Putting prevention into practice:

an education module

FACILITATOR GUIDE

The Royal Australian College of General Practitioners

Putting prevention into practice: an education module
Facilitator guide

ACKNOWLEDGMENTS

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The Royal Australian College of General Practitioners acknowledges that the video case study used in the module is owned by the Commonwealth of Australia.

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Contents

iii

Foreword 01

A significant proportion of death, illness and injury in Australia is preventable. General practitioners (GPs) and general practice team members play an essential role in promoting health and preventing disease.

More than any other area of medicine, general practice is the specialty that helps patients work toward being the healthiest they can be. It is personalised care based on an ongoing relationship with patients in the context of their family, friends and community.

The second edition of The Royal Australian College of General Practitioners (RACGP) *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* ('green book') was distributed to all Australian general practices in late 2006. The green book outlines strategies that GPs can use in the consultation and that practices can implement, as well as how to use community resources effectively.

The RACGP has developed this education module to support the use of the green book. The module provides a practical and inspirational guide to successful prevention activities in practices. It outlines the theory behind prevention and provides practical case studies, activities and strategies that can be used to implement prevention in your own practice. It also helps teams identify what prevention activities to focus on, develop a systematic approach to prevention, and identify and address any barriers that may arise. By implementing strategies that are known to work, I hope that much time and effort will be saved.

The module can be used as a small group learning activity, in larger formal training workshops or by individual practitioners. Acknowledging the importance of the entire practice team in prevention, the module has been designed for use by GPs, practice nurses, practice managers and others in the general practice team.

I would like to thank the Australian Government Department of Health and Ageing for providing the funding for the development of this module. The RACGP also greatly appreciates the input of the Australian Association of Practice Managers, the Australian General Practice Network, and Australian Practice Nurse Association who have provided advice and direction. Dr John Litt, green book medical editor, has been an important contributor. The RACGP Quality Care Unit initiated this project and oversaw its development. A number of GPs, practice nurses, practice managers and division of general practice staff reviewed the materials and provided advice and suggestions.

The RACGP is proud to play a significant role in building the capacity of GPs to provide preventive health care and in working with national organisations to ensure a sustainable general practice role in prevention.

I hope you find this module interesting and that it stimulates prevention activity in your practice. I encourage your participation and commend your efforts to improve preventive care in general practice.

Dr Vasantha Preetham
RACGP President

Introduction 02

This *Putting prevention into practice* education module is designed to provide general practice teams with the ability to successfully implement relevant prevention strategies into everyday practice.

The aim of the module is to increase knowledge, understanding and practitioner skills in putting prevention into practice, and to raise awareness of the value of evidence based strategies for the implementation of prevention in the general practice setting. It contains a mixture of the theory behind implementing prevention, and practical case studies and activities to help develop prevention programs.

As implementing prevention activities into practices takes a team approach, the module has been designed for the whole practice team: GPs, general practice registrars, practice managers, practice nurses, other practice staff as well as divisions of general practice.

Module development

The RACGP Quality Care Unit developed this module with funding from the Australian Government Department of Health and Ageing. An advisory committee comprising the key stakeholders oversaw the development to ensure that the module is applicable and accessible to all target groups.

Quality assurance and continuing professional development

This module has been designed as an RACGP category 1 QA&CPD activity. The Australian Practice Nurse Association will provide 6 hours of CPD points as a Group A activity, and practice managers may be eligible for points through the Australian Association of Practice Managers.

Module structure

The module is divided into separate interrelated components:

- pre-course activity
- an outline of preventive strategies and the PRACTICE framework
- applying the PRACTICE framework at various levels: the consultation, the practice, and community and health care system, and
- post-course activity.

When completed in its entirety, this module forms a 6 hour active learning module (ALM) for RACGP QA&CPD Category 1 points. Facilitators who do not wish to run the full course may run sections of it and apply for Category 2 points.

The slides have been divided into three 2 hour sessions and may be run as two 3 hour sessions, or other timing depending on the facilitator's preference.

You may wish to ask participants to complete the pre-course activity before attending the workshop or alternatively allocate extra time at the beginning of the first session. The post-course activity, which builds on the pre-course activity and brings together learning from the module, could be completed at the end of the workshop or you could ask participants to complete it as an activity afterward and return a copy to you. If you do not run the module as an ALM for QA&CPD points, it is not necessary to use the pre- and post-course activities.

Delivery

For presentation by a facilitator in ALM style, a facilitator guide, PowerPoint slides and participant workbook, are available.

You may wish to break into smaller groups for some of the discussion questions and case studies, and report back to the larger group. Use of whiteboards or large sheets of paper to complete activities and placed around the room are useful.

You may also like to ask individuals to bring their own examples of implementing prevention programs to discuss.

You may also like to invite additional speakers, eg:

- practices or organisations who have implemented successful prevention programs (and where there is supportive evidence of this) to present to the group. Discussion could focus on what elements of the PRACTICE prevention framework were used in the program, why it was successful, and how barriers were overcome.
- GPs or practice nurses with expertise in case study topics to lead discussion on some of the case studies.

Facilitator instructions

It is anticipated that facilitators who deliver the module will have some experience in delivering education and will not need background or qualifications in prevention.

To assist in facilitating a prevention workshop, this facilitator guide and accompanying slides have been provided. The participant workbook must also be provided to participants. It contains background information and details of case studies, with space for participants to answer questions and make notes. Facilitators may wish to provide participants with slide handouts at the end of each session.

It is recommended that facilitators read the green book in its entirety in preparation for facilitating this module. The RACGP *Guidelines for preventive activities in general practice* ('red book') will also provide background on different areas of prevention.

The RACGP *SNAP guide* and Department of Health and Ageing's Lifescripts resources provide valuable information on approaches to prevention re smoking, nutrition, alcohol and physical activity. The Lifescripts CD-ROM (available free of charge) assists in the motivational interviewing aspects of the module, as well as video case study examples. One of these video case studies is used in the module, and the others are similar to the role play examples.

This guide contains additional material that can be used to summarise key points during the workshop. It also contains suggested responses to case studies and exercises that can be used as a guide for discussion. Note that the sample strategies provided are examples only. There are several ways to approach the answers to the discussion points, so although the sample answers presented are helpful, they are not the only correct answers. Many different responses will arise in discussion.

You may wish to ask participants to bring their own prevention projects to the workshop, so that they can discuss areas of particular interest. The pre-course activity will also highlight areas that practices may wish to develop. Some case studies can be adapted to suit the interests of the group, eg. if the group has a particular interest in cervical screening, the diabetes screening case study could be adapted to cervical screening (or any other screening program). The final case study on depression screening which brings together many aspects of the module could also be undertaken using a different screening program. However, bear in mind that it is the process that is important and having undertaken the module, participants should have the knowledge and ability to implement prevention in the area of their choice, not only prevention specifically used as examples.

Resources

Resources to be used in conjunction with this module are:

- *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (green book) available at www.racgp.org.au/guidelines/greenbook
- *Guidelines for preventive activities in general practice* (red book) available at www.racgp.org.au/guidelines/redbook
- *Smoking, nutrition, alcohol and physical activity: a population health guide to behavioural risk factors in general practice* (SNAP guide) available at www.racgp.org.au/guidelines/snap
- *National guide to a preventive assessment in Aboriginal and Torres Strait Islander peoples* (National guide) available at www.racgp.org.au/guidelines/nationalguide
- Lifescripts resources for general practice available at www.health.gov.au/lifescripts or www.adgp.com.au/site/index.cfm?display=5267.

Hard copies of the RACGP publications can be ordered from the RACGP Publications Unit available at www.racgp.org.au/publications/orders.

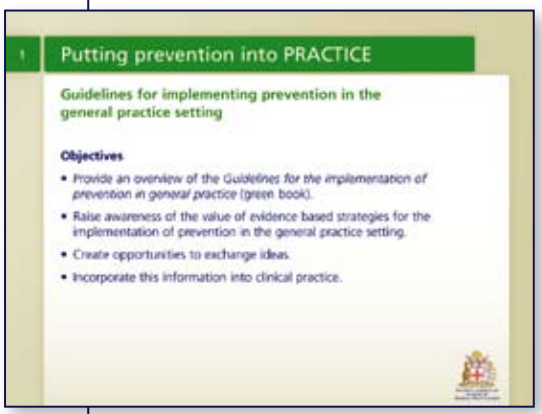
Suggestions and examples

If you have any suggestions for improving the module or examples of programs that practices have implemented that could be included in the module, please contact the RACGP Quality Care Unit.

