RACGP

Royal Australian College *of* General Practitioners

Putting prevention into practice

Guidelines for the implementation of prevention in the general practice setting

Third edition

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Healthy Australia.

Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting. Third edition

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Acronyms and abbreviations

5As	ask, assess, advise/agree, assist, arrange
APNA	Australian Primary Health Care Nurses Association
AUSDRISK	Australian Type 2 Diabetes Risk Assessment Tool
BMI	body mass index
CALD	culturally and linguistically diverse
CCF	congestive cardiac failure
CIS	clinical information system
CISS	*Computer and information security standards*
CME	clinical medical education
COM-B	capability, opportunity, motivation and behaviour
COPD	chronic obstructive pulmonary disease
CPD	continuing professional development
CVC	Coordinated Veterans' Care
CVD	cardiovascular disease
DASS	Depression, Anxiety and Stress Scale
DMAIC	define, measure, analyse, improve, control
ED	emergency department
EPC	extended primary care
FAV	family abuse and violence
FOBT	faecal occult blood test
GASP	GPs Assisting Smokers Program
GP	general practitioner
HANDI	*Handbook of non-drug interventions*
HbA1c	glycated haemoglobin
HHS	hyperosmotic hyperglycaemic syndrome
IT	information technology
KTA	knowledge-to-action
MBS	Medicare Benefits Schedule
MI	motivational interviewing
NBCSP	National Bowel Cancer Screening Program
NHS	National Health Service
NPT	normalisation process theory
PDSA	plan, do, study, act
PHN	Primary Health Network
PLAN	Planning learning and need
PN	practice nurse
PPIP	Putting Prevention into Practice (program)
PRACTICE	Principles, Receptivity, Ability and capacity, Coordination, Targeted, Iterative cycles, Collaboration, Effectiveness and efficiency
QI	quality improvement
QI&CPD	Quality Improvement and Continuing Professional Development (Program)
RACGP	The Royal Australian College of General Practitioners
RE-AIM	reach, effectiveness, adoption, implementation, maintenance
SIP	Service Incentive Payment
SMART	Specific, Measurable, Assignable, Realistic, Time-related
SNAP	smoking, nutrition, alcohol, physical activity
TPB	theory of planned behaviour

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Introduction

Focusing on prevention is an important response to Australia's increasing healthcare needs.

In general practice, we are well trained and skilled in caring for, and working alongside, patients who present with multiple issues and health-related problems. What we don't do often is step back from the individual before us and consider our patients as a community or population. Yet this shift in focus holds enormous potential to improve health outcomes. While we continue supporting individuals to take greater responsibility for their health and prevent illness, if we also work at a practice population level, we have opportunities to affect the broader determinants of health and illness.

Improving preventive care for individuals and communities leads to better health.[1] To this end, multiple evidence-based recommendations have been developed. The *Guidelines for preventive activities in general practice, ninth edition* (Red Book) is a key source of these. However, when we look across general practice, implementation and delivery of preventive services is variable.[2,3]

It is not our medical knowledge that can adversely affect our ability to deliver preventive care. Rather, it is our ability to recognise and overcome a combination of individual factors (eg time pressures, competing demands, skill levels, attitudes) and practice systems and organisational factors (eg availability of a team, clarity of roles, lack of resources, a culture focusing on treatment rather than prevention). Putting preventive recommendations into practice requires knowledge in areas we are not well taught, such as implementation science, change management, organisational behaviour, and data collection and analysis.

In *Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting* (Green Book), we aim to give you enough useful knowledge in the above areas to create a clear and actionable plan to improve your practice's preventive care.

The Green Book

Since 1998, The Royal Australian College of General Practitioners (RACGP) has published the Green Book to support evidence-based preventive activities in primary care.

What is the Green Book?

The Green Book is designed to help you put preventive care recommendations from best practice guidelines into practice. It provides case studies to reflect on and contains advice about practical processes, strategies and tools for implementing and sustaining preventive activities.

The Green Book brings together the evidence and the lessons learned from the literature and from real-life general practice experiences to make implementation of preventive activities as straightforward and effective as possible.

These lessons include:

- Simply disseminating guidelines within your practice is not enough to change practice
- Using a practical framework that is guided by theory can improve success
- Implementing all recommendations from evidence-based guidelines may be unrealistic and unachievable – what you chose to implement depends on your practice context (ie established need, clinician preference, complexity, capacity/capability and resources available)
- Improving implementation depends on changing multiple behaviours of multiple people (ie healthcare professions, practice managers, administrators)
- Implementation efforts are more likely to be successful if you have strong organisational leadership and whole-of-practice engagement
- You need to set goals that you can measure

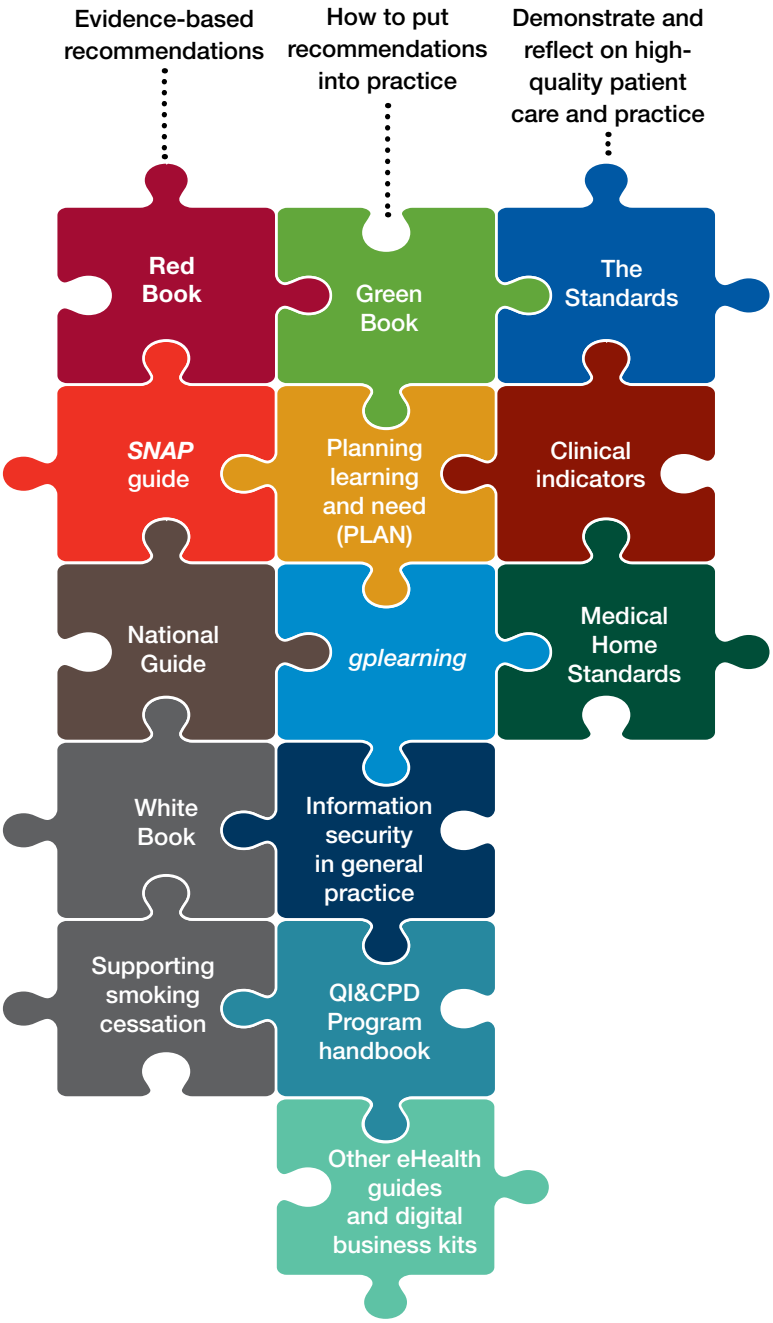
By aligning leadership, building capacity for change, creating a culture of quality improvement (QI), and selectively choosing the relevant processes needing change, general practices can organise their environment to successfully deliver preventive services.[4]

How does the Green Book fit in with other RACGP publications?

You can think of the Green Book as a practical companion to the RACGP's Red Book. However, it also works to support the implementation of other RACGP publications such as *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice,* second edition, and the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, third edition (National Guide) (Figure 1).

The Green Book is also a resource to help your practice meet the RACGP *Standards for general practices,* fifth edition (the Standards).

Figure 1. How the Green Book fits with other RACGP publications



Who is the Green Book for?

The Green Book is a practical resource for strengthening preventive activities in general practice. As an interdisciplinary approach to prevention is typically more likely to be successful,[5] the Green Book is a central resource for your whole practice and for those working with your practice, including:

- members of the practice team involved in or interested in QI
- members of practice teams responsible for implementing evidence-based guidelines
- practice management decision-makers
- groups working with general practices to improve Australian healthcare, such as Primary Health Networks (PHNs), particularly QI support officers
- peak bodies (eg Consumers Health Forum, Diabetes Australia, Cancer Australia, Heart Foundation)
- allied health professionals.

It may also be useful for patients and carers.

Organisation of the Green Book

Throughout the Green Book, you will find symbols that signal the type of information presented.

Where you see this symbol …	The information relates to …
	General practice – a whole-of-practice approach
	External organisations (PHNs, peak bodies)
	A practice management point
	A clinical point
	An idea you could use in general practice
	A case study from one of our contributors
	An experience from general practice

Resources

- Cancer Australia, https://canceraustralia.gov.au
- Consumers Health Forum of Australia, https://chf.org.au
- Department of Health, Primary Health Networks, www.health.gov.au/PHN
- Diabetes Australia, www.diabetesaustralia.com.au
- Heart Foundation, www.heartfoundation.org.au

The RACGP:

- Practice guides and tools: Clinical indicators, *Clinical indicators for Australian general practice*, www.racgp.org.au/clinicalindicators
- *gplearning*, http://gplearning.racgp.org.au/
- *Guidelines for preventive activities in general practice* (Red Book), ninth edition, www.racgp.org.au/your-practice/guidelines/redbook
- *Information security in general practice*, www.racgp.org.au/your-practice/ehealth/protecting-information/information-security
- *National guide to preventive health assessment for Aboriginal and Torres Strait Islander people* (National Guide), third edition, www.racgp.org.au/your-practice/guidelines/national-guide
- Planning learning and need (PLAN), www.racgp.org.au/education/qicpd-program/gps/planning-learning-and-need-(plan)
- *QI&CPD Program: 2017–19 triennium handbook for general practitioners*, www.racgp.org.au/download/Documents/QICPD/2017/QICPD-Handbook-triennium-2017-19.pdf
- *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice,* second edition, www.racgp.org.au/your-practice/guidelines/snap
- *Standards for general practices*, fifth edition, www.racgp.org.au/your-practice/standards/standards-for-general-practices-(5th-edition)
- *Standards for patient-centred medical homes: Patient-centred, comprehensive, coordinated, accessible and quality care*, www.racgp.org.au/download/Documents/Standards/RACGP-Standards-for-Patient-Centred-Medical-Homes.pdf

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1. Understanding the basics

Key points

- Prevention is relevant to patients across all life stages and applies to the whole natural history of disease.
- Implementing preventive activities involves recognising the challenges of implementation and using evidence-based strategies to overcome them.
- Successful implementation of preventive care requires coordination and collaboration within the practice team and with external organisations (eg PHNs).
- Focusing on prevention is part of a QI approach.

The Green Book brings together two main themes: **prevention** and **implementation**. Both of these sit within **QI** and are inherently associated with **behaviour change**.

1.1 About prevention

What is prevention?

While many general practitioners (GPs) and practice nurses (PNs) discuss lifestyle with their patients, this is only the tip of preventive care.[1] **Prevention** in the healthcare context focuses on the health of individuals, communities and defined populations. It includes all measures that protect, promote and maintain health and wellbeing, and that prevent disease, disability and death.[2–4]

Prevention in practice requires us to extend our patient-centred approach from individuals and families to the entire practice population.

I've always been taught to do acute episodic care in response to patient demand. But I have realised that to really look after my patients, I have to do chronic disease management and prevention, and that I need to do it in a proactive and planned way.

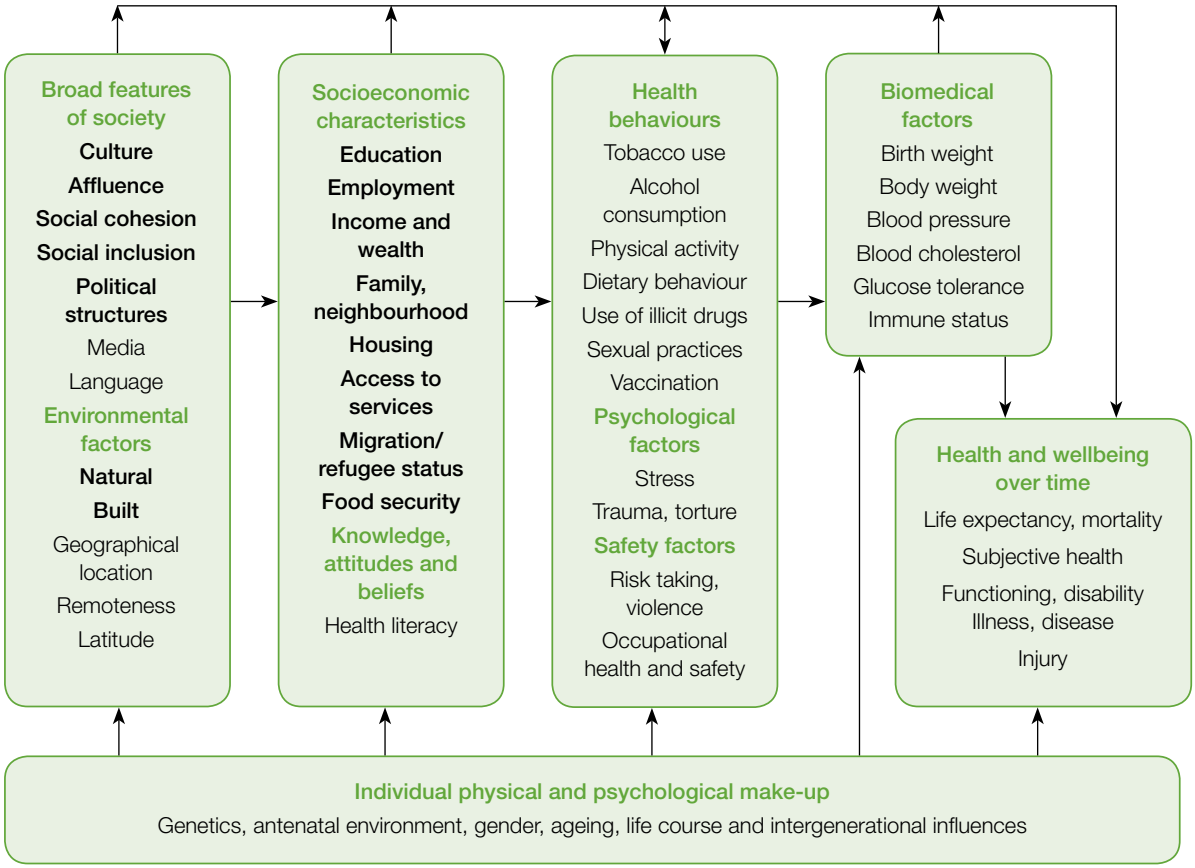
– Assoc Prof Charlotte Hespe, Green Book Editorial Committee

Prevention, people and practice population

Prevention is relevant across a person's lifespan: from pre-conception, fetal stage, childhood and adolescence through to middle age and older. The Red Book shows the preventive activities that apply across age groups.

There are many determinants of health and illness (Figure 2). A preventive approach recognises these and how they interact. It also reaches beyond individuals who seek out or are most receptive to preventive care to encompass the entire practice population.

Figure 2. The determinants of health and illness



Note: Bold highlights selected social determinants of health.

Reproduced from Australian Institute of Health and Welfare. Australia's health 2014. Cat. no. AUS 178. Canberra: AIHW, 2014; p. 5.

Prevention and disease

Just as prevention is relevant across a person's lifespan, it also applies to the natural history of disease (Figure 3). Preventive measures can be applied at any stage along the natural history of a disease to prevent progression. The stages may be divided into the following:[5]

- **Primordial** – consists of actions to minimise future hazards and address broad determinants of health (eg environmental, economic, social, educational, behavioural and cultural factors) rather than preventing personal exposure to risk factors, which is the goal of primary prevention
- **Primary** – seeks to prevent the onset of disease via risk reduction (eg immunisation, smoking cessation)
- **Secondary** – the early detection and prompt intervention to correct departures from good health or to treat the early signs of disease (eg cervical screening, bowel screening, mammography, blood pressure monitoring and blood cholesterol checking)
- **Tertiary** – reducing impairments and disabilities, minimising suffering caused by existing departures from good health or illness, and promoting patients' adjustment to chronic or irremediable conditions (eg prevention of complications).

You may also come across **quaternary** prevention, which is action taken to identify patients at risk of over-medicalisation, to protect them from new medical interventions and to suggest ethically acceptable ones.[6,7] Electronic health records may in the future be able to assist us in avoiding unnecessary repeat testing and medication errors, thereby playing a role in quaternary prevention.

In reality, the stages of prevention blur.

Figure 3. Primary, secondary, tertiary and quaternary prevention

Doctor view

Patient's view

Primary (prevention)	Secondary (prevention)
Action taken to avoid or remove the cause of a health problem in an individual or a population before it arises. Includes health promotion and specific protection (eg immunisation).	Action taken to detect a health problem at an early stage in an individual or population, thereby facilitating cure, or reducing or preventing it spreading or its long-term effects (eg methods, screening, case finding and early diagnosis).
Quaternary (prevention)	**Tertiary (prevention)**
Action taken to identify a patient or a population at risk of over-medicalisation, to protect them from invasive medical interventions and provide for them care procedures which are ethically acceptable.	Action taken to reduce the chronic effects of a health problem in an individual or a population by minimising the functional impairment consequent to the acute or chronic health problem (eg prevent complications of diabetes). Includes rehabilitation.

Reproduced from PH3C Primary Health Care Classification Consortium. Quaternary prevention. Erlangen, Germany: PH3C, 2016. Available at www.ph3c.org/4daction/w3_CatVisu/en?wCatIDAdmin=1128 [Accessed 21 March 2018].

Prevention and coordinated healthcare

Effective prevention usually requires teamwork within the practice as well as links with other (clinical and non-clinical) services.

Prevention and health promotion are among the core responsibilities of GPs and PNs.[3] Through a range of strategies, GPs and PNs have the potential to influence patients to:

- understand the factors that influence health across a lifespan
- change their lifestyle (eg smoking, nutrition, alcohol, physical activity)
- undergo risk assessments (eg cardiovascular disease [CVD], type 2 diabetes, fractures)
- participate in screening (eg breast cancer, bowel cancer, mental health)
- self-manage chronic conditions
- enrol in interventions/programs to prevent functional decline
- increase health vigilance.

GPs and PNs may also pursue prevention through health advocacy or lobbying within their discipline.

The preventive approach incorporates opportunistic and planned interventions from the perspective of the whole practice as well as for the individual practitioner and patient. It may include auditing medical records to identify those who are missing out, using special strategies to support patients with low literacy, and being proactive in following up patients who are most at risk.[8] External help (eg from PHNs) is often needed to support practices in these types of activities. PHNs are able to help in a range of ways, including de-identified data reviews.

The RACGP has developed a resource on *Secondary use of general practice data*. This resource provides support to decide whether it is appropriate to release de-identified healthcare data at the request of an external organisation.

PHN case study

A couple purchased a retiring GP's practice. They were new to the business and sought assistance from us, their local PHN.

We assisted them in recruiting a PN by advertising on the PHN website and in monthly newsletters. We provided in-practice training for the PN who had come from a hospital setting – educating the nurse on the cycles of care, using recall reminder systems and maintaining practice protocols such as cold-chain.

We provided software installation and training to the practice, which enabled them to audit their aspects of their practice. With this software, we provided the practice with a report and supported them over the next 12 months in improving their recording of risk factors, patient data entry, and identifying patients with missed diagnoses and billing opportunities. Additionally, this process served as a continuing professional development (CPD) opportunity in quality improvement for the GPs, who now often frequent our free CPD nights.

The business owners felt this help was invaluable.

– Alessandro Luongo, Clinical QI Coordinator, South Western Sydney PHN

Measures to improve access to preventive healthcare by Aboriginal and Torres Strait Islander peoples are especially important, given their higher burden of disease and the barriers that exist to preventive healthcare. More information is available in the National Guide.

Collaboratives case study

Health and Wellbeing North Ward is a multi-skilled and integrated medical practice offering primary care alongside other allied health providers. As a collective, it focuses on the proactive identification and treatment of risk factors before disease appears, and on patient-centred management of existing conditions.

The practice has a large Aboriginal and Torres Strait Islander community in its area. To provide holistic and culturally aware care, the practice employs a specialist Aboriginal and Torres Strait Islander healthcare worker. Having a dedicated staff member for this community allowed the practice to:

- run regular day clinics to address chronic condition management
- offer consistent appointments for the local Aboriginal and Torres Strait Islander population and the local school that educates Aboriginal and Torres Strait Islander children from the broader area
- provide home visits to those with access and/or language barriers
- offer Medicare-rebatable healthcare plans for chronic and mental health conditions through their multidisciplinary set-up.

