals	290	10.2	372	9.0	238	4.7	330	4.3	456	11.6	1686	7.1
 General Practice	43	1.5	116	2.8	94	1.9	419	5.4	320	8.1	992	4.2
 Workplace	3	0.1	218	5.3	223	4.4	162	2.1	108	2.7	714	3.0
 Family and Friends	198	7.0	352	6.8	261	5.2	329	4.3	261	6.6	1404	5.9
 Proactive marketing	0	0	3	0.1	478	9.5	1303	16.9	16	0.4	1800	7.6
 Other	474	16.7	803	19.4	226	4.5	348	4.5	252	6.4	2103	8.9
TOTAL	2832		4133		5033		7704		3948		23650	

Mass media campaigns

provide **universal reach** and “branding” awareness to support GHS utilisation.

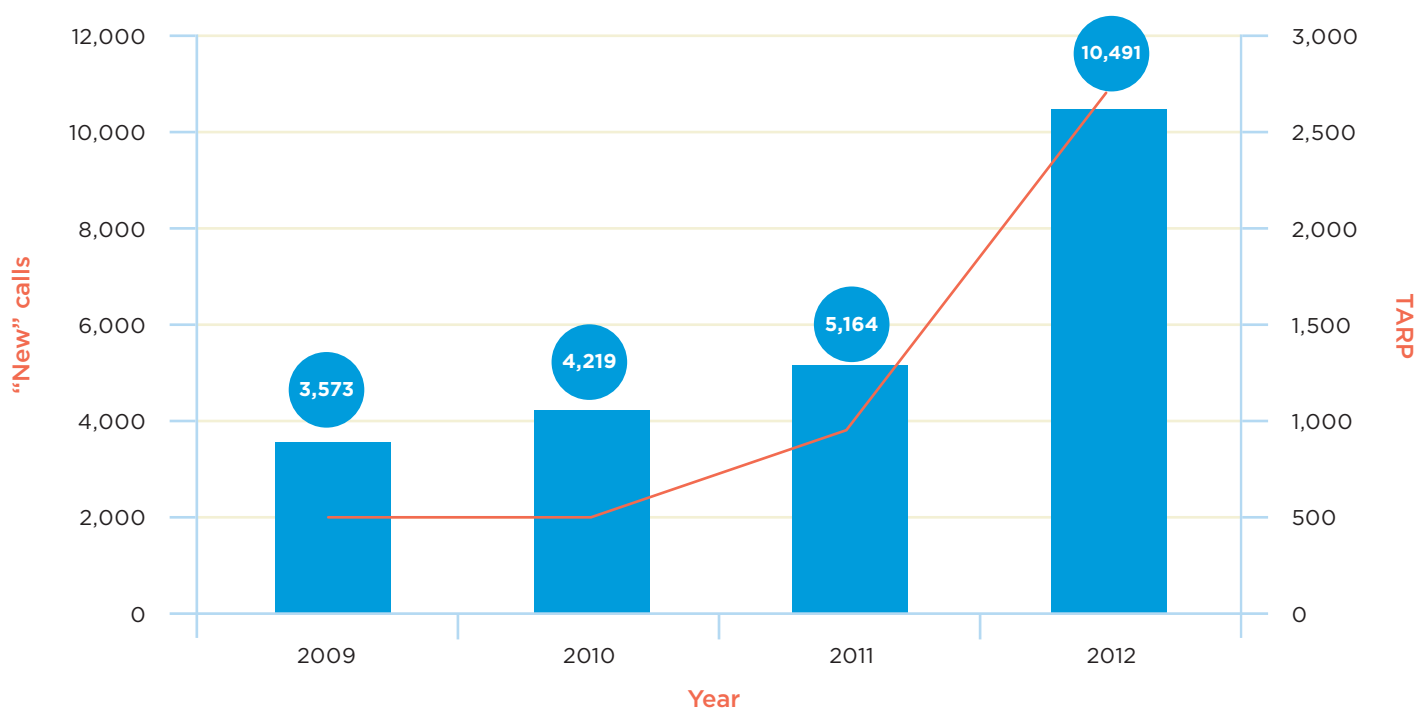
Targeted promotions and **partnerships** ensure that GHS continues to be used most by those from **vulnerable communities**.



Evaluations of the GHS marketing and promotional efforts have shown the following:

- There was a dose-response relationship between mass media advertising and number of contacts to the GHS (and corresponding GHS participants)¹⁵ (Figure 3).
- Television was the most commonly cited type of media followed by mailed out information, for those participants who nominated mass media as their referral source (Figure 4).
- Television, print and mailed out information were more often cited as the source of referral by males, those aged 18 – 49 years, employed and those from the lowest socio-economic groups¹⁶.
- During 2009 – 2013, during the months when mass media advertising was present, twice as many calls were received than when no advertising was present.
- Participants recruited via proactive marketing were significantly more likely to be males, aged 50 years or over, have a high school education and become information participants when compared to other referral source participants¹⁷.
- Longer term impact of the mass media campaign suggests that participants who cited mass media as their referral source were significantly more likely to enrol in the coaching program¹⁸.