Further information

If you have any queries about the program, please contact the RACGP Quality Care Unit on 03 8699 0559 or email qualitycare@racgp.edu.au.

03 Putting prevention into PRACTICE



Slide 1

SLIDE 1 Putting prevention into PRACTICE

Welcome to putting prevention into PRACTICE – an ALM designed to help GPs and practice staff increase their knowledge and understanding of how prevention strategies can be introduced into their practices.

The vital role of GPs and practice staff in implementing prevention strategies at all levels of the health care system is highlighted by interactive case studies.

Learning objectives

Upon completion of the putting prevention into PRACTICE module, participants should be able to demonstrate:

Behaviour

- Proactively and systematically review patients for relevant preventive care and focus on those who will benefit most from preventive care.
- Display increased confidence in implementing prevention in general practice.

Attitude

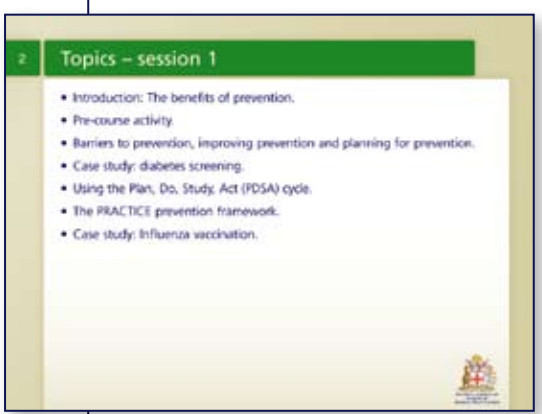
- Appreciate the pivotal role of general practice in the implementation of effective preventive strategies.
- Value evidence based strategies in the implementation of prevention in the general practice setting.

Skills

- Confidently use motivational interviewing and behavioural counselling.
- Implement practice prevention plans that utilise the PRACTICE prevention framework.
- Improve their performance in the delivery of prevention.

Knowledge

- Understand the principles of effective and efficient prevention strategies.
- Understand how to implement preventive care in health management.



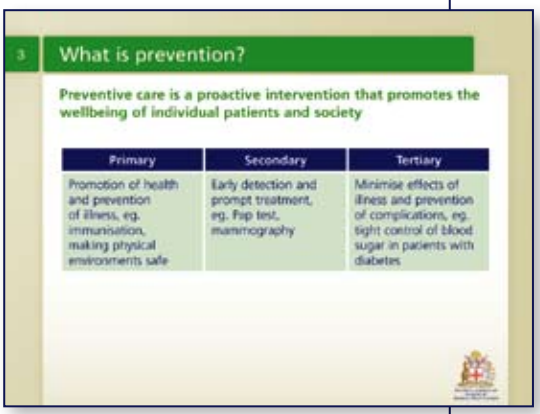
Slide 2

SLIDE 2 Topics – session 1

At the completion of this session, you will be able to:

- understand preventive care and its role, benefits and barriers in general practice
- conduct a needs assessment
- use the PDSA cycle to implement a screening program
- understand the PRACTICE prevention framework and how consideration of these elements will facilitate improvement in delivery of preventive care.

SLIDE 3 What is prevention?



Slide 3

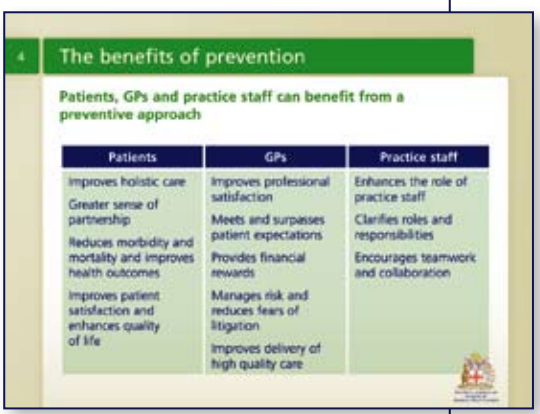
Preventive care is a proactive intervention that promotes the health and wellbeing of individual patients and society. Given the steady increase in demand for health care, it is important to implement strategies that reduce the burden of illness in the community rather than only provide more care.

Prevention can be divided into three categories:

- primary preventive care involves the promotion of health and the prevention of illness, eg. immunisation, making physical environments safe, and healthy lifestyle advice
- secondary preventive care involves early detection and prompt intervention to correct departures from good health or to treat the early signs of disease, eg. Pap tests for cervical screening, breast cancer screening with mammography, blood pressure monitoring and blood tests for cholesterol levels
- tertiary preventive care involves managing illness to prevent impairments and disabilities, minimise suffering caused by existing departures from good health or illness, and promote a patient's adjustment to chronic or irremediable conditions, eg. tight glycaemic control to prevent complications in patients with diabetes.

In general practice, a preventive approach includes both opportunistic and planned interventions.

SLIDE 4 The benefits of prevention



Slide 4

General practitioners are at the forefront of the provision of preventive care in Australia and have enormous potential to both promote health and minimise the impact of disease through encouraging patients to take greater responsibility for their health.

Patients, their GPs and practice staff can all benefit from the implementation of preventive care.

Most patients value GPs taking a holistic approach to their care. Patients often respond positively to brief prevention activities and interventions. Effective preventive care for patients can enhance their quality of life, reduce unnecessary morbidity and mortality and improve health outcomes.

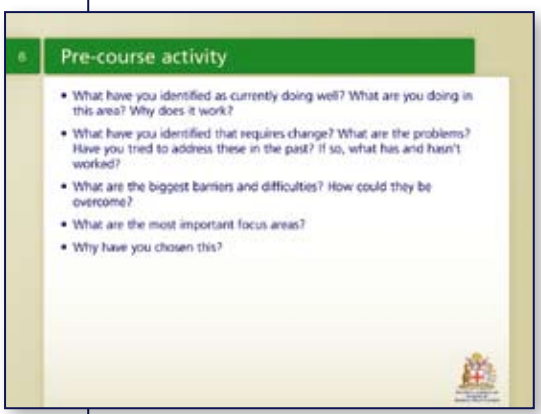
For GPs, preventive care can help to improve professional satisfaction and help in surpassing their patients' expectations. Government financial incentives and programs are available. These include the practice nurse incentive, asthma cycle of care, diabetes program, immunisation program and the 45 year old health check. In addition, implementing preventive care may also increase the potential to better manage risks and address fears of litigation.

For practice staff, efficient approaches to prevention can enhance their role in the delivery of care and achieve better results. Implementation of preventive care in general practice can also clarify the role and responsibilities of practice staff and encourage teamwork with the key players involved.

Slide 5

SLIDE 5 For discussion

Note to facilitator: Engage with participants and encourage them to provide responses and feedback on this point before proceeding.

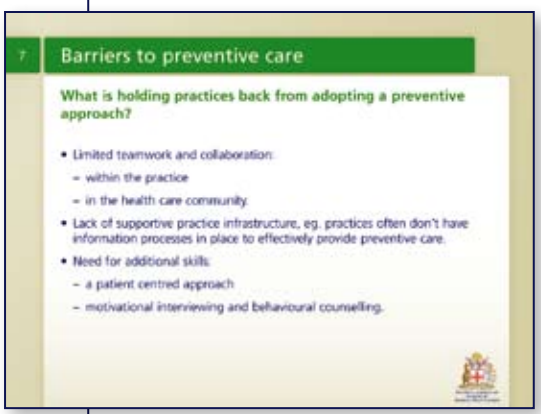


Slide 6

SLIDE 6 Pre-course activity

The practice prevention inventory, which forms the pre-course activity, is a useful tool to help assess current performance in prevention and plan prevention activities. The planning activity will be undertaken as part of the post-course activity.

Discussion will be based on participants' responses to the inventory. It will also identify particular areas of interest for the group.