Patients responded very positively toward the extra care. Patient feedback surveys showed a 95% positive reaction, and practice numbers grew by 38% over two years. The care fostered a sense of loyalty and community among patients, with follow-up appointments kept and measurable improvements in health outcomes.

– Adapted from Improvement Foundation Australia. Australian Primary Care Collaboratives Program, Case study: Health and Wellbeing North Ward, 'Multi-skilled, holistic agency adopts "wellness" philosophy'. Adelaide: Improvement Foundation Australia, [no date].

Teamwork within an Aboriginal and Torres Strait Islander health service – Health checks

Patients aged 18 years and over are identified and screened for cardiovascular risk, chronic diseases and smoking via the Medicare Health Assessment for Aboriginal and Torres Strait Islander People (Medicare Benefits Schedule [MBS] item 715).

Suitable clients are invited to participate in after-hours exercise group sessions with a personal trainer, twice a week for two hours. Sessions include advice and education on diet and healthy eating, with the aim to decrease body mass index (BMI), increase health literacy and provide better management of chronic disease. Smoking cessation support is also offered and promoted.

– Fiona Thompson, Clinical Services Manager, Pangula Mannamurna Aboriginal Corporation

Visit 'Key Aboriginal and Torres Strait Islander organisations' for a list of useful contacts.

1.2 About implementation

What is implementation?

Implementation in the healthcare context is the use of strategies to adopt and integrate evidence-based health interventions and to change practice patterns within specific settings.[9] Note the use of 'strategies', plural. There is no single (and simple) way of putting evidence-based preventive activities into practice.[10]

What factors affect implementation?

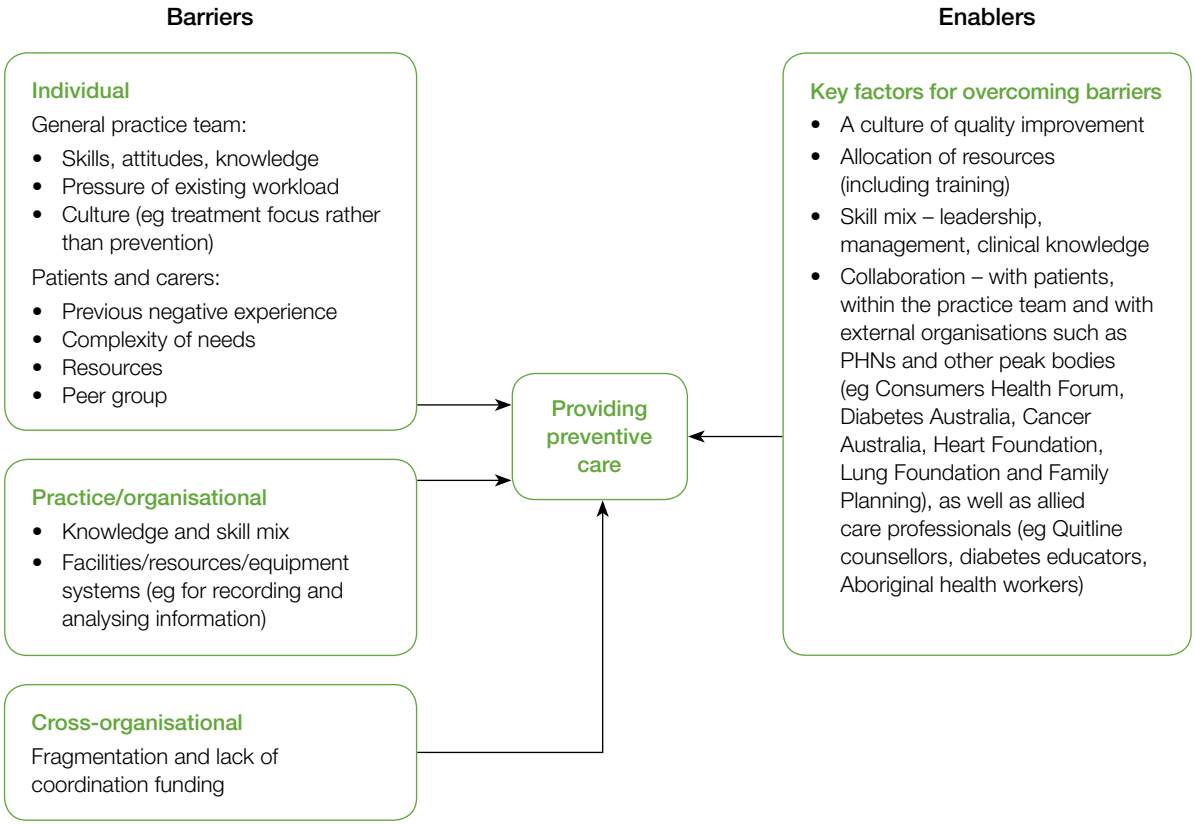
Implementation science helps us identify and understand the determinants, processes and outcomes of implementation.[11,12] There are many individual and organisational factors that influence implementation (Figure 4).

Evidence-based medicine should be complemented by evidence-based implementation.

– Richard Grol[13]

While research has yet to provide many absolute recommendations for implementation strategies proven to be effective in all settings, we do know that improving implementation is highly dependent on changing the behaviour of health professionals, managers and others working within and with the healthcare system.[14,15] This typically involves changing organisational behaviour rather than (or as well as) individual behaviour.

Figure 4. Barriers and enablers of implementation



The most cited enablers of preventive care are:

- availability of a PN[16,17]
- collaboration with other disciplines.[1]

Refer to the Australian Primary Health Care Nurses Association (APNA) for information about the role of PNs in preventive care.

The introduction of financial support for childhood vaccinations provided motivation for individual and organisational change. By rewarding GPs per child vaccination and the practice for meeting population targets, significant increases in completed childhood immunisation schedules were achieved.

– Prof Danielle Mazza, Green Book Editorial Committee

Refer to 'Clinical indicator 8: Childhood immunisation rates'.

Getting the best outcome means that we need to pay attention to all steps in the process. Consider a relay race – winning is more likely if every sector is maximised. In such races, the strongest competitor is frequently allocated the final leg to catch up.

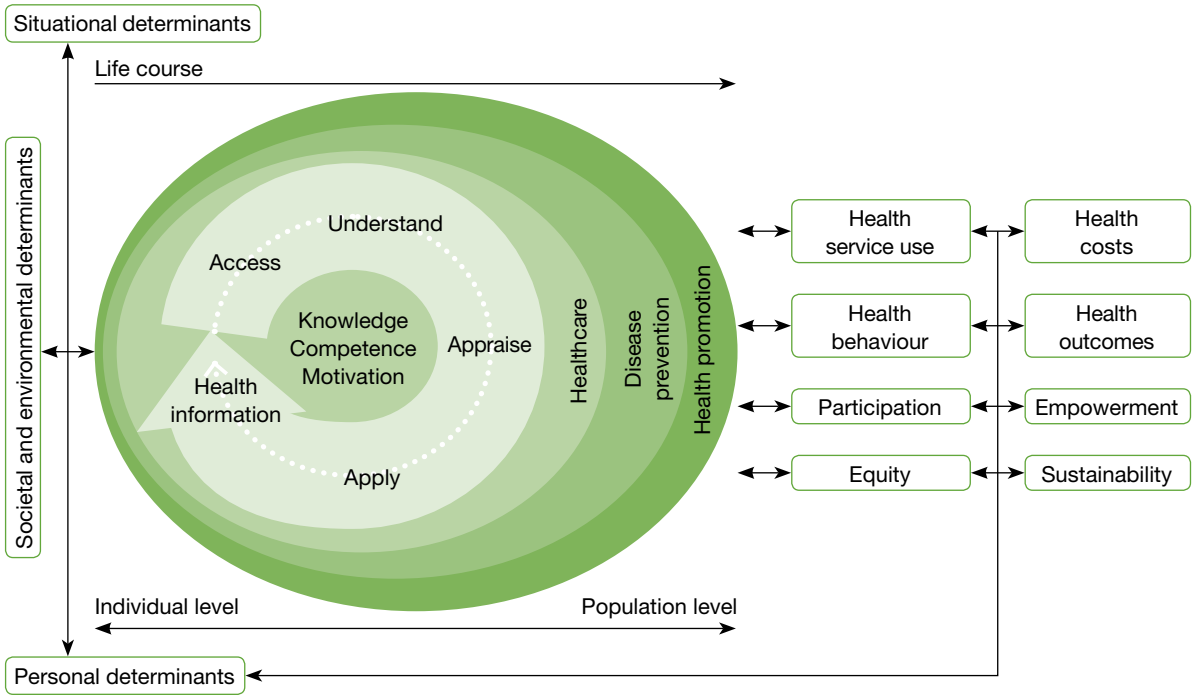
In healthcare, there is often much less attention paid to the final leg (implementation). By focusing as much attention on the final leg as on the earlier stages (or strategies), we can dramatically improve outcomes (ie high coverage can improve outcomes even when the intervention efficacy may be modest).

– Assoc Prof John Litt, Green Book Editorial Committee

Implementation of prevention in context

Interventions may be delivered at different levels: during face-to-face patient consultation, at a practice patient population level, or targeting the community where a practice is located (Figure 5).

Figure 5. Levels where interventions may be delivered



Reproduced from Sorensen K, Van den Broucke S, Fullam J, et al. Health literacy and public health: A systematic review and integration of definitions and models. BMC Public Health 2012;12:80.

Cervical cancer screening is primarily undertaken in general practice in Australia. Yet it is supported by a large number of community-based organisations like the Cancer Councils and other healthcare services such as community health centres. These organisations promote cervical cancer screening in the broader community, raising awareness and increasing health literacy.

In addition, GPs receive financial support through the Service Incentive Payment (SIP) program to undertake cervical cancer screening in those women who have not had a Pap test in four or more years. This support encourages screening and is an illustration of targeting screening at different levels (ie community, practice and patient).

– Prof Danielle Mazza, Green Book Editorial Committee

1.3 Bringing prevention and implementation together

A quality improvement (QI) approach

Implementing preventive activities in your practice is an aspect of a broader QI approach.

Implementing a QI approach to prevention usually involves several elements:

- broadening of focus from just thinking of care of the individual to actively reflecting on the larger population[18,19]
- planning for change[20]
- promoting a culture of QI in the practice team[21–23]
- a collaborative team approach to prevention[24-30]
- a realistic framework for implementation[31]
- being outcomes-focused[23,32]
- acknowledging the context and complexity of general practice[33–42]
- choosing implementation strategies that are evidence-based, efficient and 'do-able' in general practice.[43,44]

Preventive care is part of a broader QI approach.

Alignment with other QI frameworks

Quadruple Aim

Implementing preventive care aligns with the Quadruple Aim framework for delivery of high-quality care, which has the goals of:[45–47]

- improving the individual experience of care
- improving the health of populations
- reducing the per capita cost of healthcare
- improving the experience of providing care.

Achieving these goals and successful implementation of prevention both require an engaged and resourced team, as well as effective and collaborative organisations.[47]

Patient-centred medical home

Although preventive care tends to have a population focus, it still aligns with the patient-centred medical home (Medical Home) model, which has five elements:[48,49]

- comprehensive care

- patient-centred care
- coordinated care
- accessible services
- focus on quality and safety.

A successful Medical Home will provide high-quality preventive care to its patient population (refer to the RACGP's *Standards for patient-centred medical homes,* Standard 4: Comprehensive preventive, acute and chronic disease care*).*

To help practices implement a Medical Home approach, the North Coast PHN has created a website with resources such as videos and print materials, including the *Patient centred medical home: A quality improvement handbook for general practice*.

Resources

- Australian Institute of Family Studies, Key Aboriginal and Torres Strait Islander organisations, www2.aifs.gov.au/cfca/knowledgecircle/key-aboriginal-and-torres-strait-islander-organisations
- Australian Primary Health Care Nurses Association, www.apna.asn.au
- BreastScreen Australia, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/breast-screening-1
- Department of Health, Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK), www.health.gov.au/preventionoftype2diabetes
- Department of Health, National Bowel Cancer Screening Program, www.cancerscreening.gov.au/internet/screening/publishing.nsf/content/bowel-screening-1
- Garvan Institute of Medical Research, Bone fracture risk calculator, www.garvan.org.au/bone-fracture-risk
- National Vascular Disease Prevention Alliance (NVDPA), Australian absolute cardiovascular disease risk calculator, www.cvdcheck.org.au
- North Coast Primary Health Network, *Patient centred medical home: A quality improvement handbook for general practice,* http://ncphn.org.au/medical-home/wp-content/uploads/2016/12/NCPHN-PCMH-Handbook-v1.0.pdf

The RACGP:

- *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice,* second edition, www.racgp.org.au/your-practice/guidelines/snap
- Practice guides and tools: Clinical indicators, *Clinical indicators for Australian general practice,* www.racgp.org.au/clinicalindicators
- *Guidelines for preventive activities in general practice* (Red Book), ninth edition, www.racgp.org.au/your-practice/guidelines/redbook
- *National guide to preventive health assessment for Aboriginal and Torres Strait Islander people* (National Guide), third edition, www.racgp.org.au/your-practice/guidelines/national-guide
- *Secondary use of general practice data,* www.racgp.org.au/download/Documents/e-health/Secondary-use-of-general-practice-data.pdf
- *Standards for patient-centred medical homes: Patient-centred, comprehensive, coordinated, accessible and quality care,* www.racgp.org.au/download/Documents/Standards/RACGP-Standards-for-Patient-Centred-Medical-Homes.pdf

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2. Whole-of-practice prevention

Key points

- Prevention requires consideration of practice populations (without taking away from individual care) – high-quality data is important in obtaining useful information.
- Every member of the practice team plays a role in preventive care.
- Your preventive care team will also include people outside your practice (eg PHN QI support officers, allied healthcare providers, disease and consumer peak bodies).

While few would disagree that prevention is an important part of high-quality, comprehensive healthcare, much of the healthcare system (including general practice) is focused on reactive care. Although we can intuitively see how prevention can reduce the need for reactive treatment, it can be difficult to change focus when the demand for treatment is so much 'louder', more urgent and resource hungry compared to preventive care.

When you're up to your neck in alligators it is hard to think about draining the swamp.

– Assoc Prof John Litt, Green Book Editorial Committee

In this section of the Green Book, we will look at how we can broaden our focus to incorporate prevention without detracting from the quality of reactive care. The key elements of this shift are:

- having a comprehensive understanding of your practice population (so that you can target preventive activities and resources to their needs)
- involving all members of the practice team in preventive care (sharing the workload and responsibility)
- collaborating with external groups and support services.

Effective prevention requires partnership and collaboration on multiple levels – that is, between:

- the patient and GP
- the patient and practice team
- the GP and practice team
- the GP and allied healthcare professionals
- the practice team and PHNs and/or the broader community and health system.

If you want to improve the quality of prevention in your practice, your whole practice needs to be involved.

Think about the roles of the individual members of the practice team and what contribution they can make towards preventive care.

– Prof Mark Harris, Green Book Editorial Committee

2.1 Your practice population

Putting prevention into practice requires a shift from the usual practice of each GP managing the needs of each patient as they present, to taking a step back and looking at your practice population and what its constituents need for good health.

Who are your patients?

Thinking about your practice population, do you know how many patients you are currently responsible for? This isn't simply the number of patients registered on your database. Think of your active patients being the ones who currently consider your practice as their Medical Home.

How well do you know these active patients? Can you easily answer the following questions?	
Do you know the age distribution of your active patients?	What are the needs of your patient groups and what community resources are available to assist them to meet these needs? What clinical areas of need can you influence?
To what ethnic, cultural and language groups do you provide regular care?	GPs will often attract patients based on language and culture. However, this is not always recognised and supported by the practice. For example, a GP who can consult in Greek may attract Greek patients, but the practice does not have appropriate written materials available. Does your practice have supportive materials for your culturally and linguistically diverse (CALD) populations? What are the preventive care needs and potential challenges for these groups (eg Chinese populations tend to have low Pap test rates)? How do you address the determinants of health for these groups (eg education levels, health literacy)?
Do the communities these patients belong to have specific needs or challenges?	For example, do you provide care for refugees or communities affected by natural disasters (eg drought, floods, fires) or mass job losses?

Being able to answer these questions accurately relies on having the right information. Some of it may be available through the practice, but other information (eg the socioeconomic status of your patients) might be more readily available through your PHN. Collecting and analysing that information requires teamwork.

Health literacy

The capacity of your patients to acquire, understand and use health information (ie their health literacy) influences how they manage their health and how they interact/communicate with health providers.[1,2]

There are a number of tools for assessing health literacy levels. Your PHN may be able to provide suitable tools for people in your community.

Patients with low health literacy may understand information better when:

- key points are prioritised
- plain language is used (and in the patient's preferred language)
- images are used
- questions are encouraged.

One of the easiest ways to improve understanding is using the teach-back method. This involves asking the patient to recall and restate in their own words what they have been told.

Red Book for patients

When a patient asks for a routine check-up, with no specific current concerns, I start by asking what they think are the key areas to be covered in a check-up for their age group. This gives me a good start to understanding their health literacy and their priorities.

I then show them the Red Book lifecycle chart to compare and contrast their thoughts with what the evidence says will be most useful for their health.

It's a great way to get the conversation started and often helps reframe patients' expectations when they may be expecting lots of 'screening tests' that are of low value and possibly harmful.

– Dr Caroline Johnson, Senior Lecturer, Melbourne Medical School

What are their health needs?

Now consider an area requiring focus in your practice. Using diabetes as an example, how easily can you answer these questions?

- Does the practice have a register of all patients with diabetes?
- Do you know how many have had a glycated haemoglobin (HbA1c) measurement in the last 12 months?
- Do you know who are the less frequent attenders?
- For those with a known HbA1c that is high, do you know anything more about this group (eg visit frequency, other risk factors such as obesity and smoking)?

Again, you need to have the information available to answer these questions. Most practice management software systems have the capacity to provide the information – as long as it's recorded correctly.

When delivering a workshop on the early detection of lung cancer some years ago, I came across a GP working in a rural country town in South Australia. The town had a mine, which employed a large number of the population. This GP was very aware of the high rates of smoking in the local community and so approached the mine to work with him in trying to reduce rates of smoking in the workers. They developed strategies to support workers to restrict their smoking while at work and support them to quit.

I remember this GP because he epitomises for me someone who was able to take a population view of the risk factors in his practice population.

– Prof Danielle Mazza, Green Book Editorial Committee

SA PHN Immunisation Hub

In order to better understand regional levels of immunisation, increase childhood immunisation rates to 95% and decrease the number of hospital presentations/admissions due to vaccine-preventable diseases, the Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub (the Hub).

The Hub is a multifaceted approach to:

- determine low-coverage areas through careful examination of Australian Immunisation Register (AIR) data
- bridge gaps in immunisation service provision
- support the skill base of immunisation providers
- promote the need for a well-immunised community.

The Hub provides education, mentoring and networking for general practice and other service providers, and engagement, advocacy and resources for the community. The PNs found this a valuable opportunity to connect.

This story demonstrates how PHNs can assist individual practices to better understand their practice population.

5-2-1-0 Let's Go!

The 5-2-1-0 Let's Go! program is a childhood obesity prevention program. It was developed by the Barbara Bush Children's Hospital and has been implemented throughout Maine (USA) and in neighbouring states.

The program has a message that's simple to deliver and easy to understand:

- **5** or more fruits and vegetables
- **2** hours or less recreational screen time
- **1** hour or more of physical activity
- **0** sugary drinks, more water

Program developers work with schools, childcare and out-of-school programs, healthcare practices and community organisations to change the environments with which children and families interact. They also produce a range of resources (eg toolkits and brochures) for different settings and in different languages.

2.2 Your practice team

Practice teams will vary in size and composition. It's not the size, but the diversity of the team, that's most important in terms of improving quality.[3] Each member of your practice team will have some complementary expertise that can be harnessed to improve preventive care.

Bringing the team together requires a common purpose, leadership and a culture of QI.

A culture of QI

A culture of QI means that quality is prioritised. It is a continuous process integrated into the way the practice operates and where every member of staff is involved in the delivery, review and improvement of care.[4] It also implies receptiveness to change.[5]

A key element of a QI approach is patient-centred care:

> *Patient-centred care is recognised as a dimension of high-quality healthcare in its own right and is identified in the seminal Institute of Medicine report,* Crossing the Quality Chasm,[6] *as one of the six quality aims for improving care.*[7]

Although an overall culture of QI is vital, a total overhaul of practice workflow is rarely necessary to improve preventive healthcare.

When seeding a culture of QI in our practice, we found that identifying change champions within the practice was key.

– Dr Cory Lei, Green Book Editorial Committee

We recognised that we had to have a dedicated meeting time for QI, supported by monthly reports on data and a dedicated staff member to do and follow up the actions.