Figure 3: “New” calls to the GHS by year (February 2009 - December 2013)

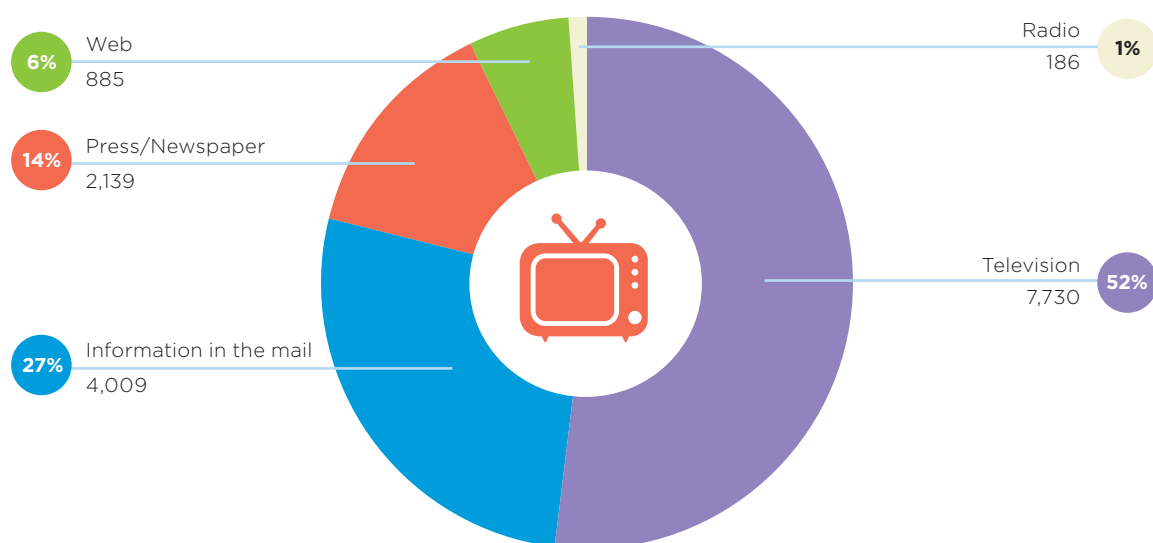


■ New Calls to the Service
— Television Target Audience Rating Points (TARP)

Note: Service usage data was not available for 2013.



Figure 4: Type of mass media most commonly cited by GHS participants (February 2009 – December 2013)



For the Aboriginal GHS participants:

- 30%** cited **television** as their “source of referral”
- 13.9%** referrals were from **Aboriginal Community Controlled Health Services**, and
- 13.8%** were from **GP** and other **health professionals**

2.3 Referral from GP and other health professionals

GP and other health professionals have been an important referral source to the GHS. There have been increases in the proportion of referrals that have come from health professionals and GP since the Service commenced in 2009.

A study examining the profile of GHS participants based on their “source of referral” has shown some important differences in relation to the socio-demographic and risk factor profile of those who had completed the coaching program¹⁹.

- Males were more likely to cite GP as their referral source than a referral from another health professional
- 46.5% of GP referrals had a high school education
- 54.7% of GP referrals were not in paid employment
- 61.9% of health professional referrals were from locations other than major cities
- 81.3% of health professional referrals were from the lowest three quintiles of advantage
- A greater proportion of coaching participants referred by GP were classified as obese (74.2%) and had a greatly increased waist circumference risk (84.6%).

2.4 Socio-demographic profile of GHS participants

The socio-demographic profile of these GHS participants is presented in Table 2.

For the period **2012 to 2013** there has been a

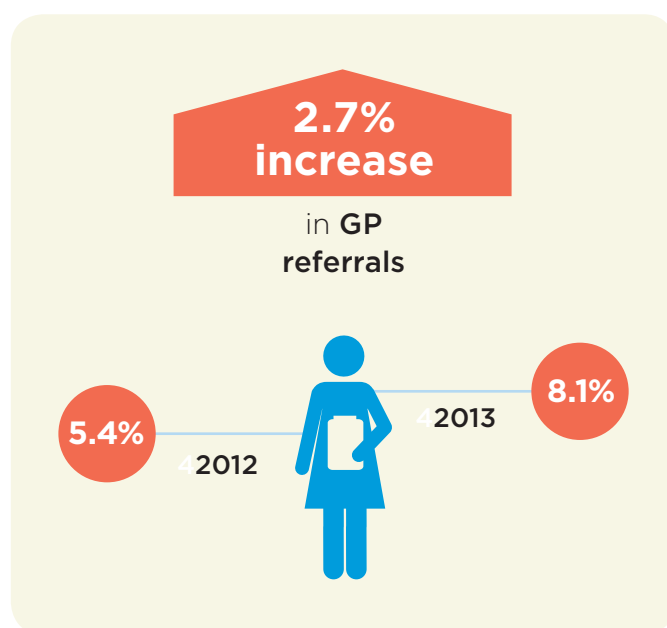


Table 2: Socio-demographic characteristics of Coaching and Information-only participants
(February 2009 – December 2013) ≠

			Coaching		Information		ALL		
			n	%	n	%	n	%	
	Gender	Female	13316	73.3	3786	69.0	17102	72.3	**
	Age	18-49 years	8543	47.0	2734	49.9	12373	47.7	**
	Education	High school education	7917	44.0	2545	47.8	10462	44.8	**
	Employment	Paid Employment	11050	61.3	3495	65.4	14545	62.2	**
	Aboriginal status	Aboriginal	654	3.6	139	2.5	793	3.4	**
	Language	Other than English	1439	7.9	559	10.2	1998	8.4	**
	SEIFA	3rd 4th & 5th quintile (most disadvantaged)	12045	66.4	3658	66.8	15703	66.5	NS
	Region	Major City	10840	59.8	3267	60.3	14137	59.9	NS

** Significant at $p < 0.001$; NS not significant, ≠ consenting participants only

Importantly, the GHS is attracting participants in the lowest quintiles of advantage (as measured by Socio Economic Index for Areas: SEIFA²⁰), with a higher proportion of participants from the 3rd, 4th and 5th quintiles (most disadvantaged) than would be expected from the proportion of NSW adults in those quintiles (Figure 5). Similarly, there are a greater proportion of participants from regional locations, compared to major cities (as measured by Accessibility/Remoteness Index of Australia: ARIA²¹) than would be expected from the proportion of NSW adults who reside in those locations (Figure 6).

The GHS is also attracting a significant number of females and those in paid employment.



