Contents

Lifescripts

Advice for Healthy Living

Lifescripts in your Division:

Supporting Lifestyle Risk Factor Management in General Practice

A Guide for Divisions of General Practice

Lifescripts in your Division: Supporting Lifestyle Risk Factor Management in General Practice.

Prepared by the Lifescripts consortium, led by Kinect Australia, comprising the National Heart Foundation of Australia, Department of General Practice, Flinders University, Southcity GP Services, Centre for GP Integration Studies, University of New South Wales, and the Faculty of Health, University of Newcastle.

Funded by the Australian Government Department of Health and Ageing.

Suggested citation: National Heart Foundation of Australia and Kinect Australia for the Lifescripts consortium. Lifescripts in your Division: Supporting lifestyle risk factor management in general practice. A guide for Divisions of General Practice. Canberra: Commonwealth of Australia, 2005.

ISBN: 0 642 82702 8
Version 1.0
June 2005

The information contained in this Divisions guide is based on the current evidence and national guidelines. The MBS items mentioned here are correct at the time of printing.

Contents

Foreword

In Australia chronic diseases are estimated to be responsible for around 80 per cent of the total burden of disease. Seven out of ten presentations to general practice are attributed to chronic disease. Behavioural factors, such as smoking, nutrition, alcohol intake, physical activity and weight, play a significant role in the overall disease burden and its impact on physical, social, and economic well-being.

In 2002 the Australian Government commissioned a review of the Divisions network. In response to the review findings, the Government specified a number of primary care priority areas; importantly incorporating prevention and early intervention, better management of chronic disease, and integrated multidisciplinary care. Participating in the Lifescripts initiative will assist Divisions in meeting these priority areas identified by the Government.

The management of behavioural factors that impact on chronic diseases – and, in fact, can prevent such diseases developing and/or becoming worse – has become a major focus within the primary care setting. The Lifescripts initiative has been developed to sustain this focus and provide GPs and the primary care team with greater support to enhance what they are already doing in relation to chronic disease risk factor management.

Australian Divisions of General Practice is taking a lead role in this initiative and will provide support to State-based organisations and Divisions to assist with its effective dissemination and implementation. The Divisions Network is in a unique position to support general practice in implementing preventative health measures. Divisions have local knowledge and grass-roots effectiveness, and they are supported by a linked network which ensures that their efforts are grounded in quality research and enhanced by national resources and programs. They are ideally placed to support GP interventions to reduce lifestyle risk factors in patients.

Lifescripts has grown out of the Smoking, Nutrition, Alcohol and Physical activity (SNAP) initiative and is designed to be incorporated into existing activities and planning of Divisions. In this sense, Lifescripts is not a new program, but can be effectively utilised by Divisions that are already working with their members on preventive health activities. Lifescripts is intended to assist Divisions in their important role in supporting patient lifestyle intervention by GPs.

The Lifescripts package contains a variety of evidence-based resources and manuals (for Divisions, practices and consumers), which have been designed for flexibility. Users can choose selected materials either opportunistically or within a structured, systematic approach. The Lifescripts packs are there to serve a purpose, and that purpose is to promote healthy lifestyles and reduce the prevalence and impact of chronic disease in our communities.

Dr Rob Walters
Chair
Australian Divisions of General Practice

Abbreviations

ACCHS	Aboriginal and Torres Strait Islander community controlled health service (or Aboriginal community controlled health service)
ADGP	Australian Divisions of General Practice Limited
BMI	Body mass index
CGPIS	Centre for General Practice Integration Studies, University of New South Wales
EPC	Enhanced Primary Care (MBS initiative)
FECCA	Federation of Ethnic Communities' Councils of Australia
MBS	Medical Benefits Schedule
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
Green book	National Quality Committee of the Royal Australian College of General Practitioners. 2nd Edition. Putting prevention into practice. A guide for the implementation of prevention in the general practice setting. Melbourne; RACGP, 2005.
Red book	National Preventive and Community Medicine Committee of The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. Updated 5th Edition. Aust Fam Physician 2002; 31(Suppl): S1–S64.
SBO	State-based organisation
SNAP	Smoking, Nutrition, Alcohol and Physical activity
SNAP guide	Harris M (Ed). Smoking, nutrition, alcohol and physical activity (SNAP). A population health guide to behavioural risk factors in general practice. Melbourne; The Royal Australian College of General Practitioners, 2004.

Summary

Current risk factor statistics suggest that the burden of chronic disease among Australians could be significantly alleviated by reducing lifestyle-related risk factors –smoking, risky alcohol use, poor nutrition, physical inactivity and overweight or obesity. This is a realistic goal and a well-acknowledged role of general practice; there is good evidence that GPs can effectively promote a healthy lifestyle among their patients. Lifestyle risk factor management is especially important for patients at risk of developing a chronic disease, such as cardiovascular disease or diabetes, and for those with existing chronic diseases.

The Lifestyle Prescription Initiative is a part of the Focus on Prevention package introduced by the Federal Government in the 2003–2004 budget. The Lifescripts practice resources (Table 1) help GPs incorporate lifestyle risk factor management into their normal consultations. Building on earlier work around the SNAP framework, Lifescripts aims to make it easier for GPs and their practices to manage lifestyle-related risk factors, by providing a framework for:

- broaching and discussing lifestyle risk factors
- advice in the form of a written script and associated patient education
- referral to other providers to support healthy lifestyle choices.

Lifestyle 'prescriptions' are tools for GPs to use when giving patients healthy lifestyle advice – whether about quitting smoking, eating a healthier diet, reducing alcohol use, increasing physical activity, managing body weight, or a combination of these. The waiting room materials are designed to get patients thinking about risk factors before they see their GP. The assessment tools and guidelines are designed to support the roles of GPs and other practice staff.

The Lifescripts initiative will be implemented through participating divisions of general practice, supported by State Based Organisations (SBOs) and the Australian Divisions of General Practice (ADGP).

What this guide contains

This guide is intended to help divisions incorporate Lifescripts within their activities. It was shaped by a scoping study that consulted divisions and SBOs in late 2004.[a] The guide includes:

- basic information on lifestyle risk factors for chronic disease *(Section 1)*
- an overview of the Lifescripts package for general practice *(Section 2)*
- ideas for incorporating this initiative into existing programs and/or building new activities *(Section 3)*
- suggestions on strategies for supporting practices who choose to adopt Lifescripts activities *(Section 4)*
- case studies of divisions that have already run lifestyle risk management programs *(Section 5)*.

This guide is based on the assumption that divisions already know the practices in their area and have their own approach to training, practice support and other basic elements of the division's craft. Recognising that divisions are as diverse as their practices, the guide does not suggest any fixed programs, but instead provides a range of suggestions from which divisions can select or develop their own options.

The guide suggests a range of effective activities relevant to general practice, which will also assist your division to work within various National Quality and Performance System domains (Table 2).

a. Scoping study (scoping supporting tools for the implementation of lifestyle prescriptions) conducted by Market Access Consulting and Research Pty Ltd, 2004.

The Lifescripts package for general practice has been designed for flexibility, so that practices can opt to use selected materials (Table 1) either opportunistically or within a structured systematic approach — depending on patient demographics, current systems, interest and commitment to prevention.

Similarly, your division may choose to offer support in one or more lifestyle risk areas, or in the implementation of some or all activities in an area. This guide will help you decide.

key point

Table 1. Lifescripts practice resources

Samples of all GP and consumer resources in the Lifescripts package are included in the kit accompanying this guide.

Item	Description
Consumer materials and resources	
Waiting room checklist*	Short self-administered questionnaire to prompt patients to consider lifestyle risk factors
Waiting room flyer*	Leaflet announcing the practice's participation in Lifescripts and inviting patients to ask for information Alternative version for Aboriginal and Torres Strait Islander patients
Waiting room poster*	Poster announcing the practice's participation in Lifescripts and inviting patients to ask for information Alternative version for Aboriginal and Torres Strait Islander patients
Lifescripts stationery for notice board*	Blank Lifescripts letterhead for the practice's own Lifescripts-related announcements (e.g. walking groups, cooking demonstrations, practice nurse clinic information, community information days)
Resources for GPs and practice nurses	
Practice manual*	Practical suggestions for using the Lifescripts material
Assessment tools:* – Smoking – Nutrition – Alcohol – Physical activity – Weight management	Questionnaire-based assessment tools to assess each lifestyle risk factor Can be self-administered or administered by the practice nurse or GP
Assessment and management guidelines:* – Smoking – Nutrition – Alcohol – Physical activity – Weight management	Summaries of structured approaches to identifying and managing lifestyle risk factors
Prescriptions:* – Smoking – Nutrition – Alcohol – Physical activity – Weight management	Script pads to help structure the GP's advice to the patient on managing each risk factor.
Using motivational interviewing and Lifescripts resources	CD-ROM demonstrating motivational interviewing skills in the management of lifestyle risk factors (overweight and risky drinking) using the Lifescripts resources in practice Also contains electronic copies of all consumer, GP and practice materials and resources
Administrative resources	
Lifestyle summary record	Sticker for medical files
Desk stand	Stand for Lifescripts flyers

*Supplied as printed items and electronic versions that will be incorporated into Medical Director practice management software.

Table 2. Lifescripts and strategic planning in your division

National Quality and Performance System priority area	Relevance of Lifescripts
Integration	Supporting patients to make and sustain behavioural changes will often involve other providers, medical and community services and facilities. Activities targeting lifestyle risk factors will require partnerships with these services, which can be used to support other forms of multidisciplinary care e.g. chronic disease management.
Prevention and early intervention **Chronic disease management**	Lifestyle risk factors are major causes of chronic disease. Reducing lifestyle risk contributes to preventing and managing chronic disease.
General practice support	Lifescripts activities can provide a focus for developing the roles of GPs, practice nurses, practice managers and administration staff within the practice. Existing practice support activities can be adapted to support risk factor management.
Quality support	Lifescripts resources and approaches are based on the best available published evidence for effective general practice-based interventions.
Consumer focus	Lifescripts resources include strategies for involving consumers in their own health management: ■ waiting room tools to encourage patients to voice their own health needs and goals (e.g. checklist, poster, flyer) ■ motivational interviewing techniques that promote effective self-management (CD-ROM) ■ a strong emphasis on tailoring all medical advice to suit the individual's needs and circumstances (e.g. prescriptions).

Strategic approaches

The following are some of the areas in which Lifescripts activities can become a robust component of your strategies for meeting local objectives:

Practice systems development and support	The Lifescripts resources can be used to support the development of effective and efficient practice systems around risk factor management.
GP professional development	Lifescripts materials could be used within continuing professional development activities on motivational interviewing, the principles of supporting behaviour change, or identification and management of a specific lifestyle risk factor.
General practice staff professional development	Lifescripts materials could be used within continuing professional development activities for practice nurses on motivational interviewing, the principles of supporting behaviour change, or for a specific lifestyle risk factor. Lifescripts materials could be the basis of professional development activities for practice managers and administrative staff on recall and reminder systems, patient engagement in self-management, and the principles of lifestyle risk factor management.
GP health system integration – primary care	Activities targeted to one or more lifestyle risk factors can be a focus for developing better linkages that support integration and multidisciplinary care.
Public education/health promotion	Lifescripts materials provide a framework for: ■ broaching the subject of lifestyle-related risk with patients ■ prompting people to ask about health and behaviour issues ■ educating people about healthy lifestyle choices and self-management opportunities

Introduction

Lifestyle risk factor management is increasingly been recognised as an important strategy for preventing chronic disease (Figure 1). A wealth of useful resources to support these interventions has been developed by various stakeholders, including GPs, RACGP, tertiary institutions, divisions of general practice, government departments, NGOs and local interest groups. To be used effectively, these resources must be both familiar and available at every clinical encounter – in the minds and at the fingertips of practice staff, particularly GPs and practice nurses.

In response to this need, the Lifescripts initiative has brought together the most effective, evidence-based resources and tools and provided them in an easy-to-use format. The support materials are centred around pads for writing lifestyle prescriptions – individually tailored written advice for managing one or more risk factors. An electronic version will be incorporated in later versions of Medical Director practice management software.

The Lifescripts initiative is built upon and is consistent with the SNAP Framework developed by the Joint Advisory Group on General Practice and Population Health in 2001,[1] and with the approaches to implementation set out in guides published by RACGP:

- Smoking, nutrition, alcohol and physical activity (SNAP). A population health guide to behavioural risk factors in general practice[2]
- Putting prevention into practice. A guide for the implementation of prevention in the general practice setting (the 'Green book').[3]

The Lifescripts initiative is based on the assumptions that:

- divisions of general practice play a key leadership and support role in disease prevention and chronic disease management in general practice
- patients are most likely to adopt healthy lifestyle choices when they are given tailored advice, and assistance that acknowledges their individual circumstances and preferences[2,3]
- written information helps patients remember advice[4,5]
- general practices can incorporate effective lifestyle risk factor management into their everyday services. Providing brief (1-minute) interventions for lifestyle change is more effective than spending a lot of time on a few patients[3,6]
- GPs can effectively manage lifestyle risk by using a range of strategies, from opportunistic assessment and brief intervention, to more structured and planned interventions, through to systematic, whole-of-practice approach (the most effective approach).[3]

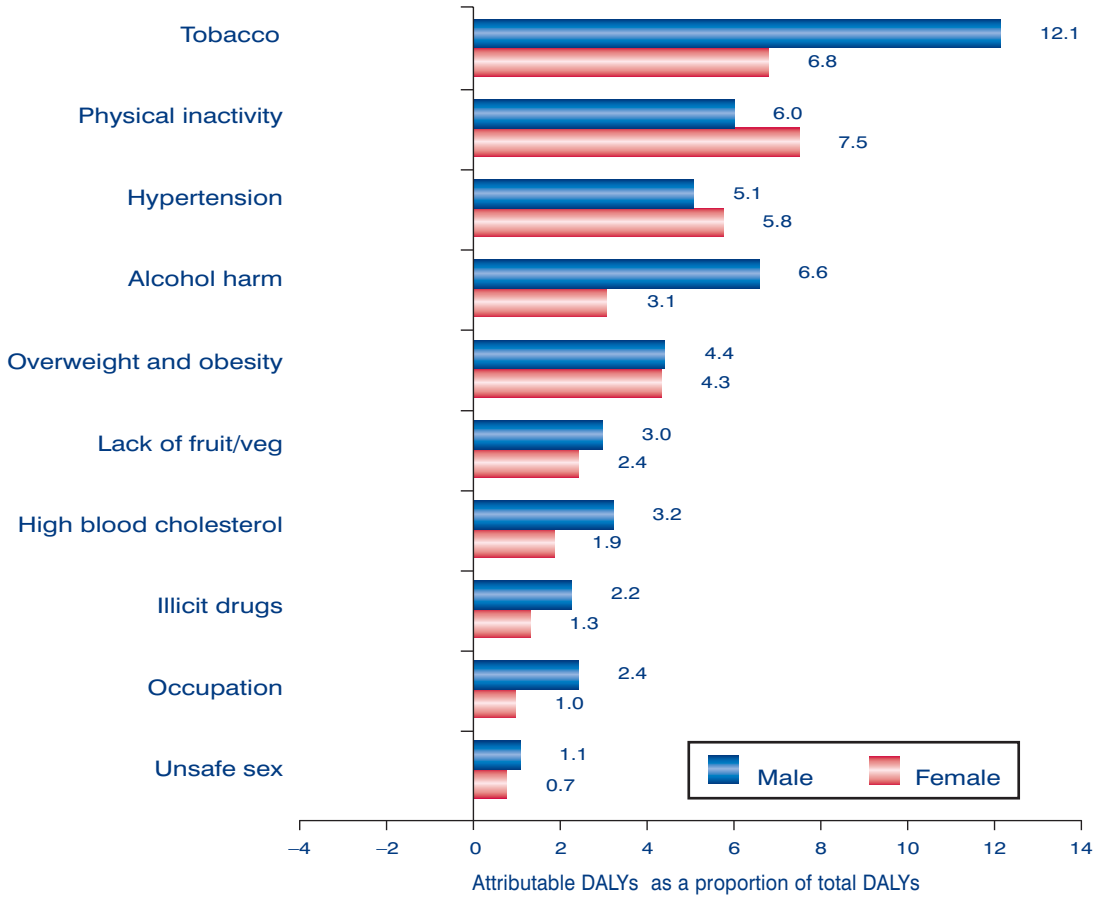
Lifescripts in your division

Selected components of Lifescripts can be incorporated into the established activities of any division. The suggested activities will usually fit easily within existing division programs – whether or not your division is already involved in lifestyle risk factor management activities.

