healthy habits

RACGP Healthy Habits

Implementation guide

RACGP
Royal Australian College of General Practitioners

Australian Government
Department of Health and Aged Care

Welcome to Healthy Habits

Healthy Habits is an evidence-based digital health approach to improving and monitoring patient reported lifestyle behaviours.

It's an RACGP initiative, funded by the Commonwealth Department of Health and Aged Care, that supports GPs, primary health care nurses and practice teams to work with patients to establish and achieve exercise and nutrition goals. The initiative provides the tools and resources to efficiently and effectively encourage and support patients to adopt positive lifestyle changes. Healthy Habits resources can also increase clinician knowledge, skills and confidence in providing physical activity and nutrition advice to patients.

Implementing Healthy Habits in your practice

Anyone working in a general practice can register for Healthy Habits. The RACGP will conduct some verification checks and confirm your practice's registration. Then you and your practice team will have full access to Healthy Habits. This document gives you an overview of how to set up Healthy Habits in your practice and what to expect. You can find an online version of the implementation guide at https://healthyhabits.racgp.org.au/support

1. Typical roles and responsibilities

Healthy Habits champion

You might like to nominate someone to champion Healthy Habits. This person should be passionate about lifestyle medicine and motivated to encourage the uptake of Healthy Habits in the practice. They could be responsible for:

- Staying on top of Healthy Habits news and developments and keeping other staff informed
- Checking in on how staff members are going with Healthy Habits
- On-boarding staff members to the initiative

Initiating Continuing Professional Development (CPD) opportunities for themselves and others via the Healthy Habits Resource Hub.

Practice Manager

- Introduce processes to facilitate the Healthy Habits initiative
  - Explain the business case for implementing Healthy Habits in the practice, including opportunities to claim Medicare Benefits Schedule (MBS) item numbers
  - Set up systems to identify, recall and follow up eligible patients
  - Collate, monitor and analyse data on patients' activity as a cohort.
- Support clinical team members with data management and reporting
  - Consider utilising involvement in Healthy Habits to meet requirements for Practice Incentives Program Quality Improvement (PIP QI) or practice accreditation purposes.
  - Develop communication and support strategies to keep all staff informed.

General Practitioner

- Identify and assess who would benefit from the Healthy Habits app during consultations
- Support patients to identify appropriate physical activity and nutrition goals
- Use Healthy Habits resources to educate and engage with patients about physical activity and nutrition
- Add Healthy Habits to the GP Management Plan (GPMP) / Team Care Arrangement (TCA) of a patient where appropriate
- Sign up patients to the app either during the consultations or via a primary health care nurse
- Monitor the Clinician Dashboard to review patient data and provide further advice in follow-up consultations
- Send prompts/messages of encouragement and acknowledgment to patients from the Clinician Dashboard
- Review practice cohort data via the Clinician Dashboard to identify trends and insights.

Primary Health Care Nurse

- Assist with identifying suitable patients for Healthy Habits
- Introduce patients to Healthy Habits in consultations
- Support patients to download app and connect to the practice
- Support patients to identify appropriate physical activity and nutrition goals
- Use the Healthy Habits resources to educate and engage with patients about physical activity and nutrition
- Use the Clinician Dashboard to review patient data and provide advice in follow-up consultations
- Send prompts/messages of encouragement and acknowledgment to patients from the Clinician Dashboard
- Review practice cohort data via the Clinician Dashboard to identify trends and insights
- Work with the practice manager to implement reminder system
- Identify quality improvement activities related to implementing Healthy Habits, for example PIP QI incentive requirements.

Receptionist

- Be aware of Healthy Habits and the practice processes for identifying suitable patients and registering them for the app
- Assist with patient recall and reminder processes
- Provide information about the Healthy Habits app and program and/or send QR code to download and connect to practice
- Assist with enquiries about Healthy Habits and refer patients to the GP or primary care nurses for more information.

2. Identifying and enrolling patients in Healthy Habits

It's important to consider how you'll identify and attract suitable patients to the initiative. Below are some examples of how you could achieve this:

- Use your clinical information system to identify a particular cohort of patients (e.g. 40–60-year-old, BMI over 25 and/or with a chronic disease related to overweight/obesity) and invite them to make an appointment to discuss Healthy Habits
- Initiate conversations within a consultation by asking your patient if they are interested in discussing simple ways to improve their physical activity or nutrition
- Promote Healthy Habits in your waiting room with posters and patient brochures supplied by the RACGP.
- Promote Healthy Habits on your website, waiting room TVs, social media or practice newsletter using our downloadable promotional posters.