The **GHS** is being **used** by those in the **community** who are

most in need

including those in the **most disadvantaged quintiles**

those in **regional** and **remote locations** and

those who have a high risk of **chronic disease**.

Figure 5: SEIFA Index: Comparison between GHS participants and NSW Adults (20 years+)

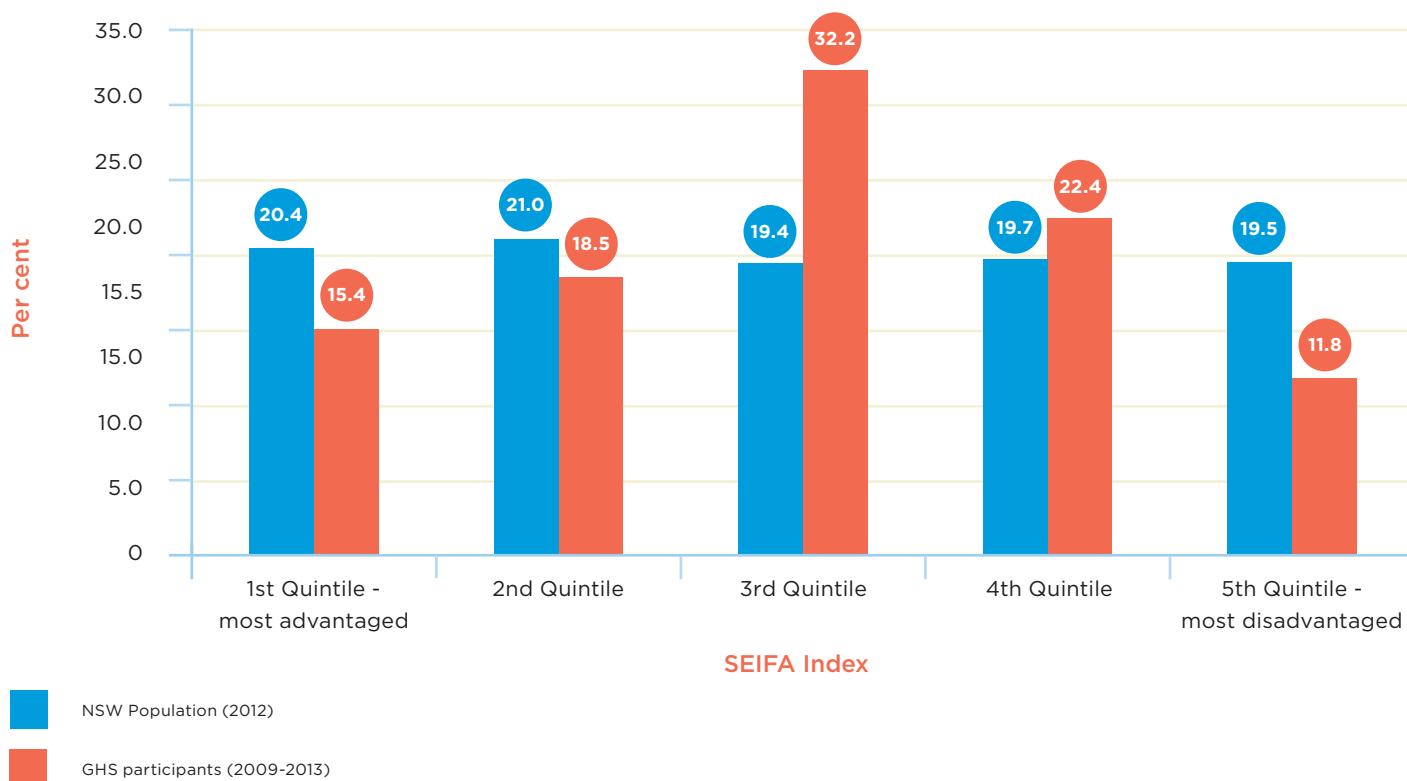
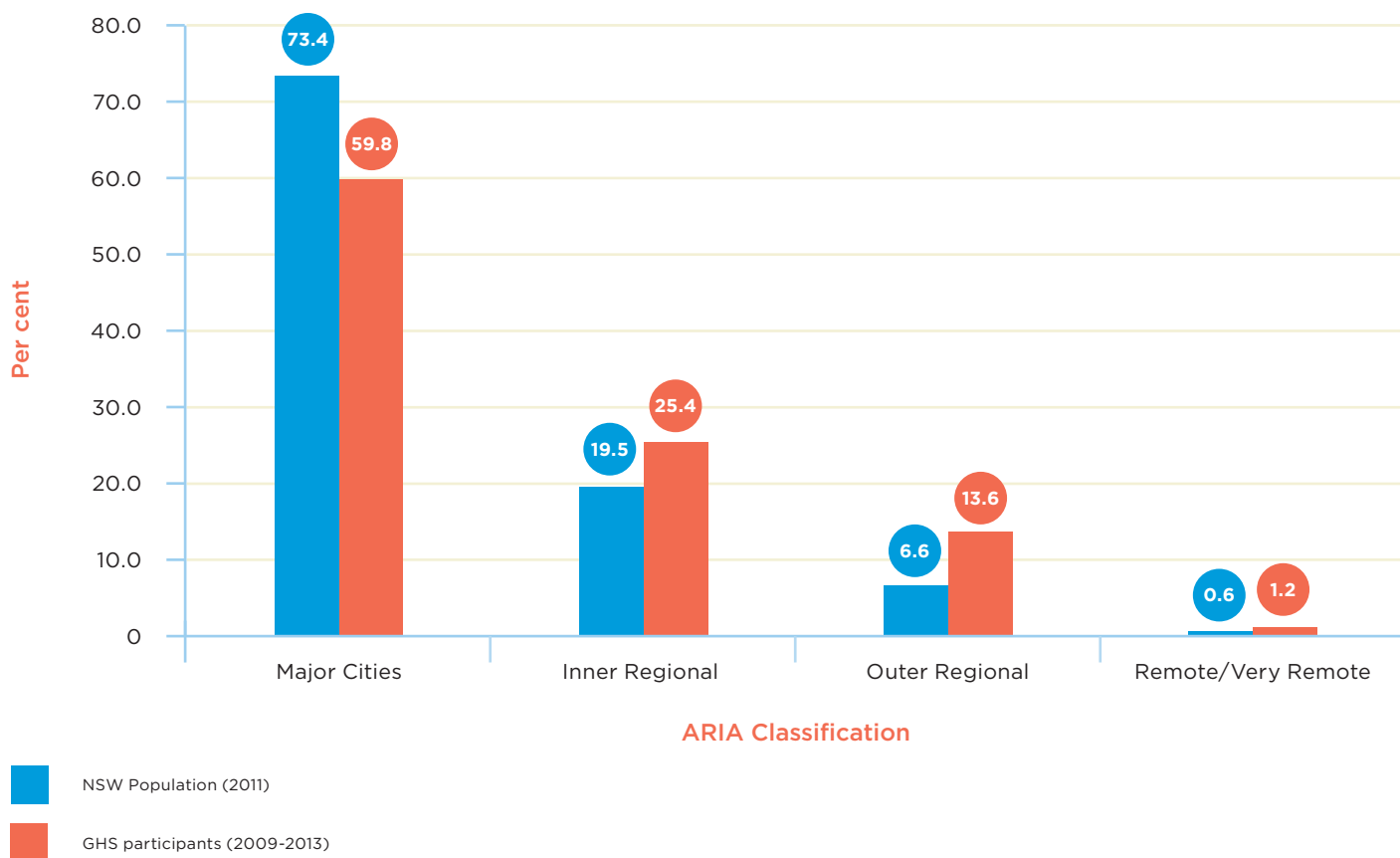