Supporting lifestyle risk factor management in general practice can become an important component of a division's programs in the areas of prevention/early intervention, chronic disease management, diabetes, general practice support, quality support and consumer focus. Section 3 of this guide suggests some ideas for making a Lifescripts activity part of your strategy for meeting objectives within the National Quality and Performance System. ADGP will coordinate and support a targeted roll-out of this initiative to interested divisions. Refer to the ADGP website for further information. (www.adgp.com.au)

Figure 1. **Disease burden due to lifestyle risk factors**

Proportion of total disease burden attributed to selected risk factors, by sex, Australia, 1996.
Source: Australian Institute of Health and Welfare. The burden of disease and injury in Australia (www.aihw.gov.au).



DALY: disability-adjusted life-years (measure of disease burden based on comprehensive estimates of the incidence, prevalence and disease duration and associated morbidity; Alcohol harm: refers to the excess mortality caused by moderate, risky and high-risk drinking levels.

Section 1. Lifestyle risk factor management

GPs are well placed to help the community view lifestyle risk factors (smoking, poor nutrition, risky drinking, physical inactivity and overweight) as significant health issues to be taken seriously. These risk factors are common among general practice patients. Of adults attending general practice consultations, it can be expected that:[2]

- around half will be overweight or obese
- about one in five are smokers
- about one in four engage in risky drinking
- around two-thirds do less than the recommended levels of physical activity.

Identifying people who will benefit from lifestyle risk factor management, providing advice and tracking progress are standard activities of many general practices. The 'Red book' sets out evidence-based schedules for prevention.[7] There is good evidence that general practice-based programs can effectively reduce the burden of disease through lifestyle risk factor management, particularly in the areas of smoking, alcohol use and physical activity.

Smoking: GPs can help smokers quit by providing brief advice, suggesting strategies to overcome individual barriers to quitting, medical treatment to minimise nicotine withdrawal symptoms, and referral to support services such as Quitline.[8]

Risky alcohol use: brief advice from a GP is very effective in correcting risky drinking in people who are not yet physically or psychologically dependent on alcohol.[9] General practice is therefore a good place to identify non-dependent people who engage in risky drinking, and intervene early. GPs can also provide treatment and referral for dependent drinkers.

Physical activity: patients increase their physical activity levels in response to brief advice and written materials given by the GP. Longer counselling sessions and programs that involve follow-up visits are also effective.[10]

Although there is less published general evidence for practice-based interventions in the areas of nutrition and weight management, GPs and practice nurses are well placed to help patients adopt healthier eating habits and achieve a healthy body weight.[11,12]

Of adults attending general practice consultations, around half will be overweight or obese, one in five will smoke, one in four will engage in risky drinking, and two-thirds will do less than recommended physical activity levels.

The social context of health

The biopsychosocial model of health recognises that the health of individuals and communities is determined by a wide range of economic, social and environmental influences, as well as by heredity, health care and individual behaviour. It is crucial for health professionals to consider these influences when assisting patients to make real and lasting change to their lifestyle for improved health outcomes.

When working within a social model of health it is also important to recognise the link between mental and physical health. GPs need to consider both the physical and mental health benefits for patients from quitting smoking, increasing physical activity, healthier eating, drinking in moderation and managing their weight. Patients with a mental illness can also benefit from Lifescripts as part of their mental health care. Conversely, each patient's mental health status must be taken into account when assessing risk factors for chronic disease and developing a tailored management plan.

General practice can make a significant difference in smoking cessation because:

1. **Opportunity:** 80% of Australians visit their GP at least once per year and most smokers have several visits
2. **Credible/expectation/ acceptable:** Patients see GPs as having a key and supportive role in smoking cessation
3. **Feasible:** Advice can take less than 1 minute
4. **Effective:** Brief, repeated, non-judgemental advice works
5. **Efficient:** Smoking cessation is both doable and worthwhile.

Zwar et al. 2004[8]

I drink a lot less now than I did in my early thirties, partly because I've had children since then – but I suppose it was largely a result of the GP bringing it up about 5 years ago.

I was surprised – I wasn't annoyed. I didn't mind her asking [about alcohol], and in hindsight I think it was a good thing. It depends how they ask it – you feel like you're being judged, because you don't know what the right answer is. Also they have to follow it up.

Bringing it up made me think about it. It doesn't matter if you read about safe alcohol use in a magazine or somewhere; I think it's only if it's one-to-one with your GP that it has any impact.

Andrea — general practice client

Contribution of lifestyle factors to chronic disease

Smoking, poor nutrition, risky alcohol use, physical inactivity and overweight and obesity are responsible for a large burden of disease among Australians.

Smoking

Smoking causes more deaths and disease in Australia than any other preventable risk factor, and is responsible for an estimated 19,000 deaths and 142,500 hospital admissions per year.[13]

Life-long smokers have a 50–60% chance of dying from a tobacco-related disease, and half of these deaths will occur in middle age (25–54 years).[14,15]

Approximately 21% of men and 18% of women smoke daily.[16] At any time, just over half of these are seriously thinking about quitting within the next 6 months[17] and almost half have tried to quit during the past 12 months.[18]

Approximately half of all Aboriginal and Torres Strait Islanders aged 15 and over smoke (double the rate of the general population).[19]

Nutrition[12,20]

The adult daily requirement of 5 serves of vegetables and 2 serves of fruit protects against coronary heart disease, hypertension, stroke and some cancers.

High vegetable and fruit intake may also be associated with reduced risk of developing type 2 diabetes, hypertension, cataracts and macular degeneration.

Diets high in saturated fats contribute to insulin resistance and increase the risk of type 2 diabetes and coronary heart disease, and have been linked to several cancers.

Low fluid intake has been reported to increase the risk for kidney stones, colon and urinary tract cancers, childhood obesity, mitral valve prolapse, and to impair physical and mental performance.

Alcohol

Excessive alcohol consumption contributes significantly to the burden of chronic disease in Australia. Alcohol use is associated with disease and injury, foetal injury, sleep disturbance, pancreatitis, cancer, cirrhosis of the liver, cardiomyopathy, sexual dysfunction, brain damage, and alcohol dependence.[2,21] Other alcohol-related problems include road traffic accidents, crime, social problems and lost productivity.[2]

Although there is a higher proportion of non-drinkers among Aboriginal and Torres Strait Islanders than other Australians, rates of high-risk drinking are higher among Aboriginal and Torres Strait Islanders who do drink: 21% of men (compared with 8% of other Australians) and 9% of women (compared with 3% of other Australians).[19]

Physical activity

In women, insufficient physical activity is responsible for more premature death and illness than any other modifiable behavioural risk factor, whereas in men it is second only to tobacco smoking.[22]

Just 30 minutes per day of moderate-intensity activity provides health benefits and reduces risk for a range of conditions in all population groups. The preventive benefits of physical activity are best documented for cardiovascular disease, diabetes, stroke, mental illness, prevention of falls and obesity.[23]

Nearly half of the Australian population is not active enough to achieve these documented health benefits. About 6 million adults aged 18–75 years (44% of the population) can benefit from increased activity.[24]

Weight management

Approximately 56% of Australian adults and 27% of children are overweight or obese, and the rates are increasing.[25]

Approximately 30% of Aboriginal and Torres Strait Islander men and women aged over 30 are obese.[19]

Overweight and obesity are associated with increased risk for cardiovascular disease, diabetes, cancers and mental health problems.[12] Modest weight loss (10%) reduces risk and enhances treatment of hypertension, diabetes and hyperlipidaemia.[11]

The risk of developing diabetes is 25-fold higher among women with body mass index (BMI) of 31 kg/m^2, and 50-fold higher for those with BMI of 35 kg/m^2, compared with those within the healthy weight range.[26]

The interlinked risk factors of obesity, inactivity and poor nutrition have been estimated to be responsible for at least as great a disease burden as tobacco.[25]

For more information on links between chronic disease and lifestyle risk factors, refer to the recommended reading and the Lifescripts materials provided in the division kit.

Section 2. Lifestyle prescriptions

To the public

- **A healthy lifestyle helps you live longer, feel better, improves quality of life and can help prevent some long-term illnesses.**
- **Your GP can help you make and keep healthy habits.**

To GPs

- **Prevention of disease through lifestyle risk factor management will significantly improve your patients' health.**
- **Lifestyle risk factor management can fit in with your way of practising medicine.**
- **Patients see GPs as having a key role in promoting good health.**

To practices

- **Involving all of the practice staff – GPs, nurses, practice managers, receptionists – is an effective approach to incorporating risk factor management activities within a practice.**
- **Some brief interventions are effective in reducing lifestyle risk.**

Key messages about lifestyle risk factors

A lifestyle prescription involves the GP working with a patient to develop individually tailored written advice for managing one or more risk factors. The concept is based on the principle that patients prefer to be given written information, and that writing prescriptions and giving written advice are already standard practice for GPs.

Patients are more likely to adhere to preventive health advice if they:[2,3]

- feel that the GP has listened to them and understood their fears and concerns
- believe that the lifestyle change is important and relevant to them
- believe that the GP recognises their autonomy and treats them as an equal partner in the consultation
- believe that they can choose from a range of options
- have articulated the reasons for change (in their own words)

- perceive the benefits of change as outweighing the costs
- receive clear and specific advice from the GP
- feel confident and able to carry out the advice.

The prescriptions

The Lifescripts initiative includes prescription templates for:

- a smoke-free life
- healthy eating
- low-risk alcohol use
- an active lifestyle
- healthy weight.

All the prescriptions guide the GP in providing tailored advice that suit the patient's own preferences and constraints, and they prompt the GP to set a follow-up consultation to review patients' progress.

Lifescripts practice support materials

- Lifescripts waiting room **checklist** – invites patients to fill in a quick survey to indicate any lifestyle areas in which they would like help. The GP can use the information to identify patients who are ready, or almost ready, to make healthy lifestyle changes, and direct further assessment and advice.
- Lifescripts waiting room **flyer** – announces that the practice can offer lifestyle help and invites patients to indicate areas in which they would like more information.
- **Assessment tools** for smoking, nutrition, alcohol use, physical activity and body weight (can be administered by the GP or practice nurse, or self-administered by the patient).

The Lifescripts support materials are based on the 5As model for health-related behaviour change: Ask, Assess, Advise, Assist and Arrange

The 5As approach

The Lifescripts support materials are based on the '5As' model for bringing about health-related behaviour change.[2,27]

1. **Ask** patients about their lifestyle to identify those with risk factors.
2. **Assess** the severity of the risk factor (e.g. how much the person smokes, how much alcohol they drink, how active they are) and its relevance to the individual's health (e.g. age and sex, presence of impaired glucose tolerance, pregnancy, family history of cardiovascular disease). Also assess the person's readiness to change and motivation.
3. **Advise** the patient by providing written information (e.g. a lifestyle prescription), brief advice and using motivational interviewing techniques (see the motivational interviewing CD in the division kit).
4. **Assist** the patient to make the changes by providing support and pharmacotherapy where appropriate (e.g. nicotine withdrawal treatment, treatment for alcohol dependence).
5. **Arrange** further support such as referral to special services, access to social support groups, contact details for phone information or counselling services, and follow-up consultations to monitor the patient's progress in adhering to your advice.

- **Guidelines** for assessment and management of each lifestyle risk factor within the general practice. The reverse of each guideline summarises the key evidence for the link between the risk factor and chronic disease, the key health messages, and the evidence for the efficacy of general practice-based interventions.

Other support materials

- Lifescripts **Practice manual** – a 'how-to' booklet guiding practices in considering the evidence for lifestyle interventions, choosing the type and intensity of Lifescripts activities to implement, determining staff tasks and roles, regardless of current capacity, staff or systems, and addressing barriers to successful implementation.
- **Using motivational interviewing and Lifescripts resources** – CD-ROM containing information and video demonstrations on motivational interviewing and using the Lifescripts materials.

Electronic versions of the prescriptions and practice support materials will be incorporated into later versions of Medical Director practice management software.

Section 3. Incorporating Lifescripts into your division

Choosing a Lifescripts approach for your division

Consider how Lifescripts might fit into your division's program

Consider the extent to which implementation of Lifescripts will suit your division – whether as a stand-alone activity, or integrated into existing programs; taking up one aspect or several. Your approach will depend on capacity as well as the scope and way in which you work with practices.

Because the Lifescripts materials have been designed to be used flexibly, a Lifescripts activity will be viable for the majority of divisions. Read the Practice manual to see how Lifescripts activities can involve various levels of intensity from an opportunistic approach to a systematic, whole-of-practice approach. The Green book (2nd edition) outlines evidence-based implementation strategies in more detail.[3] Think about where an activity will fit within your current capacity. Lifescripts could be incorporated into current activities such as practice support, chronic disease management, prevention and early intervention, integrated multidisciplinary care, practice nursing, and consumer or community engagement.

Division staff will need to become familiar with the range of options for the type and intensity of Lifescripts activity that can be adopted in a general practice.

Build support for the initiative within your division

As for any initiative, the support of the Board and other division staff will be important for the success of Lifescripts activities. Standard strategies that might help to foster enthusiasm within your division are:

- Discussing the project with the division CEO and/or Board members who are supporters of lifestyle risk factor management
- Looking for positive experiences with lifestyle risk factor management programs among other divisions with similar circumstances to your own (*see the case studies in Section 5 for some examples*)
  - Recruit the support of a member GP who has successfully adopted lifestyle risk factor management into practice routines and will champion the activity
  - Familiarise yourself with some examples of practices that have successfully incorporated lifestyle risk factor management programs, and provide your staff with encouraging examples
- Giving a presentation to division staff on lifestyle risk factor management, based on the materials provided in the Lifescripts package.

Plan the type and intensity of your activities

Table 3 provides a range of suggestions for activities of varying intensity, ranging from simple tasks to detailed interventions, and indicates the National Quality and Performance System priority areas relevant to each activity. The suggestions might fall predominantly

Table 3. **Choosing your level of involvement in Lifescripts activities**

Strategic approach	Level of involvement ***Least intensive option*** ←	
Practice systems development and support	Provide details of Quitline to practices (PEI, CDM) Check practices have/want Lifescripts kit (PEI, CDM) Encourage practices to appoint a lifestyle risk management coordinator (GPS)	Provide a local referral directory for selected lifestyle risk factors (INT) Include questions on Lifescripts on GP needs assessments (GPS, CDM) Building Lifescripts elements into existing programs e.g. prevention and early intervention, chronic disease management (CDM, PEI)
GP and practice staff professional development	Alert GPs and practice staff to training opportunities in: multidisciplinary approaches to lifestyle risk (INT, PEI, CDM) information management, referral and business systems to support lifestyle risk interventions (GPS) evidence for lifestyle risk reduction (QS)	Organise GP and practice nurse seminars by local providers and services on lifestyle risk and referral opportunities (INT, GPS, CDM) Incorporate elements of Lifescripts into existing education programs, including training for practice nurse and practice manager networks (PEI, CDM, QS) Encourage development of extended roles for practice nurses and practice managers around Lifescripts (PEI, CDM, QS)
GP health system integration – primary care	Invite local primary care providers to submit information for division newsletter on approaches to lifestyle intervention and opportunities for GP collaboration (INT) Give advice and information about practice systems for working with primary care providers on lifestyle risk areas (GPS, CDM)	Provide GPs with regularly updated register of local primary care providers interested in supporting patients in lifestyle intervention (INT, CDM)
Public education/ health promotion	Provide access to Lifescripts consumer materials (posters, flyers, checklist, notice board stationery) (GPS, CF, CDM) Inform local health services that practices are offering lifestyle intervention support to patients (INT, CDM)	Place Lifescripts consumer materials in waiting areas of local health services (INT, CF) Give advice and information about practice systems for targeting patients who may benefit from a lifestyle prescription (GPS, CDM)

Some suggested strategies for incorporating Lifescripts into your division's current activities, under the National Quality and Performance System priority areas of integration (INT), prevention and early intervention (PEI), manage chronic disease (CDM),

within local domain objectives. Divisions can choose a range of activities or incorporate several to develop a stand-alone program, depending on capacity, existing programs and Agreement/Annual plans. An efficient approach is to incorporate Lifescripts into current activities, so as to exploit existing capacity and promote sustainability. You can include Lifescripts in your division's planning and reporting documents under local objectives.

