Focus on Prevention

Community Awareness and Infrastructure

Lifestyle Prescriptions

Australian Government

Department of Health and Ageing

LIFESTYLE PRESCRIPTIONS WORKSHOP – RECORD OF PROCEEDINGS

November 2003

National Lifestyle Prescriptions Workshop

A report for the Australian Government Department of Health and Ageing

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Glossary of Acronyms

GP	General Practitioner
IM	Information Management
IT	Information Technology
JAG	Joint Advisory Group
NGO	Non government organisation
NHMRC	National Health and Medical Research Council
SBO	State Based Organisation
SPARC	Sport and Recreation New Zealand
SNAP	Smoking, Nutrition, Alcohol and Physical Activity

National Lifestyle Prescriptions Workshop

Canberra, 26-27 November 2003

Introduction

Preventive care is becoming the focus of health care systems both nationally and internationally. In Australia, the release of the Commonwealth's *Focus on Prevention* package reflects this growing trend to provide consumers with preventive health care. The *Focus on Prevention* package was introduced in the 2003-04 Federal Budget, with the aim of shifting emphasis within the health system away from managing the consequences of illness and disease towards disease prevention and health promotion.

The *Focus on Prevention* package has three components:

- Community Awareness and Infrastructure;
- Primary Care Providers Working Together; and
- the development of a priority setting mechanism for prevention.

The Community Awareness and Infrastructure initiative will seek to raise awareness of the role of health professionals in prevention. The Primary Care Providers Working Together initiative will support small teams of primary health care providers to come together to identify and act on opportunities to reduce lifestyle risk factors, and maintain good health for their patients with chronic conditions. The development of a priority setting mechanism for prevention is a cost-neutral component of the package that will assess the relative efficiency of a range of alternative disease prevention interventions to better inform decision-making.

A major component of the *Community Awareness and Infrastructure* initiative is the move to build a national approach to lifestyle prescriptions. Lifestyle prescriptions are tools to be utilized by general practitioners (GPs) to identify and manage health risk factors in their patients. Targeted risk factors include smoking, being overweight or obese, poor nutrition, the misuse of alcohol and a lack of physical activity. Lifestyle prescriptions aim to assist GPs to set goals with their patients and provide advice and support to address risk factors. Similarly, lifestyle prescriptions will enable GPs to prescribe patients with preventive actions to lower the risk of, and support people with, chronic disease and illness.

Lifestyle prescriptions complement a number of other existing activities, initiatives and working groups. These include the National Obesity Taskforce, the review of the Divisions of General Practice, the work of the National Health Priorities Action Council and the Australian Chronic Disease Prevention Alliance, and the recommendations of the Red Tape Taskforce. In particular, a major support structure for lifestyle prescriptions is the Joint Advisory Group's Smoking, Nutrition, Alcohol and Physical Activity Framework for General Practice (JAG/SNAP Framework).

The introduction of lifestyle prescriptions is being progressed through the Australian Government's *Focus on Prevention* package. Initial research focused on similar state and international initiatives. These provided suggestions for the structure and form of lifestyle prescriptions, and highlighted likely implementation issues. The next step in the roll out of lifestyle prescriptions was the **National Lifestyle Prescriptions Workshop** (Canberra, 26-27 November 2003).

The aim of the workshop was to seek information and advice from key stakeholders regarding the national implementation of lifestyle prescriptions. The workshop achieved this by bringing together stakeholders and providing them with an avenue for sharing experiences and expertise regarding similar projects that exist and which may inform or impact on the development of lifestyle prescriptions. The workshop also provided a forum for the discussion of issues, barriers and challenges that need to be considered in the initiative. A major objective of the workshop was to inform implementation of lifestyle prescriptions in a manner that builds on existing activities and infrastructure, in recognition of the financial parameters around lifestyle prescriptions.

The workshop brought together a full range of expert stakeholders to inform the implementation of lifestyle prescriptions. The range of participants included (but was not limited to): representatives from similar international and national initiatives, Commonwealth officers, representatives of consumer and practitioner groups, and academic informants (the full list of workshop participants is included in Appendix A). The two-day workshop consisted of a series of presentations, followed by small group and plenary discussions guided by key discussion questions. The agenda for the workshop, including discussion questions, is included in Appendix B.

This report reflects the views expressed by participants of the workshop. The outcomes of the workshop discussions are reflected in this report, however the report is not an Australian Government position and does not bind the Department or any participants of the workshop to any particular course of action.

Key Themes and Learning Points

Key themes and learning points from the workshop have been summarised below.

Lifestyle prescriptions: forms

- The general consensus was that the Commonwealth model (Appendix D) was suitable, with some suggestions for change. These changes have been noted below.
- A national model should be devised but should have the capacity to be flexible at the local delivery level.
- Work within existing programs (with special attention to the JAG/SNAP Framework). Flexible models are needed for different risk factors that remain linked with each other.
- Referral networks need to be established, defined and made widely available. Engage multi-disciplinary professionals (nutritionists, psychologists, practice nurses).
- Design and implement simple, user friendly prescription tools.
- Design and implement simple, user-friendly assessment tools. Consider tools that are self-administered (for example, in the patient waiting room).
- Ensure intervention is brief.
- Ensure that a planned evaluation is undertaken using valid measures. Evaluation data may then be used as part of the evidence base and can be reflected back to GPs as evidence for the efficacy of the program.

Lifestyle prescriptions: processes

- The form of the prescription needs to be flexible enough to fit into the existing practice processes. For example, both paper and computerised prescription mechanisms should be available.
- Focus on providing patient behaviour change AND patient support to do this.
- Build on existing IT systems.
- Suggestion that program should be piloted at an area level or a risk group level, and then rolled out.
- Engage both practitioners and consumers throughout the design, implementation and evaluation.

Lifestyle prescriptions: training

- Identify training needs at a practice level.
- Deliver flexible training (for example, provide on-line training that GPs can do in their own time).
- Accreditation of referral providers.
- Overcoming resistance to change.
- Patient self-management is an important aspect of sustainability.

Lifestyle prescriptions: infrastructure and support

- Social marketing to increase community awareness and manage negative perceptions.
- Provision of incentives for GPs.
- Engage full range of stakeholder organisations: federal, state/territory and local governments, non-government organisations (NGOs), state based organisations (SBOs), divisions of general practice etc.
- Identify and negotiate funding sources and structures.
- Ensure that the systems, structures and processes surrounding lifestyle prescriptions are kept as simple as possible and do not add a further process burden on General Practitioners.
- Provide special support for GPs in remote or rural areas.
- Workforce development to include engagement of tertiary education providers.
- Divisions of General Practice are integral to the roll out of programs and support of GPs.

Lifestyle prescriptions: target populations

- The distinction between population and the individual was raised in relation to a number of issues. In particular, there is a need to differentiate between population level effects and individual effects.
- There is a need to be mindful of placing further disadvantage on marginalised social groups, for example, Aboriginal and Torres Strait Islander people.

- For example, the name ‘lifestyle prescriptions’ implies that consumers can make the necessary changes to their lifestyle because they have lifestyle choices. Social and structural inequities mean that some groups do not have access to as many options for a healthy lifestyle.
- Need to develop a generic program that can be tailored to ‘at risk’ groups. The point was made that these programs could build on existing programs (for example, the Indigenous Well Person’s Health Check).
- Need to ensure that referral sources are affordable for the consumer.

Lifestyle prescriptions: the referral process

- Knowledge of, and trust in the quality of the referral service environment is needed: practitioners can refer only when the services are there, and are of high quality.
- Individual factors affect when the referral process may take place. Such factors include the type of risk factor, the level of risk, patient’s readiness for change and patient preferences.
- Need to emphasise prevention and reduce stigma around certain risk factors.
- Need to establish a range of entry points with a particular emphasis on building patient and GP capacity to refer (knowledge, skills ability).
- A range of strategies are required to ensure that appropriate referral mechanisms are established - for example, service directories, engagement of divisions, use of social marketing campaigns.
- A range of support mechanisms were identified - telephone help lines, group sessions.
- Adherence to best practice principles (efficiency, personal contact, patient choice and ethical principles).
- A number of barriers to the referral process were identified:
  - Funding and infrastructure blocks.
  - Lack of role clarity / failure to engage GPs.
  - The potential to overwhelm both GPs and referral providers with sudden influx of patients.
  - Special issues for remote populations and socially disadvantaged populations (access, affordability etc).
  - Concerns about accessibility, affordability, availability and quality of services.
  - Need to build capacity of divisions to facilitate the system surrounding lifestyle prescriptions.
  - GP concerns about losing their patients. Some participants noted that GPs may be reluctant to refer their patients to other professionals, for fear they may potentially lose a patient whose problem may suitably be addressed in a general practice setting. Similarly, it was noted that GPs may be uncomfortable referring their patients on to an unknown provider, due to uncertainty regarding their skills and the quality of care that would be provided.

- The future of the referral process:
  - Map service capacity, define and map pathways and partnerships. Evaluate these referral networks and use this information as feedback for stakeholders and for further refinement of the pathways/networks.
  - Use divisions as advocates and as collaborative links between the local, state and national level (NGOs, SBOs, government, consumer reps).
  - Engage allied health professions (including ensuring that they are adequately funded).
  - Increase awareness raising in community and professional groups.
  - Work with existing programs; 'think laterally'.
  - Define roles: NGOs, SBOs, government, consumer representatives.
  - Improve role definitions at the practice level, especially the role of the practice nurse.
  - Improve information sharing between referral networks.