– Assoc Prof Charlotte Hespe, Green Book Editorial Committee

Team roles and capabilities

Every QI team focusing on prevention (Figure 6) should include at least one member for each of the following:

- **Change champion(s)** – this person or people are catalysts for the consideration and adoption of change within the practice.
- **Clinical leadership** – this person needs to provide solutions to the preventive care needs of your patients and understand how changes will affect broader clinical care and impact on other parts of the practice.[3]
- **Technical expertise** – your team may need several forms of technical expertise, relating to areas such as QI processes, health information technology (IT) systems needed to support the proposed change (eg audits), and specifics of the area of care affected by preventive activities.[3]
- **Day-to-day leadership** – this person is the lead for the QI team and ensures completion of the team's tasks, such as data collection, analysis and change implementation. This person must work closely and effectively with the other team members and understand the full impact of the team's activities on other parts of the practice as well as on the area they are targeting.[3]
- **Patient care management** – these team members work closely with patients and their families, and assess patients' care needs; develop, reinforce and monitor care plans; provide patient education and encourage self-management; communicate information across clinicians and settings; and connect patients to community resources and social services.[5]
- **Practice facilitation** – this team member could either be internal or external to the practice team and works with practice staff to help organise, prioritise and sequence QI activities; train practice staff to understand and use data effectively (to identify need and evaluate interventions); and redesign workflows and processes so staff can better serve patients.[5,8] Although this individual does not usually participate on a daily basis with the team, they can assist the team in obtaining resources and overcoming barriers encountered when implementing improvements.[9,10] PHN QI support officers may fulfil this role.

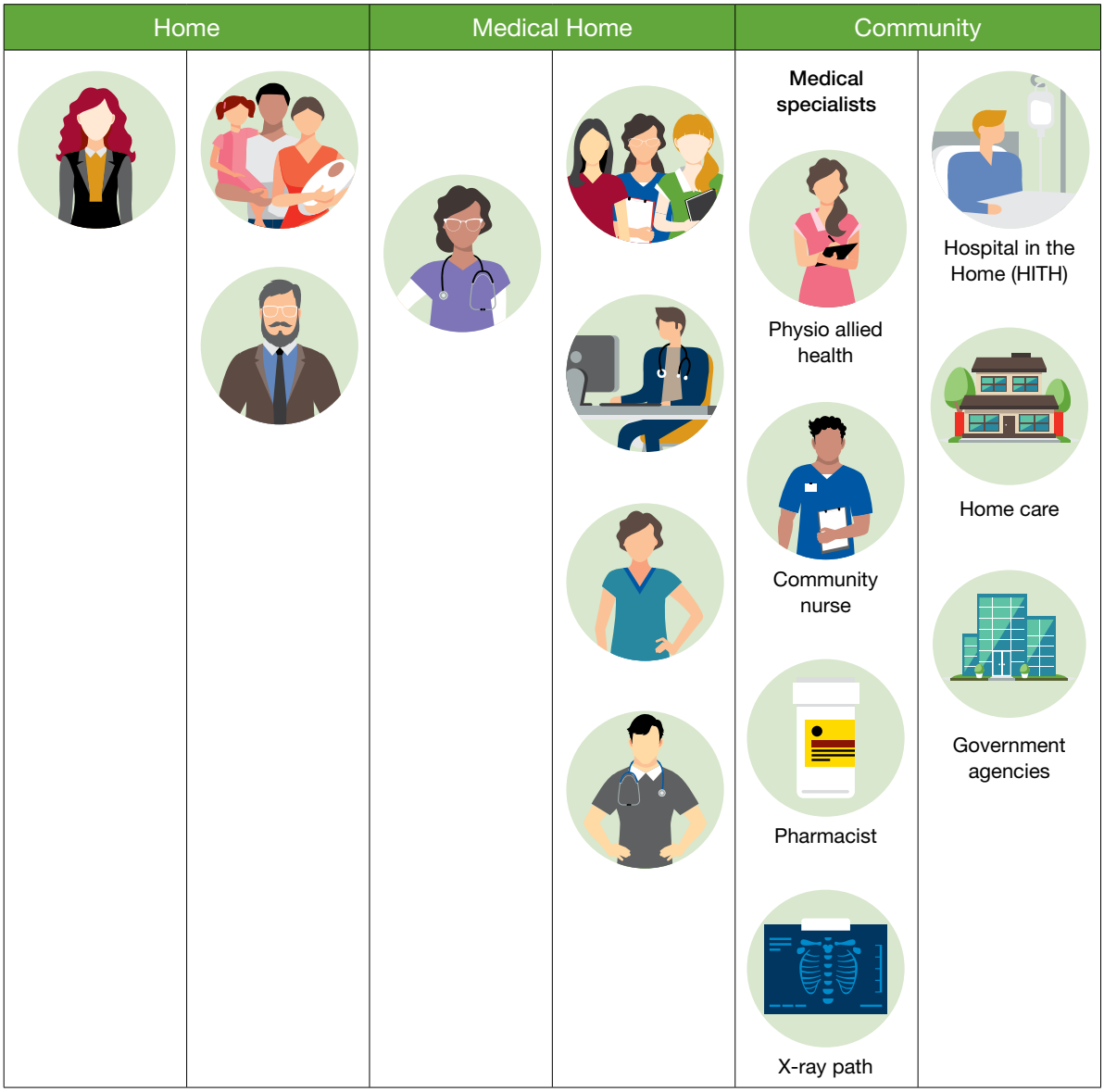
Depending on the complexity of your prevention QI project and the skills of your team, you may have the capacity to fill these roles from within your practice. In some practices wanting to make small or simple improvements, a single person may drive the whole project. However, many, if not most, practices will need to bring in some help from external sources for larger projects, particularly for technical expertise and practice facilitation. Key resources for expertise include your PHN and local health district.[11]

A change champion might not be one of the usual suspects (such as the principle GP). It may be the PN, or practice manager, who has a vision to take the rest of the practice with them.

It's important to recognise that people outside your practice (within the healthcare neighbourhood/community) may be part of your QI team too.

– Prof Mark Harris, Green Book Editorial Committee

Figure 6. The QI team



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2.3 Team collaboration

When bringing together a team, consider the nature and extent of collaboration necessary. Factors important in the development of collaboration include:[12–17]

- sharing of vision, goal-setting, planning, and protecting QI time
- clarification of roles, responsibilities and tasks
- sufficient support and resources
- regular and open communication
- adequate time to develop relationships, working arrangements and trust
- adequate commitment to the process
- recognition and acceptance of separate and combined areas of activity
- familiarity and acknowledgment of expertise
- local advocates and champions
- decision-making, problem-solving and goal-setting
- opportunities for cooperation and coordination.

While all of the points above are important, I find the following are the most important:

- Understand and respect the roles and capabilities of all members of the team (including non-clinical).
- Identify common goals and understanding – what makes sense to everyone.
- Foster open communication where it is okay for everyone to have a say.
- Reflect on how the team is actually working – seeking comment from all the team members (did everyone feel able to contribute, be heard).

Protected time is important, but it doesn't have to be extensive. Some of the best teamwork can come from 10–15-minute informal meetings at the beginning or end of clinical sessions.

– Prof Mark Harris, Green Book Editorial Committee

All members of the team should work together to maximise the ability of patients to lead their own healthcare.[11]

Working together to provide comprehensive care: Case study

Background

A north-west Queensland practice team and broad range of allied health providers and specialists are brokered through a subsidised scheme on a monthly roster. They have a total patient load of 5400, with 2900 active patients.

The group provided high-quality comprehensive primary healthcare with a key focus on Aboriginal and Torres Strait Islander patients that present with chronic comorbidities.

Issue

Patient information systems were incomplete and did not accurately reflect the active client load. Follow-up items of care were undertaken in an ad hoc manner without due diligence to providing comprehensive primary healthcare against cycles of care.

Goals

To ensure patients have access to the cycles of care against particular comorbidities, such as type 2 diabetes or CVD.

To maximise capacity in both the administrative and clinical team to incorporate principles of improvement, namely ensuring data quality and adequacy of patient record information.

Process

The first step was to ensure that the data contained in the patient records was appropriately recorded (clean), and that demographic information was current and completed. Administrative and clinical staff were trained in the use of a data cleansing tool, and were tasked with ensuring data was clean and complete. This activity identified missing demographic information and prompted all clinical staff to complete clinical information for each patient being seen for the day.

Once the clinic had access to high-quality data, systematic recall processes were put in place. At weekly meetings, there was a focus on the follow-up care items suggested for chronic comorbidities. Ongoing reviews of increases in episodes of care were also discussed, and priorities were set for the following week.

Outcomes

- Completed demographic information now ensures record accuracy.
- Increased identification of patients with chronic obstructive pulmonary disease (COPD), risk of CVD and type 2 diabetes.
- Smoking status is recorded on 78% of patient records for patients aged ≥18 years.
- Follow-up care has increased by 45% for type 2 diabetes cycles of care.
- Review of recall systems review has resulted in an increase of 200% in recalls.
- Communication and role autonomy across the administrative and clinical team has been strengthened.
- The Continuous Quality Improvement program has been added to the weekly staff agenda.
- Local hyperosmotic hyperglycaemic syndrome (HHS) reports indicate that hospital/emergency presentations have reduced.
- The Aboriginal community-controlled health service has positioned itself as an employer of choice.

Conclusion

The Aboriginal community-controlled health service has access to patient information systems that reflect their current client load and the team is committed to ongoing Continuous Quality Improvement.

The team are involving all staff from when the patient walks through the doors to when they leave, maximising care and ensuring role autonomy with staff. All position descriptions have been reviewed to include QI. Performance appraisals set and measure achievements against measurable indicators. The Aboriginal community-controlled health service has included the use of the data tools in induction and orientation processes. The service has established and embedded principles to ensure ongoing improvement of the data systems that support patient care.

– Ms Lauren Trask, Accreditation Specialist, Queensland Aboriginal and Islander Health Council

Resources

- *Guidelines for preventive activities in general practice* (Red Book), ninth edition, Preventive activities over the lifecycle, www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition-lifecycle-charts-v2.pdf
- Agency for Healthcare Research and Quality, *Developing and running a primary care practice facilitation program: A how-to guide*, https://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf
- Department of Health, Primary Health Networks, www.health.gov.au/PHN
- Health Literacy Tool Shed, https://healthliteracy.bu.edu
- The Medical Home, The person centred health system and the medical home, http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home
- MaineHealth, Let's Go!, https://mainehealth.org/lets-go
- North Western Melbourne Primary Health Network, Teach Back: A technique for clear communication, www.youtube.com/watch?v=d702HIZfVWs&feature=youtu.be
- NSW Government, Local health districts and specialty networks, www.health.nsw.gov.au/lhd/pages/default.aspx

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3. Approaches to implementation

Key points

- Using a framework can make implementing preventive care activities easier and more successful.
- Which of the relevant frameworks you choose will depend on your situation and goals.
- Understanding behaviour and behaviour change is a component of many frameworks and a key part of successful implementation.

When you decide to improve preventive care in your practice, having a framework to help you plan and implement strategies and interventions can be beneficial. There are several frameworks (and theories) that are relevant to preventive care implementation in general practice, and it can be challenging to select the 'right' one.[1]

It's important to note that:

- many strategies and interventions have been shown to be effective when implemented individually or collectively[2–56]
- there is no one framework that is more effective for implementing strategies and interventions than the others across all situations[20,22,23,57–64]
- many of the theories and frameworks help us understand behaviours and identify techniques to change both patient and practice behaviours.[65]

3.1 Using an implementation framework to help you put prevention into practice

Any implementation frameworks or associated strategies you adopt should be realistic, feasible, transparent and congruent with the goals and philosophy of the practice and practice team.[66–70]

Table 1 compares some of the relevant theories and frameworks. When looking at these, consider whether you will be able to sustainably implement them into normal practice routines, and how this might be done so that they become part of the practice culture.

Table 1. Implementation theories and frameworks

Theory/framework	What is it?	Who does it?
Patient or practitioner behaviour change		
5As[71–74]	The 5As (ask, assess, advise/agree, assist, arrange) is an intervention framework that helps raise a topic with a patient and support change Refer to Appendix A1	GPs, PNs, allied health professionals (eg diabetes educators, Quit educators)
Motivational interviewing[21,75–82]	Motivational interviewing is a counselling approach that helps resolve ambivalence and increases motivation to change Refer to Appendix A2	GPs, PNs, allied health professionals, as well as family members and carers

Table 1. Implementation theories and frameworks

Theory/framework	What is it?	Who does it?
TPB[83–87]	The TPB (theory of planned behaviour) suggests that human action is guided by behavioural beliefs (about likely consequences), normative beliefs (about expectations of others) and control beliefs (perceived behavioural control)	Members of your QI team
COM-B [88,89]	COM-B (capability, opportunity, motivation and behaviour) is a simple model to understand your team's behaviour and identify barriers to implementation Refer to Appendix B1	Members of your QI team (eg practice facilitator)
Implementation and QI frameworks		
DMAIC[90–93]	DMAIC (define, measure, analyse, improve, control) is a data-driven improvement framework used in various sectors, not just healthcare Refer to Appendix C3	Members of your QI team
KTA[94–96]	The KTA (knowledge-to-action) framework is used to implement best practice guidelines. It comprises a knowledge creation process and an action cycle Refer to Appendix C2	Members of your QI team
NPT[23,68,97–101]	NPT (normalisation process theory) is an 'action' theory – it is concerned with what people do rather than attitudes or beliefs. It divides actions into four categories that represent different kinds of work that people do around implementing a new practice: coherence, cognitive participation, collective action and reflexive monitoring	Members of your QI team
PDSA[90]	The PDSA (plan, do, study, act) is a cyclical framework for QI Refer to Appendix C1	Members of your QI team
PRACTICE[102,103]	PRACTICE (Principles, Receptivity, Ability and capacity, Coordination, Targeted, Iterative cycles, Collaboration, Effectiveness and efficiency) is a useful evidence-based framework to help with the implementation of a range of preventive activities We will use this framework as a worked example in Chapter 4	Members of your QI team
RE-AIM[2,104–110]	RE-AIM (reach, effectiveness, adoption, implementation, maintenance) is used to translate research into practice and help plan interventions/programs for real-world settings	Members of your QI team

GPs, general practitioners; PNs, practice nurses; QI, quality improvement

3.2 An overview of the PRACTICE framework

In Chapter 4, we use the PRACTICE framework as an example. This framework has the advantage of incorporating elements of other frameworks where those elements are supported by good evidence.[9,102,103,111,112] Table 2 provides an overview of the PRACTICE components.

Table 2. PRACTICE components[102]

Components		Issue
P	Principles	What underpins the process?
R	Receptive	What's in it for me (patients and practice)?
A	Ability and capacity	Can I do it?
C	Coordination	Who will organise it?
T	Targeted	Who needs it?
I	Iterative cycles	How can I ensure that it happens?
C	Collaboration	Who can help me?
E	Effectiveness and efficiency	What works to put it in to practice? How can I make it a part of the routine?

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Resources

- Normalization Process Theory, Implementing and evaluating complex interventions, www.normalizationprocess.org
- RE-AIM, www.re-aim.org/about
- Value Based Management.net, Theory of planned behaviour, www.valuebasedmanagement.net/methods_ajzen_theory_planned_behaviour.html

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4. Putting prevention into practice

Key points

The PRACTICE framework:

- is useful when implementing preventive activities – it incorporates elements of several other theories and frameworks
- helps identify and overcome barriers to implementation (eg engagement, collaboration and systems)
- helps remind us that change is incremental and that we should plan for and recognise 'small' successes along the way.

In this chapter, we will look at the process of using a framework for selecting, planning and implementing preventive activities. We will use the PRACTICE as an example of an implementation framework.

Before starting your prevention activity, it is useful to do some planning. Draw a plan outlining how you will address each element of PRACTICE and seek the feedback of your team.

– Dr Cory Lei, Green Book Editorial Committee

4.1 Principles

When planning preventive interventions, start by collaborating with your practice team to establish a set of principles that will guide your team through the improvement process. We have looked at the general principles of putting prevention into practice in chapters 1–3. To recap, they are:

- broadening our focus from the individual to the group or population
- having a practice culture that values and promotes quality improvement (and is open to the change needed to achieve it)
- working collaboratively on all levels (patient–practice team; within the practice team; practice team–other supportive organisations)
- having a realistic plan
- using implementation strategies with good evidence of effectiveness (detailed in this chapter).

This is a great opportunity to do a proper analysis and develop a plan:

- Look at your practice population: What's the overall picture?
- In terms of what you do, where are the gaps?
- What are your priorities?
- Instead of assuming that you do some things well, look at the data and work out ways to improve.

– Assoc Prof Charlotte Hespe, Green Book Editorial Committee

Selecting the area of prevention to improve

One of the early steps in improving preventive care is identifying a target or a 'problem to be solved'.

This may be a population/group (eg smokers, risky drinkers) or an intervention (eg immunisation, screening). Tools that can help you identify a target include:

- practice guidelines (eg Red Book, *SNAP* guide)
- practice data (eg clinical audits, recalls and reminders)
- local need (eg as identified by PHNs)
- national health programs and initiatives
- quality indicators (eg RACGP clinical indicators, RACGP standards)
- PLAN practice profile analysis and self-assessment report.

Sometimes a sentinel event can be a trigger for quality improvement.

For example, in late 2016, a thunderstorm asthma event occurred in Victoria, resulting in many thousands of people experiencing breathing difficulties, widespread health service use and even deaths. This triggered many practices to implement preventive activities focused on ensuring their asthmatic patients were receiving the best possible care.

– Prof Danielle Mazza, Green Book Editorial Committee

To work out what needs to change, you need to analyse the gap between current practice and evidence-based best practice. This gap analysis will also provide you with a way of measuring progress.

It is important to be clear about the behaviours that need to be changed, any relevant contextual changes that also need to be made, and the level at which the intervention will be delivered (individual, whole of practice or practice population, or community).

Working together for better health outcomes for our patients

Having high-quality data is in everyone's best interest. There is no better way to facilitate the active management of a practice population, particularly for those at high risk. We have a whole-of-practice, proactive and continuous approach to data quality. Our clinical team values the practice team's quality improvement efforts as it helps them manage their patients in a more optimal way.

First, we ensure that the information collected from patients is relevant, complete and recorded correctly. Second, we identify gaps in our data and have strategies to remedy them. Throughout this process, we communicate our goals and track our progress with the team.

An example of this is our diabetes program, which stemmed from a diabetic audit – we now have 65% of our patients with HbA1c <7% which is an excellent result. These wins remind us that the numbers are not 'just data', these are our patients – our community – and we are working together for better health.

– Ms Kylie Gibson, Practice Manager, Fisher and Holder Family Practice ACT

General practice case study

Staff at a practice identified overweight and obesity as a problem they wanted to tackle (67% of patients aged >40 years were overweight and obese).

But the practice GPs felt frustrated in supporting patients to lose weight – their patients rarely took on or adhered to preventive advice. Patient health literacy was identified as a problem; the GPs agreed that many of their patients did not fully understand how much they should be eating or how to go about exercising.

At a staff meeting, each staff member contributed to the discussion regarding the issues faced. The PN was interested in being more involved in weight management but lacked sufficient time to take patients through a structured program involving multiple sessions.

So, the following strategy was devised: As overweight and obese patients were identified by the GPs, they were offered an appointment with the PN for a health check, which involved some brief education and goal-setting. The PN then assisted the patients to register for free telephone weight management coaching provided by the state health department. The PN then followed patients up after a few weeks to determine if they found it helpful and what progress they were making.

– Prof Mark Harris, Green Book Editorial Committee

4.2 Receptivity (and engagement)

Change is often more effective and efficient if a whole-of-practice approach is adopted. This means addressing receptivity to change and using strategies that promote engagement on all levels. This area is often overlooked.

Questions to ask include 'Why consider changing?' and 'What's in it for our patients and our practice?' It is also important to consider:

- how receptive and engaged your practice team will be to implementing new prevention activities
- what preventive activities your practice population is likely to be receptive to.

Taking time to think about how you can address these within your practice can improve your chance of success.

When considering preventive activities relating to overweight and obesity, there may be resistance because people feel they are being stigmatised. As a practice, we need to recognise this and address it. For example, consider using the word 'weight' rather than obesity.

– Prof Mark Harris, Green Book Editorial Committee

General practice wellness and weight

The Stirling Central Health Clinic facilitates 'Wellness and Weight' groups for working adults aged 40–49 years with a BMI of >25 kg/m^2. Six group sessions of approximately 10 participants are run over a number of weeks and held after-hours. The group sessions focus on encouraging and enabling participants to identify and increase positive health activities rather than focusing solely on weight loss. Education is presented from a weight-inclusive perspective using positive language and includes presentations on mindful eating, positive body image, stress reduction, enjoyable activity versus 'exercise', and nutrition. Presenters include a clinical psychologist and dietician with a special interest in the management of obesity.

Participants develop and set SMART (Specific, Measurable, Assignable, Realistic, Time-related) program goals in conjunction with the PN, and outcomes are measured at three, six and 12 months. Measurements taken include BMI, blood pressure and bloods, as well as measurements of happiness and Depression, Anxiety and Stress Scale (DASS) score. Participants are also asked to identify healthy activities they would like to try and, where possible, one-off 'try before you buy' sessions are arranged in addition to the six sessions. Activities identified have included Pilates, a healthy cooking class and a screening of the documentary *Embrace*.

One of the most valuable outcomes has been the social support the participants find within the group setting, which helps them to continue their health-positive journey upon conclusion of the group sessions.

– Sally Jarrett, Practice Manager, Stirling Central Health Clinic

Unless we understand the barriers that will arise, the process won't be successful. We need to listen to the concerns of our team and offer explanations and solutions. For example, staff in a practice wanted to engage more in prevention, but felt they were lacking the staff to do so. Staff with the most appropriate expertise were identified and re-tasked.

– Assoc Prof John Litt, Green Book Editorial Committee

What makes our team receptive?