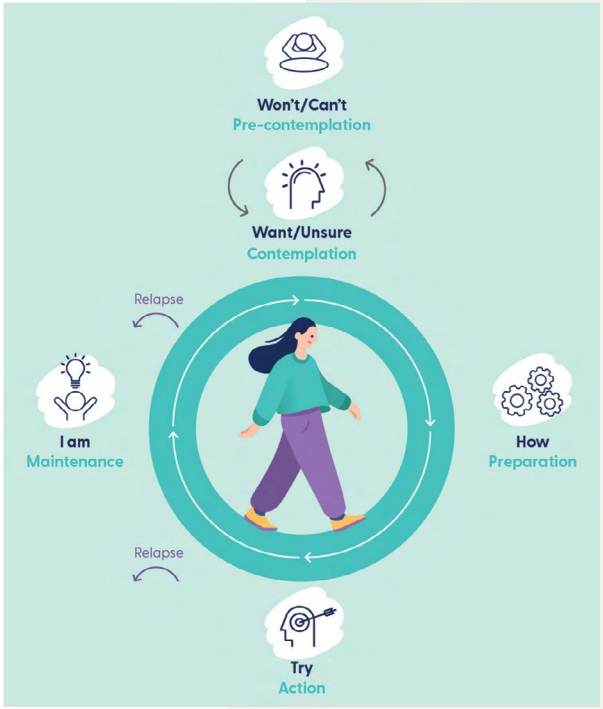
Assessing patient readiness

It's important to determine how ready or open each patient is to change. Patients who are in early stages of behaviour change (contemplation and preparation) would be well suited. The Patient Pathways guide provides advice for you to support patients at all stages of change.

Identifying suitable patients for Healthy Habits

Healthy Habits has been designed to support clinicians to target patients at increased risk of disease associated with living with overweight (including obesity) and physical inactivity. Through pilot testing, we've found that additionally, patients with some of the following characteristics tend to get the most out of Healthy Habits:

- Aged 40 years and over
- Have low levels of physical activity
- Are at risk of, or have chronic disease related to lifestyle
- Are on a Chronic Disease Management Plan
- Would benefit from more physical activity and a better diet
- Have limited knowledge of health and nutrition
- Have a smart phone and can download and use apps
- Haven't engaged much in healthy living apps or programs before.



3. Billing and MBS

To help practice owners and managers monitor whether Healthy Habits is feasible for their business we've collated a list of MBS item numbers that could be used when either running a dedicated Healthy Habits based consultation or incorporating Healthy Habits into a more complex appointment. Please note, this is general advice, and it's the responsibility of the GP or practice to ensure the appropriate MBS item numbers are claimed.

Regular consultation items	Item number
Level B consultation (lasting <20 minutes)	23
Level C consultation (lasting ≥20 minutes)	36
Chronic Disease Management items	
Preparation of GP management plan (GPMP)	721
Coordination of Team Care Arrangements (TCA)	723
Review of GPMP	732
Service provided by Nurse or Aboriginal and Torres Strait Islander health practitioner as part of GPMP or TCA	10997
Case conferencing	
GP attendance to organise and coordinate case conferencing as member of multidisciplinary team (lasting ≥15 minutes, <20 minutes)	735
As above (lasting ≥20 minutes, <40 minutes)	739
As above (lasting ≥40 minutes)	743
Health Assessments	
Heart Health assessment by GP lasting at least 20 minutes on patient ≥30 years old	699
Standard health assessment by GP (lasting >30 minutes, <45 minutes)	703
As above (lasting ≥45 minutes, <60 minutes)	705
Health assessment of person of Aboriginal or Torres Strait Islander decent by GP (once every 9 months or more)	715
Follow up by nurse or Aboriginal or Torres Strait Islander health practitioner for an Indigenous person who has received a health assessment	10987

4. Practice workflows and fitting Healthy Habits into a consult

It can be challenging to integrate a new initiative into your practice without disrupting your usual workflows. Healthy Habits has been designed to minimise this impact and compliment the way your practice already works. Here are three examples of how Healthy Habits can be worked into common general practice consultations.