Lifestyle prescription: implementation issues

- In discussion about the capacity of GPs to implement the referral process, the key issues raised were:
  - Learn from existing interventions (for example, smoking cessation).
  - Incorporate findings of Red Tape Taskforce.
  - Recognise that at high level of risk may point to need for intervention by a clinical psychologist or psychiatrist, while low levels of risk may be manageable by the general practitioner. Need to equip GPs with knowledge to recognise this.
  - Seek to build infrastructure and support mechanisms for sustainability (including demand management).
- The key issues raised in regards to enabling lifestyle prescriptions in a practice setting were:
  - Work is needed at local/state/national level to develop allied health and multidisciplinary referral destinations.
  - Challenge is to link separate risk factors together and with other relevant initiatives.
  - Need to create a balance between planning and action. Whilst careful planning is needed, there is a danger in losing momentum and support etc.
  - Attention needs to be given to system development. For example, simultaneous development of individual practices, the divisions of general practice and other involved organisations. It was suggested that state based planning initiatives involving the full range of stakeholders would ensure integration and sustainability. Need to develop partnerships, training, networks and workforce.

Lifestyle prescriptions: the role of the practice nurse

- There is a need to provide appropriate accreditation, education, training and career pathways for practice nurses, in order to facilitate the roll out of lifestyle prescriptions.
- The need to define roles at the practice level, with attention to extending the role of the practice nurse into the key areas of clinical care, clinical organisation, practice management, integration/liaison and support for the referral process.
- Evidence suggests that nutrition, alcohol and smoking are risk areas that the practice nurse has the potential to impact on (as well as the GP).

Issues and priorities

At the end of the workshop, the key issues and priorities for action were outlined:

- Short-term high priority actions include:
  - The development and/or the dissemination of national tools including where necessary the testing of any new tools. These tools are to be wherever possible computer-based, able to be progressively integrated with existing practice and Aboriginal Medical Service software and with the capacity for self-administration by consumers.
  - The development of a specific targeted approach for Aboriginal and Torres Strait Islander populations linked with the Well Person's Health Check.
  - Capacity development in the Divisions to support the rollout of lifestyle prescriptions. This will include networking and other opportunities to support Divisional staff and showcase success.
  - State and Territory level negotiations to support the rollout of lifestyle prescriptions.
  - Awareness raising at all levels.
- The key principles to underpin these activities are:
  - Developments should not widen existing inequalities in health status.
  - The importance of acting in concert with and/or influence other Commonwealth, State and Territory and Local Government programs in the interests of developing the infrastructure to support lifestyle prescriptions.

  Implementation of activities should seek to give priority to those populations at most risk.

Challenges to implementation of lifestyle prescriptions: The New Zealand example

Green Prescriptions, the New Zealand equivalent to lifestyle prescriptions, is a tool to improve the general health and wellbeing of New Zealanders, and helps to increase levels of physical activity in a section of the population considered by GPs to be 'inactive'. An overview of the program was presented at the workshop by Ms Diana O'Neill, Senior Policy Advisor (Health), Sport and Recreation New Zealand (SPARC). (The full presentation is included at Appendix C.)

The impetus for the program came from the need to target the 30% of the New Zealand population who are inactive, with the expectation that it will impact upon the level of related risk factors. Green Prescriptions is a program run via the regional sports trusts, in which an area manager provides patients with motivational counselling and advice over the telephone, after an initial consultation with a health professional. The presentation focused on how the program evolved as various challenges were overcome. After a brief description of the program, a number of key barriers, and responses to these, were described. The key challenges described were:

- Getting buy in from stakeholders
- Identifying roles and responsibilities
- Identifying the population target market
- Clarifying who will issue prescriptions
- Creation and management of demand
- Training issues
- Evaluation of the program
- Development of supporting resources
- Patient confidentiality issues
- Sustainability for the patients and the program
- Delivery of the program, including funding sources
- Development of the program within the existing health system.

In the plenary discussion that followed, a range of key points were raised:

- Since the implementation of Green Prescriptions, the development of a patient support system has decreased the time taken by GPs to issue a prescription from 5-7 minutes to about 2 minutes.
- Green Prescription is supported by enough funding to employ patient support workers. Lifestyle prescriptions diverge from Green Prescriptions in that it will seek to work within existing resources and supports, rather than attract new funding.
- There is a need to involve consumer representative groups in an early and continuing manner in implementation of lifestyle prescriptions, rather than only in the evaluative stage, as in the case of Green Prescriptions.
- As consumers' behaviour becomes more sustained, the degree of support they need decreases. Similarly, face to face and group support emerged as more effective than telephone support in the roll out of Green Prescriptions.
- It is estimated that about a third of the people issued with Green Prescriptions require support. Other people with Green Prescriptions may not require support, or may not have acted on the script.
- Patients are made aware of the issues surrounding confidentiality before their script is passed on to a support worker.

What is a lifestyle prescription?

Using the Green Prescriptions as a preliminary structure, the participants discussed key issues surrounding potential forms of lifestyle prescriptions. A few key issues surrounding the definition of a lifestyle prescription were presented to contextualise the discussion:

- A prescription form for each risk factor is the preferable format as it has the potential to offer greater flexibility for GPs and their patients. A linked format for each prescription would be necessary to allow continuity of prescribing across risk factors.
- For the patient, a lifestyle prescription will be written lifestyle advice from their GP. For the GP, a lifestyle prescription will be a process of assessment, advice, information and/or referral that encourages and supports the management of behavioural risk factors in a general practice setting.
- Lifestyle prescriptions will follow a five-step model: identify lifestyle issues; assess and discuss, written recommendation for action, information, refer.
- Lifestyle prescriptions should draw on existing expertise and experience, build on existing programs and tools and provide information and resources to facilitate opportunistic intervention by GPs, where appropriate.

The plenary discussion that followed focused on the following points:

- What would a national approach to lifestyle prescriptions consist of?
- Existing models and adaptations?
- Critical success factors?

The key decisions raised in the group discussions are presented below:

Lifestyle prescriptions: A national approach working within existing models

- The general consensus was that the Commonwealth model (Appendix D) was suitable, with some suggestions for change. These changes have been noted below.
- Participants suggested that a national model with the capacity to be flexible at the local delivery level should be devised.
- There is a need to work within existing programs (with special attention to the JAG/SNAP Framework, Active Script, Enhanced Primary Care packages, Practice Incentive Payments and Service Incentive Payments).
- There is a need to devise different models for different risk factors that remain linked with each other.
- Referral networks need to be defined, established, and made known widely . A range of multi-disciplinary professionals (nutritionists, psychologists, practice nurses) need to be engaged in developing these networks.
- It was noted that lifestyle prescriptions should consist not only of written prescriptions and referrals, but of a level of patient support as well.
- The success of lifestyle prescriptions can by supported by social marketing campaigns to raise awareness, workforce development activities and organisational development activities.
- The final form of the lifestyle prescription initiative needs to work within the range of technological capabilities (IM and IT) at general practice.

Lifestyle prescriptions: critical success factors

- One imperative forwarded by the participants was the need to design and implement a few simple, brief prescription and assessment tools. It was suggested that self-administered assessment tools could be considered (for example, available in patient waiting rooms).
- A number of initiatives were suggested to support GPs in the implementation of lifestyle prescriptions, including incentives, role clarification (that is, GPs should not be seen as experts in the management of all the risk factors), and attention to issues of role overload (for example, there is a need to ensure that the final model incorporates a brief intervention that ideally takes up no more than 1-3 minutes of consultation time).
- The implementation of lifestyle prescriptions needs to be supported at a population and individual level (that is, consumer awareness raising activities accompanied by support for individual patients).
- Attention must be paid to developing the support structures surrounding lifestyle prescriptions at all levels. There should be coordination of the roles of the Commonwealth and State and Territory governments, NGOs, SBOs, private sector organisations, consumer organisations and the Divisions of General Practice. This includes clear funding and accountability structures.
- The lifestyle prescription initiative must be designed so that it is successful in the full range of general practice environments, including metropolitan, regional, rural and remote settings.
- The development of clear referral networks, accompanied by accreditation pathways at a local and national level was seen as critical to the success of the initiative. Risk groups need to be targeted to ensure that the initiative reaches them and does not further marginalise socially and economically disadvantaged groups. Particular attention needs to be paid to developing options for consumers who cannot afford the cost of the service they are referred to and for Indigenous groups.
- A full range of stakeholders (including consumer groups) needs to be engaged at all stages in the design, implementation and evaluation of the program.
- Ongoing evaluation using valid measurements will ensure the program evolves and is sustainable.
- The difference between the individual and population level effects was raised at a number of points during the workshop. It was agreed that a decision must be made as to what the ratio of 'successful' to 'unsuccessful' patients constitutes an acceptable cost-benefit ratio.

What training and resources are required to implement lifestyle prescriptions successfully within a practice?

Building on suggestions for possible structures and forms for lifestyle prescriptions, training and resource issues were considered. The Victorian *Active Script* program, outlined by Ms Nancy Huang, Assistant Director of the Victorian Council of Fitness and General Health, provided a context for this discussion. (Appendix C includes the outline of her presentation.) The Active Script program took a broad view of 'education' in trying to change practitioner behaviour, using a multifaceted approach. Education strategies were designed to align with the principles of adult learning models. That is, information should be useful and relevant, techniques should be experiential and self-directed, and training should be contextualised in

the practice environment. Practice visits, GP health sessions, follow up phone calls, assessment tools and prescription tools were the most successful training and resources provided to GPs in the roll out of the program.

The group discussion that followed considered:

- Education and training needs
- What training and education is currently available?
- What tools, guidelines and information already exist?