GPs, PNs and the practice team as a whole are more likely to be engaged in delivering preventive care if they believe it is beneficial and achievable.[1–5] How you deliver preventive care also affects engagement (Table 3).[6–10] Leadership is a key contributor to both engagement and capability for change. This can take a number of forms, including having 'local champions', facilitators and opinion leaders.[11–17]

Table 3. Improving general practice engagement in preventive care delivery

Beliefs	Capacity	Process
Members of the practice team are more likely to engage if they: • believe that prevention is an important and worthwhile part of their role and congruent with professional and practice goals • believe that they can deliver it effectively and/or efficiently • can see the benefits and that the process is worthwhile (for the GPs, PNs, whole practice team, patients and wider community), or provides a relative advantage over existing approaches • believe that prevention is feasible, can be tailored to the contextual setting and is sustainable in their practice	Practice team members are more likely to engage if they: • have the relevant skills • have the time and necessary resources • have patients that are receptive to their efforts	Engagement is more likely if the process: • is transparent (ie everyone is clear about what needs to be done) • is respectful (eg of abilities, skills, workload) • is congruent/consistent with the professional goals and the practice goals • encourages mechanisms/strategies that help make the outcomes visible • acknowledges the contributions of each team member

Making success visible

An important motivator is seeing success. Lack of visible outcomes makes implementation of many prevention activities more problematic. We cannot know with certainty that our efforts have prevented the occurrence of an illness or disease in any individual. This is especially true for long-term outcomes. For example, advice about smoking is provided in the expectation that the patient will be less likely to get lung cancer or heart disease. However, the patient may not feel any different (and may occasionally grieve for giving up something they enjoy), and the team may never see how their efforts affected the patient's future.

A useful strategy is to select appropriate (observable or measurable) proxy measures of an outcome that may not be easy to measure (eg absolute cardiovascular risk as a marker of [reduced] risk for vascular disease). The prevention equivalent is to monitor the uptake of prevention activities (eg immunisation coverage) or, alternatively, the patient-reported behaviour (eg smoking status, alcohol consumption). This helps to ensure that all involved can see that something is being achieved. Providing meaningful feedback will require measurement of performance.

Change is incremental. To assist with engagement, it is often useful to have smaller targets along the way that you are working towards. One idea to make this visible and to keep everyone engaged is to make a wall chart in the staff area of your practice showing the progress you are making in your program.

– Dr Cory Lei, Green Book Editorial Committee

We can take the SMART acronym[18] used in project and business management when we look to make improvements:

S – Specific (target a specific area for improvement)

M – Measurable (have a quantity or an indicator of progress)

A – Assignable (so that you can specify who will do it)

R – Realistic (goals should have achievable outcomes; they should also be 'Relevant' to your broader priorities)

T – Time-related (have clear time frames and deadlines)

– Dr Cory Lei, Green Book Editorial Committee

4.3 Ability (and capacity)

Determining the capability and capacity of the practice for change is an important early step.[3,19,20]

Many factors affect your practice's capacity for change. These include a wide array of strengths, skills, resources and competencies, including:

- leadership and decision-making
- culture
- communication and relationships
- management infrastructure
- information mastery (access to and use of information, such as clinical information system [CIS] capabilities).

Each of these are discussed in more depth in subsequent sections.

Assessing your practice's ability to change

What are our attitudes, beliefs and values about prevention activities and our patients' ability to change?

Positive practice team beliefs and values about preventive care are associated with improved performance.[21–24]

Do we have sufficient skills?

Necessary skills include:

- motivational interviewing techniques/skills,[25] interviewing strategies and effective behavioural strategies
- behavioural skills for brief intervention strategies[22,26–28]
- counselling skills.

Motivational interviewing (MI) underpins health coaching. In general practice, this is a very powerful approach. Many different programs and services that incorporate coaching use MI.

Behaviour change: GASP case study

GPs and PNs often find it challenging to help patients change their behaviour. They feel frustrated with their current approaches and often believe that alternative approaches, such as MI, are too difficult or time consuming.

In the GPs Assisting Smokers Program (GASP), GPs and PNs attend a 2.5-hour workshop that provides information on effective MI strategies and opportunities to practise/hone their approaches with simulated patients using vignettes that reflect real-world examples. Experienced facilitators oversee the role-plays, provide feedback and demonstrate effective strategies.

One MI skill is the ability to elicit 'behaviour change' talk. This means eliciting the beliefs, needs and reasons that often underpin the patient's motivation to change their behaviour. One strategy is to ask about the patient's desires, ability, reasons and needs. Possible questions include the following.

Desire

- How would you like things to change?
- What don't you like about how things are now?
- What do you hope will be different?

Ability

- What do you think you would be able to change?
- Of the options you have considered, what seems most possible?

Reasons

- Why do you want to lose weight? To stop smoking? To be more physically active?
- How do you think your diet is affecting your health?

Needs

- What about your behaviour causes you concern?
- What worries you about your behaviour?
- What concerns you?
- What can you imagine happening to you as a result of your behaviour?
- What do you think will happen if you don't make a change?

GPs and PNs found their perceived skills and confidence rose following the workshop, as did their preparedness to use MI in their own settings.

– Assoc Prof John Litt and the GASP team, including Flinders University and Quitline South Australia

Do we have a supportive organisational infrastructure?

How can a practice, as an organisation, support preventive care? A systematised approach is needed, and includes:[29–37]

- a culture of QI
- practice policies that support preventive care
- clinical protocols and procedures that are modelled on existing guidelines
- a business plan that demonstrates viability and sustainability of the activity
- a range of delivery options (eg use PN skills; multidisciplinary clinics in areas such as asthma, multimorbidity, diabetes; referral options such as Quitline counsellors, exercise physiologists)
- information management, IT systems and CIS
- patient education and shared decision-making materials, waiting room resources
- screening and information-gathering materials and strategies
- consultation materials
- recognition of practice team achievements.

Can enough time be set aside for the process?

Adequate time needs to be set aside for meetings, planning the various activities and bringing everyone up to speed on the process. It is helpful to quarantine dedicated time during the week when the practice team can work on prevention activities.

4.4 Coordination of people and processes

In planning and implementing prevention activities, a number of processes and activities will help to make it happen. One such process is good coordination. Coordination can be improved in the practice through:

- the presence or support of a facilitator (this might be provided by a PHN)[38–40]
- clarification of roles and responsibilities in prevention[41] (Are there clear job descriptions? Are the various roles and responsibilities delineated?)
- good communication, keeping all team members informed
- setting aside sufficient time for planning, having as many team members as possible attend the practice meeting, and discussing delivery of the programs
- having a written plan that includes the goals, objectives and proposed strategies so that the process is clear and explicit.[42]

Putting prevention into practice

The Putting Prevention into Practice (PPIP) program suggested that practices create a facilitator position to coordinate improving delivery of cardiovascular screening and prevention.

After undertaking a business case, one large practice recruited one of their staff with the necessary skills to a role created specifically to improve preventive care. This new facilitator convened a number of meetings, provided feedback on progress and solicited input on the various proposed approaches. GPs and PNs commented on the effectiveness of this facilitator in ensuring screening and prevention processes were coordinated and efficient.

– Ms Anne Fritz, Practice Manager, Kingston Family Practice, Brighton, South Australia

Responding to family abuse and violence – A whole-of-practice response

Practices can arrange for a whole-of-practice meeting for an hour to discuss a case study about family abuse and violence (FAV). It can involve how FAV might present and be managed in the waiting room and by the GPs and/or PNs. It encourages all practice team members to consider these issues and support each other. It should also consider the need to find resources and places or referral, and have this information recorded in the practice database.

– Dr Libby Hindmarsh, co-author of the RACGP White Book

4.5 Targeted to people and priorities

Targeting involves identifying the priority prevention areas and obtaining consensus from all participants, including on the level of need for the prevention activities. It can also mean identifying the specific groups that you wish to address. For example, if you wish to improve immunisation coverage rates, it would be more efficient to focus on those who are not immunised than on the entire practice cohort, unless the level of coverage is very low or is very variable. In the latter case, targeting the entire cohort would be the better option.

The identification of prevention areas to tackle first is influenced by a range of factors such as burden of illness, frequency, ability of the GP to alter the outcome, feasibility, professional values and preferences.

It is helpful to obtain some form of objective information (from your local community as well as from your practice) about the extent or nature of the problem.

Who needs the preventive activity?

Targeted groups can include those eligible for specific prevention activities, those at higher risk and those who express greater interest in making changes. Targeting at-risk and priority populations is especially important. Prevention reduces health inequalities in disadvantaged groups and patients with chronic disease and/or ‘at risk’ behaviours. While an opportunistic approach to prevention targets individuals attending the practice, it rarely encompasses all patients eligible for a prevention activity.

Consider your community and whether or not your practice is adequately serving high-risk groups. For example, if your local community has a high proportion of Aboriginal or Torres Strait Islander patients, assess whether their health needs are being met by your practice.

Secondary prevention of coronary artery disease: Case study

We instituted a project at the Fairfield GP Unit to improve our care of patients who are known to have coronary artery disease (ie secondary prevention).

We focused on increasing the percentage of patients with established coronary artery disease who had a GP management plan completed in the previous 12 months. We chose this secondary outcome because we believed that if a plan had been completed, a number of issues such as smoking, hypertension, exercise and lipid control would have been addressed.

We undertake a monthly data extraction from our electronic medical records and produce a run chart of the percentage of patients with a GP management plan completed in the last 12 months. This data is then presented to the whole team at our regular monthly practice meeting.

We learned that we needed to improve our coding of patients with coronary artery disease so that we can identify who is or is not receiving good care. We suspect we still haven't identified all our patients, given the known prevalence of coronary artery disease.

We found that recalling patients improved our figures. By making GP management plan completion rates part of the monthly meetings, we tried to make sure we keep working on this issue.

We would recommend to others to focus on a particular area for improvement and delegate a small team to work on it. An enthusiastic medical student helped us with the project. We used formal quality improvement processes such as the Langley and Nolan 'Model for Improvement' and rapid improvement (PDSA) cycles.

– Dr Andrew Knight, Fairfield GP Unit, NSW

Setting a level of performance (What's our goal?)

Identifying a target goal provides something to aim for and a benchmark against which to measure progress.

Identifying and addressing barriers to implementation

It is also useful to identify the actual and potential barriers and difficulties that may be encountered when trying to improve performance.[43–48] For example, consider the health literacy of the target population, as this may be a significant barrier to patients engaging with and taking up preventive activities and adhering to preventive advice. One simple strategy is to ask all the practice team about the potential (and actual) challenges that they will likely face if implementation is to proceed. Also ask the team about possible ways of addressing these barriers and challenges.

Knowing how well the practice is performing, together with an understanding of barriers, will assist in the development of appropriate strategies to overcome the difficulties.

When implementing prevention activities for our Aboriginal and Torres Strait Islander patient group, we identified that the biggest barrier was keeping appointments. The practice team agreed to change our approach to targeting patients opportunistically in the waiting room. This meant ensuring nursing staff have capacity to do this without disturbing the flow of appointments. We achieved this by empowering the nurses to:

- review the appointment book and the waiting room, both in the morning and during the day, to identify potential patients to invite in for 'added value care'
- invite the patients to spend some time updating their records while they are waiting for their doctor. They are often able to get preventive care activities started or finished while patients are waiting. They are also able to have patients come back to finish their prevention activities after seeing the doctor (if not completed during the appointment)
- have adequate 'unscheduled' patient time slots to enable this flexible approach to care.

– Assoc Prof Charlotte Hespe, Green Book Editorial Committee

Common challenges to effective implementation relate to a practice's capability in terms of whether practice members have:

- adequate knowledge
- positive attitudes/beliefs about prevention
- sufficient skills
- enough time, resources and personnel
- adequate organisational infrastructure.

Taking a holistic (whole-of-practice) approach to implementation

Making changes at one level (eg the individual practitioner) without considering the implications or paying attention to other levels (eg organisational or system issues) is less likely to be associated with successful implementation.[1,3,8,11,12,14,49–101] Implementation needs to be targeted to each of the following levels:

- individual (eg education, skills development, feedback, academic detailing, guidelines)
- group (eg team development, clinical audit, guidelines)
- organisation (eg organisation culture and development, continuous improvement)
- larger system (eg accreditation, payments systems/incentives, national bodies).

Interventions selected need to tailor the process to the context of both the practice and the patients.

Improving influenza vaccination in patients 65 years and older

Rather than sending out reminder letters to patients when the flu vaccine becomes available, it is better to flag the case notes of this group as more than 90% will come to the practice in the months prior to the flu season. Many are used to having the flu vaccine, and this can be offered when they attend for other reasons. By May, the number in the target group who have not been vaccinated will be relatively small and likely comprise various groups, including infrequent attenders and those less (or not) interested in getting the flu vaccine. A tailored phone call or SMS from the PN coupled with a strong GP recommendation will further increase coverage rates and save the practice cost and time sending numerous letters.

Offer pneumococcal vaccine or the zoster vaccine when giving the flu vaccine to save the patient an extra visit.

– Assoc Prof John Litt, Green Book Editorial Committee

In summary, effective targeting is more likely if you have addressed these questions:[102]

- Whose health are you seeking to improve (target population/s)?
- What behaviour are you seeking to change (behavioural target)?
- What contextual factors need to be taken into account? (What are the barriers to, and opportunities for, change? What are the strengths/potential of the people you are working with?)
- How will you know if you have succeeded in changing behaviour? (What are your intended outcomes and outcome measures?)
- Which social factors may directly affect the patient's behaviour, and can they be tackled?
- What assumptions have been made about the theoretical links between the intervention and outcome?

4.6 Iterative cycles

The iterative cycles component of the PRACTICE framework relates to the fact that putting prevention into practice is an iterative process; that is, measurement of the desired target is repeated to see whether improvement occurs.

Change is an incremental process. The only way of knowing whether an intervention has made a difference is to measure the situation before and after the intervention.

How do you know that you are making a difference?

Is there a cyclical planning process that measures progress and ensures necessary adaptation?

Measurement and evaluation are essential to determining that the implementation processes have been carried out, barriers to implementation identified, and implementation strategies have been effective. This process creates a learning cycle, ideally leading to more effective strategies being developed and/or to discarding ineffective strategies. Improvement takes time and a commitment to reflect on progress.[103] An iterative approach will help both the GP and practice address the following questions.

Does the practice use a 'plan, do, study, act' (PDSA) process to review progress and develop strategies for improvement?

Assessment and feedback can be used to adjust an intervention or determine priority areas.

- Does the implementation process need to be changed?
- Is there a logical, evidence-based argument that an alternative implementation approach is preferable to the current one?
- Is there evidence that the GPs and the practice are not using a preferred alternative? Can you measure your progress in implementing changes? What is the problem with the current approach? What strategies are used to identify progress?

Measurement usually requires identification of a particular cohort of patients in a target group. Practice registers, patient surveys and data-mining tools can assist in identifying eligible patients to be included in the target group.

Is there an opportunity for reflection?

Deciding on a change to the delivery of preventive care requires both measurement of progress and a discussion of the findings. All those involved need to be informed of the progress in order to facilitate making further changes.[104]

It is important to have a means of tracking your progress and ensuring your plans are on schedule. A reminder system that is visible to your practice team will prove helpful. Consider having an interactive chart that has a timeline displayed in the staff room.

– Dr Cory Lei, Green Book Editorial Committee

Figure 7. Gantt chart in practice

Gantt chart example

Task	Time									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Task 01										
Task 02										
Task 03										
Task 04										
Task 05										

4.7 Collaborating to make it work

The whole process is also more feasible if the practice collaborates with others who have relevant skills or programs (eg allied health providers such as Quitline counsellors, diabetes educators). Collaboration with the patient is also an essential element and part of the patient-centred approach. Knowledge of local services, supports and agencies can facilitate collaboration. The local PHN should be aware of potential partners and supports.

Nevertheless, better collaboration is often challenging. Groups tend to promote an inwardly focused identity and values. Similarly, group members develop strong in-group norms and behaviours that collectively create mental or physical boundaries. This makes it more difficult for external agents and persons to engender networked behaviours and collaboration.[105]

Strategies to improve collaboration include:[105]

- more attempts to gain a better understanding of the nature of gaps (social or physical spaces, structural holes, disconnected ties) between teams and groups
- use of opinion leaders and facilitators to help span boundaries; these boundary spanners are people who bridge two or more groups, enabling exchange of information or communication
- using strategies to stimulate more interactive relationships (eg joint agendas, identifying common purpose, sharing a common space).

GPs Assisting Smokers Program

As part of GASP, GPs and PNs were offered an opportunity to enhance their counselling skills in smoking cessation by attending a 2.5-hour workshop on motivational interviewing and brief behaviour change. There were two workshop leaders: a GP and a Quitline counsellor. Several strategies were used to enhance the recognition and referral to Quitline counsellors:

- the GP and the Quitline counsellor conjointly ran the workshop
- in small group sessions, each facilitator demonstrated their approach to counselling
- a one-minute 'referral to Quitline' spiel was developed to provide GPs and PNs with an efficient approach for referral to the Quitline.

The benefits of involving the Quitline counsellor were many. GPs and PNs saw, first hand, the high-level skills and competencies of a Quitline counsellor. This had several follow-on effects, including greater subsequent referrals to the Quitline and greater preparedness of the practices to use PNs as counsellors. It saved the GPs time and many PNs embraced the opportunity to improve counselling skills that they have used with a number of different patient groups, including patients with asthma and diabetes.

Participants commented positively on the conjoint approach and how it added to the effectiveness of the GP and practice team intervention. They reported that Quitline referrals in their practices were subsequently monitored and improved.

– Assoc Prof John Litt and the GASP team, including Flinders University and Quitline South Australia

Who can help us?

Are all the key players involved?

Provision of best practice in both prevention and management of chronic illness would add an additional 9–10 hours to a normal day,[106,107] making it difficult to provide high levels of prevention outside a partnership approach. Partnerships and collaboration operate at different levels: between the GP and patient; PNs and patient; GPs, PNs and practice team; and between the practice, PHN and/or the broader community and the health system.

There is evidence that when GPs and PNs regard patients as active partners in seeking preventive healthcare advice, patients are more likely to adhere to treatment plans.[108,109] This requires teamwork and respect for others' ideas and views.[110] Referring to, and communicating with, certain services and community agencies may be the most cost effective way of providing particular types of prevention activities for patients. Improving the integration of preventive activities through greater collaboration leads to enhanced effectiveness and efficiency.[96,111]

To what extent does the practice coordinate with other services and agencies?

A range of other players and agencies are involved in promoting health and preventing disease. A number of studies[40,112] have demonstrated that collaboration and teamwork is associated with the largest gains in prevention outcomes. Partnerships are associated with improved delivery of care.

4.8 Effectiveness (and efficiency)

Much time can be spent providing either ineffective care or effective care inefficiently. Effective strategies for prevention in general practice are increasingly well documented. The RACGP *Standards for general practices* require practices seeking accreditation to demonstrate that they use appropriate guidelines in consultations with their patients.

Box 1. Guidelines

Many guidelines have been produced to aid effective implementation of a range of prevention activities. These include the RACGP's:

- *Smoking, nutrition, alcohol, physical activity* (*SNAP*): A population health guide to behavioural risk factors in general practice, for strategies to address lifestyle-related behaviours
- *Abuse and violence: Working with our patients in general practice* (White Book), to assist with the identification and management of patients who are victims of abuse or violence
- *Supporting smoking cessation: A guide for health professionals*, to assist patients who smoke to quit.

Effectiveness (What works?)

Are we strategic in our approach to implementation?

General practices are more effective when they are strategic. Specifically, they should focus on:

- target conditions that have a significant burden of morbidity[113]
- use implementation approaches that have a theoretical rationale[114–121]
- areas where there is a clear and accepted role for the GP and the practice team, and the prevention target can be influenced by the actions of each
- activities with clear aims and objectives.

Box 2. Making the process more strategic[3,122–128]

Questions to ask:

- Is it important? (burden of illness)
- Am I likely to be effective? (role, impact)
- Can I make the outcome visible? (feedback, observable/measurable)
- What will assist getting a quick return? (reward/reinforcement)
- Is it desirable? (congruent, win–win, all stakeholders)
- Is it do-able? (realistic)
- Can we make it a routine part of the practice workflow? (sustainable)

You may wish to improve the level of immunisation coverage against pneumococcal pneumonia in at-risk or older patients. Pneumococcal pneumonia has a significant burden in older patients, and an effective vaccine is available.

If, for example, a recent audit of this group demonstrated pneumococcal coverage of around 44%, a realistic aim would be to increase this coverage to 60% in the first instance. There is good evidence that a GP recommendation to have the pneumococcal vaccine is a significant influence on the patient's preparedness to get the vaccine.

A GP recommendation also tends to counter any patient concerns or uncertainties about immunisation. In this instance, the focus of the intervention could include having the target population identified on their medical records so that when they attend the practice, the GP or PN is prompted to offer the pneumococcal vaccine.

– Assoc Prof John Litt, Green Book Editorial Committee

Do we use effective strategies?

Some examples of effective strategies that support improved prevention performance in general practice include:

- identifying and instituting a prevention coordination role within the practice
- securing the services of a PN
- developing a strong, multidisciplinary teamwork approach
- ensuring good information management systems for efficiency
- making the best possible use of existing partnerships, PHNs and other community supports.

There are many technology-based implementation strategies (eg using an app to promote changes to diet), but for some there is inconclusive evidence to support their effectiveness. If you choose to use interventions such as apps as part of your preventive programs, the outcomes should be carefully monitored.