Scenario 1: A patient with chronic disease is receiving care under a General Practice Management Plan (GPMP) or Team Care Arrangement (TCA)

Patient 1 – Chronic disease client	Recruitment – 30 min	First visit – 1 hour	2, 4, & 8 weeks – 15 min	3-month care planning – 30 min	4.5 months – 15 min	6 months – 30 min
GP	• GPMP/TCA prepared for patient • Client assessed for suitability and readiness to change • Sends patient app information from Healthy Habits website and/ or sends personalised link to patient to download app and connect to practice.	• GP reviews patient progress, identifies red flags, and recommends follow up type • Addresses concerns identified in review and/or escalated by nurse				
Primary Health Care Nurse	• Connects patient to Healthy Habits Clinician Dashboard (if not already connected) • Onboards patient to Healthy Habits	• Draws on Healthy Habits Patient Pathways to reassess readiness for change and provide relevant advice. • Refers to condition specific advice in the Healthy Habits Patient Pathways where required. • Goals added into the Healthy Habits app • Discusses communication preferences i.e., app notification from practice, phone call • Provide relevant resources to support patient from Resource Hub	• Reviews goals and sets new ones where applicable OR • Provide relevant resources to support patient from Resource Hub • Send one-way message (no billing)	• Chronic disease review • Reviews goals and sets new ones where applicable OR • Telehealth CDM review	• Reviews goals and sets new ones where applicable OR • Send one-way message (no billing)	• Chronic disease review • Reviews goals and sets new ones where applicable OR • Telehealth CDM review
Reception/Admin	• Books patient's next appointment and update reminders • Answers basic app related enquiries and follow up with the RACGP Healthy Habits team for technical support					

Scenario 2: Health Assessment or Heart Health Check

Patient 2 – Health Assessment client	Recruitment – 30 min	First visit – 30 min	2 weeks – 15 min	4 weeks – 15 min	8 weeks – 15 min	3 months – 30 min
GP	• Patient undergoes Health Assessment/Heart Health Check and Healthy Habits is suggested by GP • Client assessed for suitability and readiness to change • Sends patient app information from Healthy Habits website and/ or sends personalised link to patient to download app and connect to Practice	• GP reviews patient's progress, identifies red flags, and recommends follow up type • Addresses concerns identified in review and/or escalated by nurse				• GP reviews patient progress • GP and patient reflect on experience to date and discuss next steps
Primary Health Care Nurse		• Draws on Healthy Habits Patient Pathways to assess readiness for change and apply relevant use. • Refers to condition specific advice in the Healthy Habits Patient Pathways where required. • Goals added into the Healthy Habits app • Discusses communication preferences i.e. app notification from practice or phone call • Provide relevant resources to support patient from Resource Hub	• Reviews goals and sets new ones where applicable OR • Send one-way message (no billing) • Provide relevant resources to support patient from Resource Hub			
Reception/Admin	• Books patient's next appointment and update reminders • Answers basic app related enquiries and follow up with the RACGP Healthy Habits team for technical support					

Scenario 3: Patient asks about Healthy Habits after seeing information in your waiting room

Patient 3 – Patient initiated enrolment	Enrolment	First visit – one hour	2, 4, & 8 weeks – 15 min	3-month care planning – 30 min	4.5 months – 15 min	6 months – 30 min
GP	• Patient discusses Healthy Habits with GP • GP refers patient to nurse or reception for on-boarding following consultation	• GP reviews patient progress, identifies red flags, and recommends follow up type • Addresses concerns identified in review and/or escalated by nurse				• GP reviews patient progress • GP and patient reflect on experience to date and discuss next steps
Primary Health Care Nurse	• Enrols patient • On-boards patient if available during patients visit • Client assessed for suitability and readiness to change • Sends patient app information from Healthy Habits website and/or sends personalised link to patient to download app and connect to practice	• Assess readiness to change • Apply coaching strategies per patient pathways • Set goals and add to app • Discuss follow up preferences i.e. face to face or telehealth appointment • Discuss communication preferences i.e., app notification from practice or phone call • Provide relevant resources to support patient from Resource Hub	• Reviews goals and sets new ones where applicable • Provide patient with encouragement and support • Provide relevant resources to support patient from Resource Hub			
Reception/Admin	• Book patient's next appointment and update reminders • Answers basic app related enquiries and follow up with the RACGP Healthy Habits team for technical support					

5. Training and education

The Healthy Habits initiative provides educational resources and tools for GPs and their teams to enhance their knowledge and skills to work with their patients more effectively, particularly those with high risk factors for chronic disease, to encourage lifestyle change through improved diet and increased physical activity.

Patient Pathways

The Healthy Habits Patient Pathways is a tool that clinicians can use help raise the topic of lifestyle change with patients and guide conversations in an encouraging and supportive way that motivates patients. The Patient Pathways encourage a structured motivational interviewing approach drawing on the 5 As framework for identifying and managing behavioural risk factors in primary healthcare.