The issues raised in the discussions that followed:

Education and training needs and opportunities

- Training for GPs should be as specific as possible, and embedded in their day-to-day practice. This could incorporate case based learning.
- Ongoing quantitative evaluation should be added to the broader evidence base, and fed back to all the interested parties. Outcomes should be differentiated according to state level and national level data, and outcomes salient to different organisations and systems.
- The role of different stakeholders in the implementation of the initiative needs to be clarified as part of the training needs analysis.
- Readiness for change needs to be created with health professionals before training efforts take place.
- The systems and processes surrounding the referral networks need to be clarified during training, with particular attention to defining which clients should be referred, and delineating how referrals should take place.
- Training initiatives should be wide-ranging. Attention should be paid to workforce development initiatives, with a view to incorporating lifestyle prescriptions training in undergraduate, postgraduate and continuing education programs.
- Training initiatives should take a broad focus and include motivational interviewing techniques, education for other service providers regarding general practice systems (and *vice versa*).
- Consumer self-management was suggested as another possible training avenue, which could increase the sustainability of the program.
- Training programs were seen as an opportunity to engage a broad range of health professionals.
- Education initiatives should not only seek to increase knowledge and skills, but also build capacity at a practice level.
- Target groups should be identified, and training and education for health professionals should be subsequently designed to meet their needs.
- Training resources and techniques should be particularly focussed on groups who are difficult to reach, both in terms of low readiness for change and geographical isolation.
- The design of lifestyle prescription assessment, prescription and referral tools should be guided by the goals of standardisation and quality. In particular, it was suggested that the stages of change model would be useful when designing assessment tools, and consideration should be given to self-administered assessment tools.

- A training program should be designed at a national level, but delivered locally.
- Prior to developing any resources, an audit of existing tools and programs should be undertaken. This will avoid redundancy and reduce costs.
- Training and resources should be delivered in a flexible manner. In particular, it was suggested that support should be available electronically.
- Training should be incorporated into existing continuing education programs. Practice visits should be considered.
- There is a need to develop best practice guidelines.
- A number of existing resources were identified: Smoking, Nutrition, Alcohol and Physical Activity guidelines, Royal Australian College of General Practice guidelines, (National Health and Medical Research Council (NHMRC) Alcohol Guidelines and existing dietary guides.
- Self-reflection and peer comparison feedback were raised as suggestions for inclusions as assessment tools.
- Training and resources should be evaluated, and this data used to improve subsequent training and resources.
- Training resources should focus on utilizing and creating a culture of research (learning organisations).
- Education resources should clearly define how multiple presenting risk factors should be prioritised.

How do we optimise the use by general practice of the tools and resources required for implementing lifestyle prescriptions?

The *Active Script* program was also used as a framework to discuss the optimal use by general practitioners of the tools and resources required for the implementation of the lifestyle prescriptions initiative. Ms Sonya Tremellen, Population Health, General Practice Division of Victoria, advanced a number of imperatives (see Appendix C for the full presentation):

- Tools should be simple and practical – the gold standard is not always possible.
- Define which group of patients for whom systematic use of the tool is to be implemented. The key tension in this respect is whether to focus on a disease or the individual. It was noted that funding sources are likely to be more targeted to specific diseases, rather than risk factors in individuals.
- Tools need to be matched with an 'enabler' to tailor the pathway that the patient takes to whatever extent is needed for them to adopt the advice offered by the GP. It was suggested that the enabler could sit at the division level, to ensure that the GP doesn't lose their patient.
- Tools and support must be tailored to the variety of practice settings and systems that exist.

A number of strategies are available for the roll out of lifestyle prescriptions, but the focus should be on choosing strategies that will build a sustainable program. Key success factors for building sustainable programs include a strong policy platform, compelling clinical

evidence, compelling business case, GP champions, capacity in the Divisions, and capacity in practices.

The group discussions that followed considered:

- Best ways to disseminate information, tools, etc?
- How do we encourage and assist GPs to use existing information and tools to underpin lifestyle interventions?
- In this context, how do we build support for Lifestyle Prescriptions?
- GPs and IT capacity.

Key issues raised were:

Maximising uptake and support of lifestyle prescriptions

- Capacity building activities must occur at both the divisional and practice level.
- A system change that allowed GPs to extend consultation times (for example, through the Medical Benefits Scheme) would improve uptake of the program.
- Improvements to the existing IT systems are needed in practices to facilitate the uptake of the program.
- The program must minimise the red tape burden on GPs.
- The program should be piloted before it is rolled out and continually evaluated, with this data being distributed to all stakeholders.
- Tools should be screened for usability to facilitate uptake.
- Use professional colleges and engage in social marketing to raise awareness.
- Linking lifestyle prescriptions to current programs will facilitate uptake.
- Engaging all practice staff will ensure that the program is sustainable.
- Promote communication networks between the GP, patient, and referral service providers.

Dissemination issues

- The Divisions of General Practice will play a vital role in multi-pronged dissemination of the program; capacity building activities need to occur to support this role.
- Consistent messages should be tailored to different target groups, using face-to-face communication whenever possible. Similarly, the program should be named appropriately so that it doesn't appear to be an extra burden.
- Use methods such as pilot programs, change champions, capacity building.
- Use existing programs to disseminate information.
- Provide financial and other incentives to improve dissemination.
- Utilize the literature to ensure the methods chosen have a strong evidence base.
- Evaluative feedback should acknowledge the limitations of the lifestyle prescriptions initiative and how these are being addressed, as well as GP achievements.

General practice and the referral process

The workshop also included discussion of issues surrounding the implementation of the referral process in general practice settings. A major component of lifestyle prescriptions is the referral of high-risk patients onwards to specialised health professionals.

Professor Mark Harris, (Professor of General Practice and Director of the Centres for Primary Health Care and Equity Research in the School of Public Health and Community Medicine, University of NSW) spoke about general practice and the referral process in reference to the SNAP risk factors. According to Professor Harris, a number of factors facilitate the referral process: GP knowledge of the service and the referral provider, low patient cost, ease of communication and report back. Professor Harris then outlined an approach for both practices and the divisions for implementing the referral process at five levels – planning, teamwork, systems, links, and evaluations. (The full presentation has been included in Appendix C).

The discussion session focused on:

- When to refer?
- Barriers to, and opportunities for referral?
- How do GPs identify appropriate referral options?
- What do we need to do to improve referral pathways?

Key points raised in the following discussion were:

When to refer

- Referral can only occur when the GP is knowledgeable of the service environment. The service environment must have a number of credible, high quality service providers available.
- GPs must be able to assess the level of risk of the patient when making the decision about whether to refer. The level of risk depends on the risk factor (for example, drug use may be more problematic than smoking).
- Referral should be part of an early intervention.
- Referral may only occur after obtaining consent from the patient, and referral options should be devised in collaboration with the patient. Collaboration with the patient should include an assessment of the patient's readiness for change, available resources and perceptions of stigma associated with their risk factor.
- It was suggested that lifestyle prescriptions should incorporate self-referral mechanisms for patients for which this is suitable.

Barriers and opportunities to referral

- The design and implementation of the referral component of lifestyle prescriptions should work within the existing funding and infrastructure at all levels (national, state and territory, divisional and practice).
- There is a need to create awareness of the role of the GP in lifestyle prescriptions in both the patient and GPs.
- Referral services must be accessible, particularly for socially disadvantaged or geographically isolated groups.

- There is a need to engage allied health professionals.
- There is a need to ensure the demand created does not overwhelm the available services.
- Telephone services provide an opportunity for acceptable and accessible services.
- There is a need to promote the concept of 'shared care' among a patient's multiple health professionals.
- Referral services should be promoted and clearly defined.
- Referral services must be properly monitored for quality.
- The risk of losing patients acts as a significant barrier to referral.
- Existing programs and the capacity of the Divisions both act as a significant opportunity to implement referral pathways.

How can GPs identify appropriate referral options?

- The Divisions can be engaged to help GPs identify appropriate referral options.
- Social marketing campaigns can assist GPs identify options.
- A service directory could be produced.
- Multiple entry points to service providers could create more referral options.
- Group sessions, help lines and web-based services are cost effective referral services.
- A practice nurse could assist GPs identify appropriate referral options.

What is needed to improve referral pathways

- There is a need to map and define existing service pathways.
- There is a need to map service capacity and develop referral partnerships.
- Feedback mechanisms should be built in order to monitor the efficacy of current referral pathways.
- The focus of referral pathways should be local.
- The Divisions of General Practice could act as advocates and key collaborative points to improve synergy between national, state/territory and local governments, NGOs, SBOs, private organisations and consumer groups.
- It was noted that referral networks could be made more accessible if the allied health professions were funded under the Medical Benefits Scheme.
- Providers should be co-located, and opportunities for different providers to meet face to face should be generated.
- Information for GPs and consumers about risk factors should be linked to referral services.

How do GPs incorporate lifestyle intervention in the patient consultation?

A major potential barrier to the successful implementation of lifestyle prescriptions is the concern that GPs will not have enough time to incorporate lifestyle prescriptions into patient consultations. Dr John Litt, Senior Lecturer, Department of General Practice, Flinders University, spoke about how General Practitioners can incorporate lifestyle intervention in the patient consultation (the presentation has been included in Appendix C).

Dr Litt suggested that effective implementation strategies can be structured within a CREATIVE framework – **C**oordinated, **R**eceptive, **E**ffective, **A**bility, **T**argeted, **I**terative cycles, **V**alues, **E**fficient. Key roles for the practice nurse include education and informing patients, counselling and advice, identifying SNAP risk factors, follow-up, ensuring appropriate tools are available to conduct assessment and management, linkages and quality improvement. The key message of Dr Litt's presentation was that for GPs to be able to incorporate lifestyle interventions into the patient consultation they need to be within a one to two minute timeframe.

Group discussion was sought to answer:

- The role of the Practice Nurses in delivering lifestyle prescriptions.
- How much can GPs do?
- How to embed lifestyle prescriptions in a practice setting to complement lifestyle advice in a consultation?