Slide 7

SLIDE 7 Barriers to preventive care

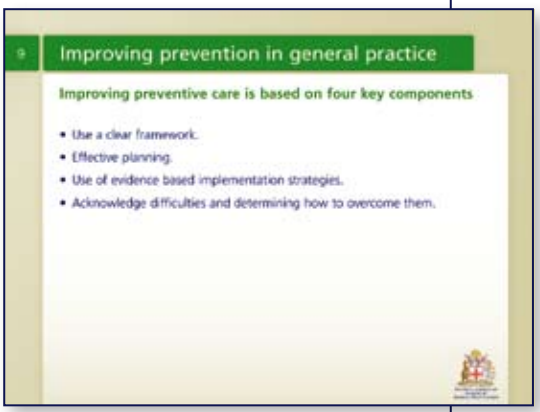
Evidence suggests that work pressures, time constraints, limited teamwork (either within the practice or in the health care community) and lack of a supportive infrastructure (ie. deficient information management or IT systems) make it difficult for practices to adopt a preventive approach in their daily practice. General practitioners may also require additional skills or knowledge in adopting a patient centred approach and in motivational interviewing or behavioural counselling techniques. The ability to provide preventive care is also constrained by financial incentives and arrangements that do not enhance quality service.

Slide 8

SLIDE 8 For discussion

SLIDE 9 Improving prevention in general practice

Effective implementation of preventive care in general practice is based upon the use of an appropriate framework, clear and well defined planning processes, and the use of evidence based strategies. Improving prevention in general practice also requires acknowledging difficulties or barriers to change and determining how to overcome them.



Slide 9

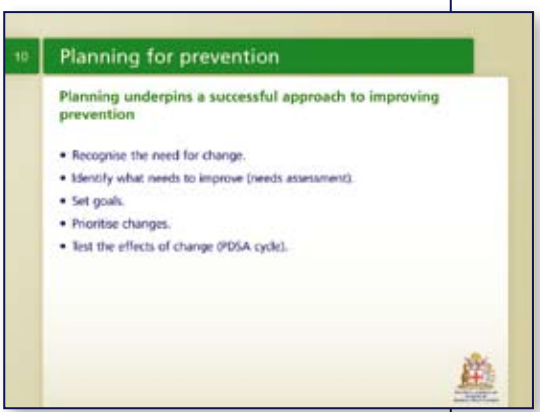
SLIDE 10 Planning for prevention

Planning underpins a successful approach to improving prevention for patients in general practice. The first step in planning for change is recognising the need for change. Next, identify the specific improvements that can be made and set goals.

Determine what needs changing by conducting a needs assessment, ie:

- Ask your patients about their prevention needs and priorities.
- Use the practice prevention inventory and plan (green book, *Appendix 1*) as a tool to assess your current performance in prevention. (This tool is similar to the one in the pre-course activity for this workshop.)
- Use case note audits to identify areas for improvement.
- Use your practice team's knowledge and your patient register to identify practice prevention priorities.
- Gather and use population health data.
- Use or adapt a set of priorities identified by a reputable source.

Your division of general practice can help with a needs assessment. The information obtained should be discussed with your practice team and together prioritise the changes you want to make. The next step is to test the effect of making a change and whether it leads to improvements. The 'plan, do, study, act' (PDSA) cycle can be used to monitor the effects of change.



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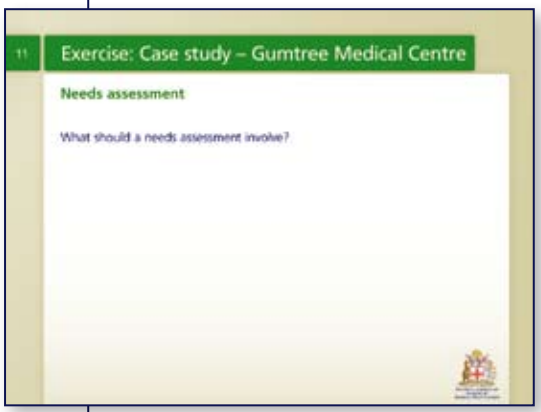


Slide 11

SLIDE 11 Exercise: Case study – Gumtree Medical Centre

Scenario

The practice team at Gumtree Medical Centre is concerned that existing services and strategies are not adequately meeting the preventive care needs of their patients. To address this concern, the practice team decides to conduct a needs assessment to identify practice prevention priorities with the aim of improving preventive care services within the practice.

Question

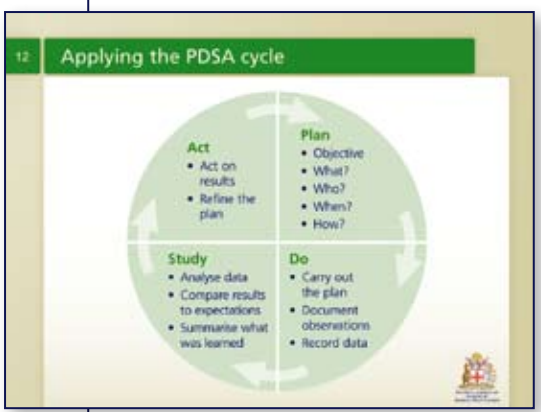
What should the needs assessment involve?

Answer

The needs assessment should involve (for example):

- a patient survey to ask patients attending the practice about their prevention needs and priorities. (green book, *Appendix 4* provides a sample survey)
- a case note audit to assess the current provision of preventive care and areas for improvement
- consultations with practice team members to determine what they perceive as practice prevention priorities.

Note to facilitator: The sample answers provided are examples only. There are several ways to approach the answers to the discussion points, so although the sample answers presented here are helpful, they are not the only correct answers.



Slide 12

SLIDE 12 Applying the PDSA cycle

The PDSA cycle consists of a sequence of four repeatable steps: plan, do, study and act. The 'plan' stage involves developing a plan for improving a process:

- What is the objective or aim of the project?
- What do you want to achieve, what actions are required and in what order?
- What resources are required?
- Who will be responsible for each step?
- When will each step be completed?
- How will the effects of change be measured?

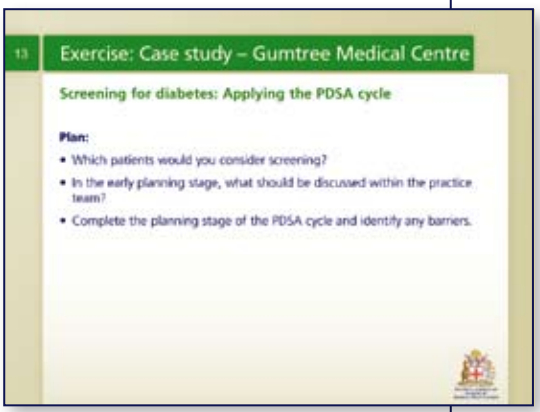
The 'do' stage is an experimental or pilot stage where the plan is put into practice and the effect of the change tested by the collection of data.

In the 'study' stage the results of the experiments are evaluated:

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

The 'act' stage is used to act on what was learned and make any adaptations or improvements or to acknowledge and celebrate successes.

SLIDE 13 Exercise: Case study – Gumtree Medical Centre



Slide 13

Scenario

The needs assessment conducted by the Gumtree Medical Centre shows that diabetes is considered a priority area by patients and that the practice could improve on prevention activities for diabetes. Therefore the practice team decides to implement a program to screen for diabetes.

Question

Of the patients presenting to the practice for other reasons, which patients would you consider for screening?

Answer

The RACGP red book[1] indicates that:

- all patients should be screened every 3 years from 55 years of age. Women with previous gestational diabetes and people aged 45 years and over with a first degree relative with type 2 diabetes should also be screened every 3 years
- those at high risk should be screened every 12 months. This includes patients with impaired glucose tolerance or impaired fasting glucose; Aboriginal and Torres Strait Islander peoples 35 years and over; high risk culturally and linguistically diverse groups aged 35 years and over (specifically Pacific islander peoples, people from the Indian subcontinent or of Chinese origin); people 45 years and over who have obesity and/or hypertension; all people with clinical cardiovascular disease; and women with polycystic ovarian syndrome who are obese.

Scenario

A team meeting is organised to discuss how the diabetes screening program will be implemented.

Question

In the early planning stage, what should be discussed within the practice team?

Answer

- What are the benefits of a screening program for diabetes for our patients, and for us?
- What are our goals?
- What changes do we need to make, and in what order?
- Who will be responsible for each step?
- What are the barriers to implementing a screening program for diabetes?
- What would facilitate implementing a screening program?

Question

In your participant guide, outline a plan for implementing a diabetes screening program in general practice.