There is specific information for a range conditions that are affected by living with overweight (including obesity) and inactivity, including cardiovascular disease, diabetes and musculoskeletal conditions and other common conditions such mental health which supports you to provide tailored advice. You can follow the interactive pathway with your patient or download the full pathway as a PDF to work through. There's also an option to download a copy of the responses you've recorded at the end of the pathway to then upload to the patient's profile in your clinical software. The patient pathways are available at https://healthyhabits.racgp.org.au/patient-pathway

Resource Hub

The Healthy Habits Resource Hub is an easily searchable database of information, programs, guidelines and training opportunities on physical activity, nutrition and factors that contribute to health and wellbeing such as sleep, mental health, alcohol consumption and chronic conditions.

The Resource Hub houses a CPD directory for clinicians to access and identify relevant training and education to enhance knowledge and skills in supporting patients to move more and eat well. There's a range of health professional CPD offerings including RACGP accredited courses for RACGP members and Australian Primary Health Care Nurses Association courses. To start searching visit https://healthyhabits.racgp.org.au/resource-hub

6. Quality improvement

Plan, Do, Study, Act cycle template

A Plan, Do, Study, Act (PDSA) cycle is a simple tool to help improve clinical practice. PDSA cycles help practices to implement a planned improvement by breaking it down into smaller, more manageable stages. The Healthy Habits PDSA cycle template has been produced to help you not only assess, reflect on, and improve your practice's use of Healthy Habits, but provide an opportunity to contribute to your practice's quality improvement activities as part of general practice accreditation. Completing PDSA cycles can also contribute to Continual Professional Development (CPD) requirements for clinicians and general practice staff. GP members can self-report CPD hours attributed to this activity.

A PDSA cycle template has been developed to assist practices with implementing QI activities relating to Healthy Habits.

Utilising Healthy Habits as a part of general practice accreditation

Incorporating Healthy Habits into practice activities can help you provide examples of how your practice achieves the following indicators at your next accreditation visit:

Criterion C1.3 – Informed patient decisions
C1.3 B Our patients receive information to support the diagnosis, treatment, and management of their conditions.

Criterion C3.4 – Practice communication and teamwork
C3.4 B Our practice encourages involvement and input from all members of the practice team.

Criterion C4.1 – Health promotion and preventive care Indicator
C4.1 A Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

Criterion C7.1 – Content of patient health records
C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors.

Criterion QI1.1 – Quality improvement activities Indicators

The PIP QI incentive provides payments to general practices who participate in quality improvement (QI) activities. Implementing Healthy Habits provides multiple opportunities for practices to focus on QI processes. A PDSA cycle template has been developed to assist practices with implementing.

Ready to start implementing Health Habits at your practice?

Here's a handy checklist:

1. Program planning

- ☐ Identify the roles and responsibilities for each team member. Consider how the whole practice team can be involved and help at different steps. Identify a practice 'champion' or initiative lead
- ☐ Consider how Healthy Habits can be aligned to PIP QI activities. Refer to the PDSA cycle template below.
- ☐ Put in place operational processes required to implement Healthy Habits e.g. recall and reminder system and clarity on claimable MBS items.
- ☐ Consider how you will sign up patients e.g. will the practice reach out to patients? Will GPs or practice nurses initiate conversations in consultations? How will you respond to patients enquiring about it at reception or within a consultation?

2. Register for Healthy Habits

- ☐ Follow the instructions online for "Setting up your practice'.
- ☐ Invite other members of the practice to the clinician dashboard once the practice has been verified by the RACGP.
- ☐ Consider creating a test patient profile to practice connecting a patient to the clinician dashboard.

3. Inform and educate staff on the features of the initiative

- ☐ For clinicians: Patient Pathways, Clinician Dashboard, Resource Hub, app.
- ☐ For practice admin: Patient support, app, appointment scheduling expectations.

4. Communications plan

- ☐ Identify and notify patients who would benefit from the Healthy Habits initiative.
- ☐ Use posters and brochures downloadable from the RACGP to promote Healthy Habits at your practice.
- ☐ Consider including information about Healthy Habits on your practice website or social media pages.

5. Monitor use and follow up

- ☐ Check-in with staff to see how they're finding Healthy Habits, provide support where required.
- ☐ Review practice cohort data via the clinician dashboard to identify trends and insights and plan accordingly.
- ☐ Conduct PDSA cycle to reflect on and improve experience with Healthy Habits.
- ☐ Provide feedback to RACGP Healthy Habits team at heathlyhabits@racgp.org.au

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