Suggested strategies you might consider to meet objectives in local and national domains → ***Most intensive option***	
Provide and regularly update a local referral directory in all lifestyle risk factor areas (INT) Address Lifescripts-related issues as part of support for accreditation (PEI, CDM, GPS) Encourage practices to develop teamwork around Lifescripts activities, including regular practice meetings that include GPs and other staff (PEI, CDM)	Set up systems for feedback from referral services to GPs (INT, CMD, GPS) Use practice visits to assess practice systems and suggest ways of improving them, with follow-up visits for ongoing support. Focus explicitly on lifestyle risk factors, or as relevant to other interventions e.g. diabetes management. Systems assessed might include clinical information systems, recall, audit, booking systems, systems for managing and ordering resources (GPS, CDM)
Invite local providers to GP and practice nurse training on multidisciplinary care in one or more lifestyle risk areas (INT, CDM, GPS, QS) Provide access to training for motivational interviewing and stages of change (PEI, QS) Give a presentation at practice visits (PEI, GPS, QS) Incorporate a presentation on one lifestyle risk factor within an appropriate CPD program e.g. diabetes, cardiovascular disease etc. and practice nurses to attend (INT)	Organise a CPD program, using local, state or territory presenters, which incorporates some or all lifestyle risk factors, and practice nurses to attend (INT, QS) Use practice visits to offer staff development around Lifescripts knowledge, skills, behaviour and attitudes (QS, GPS, CDM) Develop a tailored interactive Category 1 CPD program in multidisciplinary approaches to all lifestyle interventions and practice nurses to attend (INT)
Coordinate local primary care providers to collaborate with GPs in targeting one or more lifestyle risk area (INT, CDM) Strengthen personal relationships between referral services and GPs e.g. through joint CPD events (INT, CDM)	Work with local primary care providers to develop collaborative approaches to lifestyle risk e.g. referral systems, management plans and care arrangements, case conferencing (INT, CDM) Develop/strengthen relationships with potential referral agencies for selected lifestyle risk areas, e.g. by improving relationships, formalising referral systems, developing joint programs, developing systems for feedback from referral services (INT, CDM)
Work with local health services and other providers on multidisciplinary campaign targeting one risk factor (INT, CDM) Place articles on lifestyle risk in the local paper, preferably using GPs as spokespeople (PEI, CF, CDM)	Work with local health services and other providers to develop a campaign promoting lifestyle intervention in all risk areas (INT, CDM) Work with local health services and other providers to develop consumer forum including promoting lifestyle intervention in all or risk areas (INT) Work through community organisations, particularly where the division has existing relationships (PEI, CF)

general practice support (GPS), quality support (QS) and consumer focus (CF). Suggestions are listed according to the strategic approaches outlined in national planning and reporting documents for divisions.

Organise suitable training for division staff

Your staff may need specific training to work with practices and other partners on lifestyle risk factor management programs. Contact ADGP or your SBO for more information about training opportunities for your division.

Investigate opportunities for joining training sessions provided to local health services and other training initiatives run by community groups including NGOs.

Build support among general practices

Assess the attitudes of your member practices towards incorporating Lifescripts activities.

- Gauge the willingness of individual practices to become involved. You can apply the 'stages of change' model to this process (see motivational interviewing CD-ROM).
- Start working with practices that are interested and build outwards, using the leaders' successes to encourage their peers.
- Be aware that some practices may be concerned about participating in any more activities. You can guide them in taking up only activities that will be manageable within the practice (e.g. 1-minute interventions or waiting room material on self-management options such as Quit).

Section 4 includes suggestions for recruiting practices, once you've gone ahead with your activity.

Consider the special needs of your member practices

You can use local population data to identify lifestyle risk factors that are particularly important to your practices and to determine the special needs of local communities. Demographic and morbidity data are available from public health units. Many divisions already undertake these kinds of analyses as part of their core activities, so much of this information may already be available.

You can also tailor Lifescripts activities to meet local needs by consulting the ACCHS[b] in your area, local ethnic organisations and other community groups.

b. Aboriginal Community Controlled Health Services (ACCHS) or Aboriginal Medical Services (AMS) are primary health care services, funded for the Aboriginal and Torres Strait Islander population and staffed by GPs, Aboriginal health workers, nurses and other health care professionals, with an emphasis on preventive health care. They are governed by representatives of the local community.

Aboriginal Australians die much younger, are hospitalised more often and suffer more complex health problems during their shorter life span than non-Aboriginal Australians.

A medical practitioner's guide to Aboriginal health. AMA 1998[31]

Lifescripts and Aboriginal and Torres Strait Islander patients' health needs

The RACGP recognises that improving the health of Aboriginal and Torres Strait Islander people is one of Australia's highest health priorities at all levels of the health system, and that community control in health is a key means of addressing the vast health inequalities that currently exist.[28] The Divisions of general practice – Future Directions document clearly asserts that divisions have a role in improving the health of Aboriginal and Torres Strait Islander people through working with ACCHS and improving access to mainstream health services (see www.health.gov.au). Many divisions of general practice already have a relationship with their local ACCHS or AMS,[b] or have identified the need to establish one.

The Lifescripts initiative provides an excellent opportunity for divisions and ACCHS to support and learn from each other and apply existing in-principle agreements to a practical program. The Lifescripts practice manual and the Aboriginal and Torres Strait Islander consumer resources (waiting room poster and patient flyer) promote the link between Lifescripts and the EPC Adult Health Check (MBS item 710). The Lifescripts tools have been developed in line with the Health Check to assist health providers make or arrange any necessary interventions and referrals, and the prescriptions can assist in documenting the patient's strategy for good health.

ACCHS and AMS have a wealth of experience in preventive health and many have very effective whole-of-practice systems in place, providing successful models for general practice. The Indigenous health report by James Cook University and Queensland Divisions of General Practice describes approaches to successful collaboration with Aboriginal and Torres Strait Islander organisations.[29] The report identifies barriers to increased general practice involvement in Aboriginal and Torres Strait Islander health and strategies for overcoming these.

Current Memoranda of Understanding provide good models for divisions wanting to work with ACCHS and exist between:

- ADGP and the National Aboriginal Community Controlled Health Organisation (www.adgp.com.au)

- The Queensland Aboriginal and Islander Health Federation (QAIHF) and Queensland Divisions of General Practice (QDGP)
- The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and General Practice Divisions of Victoria (GPDV) (www.gpdv.com.au).

The Memorandum of Understanding between ADGP and the National Aboriginal Community Controlled Health Organisation provides an important framework for these peak organisations to work together and further support divisions of general practice, ACCHS and communities to work together to improve Aboriginal and Torres Strait Islander health.[30] Divisions that want to work with their local ACCHS to implement Lifescripts should contact their SBO or state affiliate of the National Aboriginal Community Controlled Health Organisation.

The Lifescripts initiative provides an excellent opportunity for divisions and ACCHS to support and learn from each other.

Assessing and developing capacity to support the activity

Assess current capacity within your division

Planning a Lifescripts activity will involve systematic assessment of your division's current capacity to take up Lifescripts in five key areas:[32]

- Organisational systems and structures
- Current staff and training requirements
- Existing resources
- Current partnerships
- Leadership support e.g. Board ratification.

Your capacity assessment at the division level will involve asking the following questions:

- Which staff have skills and experience appropriate to running lifestyle risk factor management activities?
- Where can Lifescripts be integrated into the existing programs on which staff are already working?

Capacity building checklist for Lifescripts

- ☐ Do management and staff consider lifestyle risk factor management to be a health priority area for practices and patients?
- ☐ Have local needs in lifestyle risk areas been identified?
- ☐ Which of the division's partners have experience, skills or connections that could promote lifestyle risk factor management?
- ☐ How will we continue to access reliable up-to-date information on lifestyle risk factor management?
- ☐ What will be the best way of communicating with practices during the program?
- ☐ How do we currently communicate evidence-based information on preventive health care to general practices (e.g. newsletters, meetings, visits)?
- ☐ Will these methods need to be supplemented?

Do current communications networks within the division ensure that all staff members will:

- ☐ be kept informed of lifestyle risk factor management activities?
- ☐ include information on lifestyle interventions, where relevant, when contacting practices about other programs?

- ☐ Which of our staff's skills are relevant to lifestyle risk factor management programs and what further training do staff need?
- ☐ Which staff members have experience in promoting similar practice programs (e.g. preventive health initiatives)?

What are the information management/information technology needs?

- ☐ Do existing systems meet these needs?
- ☐ Do new systems need to be developed?

- ☐ Which staff members have experience in evaluating a similar program?
- ☐ Which staff members have experience in modifying a practice program in response to outcomes of evaluation?
- ☐ Does the division have strong links with expert organisations (e.g. foundations and other NGOs) that support lifestyle risk intervention in general practice?

- What further staff education and training is needed to support lifestyle risk factor management?
- How might the lifestyle risk factor management program build up over the period of the division's business plan? How can capacity grow to meet needs?
- How would the division's current partnerships with local services support lifestyle risk factor management? (Consider public health promotion units, cardiac rehabilitation programs, community health services and other primary health care services.) What new collaborations and partnerships are needed?

- Can the activities be supported within current funding arrangements? Is new funding needed? What are the options?
- How do current management practices facilitate a Lifescripts activity? Are there any changes that might better support the activity?
- Which NGOs (e.g. foundations) work with general practice to support lifestyle intervention? (Contact your SBO about programs and services available in your state or territory.)

Review current practice support networks, partnerships and referral networks

Look for existing links that may be used to facilitate the Lifescripts initiative, including local, regional or state-wide projects addressing lifestyle risk factor management that may support or enhance the implementation of Lifescripts.

Consider the following:

- Set up a local referral directory for all relevant medical, allied health and other service providers (Table 4).
- Provide GPs with information on costs to patients for each provider, to enable GPs to offer the least expensive options for low-income patients.
- Work with selected general practices to develop efficient referral processes that will streamline Lifescripts activities (e.g. referral letter templates, information on waiting lists of local providers, lists of available services).
- Develop a feedback form to make it easier for GPs to communicate with community-based providers who agree to accept lifestyle risk factor management referrals from GPs.
- Make sure GPs and practice staff are fully aware of MBS item numbers applicable to lifestyle risk factor management programs in various patient populations (*see Practice manual*).

Access other high-quality education material for patients and health professionals from organisations such as the National Heart Foundation of Australia and Cancer Council.

You might also choose to develop new links with agencies and organisations whose goals in promoting healthy lifestyle may be consistent with those of practices *(see Resource directory)*.

Table 4. Types of services you might include in a local referral directory

Lifestyle risk factor	Provider/service
Smoking	Quitline 13 QUIT (13 7848) Quit programs (including structured call-back program, available in some states) Clinical psychologists Counsellors Local public health services
Nutrition	Community health centre dietitians Public and private hospital clinical dietitians Private practice dietitians Naturopaths
Alcohol	Clinical psychologists Addiction medicine specialists Psychiatrists Drug and alcohol counsellors Local public health services
Physical activity	Exercise physiologists The Heart Foundation Heartmoves programs (available in some states) Local walking programs (e.g. The Heart Foundation Just Walk It program, available in most states; VICFIT Walk and Talk program) Cardiac rehabilitation programs Community health physiotherapists Private practice physiotherapists Public hospital physiotherapists Local public health services Fitness centres
Weight management	Community health centre programs Commercial weight loss programs (*see also: Nutrition, Physical activity*)

Section 4. Supporting Lifescripts in general practice

This section provides suggestions on how divisions can support Lifescripts activities in general practice. You will probably gain the most benefit from this section if you have already read the Practice implementation guide provided to GP and practice staff.

Divisions of general practice can support lifestyle risk factor management programs by assisting their practices with planning, workforce planning, education and training, information management and information technology, communication, community awareness and patient education, clinical partnerships and referral mechanisms, and research and evaluation.[1]

Since practices operate in a variety of ways and allocate responsibilities differently, it is crucial to find out which practice staff member is responsible for the organisational management of the practice. This may be a GP, practice nurse or practice manager. Lifescripts will be most effectively implemented and sustained if one member of the practice is designated the role of coordinating the activities.

Lifescripts implementation options for practices

Recognising that practices' willingness and ability to adopt lifestyle risk factor management programs will depend on available resources, consultation load and patient demographics, the Practice manual encourages GPs to choose the type and intensity of Lifescripts activity from the following options:[3,6]

- **Opportunistic** – involves the detection or management of risk factors as part of the routine activities as patients present (usually for other reasons). An opportunistic approach is more likely to be characterised by brief interventions lasting perhaps 1 minute and occasionally more intensive interventions, involving 1–5 minutes, e.g. assessment of 'readiness to change' and the use of motivational interviewing techniques.

- **Planned (or structured)** – a proactive and comprehensive approach to risk factor management, which may be undertaken by GPs or by some or all of the practice staff. This approach involves systematically identifying and managing risk factors, using organisational structures and systems within the practice, and involves coordination and teamwork. It may includes both brief and more intense clinical interventions, that are used depending upon the circumstances, and which are integrated with recalls, reminders, special education sessions, follow-up, referral and linkages with other services.

Approximately 85% of opportunities for improvement lie with changing processes in a system, but only 15% lie with changing individuals.

A worksheet to help GPs and practice staff decide on the appropriate intensity of a Lifescripts activity is supplied in the Practice manual and in the division kit.

While it is important to encourage and support each practice's chosen approach to lifestyle risk factor management within this spectrum, the most effective is a whole-of-practice approach in which responsibility and tasks are spread across all staff roles.[33] Systems analysts have found that approximately 85% of opportunities for improvement lie with changing processes in a system, but only 15% lie with changing individuals.[34] Research evidence demonstrates that the use of reminder notes on patients' medical records and patient reminders (e.g. telephone calls, letters, or postcards) can be effective in improving preventive care in general practice.[33]

- **Spending only 1 minute of the consultation to talk about a lifestyle risk factor, using the Lifescripts resources, can make a difference to patient risk and health outcomes.**
- **Adopting Lifescripts into general practices may not require major changes or modifications to systems or staff roles.**
- **Lifescripts is designed to suit practices at all stages of readiness or willingness to integrate prevention into their routines. GPs and practices can make a start immediately, by using as many or as few of the Lifescripts resources and tools as suit the practice context.**
- **Practices can become efficient at lifestyle risk factor management through small incremental changes that build up capacity to deliver effective interventions and move towards a culture of preventive intervention.**
- **Divisions and community-based organisations are very important in supporting practices' strategies for helping patients make healthy behaviour changes.**

Key points: the Lifescripts approach in general practice

Lifestyle interventions can be integrated throughout practice systems and procedures, using a range of strategies such as:

- waiting room posters
- reading material in the waiting room
- questionnaires to identify patients interested in making healthy lifestyle changes
- prompts in patients' files to remind the GP about an individual's risk factors at every consultation.

In addition to the Lifescripts support materials, you can provide customised materials or source materials especially suited to your clients' geographical and demographic characteristics. A checklist for assessing the quality of consumer resources is supplied in the division kit, to help you select the most appropriate materials. You might also consider:

- testing GP responses to your short-list of materials by conducting a survey through practice visits or running a discussion session with the GPs attending an educational session or division meeting
- setting up an advisory panel of GPs, practice nurses and practice managers to evaluate your collection of support materials and identify those most likely to be effective in the local setting
- canvassing patients' responses to consumer materials by running a discussion group at a community organisation or through a practice
- liaising with organisations with expertise in special populations, e.g. National Aboriginal Community Controlled Health Organisation, Federation of Ethnic Communities' Councils of Australia.