The RACGP's *Handbook of non-drug interventions* (HANDI) provides examples of some effective apps. The RACGP also has released the resource *mHealth in general practice: A toolkit for effective and secure use of mobile technology*.

Effective implementation strategies and processes are described in Table 4. Strategies that tend to be less preferred by GPs can often be more effective (eg practice register and reminder systems, team meetings, appointment of a prevention coordinator).

Table 4. Effectiveness of implementation strategies

Strategy	Effectiveness	Comments/requirements
Organisational		
Organisational changes and improvements such as: • clarification of roles • delegation of tasks • practice policy/standing orders, protocols • incentives • computer decision support (eg practice registers and reminders)	Highly effective[1,13,56,71,89,126,129–133]	Contributes to implementation of preventive interventions and helps sustain them Impact varies with area, capacity and acceptability
Continuous Quality Improvement (program)	Effective[85,98,134–136]	Needs active GP involvement and feedback, and a supportive practice infrastructure
Practice coordinator/facilitator/ educational outreach[49,72,137–141]	Effective[47,64,140,141]	May be someone within the practice or external

Table 4. Effectiveness of implementation strategies

Strategy	Effectiveness	Comments/requirements
Teamwork	Effective[15,98,105,142–149]	
Specific clinics	Somewhat effective[150–153]	More effective for conditions involving a team of health professionals and where large numbers of patients need to be seen
Health checks	Somewhat effective[86,154–156]	Potential for over-diagnosis, and unnecessary interventions with associated harms. Needs to be implemented with appropriate follow-up
Local opinion leaders/ champions	Effective in some situations[12,56,139,157]	Opinion leaders are from the local peer group, viewed as a respected source of influence, considered by associates as technically competent, and trusted to judge the fit between the evidence base of the practice and the local situation[158] Assist in spreading information and examples
Patient		
Reminders for patients	Very effective[159–163]	Needs to be targeted
Motivational interviewing	Effective[164–173]	Effectiveness varies across areas
Health coaching	Effective[74,94,174–176]	Considerable overlap with motivational interviewing; more useful in chronic disease and facilitating self-management Health coaching is a structured, supportive partnership between the participant and the coach that effectively motivates behaviour change
Patient education and printed educational materials	Variable effectiveness[76,177,178]	Need to be combined with other interventions
Shared decision-making	Variable effectiveness[81,179–184]	Key characteristics: • at least two participants (physician and patient) need to be involved • both parties share information • both parties take steps to build a consensus about the preferred treatment • an agreement is reached on implementing treatment[185]
mHealth/eHealth (eg SMS, social media)	Variable (but generally positive) effectiveness[162,163,186–191]	eHealth is the application of information, computer or communication technology to some aspects of health or healthcare mHealth is when it is delivered through a mobile phone
Healthcare worker		
Delegation to the PN or other substitution of care	Effective[70,88,192–195]	Needs to be a clear outline of the role of the PN, and adequate training and support
Reminders for the GP	Variable effectiveness[135,139,160,196–200]	Computerised reminders have a similar impact to manual reminders Needs to be targeted
Health summary sheet/flow sheets	Somewhat effective[201–207]	Acts as a prompt and *aide-memoire*; impact higher if used in conjunction with other strategies Practice accreditation standards require a minimum number to be completed

Table 4. Effectiveness of implementation strategies

Strategy	Effectiveness	Comments/requirements
Case note audit +/– feedback	Effective[72,133,137,208–210]	Impacts particularly on prescribing and test ordering
Feedback	Effective in some situations; usually evaluated in conjunction with audit[91,211]	Presentation is multi-modal, including either text and talking or text and graphical materials Delivery comes from a trusted source Feedback includes comparison data with relevant others Feedback is more effective when accompanied by explicit goals and an action plan Recipients of targeted behaviour should be amenable to feedback Recipients should be capable and responsible for improvement Target performance needs to be provided Goals set for the target behaviour are aligned with personal and organisational priorities Goals for target behaviour are specific, measurable, achievable, relevant, time-bound A clear action plan is provided when discrepancies are evident
Medical education	Variable effectiveness[12,71,83,212–214]	Learning is more effective if it is linked to clinical practice and self-directed, multifaceted active educational methods
Extra-professional education	Limited evidence[95,105,215,216]	Occurs when two or more professions learn with, about, and from each other to enable effective collaboration and improve health outcomes[215]
Lectures	Not effective[12,79,83,217]	

Adding implementation strategies does not necessarily increase the level of performance. The process needs to be strategic. It should:

- address practice systems and infrastructure
- provide adequate leadership (eg local champion, planning and coordination)
- encompass a wide array of strengths, skills, resources and competencies.

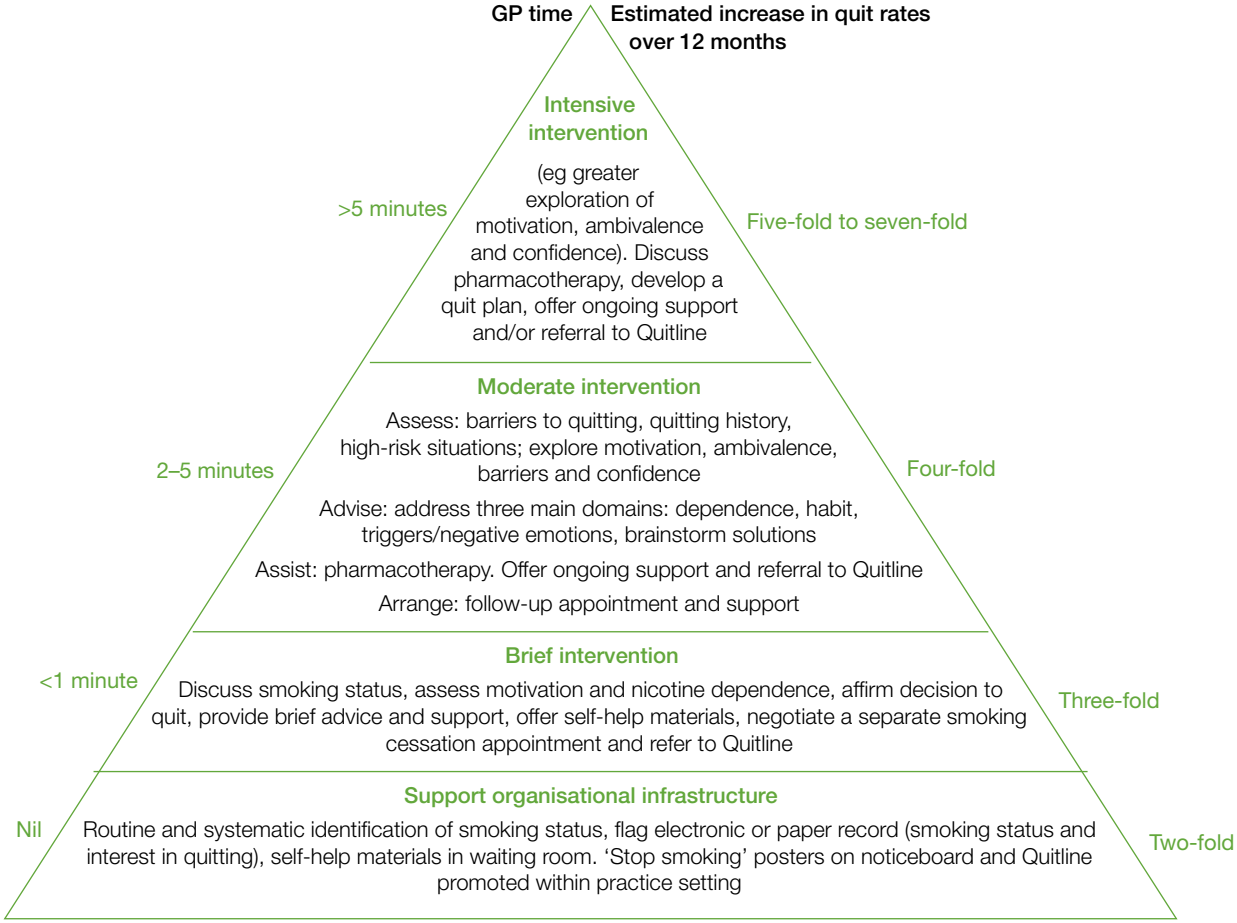
Do we use time effectively?

It does not always follow that spending an increased amount of time with a patient on a preventive issue leads to a proportionally better outcome. For example, spending 20 minutes counselling a patient who smokes does not necessarily provide four times the benefit of spending just five minutes counselling the same patient.

Sometimes less is more, and you may be more effective by providing some components of the prevention activities to all patients than providing considerable input to fewer patients. The ‘reality pyramid’ provides an incremental and systematic strategy to improve the delivery of lifestyle advice in the GP setting, using smoking cessation as an example (Figure 8).

Writing down the various intervention components and the chronological sequence of steps will also help the implementation to be more systematic.

Figure 8. Reality pyramid for smoking cessation



Reproduced with permission from Litt JCB, Shelby-James T, Edwards D. GASP (GPs Assisting Smokers Program): Final report to the SA Anti-Tobacco Ministerial Advisory Taskforce. Adelaide: GASP, 2002.

The pyramid highlights the 'less is more' (one minute for prevention) approach. The base level of the pyramid outlines the practice infrastructure that supports the GP (and others) to provide preventive care. It emphasises the value of teamwork and demonstrates that using other practice resources and establishing appropriate reminder and referral systems can facilitate brief interventions. It supports the notion that it is unrealistic to expect the GP to be the sole provider of preventive care within the practice. It provides a prompt for the best use of time during a consultation, starting with a very brief intervention for most patients and then using more intense strategies with fewer patients. The interventions should cover the activities likely to have the biggest impact for the patient in most circumstances. It recognises that spending more time is often necessary, but reflects the reality that most GPs have about a minute of 'disposable' time to raise and/or discuss an issue they think is pertinent and important to the patient. The one minute can be spent in a number of ways:

- focusing on specific evidence-based guidelines
- justifying why an additional consultation is worthwhile (you might suggest to the patient that the unassisted quit rate is around 3–7%, whereas with GP assistance, together with external support, this success rate can be boosted fourfold to sixfold;[218–220] given the difficulty with quitting, anything that helps maximise success seems a sensible choice, provided it is acceptable to the patient)
- justifying why seeing someone else (eg PN) may be helpful
- outlining the value and effectiveness of the Quitline.

– Assoc Prof John Litt, Green Book Editorial Committee

Do we apply effort effectively?

Considerable effort may be required before you begin to see change. Things may then proceed relatively smoothly with less effort. Reaching the final stage of desired improvement may also require extensive effort. For example, moving from 90% to 100% vaccination coverage may take more effort than getting to the 90% in the first place.

Efficiency (How can I make the intervention easily do-able and routine?)

An effective preventive intervention should also be delivered efficiently. It needs to be incorporated into the practice routine without creating significant extra work in order to be sustainable.

It is not possible for general practices to provide all recommended prevention services. You need to decide where to focus attention in order to deliver the best possible outcomes with the available resources for the groups of patients targeted. Some useful questions to consider are:

- What is the cost and staff time to do this?
- Does it make good business sense?
- Are there any resources that you are underusing, or are you duplicating services?

For example, GPs may continue to be offering the influenza vaccine to patients they are seeing rather than getting the PN to run a flu vaccination clinic. Using the latter strategy would give the GP more time to talk to the patient about other important medical issues.

Does it fit with our practice and our culture?

To make prevention processes sustainable, ensure that the process is:[221,222]

- adapted to the local context
- consistent with the practice and professional goals
- integrated into workflows so that, where possible, it doesn't take more time.

It is important to also monitor and review practice procedure and policy manuals, clarify roles and tasks, appoint a coordinator and encourage all staff to contribute.[223] You will need to ensure that the QI process incorporates a review of the outcomes.

What is the most important contribution we can make?

GPs and practice teams should complement prevention activities by using effective or more efficient population-based or community-based prevention strategies. Examples include:

- population screening programs (eg breast screening, cervical screening, bowel screening)
- population registers (eg immunisation register, cancer registers)
- screening for familial disease (eg family history questionnaire for cancer, heart disease and diabetes), which is often under-recorded
- childhood health programs (eg Healthy Kids weight management resources for health professionals)
- media strategies to address issues such as smoking cessation and hazardous drinking.

Most established national programs have reached coverage of 50–60% (eg BreastScreen Australia, 54% participation;[224] cervical screening, 56% participation[225]). GPs are key influencers in screening participation and play a significant role in improving coverage.[226,227]

Putting it all together with a complex patient: Case study

The patient, female, aged 91 years, is a war widow living alone in a suburban area, with one son (aged in his 70s) living a 15-minute drive away. She has multiple comorbidities:

- vasculopathy (coronary artery bypass graft and small cerebrovascular accident)
- biventricular failure, well controlled on diuretic
- unstable angina
- 'burnt out' rheumatoid arthritis
- anxiety disorder/multiple phobias
- low BMI, frail, with falls risk and accidental injury risk both high
- multiple drug allergies/intolerances.

She has had frequent hospital admissions related to left ventricle function, unstable angina and injuries.

The patient goals are to:

- stay at home (when she is no longer able to go out for lunch) and die there
- not be a burden to her son
- avoid admission to two out of three local hospitals at all costs (she has a phobic reaction to two).

The GP aims and goals are to:

- allow the patient to stay in her own home as long as possible
- give her a sense of control over her healthcare transactions
- avoid identified risks.
- The main risks are:
- falls and injuries
- medication misadventure post-hospital admissions
- unavoidable nursing home admission.

Who helped the practice and you as GP?

We looked at what the Coordinated Veterans' Care (CVC) program offered. Strategies employed within the CVC program to manage risks and support patient goals:

- The GP is supported to operate within a community team structure, independent of extended primary care (EPC) structures, and to do 'non–face-to-face' work/extended liaison.
- The PN role is able to expand and consolidate, evolving into a pivotal role, formalised in broad enablers (improved coordination and collaboration; better targeting of care and identification of barriers; improved ability of the PN, the patient and the patient's family to identify and manage issues as they arise; improved efficiency). The PN is involved in day-to-day management under CVC funding.

What did you do to make it happen?

- Drilling down – we wrote the above features into a CVC plan and reviewed this regularly to ensure implementation was happening as it should and to explore opportunities to expand.
- We involved the PN from the beginning.
- The GP was supported to work within a team structure, especially before, during and after admissions to hospital. This overcame the barrier imposed by the descriptor around use of EPC case conference items.

What specific strategies did you use?

- Congestive cardiac failure (CCF) – early detection via phone of exacerbation of health problems, with added opportunity to conduct wider phone assessment as indicated.
- Employed sick day management plan as required for the patient.
- A shared plan around emergency admissions – we organised a direct link for patient or son by mobile phone with the GP if an ambulance crew was attending. The GP would speak to the crew and emergency department (ED) at the only hospital acceptable to the patient and arrange transfer (this was often critical, as private EDs are frequently 'on bypass' and crews are otherwise instructed to transport all patients to a public ED). This strategy came into play about once yearly.
- Advocacy and active contribution to management during hospital admission (eg GP successfully advocated to arrange blood transfusion prior to discharge after skin graft for shin wound, resulting in symptomatic improvement in CCF and [likely] accelerated healing)
- Better clarification of roles and responsibilities.

CVC enables an individualised and high-quality (bespoke) plan by acknowledging several factors that enable this type of more detailed and dynamically responsive care.

What outcomes/improvements do you think you achieved?

- Vastly enhanced patient confidence that her needs were being met
- High-level support for son
- Readmission avoidance
- Tight medication control
- Good time management (minimisation of wastage from poor communication)
- Team satisfaction with results and a sense of cohesion

What made the most difference?

Communication made the biggest difference.

The involvement of the PN in this new level of communication was paramount, with a move away from a narrow role of relaying messages and basic triage.

Central to this was the formalisation of this broader role of the PN through the renaming of this role in the CVC descriptor. Our nurses were pleased to embrace this recognition.

Instead of having the PN conduct a holistic health assessment once a year, this occurred on a continuous basis.

The program gave the PN a sense of ownership and provided the PN with an extra quarterly payment as a reward for extra effort.

Other advantages were in:

- talking through issues, conducting phone and onsite assessment, trouble shooting and safety netting
- liaison with family, being able to include them in real-time decision-making.

What would you say to GPs who may consider doing similar things? What would you do differently?

Meet face to face more often with key community care team members for optimal shared understanding when a situation becomes critical (eg trying to avoid an admission).

For frail, elderly people with multimorbidity at home, the ground can shift in a 24-hour period. Micromanagement is necessary to prevent deterioration in health status with ensuing hospital admissions or nursing home attendance.

Relationships are crucial to the success of these strategies – most older people cling to the advice of those, and only those, they trust. This is why they sometimes wait for their own physician to return from leave.

Enacting the detail of a care plan is important, with, for example, weekly phone-ins and maintaining a current weight or fluid chart.

A 'hospital in the home' set-up can be achieved in a limited fashion if parameters are clearly defined. Twice-daily review for 2–3 days can be very effective. Geographic proximity is important.

You can keep someone at home with diarrhoea and heart failure for one night, but only if you can check on them the next day.

Liaison with a pharmacist is more vital than ever, with multitudes of brands of drugs and dwindling commitment to providing continuity of personnel or product. Frequent checking of packets for errors will help avoid medication misadventure.

Having a person stay at home sick rather than go to hospital requires confidence in covering the dusk-to-dawn phase (eg ensuring the patient/carer has a number they can call if things go wrong).

In the case described, our patient required someone to direct the ambulance to the correct ED.

In terms on return on effort, do you think the whole process was worthwhile?

Very much so! Basically, this is how I was already operating but didn't feel like I could ask much of our PN without dedicated funding.

The feedback from patient and family was superb, and we even regularly heard second-hand from others (eg the ambulance service) about how well the system worked and how different it was from normal care.

– Dr Christine Boyce, Hobart GP

Resources

- Agency for Healthcare Research and Quality, *Developing and running a primary care practice facilitation program: A how-to guide,* https://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf
- NSW Government, Healthy Kids for Professionals, Conversation starters, https://pro.healthykids.nsw.gov.au/conversation-starters

The Royal Australian College of General Practitioners:

- *Abuse and violence: Working with our patients in general practice* (White Book), fourth edition, www.racgp.org.au/your-practice/guidelines/whitebook
- Practice guides and tools: Clinical indicators, *Clinical indicators for Australian general practice,* www.racgp.org.au/clinicalindicators
- Family history screening questionnaire, *Guidelines for preventive activities in general practice* (Red Book), ninth edition, www.racgp.org.au/your-practice/guidelines/redbook/appendices/appendix-2a-family-history-screening-questionnaire
- *Handbook of non-drug interventions* (HANDI), www.racgp.org.au/your-practice/guidelines/handi
- *mHealth in general practice: A toolkit for effective and secure use of mobile technology,* www.racgp.org.au/download/Documents/e-health/mHealth-in-general-practicepdf.pdf
- Planning, learning and need (PLAN), www.racgp.org.au/education/qicpd-program/gps/planning-learning-and-need-(plan)
- *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice,* second edition, www.racgp.org.au/your-practice/guidelines/snap
- *Standards for general practices,* fifth edition, www.racgp.org.au/your-practice/standards/standards-for-general-practices-(5th-edition)
- *Supporting smoking cessation: A guide for health professionals,* www.racgp.org.au/your-practice/guidelines/smoking-cessation

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5. Setting up the practice for preventive care

Key point

Just as the whole practice is involved in preventive care, the practice's physical and digital environments can be also be adapted to improve prevention.

In this chapter, we explore ways practice team members can work together to manage patient information and create an environment (physical and digital) to support preventive care.

5.1 Managing patient information to support preventive care

Health summaries

Members of the clinical team routinely collect information that should be transferred to a patient's health summary. A complete health summary makes a useful statement of the patient's main health issues and brings all the important information together in the one place. They are also useful reminders of what prevention interventions have been taken and to prompt for what needs to be done.[1–3] This contributes to better continuity of care and patient safety within the practice and when patients seek care in other settings.

Connectivity to registries

Some information may also be transferred to national registers (eg immunisation data) or state-based and territory-based systems (eg cervical screening, bowel screening or familial cancer registries) in order to improve care. Where the practice participates in national registers, patients should provide consent for the transfer of related health information to a register or be made aware that they can opt out of such registers.

Practices may also establish internal registers to flag patients with a higher priority for preventive interventions. This can be readily assisted by a practice using clinical software or additional data-mining software to reflect population-level priorities.

An example of an internal register that practices may want to establish is one related to high-risk familial cancer. Family history tends to be under-recorded and underused in general practice.

When asking about family history of cancer, it is important to identify the number of family members affected, their age when the cancer was identified and their connection to the patient. The latter is best depicted in a genogram. A number of brief screening tools can help the GP identify family history of cancer more efficiently and comprehensively. The RACGP family history screening questionnaire can assist with this.

– Assoc Prof John Litt, Green Book Editorial Committee

Three areas where registers are important, particularly for medico-legal reasons, are for patients:

- on some form of anticoagulant (eg warfarin or novel oral anticoagulants)
- at high risk of cancer because of their family history
- with diabetes.

– Assoc Prof John Litt, Green Book Editorial Committee

It's also important to identify within the practice's record software particular groups of patients who might need special preventive interventions. This may include Aboriginal and Torres Strait Islander peoples, refugees and vulnerable population groups (eg with developmental disability). This may require an adaption of the field within the records so that these patients can be readily identified for individual care and clinical audit.