Answer

Objective: To implement a diabetes screening program in at risk patients.

Achieve: Develop procedures for screening for diabetes.

Actions: There are a number of possible ways this could be done:

- develop procedures and reminder systems for GPs to assess risk
- use of practice prevention survey
- use of Diabetes Australia 'tick test'
- systems for recording which patients have been screened
- clarification of roles and responsibilities
- follow up procedures and management of patients where required.

Resources:

- Training is provided to practice nurses and GPs to enhance skills in this area. In addition to diabetes specific training, this may also include motivational interviewing and behavioural risk factors.
- Local pathways for diabetes care will be investigated to assist with referrals.
- Resources will be on hand, eg. Diabetes Australia consumer information, Lifescripts and the *SNAP guide*.
- The *Diabetes Australia/RACGP handbook, Diabetes management in general practice* may also be useful.

When: The initial phase will be a 1 month period followed by review.

Who:

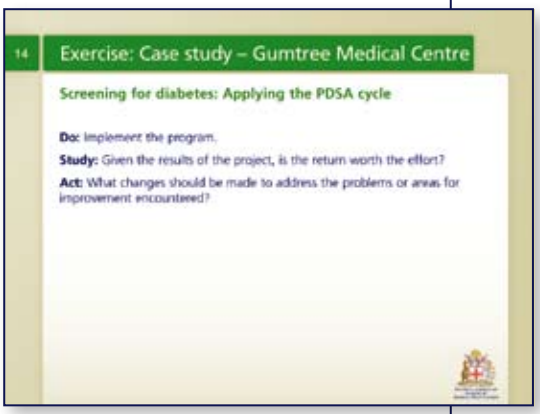
- Reception staff will ask eligible patients to complete a survey and record those who have completed it.
- GPs will be responsible for screening at risk patients.
- Practice nurses will provide support and advice to patients diagnosed with diabetes or prediabetes, or those considered at risk due to other factors (eg. SNAP factors).

How: Program success will be measured by proportion of patients screened.

Possible barriers:

- Lack of time during consultations to incorporate preventive screening, as well as conflicting preventive priorities (eg. smoking, physical activity, weight).
- Cost and availability of referral services for patients.
- Increased workload – follow up requirement for patients with raised fasting blood sugar, increased demand on GPs and practice nurses for behavioural advice.
- Willingness of patients to return to practice/laboratory for fasting blood test.

SLIDE 14 Exercise: Case study – Gumtree Medical Centre



Slide 14

Scenario

The program was implemented. The practice team decided to use the Diabetes Australia 'tick test' as an initial screening test. Reception staff flagged patients aged 45 years and over, and asked them to complete the test while waiting to see the GP. The patient then took it with them into the consultation. The receptionist noted on the patient's record that the test had been completed. The GP then reviewed the test and discussed the need for fasting blood sugar tests with the patient where required.

After 1 month, the practice team met to review the program's success, discuss their experience, and whether there has been any improvement. The number of patients screened, diagnosed with diabetes and prediabetes during the month was noted. While the number of diabetes diagnoses was low, there were a number of patients with prediabetes or those with negative screening test but identified risk factors. The patients had generally been receptive to the proactive approach to screening, however, some had not been willing to return for a blood test. The GPs reported that it was often difficult to discuss diabetes due to time constraints, as the patient was presenting for other reasons. In many cases, other risk factors were indicated which required advice (ie. weight loss and physical activity), and although this was a good opportunity to raise it, time was again an issue.

It was also noted that patients aged 35–45 years and considered at high risk were not included in the screening. As the risk for these patients is based on ethnic background, it was not easy to select patients for the screen tick box.

The practice nurse was concerned that they collected useful information that was not always recorded on the patient's health summary and that it would be useful to flag patients for follow up in 12 month or 3 years as necessary.

It was noted that both GPs and practice nurses had experienced an increased workload due to the number of patients who required advice on diet, weight loss and physical activity.

Question

Is the return worth the effort?

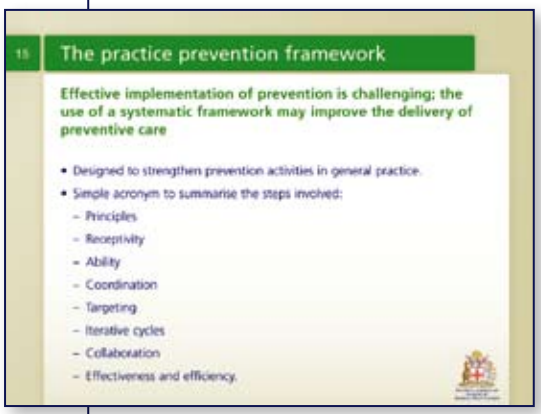
Question

What changes could be made to address the problems encountered or areas for improvement?

Answer

- To address time constraints, it was noted that GPs could ask the patient to make another appointment to discuss this, where possible in the morning so he/she could have a fasting blood tests taken when he/she attended. It was agreed that referrals to the practice nurse for advice on behavioural risk factors would also be an effective way to manage time issues and ways that nurses could free up time were discussed.

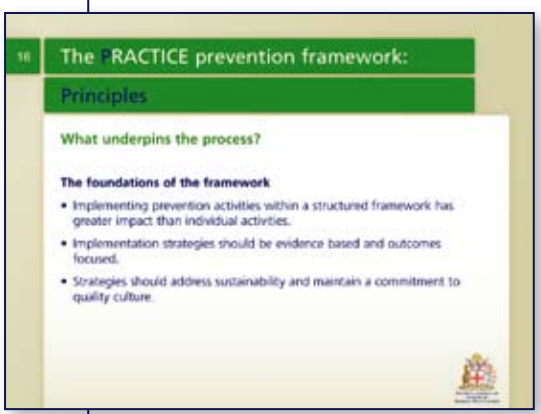
- Rather than ask all patients aged 35–45 years to complete the test, GPs decided to remain aware of the increased risk in this age group and discuss diabetes with those patients who may be at risk. To assist in this process, the practice team decided to discuss recording self identified cultural background at a future meeting.
- Waiting room posters were developed to support the tick test and be a prompt to patients, who may be in the younger age group, to raise the issue with the GP.
- Where GPs did not have time to record additional information in the health summary, it was decided that they would pass the tick test back to the practice nurse/receptionist so that this information could be recorded.
- A section was added to the tick test for the GP to complete which enabled the practice register to be updated so that patients were flagged for review in 12 months or 3 years as required.
- The practice nurses agreed to develop a set of resources for patients that could support behavioural advice. This includes the RACGP *SNAP guide*, Lifescripts resources, and Diabetes Australia patient information. The practice also decided to engage with their local division of general practice to access their diabetes resources, and prepare a referral directory for dieticians, exercise programs, diabetes educators and other support services.
- After implementing these changes, the practice agreed to meet in 1 month to review the process.



Slide 15

SLIDE 15 The PRACTICE prevention framework

Implementation of preventive care can be challenging. The 'PRACTICE' prevention framework has been designed to strengthen prevention activities in general practice. PRACTICE provides a simple acronym to summarise the steps involved in the framework. The core elements of the PRACTICE prevention framework are principles, receptivity, ability, coordination, targeting, iterative cycles, collaboration, effectiveness and efficiency. Consideration of these elements will facilitate improvements in the delivery of preventive care.



Slide 16

SLIDE 16 The PRACTICE prevention framework – Principles

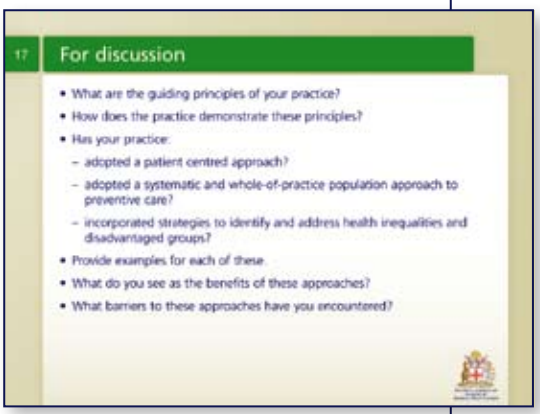
The evidence suggests that implementing prevention activities within a structured framework has greater impact than individual activities.

The PRACTICE framework guiding principles include the use of evidence based and outcomes focused prevention programs. Prevention strategies should also address sustainability and maintain a commitment to quality care.