Making it happen

The Joint Advisory Group on General Practice and Population Health has identified the following areas where divisions support lifestyle risk factor intervention:[1]

- Developing structures that support payments and incentives to GPs to undertake lifestyle intervention
- Informing GPs and practices about available payments and incentives for lifestyle intervention activities

Working with practices to support Lifescripts

Publicity and promotion

- **Place articles on Lifescripts in division newsletters and on websites.**
- **Promote Lifescripts through local divisional networks, including practice nurse networks.**
- **Give presentations on Lifescripts at meetings and during practice visits.**

Planning

- **See Table 5**
- **See Figure 2**

Practical help with materials

- **Ensure practices can easily obtain and re-order the Lifescripts printed materials.**

Incorporate into practice system support programs

- **Provide information on how Lifescripts services for selected patients might fall within MBS reimbursement criteria for EPC and other relevant MBS items, including the Aboriginal and Torres Strait Islander Adult Health Check items.**
- **Build Lifescripts-related reminders, recalls and prompts into information management systems.**
- **Develop and support local referral programs.**
- **Link with relevant local population health programs.**
- **Include Lifescripts-related outcome measures in practice audits.**

Education and professional development

- **Promote the motivational interviewing CD-ROM.**
- **Contact your SBO about education and training opportunities.**
- **Link with local services and NGOs training (e.g. public health units, community health).**
- **Consider inter-division training sessions.**
- **Satellite sessions for practices in rural and remote divisions.**
- **Joint education sessions with all members of the practice team when taking a whole-of-practice approach.**

- Establishing effective data management systems
- Training GPs and practice staff in how to apply for incentives and practice payments, including making use of EPC or other relevant MBS items to engage with local primary health care providers, where appropriate, in case conferences and management plans and care arrangements
- Collaborating with GP and population health academic units, local population health experts and primary health care providers in developing or adapting locally and culturally relevant lifestyle risk factor management training materials and programs

- Developing structures to support GPs working collaboratively with consumers and consumer groups on lifestyle risk factor modification strategies
- Coordinating local partnerships with relevant agencies and local service providers to meet the needs of the local community, especially Aboriginal and Torres Strait Islander populations and other specific population groups
- Establishing regional collaborations with other divisions, local government, state-based organisations, Aboriginal and Torres Strait Islander community controlled health services, the National Aboriginal Community Controlled Health Organisation, ethnic community organisations or the Federation of Ethnic Communities' Councils of Australia to:
  - identify local community needs and access hard-to-reach groups
  - develop or adapt nationally developed patient information material to meet the needs of local communities to ensure cultural relevance
  - develop locally relevant and culturally appropriate communication strategies
- Providing links between practices and community-based lifestyle risk factor modification programs and facilitating referral of patients to these programs
- Developing appropriate patient confidentiality and informed consent guidelines and protocols for use in general practices in order to facilitate referrals to other primary health care providers
- Developing and maintaining local referral directories for practices
- Establishing mechanisms for collection and analysis of lifestyle risk factor data for planning, policy development and research at the regional level.

Note! Acknowledge that not all practices will immediately use Lifescripts-related materials that you provide, and may have their own preferred activities and referral services.

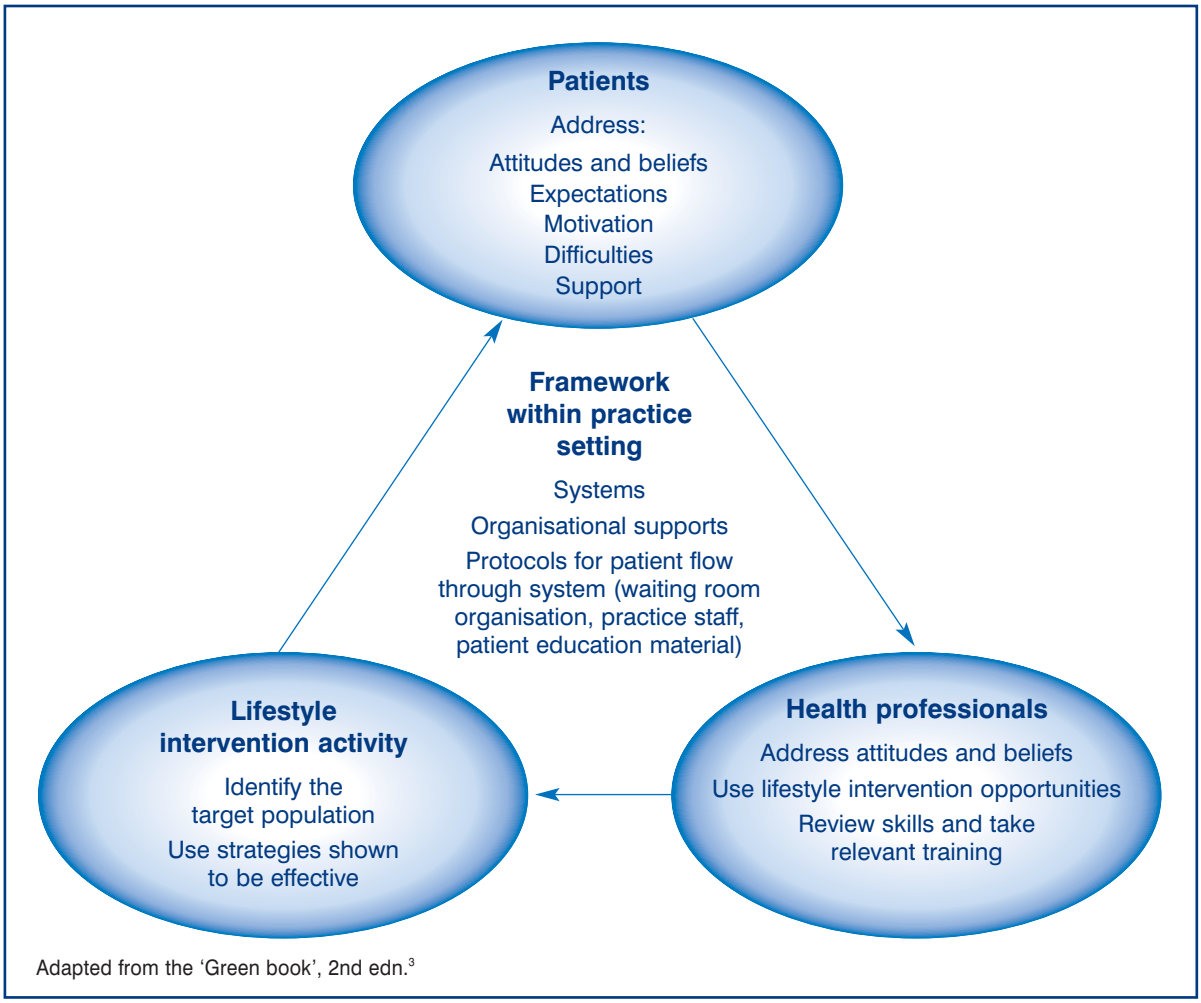
- Don't be discouraged if GPs or practices are not initially enthusiastic about Lifescripts. They may gradually become interested as you provide opportunities for training, information in newsletters and as peers become involved.
- Some GPs won't feel confident about promoting lifestyle risk factor management to their patients until they become familiar with the evidence. By offering Lifescripts resources as a logical and systematic way to deliver lifestyle advice, and by continuing to provide simple, consistent messages about each risk factor, you may instil this confidence over time.

Table 5. Supporting practices at the planning stages

Practice task	Division support for this task *(some sample options)*
Conduct a needs analysis for a Lifescripts activity	■ Carry out part of the needs assessment, such as obtaining relevant health statistics for the geographical area or conducting capacity assessment ■ Work with practice staff to develop locally relevant questionnaires designed to assess patients' needs and attitudes to lifestyle risk factor management (e.g. design a customised quiz relevant to local demographics and issues, for patients to fill out in the waiting room)
Analyse the flow of patients and information through the system to determine how Lifescripts can be integrated into existing practices	■ Write up a case study for the division newsletter to illustrate how a practice conducted such an analysis effectively ■ Provide local referral guides
Business management	■ Provide up-to-date information on reimbursement options that may be relevant to services provided in implementing Lifescripts activities (see Practice manual)
Determine the implementation approach best suited to the practice (opportunistic or structured) Determine which components of the Lifescripts program will be adopted	■ Encourage practices to review efforts regularly ■ Encourage practices to continue through the implementation spectrum from opportunistic to planned/structured to whole-of-practice ■ Help practice staff become familiar with the materials and choices via presentations and practice visits. ■ Where appropriate, encourage practices to set small goals, evaluate these after a short time, and consider incorporating more of the Lifescripts strategies later ■ Supplement the Lifescripts materials with additional tools to meet local need
Set goals and plan how performance will be evaluated	■ Provide systems for collecting and analysing desired outcome data

Divisions can work with practices to support practice staff as they work through some of the necessary steps to plan the activities, using some of the suggested options in the table.

Figure 2. **Integrating a lifestyle intervention into general practice, within existing systems**



Adapted from the 'Green book', 2nd edn.[3]

Recruiting GPs and practices

How you publicise and promote Lifescripts will depend on your division's resources, circumstances and needs. The following are some suggestions you may want to adapt.

- Announce Lifescripts in the division newsletter.
- Send out a one-page expression of interest form to all practices and GPs, inviting them to indicate their level and area/s of interest and whether they would like to be contacted by the Lifescripts coordinator with more information.
- Discuss Lifescripts or give a short presentation during practice visits.
- Include a session on Lifescripts within satellite seminars, videoconferences, teleconferences and internet-based programs or discussions.

- Run a short presentation within another event through which you will reach as many practices as possible. Use the discussion time after the presentation to assess GPs' knowledge, needs, and readiness to incorporate Lifescripts into their practices.
- Give a short presentation at practice nurse training sessions and gauge enthusiasm and skills.
- Launch the Lifescripts activity with a continuing professional development event, either stand-alone or as a component of another training event in a relevant area such an chronic disease management.
- Publicise successful implementation of Lifescripts activities at practices within your division, through your newsletter and other publicity methods.

Lifescripts and business management

At present, there is not a specific MBS item or incentive payment for Lifescripts, but other reimbursement methods relevant to chronic disease management may apply.

For practices operating in a competitive environment Lifescripts can be an opportunity to offer something more to patients. Practices already overworked can use Lifescripts to maximise the impact of brief interventions. Practices that want to adopt a systematic, whole-of-practice approach to Lifescripts can link risk factor management with existing general practice initiatives (listed below).

Current MBS items

There are several MBS items available for those with chronic or terminal medical conditions and complex care needs including:

- *Health Assessments*, including Aboriginal and Torres Strait Islander Adult Health Check (item 710)
- *Multidisciplinary Case Conferences* – Lifescripts can be part of the goals and strategies discussed for patients with chronic conditions and complex care needs
- *Chronic Disease Management* (as introduced 1 July 2005) – Lifescripts can be built into GP management plans and team care arrangements for patients with chronic conditions, including patients with complex care needs.

Sample strategic approach to recruitment

Objective: to recruit GPs (and other practice staff) who may benefit from implementing Lifescripts in their practice

Strategies to realise this objective

GP level

- Include questions about lifestyle prescriptions in annual needs assessment questionnaires.
- Announce Lifescripts in the division newsletter.
- Run a short presentation within another event through which you will reach as many practices as possible. Use the discussion time after the presentation to assess GPs' knowledge, needs, and readiness to incorporate Lifescripts into their practices.
- Give a short presentation at practice nurse training sessions and gauge enthusiasm and skills.
- Launch the Lifescripts activity with a continuing professional development event, either stand-alone or as a component of another training event in a relevant area such an chronic disease management.
- Publicise successful implementation of Lifescripts activities at practices within your division, through your newsletter and other publicity methods.

Practice level

- Promote the activity through local divisional networks e.g. practice nurse division activities.
- Demonstrate how Lifescripts works during practice visits.
- Provide materials for practice managers to use to brief staff on the activities and support materials.
- Encourage and support a whole-of-practice approach by including all staff members in information and training initiatives, where this is appropriate.
- Target the appropriate practice staff member in each practice to lead the implementation. (This will not always be the principals; it may be the practice manager, practice nurse or a junior GP or GP registrar.)

Division level

- Give a presentation to the Board on Lifescripts.
- Identify a potential champion among the Board members or member GPs and recruit that person to canvass interest among Board members and other GPs.
- Make contacts with other divisions planning to implement Lifescripts, and learn from their experience of successful implementation of Lifescripts or other lifestyle risk factor interventions.
- Consider inter-divisional collaboration (e.g. joint education sessions, development of referral networks or other shared resources).

Current PIP items

PIP provides payment to general practices for providing standards of care for chronic illnesses (diabetes, asthma, cervical screening and mental health), for establishment of chronic disease registers and recall systems and funding for practice nurses in rural practices. To receive PIP payments the practice must be accredited or registered for accreditation (see Health Insurance Commission website: www.hic.au).

- Diabetes Annual Cycle of Care – assessing diet, physical activity levels and smoking status are requirements of the cycle. Use this opportunity to complete the 5As process and write a prescription to address the relevant risk factors.
- Practice Nurse Incentives – available in rural, remote and other areas of high need. A practice nurse can take a key role in prevention activities, reducing GP workload and providing rapid access to care for patients.
- Allied health service incentives (including Aboriginal health workers) – consider referring patients with a Lifescripts prescription for healthy weight, physical activity or nutrition to a dietitian or physiotherapist to complement care plans. An Aboriginal health worker can coordinate prevention activities, management plans and care arrangements and other services, where relevant.

Practice nurses

It may be cost-effective to employ a practice nurse to be responsible for some aspects of a Lifescripts program, according to skills and experience (e.g. identifying patients who might benefit from a lifestyle intervention, conducting assessments and providing counselling, as well as preparing management plans and care arrangements and conducting components of Health Assessments). ADGP has developed a series of case studies that illustrate the roles of practice nurses in a variety of practice models, and which can help practice owners assess the financial feasibility of employing a nurse (available on the ADGP website www.adgp.com.au by selecting Nursing in general practice from the programs menu).

Upskilling for GPs and practice staff

Divisions can both provide training for GPs and practice nurses in lifestyle intervention, and direct practice staff to training programs available from other providers. Joint education sessions are particularly useful when targeting a whole-of-practice approach and building teamwork within the practice. If your division has the capacity to develop your own continuing professional development activity, you can tailor the learning program based on risk factor management, motivational interviewing, screening issues, assessment,

patient self-education resources, support networks and relevant referral opportunities.

Check with providers regularly for the availability of continuing medical education courses on topics relevant to lifestyle risk factor management, such as motivational interviewing, writing lifestyle prescriptions, and working with Aboriginal and Torres Strait Islander communities to reduce lifestyle risk factors.

Lessons learned from the Active script program[35]

Training for GPs should be a high priority in the implementation plan for divisions adopting a lifestyle intervention such as Lifescripts for the first time. Training can be a combination of:

- **Dedicated presentations**
- **Short presentations within other training activities**
- **Practice visits**
- **Regular follow-up and reminders to use the materials**
- **Offers to provide more information as practitioners need it.**

In the Active script program, GPs who undertook training were more likely to report being confident about incorporating the activity into their practices.

Help practices identify barriers and enablers to incorporating Lifescripts

When considering whether to adopt a lifestyle intervention, all practices will encounter barriers that need to be overcome first *(see Box 1)*. Commonly reported barriers to preventive health practices include:[33]

- Time constraints
- Competing demands
- Uncertainty about conflicting recommendations
- Inflexible consultation schedules to meet demand (e.g. inability to lengthen consultation times)
- Inability to increase GP consultation load to meet anticipated increase in workload as a result of screening and assessing patients for lifestyle risk factors
- Lack of allied health staff
- Lack of community supports and programs
- Patient demographic profile for the practice (e.g. a predominantly geriatric practice may encounter special difficulties in promoting physical activity; smoking may be the norm for some demographic or ethnic groups).

All in the timing

Lack of GP time will almost always be cited as a barrier to incorporating Lifescripts activities. However, in almost all practices it will be feasible to introduce at least systematic practice-level changes (0 minutes for GP) and brief intervention (<1 minute). Even frugal use of time has been shown to be effective in the areas of alcohol, physical activity and smoking (Figure 3).

Where possible, provide GPs with evidence for what can be achieved with minimal time expenditure. For example, the smoking cessation literature shows that a practice can achieve significant increases in quit rates using strategies that do not impinge on consultation time *(see Box 2)*.