This will also enable creation of a registry of each of these groups if a practice decides to use these for recall (eg for health assessments).

– Prof Mark Harris, Green Book Editorial Committee

Data-driven QI

Practices might also use coded data collected in the practice's clinical software (eg smoking status, diabetes register) to improve the targeting and use of prevention activities (eg smoking cessation, weight management). They may also use information collected and transferred from private pathology providers (eg diabetes screening, cervical screening).

Gathering this data is not only a QI activity (refer to the Standards, Criterion QI1.1 – Quality improvement activities); it provides a check that the practice is identifying all relevant patients for their health promotion and preventive care activities.

Letter to 49-year-olds to encourage bowel screening

General practices can send a letter to their 49-year-old patients to encourage them to complete the National Bowel Cancer Screening Program (NBCSP) test when they receive it in the mail around their 50th birthday. There is strong evidence that a letter signed by a person's GP endorsing the faecal occult blood test (FOBT) is an effective method to increase participation in bowel cancer screening. The NBCSP has developed a template letter that GPs can use to recommend screening to patients outside regular consultations.

– Alice Creelman, Cancer and Palliative Care Branch, Population Health and Sport Division, Department of Health

Mismatch between patients with colonoscopy as coded diagnosis versus patients with recalls: Case study

Activity

My PN colleague was looking at our practice recall system and how we might streamline lists and make sure that coding was correct, in order that we could easily manage mail merge recalls and put action notification in patient files. While doing this exercise, I noted that there were very few recalls in the system for colonoscopies.

We then looked at how many patients had been coded as having a colonoscopy performed versus how many had recalls.

We also looked at how many patients had family history of bowel cancer coded. From some files of people who had had colonoscopies, we noted that there was a family history noted in free text in a patient profile but not coded in a searchable way.

Action

We checked the files of all patients who had coded colonoscopies and read the colonoscopy reports and specialist recommendations for follow-up. We coded all those with family history of bowel cancer so that we could easily search for those patients and ensure this would appear in their medical history.

I needed to carry out some backend adjustments of the recall lists via the maintenance function in the recall system used at our Leichhardt practice, especially where the doctors had free text in the 'reason for recall' section or there were multiple names for the same condition.

We put recalls for surveillance on all those that were indicated as needing follow-up surveillance – whether at three years or five years.

We presented the activity at the combined staff meeting to let all staff know this was happening and to engage the team.

We put the action list in all the patient files so that any health professional opening the patient file would see the action and follow-up regarding bowel cancer testing/colonoscopy. With our clinical information system, once you have put an alert in the 'action' list, this will be the first screen to open in the patient file and you cannot navigate the file until you close the box (hopefully having read, noted and actioned the alert where necessary).

We looked at the patient registration form. This had previously been amended to include family history questions for several conditions (eg diabetes, breast and bowel cancer), but these were not always being added at the new patient visit. This process was also discussed with the team to ensure that these risks were recorded and coded in a searchable way.

Outcomes

Invitations were sent to all patients who required screening due to family history and risk of bowel cancer to visit their GP and discuss the issue.

Recalls were sent for those who had not been added to the initial recall but who required ongoing surveillance and were due for screening.

Recalls were added for those who required future follow-up.

Although the GPs were used to adding the coding for a procedure, they were more aware of adding recalls at the time of reviewing a specialist report.

After implementing the changes to our systems, the team was more engaged in recording a coded family history for bowel cancer. Similar exercises were carried out for family history of breast cancer risk mammogram recalls.

There were other patients picked up in this exercise, where family history was not an issue but specialist-recommended recalls for follow-up had not been added.

Our senior registrar was conducting a population health project on bowel screening, and because we had a system in place where family history was coded and recalls were in place, measuring the practice's starting point became far easier.

– Ms Karen Booth, Green Book Editorial Committee

Using your data to improve your practice

Below is an example of how we used our practice computer system to improve our patient care while also improving our income.

With the Australian Government program to fund the shingles vaccine for all patients aged 70–79 years, our nurses have used our database to target these patients with telephone calls advising them this is available and arrange appointments for this at the same time, if they were willing.

With dedicated work, since inception of the program in November 2016, we have reached all of our patients in this age group who have not had shingles in the last year and are not on an immunosuppressant (these are contraindications) and offered them the vaccination. Our nurses performed a simple search in our practice software. With more sophisticated searches, we plan to use an extraction tool to extract data.

We started with those patients who were aged 79 years and about to turn 80 (and who then would no longer qualify under this program) and worked backwards to age 70 years. We have called everyone in this cohort and have successfully vaccinated over 70% of them, which we are informed is more than double the average for other practices Australia-wide.

Having accurate data has made things much easier. Calling these people also gave us an opportunity to tidy up our database by removing (inactivating) those patients who no longer attend. Fortunately, because we pay strict attention to inactivating deceased patients when we learn of their passing, we did not have any embarrassing calls asking if dead people wanted a vaccination!

– Dr Rob Hosking, Bacchus Marsh GP (adapted from his blog entry, posted on 21 November 2017)

Recording demographic data

Since we started routinely asking all patients if they identify as Aboriginal or Torres Strait Islander, the number registered has gone from one to 300 (over a four-year period). Recording this in the practice software demographic section enables our PNs to optimise the uptake of the Indigenous Chronic Disease Package.

– Dr Michael Fasher, GP and Adjunct Associate Professor, University of Sydney

Box 3. Reminders, recalls and prompts

Having a robust reminder and recall process supports safe, high-quality care to patients.

Reminders are used to initiate prevention, before or during the patient visit. They are 'an offer' to provide patients with systematic preventive care.

Recalls are a proactive follow-up to a preventive or clinical activity. These occur when it is crucial for a patient to attend the practice (eg after an abnormal test result).

Prompts (or flags) are usually computer generated, and designed to opportunistically draw attention during the consultation to a prevention or clinical activity needed by the patient.

A recall system differs from a reminder system in that reminders are used as preventive activities for patients and do not have to be followed up if the patient does not attend the practice. The patient can be removed from the reminder list, but it is recommended that the reminder is noted in the patient's medical notes. A recall system is used to recall the patient back to the doctor for something clinically significant. Therefore, every attempt must be made to contact the patient and it is essential that the attempts are documented and initialled in the patient's record. Any recall appointment should be marked as a 'recall appointment' so that you will be able to check if the patient attended the practice.[4]

To ensure the system is effective, fail-safe and sustainable, you could consider a team approach when coordinating the recall and reminder system for tests, test results, referrals and appointments. This includes defining the roles of GPs and other clinic staff. When using electronic recall and reminder systems, the data is only as good as what is entered. This reinforces the need to have adequate systems, policies and procedures in place. You could have a planning session with all GPs and staff to evaluate past systems and ensure they fit the criteria of being effective, fail-safe and sustainable.[4]

You might want to look at some of the commercially available software that bolts on to your practice management system and allows for more sophisticated on-screen prompts.

– Assoc Prof Charlotte Hespe, Green Book Editorial Committee

5.2 Creating an environment that supports prevention

The practice's digital environment

Practice website

Your practice website can also be used for patient education. All resources created should be made available online. Where possible, this information should be available in patients' preferred language.

Box 4. Tips for setting up a high-quality website

- Ensure that any recommended activities or interventions are supported by evidence
- Have a policy of regularly reviewing the material
- Provide links to reputable sources of information
- Survey your patients to see what information they would like to access
- Consider using the practice website for making appointments
- Include some useful preventive care or other tools (eg prevention survey) on the website[2]

An increasing amount of information and educational materials is available online. Many patients will have previously accessed this information, or will do so after visiting the practice. It is therefore important your practice website features other recommended websites that provide unbiased and evidence-based information.

The Victorian Department of Health's Better Health Channel is a good example of a useful online resource. You may consider placing this on your own website, together with some other credible health information website links, such as:

- Immunise Australia
- HealthPathways
- Australian Immunisation Register
- Quit
- healthdirect
- RACGP – 'Appropriate diagnostic testing: Patient information'.

Find out more about making the best use of your general practice website at RACGP Digital Business Kit – Your practice website (www.racgp.org.au/digital-business-kit/your-practice-website).

Mobile health, including smartphone apps

Mobile health (mHealth) is a general term for the use of mobile phones and other wireless technology in medical care. Text messaging interventions have the advantages of tailoring, interactivity, personalisation and high message repetition.

The most common application of mHealth is the use of mobile phones and other communication devices to educate consumers about preventive healthcare services. However, mHealth is also used for disease surveillance, treatment support, epidemic outbreak tracking and chronic disease management.

Smartphone apps can be used to:

- provide information
- provide prompts
- record information (eg diet, exercise, blood glucose levels, sleep)
- provide support and connect with others (eg smoking cessation apps often have a buddy system).

It can be difficult to gauge the quality of apps before recommending them to patients. Many of the interventions have no long-term data, and evidence of effectiveness, while generally positive, is mixed.[5–18] The RACGP has a number of resources on what to look for in an app:

- *mHealth in general practice: A toolkit for effective and secure use of mobile technology*
- 'Factsheet: Health apps'
- *Handbook of non-drug interventions (*HANDI) – lists apps with good evidence of benefit.

Your PHN is another source for apps for health. The UK's National Health Service (NHS) also has an app library.

I recently learnt about the Couch to 5K podcast series from a UK colleague. This series of podcasts developed by the NHS is played on your phone and guides you through a half-hour exercise program that over nine weeks takes you from being sedentary on the couch to running 5 km. Cheaper than a personal trainer, I have recommended it to many of my patients.

– Prof Danielle Mazza, Green Book Editorial Committee

Practice newsletter

A practice newsletter may be a useful way of informing patients about preventive issues. You may distribute this via email, social media or on your website.

The waiting room

Waiting room materials

The waiting room can be an important place for patients to access health information.[19,20] Materials such as posters and leaflets are often available from health promotion units of state health departments, your primary care organisation and non-government organisations such as the Heart Foundation, Diabetes Australia, Cancer Council, Quit and other peak bodies.

The effectiveness of these materials is debatable. Generally, a more targeted and personalised approach to providing health information is considered more effective.

Where posters and leaflets are used, the information should be clear, simple, engaging, timely (eg for influenza season, Movember) and unbiased. If possible, it should be available in the languages used by patients attending the practice. Materials need to be replenished and rotated regularly. A poster that is left in the practice for years will become all but invisible.

A 'less is more strategy' should also be used. Much of the material on noticeboards is not readable unless the patient walks up to it. Most patients won't do this. Sensitive material may be better portrayed in more discreet locations (eg sexually transmitted infection advice on the back of the toilet door).

Two pieces of advice:

- Check the validity of materials and regularly update.
- Showcase a topic of the month – use the Department of Health Calendar of Events to pick your health topics.

– Ms Jan Chaffey, Green Book Editorial Committee

If you have a TV in the waiting room and you're just playing daytime TV shows, you're missing an opportunity to provide useful information to patients. There are specialised video materials available for waiting rooms. These can both entertain and inform.

You can also have your own material (eg presentation slides) incorporated into these videos.

– Ms Karen Booth, Green Book Editorial Committee

Patient education is more effective when personalised and handed out to the patient by the GP or practice staff.

– Assoc Prof John Litt, Green Book Editorial Committee

Note: you can also provide information in different formats – for example, you can email information to the patient and provide links to useful websites.

A practice notice board can provide information about self-help groups and local programs, as well as contact information for patients to self-refer. It is important to keep the notice board up to date. Some practices now provide computers in the waiting room that allow patients to access education material from selected websites.

NPS MedicineWise also has a *MedicineWise handbook*, which is a consumer resource designed to be read by patients in waiting rooms. It defines health and medical terms and offers summaries on each page.

Aboriginal medical services often develop culturally appropriate material for their patients. Visit the Australian Institute of Family Studies' Key Aboriginal and Torres Strait Islander organisations for a list of useful contacts.

The staff room

The staff room is an under-used area for messaging to and engaging staff. You should have a chart in your practice staff room showing your progress with the prevention intervention activity and achievements to date.

The reception area

It is worthwhile highlighting to the practice reception staff that they are an essential part of the healthcare team. Through their various activities they influence healthcare outcomes, not just administrative aspects. Examples includes their roles in prompting patients, checking reminder systems, assembling practice registers and refreshing the waiting room.

Reception staff can be involved in prevention in a multitude of ways, such as:

- ensuring that each patient's details are complete and appointments are appropriately labelled (eg 'recall appointment')
- asking if patients would like to fill out a risk assessment tool while waiting (eg Australian absolute risk cardiovascular disease calculator, Australian Type 2 Diabetes Risk Assessment Tool [AUSDRISK]) or a brief questionnaire regarding smoking, nutrition, alcohol, physical activity (SNAP)
- providing more information about waiting room education materials.

You can also provide health information (such as on influenza shot programs and health checks) for patients on hold on the telephone. Be sure to review this in a timely fashion to ensure the relevance of the information being provided.

Using waiting time for prevention

While waiting for their appointment, patients can fill out a brief questionnaire to identify SNAP risk factors and to assess thoughts about change.

For example:

- Do you smoke tobacco?
- How do you feel about your smoking at the moment?
- Are you ready to stop smoking now?
- How confident do you feel about your ability to stop smoking?

For more information, refer to the RACGP's *SNAP* guide and *Supporting smoking cessation: A guide for health professionals*.

Also refer to the RACGP's *Clinical indicators for Australian general practice*: 6. Screening for smoking status; and 7. Screening for alcohol consumption.

The consulting room

Patient education materials

Patient education materials handed directly to patients by the GP or PN can have significant impact. These should ideally be stored on computers used in the consulting rooms. The quality of the materials should be checked.[21] Consider the currency and sources of information, as well as their reliability, relevance and accuracy.

These materials should be tailored to the patient's:

- language (and be culturally appropriate)
- health problems (eg existing CVD)
- interest and willingness to change.

It's important to check a patient's level of understanding of the information provided. Generally speaking, written information should be at a reading age of eight years (the reading age of a newspaper such as the *Herald Sun* is 12 years).

– Prof Mark Harris, Green Book Editorial Committee

Consider a variety of resources to cater for differing levels of literacy and health literacy among the groups attending your practice. These materials should also be evidence-based and provide a balanced approach to the problem.

State health departments often have multilingual patient education materials available for download or for purchase. Check with your local state or territory health departments for multilingual resources and referral centres available to your area.

NPS MedicineWise offers a range of materials in hard copy, online and via a smartphone app. These help patients better manage their medicines and learn about how lifestyle choices directly affect health, as well as how they can help prevent ill health.

Another useful strategy for the practice to consider is the 'walking interview'.

This involves accompanying a patient who is unfamiliar with the practice as they experience booking an appointment, registration and waiting to be seen.

Staff should obtain feedback from patients.

This can be useful for a number of patient groups such as people from CALD backgrounds, Aboriginal and Torres Strait Islander background and patients with a disability. It helps to determine the relevance and accessibility of practice information and systems, and where changes are required.

– Prof Mark Harris, Green Book Editorial Committee

On your bike

One GP in our clinic rode to work. He parked his bicycle in the consulting room, unashamedly. In doing this, he acted as a passive role model and provided a conversation piece, with some patients asking about the bike.

'Yes, I ride my bike in to work. Do you know it's hardly any longer than by car, and incidental exercise like this has proven benefits for people like you and me – even folk with chronic disease?'

'Yes, bike riding is a little more dangerous. But there is some evidence that the exercise benefits outweigh those risks: you're actually better off riding than driving!'

– Professor Chris Del Mar, Faculty of Health Science and Medicine, Bond University, Queensland

Resources

- Australian Institute of Family Studies, Key Aboriginal and Torres Strait Islander organisations, www2.aifs.gov.au/cfca/knowledgecircle/key-aboriginal-and-torres-strait-islander-organisations
- Department of Health, The Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK), https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/6d252140-1ff0-47b2-a83f-3cc3db348131.pdf
- Department of Health, National Bowel Cancer Screening Program, GP letter template, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/gp-template-letter
- Department of Health, The National Immunisation Program, www.immunise.health.gov.au
- Department of Health, Calendar of events, www.health.gov.au/calendar
- Department of Human Services, Australian Immunisation Register, www.humanservices.gov.au/individuals/services/medicare/australian-immunisation-register
- Health Pathways Community, www.healthpathwayscommunity.org/About.aspx
- Healthdirect, www.healthdirect.gov.au
- National Health Service (UK), Couch to 5K: A running plan for beginners, www.nhs.uk/Tools/Pages/Couch-to-5K-running-plan.aspx

- National Health Service (UK), NHS apps library, https://apps.beta.nhs.uk
- National Vascular Disease Prevention Alliance (NVDPA), Australian absolute cardiovascular disease risk calculator, www.cvdcheck.org.au
- NPS MedicineWise, www.nps.org.au
- NPS MedicineWise, *MedicineWise handbook,* https://webapps.nps.org.au/medicinewisehandbook
- Quit, www.quit.org.au

The Royal Australian College of General Practitioners:

- Appropriate diagnostic testing: Patient information, www.racgp.org.au/download/Documents/Policies/Clinical/Patient-information-on-appropriate-diagnostic-testing.pdf
- Practice guides and tools: Clinical indicators, *Clinical indicators for Australian general practice,* www.racgp.org.au/clinicalindicators
- Digital Business Kit, Your practice website, www.racgp.org.au/digital-business-kit/your-practice-website
- Factsheet: Health apps, www.racgp.org.au/download/Documents/e-health/2017/Recommending-Health-Apps-Factsheet.pdf
- Family history screening questionnaire, *Guidelines for preventive activities in general practice* (Red Book), ninth edition, www.racgp.org.au/your-practice/guidelines/redbook/appendices/appendix-2a-family-history-screening-questionnaire
- *Handbook of non-drug interventions* (HANDI), www.racgp.org.au/your-practice/guidelines/handi
- *mHealth in general practice: A toolkit for effective and secure use of mobile technology,* www.racgp.org.au/download/Documents/e-health/mHealth-in-general-practicepdf.pdf
- *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice,* second edition, www.racgp.org.au/your-practice/guidelines/snap
- *Standards for general practices,* fifth edition, Criterion QI1.1 – Quality improvement activities, www.racgp.org.au/your-practice/standards/standards-for-general-practices-(5th-edition)
- *Supporting smoking cessation: A guide for health professionals,* www.racgp.org.au/your-practice/guidelines/smoking-cessation
- Victorian Government, Better Health Channel, www.betterhealth.vic.gov.au

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Appendix A. Frameworks to change patient behaviour

A.1 The 5As

The 5As is a key framework for organising the provision of preventive care in primary healthcare.[1,2] This includes the actions taken by healthcare providers in supporting their patients to change their risk (Table A1).

Table A1. The 5As

Ask	Identify patients with risk factors
Assess	Assess: • level of risk factor and its relevance to the individual in terms of health • readiness to change • health literacy
Advise/ agree	Provide written information Provide brief advice and motivational interviewing Negotiate goals and targets (including a lifestyle prescription)
Assist	Develop a risk factor management plan that may include lifestyle education tailored to the individual (eg based on severity of risk factors, comorbidities) and pharmacotherapies Provide support for self-monitoring
Arrange	Arrange: • referral to allied health services or community programs • phone information/counselling services • follow-up, prevention and management of relapse

A.2 Motivational interviewing

Motivational interviewing (MI) is a non-confrontational, client-centred counselling strategy aimed at resolving ambivalence and increasing a person's motivation to change.[3,4] It is an acknowledged care skill required by a wide range of healthcare workers.[5–10] The MI approach has strong evidence of benefit and impact on health outcomes across a number of areas, including lifestyle change, chronic disease and adherence.[11–21]

MI involves:

- helping the patient to identify areas for change (ie engage in 'change talk')[3,4,22]
- highlighting any discrepancies between present behaviour and broader goals
- encouraging the patient to examine the benefits they would experience from improving their lifestyle (eg nutrition, physical activity) and self-management skills
- asking the patient to compare potential outcomes if they do make changes versus if they do not
- asking the patient to identify any challenges, barriers or negative aspects involved in making improvements (eg costs, access to good food)

- helping the patient determine specific and achievable solutions to the challenges, barriers and negative aspects involved in change
- establishing the patient's motivation and confidence to make changes
- asking the patient to summarise, in their own words, their goals and how they are going to achieve them.[23]

A core component of the MI approach is the MI 'spirit'.[3] This is based on four key elements: collaboration between the practitioner and the patient; evoking or drawing out the patient's ideas about change; emphasising the patient's autonomy; practising compassion.

There are various contributors and barriers to consider when determining the best approach to assess and assist behavioural change, including cultural issues, physical environment/residence, beliefs and expectations, literacy, interest and motivation, addictive behaviour, coping style, and emotions and mood.

For patients who are not confident about their ability to succeed, various methods can be used to help them commit to making a change. Asking patients to weigh up the pros and cons of making a change or staying the way they are is a common technique. This is called 'decision balance' and can help patients decide whether to make a change immediately.

For those patients who are ready to make a change, time can be spent explaining and planning how they can make that change. Patients who have already made a change may require follow-up to monitor progress and deal with any relapses or difficulties.

The process can provide the GP with insight into issues that patients might have regarding their current lifestyle, and the importance of, and their motivation and ability to, make any changes in their behaviour.