Figure 6: ARIA Classification: Comparison between GHS participants and NSW adults (20 years+)



The socio-demographic profile of GHS participants over the time GHS has been operating has also changed²², with increases in the proportion of

- coaching participants (a 29.6% increase, from 67.9% in 2009 to 97.5% in 2013),
- males (an 8.2% increase, from 19.5% in 2009 to 27.7% in 2013), and
- Aboriginal participants (a 2.4% increase, from 2.3% in 2009 to 4.7% in 2013).

Other changes in the socio-demographic of participants are detailed in Table 3.

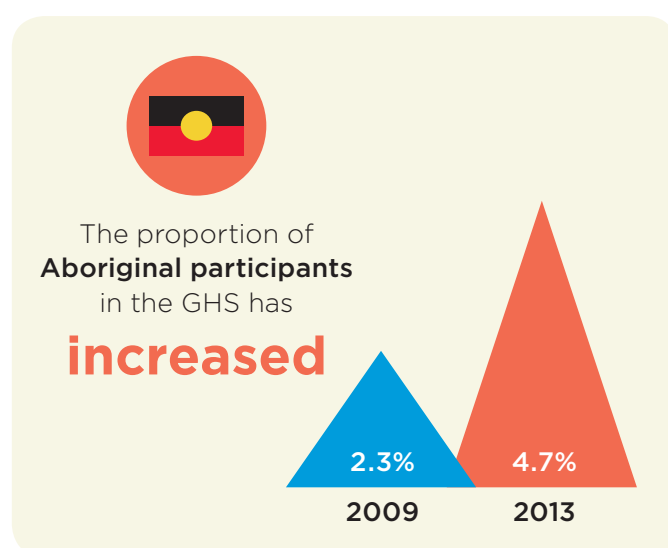


Table 3: Socio-demographic profile of all GHS participants over time (February 2009 – December 2013)

	2009		2010		2011		2012		2013		ALL	
	n	%	n	%	n	%	n	%	n	%	n	%
Males **	553	19.5	968	23.4	1479	29.4	2464	32.0	1084	27.7	6548	27.7
18-49 years **	1555	54.9	2278	55.1	2528	50.2	3089	40.1	1827	46.3	11277	47.7
High school education	1219	43.3	1582	39.3	2275	45.4	3734	48.7	1652	43.4	14869	55.2
Paid employment**	1917	68.0	2852	70.8	3189	63.6	4295	55.9	2292	59.9	14545	62.2
Aboriginal **	66	2.3	108	2.6	151	3.0	291	3.8	177	4.7	793	3.4
Language other than English **	224	7.9	374	9.0	328	6.5	628	8.2	444	11.2	1998	8.4
3rd, 4th & 5th quintile (most disadvantaged) **	1777	62.8	2519	61.1	3372	67.1	5708	74.2	2327	59.1	15703	66.5
Major City	1751	61.9	2421	58.8	2956	58.8	4457	58.0	2552	64.9	14137	59.9
Coaching participant **	1923	67.9	2478	60.0	3125	62.1	6793	88.2	3848	97.5	18167	76.8

** Significance for trend using linear by linear chi-square tests at $p < 0.001$

With the introduction of an amended medical screening process in May 2012 there has been a significant decrease of 11.3% in the proportion of participants that required medical clearance prior to commencing coaching.

Importantly, this change in medical clearance has also resulted in a greater proportion of:

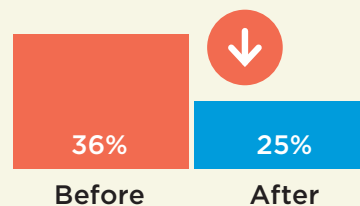
- males
- those aged over 50 years
- those with a high school education
- Aboriginal participants
- those who speak a language other than English at home and
- those located in major cities participating in the coaching program.