Barriers for patients

- **Not interested in quitting**
- **Smoking is a stress reliever**
- **Worry about gaining weight if quit**
- **Lack of peer support to quit (e.g. all friends smoke)**
- **Poor role models (e.g. GPs and other health care workers who smoke)**

Barriers for GP

- **Lack of skills in motivational interviewing**
- **Fear of failure**
- **Low priority relative to other health areas that must be dealt with**
- **Fear of upsetting the doctor–patient relationship**

Barriers within systems

- **Inadequate data management systems**
- **Lack of time and financial incentives**
- **Lack of coordination with support agencies**

Box 1. Typical barriers to promoting smoking cessation in a general practice[36]

Supportive organisational infrastructure (no consulting time)

- Routine systematic identification of patients' smoking status
- Flagging records (electronic or paper) with smoking status and interest in quitting
- Self-help materials in waiting areas
- 'Stop smoking' posters
- Verbal promotion of Quitline by all practice staff

Brief intervention (<1 minute)

- Discussion of patient's smoking status
- Assessment of motivation and nicotine dependence
- Affirmation of decision to quit
- Brief advice and support
- Self-help materials
- Negotiating a separate smoking cessation appointment
- Referral to Quitline

Moderate intervention (≤5 minutes' consulting time)

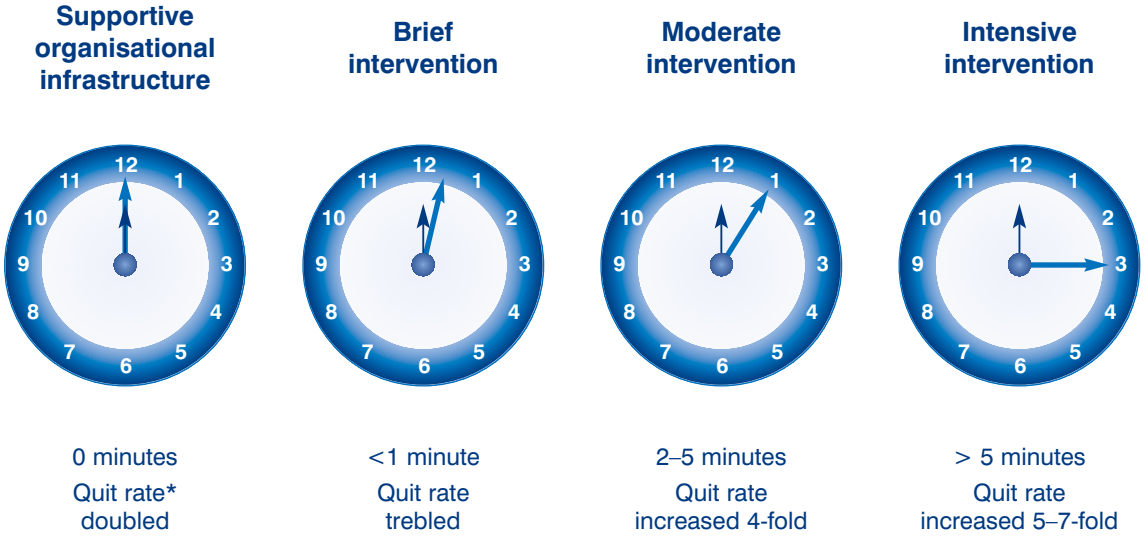
- Assessment of barriers to quitting
- Taking quit history
- Identifying high-risk situations
- Exploration of motivation
- Assessment barriers and confidence
- Advice on dependence, habit, triggers, negative emotions
- Brainstorming solutions
- Pharmacotherapy
- Offering ongoing support and referral to Quitline
- Organising follow-up appointment and support

Intensive intervention (full consultation time)

- Exploration of motivations, ambivalence and confidence about quitting in more depth
- Discussion of pharmacotherapy (e.g. nicotine replacement therapy, bupropion)
- Development of quit plan
- Offering ongoing support and/or referral to Quitline

Box 2. Smoking cessation by numbers[36]

Figure 3. **GP time expenditure for smoking cessation**



Adapted from the 'Green book', 2nd edn[3] and Litt et al.[36]
*Estimated increase in quit rates over 12 months among patients attending the practice, compared with not applying the intervention.

Know the common barriers

Divisions can encourage practice staff to understand they are not alone in their reservations about making changes. Make practice staff aware of common barriers that other practices have experienced and overcome.

Encourage practice staff to understand that patients who appear uninterested in making lifestyle changes may simply be waiting for the GP to broach the topic. The following are some common attitudinal barriers to lifestyle risk factor management.

Patients think:

If a lifestyle habit is important to my health, the GP will raise it. (In fact, GPs may avoid broaching the subject due to a range of reasons from the desire to be tactful to lack of time).

I know I should give up smoking, cut down drinking, eat less fat and more fruit and vegetables and exercise more, but…. I like it or I will start at Christmas OR It is just too hard.

Many GPs have negative perceptions of dealing with people who have alcohol and other drug-related problems. However, GPs can be very effective at altering the consumption habits of non-dependent drinkers. If the matter is raised, most Australians who drink too much will respond to a structured discussion with their GP about their alcohol consumption patterns. This may be where the general practice "main game" ought to be.

Holmwood, 2002[37]

GPs think:

The patient does not want to give up unhealthy habits. (In fact, patients often recognise the need to change once the risks and benefits are explained.)

If the patient is at all prepared to overcome unhealthy habits, he or she will broach the subject. (In fact, patients often wait for the GP to raise the topic.)

I can't tackle lifestyle risk factors effectively in the time I have, so it's a waste of time to attempt it. (In fact, there is evidence that very rapid interventions can be effective in helping a person quit smoking, reduce alcohol intake to a moderate level, or increase physical activity levels.)

Look for enablers

GPs are more likely to adopt lifestyle interventions when:[35]

- they have skills and knowledge training in the specifics of what and how to advise patients
- they understand how to use very brief interventions
- they have access to good referral systems to support and reinforce the advice to patients
- they are made aware of evidence for the efficacy of GP intervention.

Patients are more likely to adopt lifestyle interventions when:[35]

- they are given reliable, consistent information on the benefits of adopting healthy lifestyle choices
- lifestyle changes are promoted through the positive benefits of enjoyment of life (where relevant), rather than focusing only on avoidance of illness

- they are encouraged to begin by setting small, achievable goals, so that the feeling of satisfaction with early success is the reward
- they have access to local programs that support the lifestyle change
- the GP or practice nurse taps into personal motivators to recommend the most appealing options (e.g. older women are motivated by the social benefits of physical activity, so walking groups and supervised exercise programs will be most appealing; older men are more motivated by health benefits).

You are likely to be more actively involved in prevention if you believe that:

- **Prevention is an important and worthwhile part of your role**
- **You are an effective agent in providing a range of preventive activities**
- **You have the relevant skills**
- **You have the time and necessary resources**
- **Patients are receptive to your efforts**
- **Prevention is both feasible and sustainable in your setting.**

Be realistic about what you can achieve. It is worth remembering that the benefits of prevention are mainly seen at a practice or population level, rather than in each individual patient.

Information for GPs in the 'Green book', 1st edn, 1998[38]

Providing ongoing support

Once practices have taken up Lifescripts, you can continue to support them by providing regular information and encouragement. Consider the following options:

- Include a regular Lifescripts section in your division newsletter, or set up a Lifescripts newsletter for updates and information
- Publicise successful implementation of Lifescripts, to encourage GPs through seeing their peers' positive experiences
- Set up a Lifescripts network (e.g. via e-mail or internet) to encourage participating GPs and practice staff to exchange experiences, problem-solving ideas and successes
- Run Lifescripts seminars or workshops
- Include updates on Lifescripts in videoconferences, teleconferences or internet-based sessions.

Section 5. Case studies

Case 1. Harnessing existing systems and services

In response to the significant burden of cardiovascular disease, diabetes and cancer among communities in the western Victorian region, West Vic Division of General Practice set out to target physical inactivity.

The project: promoting physical activity

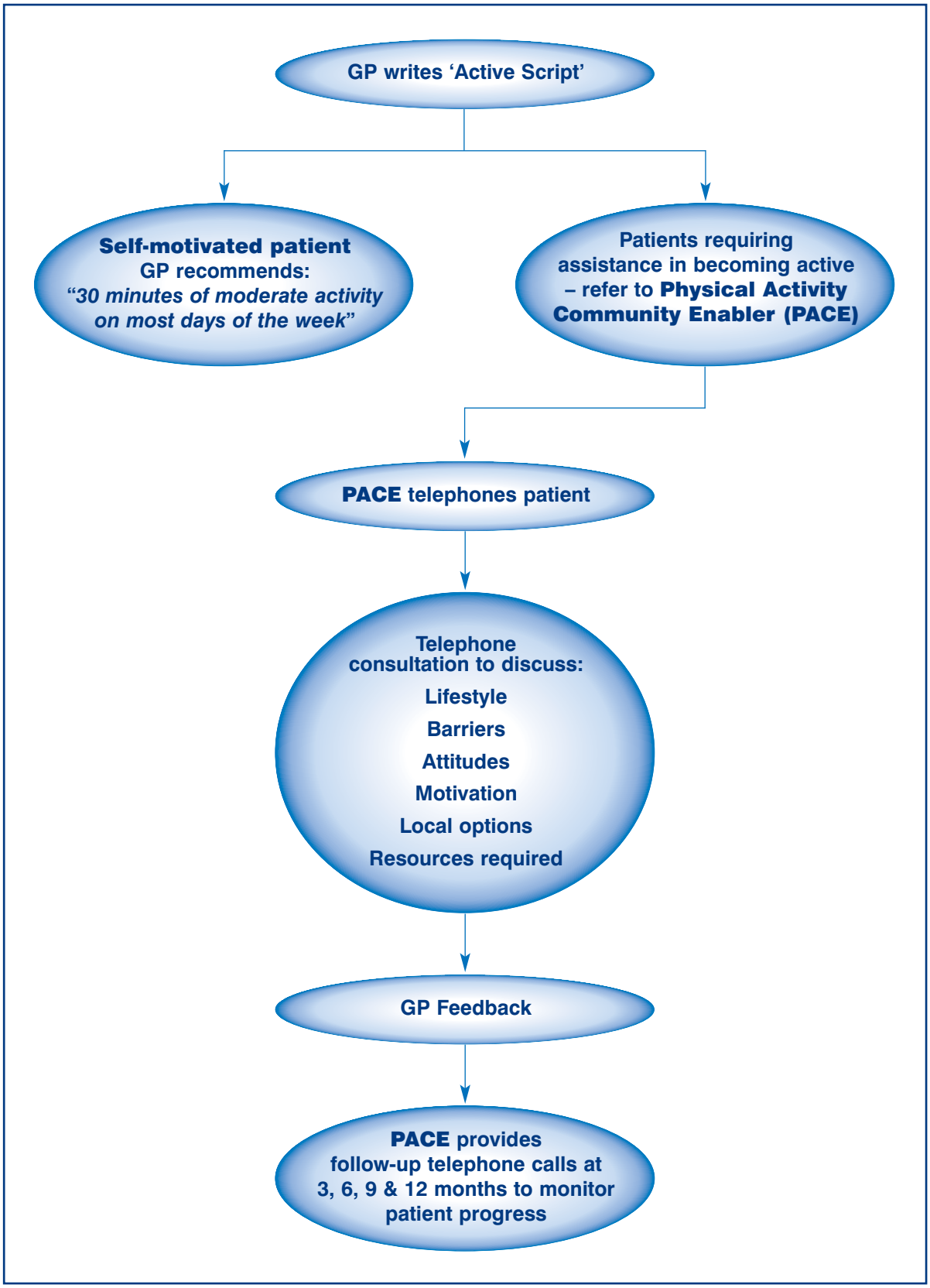
The physical activity community enabler (PACE) model for promoting physical activity in general practice was chosen to meet the needs of local GPs and utilise available local resources and services. In this model, an 'enabler' provides a link between community members, general practice and allied health professionals to help people increase physical activity levels (Figure 4).

Enablers are community health nurses, physiotherapists and dietitians with Certificate III–IV fitness leadership training. They are based within local area health services and provide the service as part of their existing job roles and through existing funding. On referral from the GP, the enabler phones the patient to provide personalised assistance in getting started, and in accessing services and providers.

Steps towards the goal

- The Health Promotion Officer and Project Manager assessed existing programs and reviewed published clinical literature on the benefits of physical activity, then distilled this information for local GPs.
- A pathway for patient referral and GP feedback was developed with GP input. In response to the expressed preferences of GPs, a paper-based triplicate script pad was designed for advice and referral, which was also made available electronically. This part of the project links closely with the division's ongoing information technology program, through which practice templates for a range of therapeutic areas have been designed and interlinked.
- From its inception, the PACE program was integrated into other division activities through continuing professional development and other programs.
- West Vic also developed a common referral pathway to integrate all the division's programs that provide a referral service. This approach promotes holistic health care. For example, the local community mental health team recognises the important role of physical activity in both reducing the risk of mental illness and managing some conditions, and therefore regularly recommends PACE to referring GPs when providing feedback on clients.

Figure 4. **PACE model (West Vic, Nov. 2003 health promotion)**



Meeting challenges

Although GPs were willing to adopt health promotion activities, division staff found that the challenge was to plan systems to help them achieve this, given time constraints in busy practices. As GPs considered themselves busy managing sickness, addressing wellness demanded new ways of doing business.

The PACE system overcomes this problem because the enabler acts as a coordinator to relieve the GP of the tasks of organisation and administration. However, GPs still need intermittent prompting to remember to use the PACE service.

Building links and partnerships

West Vic worked with local and state-based organisations to develop and support the PACE program:

- West Vic consulted local GPs to develop a service model that suited local practice styles.
- Local Primary Care Partnerships (a Victorian State-funded system) supported the initiative and funded the PACE pilot program.
- Other local health services and health professionals supported the concept of a structured system for helping patients achieve increased levels of physical activity.
- Local training was organised to enable a group of 21 key staff from local health services to achieve national accreditation in fitness instruction (Certificate III–IV in Fitness). The cost to participants was subsidised by Primary Care Partnerships and supported by the employing health service.
- Some local sport and recreation providers, engaged through the regional Sports Assembly, reviewed their services to make activities more accessible to new members.
- West Vic used selected elements from models for the promotion of physical activity in general practice developed by the Victoria Council on Fitness and General Health (VICFIT) and Sport and Recreation New Zealand's Green Prescription.

Evaluation

- Greater Green Triangle and Deakin University have undertaken formal evaluation of the enabler component of the service, and are currently assessing results.
- Informal feedback from GPs and patients to the division has highlighted strengths and helped division staff identify aspects of the service that require further development.

Strengths and successes

- The personalised help provided by the enabler has been successful in engaging patients who would otherwise not have attempted to contact physical activity-related services by themselves.
- The PACE system ensures that the GP stays at the hub of the service and is confident of remaining aware of the patient's progress – while receiving support in this coordinating role through regular feedback from the enabler.
- The PACE system can increase capacity as need arises; there are now seven enablers within the West Vic division. The number of patient referrals and participating GPs continues to rise.

Case information provided by Joanne Martin (Health Promotion Officer) and Jane Measday (Senior Project Manager)

Case 2. Linking with other services to support patients' behaviour changes

Having learned that safety concerns and medicolegal worries were dampening GPs' keenness to promote physical activity among patients with diabetes, Illawarra Division of General Practice developed a program to facilitate referral to exercise physiologists.

The project: better links with exercise physiology services

While assessing how best to support GPs in their efforts to encourage sedentary diabetes patients to be more active, the Illawarra division (NSW) identified some significant barriers that impede this process:

- Difficulty changing patient health behaviours (e.g. physical activity levels related to patient beliefs, self-confidence and other self-efficacy issues)
- GPs capacity to provide health-behaviour change counselling, motivation and support, and physical activity advice to patients within the time constraints of the general practice consultation
- GPs were concerned about their ability to accurately assess the level of risk for patients taking up moderate physical activity
- GPs were concerned about medicolegal issues associated with recommending physical activity to patients with diabetes
- The region offered limited physical activity programs suitable for patients with diabetes complications or co-morbidities
- GPs scepticism that a physical activity intervention applied within the local community could reproduce similar improved (patient) outcomes that have been demonstrated in the limited controlled trials to date
- Patients reluctance to use fitness centres or participate in community-based physical activity classes.

Referral to exercise physiologists (EPs) was chosen as a practical way to help overcome these problems. The aim was to set up an efficient process for GPs to refer patients with type 2 diabetes to a physical activity program provided by EPs. It was hoped that the initiative would:

- enable GPs and EPs to collaborate efficiently in counselling patients to increase their physical activity levels
- overcome GPs' concerns about prescribing physical activity to patients at risk for adverse effects if unsupervised
- improve patients' adherence to the health advice
- enable patients to participate in cost-effective home-based exercise programs designed by an EP
- improve patients' fitness and clinical parameters including HbA1c and blood pressure
- be financially affordable for patients.