The key issues raised in the plenary discussion were:

Role of practice nurses

- It was suggested that Commonwealth funding for a practice nurse in every practice would greatly help implementation.
- Career structuring, mechanisms for education and training or the distribution of the available workforce within the health system need to be considered.
- It will also be necessary to address the barriers to practice nurses' performing interventions and to recognise they will not be the same as those faced by GPs. In rural areas there is a reasonably high uptake of Practice Nurses, but little evidence that they will provide lifestyle interventions. A proposed solution is to ensure practices make internal roles clear - for example, by making lifestyle prescriptions an explicit part of the practice nurse role.
- For the education and training of practice nurses, there is a strong need for an accredited training stream. Although a fair amount of training is now given in content areas, very little systematic training is provided in how to build the required support for implementation (practice systems). Training should be driven by need and not by what people will choose to go to, as this is usually what they already do well.
- Practice nurses would probably be best to take on a clinical-coordinator role, as opposed to a one on one counselling role. There are four suggested roles for the practice nurse: clinical care, clinical organisation (for example reminders and recall), practice management, and integration or liaison with the community.
- There is some evidence to suggest the effectiveness of practice nurse intervention in nutritional advice.

- It would be important to analyse earlier interventions (such as smoking cessation campaigns), and replicate these lessons within the other risk factors. This will help to identify what both practice nurses and GPs can and should do.

How much can GPs do?

- GPs and practices should not be 'set-up for failure'. There is a need for policy change and consideration of the broader social determinants of patients' behaviour.
- It is important to be mindful of the pressure building on GPs and Divisions and they should not be expected to do everything. The implementation needs to be contextualised and supported by broader strategic development.
- There is evidence from practice organisational research that what really counts within a practice is teamwork.
- Different professionals should be involved with the different risk factors - for example, the role of the clinical psychologist in alcohol related issues. Hazardous or harmful alcohol consumption can be dealt with by GPs, whereas alcohol dependency requires specialist referral services to a clinical psychologist or psychiatrist.
- GPs need to have a generalist understanding of how to do brief interventions. The role of the GP is potentially quite small and supplemented by support from appropriate people. There is a need to involve professionals beyond the practice.
- Engaging GPs and meeting their practice and training needs will improve the implementation of the lifestyle prescriptions initiative.

Embedding lifestyle prescriptions in a practice setting

- Skills, workloads, referral options and infrastructure issues in General Practice need to be addressed.
- A challenge is how to link all the relevant parts in other initiatives and then identify the gaps and seek to influence the States and Territories, private sector and NGOs to fill these gaps.
- There needs to be real work at the State and Territory level about providing allied health professionals and multidisciplinary referral destinations.
- It is important to establish what GPs need to make things happen and then to work with the Divisions in order to provide these necessary elements such as the IT infrastructure and the referral system.
- It is important to build on opportunities and enthusiasm to start and roll these out whilst building momentum and capacity. Focus on achieving short-term aims that don't compromise the credibility of the whole plan in terms of long-term goals or strategies.
- There are limited funds available ($4.3 million over three years) therefore it is important to focus on things that are 'doable' such as the capacity to influence other established initiatives.
- Implementation and embedding of lifestyle scripts should be thought of in terms of capacity building and working towards a sustainable model. Ensure that all the correct implementation components are planned for and measured.
- There is a need for evidence about what interventions work best and time frames for the different risk factors.

Monitoring, evaluation and additional issues for consideration

In response to a number of suggestions by the Commonwealth, the group raised these key issues:

- The decision about the choice of detailed Performance Indicators must be made after the extent and nature of the activities for the rollout of the lifestyle prescription initiative have been finalised.
- Workshop participants suggested the adoption of the REAIM model (Glasgow *et al* 1999) as it provides a useful framework covering reach, efficacy, adoption, implementation and maintenance. Evaluation is fundamental to the process, as it not only allows for the monitoring of these five elements but also ultimately for outcomes.
- We must ensure that we know enough to say we have evaluated something that actually exists (ie ensuring that a type 1 error is avoided). To achieve this, we must plan how to identify and then use the range of existing data collection vehicles such as the Annual Survey of Divisions and other population level surveys to monitor the extent and nature of the implementation and program research.
- Consumers must be involved in every stage of the development, implementation and evaluation of the activities chosen for the rollout of lifestyle prescriptions nationally.
- If the rollout activities stopped at the Divisions of General Practice, success might be limited. The rollout needs to encompass the allied health providers or their representative organisations and key organisations in the government and non-government sector whose support is needed to deliver the referral destinations that GPs will be referring patients to.
- It was strongly recommended that capacity building within the Divisions must include the development of high level buy-in at the Board and Management levels and not just at the program or project officer level.
- It was strongly recommended that the Australian Government as a part of the change management process should underpin the agreed short-term activities with negotiations and communication with State and Territory Health and other relevant portfolios (e.g. sport and recreation) about referral pathways, awareness raising and how lifestyle prescriptions are positioned in the Health system.
- It was suggested that consumer participation should be made a requirement of all grants provided in the rollout of lifestyle prescriptions.
- It was suggested that it would be useful to involve Medical Industry Software developers earlier rather than later in the rollout process.
- It was further suggested that it would be useful to scope the cost desirability and accessibility of funding State or Regional Coordinators to develop State and Territory plans, etc.
- There is a need for ongoing national leadership, support and facilitation.
- With the limited budget, every effort must be made to identify and link with other Commonwealth, State/Territory and Local Government and non-Government initiatives.
- The Commonwealth should lead by example, and ensure that the Community Sector is involved in working parties and consultation processes.
- The question whether GPs always need to be the ‘gatekeeper’ was raised. It was noted that Allied Health Professionals, community health staff, non-government providers and

others outside the health industry (ie sport and recreation) would be interested and should be considered in areas where Divisions do not show interest. The role of pharmacists could also be considered in the future.

- Participants also raised a number of cautions:
  - The conceptualisation of lifestyle prescriptions may assume a level of choice that those outside of the mainstream do not have.
  - A focus on only individual level behaviour change without attention to broader social determinants of health status may set people up to fail and decrease rather than improve self-efficacy.
  - In relation to young people, the GP may not be the most appropriate or credible source of lifestyle information and advice.
- In the long-term, the rollout of lifestyle prescriptions should include intersectoral broad primary health care initiatives at the State/Territory and Local level.
- There is enough that is different about Aboriginal communities, services and infrastructure to warrant specific and targeted initiatives linked (for example) with the rollout of the Well Person's or Adult Health Check.
- Divisional capacity building should include networking and other opportunities for staff to get support and mentorship and for the showcasing of success.
- It was suggested that the name "lifestyle prescriptions' should be tested through market research.
- Lifestyle prescriptions must be positioned as tools, assistance or support - not as something new and additional.
- Local organisations, services and providers should be canvassed to determine their capacity to cope with demand.

Appendix A: List of Workshop Participants

Rachel Balmanno	Department of Health and Ageing
Bill Bellew	Director Centre for Health Promotion, NSW Health
Nerida Bellis-Smith	Professional Services Director, Dietitians Association of Australia
Andrew Boyden	Medical Affairs Manager, Heart Foundation of Australia
Raina Brands	Siggins Miller
Margaret Brown	Health Consumers of Rural And Remote Areas (CHF)
Bev Buckridge	Project Officer, Hastings Macleay Division of General Practice
Fiona Bull	Senior Lecturer - Physical & Health Education, University of WA
Nicola Burton	Research Officer, QUT School Of Public Health
Debra Cottrell	CEO, Goulburn Valley Division of General Practice
Margaret Cox	Department of Health and Ageing
Scott Davis	Community Quality Use Of Medicines Program Manager, National Prescribing Service Limited
Lindy Dunn	Assistant Director, Department of Veterans' Affairs
Kylie Easton	Education and Quality Assurance Program, National Prescribing Service
Helen Egan	Executive Officer, Australian Chronic Disease Prevention Alliance (ACDPA)
Anna Fergusson	Programs Coordinator, SA Divisions Of General Practice
Vanessa Firenze	Chronic Disease Management Program Officer, Sutherland Division of General Practice
Nicole Fitzgerald	Department of Health and Ageing
Christine Frew	National Health Services & Planning Manager, Australian Kidney Foundation
Jane Giles	Manager, Diabetes Outreach in SA
Susan Goodman	Health Promotion Officer, Alliance of NSW Divisions
Mark Harris	Professor of General Practice and Head of School University of New South Wales
Bronwen Harvey	Medical Advisor, Department of Health And Ageing
June Hicks	Nutritional Advocate, Nutrition Australia
Coletta Hobbs	SNAP Project Coordinator - Senior Research Fellow, Centre for General Practice Integration Studies
Nancy Huang	Assistant Director, VICFIT
Sarah Hurren	Department of Health and Ageing
Mike Jones	General Practice Divisions of Western Australia
Helen Kehoe	Policy Officer, National Aboriginal Controlled Community Health Organisations
Ian Kett	Executive Director, VICFIT
Klaus Klaucke	Director, Tobacco, Drug Prevention & Youth Policy Australian Government Department of Health and Ageing
Erin Lalor	Chief Executive Officer, National Stroke Foundation
John Litt	Senior Lecturer, Flinders University Department of General Practice
Elaine Lomas	GP Policy Officer, National Aboriginal Controlled Community Health Organisations