MI has superseded the trans-theoretical model of behaviour change (ie the stages of change model).[24,25] The latter is intended to provide a comprehensive conceptual model of how and why changes occur, whereas MI is a specific clinical method to enhance personal motivation for change.[25]

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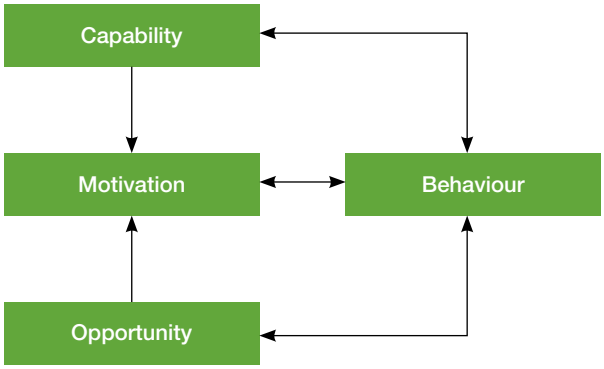
Appendix B. The COM-B model

The COM-B model

COM-B (capability, opportunity, motivation and behaviour) is a simple model to understand behaviour. This model recognises that behaviour is part of an interacting system involving all these components (Figure B1). It can help identify the sources of a behaviour that could be an appropriate target for an intervention. It can also be used to understand (and overcome) barriers.[1]

Figure B1. The COM-B model[2]



Using COM-B: Example

Your practice has identified that patients with mental health disorders are at increased risk for cardiovascular disease (CVD), in part due to low levels of physical activity. The practice team would like to offer support to these patients to increase their physical activity. This means that GPs in your practice need to change current patient behaviour and offer physical activity interventions to patients with mental health issues.

Using COM-B, you identify the following:

- **Capability** – GPs in the practice don't know what services are available for patients with mental illness.
- **Motivation** – GPs don't feel comfortable burdening their patients.
- **Opportunity** – GPs feel that they don't have time in a standard appointment to offer behavioural support to increase physical activity, particularly in patients with low motivation levels.

This gives your practice a starting point for where to focus when planning an intervention. In this case, you would look to improve:

- capability, by ensuring GPs know what the effective physical activity interventions are for this group of patients, what services and resources are available to provide these, and how to access them (refer to the RACGP's HANDI, 'Exercise: Depression')
- GP motivation, by providing good quality evidence of benefit of physical activity in patients with mental health issues (to increase belief that it is a good thing to do) and highlighting the negative consequences of not doing it (similar to the decision balance process of motivational interviewing [MI])
- opportunity, by having more time to do it (longer appointment times) and having all members of the team involved (spreading the workload and being part of a 'crowd' who are doing it).

Resource

The Royal Australian College of General Practitioners, *Handbook of non-drug interventions* (HANDI), *'Exercise: Depression',* www.racgp.org.au/your-practice/guidelines/handi/interventions/mental-health/exercise-for-depression

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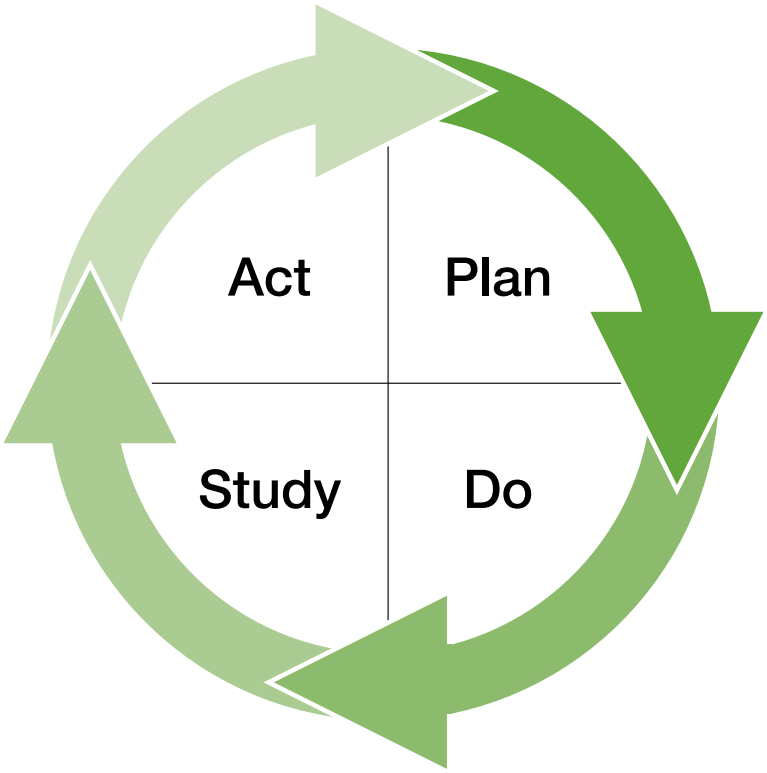
Appendix C. Implementation frameworks

C.1 The 'plan, do, study, act' cycle

The 'plan, do, study, act' (PDSA; Figure C1) cycle uses simple measurements to monitor the effects of change over time. It is widely used in healthcare improvement, either as a standalone method or as part of wider QI approaches, such as the Model for Improvement, Total Quality Management, Continuous Quality Improvement, Lean, Six Sigma or Quality Improvement Collaboratives.[1]

The PDSA encourages starting with small changes, which can be built into larger improvements quickly, through successive cycles of change. It emphasises starting unambitiously, reflecting and building on learning. It can be used to test suggestions for improvement quickly and easily based on existing ideas and research, or through practical ideas that have been proven to work elsewhere.

Figure C1. PDSA cycle



Plan the change (P)

- What do you want to achieve, what actions need to happen and in what order?
- Who will be responsible for each step and when will it be completed?
- What resources are required?
- Who else needs to be kept informed or consulted?
- How will you measure changes to practice?

- What would we expect to see as a result of this change?
- What data do we need to collect to check the outcome of the change?
- How will we know whether the change has worked or not?

Do the change (D)

Put the plan into practice and test the change by collecting the data. It is important that the 'do' stage is kept as short as possible, although there may be some changes that can only be measured over longer periods. Record any unexpected events, problems and other observations.

Study (S)

- Has there been an improvement?
- Did your expectations match what really happened?
- What could be done differently?

Act on the results (A)

Make any necessary adaptations or improvements, acknowledge and celebrate successes. Collect data again after considering what worked and what did not. Carry out an amended version of what happened during the 'do' stage and measure any differences.

Cycles of improvement may occur at different levels, and new actions may be planned as a result of previous cycles. Few organisations or individuals achieve all of any desired change in one step. Improvement is most often an iterative process of a number of small changes, with reflection on the impact of each and revision of behaviour. The process is iterative or occurs over a number of cycles.

As progress occurs, new skills may be learned, barriers to change overcome and new areas targeted for improvement. Testing small changes sequentially means design problems may be detected and amended earlier rather than later. Similarly, performance tends to fall away with time. Repeated measurement of both process and outcomes helps to identify current performance and any areas of concern. Self-assessment of performance, while necessary, often overestimates performance and might not be accurate or sufficient. When reviewing your progress:

- check that your goals have been achieved
- decide if the goals have been realistic
- see if the energy invested has led to the desired degree of change. Is the return worth the effort?
- document which factors have helped or hindered the change
- consider if there any further strategies or measures needed to bring about the desired changes and/or improve cost effectiveness

C.2 Knowledge-to-action framework

The knowledge-to-action (KTA) framework[2] includes seven essential components for the knowledge translation necessary for successful implementation guidelines:[3]

1. Identify the problem – identify, review, select knowledge tools/resources
2. Adapt knowledge tools/resources to local context
3. Assess barriers and facilitators to knowledge use
4. Select, tailor and implement interventions
5. Monitor knowledge use

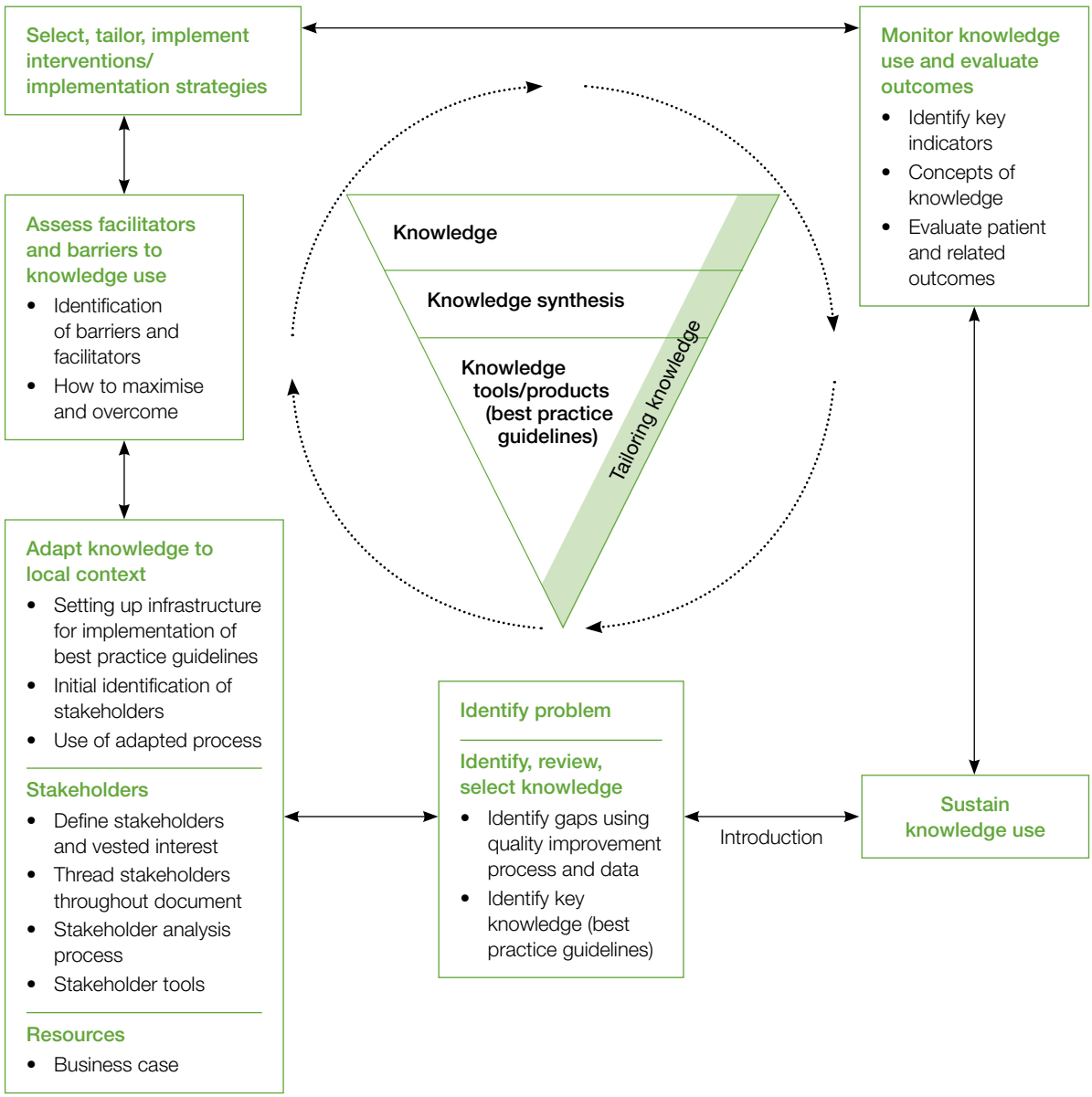
6. Evaluate outcomes
7. Sustain knowledge use[4]

While each phase reflects on the previous and prepares for the next,[4] two key processes comprise the KTA framework. The first is the knowledge creation process, which focuses on the identification of critical evidence and results in knowledge products. The second is the action cycle.[4]

These components reflect a dynamic and iterative process.

Figure C2 offers an example of how the KTA framework can be implemented.

Figure C2. The KTA process: Example



Adapted with permission from Straus S, Tetroe J, Graham I, editors. Knowledge translation in health care: Moving from evidence to practice. Chichester, West Sussex, UK: Wiley-Blackwell BMJ Books, 2009.

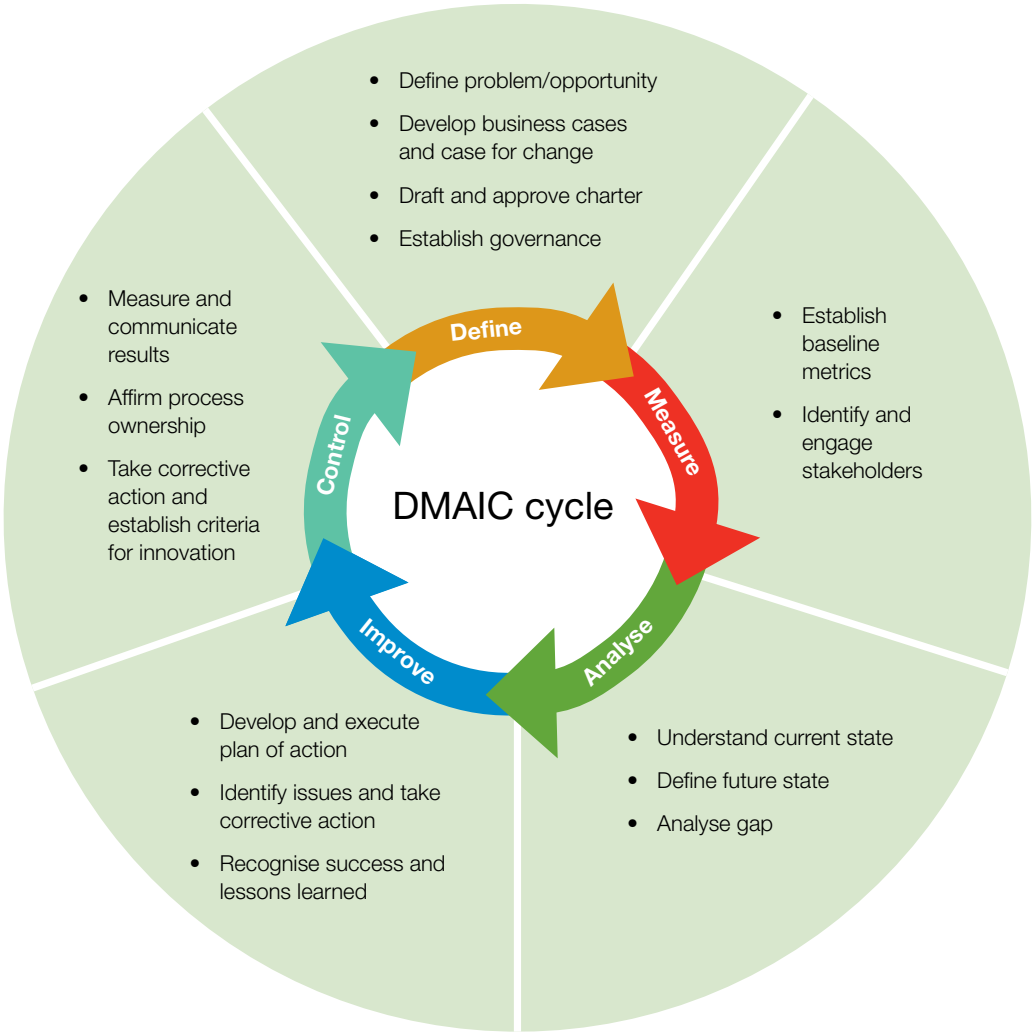
C.3 The DMAIC model

The DMAIC (define, measure, analyse, improve, control) model is a data-driven quality improvement (QI) tool. It is an integral part of a Six Sigma initiative, but can be used as a standalone procedure or as part of other process improvement initiatives.[5–7]

DMAIC is an acronym for the five phases that make up the process:

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements.
- **Measure** process performance.
- **Analyse** the process to determine root causes of variation, poor performance (defects).
- **Improve** process performance by addressing and eliminating the root causes.
- **Control** the improved process and future process performance.

Figure C3. The DMAIC model



Adapted with permission from Holtz T. New CIO priority list – Why care and what to do. Houston, TX: TBO International, 2014. Available at www.tbointl.com/blog/new-cio-priority-list [Accessed 21 March 2018].

Resource

Six Sigma, Six Sigma DMAIC roadmap, www.isixsigma.com/new-to-six-sigma/dmaic/six-sigma-dmaic-roadmap

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Appendix D. Case studies and stories presented in the Green Book

D1. Primary Health Network helping new owners of a practice

PHN case study

A couple purchased a retiring GP's practice. They were new to the business and sought assistance from us, their local PHN.

We assisted them in recruiting a PN by advertising on the PHN website and in monthly newsletters. We provided in-practice training for the PN who had come from a hospital setting – educating the nurse on the cycles of care, using recall reminder systems and maintaining practice protocols such as cold-chain.

We provided software installation and training to the practice, which enabled them to audit their aspects of their practice. With this software, we provided the practice with a report and supported them over the next 12 months in improving their recording of risk factors, patient data entry, and identifying patients with missed diagnoses and billing opportunities. Additionally, this process served as a continuing professional development (CPD) opportunity in quality improvement for the GPs, who now often frequent our free CPD nights.

The business owners felt this help was invaluable.

– Alessandro Luongo, Clinical QI Coordinator, South Western Sydney PHN

D2. Providing care to practice communities

Collaboratives case study

Health and Wellbeing North Ward is a multi-skilled and integrated medical practice offering primary care alongside other allied health providers. As a collective, it focuses on the proactive identification and treatment of risk factors before disease appears, and on patient-centred management of existing conditions.

The practice has a large Aboriginal and Torres Strait Islander community in its area. To provide holistic and culturally aware care, the practice employs a specialist Aboriginal and Torres Strait Islander healthcare worker. Having a dedicated staff member for this community allowed the practice to:

- run regular day clinics to address chronic condition management
- offer consistent appointments for the local Aboriginal and Torres Strait Islander population and the local school that educates Aboriginal and Torres Strait Islander children from the broader area
- provide home visits to those with access and/or language barriers
- offer Medicare-rebatable healthcare plans for chronic and mental health conditions through their multidisciplinary set-up.

Patients responded very positively toward the extra care. Patient feedback surveys showed a 95% positive reaction, and practice numbers grew by 38% over two years. The care fostered a sense of loyalty and community among patients, with follow-up appointments kept and measurable improvements in health outcomes.

– Adapted from Improvement Foundation Australia. Australian Primary Care Collaboratives Program, Case study: Health and Wellbeing North Ward, 'Multi-skilled, holistic agency adopts "wellness" philosophy'. Adelaide: Improvement Foundation Australia, [no date].

D3. Working together to improve the health of Aboriginal and Torres Strait Islander peoples

Teamwork within an Aboriginal and Torres Strait Islander health service – Health checks

Patients aged 18 years and over are identified and screened for cardiovascular risk, chronic diseases and smoking via the Medicare Health Assessment for Aboriginal and Torres Strait Islander People (Medicare Benefits Schedule [MBS] item 715).

Suitable clients are invited to participate in after-hours exercise group sessions with a personal trainer, twice a week for two hours. Sessions include advice and education on diet and healthy eating, with the aim to decrease body mass index (BMI), increase health literacy and provide better management of chronic disease. Smoking cessation support is also offered and promoted.

– Fiona Thompson, Clinical Services Manager, Pangula Mannamurna Aboriginal Corporation

Visit 'Key Aboriginal and Torres Strait Islander organisations' for a list of useful contacts.

D4. Using the Red Book with patients

Red Book for patients

When a patient asks for a routine check-up, with no specific current concerns, I start by asking what they think are the key areas to be covered in a check-up for their age group. This gives me a good start to understanding their health literacy and their priorities.

I then show them the Red Book lifecycle chart to compare and contrast their thoughts with what the evidence says will be most useful for their health.

It's a great way to get the conversation started and often helps reframe patients' expectations when they may be expecting lots of 'screening tests' that are of low value and possibly harmful.

– Dr Caroline Johnson, Senior Lecturer, Melbourne Medical School

D5. Risk factors in local practice population

When delivering a workshop on the early detection of lung cancer some years ago, I came across a GP working in a rural country town in South Australia. The town had a mine, which employed a large number of the population. This GP was very aware of the high rates of smoking in the local community and so approached the mine to work with him in trying to reduce rates of smoking in the workers. They developed strategies to support workers to restrict their smoking while at work and support them to quit.

I remember this GP because he epitomises for me someone who was able to take a population view of the risk factors in his practice population.

– Prof Danielle Mazza, Green Book Editorial Committee

D6. Improving immunisation rates

SA PHN Immunisation Hub

In order to better understand regional levels of immunisation, increase childhood immunisation rates to 95% and decrease the number of hospital presentations/admissions due to vaccine-preventable diseases, the Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub (the Hub).

The Hub is a multifaceted approach to:

- determine low-coverage areas through careful examination of Australian Immunisation Register (AIR) data
- bridge gaps in immunisation service provision
- support the skill base of immunisation providers
- promote the need for a well-immunised community.

The Hub provides education, mentoring and networking for general practice and other service providers, and engagement, advocacy and resources for the community. The PNs found this a valuable opportunity to connect.

This story demonstrates how PHNs can assist individual practices to better understand their practice population.

D7. Preventing childhood obesity

5-2-1-0 Let's Go!

The 5-2-1-0 Let's Go! program is a childhood obesity prevention program. It was developed by the Barbara Bush Children's Hospital and has been implemented throughout Maine (USA) and in neighbouring states.

The program has a message that's simple to deliver and easy to understand:

- **5** or more fruits and vegetables
- **2** hours or less recreational screen time
- **1** hour or more of physical activity
- **0** sugary drinks, more water

Program developers work with schools, childcare and out-of-school programs, healthcare practices and community organisations to change the environments with which children and families interact. They also produce a range of resources (eg toolkits and brochures) for different settings and in different languages.