The EPs were responsible for assessing patients for exercise and providing physical activity counselling and management. They provided a total of 5 one-to-one consultations with each patient over an 11-week period to facilitate autonomous exercise and compliance. Patients performed sessions at home (50%), at a council-run leisure centre (33%) or at both sites (17%). Individually tailored programs and consultations were provided by experienced EPs and final-year students.

It should be noted that this is the first GP Physical Activity Project in Australia to investigate clinical pre- and post-intervention data (e.g. HbA1c, fructosamine, blood pressure). This was to demonstrate to GPs that the specific model can improve patient outcomes consistent with clinical randomised trials.

Background

People with diabetes attending practices in the Illawarra region can readily be identified for targeted interventions such as lifestyle risk factor management, using a web-based information management system custom-developed for the division's diabetes program. The Automated Accessible Diabetes Information System (TAADIS), in use since mid-2003, acts as an electronic health record that enables GPs and patients to track their diabetes parameters, including weight, blood pressure, and blood glucose and lipid concentrations. It also allows the division to identify groups of diabetes patients with poor health profiles and to provide clinical feedback to GPs on their patients' aggregated diabetes results. The web site promotes patient self-care by providing diabetes information.

Steps towards the goal

- The division recruited GPs involved in the division's diabetes program, through a continuing professional development activity.
- The TAADIS database was used to identify patients with diabetes and HbA1c >7% and/or BMI >27 kg/m^2, who were then contacted by letter on approval by their GP. Patients interested in participating visited their GP to obtain referral to an EP. Other patients whose records were not held in the TAADIS database were recruited opportunistically by GPs.
- A pilot program was undertaken with five EPs.
- This project was undertaken in the context of a strong background of risk factor management within the division's ongoing activities. Risk factor management topics are regularly included in the division's in-house GP education program, in training provided for practice nurses, and in community education programs. The division works with other stakeholders to develop models of integrated care for diabetes and other chronic diseases.

Meeting the challenges

Ease of referral to EPs is hampered by poor recognition of their profession by both the community and the health system, reflected in their exclusion from the Medicare Plus allied health items. There is limited funding for divisions to deliver programs in chronic disease management, particularly for interventions centred on lifestyle risk factors.

The funding problems were overcome by working with the Department of Biomedical Science at the University of Wollongong. The principal EP for the program provided services free of charge as part of a study program. The department's student placement officer also provided assessment and supervision services free of charge while supervising final year exercise science students, who took part in the program to meet the practicum requirements of their course. A local council-operated leisure centre also supported the program by providing free use of facilities for participants who chose to do their programs in a gym during the pilot project.

Evaluation

- Through focus groups conducted in the planning stage, GPs indicated that their criteria for the project's success would include both clinical and physical fitness outcomes. Accordingly, patients were tested before and after the program for HbA1c and serum cholesterol, blood pressure, BMI, cardiorespiratory fitness and strength, physical activity compliance and quality of life measures.

- Questionnaires for GPs and patients were also used to record qualitative assessments.

The pilot program was not only successful in increasing physical activity levels, but more importantly, surrogate markers for cardiovascular events (HbA1c and blood pressure) also improved after the intervention period of 11 weeks (Tables 6, 7). Results of the pilot have encouraged GPs to continue their involvement in the project in 2005 and facilitated expansion of the program to include more GPs.

Table 6. **Pre- and post-intervention data for diabetes parameters**

Parameter		Pre	Post
HbA1c (%)	n	23	23
	Mean	8.413	7.600
Fructosamine (mmol/L)	n	23	23
	Mean	296.7	273.78
TG (mmol/L)	n	23	23
	Mean	1.1830	1.6539
TC (mmol/L)	n	23	23
	Mean	4.5609	4.4326
Weight (kg)	n	23	21
	Mean	97.63	96.48
BMI (kg/m^2)	n	23	21
	Mean	34.89	34.69
Waist (cm)	n	23	21
	Mean	114.41	111.33
Systolic BP (mmHg)	n	23	21
	Mean	138.00	128.48
Diastolic BP (mmHg)	n	23	21
	Mean	78.39	73.90
Resting HR (beats/min)	n	23	21
	Mean	73.87	71.24
Cardiorespiratory fitness (m/6 min)	n	23	21
	Mean	492.022	551.850
Upper-body strength (6-RM)	n	21	19
	Mean	72.38	96.84
Lower-body strength (6-RM)	n	22	20
	Mean	55.91	71.75

BMI, body mass index; BP, blood pressure; HR, heart rate; 6-RM, 6 repetitions maximum; TC, total cholesterol; TG, triglycerides.

Table 7. **Comparison of the pre- and post-intervention data for diabetes parameters**

Parameter	Mean	P value
HbA1c*	0.813	0.0001
Fructosamine*	22.91	0.0001
TG	0.1591	0.151
TC	0.1283	0.134
Weight	1.55	0.080
BMI	0.60	0.077
Waist	3.64	0.055
Systolic BP*	9.9	0.001
Diastolic BP*	4.05	0.002
Resting HR*	2.33	0.032
Cardiorespiratory fitness*	–60.625	0.0001
Upper-body strength*	–21.58	0.0001
Lower-body strength*	–16.25	0.0001

*Statistically significant results using non-parametric 2-tailed t-test.
BMI, body mass index; BP, blood pressure; HR, heart rate;
TC, total cholesterol; TG, triglycerides.

Strengths and successes

- GPs have willingly become involved in planning for risk factor management. A core group of GPs have quickly adopted interventions and learned new skills. Other GPs are slower to adopt new methods.
- GPs were eligible to claim EPC items for patients' assessment, counselling and referral.

Next steps

- An ongoing physical activity referral scheme is underway for 2005 in partnership with the University of Wollongong Department of Biomedical Science and council leisure centres. Exercise physiologists from partner bodies will undertake patient assessments, program design and supervision of participants.
- The scheme's economic sustainability will be supported by commercial sponsorship, provision of equipment at wholesale prices and centre membership fees at reduced rates.
- The division's role will be to coordinate the program, recruit GPs and promote to TAADIS patients.
- The trial assisted in the establishment of an official referral network between the RACGP and the Australian Association for Exercise and Sports Science (AAESS), which will facilitate the referral of patients by GPs to EPs for physical activity/lifestyle interventions (for details of the referral network see: www.racgp.org.au)
- The model is being used by the AAESS to lobby the Federal Government for inclusion of EPs in the Medicare Plus allied health items.

Case information provided by Linda Blackmore (Project Officer) and Chris Tzar (Exercise Physiologist Coordinator)

Case 3. Implementing a lifestyle risk management program, and a local collaboration to support lifestyle change

The desire to achieve effective long-term reduction in chronic disease led Sutherland Division of General Practice to look for programs that integrate both health promotion and disease prevention. Participation in the SNAP trial, and the development of a GP exercise referral scheme helped meet these objectives.

The projects: SNAP trial and exercise referral scheme

- Smoking, Nutrition, Alcohol and Physical activity (SNAP) Trial (2003–2004)
- GP exercise referral scheme – a collaborative initiative with Sutherland Shire Council and Fitness NSW and supported by the South East Sydney Health Promotion Service.
- The SNAP trial assessed behaviour risk factor management in the areas of smoking, nutrition, alcohol and physical activity, focusing on patients with existing chronic disease or high risk for developing chronic disease. The aims and methods are set out in reports available on the CGPIS website (www.commed.unsw.edu.au/cgpis) and the brief report in Case 4.

SNAP implementation

Background

The Division viewed lifestyle risk factor management strategies as being integral to several of the division's existing programs, including:

- the chronic disease prevention and management program
- the continuing professional development program, which includes the National Heart Foundation Active Practice Physical Activity Workshop for GPs, Diabetes lunchtime case study sessions for GPs, and a motivational interviewing workshop for GPs
- the workforce support and general practice support and development programs, which involves promotion of practice teams, practice staff and practice nurse networks, practice staff training and education
- the mental health program.

Barriers and enablers

- Participation by general practices varied, depending on practice capacity, organisational structure, information technology and information management systems, and whether the practice employed a practice nurse. Reasons for practices not signing up to the SNAP trial included lack of time, and the perception by some GPs that they were already addressing SNAP risk factors adequately. In practices with several GPs, it was often difficult to recruit all. Generally only one GP and the practice manager were interested; other GPs did not see the value of the SNAP trial and cited time constraints as a barrier.

- The quality of communication between GPs and other practice staff – particularly discussion of information management practices and patient education resources – was a key determiner of uptake for SNAP intervention.

- The purpose-designed recall and reminder systems for diabetes required a large amount of practice visit time by division staff to set up systems.

- Difficulties encountered in implementing the SNAP lifestyle risk factor intervention included limited links with and support from health promotion services, including drug and alcohol services and dietetics services. There was a need for better coordination between GPs, community health services and the division. Participating practices were in regions of acknowledged shortages in the health care workforce.

- The practice manager sometimes played a 'gatekeeper' role, and strongly influenced uptake of SNAP risk factor management. Where SNAP resources were provided to the practice via practice managers, their work priorities and degree of enthusiasm determined whether the resources were incorporated in to practice systems (e.g. whether digital materials were downloaded into the practice management software) and, accordingly, whether GPs were properly equipped to conduct SNAP risk factor management practices.

Lessons learned

- Motivational interviewing training for GPs was critical, and is recommended as one of the first activities undertaken towards implementation of lifestyle risk factor management activities.

- The role of the practice manager varies across the practices; some are proactive and others are not. Therefore, one size does not fit all, and an individualised approach to practices is recommended.

- division consultation with GPs and practices is important to the overall process.
- Practices vary in terms of resources, skills, communication and information technology use. Caution is needed when standardising lifestyle intervention tools, and approaches must be tailored to the individual practice.
- Practices take time to make changes.

Lifestyle risk factor management will be sustained long-term in the division through:

- the use of existing evidence-based resources in delivering education sessions for GPs on physical activity (e.g. National Heart Foundation of Australia's Active Practice GP resources for prescribing physical activity and resource guide for divisions of general practice)
- integration of risk factor management strategies into relevant program areas such as chronic disease prevention and management, GP support and development, and continuing professional development
- strong partnerships with relevant key stakeholders.

Exercise referral system

Steps towards the goal

The Division worked with the local council-run leisure centre, Fitness NSW and the area health service's health promotion service to develop a referral system.

- The leisure centre planned the program, implemented it and evaluated it, employed exercise physiologists to assess and monitor patients, provided dedicated fitness leaders during exercise sessions, and subsidised participants' use of the facility.
- Fitness NSW provided guidance for program implementation, legal aspects and dissemination strategies.
- The health promotion service was involved in planning, implementing and evaluating the program during the pilot phase, and helped meet costs of developing the GP Exercise Referral Service general practice manual.

Templates were developed for referral letters and program updates, focusing on the communication process between the GP and the exercise physiologist or fitness centre, and communication between the fitness centre/exercise physiologist and the division.

Barriers and enablers

GPs needed assurance that the facility to which they refer their patients for physical activity was safe and overseen by qualified health professionals. The division reassured GPs that the facility had exercise physiologists qualified to conduct exercise screening and prescribe physical activity for people with chronic conditions and those at risk.

Initially there was a low uptake of the referral service due to low awareness of what the program involved. The number of participating GPs and the number of patients registering for the program has increased subsequent to detailing by the project officer and community awareness campaigns.

Evaluation

Evaluation of the program has shown that:

- 95% of participants achieved an improvement in objective fitness assessed by maximal oxygen consumption (V_{O2}max) scores
- 72% achieved a reduction in BMI
- 89% reported the belief that the overall 5-week program motivated them to make lifestyle changes
- 97% achieved the minimum recommended physical activity level (30 minutes per day) or more
- 88% of GPs reported that the program was appropriate and beneficial for their patients
- 95% of GPs believed the program met a previously unmet need
- 100% of GPs intend to refer to the program again.

The program has also resulted in improved collaboration with key stakeholders in the implementation of a specifically targeted physical activity intervention. Partnership between the division and the council leisure centre has also fostered a link between the leisure centre and the local hospital heart and lung team, resulting in Heartmoves classes being offered to outpatients.

Strengths and successes

The exercise referral system has achieved increased GP prescription of physical activity to sedentary patients and an increase in the numbers of previously inactive patients undertaking regular physical activity. Currently over 450 sedentary patients have been referred to the program by 71 GPs.

Case information provided by Belinda Michie (Programs Coordinator)

Case 4. Lessons from the NSW trial of SNAP implementation 2003–2004

The Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Project was conducted by the Centre for General Practice Integration Studies (CGPIS) at the University of NSW. It was funded by NSW Health from mid 2003 to the end of 2004 with additional support from the Australian Primary Health Care Institute (APHCRI).

Aims

The aims were to develop and evaluate a model of an integrated approach to management of the four behavioural risk factors in general practice.

The objectives of this trial were:

- to develop a model for the implementation of SNAP in one urban and one rural division of general practice
- to evaluate the impact of the model on the function and organisation of general practices within each of the two divisions
- to learn lessons for the implementation of SNAP through divisions of general practice
- to disseminate these findings to other divisions.

The intervention

The intervention was conducted in close collaboration with the divisions of general practice and included the following:

- Practically oriented clinical training for GPs and nurses in SNAP, behaviour change and motivational interviewing, using actors to play the role of patients
- Provision of the RACGP evidence-based SNAP Guidelines, a '5As' chart and other support material to GPs and practice clinical staff
- Provision of patient education materials to practices, with staff education on how to upgrade their practices resources and patient information material
- Training of practice staff to set up recall and reminder systems using practice software for follow-up and recall of patients with the SNAP risk factors

- At least two visits to each practice to determine practice needs and support practices to make changes in order to improve the quality of behavioural risk factor management and encourage teamwork and communication within the practice to support this
- Liaison with Area Health Service, government and other health services providers to develop and disseminate a referral directory for practices to use to support referral to local services for each of the SNAP risk factors.

Evaluation

The project was implemented in the two divisions, with training available to all GPs, and practice visits and resources provided to the 21 enrolled practices. Division and Area Health Service staff perceived the training and practice visits to be successful. However, they found it difficult to facilitate teamwork within the practices. There was good linkage with division and some Area Health Service programs

GPs participating in the behaviour change workshops reported significantly increased confidence in their ability to assess the stage of change of patients and to do this more often. Starting from a low level, they also increased their confidence in motivational interviewing and after the trial the majority used this often in their consultations for each of the risk factors.

A survey of all GPs in the division before and after the trial revealed an improvement in the proportion using guidelines and the reported frequency of verbal advice by GPs to patients in the rural division (it was already high in the urban division). Referral rates were also higher for nutrition in both divisions but did not change after the trial. They were lowest for smoking and alcohol. Referrals for smoking increased in the rural division.

Among GPs enrolled in the trial, overall self-rated skills and knowledge in assessing and offering interventions for patients were highest for smoking and physical activity. The greatest improvements were in nutrition, alcohol and motivational interviewing, with most GPs offering nutritional interventions to their patients who were overweight. After the intervention GPs increased their use of smoking education materials and referred their patients more frequently to QUIT.

In-depth interviews in nine of the practices revealed that GPs were implementing more SNAP interventions in their consultations following the trial. However, major barriers remained, including frustration with the difficulty motivating patients, lack of time and competing demands, such as the expectation of patients that their presenting problems would be dealt with.

Many practices had established registers for their patients with chronic disease, although opportunistic reminders in the records were more frequently used than proactive recall of patients. Patient education materials were more commonly provided in the practices with systems being developed that included a person to coordinate the ordering of materials.

Administrative staff more readily took on roles related to SNAP, such as arranging follow-up, recall or referral or the ordering of patient education materials.

A number of barriers to implementation remained at the end of the trial. It was still difficult to change work practices and organisation within the practice. There was a lack of funding for SNAP activities – for example, funding was available for nurses to provide wound care and immunisation but not risk factor management. This led to a reliance on squeezing SNAP interventions into existing clinical encounters with the GP rather than expanding the role of non-GP staff.

Patient focus groups revealed that patients were comfortable about GPs taking an interest in their SNAP risk factors, but were not keen about constant reminders, especially regarding weight. They appreciated the interest of the GPs and valued the education and information given (sometimes more than from the specialists) and were enthusiastic about greater involvement of allied health professionals such as dietitians.

