RACGP Healthy Habits

Case Study: Healthy Habits Model For Improvement & Plan Do Study Act Cycle

Practice name: Rutherside Plains Family Practice*	**Date:** September
Team members: GPs, Practice Manager, Clinical Coordinator, Primary Health Care Nurse	

STEP 1: MODEL FOR IMPROVEMENT

Q1. What are we trying to accomplish?

Develop your improvement goal and record it as a S.M.A.R.T. goal.

Our aims are to:

- *Foster a team-oriented approach to support patient lifestyle changes.*
- *Identify modifiable risk factors for chronic disease in patient lifestyles.*
- *Enrol 30 patients per month in the Healthy Habits program from October to December.*
- *Integrate Healthy Habits effectively into GP practices.*
- *Increase patient awareness of how lifestyle affects health.*

Q2. How will I know that a change is an improvement

Determine what to measure to monitor your goal's progress. Identify the data to collect and the methods (e.g., CAT4 reports, patient surveys). Record baseline measurements for comparison.

- *Monitor patient enrolment and gather feedback during biweekly nurse check-ins.*
- *Collect feedback on lifestyle changes and experiences with the Healthy Habits app.*
- *Use the Healthy Habits dashboard to track patient progress and active participation.*
- *Utilise Primary Sense to identify patients with a CVD risk of 10-15% or greater, as well as those eligible for a health assessment (ages 45-49) or heart health check.*
- *Track the number of identified patients who join the program by downloading the app and connecting to the Healthy Habits dashboard.*
- *Measure general health indicators (e.g., BMI, blood pressure, weight) across the patient population.*

BASELINE MEASUREMENT:
Number of patients signed up to Healthy Habits: 0

*This Healthy Habits case study summarises an MFI & PDSA cycle completed by a general practice located in the Brisbane region. Identifying details and the practice name have been changed for privacy

Q3. What changes could we make that will lead to an improvement?

Generate a list of change ideas to achieve your SMART goal using the 'Plan, Do, Study, Act (PDSA)' cycle.

- *Idea 1: Ask GPs and Practice Nurse (PN) to identify patients who would benefit most from the program and approach them for enrolment.*
- *Idea 2: Use the 669 Heart Health Checks to assess lifestyle and risk factors, then discuss personalised health goals.*
- *Idea 3: Promote Healthy Habits via the GP practice website, waiting room posters, and doctor recommendations.*

STEP 2: PLAN, DO, STUDY, ACT
From the ideas generated from Question 3, select one to test.

IDEA

Which idea are you going to test? (Refer to Q3, step 1 above)

Ask GPs and PN to identify patients who would benefit most from the Healthy Habits program and approach them for enrolment.

PLAN

Record the plan to test your change idea, detailing who will do what, when, for how long, where, and the data to be collected. Include outcome predictions.

OBJECTIVE: *Test a strategy to enrol 30 patients per month in Healthy Habits from October to December by having clinicians identify suitable patients.*

ACTIONS:
GPs*: Refer patients to the Clinical Coordinator by assessing suitability and willingness to change during appointments, reviewing Primary Sense-identified patients, conducting a Healthy Habits consultation after a Practice Nurse (PN) assessment, and scheduling 4-week follow-up appointments.*

PN: *Opportunistically assess and refer patients, deliver Healthy Habits consultations (including a Healthy Heart Check, discussing CVD risks, app setup, and goal setting), and arrange follow-up appointments.*

Clinical Coordinator: *Develop a patient engagement script, contact flagged patients, and collaborate with PNs to track referrals and engagement.*

Practice Manager: *Support script development and monitor overall progress to ensure goals are met. Support script development.*

DATA COLLECTION: *Track the number of enrolled patients, their engagement, and any deviations from the plan.*

PREDICTIONS:
- *50% of patients will express interest in joining.*
- *High dropout rate expected due to nature of behaviour change motivation, limited personal contact and app-based engagement.*

DO

Run the test: Record your actions, observations, and data. Note any deviations and adaptions from the original plan and any unexpected consequences, both positive and negative.

EXECUTION:

- *Three GPs identified 67 patients with CVD risk and 45 patients opportunistically, totalling 112 patients. After exclusions, 89 patients were approached, and 35 enrolled.*
- *The Clinical Coordinator used a script to engage patients. Barriers to enrolment included time constraints and lifestyle readiness. Dropouts occurred due to scheduling conflicts, staffing shortages, and patient delays.*

ADAPTATIONS:

- ***Opportunistic Enrolment:*** *Identifying booked patients in advance allowed face-to-face discussions and distribution of flyers at reception. This approach had mixed results, potentially due to the time needed to explain the program.*
- ***Pre-Appointment Contact:*** *Calling patients to arrive early for appointments to discuss Healthy Habits was challenging due to nurse duties and patient scheduling issues. Over time, the nurse became more efficient in explaining the program.*

PATIENT FEEDBACK:

- *Positive feedback on app features, particularly tracking daily activities and health information and resources.*
- *Some patients needed support with setting up the app, but most found it very easy and straightforward.*

STUDY

Analyse the results and compare them to your predictions: Determine if the plan was executed successfully. Identify any problems or challenges encountered. Assess what worked and what didn't. Reflect on the lessons learned and summarise the outcomes.

ANALYSIS

- ***Results:*** *35 patients enrolled, showing high engagement and positive feedback. The involvement of GPs and PNs was crucial for motivation, but time constraints were a significant barrier.*
- ***Successes:*** *The engagement script was effective, particularly when the GP's recommendation was emphasised.*
- ***Challenges****: Time limitations for PNs due to other duties and staff absences affected patient follow-ups and in turn patient engagement in the program.*

ACT

Analyse the results and compare them to your predictions: Determine if the plan was executed successfully. Identify any problems or challenges encountered. Assess what worked and what didn't. Reflect on the lessons learned and summarise the outcomes.

ADOPT:

- *Continue setting individualised health goals during Health Heart Checks and Health Assessments to enhance patient motivation.*
- *Maintain GP-provided lists of eligible patients for targeted outreach.*

ADAPT:

- *Allow more time (20-30 minutes) for lifestyle discussions during appointments.*
- *Identify more opportunities and allocate time for PNs to engage with patients about lifestyle changes.*
- *Consider aligning lifestyle initiatives with the start of the new year.*

ABANDON:

- *Pre-appointment calls asking patients to arrive 10-15 minutes early for discussions about Healthy Habits. This approach was ineffective due to scheduling difficulties for both patients and nurses and other nursing duties that interfered with these early discussions.*

Email us at healthyhabits@racgp.org.au with any questions or visit our support webpage.

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RACGP Healthy Habits

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