Cate Lombard	Manager Health Promotion, VICFIT
Joanne Martin	Health Promotion Office,r West Vic Division Of General Practice
Alex McClelland	CDM Program Officer, St George Division of General Practice
Danielle McNamara	Department of Health and Ageing
Shannon Meikle John	Dietitian, Nutrition Australia - QLD Division
David Menzies	Senior Project Officer, VICFIT
Janet Michelmore	Director, Jean Hailes Foundation
Julie Middleton	Professional Development Manager, The Jean Hailes Foundation
Mary-Ellen Miller	Workshop Facilitator, Siggins Miller
Diana O'Neill	Manager, Active Living Greenscript NZ
Marianna Pisani	Health Promotion Section, Department of Human Services
Sue Pluck	Consumers Health Forum of Australia
Yolaine Raisin	Self-Management Project Coordinator, ACT Division of General Practice
Roslyn Ridgway	General Practitioner, Criniti/Ridgway Medical Services
Ann Roche	Director, National Centre for Education and Training on Addiction
Margaret Ryan	Practice Nurse, Criniti/Ridgway Medical Services
Helen Sherrell	Facilitator Scribe, Siggins Miller
Jane Sims	Senior Lecturer In Primary Care, University of Melbourne
Ben Smith	Lecturer, University of Sydney
Teri Snowdon	National Manager: Quality Care & Research, Royal Australian College of General Practitioners
Tony Stubbs	Physical Activity Program Manager, National Heart Foundation Of Australia - NSW
Sonya Tremellen	Population Health, General Practice Division Of Victoria
Joanne Turner	Lifestyles Programs Manager, Diabetes Australia
Claudine Wathier-Doucet	Chronic Disease Management (CDM) Project Officer, ACT Division Of General Practice
Judith Watson	GP/Physical Activity Program, GP North Division Of General Practice
Leanne Wells	National Primary Mental Health Coordinator and Principal Adviser, Mental Health Australian Divisions of General Practice
Jo Whitfield-Lowe	Department of Health and Ageing
Bruce Wight	Director, Alcohol, Substance Misuse & Injury Prevention, Department of Health and Ageing
Dianne Woods	Executive Officer NSW, Nutrition Australia
Nicholas Zwar	Professor of General Practice, University of NSW
Catharina van Moort	Department of Health and Ageing

Appendix B: Agenda

LIFESTYLE PRESCRIPTIONS WORKSHOP: AGENDA

26th and 27th November 2003, The Chifley on Northbourne, Canberra

DAY 1

8.30 – 8.50 Arrival - tea and coffee

9.00 – 10.00 Context and scene setting

- Official opening and scene setting (Rachel Balmanno, Acting Assistant Secretary, Population Health Division)
- Aims and objectives of workshop (Mel Miller, Facilitator)
- Challenges to implementation of Lifestyle Prescriptions (Diana O'Neill, Sport and Recreation New Zealand)

10.00 – 10.15 Morning Tea

10.15 – 12.00 Discussion Session 1 - What is a Lifestyle Prescription?

Introduction to Topic: Rachel Balmanno, Director, Healthy Ageing and Chronic Disease Prevention Section.

Discussion points:

- What would a national approach to Lifestyle Prescriptions consist of?
- Existing models and adaptations?
- Critical success factors?

Report back from groups, and pen discussion

12.00 – 12.45 Lunch

12.45 – 2.30 Discussion Session 2 – What training and resources are required for the successful implementation of lifestyle prescriptions within a practice?

Introduction to Topic: Nancy Huang, Assistant Director, Victorian Council of Fitness and General Health.

Discussion points:

- Education and training needs
- What training and education is currently available?
- What tools, guidelines and information already exist?

Report back from groups, and open discussion

2.30 – 2.45 Afternoon Tea

2.45 – 4.30 Discussion Session 3 – How do we optimise general practice use of the tools and resources required for implementation of lifestyle prescriptions?

Introduction to Topic: Belinda Caldwell, Population Heath, General Practice Division of Victoria.

Discussion points:

- Best ways to disseminate information, tools, etc?
- How do we encourage and assist GPs to use existing information and tools to underpin lifestyle interventions?
- In this context, how do we build support for Lifestyle Prescriptions?
- GPs and IT capacity

Report back from groups, and open discussion

4.30 – 5.00 Conclusions of Day 1 and issues to be discussed on Day 2

Mel Miller, Facilitator

7.30 Dinner

DAY 2

8.30 – 8.50 **Arrival - tea and coffee**

9.00 – 9.15 **Introduction - Key Issues from Day 1 and discussion**

Mel Miller, Facilitator

9.15 – 11.00 **Discussion Session 4 – General practice and the referral process.**

Introduction to Topic: Professor Mark Harris, Professor of General Practice and Director of the Centres for Primary Health Care and Equity Research in the School of Public Health and Community Medicine, University of NSW

Discussion points:

- When to refer?
- Barriers to, and opportunities for referral?
- How do GPs identify appropriate referral options?
- What do we need to do to improve referral pathways?

Report back from groups, and open discussion

11.00 – 11.15 **Morning Tea**

11.15 – 1.00 **Discussion Session 5 – How do general practitioners incorporate lifestyle intervention in the patient consultation?**

Introduction to Topic: John Litt, Senior Lecturer, School of Medicine Flinders University.

Discussion points:

- The role of Practice Nurses in delivering Lifestyle Prescriptions
- How much can GPs do?
- How to embed Lifestyle Prescriptions in a Practice Setting to complement lifestyle advice in a consultation?

Report back from groups, and open discussion

1.00 – 1.45 **Lunch**

1.45 – 2.15 **Discussion Session 6 – Monitoring and Evaluation**

Brief presentation by Rachel Balmanno, Director, Healthy Ageing and Chronic Disease Prevention Section, Strategic Planning Branch, Population Health Division

Group Discussion

2.15 – 4.00 **Discussion Session 7 – What else do we need to consider?**

Summary by Mel Miller, Facilitator.

Facilitator to summarise discussions including:

- Highlighting key issues raised;
- Priorities for action;
- Issues raised but not addressed; and
- Workshop Summary

4.00 **Conclusion of workshop**

Appendix C: Presentations

Presenter: Ms Rachel Balmanno, Acting Assistant Secretary, Strategic Planning Branch – Population Health Division

Brief summary

A lifestyle prescription is a tool for general practitioners (GPs) to use when providing healthy lifestyle advice to patients.

The development of an approach to lifestyle prescriptions should draw on existing:

- experience (for example, experience for the Active Script Program by VicFit in Victoria and Green Script by Sports and Recreation New Zealand.);
- evidence (for example, GP advice giving around fruit and veg in the UK);
- guidelines (for example, Smoking Cessation Guidelines); and
- resource materials.

Essentially there are two options for lifestyle prescriptions:

1. a single prescription for use with all lifestyle risk factors (eg National Prescribing Service (NPS)/ National Heart Foundation of Australia (NHFA) lipid lowering script), or
2. aA number of different prescriptions for the different lifestyle risk factors

It is proposed that the second option for lifestyle prescriptions be adopted as it offers greater flexibility for GPs by providing a suite of tools and resources that GPs can use as necessary. Specific lifestyle prescriptions for the different lifestyle risk factors will enable GPs to tailor their intervention to suit the needs of the patient at the time. Having a suite of lifestyle prescriptions will enable GPs to choose to focus their efforts on particular risk factors that are of interest to them or of particular significance for the practice population.

Under the national approach to lifestyle prescriptions being proposed, there will be two perspectives of lifestyle prescriptions:

1. for the patient, the prescription will be the written lifestyle advice that is provided by a GP; and
2. for general practice (including the GP, practice staff and Divisional staff) lifestyle prescriptions will be a process of assessment, advice, information and/or referral that encourages and supports the management of behavioural risk factors in the general practice setting.

The use of lifestyle prescriptions follows a five-step model (this model parallels the Five A's for Smoking Cessation Guidelines in Australian General Practice). The steps of the model are:

1. Identify lifestyle issue
2. Assess and discuss
3. Written recommendation for action (lifestyle prescription)
4. Information
5. Refer

It is proposed that the implementation of a national approach to lifestyle prescriptions:

- draw together existing experience, evidence, guidelines and resource materials (not trying to invent something new and in isolation to what already exists);
- develop tools and processes that are flexible enough to be integrated into different practices as the GPs choose; and
- facilitate opportunistic intervention by providing GPs with the information and resources to enable them to address lifestyle risk factors with their patients as appropriate.

Presenter: Ms Diana O'Neill, Senior Policy Advisor (Health),
Sport and Recreation New Zealand (SPARC)

What are "Green Prescriptions" (GRx)?

- Green Prescriptions are a way to improve the health of New Zealanders. They increase levels of physical activity in a section of the population currently considered by General Practitioners to be 'inactive' (less than 2.5 hours of physical activity per week).
- General Practitioners and practice nurses can promote physical activity to patients who have stable medical conditions and will benefit from increased physical activity. Such medical conditions include hypertension, obesity, diabetes, osteoporosis, anxiety and depression. Patients with unstable medical conditions are excluded from the GRx programme through the risk assessment process.
- Green Prescriptions is a starter programme. Doctors and nurses can encourage inactive patients to embark on safe and appropriate physical activity which can be carried out in their own environment and at little or no cost. Patient compliance and health gains will be monitored at regular intervals. (Patients may later choose to join a sports club or take on exercise programmes designed by fitness professionals).
- Green Prescriptions acknowledges the health message of the US Surgeon-General that an accumulated 30 minutes of moderate physical activity, preferably every day, will improve the health of most people. Patients can "snack" on activity, for example, three ten - minute walks instead of one thirty minute walk.
- Green Prescriptions offers a coordinated approach to increasing levels of physical activity where General Practitioners and Practice Nurses work in partnership with the 17 Regional Sports Trusts (RSTs) throughout NZ and Sport and Recreation New Zealand (SPARC).
- Fundamental to Green Prescriptions is the option of community support facilitated by RSTs. Professional staff in the RSTs can 'usher' patients into regular appropriate physical activities, provide personal encouragement, monitor compliance and give feedback to General Practitioners and Practice Nurses. Patients can access RSTs through an 0800 line or direct referral from the medical centre.