Feasibility and sustainability

The trial demonstrated the feasibility of the partnership between division and Area Health Service and the impact of a structured preventive intervention on general practice. The use of practical training workshops with hands-on opportunities to practice skills with actors as patients was a clear success. Practice visits and the provision of support resources achieved some change. However, there was only limited impact on the organisation and capacity of practices, partly because of the lack of financial support for activities outside the GP consultation and the other pressures operating on practices, such as workforce shortages.

The lack of high level support from the Area Health Service and the lack of a sustained division program may compromise the long-term sustainability of the change. However, both divisions had plans to continue education and practice visits in association with other programs to support chronic disease care and prevention.

Recommendations

1. There needs to be greater support for practice involvement in SNAP programs. This may take the form of incentives for practice nurses to engage in SNAP and incorporating SNAP into existing chronic disease incentives and programs.

2. Partnerships between divisions, Area Health Services, local government and NGOs need to be established in each local area. These need high level commitment to planned change in the delivery of referral services, communication and coordination of programs.

3. Division SNAP programs need to be facilitated, possibly by limited funding for incorporating SNAP into existing programs and practice visit programs, as well as in providing specific education for GPs and practice staff on SNAP, motivational interviewing, and practice administration of SNAP education and information technology systems.

4. Practice information technology systems need to capture information on nutrition and physical activity more effectively and be able to audit SNAP risk factors and interventions for quality improvement and collation of data at division levels.

Report provided by Professor Mark Harris, Director, Centre for General Practice Integration Studies, University of New South Wales

References

1. Joint Advisory Group on General Practice and Population Health. Smoking, nutrition, alcohol and physical activity (SNAP) framework for general practice. Integrated approaches to supporting the management of behavioural risk factors of smoking, nutrition, alcohol and physical activity (SNAP) in general practice. Canberra: Commonwealth of Australia, 2001.

2. Harris M (Ed). Smoking, nutrition, alcohol and physical activity (SNAP). A population health guide to behavioural risk factors in general practice. Melbourne; The Royal Australian College of General Practitioners, 2004.

3. National Quality Committee of the Royal Australian College of General Practitioners. Putting prevention into practice. A guide for the implementation of prevention in the general practice setting, 2nd edition. Melbourne; RACGP, 2005 ('Green book').

4. Turner P, Williams C. Informed consent: patients listen and read, but what information do they retain? NZ Med J 2002; 115: U218.

5. DiMatteo M, Giordani P, Lepper H, Croghan T. Patient adherence and medical treatment outcomes: a meta-analysis. Med Care 2002; 40: 794–781.

6. Litt J. How to provide effective smoking cessation advice in less than a minute without offending the patient. Aust Fam Phys 2002; 31: 1087–1095.

7. National Preventive and Community Medicine Committee of The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. Updated 5th edition. Aust Fam Physician 2002; 31(Suppl): S1–S64 ('Red book').

8. Zwar N, Richmond R, Borland R, *et al.* Smoking cessation guidelines for Australian general practice. Canberra; Commonwealth Department of Health and Ageing, 2004.

9. Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. Addiction 1993; 88: 315–335.

10. Smith BJ. Promotion of physical activity in primary health care: update of the evidence on interventions. J Sci Med Sport 2004; 7 (Suppl): 67–73.

11. Orzano AJ, Scott JG. Diagnosis and treatment of obesity in adults: an applied evidence-based review. J Am Board Fam Pract 2004; 17: 359–369.

12. National Health and Medical Research Council. Clinical practice guidelines for the management of overweight and obesity in adults. Canberra,;Commonwealth of Australia, 2003.

13. English D, Holman C, Milne E, *et al.* The quantification of drug caused morbidity and mortality in Australia. Canberra; Commonwealth Department of Human Services and Health, 1995.

14. Fiore MC. Bailey WC, Cohen SJ, *et al.* Treating tobacco use and dependence. US Department of Health and Human Services, Public Health Service, 2000.

15. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519.

16. White V, Hill D, Siahpush M, Bobevski I. How has the prevalence of cigarette smoking changed among Australian adults? Trends in smoking prevalence between 1980 and 2001. Tob Control 2003; 12(Suppl 2): 156–163.

17. Richmond R, Kehoe L, Heather N, *et al.* General practitioners' promotion of healthy life styles: what patients think. Aust NZ J Public Health 1996; 20:195–200.

18. Hill D, White V, Scollo M. Smoking behaviours of Australian adults in 1995: trends and concerns. Med J Aust 1998; 168: 209–213.

19. National Heart Foundation (WA division) and Derbarl Yerrigan Health Services. Aboriginal Health Workers Heart Health Manual. Perth; National Heart Foundation, 2001.

20. National Health and Medical Research Council. Dietary guidelines for Australian adults. Canberra; Commonwealth of Australia, 2003.

21. National Health and Research Medical Council. Australian alcohol guidelines. Health risks and benefits. Canberra; NHMRC, 2003.

22. Mathers C, Vos T, *et al.* The Australia burden of disease study: measuring the loss of health from disease, injury and risk factors. Med J Aust 2000; 172: 592–596.

23. Bull F, Bauman A, Bellew B, Brown W. Getting Australia active II. An update of evidence on physical activity for health. Australia; National Public Health Partnership, 2004.

24. Armstrong T, *et al.* Physical activity patterns of Australian adults (AIHW Cat. CVD 10). Canberra; Australian Institute of Health and Welfare, 2000.

25. Catford JC, Caterson ID. Snowballing obesity: Australians will get run over if they just sit there. Med J Aust 2003; 179: 577–579.

26. Colditz GA, Willett WC, Rotnitzky A, Mansop JE. Weight gain as a risk factor for clinical diabetes mellitus in women. Ann Intern Med 1995; 122: 481–486.

27. Goldstein M, Whitlock E, DePue J. Multiple behavioral risk factor interventions in primary care: Summary of research evidence. Am J Prev Med 2004; 27: 61–79.

28. Royal Australian College of General Practitioners. RACGP Position Statement on Aboriginal Health, Endorsed by Council 42/15, 4 August 2000 (www.racgp.org.au).

29. School of Public Health and Tropical Medicine James Cook University. James Cook University and QDGP Indigenous health final report (www.qdgp.org.au).

30. Memorandum of Understanding between NACCHO and ADGP – August 2003.

31. The Western Australian Branch of the Australian Medical Association. A medical practitioner's guide to Aboriginal health. Perth; AMA, 1998.

32. NSW Health. A framework for building capacity to improve health. Draft. State Health Publication No. (HP) 990226. Sydney; NSW Health, 2000.

33. Agency for Healthcare Research and Quality [US]. Put prevention into practice. A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville; AHRQ, 2002.

34. Gaucher E, Coffey R. Total quality in healthcare: from theory to practice. San Francisco; Jossey-Bass Publishers, 1993.

35. Huang N, Lombard C, van Dort J. Active script manual. Melbourne; Victoria Council on Fitness and General Health (VICFIT), 2003.

36. Litt J, Ling M-Y, McAvoy B. How to help your patients quit: practice-based strategies for smoking cessation. Asia Pacific Fam Med 2003; 2: 175–179.

37. Holmwood C. Alcohol-related problems in Australia: is there a role for general practice? Med J Aust 2002; 177: 102–103.

38. National Preventive and Community Medicine Committee of the Royal Australian College of General Practitioners. Putting prevention into practice. A guide for the implementation of prevention in the general practice setting. Melbourne; RACGP, 1998 ('Green book' 1st edition).

Acknowledgements

The Lifescripts resources and dissemination strategy have been developed by a consortium led by Kinect Australia (incorporating VICFIT in Victoria) and comprising the National Heart Foundation of Australia, Department of General Practice, Flinders University, Southcity GP Services, Centre for GP Integration Studies, University of New South Wales and Faculty of Health, University of Newcastle, all of which have expertise and experience in the management of lifestyle risk factors in a primary care environment. The process was overseen by a steering committee comprising representation of all consortium organisations and the Australian Government Department of Health and Ageing (Hilary Metcalf and Bronwen Harvey).

The consortium worked with a team of technical partners to develop the Lifescripts resources: Princeton Clearpoint (design, layout, editing), Meducation (medical writing), Market Access (market research), Plexus Consulting (frameworks, evaluation), With Direction (CD-ROM), the Collaborative Centre for e-Health (software specifications) and the Health Communication Network (GP software).

The consortium would like to thank all members of the Reference Group and Aboriginal Health Expert Panel who provided valuable input and direction and who commented on drafts of the material (often within very short timeframes).

The consortium also worked closely with ADGP and the Divisions network who are working on the promotion, uptake and implementation of Lifescripts.

The Lifescripts resources have been developed and produced with funding from the Australian Government Department of Health and Ageing.

Content and authors

- Smoking cessation resources – Department of General Practice, Flinders University (John Litt)
- Nutrition and weight management resources – Faculty of Health, University of Newcastle (Clare Collins, Sandra Capra, Dimity Pond and Penelope McCoy), Kinect Australia (Nancy Huang) and the National Heart Foundation of Australia (Tony Stubbs and Barbara Eden)
- Alcohol resources – Southcity GP Services (Lurline Waters and Benny Monheit)
- Physical activity resources – Kinect Australia (Nancy Huang) and the National Heart Foundation of Australia (Tony Stubbs)
- Practice manual – Kinect Australia (Nancy Huang and Kate Halasa), Department of General Practice, Flinders University (John Litt) and the National Aboriginal Community Controlled Health Organisation (Sophie Couzos)
- Division manual – National Heart Foundation of Australia (Tony Stubbs)
- Motivational interviewing case studies – Department of General Practice, Flinders University (John Litt), Kinect Australia (Nancy Huang), Southcity GP Services (Benny Monheit) and Faculty of Health, University of Newcastle (Clare Collins, Sandra Capra, Dimity Pond and Penelope McCoy)
- Dissemination strategy – Centre for GP Integration Studies, University of New South Wales (Gawaine Powell-Davies and Anna Williams)

The Lifescripts resources are the result of a wide range of organisations working together. The consortium would like to thank the organisations who have given up their time to participate in the Reference Group and the Aboriginal Health Expert Panel to ensure that the Lifescripts resources are practical and useful to general practice and the Aboriginal health sector.

Reference Group Members

Australasian Society for the Study of Obesity
Australian Association of Exercise and Sports Science
Australian Association of Practice Managers
Australian Chronic Disease Prevention Alliance
Australian Divisions of General Practice Ltd
Australian Drug Foundation
Australian Physiotherapy Association
Australian Practice Nurses Association
Centre for Culture Ethnicity and Health
Consumers Health Forum
Dietitians Association of Australia
General Practice Divisions Victoria
National Aboriginal Community Controlled Health Organisation
Quit Victoria
Royal Australian College of General Practitioners

Aboriginal Health Expert Panel

Centre for Excellence in Indigenous Tobacco Control, University of Melbourne
Muru Marri Indigenous Health Unit, University of New South Wales
National Heart Foundation of Australia
National Aboriginal Community Controlled Health Organisation
Victorian Aboriginal Community Controlled Health Organisation

Recommended reading

Guidelines

A medical practitioner's guide to Aboriginal health

The Western Australian Branch of the Australian Medical Association. *A medical practitioner's guide to Aboriginal health*. Perth; The Australian Medical Association (Western Australia), 1998.

Australian Alcohol guidelines

National Health and Research Medical Council. *Australian alcohol guidelines. Health risks and benefits*. Canberra; NHMRC, 2003.

Dietary guidelines for Australian adults

National Health and Medical Research Council. *Dietary guidelines for Australian adults*. Commonwealth of Australia; Canberra, 2003.

Draft DAA best practice guidelines for treatment of overweight and obesity in adults

The Dietitians Association of Australia. *Draft DAA best practice guidelines for treatment of overweight and obesity in adults*. Canberra; DAA, 2004.

'Green book'

National Quality Committee of the Royal Australian College of General Practitioners. 2nd Edition. *Putting prevention into practice. A guide for the implementation of prevention in the general practice setting*. Melbourne; RACGP, 2005 (www.racgp.org.au).

National guide to preventive health assessment in Aboriginal and Torres Strait Islander peoples

National Aboriginal Community Controlled Health Organisation. *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples*. Melbourne; Royal Australian College of General Practitioners, 2004.
See especially:

Alcohol – prevention of problem drinking (pages 9–10)
Diabetes prevention (mentions physical activity, diet: page 15)
Renal disease prevention (mentions smoking: page 18)

Respiratory disease – non-communicable. Smoking (page 22)
Vascular health – blood pressure (mentions alcohol, weight, physical activity, smoking: page 27)
Physical activity (page 28)
Cholesterol and lipids (page 29)
Overweight and obesity (pages 30–31)

Clinical practice guidelines for the management of overweight and obesity in adults

National Health and Medical Research Council. *Clinical practice guidelines for the management of overweight and obesity in adults*. Commonwealth of Australia; Canberra, 2003.

'Red book'

National Preventive and Community Medicine Committee of The Royal Australian College of General Practitioners. *Guidelines for preventive activities in general practice*. Updated 5th Edition. *Aust Fam Physician* 2002; 31(Suppl): S1–S64 (www.racgp.org.au).
See especially:
Section 5. Prevention of cardiovascular disease
5.2 Smoking
5.4 Weight
5.5 Nutrition
5.6 Physical activity
5.7 Early detection of problem drinking

Smoking cessation guidelines for Australian general practice

Zwar N, Richmond R, Borland R, *et al. Smoking cessation guidelines for Australian general practice*. Canberra; Commonwealth Department of Health and Ageing: 2004.

'SNAP Guide'

Harris M (Ed). *Smoking, nutrition, alcohol and physical activity (SNAP). A population health guide to behavioural risk factors in general practice*. Melbourne; The Royal Australian College of General Practitioners, 2004 (www.racgp.org.au/guidelines/snap)

Treating alcohol problems. Guidelines for general practitioners

Shand F, Gates J. *Treating alcohol problems. Guidelines for general practitioners*. Canberra; Commonwealth Department of Health and Ageing: 2003. (www.health.gov.au)

Evidence reviews

Smoking

The Cochrane Collaboration has conducted over 30 reviews of literature on smoking cessation, including investigations of the effects of nicotine replacement therapy, counselling and behaviour therapy, and interventions by nurses and doctors.
(www.cochrane.org)

Alcohol

Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction* 1993; 88: 315–335.

Physical activity

Bull F, Bauman A, Bellew B, Brown W. *Getting Australia Active II. An update of evidence on physical activity for health*. Australia; National Public Health Partnership, 2004.

Smith BJ. Promotion of physical activity in primary health care: update of the evidence on interventions. *J Sci Med Sport* 2004; 7 (Suppl): 67–73.

Weight management

Orzano AJ, Scott JG. Diagnosis and treatment of obesity in adults: an applied evidence-based review. *J Am Board Fam Pract* 2004; 17: 359–369.

Recommended patient resources

Smoking	*Quit book* (www.quitnow.info.au/quitbook/index2.htm). To obtain copies of this book contact Quitline 13 QUIT (13 7848) *Staying stopped – a guide for recent quitters* (www.quitwa.com/pdfs/Staying-stopped.pdf) Quit Victoria maintains a national database of smoking cessation resources; for information contact the Resources Officer 03 9635 5525 Resources in languages other than English: www.health.nsw.gov.au/health-public-affairs/mhcs/publications/5890.html www.quit.org.au/index2.html
Nutrition	Smart Eating – Dietitians Association of Australia website (www.daa.asn.au) Find an Accredited Practising Dietitian 1800 812 942 Nutrition Australia www.nutritionaustralia.org.au National Health and Medical Research Council. *Dietary guidelines for Australian Adults*. Canberra; NHMRC, 2003 To obtain copies of this booklet, contact 1800 020 103 extension 8654 (toll free number) or email phd.publications@health.gov.au
Alcohol	*Australian Alcohol Guidelines* (consumer resources) www.alcoholguidelines.gov.au/pdf/consbrox.pdf (brochure) www.alcoholguidelines.gov.au/pdf/consbook.pdf (booklet) To order copies of these booklets please fill out the on-line order form at www.alcoholguidelines.gov.au/resources.htm
Physical activity	*Active Australia – Everyone wants to be more active. The problem is … Getting started* (see publications section of: www.health.gov.au/internet/wcms/Publishing.nsf) To order copies of this booklet contact 1800 020 103
Weight management	*Australian Guide to Healthy Eating* (www.health.gov.au/pubhlth/strateg/food/guide) Consider also providing nutrition and physical activity resources

Assessing the quality of patient education resources

Audience

Who is the material aimed at?
Will your practice population understand and accept the information?
Does it reflect the diversity of the audience? (Consider literacy levels, language, cultural practices)

Content

Is the meaning clear and concise?
Is it informative?
Does it reflect the most important prevention areas identified?
Does it discuss common misconceptions?
Does it discuss areas of uncertainty?
Does it provide a balanced view?
Does it address all meaningful outcomes, including quality of life?
Is it about a sensitive topic which needs care in its use?
Is an action or a response asked for? (If so, this may need to be followed up.)