Examples of principles that can be adopted within a prevention program include:

- a patient centred approach which is associated with improved patient outcomes

- a systematic and whole of practice population approach, eg. does the practice identify and target all patients eligible for a specific prevention activity through using a prevention questionnaire to identify prevention needs and assist in planning
- strategies to identify and address health inequalities and disadvantaged groups, as there is evidence that contextual factors are important determinants of how preventive care is taken up.



Slide 17

SLIDE 17 For discussion

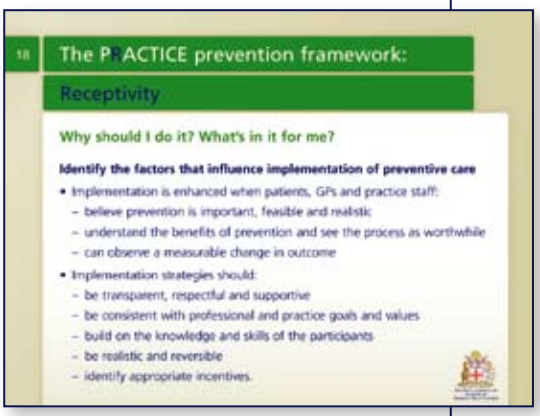
SLIDE 18 The PRACTICE prevention framework – Receptivity

Receptivity to change can influence the implementation of preventive care. Receptiveness is often overlooked and needs to be considered from the perspective of all those involved in the program. Patients, GPs and practice staff are more likely to be involved in the implementation of preventive care if they:

- believe prevention is important, feasible and realistic
- understand its benefits and see it as worthwhile, and
- can observe a measurable change in outcome.

To enhance the receptivity of the key players involved in preventive care, implementation strategies should be transparent, respectful (of participants' abilities, skills and workload) and be conducted in an open and supportive manner. Activities implemented without discussion or the active engagement of all participants is less likely to succeed. The implementation strategies used to deliver preventive care should also be consistent with professional and practice goals and values and build on the knowledge and skills of the participants.

Patients are generally more satisfied when prevention activities are included and addressed in the consultation.



Slide 18

SLIDE 19 For discussion

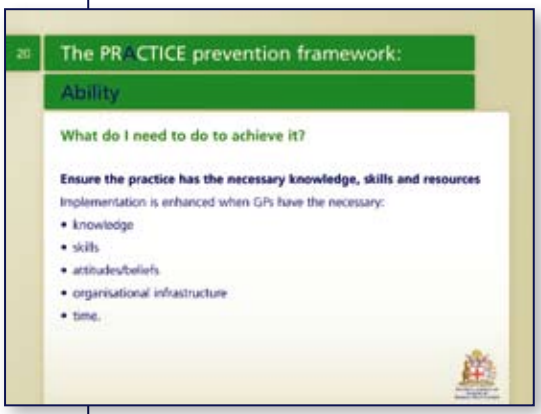
Question

What could you do to increase receptivity for GPs, staff and patients?

Answer

- Discuss planned activities with all participants and ask for feedback.
- Give practice nurses dedicated time for planning and implementing prevention activities.
- Provide GPs with adequate training and the necessary resources.
- Use motivational interviewing skills to increase patient receptivity.

Slide 19



Slide 20

SLIDE 20 The PRACTICE prevention framework – Ability

The implementation of preventive care requires the GPs and practice staff involved to have the necessary knowledge, skills, attitudes or beliefs, organisational infrastructure and time to successfully introduce change.

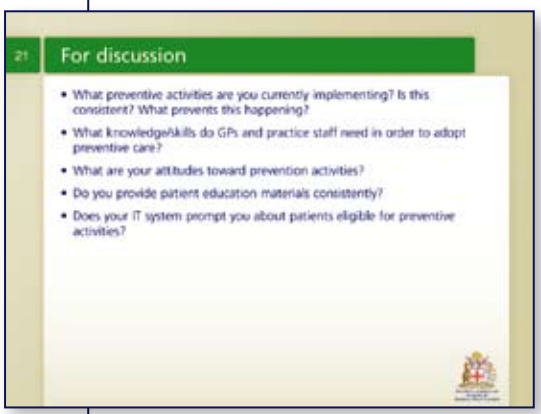
Knowledge of effective and efficient prevention strategies alone is not sufficient – GPs and practice staff must also have the knowledge of how to make change happen and to ensure that the process is maintained.

Skills integral to the implementation of preventive care in general practice include motivational interviewing and behavioural counselling.

Evidence suggests that positive GP and practice staff attitudes and beliefs about preventive care are associated with improved performance.

Organisation infrastructure supportive of the implementation of preventive care includes:

- well defined practice policies, such as on the role of the practice nurse, or the use of clinical software to manage information
- the availability of appropriate resources (eg. a practice nurse) including allocation of the time required to plan and implement prevention
- a range of delivery options (eg. delegation to a practice nurse, referral options)
- effective information management and IT systems
- screening and information gathering material (eg. surveys)
- waiting room and consultation patient education materials.



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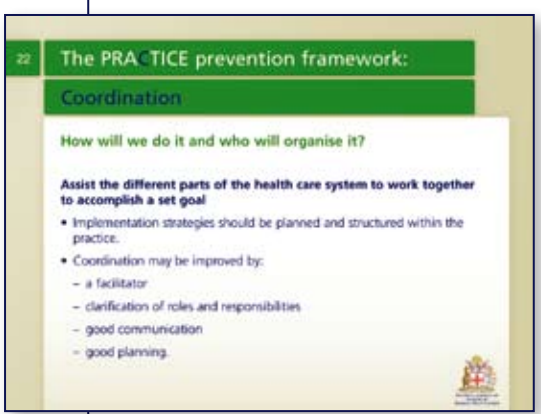
SLIDE 21 For discussion



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SLIDE 22 The PRACTICE prevention framework – Coordination

Coordination involves the processes and activities that help various groups work together effectively (in harmony) to accomplish a set goal. Coordination of prevention activities can be improved in general practice by:

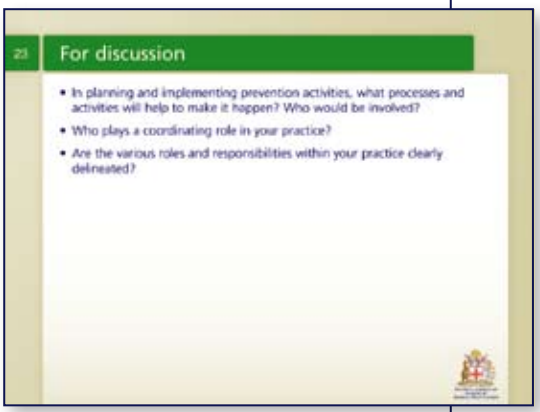
- the presence of a facilitator
- the clarification of roles and responsibilities
- good communication, ie. by keeping all staff informed
- sufficient planning.

The facilitator may require specific time to be allocated, eg. providing a practice nurse with dedicated time outside of patient contact time. This time may ultimately be funded through increased patient activity.

Example

Practice accreditation is almost invariably an activity where a coordinator is involved to oversee all the relevant tasks and activities.

SLIDE 23 For discussion



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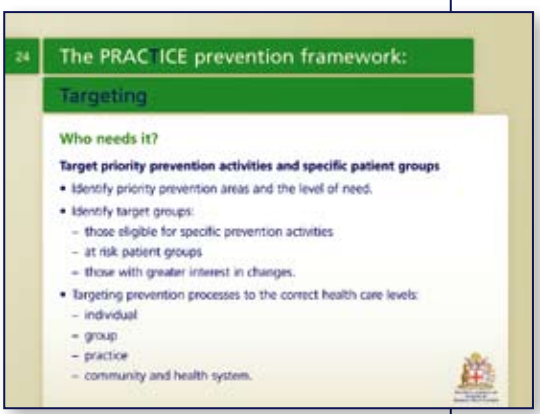
SLIDE 24 The PRACTICE prevention framework – Targeting



Slide 24

Targeting involves identifying priority prevention activities and establishing the level of need. It has been estimated that providing all the recommended high quality preventive care tasks for patients would add approximately 7.4 hours to the day of already busy doctors.[2] As GPs have limited time with each patient, it is important that each activity is based on sound research evidence of what is actually effective.