Previously **36%** of coaching participants **required medical clearance**

After the amended medical screening process in May 2012

25% of coaching participants **now require medical clearance**



2.5 Risk factor profile of GHS coaching participants

The following list details the risk factor profile of the coaching participants who registered and commenced the coaching program between February 2009 and December 2013:

- 32.5% were overweight and 52.7% were obese according to their Body Mass Index (BMI) classification
- 15.2% had an increased risk and 75.9% had a greatly increased risk of chronic disease due to their waist circumference

- 52.5% consumed less than the recommended levels of two daily serves of fruit
- 88.1% consumed less than the recommended levels of five daily serves of vegetables
- 65.7% did not undertake the recommended levels of weekly physical activity.

The risk factor profile of those who start the coaching program has not changed considerably over the first five years of its operation, as described in Table 4.

Table 4: Risk factor profile of GHS coaching participants (February 2009 – December 2013)

	2009		2010		2011		2012		2013		ALL	
	n	%	n	%	n	%	n	%	n	%	n	%
Overweight	460	33.2	585	32.3	674	31.9	1725	33.5	1083	31.2	4527	32.5
Obese	729	52.6	864	53.2	1168	55.3	2661	51.7	1823	52.6	7345	52.7
Increased waist circumference risk*	141	14.6	183	14.2	231	14.4	617	15.7	421	15.5	1603	15.2
Greatly increased waist circumference risk*	753	78.0	1063	78.1	1227	76.6	2959	75.3	2025	74.6	8030	75.9
Less than 2 serves of daily fruit	691	49.3	930	50.4	1185	56.0	2731	52.9	1381	52.0	6918	52.5
Less than 5 serves of daily vegetables	1179	84.1	1630	88.3	1946	91.9	4602	89.2	2253	84.8	11610	88.1
Insufficient Physical activity#	679	50.1	1246	70.4	1382	67.4	3312	66.2	1756	68.3	8375	65.7

* Waist circumference risk was computed differently for males and females. For males: increased risk ≥ 94 cm and < 102 cm, greatly increased risk ≥ 102 cm; for females: increased risk ≥ 80 cm and < 88 cm, greatly increased risk ≥ 88 cm.

Insufficient physical activity is defined as not engaging in ≥ 5 sessions per week of walking, or ≥ 5 sessions per week of moderate activity, or 3-4 sessions per week of walking and ≥ 1 -2 sessions per week of moderate activity, or ≥ 1 -2 sessions per week of walking and 3-4 sessions per week of moderate activity.



“

“It was very good having that person, it gave you some motivation and justification because if I hadn’t done the right thing I was honest and told her, she didn’t judge.”

ROGER



SECTION THREE:

EFFECTIVENESS OF THE GET HEALTHY SERVICE COACHING PROGRAM

3.1 Outcomes of the 6 month coaching program

GHS participants who completed the 6 month coaching program made significant improvements (Table 5) to their:

- weight
- waist circumference
- Body Mass Index (BMI)
- physical activity
- healthy eating behaviours

Participants who completed the 6 month coaching program on average



lost
3.8kg

and



5.1cm
off their **waist circumference**

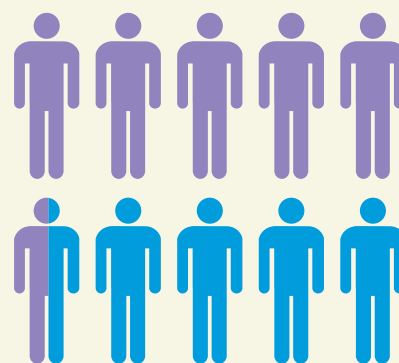
Table 5: Anthropometric and behavioural risk factor changes from baseline to 6 months for GHS coaching participants (February 2009 – December 2013)

	N	Baseline	6 months	Change	
Weight (kg) ¥	3922	85.8	82.0	-3.8	**
BMI (kg/m ²) ¥	3918	30.9	29.6	-1.4	**
Waist circumference (cm) ¥	3247	101.6	96.6	-5.1	**
Fruit (daily serves) €	3892	1.7	2.0	0.4	**
Vegetables (daily serves) €	3912	2.7	4.0	1.2	**
Sweetened drinks (daily serves) €	3741	0.4	0.1	-0.3	**
Takeaway meals (weekly serves) €	3762	0.8	0.3	-0.5	**
Walking (no. 30min sessions per week) €	3900	2.4	3.6	1.2	**
Moderate Physical activity (no. 30min sessions per week) €	3796	1.0	1.7	0.7	**
Vigorous physical activity (no. of 20min sessions per week) €	3744	0.4	0.8	0.4	**

** Significant at p<0.001; matched pair analysis; ¥ T-test undertaken for matched paired samples for significant mean difference;

€ Non parametric test undertaken for related samples for significant median difference