How do we know they work?

Results from Dr Raina Elley *et al* (2003). Effectiveness of counselling patients on physical activity in general practice: cluster randomised controlled trial.
***BMJ* 326 (7393): 793**

The 12 April 2003 issue of BMJ presented the findings of the research showing increased physical activity levels and improved quality of life over 12 months, without evidence of adverse effects.

Dr Raina Elley's study identified all sedentary 40-79 year old Waikato patients visiting their general practitioner over a five-day period. A total of 878 patients were enrolled in the study. Patients allocated to the intervention group received advice about physical activity and support from regional sports trust patient support personnel. Patients in the control group received usual care.

Physical activity during leisure time and total energy expenditure increased more in the intervention group than in the control group. Measures of self-rated "general health," "vitality," and "bodily pain" also improved significantly more in the intervention group.

A trend towards decreasing blood pressure became apparent but no changes in the risk of coronary heart disease were observed.

Dr Elley's study has shown that brief advice, coupled with ongoing telephone support, can change people's behaviour with respect to physical activity and improve general health, vitality, and bodily pain for at least a year, say the authors.

The conclusion stated is that if implemented widely, a strategy such as GRx could result in major health benefits for sedentary people.

The entire report can be viewed at: http://bmj.com/cgi/reprint/326/7393/793.pdf.

Results from the Green Prescriptions clinical trial conducted in 1995 by the Heart Foundation under contract to the Hillary Commission

A randomised trial of Green Prescription (written advice) versus verbal advice on physical activity levels showed:

- About 70% of people increased their physical activity over 6 weeks.
- Effects were greater when a written Green Prescription accompanied verbal advice.
- After 11 months 47% had maintained their increased level of activity. 72% had been back to see their GP during that time.
- Walking was the most popular activity (79%) prescribed by the General Practitioner.
- Assessment and advice took about 5 minutes (this time included the form filling necessary for research purposes).

How and when was the GRx initiative developed?

1988-1995

Research was conducted into known information about the benefits of physical activity and an international lifestyle seminar was coordinated in May 1988.

The Hillary Commission produced the following studies:

- *Life in New Zealand research*
- *The cost of doing nothing*
- *Solving the mystery of inactivity*

August 1995

GRx Clinical trials completed (National Heart Foundation under contract to Hillary Commission). Conducted with 37 Dunedin and Auckland GPs.

August/September 1996

Focus groups held with GPs in Auckland, Rotorua, Lower Hutt and Christchurch to discuss implementation of GRx.

September 1996/May 1997

Discussion with health agencies (North Health, National Heart Foundation etc). Development of GP and patient resources (NHF under contract to Hillary Commission) after consultation with GPs and GP groups. Pacific Island Heartbeat developed resources for Pacific Island languages, (Cook Island Maori, Tongan and Samoan).

May 1997

Launch of GRx in Northern region by Minister of Sport, Fitness and Leisure (Murray McCully).

July-December 1997

Training of Active Living Staff based in regional sports trusts on the implementation of GRx and their role.

Development of patient resources - walking, swimming, stretching, cycling, running, water activities and activity and medical conditions. Training of GPs/distribution of resources through Independent Practitioners Associations. Evaluation started, funded by North Health.

December 1997-March 1998

Public media campaign in Northland and Auckland-radio, bus posters and mall displays used to encourage the public to ask their GP for a Green Prescription resulted in an increase in GP uptake

May 1998

Evaluation showed that 65% of Northland and Auckland GPs were "prescribing green" (sample 317 GPs) and 97% were giving verbal advice about increasing physical activity.

July 1998

Nation wide roll-out of GRx started through IPAs, Maori health providers and individual GPs and practice nurses. Extension of computer prescribing of GRx.

October-November 1998

Appointment of GRx area managers to liaise between Hillary Commission, RSTs, GPs, practice nurses and other health professionals.

- Northland-part time
- Auckland-full time
- Waikato, Bay of Plenty, Taranaki, Eastland-full time
- Manawatu, Hawkes Bay, Wanganui, Wellington-full time
- Tasman-part time
- Canterbury-part time
- Otago, Southland-full time (funded by South Link Health IPA)

1999-2003

Calls to 0800 line steady but low in number. Most sports trusts link with doctors and practice nurses for direct referral. Patients therefore get the support they need in maintaining lifestyle change. Total referrals for the year July 2002 - June 2003 were 5809 compared with 4925 for the previous year). GRx patients receive four newsletters a year with advice and information.

Links with health agencies developed through regular contact with area managers. Agencies include: Heart Foundation, Asthma, Diabetes, Mental Health, Arthritis, Respiratory support and Maori health workers.

Two part time area manager positions developed to cover Hawke's Bay and Gisborne and second Auckland area manager brings total to ten managers (five full time and five part time).

GPs are surveyed in May and November of each year to establish uptake of GRx.
See the table below for a summary of results and contact SPARC for more information.
A randomised sample is taken of 1000 GPs and a postal survey carried out.

	Average for 1999/2000	Average for 2000/2001	November2001	May 2002	November2002	May 2003
GPs heard about GRx	96%	98%	98%	98%	98%	97%
GPs prescribed GRx	47%	51.5%%	63%	65%	73%	69%
GPs computer prescribing	12%	29%	36%	39%	38%	46%
Average number of scripts in previous month	5	3.7	2.7	4.1	3.1	3.1

Questions were added from May 2000 about patient follow-up by GPs and GP awareness of the moderate physical activity message. From May 2001 questions were added about the role of practice nurses in GRx. Another new question was added to the May 2003 survey to identify whether GPs issue a GRx to all patients they think one is suitable for, and if not, why they didn't.

The May 2003 survey showed that in 31% of the practices surveyed the practice nurse also wrote a Green Prescription. Weight issues was the main reason given to "prescribe green" (91%), followed by diabetes (71%) and high blood pressure (62%). When asked what would encourage GPs to issue more GRx "less paperwork in General Practice" and "more time in consultation" were the most common responses.

Ministry of Health funding was confirmed for GP support during 1999/2000 and Pharmac funding for 2000-2004. Increased emphasis on patient support has resulted in more personnel at regional level for follow-up calls over a three month period.

Research is conducted annually with a small sample of GRx patients to establish the reasons they were prescribed green, health benefits gained and levels of physical activity since GRx was received. Most common benefits are "generally feel better", "feel stronger and fitter" and "lost weight".

A project was started in Northland in November 2000 to determine how GRx can better meet the needs of Maori. Sport Northland has a contract with Te Hauora Whanui to undertake this work. In 2003 further contracts were signed with Hauora O Te Hiku O Te Ika (Northland) and Ngati Porou Hauora (East Coast).

There is a comprehensive range of paper resources to support the GRx initiative. For further information look on the SPARC website-www.sparc.org.nz under Green Prescription or contact Diana O'Neill, SPARC (Sport and Recreation New Zealand), P O Box 2251

Wellington NZ

Phone: (04) 496 3984. Fax: (04) 471 0813. Email: diana.oneill@sparc.org.nz

Presenter: Nancy Huang, Assistant Director, Victorian Council of Fitness and General Health

Brief summary

Continuing medical education is now an embedded feature of GPs' lives.A variety of education methods are used in the general practice setting, and research to date indicates that the effectiveness of different strategies can be extremely variable. The ultimate goals for GP training have varied between quality assurance, adoption of clinical guidelines to effecting knowledge and behaviour change in GPs.

The aim of this Discussion Session is not to provide an exhaustive review of the educational theory, design and delivery of education intervention for lifestyle prescriptions. This has been covered in detail in currently available texts within the health and social sciences disciplines. Rather, this Session aims to stimulate discussion and ideas based on what has occurred to date within the Active Script Program, and how transferable these may be to other risk factors as well as other states in Australia.

Ideas and issues canvassed within this Session will form the basis for an implementation strategy for the development and roll-out of useful resources and training modules for lifestyle prescriptions across Australia.

The Active Script Program

Establishing a direct correlation between the acquisition of new skills by learners (GPs) and patient outcomes as a result of a planned education intervention has been difficult to demonstrate in the literature. This difficulty is further emphasised where the skill area relate to the provision of 'advice' rather than a direct clinical procedures, such as the injection of a swollen knee joint. For the Active Script Program, we have taken a broad view of 'education' and incorporated a multi-faceted approach to facilitate behaviour change in the GP.

Underlying principles of ASP education opportunities:

- Adult learners need to know why they need to learn something before they put in the effort to acquire the new skills
- Adults learn best when they can see the relevance of the topic to their own experiences and practice as a GP
- Adult learners are generally self-directed and need to have some input into the planning of their education
- Adults learn best by doing, so interactive components involving the GP is important
- Adults learn best if the material is presented in the context of application to real-life situations, using problem-centred learning and real-life situations

ASP education strategies implemented by Divisions

- Formal lectures / workshops
- Academic detailing
- Whole of practice teaching
- Telephone follow up
- Written reminders
- Divisional Newsletter articles

ASP Resources produced to support these educational activities:

- Script Pad (paper based and electronic versions)
- Brief physical assessment tool
- ASP GP guide
- ASP patient record stamp
- Local area directory for physical activity opportunities
- Practice visit folder
- Physical Activity Practice Audit
- ASP newsletter articles
- Website links
- Literature Packs outlining the evidence behind ASP

Evaluation results from the ASP educational strategies will be presented and discussed in this session in order to critically appraise the advantages and limitations of each of these methods.

In summary, the ASP model worked within the first 3 years to recruit more than 700 GPs from nine Divisions into its educational interventions. The ASP was perceived to be a credible and quality program, using best available evidence, to upskill and support GPs in their role to promote physical activity.