The prioritisation of prevention activities is influenced by a range of factors such as the burden of illness, frequency, the ability to alter the outcome, feasibility, professional values, cost effectiveness and preferences. The RACGP red book may assist in identifying and targeting prevention activities.

Specific patient groups should also be targeted. Target groups can include those eligible for specific prevention activities, those at higher risk and those who express greater interest in making changes. Targeting priority patients is particularly important because preventive care reduces health inequalities in disadvantaged groups and in patients with chronic disease and/or at risk behaviour. One method of establishing both patient need and eligibility for prevention activities is to ask patients to complete a prevention survey while waiting to see a GP. A sample is provided in the green book (*Appendix 4*).

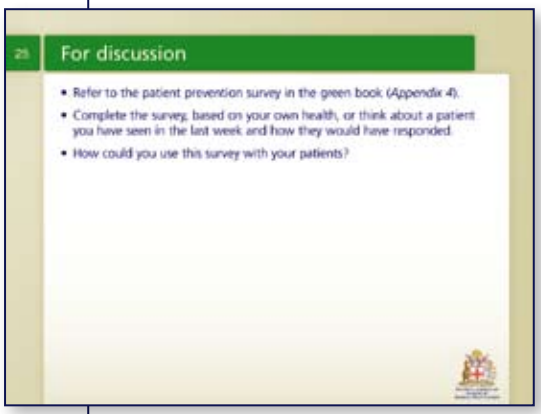
Although opportunistic prevention interventions can reach individuals attending the practice, this approach cannot target all patients eligible for a prevention activity. Planned interventions in the general practice setting encompass a more targeted approach.

Prevention activities should be targeted to the correct level of the health care system. Making changes at one level without paying attention to other levels is less likely to be associated with successful implementation. Implementation needs to be targeted to each of the following levels:

- the individual (eg. education, skills development, feedback)
- the group (eg. team development, clinical audit)
- the organisation (eg. organisation culture and development)
- a larger system (eg. accreditation, payments systems/incentives, national bodies, availability of services).

Tip

Smoking information is usually recorded in the health summary, however, if a GP records it as an active health problem, it will be more prominent and remind the GP to raise the issue.[3]



Slide 25

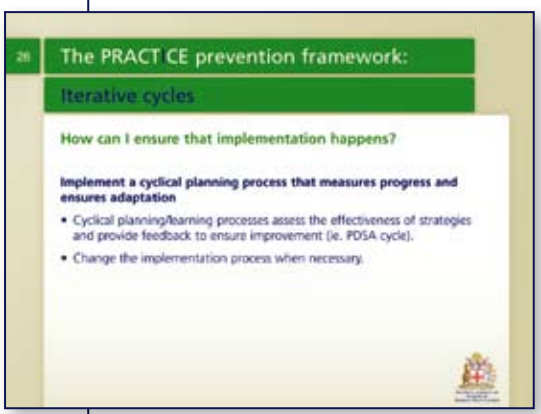
SLIDE 25 For discussion

Question

How could you use a prevention survey with your patients?

Answer

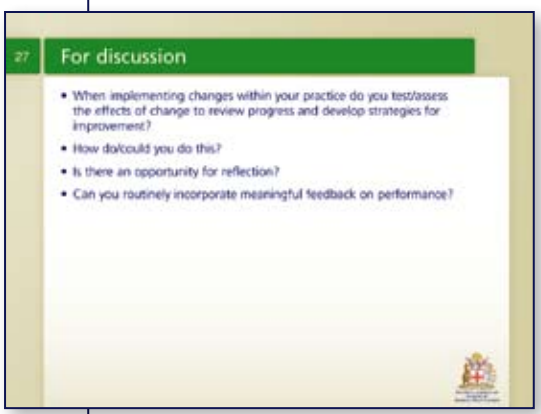
- Ask patients to complete a prevention survey in the waiting room and enter the details into the electronic record.
- Use the prevention survey in consultations.
- Practice nurses could go through the survey with patients before seeing the GP.



Slide 26

SLIDE 26 The PRACTICE prevention framework – Iterative cycles

No-one gets it right the first time. Trial and error, with the associated measurement, evaluation and feedback are essential to determine whether implementation strategies have been effective or to identify barriers to implementation. These processes create a learning cycle that will (hopefully) result in the development of more effective implementation strategies.



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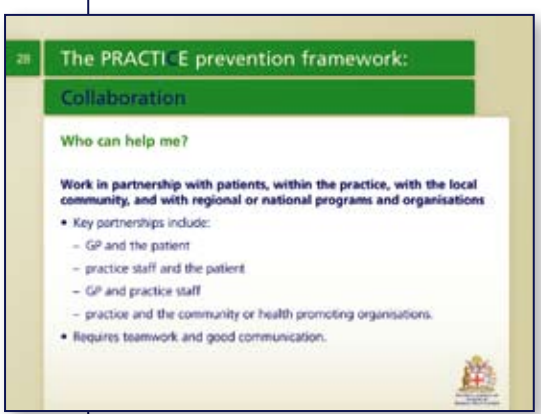
SLIDE 27 For discussion



Slide 28

SLIDE 28 The PRACTICE prevention framework – Collaboration

Partnerships and collaboration operate at different levels within the health care system between:

- GP and patient
- practice staff and patient
- GP and practice staff, and
- the practice and the division of general practice and/or the broader community, other health professionals and agencies.

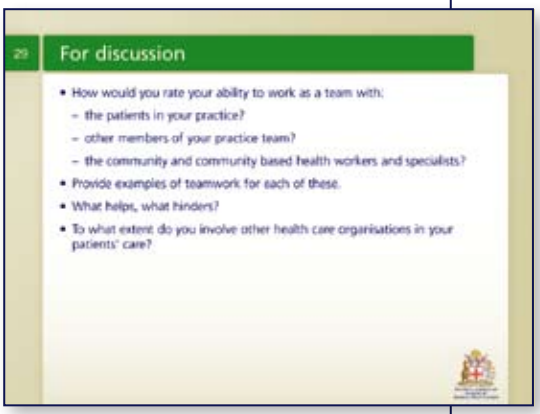
There is evidence that when GPs regard patients as active partners in their therapy, patients are more likely to adhere to treatment plans. This requires working together and having respect for others' ideas and views.

The evidence suggests that communicating with and referring patients to certain services and community agencies may be the most cost effective way of providing some types of prevention activities for patients.

Teamwork is important in collaboration and can be built by:

- providing sufficient support and resources
- shared vision, planning and goals
- ensuring team members have clear roles and responsibilities
- effective communication strategies.

SLIDE 29 For discussion



Slide 29

SLIDE 30 The PRACTICE prevention framework– Effectiveness and Efficiency

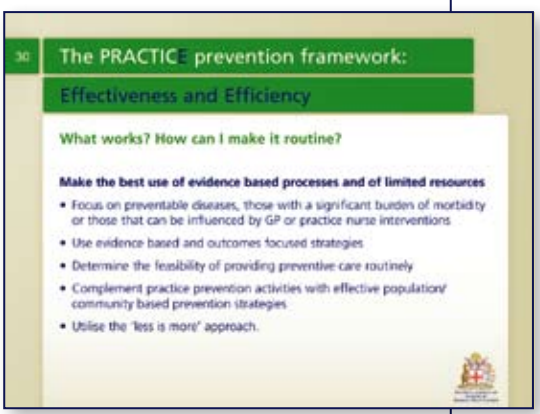
Preventive care is more effective and efficient when adopted in a strategic way.

The focus should be on preventable conditions, those that have a significant burden of morbidity and those that can be influenced by actions of GPs or practice nurses. The RACGP red book can be used as a guide to who is most at risk and the screening or preventive care that is most appropriate.

General practitioners should also use an approach that has a theoretical rationale or is outcomes focused.

Practices should also consider how feasible it is for them to provide preventive care in their daily practice. It is simply not possible for GPs and practice staff to provide all of the recommended prevention services. Therefore, practices need to decide where to focus their attention in order to deliver the best possible outcomes for patients with the resources available.

Practices should complement their prevention activities by utilising effective, efficient population or community based prevention strategies, eg. population registers such as the immunisation register and media strategies for issues such as smoking cessation and hazardous drinking.