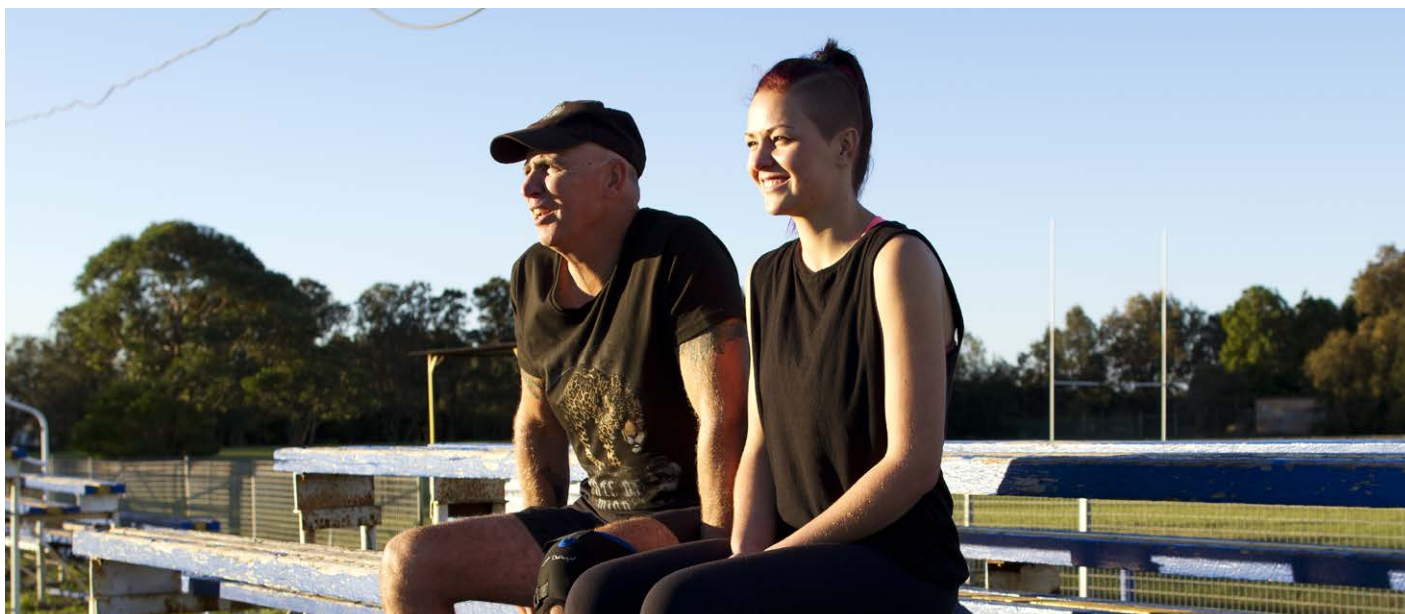
Importantly, improvements in weight, waist circumference, moderate physical activity, fruit and vegetable and take-away meal consumption remained significant after adjusting for socio-demographic characteristics²³.



56% of participants who completed the **6 month coaching program** lost between

2.5% - 10%

of their **original body weight**



“One of the things my health coach taught me was about calories, I am now very mindful of calories as well as 5 servings of fruit and vegetables... it has been a great learning experience.”

LAUREL

”



These results show that GHS is facilitating significant lifestyle improvements where it is needed most. GHS participants considerably improved their risk of chronic disease, with more than half (56.0%) losing 2.5-10% of their baseline body weight and a further 8% of participants losing more than 11% of their initial body weight. Further there have been changes in the proportion of participants who are classified as being obese (Figure 7).

Aboriginal participants who completed the **6 month coaching program** on average

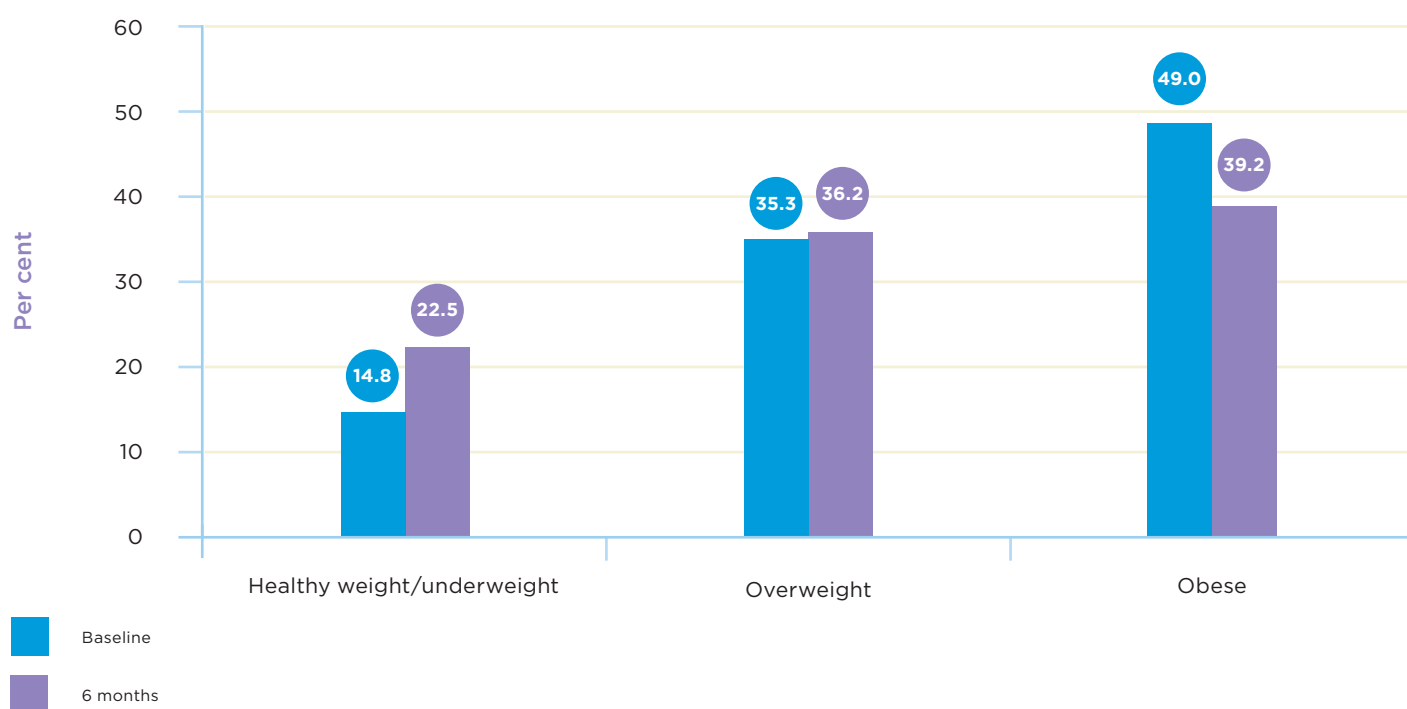


**lost
4kg**

and made significant improvements to

healthy eating and physical activity levels.