D8. Providing comprehensive care to Aboriginal and Torres Strait Islander peoples with chronic comorbities

Working together to provide comprehensive care: Case study

Background

A north-west Queensland practice team and broad range of allied health providers and specialists are brokered through a subsidised scheme on a monthly roster. They have a total patient load of 5400, with 2900 active patients.

The group provided high-quality comprehensive primary healthcare with a key focus on Aboriginal and Torres Strait Islander patients that present with chronic comorbidities.

Issue

Patient information systems were incomplete and did not accurately reflect the active client load. Follow-up items of care were undertaken in an ad hoc manner without due diligence to providing comprehensive primary healthcare against cycles of care.

Goals

To ensure patients have access to the cycles of care against particular comorbidities, such as type 2 diabetes or CVD.

To maximise capacity in both the administrative and clinical team to incorporate principles of improvement, namely ensuring data quality and adequacy of patient record information.

Process

The first step was to ensure that the data contained in the patient records was appropriately recorded (clean), and that demographic information was current and completed. Administrative and clinical staff were trained in the use of a data cleansing tool, and were tasked with ensuring data was clean and complete. This activity identified missing demographic information and prompted all clinical staff to complete clinical information for each patient being seen for the day.

Once the clinic had access to high-quality data, systematic recall processes were put in place. At weekly meetings, there was a focus on the follow-up care items suggested for chronic comorbidities. Ongoing reviews of increases in episodes of care were also discussed, and priorities were set for the following week.

Outcomes

- Completed demographic information now ensures record accuracy.
- Increased identification of patients with chronic obstructive pulmonary disease (COPD), risk of CVD and type 2 diabetes.
- Smoking status is recorded on 78% of patient records for patients aged ≥18 years.
- Follow-up care has increased by 45% for type 2 diabetes cycles of care.
- Review of recall systems review has resulted in an increase of 200% in recalls.
- Communication and role autonomy across the administrative and clinical team has been strengthened.
- The Continuous Quality Improvement program has been added to the weekly staff agenda.
- Local hyperosmotic hyperglycaemic syndrome (HHS) reports indicate that hospital/emergency presentations have reduced.
- The Aboriginal community-controlled health service has positioned itself as an employer of choice.

Conclusion

The Aboriginal community-controlled health service has access to patient information systems that reflect their current client load and the team is committed to ongoing Continuous Quality Improvement.

The team are involving all staff from when the patient walks through the doors to when they leave, maximising care and ensuring role autonomy with staff. All position descriptions have been reviewed to include QI. Performance appraisals set and measure achievements against measurable indicators. The Aboriginal community-controlled health service has included the use of the data tools in induction and orientation processes. The service has established and embedded principles to ensure ongoing improvement of the data systems that support patient care.

– Ms Lauren Trask, Accreditation Specialist, Queensland Aboriginal and Islander Health Council

D9. Improving practice data for better health outcomes

Working together for better health outcomes for our patients

Having high-quality data is in everyone's best interest. There is no better way to facilitate the active management of a practice population, particularly for those at high risk. We have a whole-of-practice, proactive and continuous approach to data quality. Our clinical team values the practice team's quality improvement efforts as it helps them manage their patients in a more optimal way.

First, we ensure that the information collected from patients is relevant, complete and recorded correctly. Second, we identify gaps in our data and have strategies to remedy them. Throughout this process, we communicate our goals and track our progress with the team.

An example of this is our diabetes program, which stemmed from a diabetic audit – we now have 65% of our patients with HbA1c <7% which is an excellent result. These wins remind us that the numbers are not 'just data', these are our patients – our community – and we are working together for better health.

– Ms Kylie Gibson, Practice Manager, Fisher and Holder Family Practice ACT

D10. Improving weight by working together

General practice case study

Staff at a practice identified overweight and obesity as a problem they wanted to tackle (67% of patients aged >40 years were overweight and obese).

But the practice GPs felt frustrated in supporting patients to lose weight – their patients rarely took on or adhered to preventive advice. Patient health literacy was identified as a problem; the GPs agreed that many of their patients did not fully understand how much they should be eating or how to go about exercising.

At a staff meeting, each staff member contributed to the discussion regarding the issues faced. The PN was interested in being more involved in weight management but lacked sufficient time to take patients through a structured program involving multiple sessions.

So, the following strategy was devised: As overweight and obese patients were identified by the GPs, they were offered an appointment with the PN for a health check, which involved some brief education and goal-setting. The PN then assisted the patients to register for free telephone weight management coaching provided by the state health department. The PN then followed patients up after a few weeks to determine if they found it helpful and what progress they were making.

– Prof Mark Harris, Green Book Editorial Committee

D11. Wellness and weight groups in practice

General practice wellness and weight

The Stirling Central Health Clinic facilitates 'Wellness and Weight' groups for working adults aged 40–49 years with a BMI of >25 kg/m^2. Six group sessions of approximately 10 participants are run over a number of weeks and held after-hours. The group sessions focus on encouraging and enabling participants to identify and increase positive health activities rather than focusing solely on weight loss. Education is presented from a weight-inclusive perspective using positive language and includes presentations on mindful eating, positive body image, stress reduction, enjoyable activity versus 'exercise', and nutrition. Presenters include a clinical psychologist and dietician with a special interest in the management of obesity.

Participants develop and set SMART (Specific, Measurable, Assignable, Realistic, Time-related) program goals in conjunction with the PN, and outcomes are measured at three, six and 12 months. Measurements taken include BMI, blood pressure and bloods, as well as measurements of happiness and Depression, Anxiety and Stress Scale (DASS) score. Participants are also asked to identify healthy activities they would like to try and, where possible, one-off 'try before you buy' sessions are arranged in addition to the six sessions. Activities identified have included Pilates, a healthy cooking class and a screening of the documentary *Embrace*.

One of the most valuable outcomes has been the social support the participants find within the group setting, which helps them to continue their health-positive journey upon conclusion of the group sessions.

– Sally Jarrett, Practice Manager, Stirling Central Health Clinic

D12. Change talk

Behaviour change: GASP case study

GPs and PNs often find it challenging to help patients change their behaviour. They feel frustrated with their current approaches and often believe that alternative approaches, such as MI, are too difficult or time consuming.

In the GPs Assisting Smokers Program (GASP), GPs and PNs attend a 2.5-hour workshop that provides information on effective MI strategies and opportunities to practise/hone their approaches with simulated patients using vignettes that reflect real-world examples. Experienced facilitators oversee the role-plays, provide feedback and demonstrate effective strategies.

One MI skill is the ability to elicit 'behaviour change' talk. This means eliciting the beliefs, needs and reasons that often underpin the patient's motivation to change their behaviour. One strategy is to ask about the patient's desires, ability, reasons and needs. Possible questions include the following.

Desire

- How would you like things to change?
- What don't you like about how things are now?
- What do you hope will be different?

Ability

- What do you think you would be able to change?
- Of the options you have considered, what seems most possible?

Reasons

- Why do you want to lose weight? To stop smoking? To be more physically active?
- How do you think your diet is affecting your health?

Needs

- What about your behaviour causes you concern?
- What worries you about your behaviour?
- What concerns you?
- What can you imagine happening to you as a result of your behaviour?
- What do you think will happen if you don't make a change?

GPs and PNs found their perceived skills and confidence rose following the workshop, as did their preparedness to use MI in their own settings.

– Assoc Prof John Litt and the GASP team, including Flinders University and Quitline South Australia

D13. Use of facilitator to improve delivery of screening and prevention

Putting prevention into practice

The Putting Prevention into Practice (PPIP) program suggested that practices create a facilitator position to coordinate improving delivery of cardiovascular screening and prevention.

After undertaking a business case, one large practice recruited one of their staff with the necessary skills to a role created specifically to improve preventive care. This new facilitator convened a number of meetings, provided feedback on progress and solicited input on the various proposed approaches. GPs and PNs commented on the effectiveness of this facilitator in ensuring screening and prevention processes were coordinated and efficient.

– Ms Anne Fritz, Practice Manager, Kingston Family Practice, Brighton, South Australia

D14. Improving care of patients with coronary artery disease

Secondary prevention of coronary artery disease: Case study

We instituted a project at the Fairfield GP Unit to improve our care of patients who are known to have coronary artery disease (ie secondary prevention).

We focused on increasing the percentage of patients with established coronary artery disease who had a GP management plan completed in the previous 12 months. We chose this secondary outcome because we believed that if a plan had been completed, a number of issues such as smoking, hypertension, exercise and lipid control would have been addressed.

We undertake a monthly data extraction from our electronic medical records and produce a run chart of the percentage of patients with a GP management plan completed in the last 12 months. This data is then presented to the whole team at our regular monthly practice meeting.

We learned that we needed to improve our coding of patients with coronary artery disease so that we can identify who is or is not receiving good care. We suspect we still haven't identified all our patients, given the known prevalence of coronary artery disease.

We found that recalling patients improved our figures. By making GP management plan completion rates part of the monthly meetings, we tried to make sure we keep working on this issue.

We would recommend to others to focus on a particular area for improvement and delegate a small team to work on it. An enthusiastic medical student helped us with the project. We used formal quality improvement processes such as the Langley and Nolan 'Model for Improvement' and rapid improvement (PDSA) cycles.

– Dr Andrew Knight, Fairfield GP Unit, NSW

D15. GPs Assisting Smokers Program

GPs Assisting Smokers Program (GASP)

As part of GASP, GPs and PNs were offered an opportunity to enhance their counselling skills in smoking cessation by attending a 2.5-hour workshop on motivational interviewing and brief behaviour change. There were two workshop leaders: a GP and a Quitline counsellor. Several strategies were used to enhance the recognition and referral to Quitline counsellors:

- the GP and the Quitline counsellor conjointly ran the workshop
- in small group sessions, each facilitator demonstrated their approach to counselling
- a one-minute 'referral to Quitline' spiel was developed to provide GPs and PNs with an efficient approach for referral to the Quitline.

The benefits of involving the Quitline counsellor were many. GPs and PNs saw, first hand, the high-level skills and competencies of a Quitline counsellor. This had several follow-on effects, including greater subsequent referrals to the Quitline and greater preparedness of the practices to use PNs as counsellors. It saved the GPs time and many PNs embraced the opportunity to improve counselling skills that they have used with a number of different patient groups, including patients with asthma and diabetes.

Participants commented positively on the conjoint approach and how it added to the effectiveness of the GP and practice team intervention. They reported that Quitline referrals in their practices were subsequently monitored and improved.

– Assoc Prof John Litt and the GASP team, including Flinders University and Quitline South Australia

D16. Collaborating to help patients with complex issues

Putting it all together with a complex patient: Case study

The patient, female, aged 91 years, is a war widow living alone in a suburban area, with one son (aged in his 70s) living a 15-minute drive away. She has multiple comorbidities:

- vasculopathy (coronary artery bypass graft and small cerebrovascular accident)
- biventricular failure, well controlled on diuretic
- unstable angina
- 'burnt out' rheumatoid arthritis
- anxiety disorder/multiple phobias
- low BMI, frail, with falls risk and accidental injury risk both high
- multiple drug allergies/intolerances.

She has had frequent hospital admissions related to left ventricle function, unstable angina and injuries.

The patient goals are to:

- stay at home (when she is no longer able to go out for lunch) and die there
- not be a burden to her son
- avoid admission to two out of three local hospitals at all costs (she has a phobic reaction to two).

The GP aims and goals are to:

- allow the patient to stay in her own home as long as possible
- give her a sense of control over her healthcare transactions
- avoid identified risks.
- The main risks are:
- falls and injuries
- medication misadventure post-hospital admissions
- unavoidable nursing home admission.

Who helped the practice and you as GP?

We looked at what the Coordinated Veterans' Care (CVC) program offered. Strategies employed within the CVC program to manage risks and support patient goals:

- The GP is supported to operate within a community team structure, independent of extended primary care (EPC) structures, and to do 'non–face-to-face' work/extended liaison.
- The PN role is able to expand and consolidate, evolving into a pivotal role, formalised in broad enablers (improved coordination and collaboration; better targeting of care and identification of barriers; improved ability of the PN, the patient and the patient's family to identify and manage issues as they arise; improved efficiency). The PN is involved in day-to-day management under CVC funding.

What did you do to make it happen?

- Drilling down – we wrote the above features into a CVC plan and reviewed this regularly to ensure implementation was happening as it should and to explore opportunities to expand.
- We involved the PN from the beginning.

The GP was supported to work within a team structure, especially before, during and after admissions to hospital. This overcame the barrier imposed by the descriptor around use of EPC case conference items.

What specific strategies did you use?

- Congestive cardiac failure (CCF) – early detection via phone of exacerbation of health problems, with added opportunity to conduct wider phone assessment as indicated.
- Employed sick day management plan as required for the patient.
- A shared plan around emergency admissions – we organised a direct link for patient or son by mobile phone with the GP if an ambulance crew was attending. The GP would speak to the crew and emergency department (ED) at the only hospital acceptable to the patient and arrange transfer (this was often critical, as private EDs are frequently 'on bypass' and crews are otherwise instructed to transport all patients to a public ED). This strategy came into play about once yearly.
- Advocacy and active contribution to management during hospital admission (eg GP successfully advocated to arrange blood transfusion prior to discharge after skin graft for shin wound, resulting in symptomatic improvement in CCF and [likely] accelerated healing)
- Better clarification of roles and responsibilities.

CVC enables an individualised and high-quality (bespoke) plan by acknowledging several factors that enable this type of more detailed and dynamically responsive care.

What outcomes/improvements do you think you achieved?

- Vastly enhanced patient confidence that her needs were being met
- High-level support for son
- Readmission avoidance
- Tight medication control
- Good time management (minimisation of wastage from poor communication)
- Team satisfaction with results and a sense of cohesion

What made the most difference?

Communication made the biggest difference.

The involvement of the PN in this new level of communication was paramount, with a move away from a narrow role of relaying messages and basic triage.

Central to this was the formalisation of this broader role of the PN through the renaming of this role in the CVC descriptor. Our nurses were pleased to embrace this recognition.

Instead of having the PN conduct a holistic health assessment once a year, this occurred on a continuous basis.

The program gave the PN a sense of ownership and provided the PN with an extra quarterly payment as a reward for extra effort.

Other advantages were in:

- talking through issues, conducting phone and onsite assessment, trouble shooting and safety netting
- liaison with family, being able to include them in real-time decision-making.

What would you say to GPs who may consider doing similar things? What would you do differently?

Meet face to face more often with key community care team members for optimal shared understanding when a situation becomes critical (eg trying to avoid an admission).

For frail, elderly people with multimorbidity at home, the ground can shift in a 24-hour period. Micromanagement is necessary to prevent deterioration in health status with ensuing hospital admissions or nursing home attendance.

Relationships are crucial to the success of these strategies – most older people cling to the advice of those, and only those, they trust. This is why they sometimes wait for their own physician to return from leave.

Enacting the detail of a care plan is important, with, for example, weekly phone-ins and maintaining a current weight or fluid chart.

A 'hospital in the home' set-up can be achieved in a limited fashion if parameters are clearly defined. Twice-daily review for 2–3 days can be very effective. Geographic proximity is important.

You can keep someone at home with diarrhoea and heart failure for one night, but only if you can check on them the next day.

Liaison with a pharmacist is more vital than ever, with multitudes of brands of drugs and dwindling commitment to providing continuity of personnel or product. Frequent checking of packets for errors will help avoid medication misadventure.

Having a person stay at home sick rather than go to hospital requires confidence in covering the dusk-to-dawn phase (eg ensuring the patient/carer has a number they can call if things go wrong).

In the case described, our patient required someone to direct the ambulance to the correct ED.

In terms on return on effort, do you think the whole process was worthwhile?

Very much so! Basically, this is how I was already operating but didn't feel like I could ask much of our PN without dedicated funding.

The feedback from patient and family was superb, and we even regularly heard second-hand from others (eg the ambulance service) about how well the system worked and how different it was from normal care.

– Dr Christine Boyce, Hobart GP

D17. Targeting patient groups to improve bowel screening

Letter to 49-year-olds to encourage bowel screening

General practices can send a letter to their 49-year-old patients to encourage them to complete the National Bowel Cancer Screening Program (NBCSP) test when they receive it in the mail around their 50th birthday. There is strong evidence that a letter signed by a person's GP endorsing the faecal occult blood test (FOBT) is an effective method to increase participation in bowel cancer screening. The NBCSP has developed a template letter that GPs can use to recommend screening to patients outside regular consultations.

– Alice Creelman, Cancer and Palliative Care Branch, Population Health and Sport Division, Department of Health

D18. Using data to improve bowel screening

Mismatch between patients with colonoscopy as coded diagnosis versus patients with recalls: Case study

Activity

My PN colleague was looking at our practice recall system and how we might streamline lists and make sure that coding was correct, in order that we could easily manage mail merge recalls and put action notification in patient files. While doing this exercise, I noted that there were very few recalls in the system for colonoscopies.

We then looked at how many patients had been coded as having a colonoscopy performed versus how many had recalls.

We also looked at how many patients had family history of bowel cancer coded. From some files of people who had had colonoscopies, we noted that there was a family history noted in free text in a patient profile but not coded in a searchable way.

Action

We checked the files of all patients who had coded colonoscopies and read the colonoscopy reports and specialist recommendations for follow-up. We coded all those with family history of bowel cancer so that we could easily search for those patients and ensure this would appear in their medical history.

I needed to carry out some backend adjustments of the recall lists via the maintenance function in the recall system used at our Leichhardt practice, especially where the doctors had free text in the 'reason for recall' section or there were multiple names for the same condition.

We put recalls for surveillance on all those that were indicated as needing follow-up surveillance – whether at three years or five years.

We presented the activity at the combined staff meeting to let all staff know this was happening and to engage the team.

We put the action list in all the patient files so that any health professional opening the patient file would see the action and follow-up regarding bowel cancer testing/colonoscopy. With our clinical information system, once you have put an alert in the 'action' list, this will be the first screen to open in the patient file and you cannot navigate the file until you close the box (hopefully having read, noted and actioned the alert where necessary).

We looked at the patient registration form. This had previously been amended to include family history questions for several conditions (eg diabetes, breast and bowel cancer), but these were not always being added at the new patient visit. This process was also discussed with the team to ensure that these risks were recorded and coded in a searchable way.

Outcomes

Invitations were sent to all patients who required screening due to family history and risk of bowel cancer to visit their GP and discuss the issue.

Recalls were sent for those who had not been added to the initial recall but who required ongoing surveillance and were due for screening.

Recalls were added for those who required future follow-up.

Although the GPs were used to adding the coding for a procedure, they were more aware of adding recalls at the time of reviewing a specialist report.

After implementing the changes to our systems, the team was more engaged in recording a coded family history for bowel cancer. Similar exercises were carried out for family history of breast cancer risk mammogram recalls.

There were other patients picked up in this exercise, where family history was not an issue but specialist-recommended recalls for follow-up had not been added.

Our senior registrar was conducting a population health project on bowel screening, and because we had a system in place where family history was coded and recalls were in place, measuring the practice's starting point became far easier.

– Ms Karen Booth, Green Book Editorial Committee

D19. Using data to improve your practice

Using your data to improve your practice

Below is an example of how we used our practice computer system to improve our patient care while also improving our income.

With the Australian Government program to fund the shingles vaccine for all patients aged 70–79 years, our nurses have used our database to target these patients with telephone calls advising them this is available and arrange appointments for this at the same time, if they were willing.

With dedicated work, since inception of the program in November 2016, we have reached all of our patients in this age group who have not had shingles in the last year and are not on an immunosuppressant (these are contraindications) and offered them the vaccination. Our nurses performed a simple search in our practice software. With more sophisticated searches, we plan to use an extraction tool to extract data.

We started with those patients who were aged 79 years and about to turn 80 (and who then would no longer qualify under this program) and worked backwards to age 70 years. We have called everyone in this cohort and have successfully vaccinated over 70% of them, which we are informed is more than double the average for other practices Australia-wide.

Having accurate data has made things much easier. Calling these people also gave us an opportunity to tidy up our database by removing (inactivating) those patients who no longer attend. Fortunately, because we pay strict attention to inactivating deceased patients when we learn of their passing, we did not have any embarrassing calls asking if dead people wanted a vaccination!

– Dr Rob Hosking, Bacchus Marsh GP (adapted from his blog entry, posted on 21 November 2017)

D20. Using demographic data to improve care

Recording demographic data

Since we started routinely asking all patients if they identify as Aboriginal or Torres Strait Islander, the number registered has gone from one to 300 (over a four-year period). Recording this in the practice software demographic section enables our PNs to optimise the uptake of the Indigenous Chronic Disease Package.

– Dr Michael Fasher, GP and Adjunct Associate Professor University of Sydney

D21. Modelling behaviour

On your bike

One GP in our clinic rode to work. He parked his bicycle in the consulting room, unashamedly. In doing this, he acted as a passive role model and provided a conversation piece, with some patients asking about the bike.

'Yes, I ride my bike in to work. Do you know it's hardly any longer than by car, and incidental exercise like this has proven benefits for people like you and me – even folk with chronic disease?'

'Yes, bike riding is a little more dangerous. But there is some evidence that the exercise benefits outweigh those risks: you're actually better off riding than driving!'

– Professor Chris Del Mar, Faculty of Health Science and Medicine, Bond University, Queensland

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