Slide 30

SLIDE 31 Case study: Influenza vaccination

Scenario

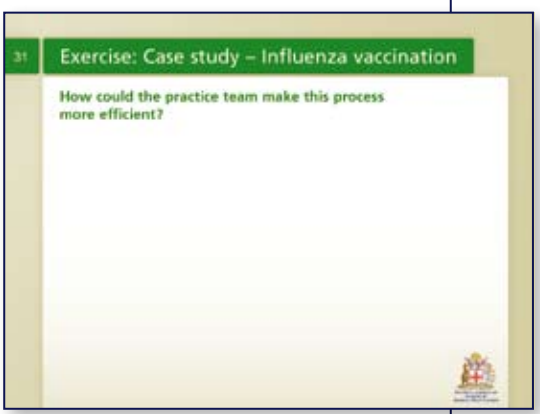
Gumtree Medical Centre routinely sends out influenza vaccination reminders to all patients aged over 65 years in February/March each year. Administratively, this is time consuming and postage costs are high. The practice team meets to discuss whether this can be done more efficiently.

Question

How could the practice team send out influenza vaccination reminders more efficiently?

Answer

- An electronic reminder could be used as a prompt when patients visit the practice for other reasons.
- Waiting room posters and information may also prompt patients to raise the subject.
- Practice staff can record flu injection status in a practice register. After the initial rush, reminders can be sent to the remainder of patients in April/May. This will be a significantly smaller mail out.



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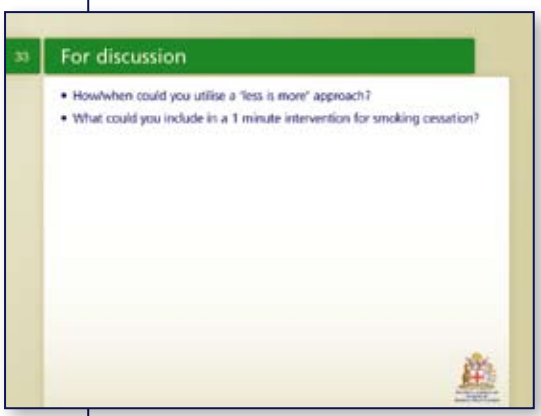

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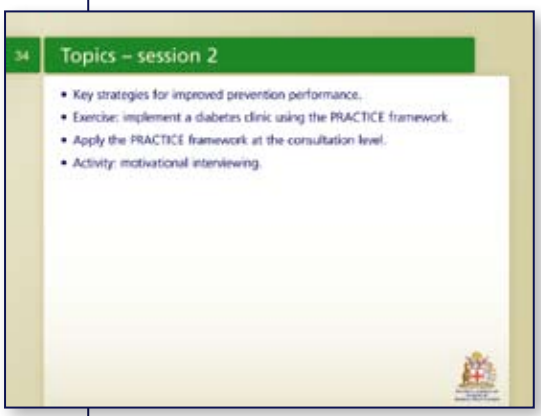


Slide 34

SLIDE 32 'Less is more': the reality pyramid

SLIDE 33 For discussion

Question

What could you include in a 1 minute intervention for smoking cessation?

Answer

Brief intervention:

ASK

Discuss smoking status.

ASSESS

Assess motivation to quit and nicotine dependence.

Affirm decision to quit.

ADVISE

Provide brief advice and support.

ASSIST

Offer self help materials.

ARRANGE

Negotiate a separate smoking cessation appointment.

Refer patient to Quitline.

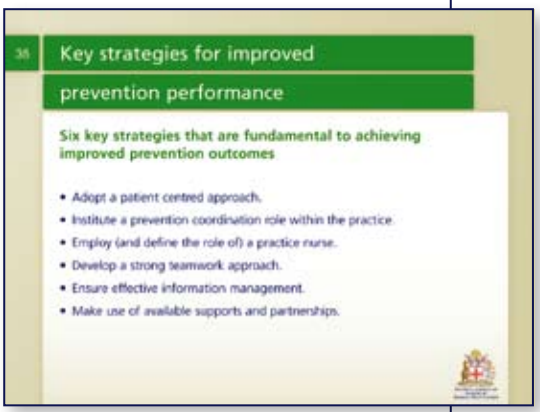
Lifescripts resources (assessment tool, prescription and 5As guidelines) can assist health professionals to conduct brief smoking interventions, and the *SNAP guide* provides a summary of the 5As. The Cancer Council SA also has a range of useful smoking cessation materials for GPs (see www.quitsa.org.au/aspx/health_professionals.aspx).

SLIDE 34 Topics – session 2

At the completion of this session, you will be able to:

- identify key strategies for improving prevention outcomes
- use the PRACTICE framework to develop a prevention plan
- understand the application of the PRACTICE framework at the consultation level
- use the 5As approach to conduct brief interventions
- use motivational interviewing techniques.

SLIDE 35 Key strategies for improved prevention performance



Slide 35

The *Putting prevention into practice* guidelines nominate six key strategies that are fundamental to achieving improved prevention outcomes:

- adopting a patient centred approach
- instituting a prevention coordination role within the practice
- employing (and defining the role of) a practice nurse
- developing a strong teamwork approach
- ensuring effective information management, and
- making use of available supports and partnerships.

Adopting a patient centred approach is associated with improved patient outcomes. Key elements include:

- actively involving the patient in the consultation
- encouraging patient autonomy
- encouraging a greater patient role in decision making
- supporting patient self management, and
- adopting a more holistic approach to clinical care that includes and values prevention.

Coordination of preventive care is needed to ensure that the organisational infrastructure supports high quality care. A practice prevention coordinator may assist in the implementation of the prevention plan, in the clarification of roles and responsibilities and support and foster teamwork within and outside the practice.

The employment of a practice nurse may reduce the GP's workload and provide more rapid access to care for patients, however, there is much more to a practice nurse's role than clinical care alone. Although the role of practice nurses varies in general practice, practice nurses may:

- be responsible for the management, coordination and higher level administration of clinical activities (eg. managing recall and reminder systems and patient registers, patient education materials and patient surveys)
- provide administrative support to the general practice as a business
- develop effective communication within the practice and between the practice and outside organisations and individuals.

Practice nurses may be cost effective as they can be supported through a range of Australian Government incentive programs including the Practice Incentives Program (PIP) Practice nurse incentive, asthma cycle of care, diabetes program, 45 year old health check, 75+ health assessment, Aboriginal and Torres Strait Islander peoples health assessment, the Nursing in General Practice Training and Support initiative and training scholarships. The Australian General Practice Network (AGPN) provides business case models and financial models for employing practice nurses on its website.[4]

A strong teamwork approach involves all participants accepting responsibility for progress in achieving a specific goal. It is important that each team member:

- understands the goal
- understands his/her role in contributing to the achievement of the goal and are confident in his/her skill levels
- understands the processes for sharing necessary information and problem solving, and know that these processes will work
- respects, and cooperates with, other team members
- has access to a supportive environment (eg. good systems infrastructure, support from their division of general practice, accessible and relevant training programs).

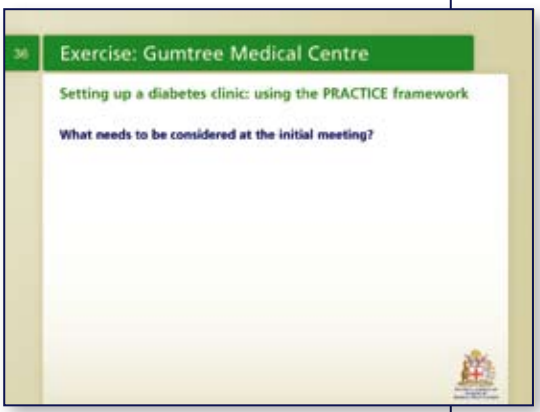
Effective information management creates value for the general practice as a business entity as well as improving patient care. Benefits from effective information management include:

- delivery of more consistent and better quality of patient care (eg. reminders and screening)
- reduction of the potential for medical errors (eg. improved accuracy and organisation of information)
- improved efficiency (eg. saves GP time)
- improved communication between GPs, patients and the health care system (eg. record linkages, patient education)
- improved access to care (eg. telehealth)
- improved access to information (eg. the internet)
- improved clinical decision making (eg. via access to high quality information, such as Cochrane reviews)
- acceptable for patients
- reduced costs.