Figure 7: Proportion of participants classified as obese and overweight at baseline and 6 months













There have also been significant improvements in the proportion of participants who are meeting recommended levels of physical activity and fruit and vegetable consumption.

Figure 8: Proportion of GHS participants meeting recommended amounts of fruit and vegetables and levels of physical activity from baseline to 6 months



The improvements made by GHS participants who complete the coaching program have remained fairly constant over time (Table 6), with no significant differences between improvements on anthropometric and behavioural risk factors.

Table 6: Anthropometric and behavioural risk factor improvements for GHS participants who complete the coaching program by year (February 2009 – December 2013)

Change	2009 (n=487)	2010 (n=539)	2011 (n=678)	2012 (n=1789)	2013 (n=429)	ALL (n=3922)
	Mean	Mean	Mean	Mean	Mean	Mean
 Weight (kg)	-3.3	-3.9	-4.2	-3.6	-4.2	-3.8
 BMI (kg/m ²)	-1.2	-1.4	-1.5	-1.3	-1.5	-1.4
 Waist circumference (cm)	-4.6	-5.1	-5.1	-5.0	-5.8	-5.1
 Fruit (daily serves)	0.2	0.3	0.4	0.5	0.3	0.4
 Vegetables (daily serves)	0.8	1.1	1.2	1.3	1.5	1.2
 Sweetened drinks (daily serves)	-0.4	-0.2	-0.3	-0.3	-0.3	-0.3
 Takeaway meals (weekly serves)	-0.5	-0.4	-0.5	-0.4	-0.4	-0.5
 Walking (no. 30min sessions per week)	0.6	1.3	1.2	1.2	1.3	1.2
 Moderate Physical activity (no. 30min sessions per week)	0.0	0.7	0.9	0.8	0.4	0.7
 Vigorous physical activity (no. of 20min sessions per week)	0.6	0.4	0.4	0.4	0.4	0.4

3.2 Outcomes of GHS coaching program for participants referred by GP and health professionals

A study undertaken for the evaluation of the GHS, focused on the differences between GP referral, other health professional referral and other sources (including mass media, family and friends and workplaces) and the health behaviour improvements coaching participants made after completing the 6 month coaching program. Regardless of the referral source, the improvements experienced by coaching participants were the same²⁴.

GPs and other health professionals have an important role in referring clients to the GHS:

- GP and other health professionals can target those in the community who are most at need of the assistance that GHS can offer, both in terms of a client's socio-demographic profile but also their risk factor profile
- Knowing that the results of those who were referred by health professionals are the same as those self-referred could also provide impetus for health professionals to refer to GHS as it places less importance on self-motivation and suggests that health professionals can ignite the motivation of clients to make significant lifestyle improvements to their chronic disease risk factors
- The GHS is an effective service that can complement patient care provided by GPs and other health professionals.

Early indications
for participants in the
**type 2 Diabetes Prevention
Module** are promising, with
those who have **completed
3 months** of the coaching
program **losing**



**on average
3.2kg**



Participants who were
referred by their **GP** or other
health professional made the
**same
improvements**
to their **risk factor profile** as
those who were **self-referred**
to the **coaching program**



3.3 Maintenance of behaviour change of coaching participants

A 12 month follow-up study (6 months after completing coaching and 12 months from baseline)²⁵ showed that the anthropometric improvements made at the completion of the coaching program were maintained for a further 6 months (12 months from baseline).

Key results relating to maintenance of behaviour change were:

- Significant decreases in weight from baseline to 12 months and these were maintained from the completion of the coaching program
- Significant improvements in waist circumference from baseline to 12 months and these were also maintained from the completion of the coaching program
- Increased fruit and vegetable consumption from baseline to 12 months; this impact was maintained for fruit consumption from the end of the coaching program but the degree of improvement was not maintained for vegetable consumption
- Improvements in the proportion of participants

undertaking recommended levels of physical activity from baseline to 12 months, however, these improvements were not maintained from the end of the coaching program

- After adjusting for baseline levels and socio-demographic variables, the coaching program had significant maintenance effects for all anthropometric measurements and for fruit consumption.

Figure 9 demonstrates the proportion of GHS coaching participants who are classified as a healthy weight and with 'no risk' waist circumference after completing the coaching program and at 6 months post follow up (12 months from baseline).