GPs who participated in ASP became more knowledgeable and motivated to provide physical activity advice to patients in a systematic way. GPs reported that they were assessing, advising and thinking about inactivity as a risk factor more frequently and systematically as a result of becoming involved in the ASP activities. Limited patient interviews showed that advice from their GPs was effective in motivating them to become more active in the short term.

The evaluation findings also confirmed the progress that has been made toward a sustainable intervention in general practice. Divisions, especially those with more than one year of support from ASP, are now incorporating physical activity promotion into core business and future business plans. The capacity of Divisions to recruit, upskill and support GPs in promoting physical activity had increased.

Transferability of learnings for Lifestyle Prescription

In thinking about the training and resource requirements for the successful implementation of the lifestyle scripts, it is useful to consider these two components:

1. **Content** - this relates to the actual information to be delivered. It will vary according to the risk factor involved, incorporating the latest guidelines and evidence for practice. It can be further determined by conducting a needs assessment of knowledge or practice gaps.
2. **Process** - this relates to the method of delivery of the information. It will vary according to the skill level of program deliverers, the resources available, and whether we want to affect knowledge, skill or attitude change in the GP.

Ideally, the steps involved would include:

a) Identify and assess need
b) Define specific and measurable learning objectives for the training and resources

c) Identify appropriate content and process of training opportunities to meet the learning objectives
d) Develop and deliver training
e) Evaluate outcomes against learning objectives

The training modules and resources already developed for the ASP have made some in-roads through these steps, especially in the promotion of physical activity. Decisions will need to be made regarding the transferability of this experience to other risk factors and for other States. Similarly, other established programs such as Active Practice (NSW National Heart Foundation), Green Prescription (New Zealand) and QUIT have taken slightly different approaches to the training and resourcing of GPs. A discussion based on a sound knowledge of what already exist will be critical in making further progress in the development of a strategy for lifestyle prescriptions.

Presenter: Sonya Tremellen Population Health, General Practice Division of Victoria

Brief summary

There are some key principles that we think are essential to address for optimising GP use of any tools. Applying these general principles to use of tools & resources required for implementation of lifestyle prescriptions would be core business for divisions in their change management role with general practice. There are probably more principles than we've identified here and it would be great to see what else people consider to be critical issues, and you may want to argue the point on these key principles. Our list is:

- **Keep the tool simple** (not a tool for each lifestyle issue, not too long, not requiring lot of data entry etc)
- **Define which group of patients for whom systematic use of the tool is to be implemented.** "Who for" goes to the heart of the program design around the use of lifestyle scripts. If just a practice decision, then risk failing to ensure adequate community options etc available. Division level means that implementation can be more comprehensive.
- **Tool needs to be matched with an 'Enabler' to tailor the pathway that the patient takes**, to whatever extent is needed for them to adopt the advice provided by the GP. The implementation model needs a corollary to the 'pharmacist', but the function could be fulfilled in any number of different ways eg practice nurse role, professional based at the division, an Information Line etc
- **Tool needs to be implemented within vastly different general practice settings and systems** – tailored support to do so is often needed. Need to think about whether it is an opportunistic approach or a planned approach and how each of the systems within the practice will need to be developed to enable the change to be made.
- **Tool must lead to accessible and varied options and opportunities within the community** for the patient to undertake lifestyle changes. This can range from allied health referrals to more walking paths in the area.
- Tool needs be seen by GPs as the **vehicle to accessing an immediate benefit for the patient.** How will the GP know that the tool is working as a vehicle in this way? Feedback on what the patient does is important & must be timely – how will this be achieved?
- Tool needs to be part of **a data collection** system so that it is possible to demonstrate to GPs that systematic prescribing of lifestyle changes makes a measurable difference to the health of their patients eg reduced BMI etc

Best ways to disseminate information?

A proposition for you to consider – a low cost, product based model *vs* a more resource intensive, capacity building model

Option 1 – Cheap but possibly effective (like building a 'house of sticks')	**Option 2 – More costly but definitely effective and sustainable** (like building a 'house of bricks')
Typical components might include: • Information in simple, easy to use format eg laminated sheet • Build into medical software eg prompts, templates etc	Typical components might include: • Information in simple, easy to use format eg laminated sheet • Build into medical software eg prompts, templates etc

• Community awareness eg advertising • Patient waiting room resources • All branded in the same way • CPD, 5pph – ready to be rolled out by divisions • Division newsletter articles provided	• Community awareness eg advertising • Patient waiting room resources • All branded in the same way • CPD, 5pph – ready to be rolled out by divisions • Division newsletter articles provided • Individualised practice support – systems thinking approach, based on evidence • Referral processes and pathways exist • Capacity building for local responsiveness • Division leadership and ownership • Any other bids?

How do we build support for lifestyle prescriptions?

Lessons from previous roll-outs of division-based programs and projects have shown us that there are two critical areas of work that are needed for effective implementation of population health programs:

1. **Practice support – to address systems development.**
2. **Linkages & partnerships at the local level – to ensure a coordinated response to what the GP is doing.**

Practice support through divisions is requiring a more sophisticated and resource intensive approach, where divisions are moving from providing a 'product consultancy' service to more of a 'process consultancy':

- Know your practice
- Awareness raising only the first step
- Importance of supporting practices at the practice level
- Importance of addressing multiple systems in order to effect change
- Importance of tailoring strategies for individual practices

Linkages at the local level are crucial for ensuring that the community and agencies are able to respond to the service demands generated by lifestyle prescriptions. Better outcomes from the GP role in a population health initiative are achieved when there is a shared commitment from across the primary care sector to achieving a particular health outcome eg increased level of physical activity

- Partnerships at the local level in which divisions represent practices
- There is a good match between the priorities of state funded agencies and the lifestyle prescription 'program' ie which target group, which risk factor?
- Local responsiveness to GP referral
- Local capacity building to support service delivery.

Summary – the big picture:

The Minimum Requirements for an effective 'roll-out' to general practice of any change aiming to achieve health outcomes are likely to include the following (based on our experience of Immunisation, EPC & CDM programs):

- **Strong policy platform** to achieve the identified health outcomes, of which general practice contribution is one component.
- **Compelling clinical evidence** for the need for change in general practice ie a gap between what is currently occurring and what the evidence says will improve health outcomes for GPs' patients.
- **Compelling business case** – need to demonstrate that delivering quality care is financially viable.
- **GP champions** – credible GP leaders at the local level who can convince their peers to 'pay attention' to the evidence – clinical and business case.
- **Capacity in divisions** eg Skilled and knowledgeable division staff to provide a comprehensive range of services to GPs and practice staff that support them to change what they do.
- **Capacity in practices** eg accredited practices, IT systems, staff to attend division training events etc.

Presenter: Professor Mark Harris, Professor of General Practice and Director of the Centres for Primary Health Care and Equity Research in the School of Public Health and Community Medicine, University of NSW

1. Background

The lifestyle risk factors are common in general practice patients:

- 32.8% were overweight
- 19.2% were daily smokers, 5.6% who were occasional smokers and 27.0% who were previous smokers
- 32.9% drank "at risk" levels of alcohol
- 65.3% reported doing less than 150minutes of moderate physical activity spread over 5 sessions per week

The approach to managing these in general practice is summarized by the 5As used SNAP and other interventions:

Ask	1.patients with diabetes, hypertension, hyperlidaemia, obesity or vascular disease
Assess	2.BMI, waist circumference, portions of fruit and vegetables per day, level of physical activity, alcohol consumption and smoking status 3.readiness to change/motivation
Advise	4.provide written information 5.motivational interviewing
Assist	6. Physical activity prescription 7.Support for self monitoring of diet (not weight) 8. Appropriate pharmacotherapy (eg Nicotine replacement therapy or acamprosate)
Arrange	8.referral to dietician, physical activity programs, QUIT program or drug and alcohol worker 9.follow up with the GP

Referral is a key management tool for all the SNAP risk factors. Referral should be considered in all patients especially those who are motivated and have significant long-term risk such as those with obesity or in complex cases.

An Australian study used a case control study to determine if people that were overweight or hypertensive fared better when their GP referred them to an onsite dietician, when the dietician initiated contact, or when there was no intervention[1]. The results of this study indicate that having the GP as a motivator increased attendance to counselling sessions and caused greater reductions in weight and blood pressure for the patients.

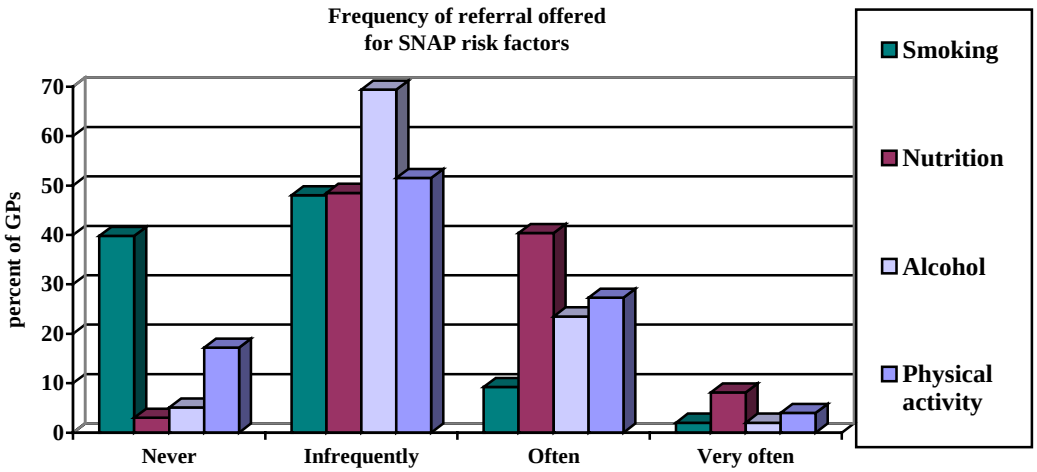
Frequency of referrals in general practice

Referrals for lifestyle are infrequent. The BEACH survey in general practice found that 2.3% of encounters involve referral to allied health or other health professionals[2]. In the needs

[1] Prichard D, Hyndman J, Taba F. 1999. Nutritional counselling in general practice: A cost effective analysis. Journal of Epidimiology and Community Health 53(5): 311-19.