Source

Is the source of the information clear?
Is the information valid, unbiased and evidence-based?
Is it topical?
Is the material up to date? Check the latest edition date.
Does it provide details of additional sources of support and information?

Clarity

Is it easy to read?
Is sufficient detail provided?
Are the aims clear?

Style

Is it positive and encouraging?
Does it promote shared decision making?
Is the physical presentation simple and engaging?
Is the print of adequate size for the elderly or sight-impaired?

Source: National Quality Committee of the Royal Australian College of General Practitioners. 2nd Edition. *Putting prevention into practice. A guide for the implementation of prevention in the general practice setting*. Melbourne; RACGP, 2005

Where to go for further support

The Division Network

Australian Divisions of General Practice
Ground Floor, Minter Ellison Building,
25 National Circuit,
Forrest, ACT 2603
Tel: 02 6228 0800
www.adgp.org.au

ACT Division of General Practice
20/41 Liardet Street, Weston, ACT 2611
Tel: 02 6287 8099
www.actdgp.asn.au

Alliance of NSW Divisions
Level 13, 9 Castlereagh Street, Sydney,
NSW 2000
Tel: 02 9239 2900
www.answd.com.au

General Practice Divisions Victoria
Level 1, 458 Swanston Street, Carlton,
VIC 3053
Tel: 03 9341 5200
www.gpdv.com.au

SA Divisions of General Practice
1st Floor, 66 Greenhill Road, Wayville, SA 5034
Tel: 08 8271 8988
www.sadi.org.au

Tasmanian General Practice Divisions Limited
Level 1, 86 Murray Street, Hobart, TAS 7000
Tel: 03 6224 1114
www.tgpd.com.au

WA Divisions State Office
10 Silas Street, East Fremantle, WA 6158
Tel: 08 9319 0500

Community resources

Arthritis Australia
(see the website for contact details of state offices)
www.arthritisaustralia.com.au

Asthma Foundations of Australia
(see the website for contact details of state offices)
www.asthmaaustralia.org.au

Australian Drug Foundation
Tel: 03 9278 8100
www.adf.org.au

beyondblue – the national depression initiative
(beyondblue is NOT a mental health service but an organisation devoted to increasing awareness and understanding of depression in the community, contact beyondblue for resources about depression and anxiety)
Tel: 03 9810 6100
www.beyondblue.org.au

Diabetes Australia
(see the website for contact details of state offices)
Tel: 1300 136 588 (local call cost)
www.diabetesaustralia.com.au

Dietitians Association of Australia
Find a Dietitian 1800 812 942
www.daa.asn.au

International Diabetes Institute
www.diabetes.com.au

Kinect Australia – Active Living for Healthier Communities (incorporating VICFIT in Victoria)
Tel: 03 8320 0100
www.kinectaustralia.com.au

Koori DrugInfo
Tel: 1300 85 85 84
www.kooridruginfo.adf.org.au

National Aboriginal Community Controlled Health Organisation (NACCHO) and affiliates
Tel: 02 6282 7513
www.naccho.org.au
Aboriginal Health Council of Western Australia (AHCWA)
Tel: 08 9202 1393
www.ahcwa.org
Aboriginal Health Council of SA Inc
Tel: 08 8132 6700
www.ahcsa.org.au
Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Tel: 08 8936 1800
www.amsant.com.au

NSW Aboriginal Health and Medical Research Council (AHMRC)
Tel: 02 96981099
www.ahmrc.org.au
Queensland Aboriginal and Islander Health Federation (QAIHF)
Tel: 07 3255 3604
www.qaihf.com.au
Tasmanian Aboriginal Centre
Tel: 03 6234 8311
www.qaihf.com.au
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Tel: 03 9419 3350
www.vaccho.com.au

National Asthma Council
www.nationalasthma.org.au

National Drug and Alcohol Research Centre
www.med.unsw.edu.au/ndarc

NSW Multicultural Health Communication Service
(provides information and services to assist health professionals to communicate with non-English speaking communities)
www.health.nsw.gov.au/health-public-affairs/mhcs/

Nutrition Australia
(see the website for contact details of state offices)
www.nutritionaustralia.org

The Cancer Council Australia
(see the website for contact details of state divisions)
Tel: 02 9036 3100
www.cancer.org.au

The National Heart Foundation of Australia
Heartline: 1300 36 27 87
www.heartfoundation.com.au
Australian Capital Territory Division
Tel: 02 6282 5744
New South Wales Division
Tel: 02 9219 2444
New South Wales Division – Newcastle Office
Tel: 02 4952 4699
Northern Territory Division
Tel: 08 8981 1966
Queensland Division
Tel: 07 3854 1696
Queensland Division – Rockhampton Office
Tel: 07 4922 2195
Queensland Division – Townsville Office
Tel: 07 4721 4686
Western Australia Division
Tel: 08 9388 3343
South Australia Division
Tel: 08 8224 2888
Tasmania Division
Tel: 03 6224 2722
Victoria Division
Tel: 03 9329 8511

The National Tobacco Campaign (Quit Now)
Tel: 02 6289 1555
www.quitnow.info.au
Cancer Council ACT
Tel: 02 6262 2222
www.actcancer.org
Queensland Cancer Fund
Tel: 07 3258 2254
www.qldcancer.com.au
QUIT NSW
Tel: 02 9391 9620
www.health.nsw.gov.au
QUIT South Australia
Tel: 08 8291 4141
www.quitsa.org.au
QUIT Tasmania
Tel: 03 6228 2921
www.quittas.org.au
QUIT Victoria
Tel: 03 9663 7777
www.quit.org.au
QUIT WA
Tel: 08 9222 2016
www.quitwa.com
Tobacco Action Project, Northern Territory
Tel: 08 8999 2661

Local organisations

To find out what is available in your local area, where you can get support, information and referral options contact your local council, which should have a directory of community services and programs.

Implementation planning checklist

Step one: Decide on the intensity of Lifescripts most appropriate for your practice now

A. What lifestyle factors are most appropriate to your practice population?

- ☐ All
- ☐ Smoking
- ☐ Nutrition
- ☐ Alcohol
- ☐ Physical activity
- ☐ Weight management

B. How are you managing lifestyle risk among your patients now?

1. Strategies

2. Resources

3. Which risk factors are you managing well?

- ☐ Smoking
- ☐ Nutrition
- ☐ Alcohol
- ☐ Physical activity
- ☐ Weight management

4. What are the gaps in risk factor management in your practice?

5. Which risk factors are current areas of interest among practice staff? For each, list the particular skills or approaches that staff members bring to managing this risk factor.

☐ Smoking	Staff member:	_____
	Skills/approaches:	_____
☐ Nutrition	Staff member:	_____
	Skills/approaches:	_____
☐ Alcohol	Staff member:	_____
	Skills/approaches:	_____
☐ Physical activity	Staff member:	_____
	Skills/approaches:	_____
☐ Weight management	Staff member:	_____
	Skills/approaches:	_____

6. Are your patients routinely screened for lifestyle risk factors (e.g. when taking patient histories or using a standard patient questionnaire)?

☐ Always
☐ Usually
☐ Sometimes
☐ Never

7. How effective are your current information management systems to identify all patients with or at risk for a given condition (e.g. diabetes) and create a register?

Not at all effective				very effective
1	2	3	4	5

C. What factors affect the feasibility of Lifescripts activities in your practice now?

1. How committed are you and your staff to prevention?

Not at all committed				very committed
1	2	3	4	5

2. How adaptable or flexible are your practice systems to integrate prevention?

Not at all flexible				very flexible
1	2	3	4	5

3. Which practice staff members are available to be involved in Lifescripts activities?

Job title _____ Name _____
Job title _____ Name _____
Job title _____ Name _____

4. Which area of change could make the most impact on lifestyle risk factors with the least amount of effort in your practice?

_____

_____

(5. For services managed by a Board e.g. Aboriginal Community Controlled Health Services)
How well informed is your Board of Management about lifestyle interventions?

Not at all well-informed very well informed

1 2 3 4 5

Step two: Implement change by choosing the range of appropriate Lifescripts resources and tools

Under each intensity option, tick all actions that would be feasible in your practice. Then assess which intensity option/s are most feasible.

Intensity option A. Opportunistic approach involving GPs only (targeting one or more risk factors)

✓	**Action**	**Change/s needed to make this action possible**
	Place selected waiting room resources* where patients will see them	
	During consultations, respond to patients' requests for lifestyle advice and inform patients about Lifescripts.	
	During consultations, use the '5As' approach to lifestyle intervention opportunistically, using the Lifescripts assessment tool/s and prescription/s [ ] Paper-based [ ] Electronic	

* Lifescripts poster, waiting room checklist, waiting room flyer

Intensity option B. Opportunistic approach involving GPs and relevant practice staff (targeting one or more risk factors) – additional to all actions listed under intensity option A

✓	Action	Change/s needed to make this action possible
	Reception staff and/or practice nurse to mention Lifescripts to patients	
	Practice nurse to administer assessment tool/s in new patients or patients with selected medical conditions [ ] Smoking [ ] Nutrition [ ] Alcohol [ ] Physical activity [ ] Weight management	
	Practice nurse to interpret assessments and give counselling [ ] Smoking [ ] Nutrition [ ] Alcohol [ ] Physical activity [ ] Weight management	

Intensity option C. Planned or structured approach involving GPs only (targeting one or more risk factors) – additional to actions listed under intensity option A

✓	Action	Change/s needed to make this action possible
	Use system for ordering waiting room resources and updates	
	Use system for patient recall, reminders and prompts	
	Refer patients to other providers and services to support behaviour change in selected risk factor areas: [ ] Smoking [ ] Nutrition [ ] Alcohol [ ] Physical activity [ ] Weight management	

Intensity option D. Planned or structured approach involving GPs and relevant practice staff (targeting one or more risk factors) – additional to actions listed under intensity options A and B

✓	Action	Change/s needed to make this action possible
	Appoint a practice staff member as Lifescripts coordinator (monitor performance, identify areas for improvement)	
	Assign and clearly state Lifescripts roles and responsibilities for each staff member	
	Administer waiting room checklist to all patients (as appropriate) [ ] Enter data into information management system (e.g. database of practice management software)	
	Offer group 'mini-clinics' for selected risk factor areas [ ] Smoking [ ] Nutrition [ ] Alcohol [ ] Physical activity [ ] Weight management	
	Arrange practical self-management education sessions (e.g. organised shopping trips)	
	Review practice performance regularly at staff meetings to obtain specific feedback from each staff member	
	Set up disease-specific patient registers (e.g. diabetes register)	
	Transfer all relevant information obtained through waiting room checklist or lifestyle risk assessments to database	

✓	Action	Change/s needed to make this action possible
	Identify patients at higher risk (e.g. older patients, new patients, patients with existing chronic disease) and contact them with regular reminders and recalls	
	Run specific sessions during which every patient is thoroughly assessed for a selected risk factor (e.g. smoking assessment on World No Tobacco Day)	
	Refer selected patients to practice nurse, Aboriginal health worker or allied health professional staff members (physiotherapist, dietitian) for more intensive counselling and advice	
	Integrate lifestyle risk assessment and advice into practice nurse's current activities (e.g. wound care, immunisation)	

Step three: Take up training and upskilling opportunities and/or support options from your local division

List relevant training opportunities

Training or support program	Provider	Relevant lifestyle risk factor

Referral directory: Smoking

Referral service	Address	Contact
National smoking cessation programs		
Quitline (24 hours)		13 QUIT (13 7848)
Local smoking cessation programs		
Other services		

Referral directory: Nutrition

Referral service	Address	Contact
Dietetic services – public		
Dietetic services – private		

Referral directory: Alcohol

Referral service	Address	Contact
Community counselling services		
Support groups		
Other services		

Referral directory: Physical activity

Referral service	Address	Contact
Local exercise classes and groups		
People with disabilities		
Exercise physiologists		

Referral directory: Weight management

Referral service	Address	Contact
Medically supervised weight-loss programs		
General weight-loss programs		

Referral directory: General community services

Referral service	Address	Contact
National community services information		
Commonwealth Carelink		1800 052 222 www.commcarelink.health.gov.au
Local community services, e.g. translation/interpreter services, transport, meals on wheels etc.		

Multi-Item Screening Tool

The Multi-Item Screening Tool (MIST) was developed by Dr Felicity Goodyear-Smith, Assoc Prof Bruce Arroll and colleagues at the Department of General Practice and Primary Health Care, University of Auckland. It includes a number of previously validated brief lifestyle and mental health screeners and has undergone extensive evaluation. Full validation against a composite gold standard is currently in progress and the tool may be modified once this process is complete.
Contact Felicity Goodyear-Smith (e-mail: f.goodyear-smith@auckland.ac.nz)

Life-style Assessment Form

What we do and how we feel can sometimes affect our health. To help us assist you to reach and maintain a healthy and enjoyable lifestyle, please answer the following questions to the best of your ability. Your answers will be kept in strict confidence. Please answer EVERY question. Your GP and/or your practice nurse will be able to see your responses.

PLEASE TICK THE ANSWER THAT IS NEAREST TO CORRECT FOR YOU

How many cigarettes do you smoke on average a day?

☐ None ☐ Less than 1 a day ☐ 1–10 ☐ 11–20 ☐ 21–30 ☐ 31 or more

Do you ever feel the need to cut down or stop your smoking?

(Tick no if you do not smoke)

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Do you ever feel the need to cut down on your drinking alcohol?

(Tick no if you do not drink alcohol OR do not feel the need to cut down)

☐ No ☐ Yes

In the last year, have you ever drunk more alcohol than you meant to?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Do you ever feel the need to cut down on your non-prescription or recreational drug use?

(Tick no if you do not use other drugs OR do not feel the need to cut down)

☐ No ☐ Yes

In the last year, have you ever used non-prescription or recreational drugs more than you meant to?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Do you sometimes feel unhappy or worried after a session of gambling?

(Tick no if you do not gamble OR do not feel unhappy about gambling)

☐ No ☐ Yes

Does gambling sometimes cause you problems?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

PTO →

During the past month have you often been bothered by feeling down, depressed or hopeless?

☐ No ☐ Yes

During the past month have you often been bothered by having little interest or pleasure in doing things?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

During the past month have you been worrying a lot about everyday problems?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

What aspects of your life are causing you significant stress at the moment?

☐ None ☐ Relationship ☐ Work ☐ Home life ☐ Money ☐ Health

☐ Study ☐ Other (specify) _____

Is there anyone in your life of whom you are afraid or who hurts you in any way?

☐ No ☐ Yes

Is there anyone in your life who controls you and prevents you doing what you want?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Is controlling your anger sometimes a problem for you?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

As a rule, do you do at least 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 or more days of the week?

☐ Yes ☐ No → If No, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Do you often feel that you can't control what or how much you eat?

☐ No ☐ Yes

Does your weight affect the way you feel about yourself?

☐ No ☐ Yes → If yes, do you want help with this? ☐ No ☐ Yes but not today ☐ Yes

Lifescripts presentation

Available for download at Australian Divisions of General Practice website (www.adgp.com.au) from mid 2005

This slide presentation can be adapted for presentations to Boards and staff of divisions of general practice, GPs, practice nurses, Aboriginal health workers and other staff of general practices and Aboriginal medical services. It includes information on:

- the Lifescripts initiative
- lifestyle risk factors and chronic disease
- how general practice can make a difference to lifestyle-related risk
- the Lifescripts approach to lifestyle risk management
- the 5As model for lifestyle intervention in general practice
- Lifescripts resources for general practice
- implementation options.