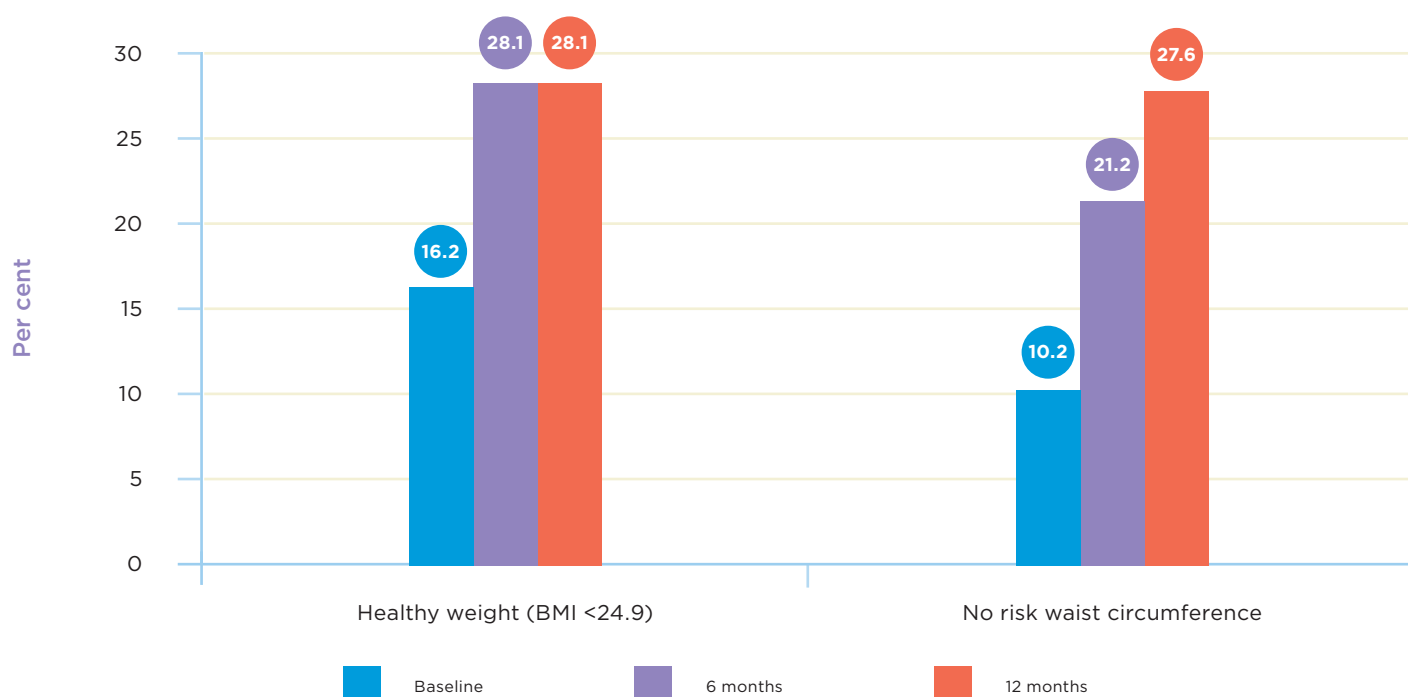
Participants who completed the 6 month coaching program

maintained

the improvements they made 6 months after the coaching program was completed.



Figure 9: Proportions in classifications of Body Mass Index (BMI) and waist circumference risk at baseline, 6 months and 12 months



3.4 Costing of GHS

A costing study undertaken of GHS in 2012²⁶ concluded that:

- Key outcomes (such as 5% or more weight loss) were more frequently achieved after 26 weeks of coaching rather than 12 weeks
- The marginal cost of keeping people in the coaching program for the full 26 weeks is smaller than the associated increase in achieving these outcomes; the 26 week program is generally also more cost effective
- The mean coaching costs ranged from \$640 to \$1,030 per person depending upon the assumptions used to develop the models (and their inclusions of fixed, variable and marketing costs)
- Models which excluded the costs of marketing had substantially lower costs as marketing costs were estimated to be \$350 per person.





“

“It was very hard to start but once you do it's too easy and now it's become part of my everyday life.”

PARMINDER



SECTION FOUR: FUTURE DIRECTIONS

The success of the Get Healthy Information and Coaching Service® in delivering significant health improvements means that further effort needs to go in to increasing participation and completion of the coaching program by the identified target groups.

This will occur through continued marketing and promotion, but also by working with general practitioners and health professionals to increase their referrals to the GHS. Workplaces will also be an important site for promoting the service and referrals through the new *Get Healthy at Work* initiative that will commence in NSW from July 2014.



Early results from the **'Get Healthy Stay Healthy Trial'** indicate that coaching participants who received text messaging for **6 months** after completing the coaching program

continued to lose weight

Future directions for 2014-15 include:

- Direct referral to the GHS following brief health checks in targeted workplaces across NSW through the *Get Healthy at Work* initiative
- Continuation of the new testimonial campaign which involves GHS participants sharing their personal experience and success with using the GHS
- Evaluating the Aboriginal module, including Social Networking analysis and an Appropriateness Study
- Implementing a new Gestational Weight Gain module for healthy weight gain during pregnancy
- Investigating the effectiveness of referral and promotion by pharmacies
- Finalising the Get Healthy Stay Healthy Trial²⁷ to assess the efficacy of a mobile telephone-delivered intervention to enhance maintenance of behavioural changes attained following the completion of the 6 month coaching program
- Investigating the feasibility of implementing a 12 month follow-up for GHS participants, and
- Conducting further economic evaluation of GHS, including a systematic review and cost-benefit analysis





PARMINDER'S Get Healthy Story

"It was very hard to start but once you do it's too easy and now it's become part of my everyday life."

Food has always been a part of Parminder's life and culture. Born and raised in India, Parminder admits that Indian food features weekly on the menu in his household, especially when his mother is in town. Parminder was struggling with his weight and after hearing the Get Healthy Service advertisement on the radio he immediately signed up.

With a wife and 2 year old daughter, Parminder never wanted his struggles with food to impact on his family. On a social level, he never wanted his family to feel like they were missing out as taking them to nice restaurants was important to him.

Physically, Parminder never wanted to pass on his bad habits to his daughter and create struggles for her future.

"I'm a family man with a 2 year old and a partner and we love to eat out. At no stage did I want my health issues to affect my family" he says.

With the help of the program and his health coach, Parminder lost 17½ kilograms by setting realistic goals every week. He admits he still indulges with Indian food but now understands the importance of a balanced diet and a healthy lifestyle. Rather than miss out, Parminder now cuts back on portion sizes and when he feels like he has indulged too much he often increases his fruit intake to flush out his system; a piece of advice from his health coach.

Since losing the weight, Parminder is amazed at how much energy he has "for the first time in my life I realised how active and energetic I was."

Eating healthily, exercising regularly and enjoying life with newfound energy have now become part of Parminder's everyday life. He exercises 4-5 times a week without the aid of a trainer and has even motivated his wife to start running. Together as a family they both understand the importance of setting a positive example for their 2 year old daughter and they spend more time outdoors in the park.



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