[2] Sayer GP, Britt H, Horn F, Bhasale A, McGeechan K, Charles J, Miller G, Hull B, Scahill S. Measures of health and health care delivery in general practice in Australia. AIHW Cat. No. GEP 3. Canberra 2000

assessment conducted as part of the SNAP trials in two divisions in NSW the frequency of reported referral was low across all four risk factors (See figure) with referrals for smoking being least frequent[3].



Similar results have been found in other studies[4] [5]. There was considerable variability in the ease of referral in the NSW trial divisions for each risk factor being most difficult for smoking alcohol and "relatively easy" for physical activity. However this may vary between divisions and states.

- *What facilitates referral by GPs?*

68% of practices in the NSW trial reported that they had computerized directories. While the frequencies of referral for nutrition, alcohol, and physical activity were highly dependent on the ease of the referral, access to community directories of services does not on its own lead to a greater ease of referral for these risk factors.

Specific strategies to improve referral from general practice in addition provision of information on the referral service include:

- Use of a "prescription"
- Provision of information on telephone hot lines (such as Quit-Line)
- Provision of patient education materials (including electronic materials) that contain information about referral services or options.

Lifestyle prescriptions have been most widely used in physical activity. This usually involves tailored education, advice and referral to physical activity programs[6] [7]. A New Zealand study of the effect of GPs' use of prescriptions for physical activity determined that for middle-aged adults, verbal advice combined with the prescription was more effective than verbal

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[3] Amoroso C. Needs Assessment for SNAP risk factors in general practice. MPH project UNSW 2003
[4] Bull F, Schipper E, Jamrozik K, Blanksby B. 1997. How can and do Australian doctors promote physical activity. Preventive Medicine 26: 866-873.
[5] Heywood A, Ring I, Sanson-Fischer R, Mudge P. 1994. Screening for cardiovascular disease and risk reduction counselling behaviours of general practitioners. Preventive Medicine 23: 292-301.
[6] Bull F, Kreuter M, Scharff D. 1999. Effects of tailored, personalised and general health messages on physical activity. Patient Education and Counseling 36(2):181-192.
[7] Bauman A, Bellew B, Vita P, Brown W, Owen N. 2002. Getting Australia active: towards better practice for the promotion of physical activity. National Public Health Partnership. Melbourne, Australia.

advice alone[8]. Use of the prescription and verbal advice also led to an improvement in health, with participants experiencing a decrease in cardiovascular risk[9]. More recently these have been incorporated into software to increase the ease of referral and similar models have been adopted for smoking.

Ultimately the likelihood of referral depends on the linkages between the practice and referral services. Anecdotally this has been successfully achieved in those divisions of general practice where a shared care relationship exists between the services and GPs or where allied health services have been employed directly by the division of general practice (such as through the MAHS program). This suggests that it is not only the information and availability that are important but the communication system underpinning the referral network. In particular the provision of feedback and a personal relationship appear to be very important to GPs.

[8] Swinburn BA, Walter LG, Arroll B, Tilyard MW, Russell DG. 1998. The green prescription study: A randomised controlled trial of written exercise advice provided by general practitioners. American Journal of Public Health 88:288-291.

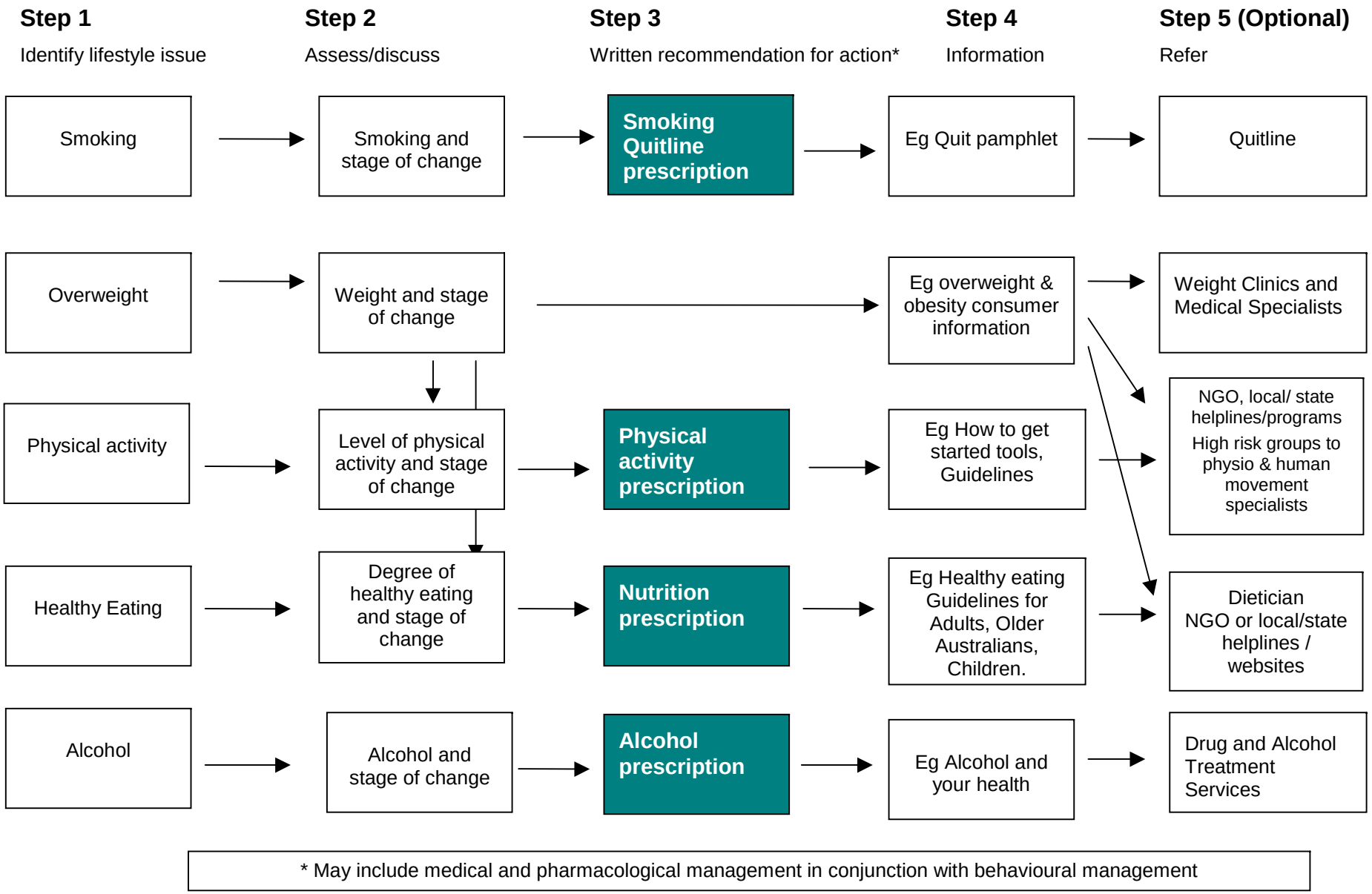
[9] Elley C, Kerse N, Arroll B, Robinson E. 2003. Effectiveness of counselling patients on physical activity in general practice: cluster randomised controlled trial. British Medical Journal. 326:793

Presenter: John Litt, Senior Lecturer, School of Medicine Flinders University

How do GPs incorporate lifestyle intervention in the patient consultations?

Implementation strategies	Strategies that you can start in the next few weeks	Strategies planned over the next 6 months
Coordination of SNAP Can one person be appointed to coordinate SNAP activities in the practice? Has a SNAP plan for the practice been developed (with consideration of: resources, capacity, skills, time, support, motivation)? Have practice staff and GP roles and responsibilities been clarified? How do the practice-based SNAP activities link with (a) Division activities? (b): other community & Public health programs?		
Receptive What are the benefits and costs in this practice of identifying the SNAP 'status' of all patients in the practice? Are the SNAP activities that you plan to implement, congruent with individual and practice goals? How will the implementation strategies be made observable/visible'? What rewards/incentives can you identify for: GPs, practice staff? Are there mechanisms to ensure feedback? What steps can be taken to ensure that the process is supported by the entire practice?		
Targeted What strategies have been used to identify the SNAP status of ALL patients? What attempts have been made to: - understand the important contextual issues? - -target both need and goals? - address the difficulties with implementing SNAP activities?		
Iterative cycles What steps have been taken to: - provide an iterative cycle: - measure need? - reflect on results? - ensure implementation? - review performance?		
Values How have the following values been addressed? - Congruence with the aspirations/ goals of the practice, staff and GPs - transparency of the implementation process (activities, communication) - acknowledgement of prior knowledge, skills and experience - respect for autonomy - promotion of empowerment		
Efficient What is required to make implementation of SNAP a routine and sustainable part of the practice? What steps have you taken to - make implementation of SNAPe a routine part of the practice? - maximise efficiency (value for effort)? - minimise complexity? - continuing rewards? - incremental steps?		

Appendix D: Commonwealth Model: Lifestyle prescriptions = standardised assessment + patient information + shaded boxes



* May include medical and pharmacological management in conjunction with behavioural management