It is important to make the best possible use of available supports and partnerships, including your division of general practice, as they may be able to assist you with implementing preventive care.

Payment incentives also are one of several motivators for strengthening prevention activities in general practice. Practices should be aware of the full range of government funded initiatives that can support prevention practice. Further information is available from Medicare Australia at www.medicareaustralia.gov.au/providers/incentives_allowances/index.shtml.

SLIDE 36 Exercise: Gumtree Medical Centre



Slide 36

Scenario

Some time after the successful implementation of the diabetes screening program, the Gumtree Medical Centre decides to investigate the possibility of starting a diabetes clinic in order to provide additional services to patients with diabetes.

Question

What needs to be considered at the initial meeting?

Answer

Principles

- What would be the benefits of a diabetes clinic for our patients and for us?
  - What do we want to achieve?
  - Is it feasible, sustainable, and congruent with the practice philosophy?
  - Is this of interest to the practice?

Receptivity

- Is the strategy congruent with practice goals and staff views?
- Do we have the resources required?
- How will we measure success?
- What partnerships can we build to help this?
- What are the benefits to staff? Patients?
- What are the barriers to starting and running a diabetes clinic?
- How would we engage patients?

Ability

- What would facilitate starting a diabetes clinic?
- What knowledge, skills and abilities do staff need?
- What changes do we need to make, and in what order?
- How can we make the best use of our IT system?
- How can we expand our capacity to incorporate this into our practice?
- What training will staff need?
- What additional resources will we need?

Coordination

- Who will facilitate setting up the clinic?
- What is our plan?
- Who will be responsible for each step?
- How can we communicate as a team?

Targeting

- How will patients be referred to the clinic?
- Does our IT system allow us to identify patients with diabetes? How would a recall system work?

Iterative process

- How will we review the clinic?
- What feedback mechanisms will we use?
- How will we overcome barriers?

Collaboration

- How can we make best use of our own skills?
- How can we make use of other health professionals?
- What supports are available from the division and other sources?

Effectiveness

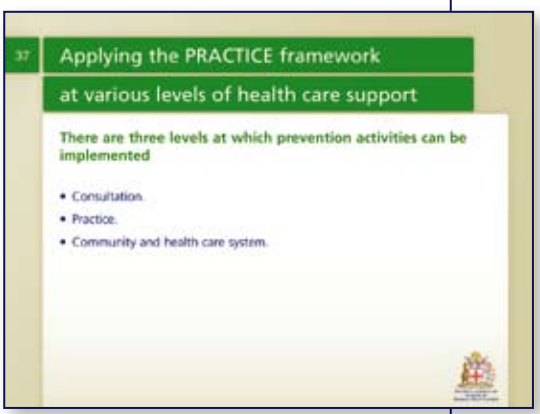
- What evidence based implementation strategies can we use?
- How can we embed this in our routine (eg. routine referral to the clinic)?
- How can IT be used to best advantage?

Applying the PRACTICE framework 04

SLIDE 37 Applying the PRACTICE framework at various levels of health care support

Prevention activities can be implemented at each of the following levels:

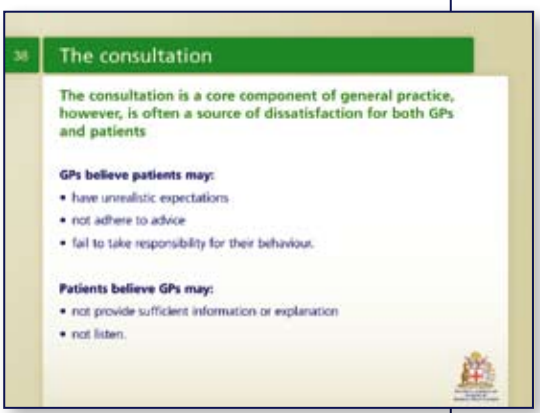
- consultation
- practice
- community and health care system.



Slide 37

SLIDE 38 The consultation

The consultation is a core component of general practice. Most are effective and run smoothly, however, the consultation can be a cause of disappointment for both GPs and patients. Many GPs express dissatisfaction when patients have unrealistic expectations, do not adhere to medical advice or fail to take responsibility for their own behaviour. Patients also express frustration when they feel they have been provided with insufficient information or explanation about their condition or treatment, when they feel that the doctor is not listening or when they disagree about the problem.



Slide 38

SLIDE 39 For discussion

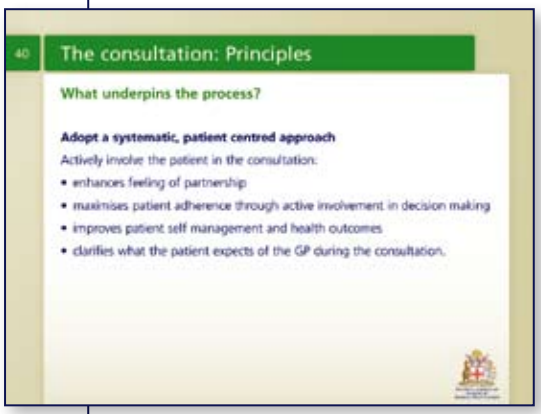
Question

Discuss strategies to address/avoid dissatisfaction.

Answer

- Training to improve GPs' communication skills.
- Ensure both GP and patient is actively involved in the consultation and listening to each other.
- Provide patient information to educate patients about their illness if there is insufficient time to discuss.
- Empower patients to be in control of their health.
- GPs accept that patients don't always follow advice, and assist with patient motivation and adherence.

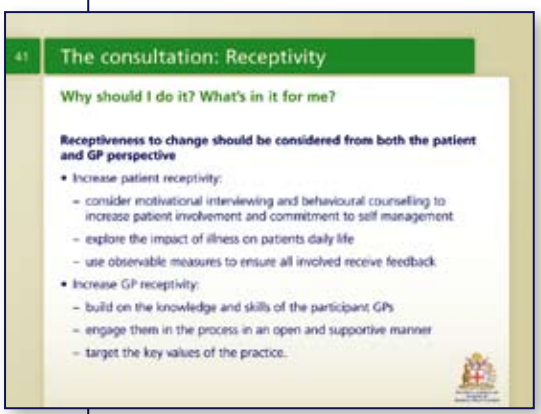
Slide 39



Slide 40

SLIDE 40 The consultation – Principles

The central principle for prevention in the consultation is to adopt a patient centred approach. The GP should aim to actively involve the patient in the consultation through shared mutual problem identification, solution development, goal setting and decision making, whenever possible. This approach can enhance the feeling of partnership between the GP and patient, can maximise patient self management and adherence, may improve patient outcomes and helps to clarify expectations of both the patient and GP during the consultation.



Slide 41

SLIDE 41 The consultation – Receptivity

Receptiveness to change and the need for preventive care should be considered from both the patient and GP perspective.

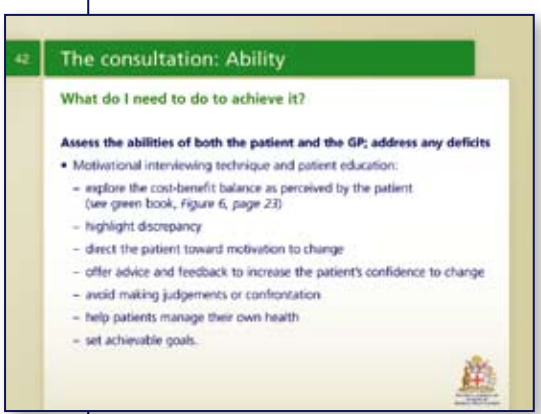
To increase patient receptivity, consider motivational interviewing and behavioural counselling to support patient involvement and commitment to improving and managing their own care and base self management strategies on the patient goals, wishes and capacities.

Explore how illness impacts on the patient's everyday life (including physical, mental, emotional and social effects) and work with the patient to support achieving better health and wellbeing as defined by the person in collaboration with the GP.

General practitioner receptivity to prevention strategies can be increased by building on the knowledge and skills of the participants, actively engaging them in the planning process and by targeting key values of the practice.

Example

The use of patient information and posters in the waiting room can facilitate patients to request prevention activities. This assists with the GP's ability, as it reduces time required during the consultation to initiate the prevention enquiry, and also increases the patient's receptivity, as it is the patient who has raised the subject.



Slide 42

SLIDE 42 The consultation – Ability

When considering introducing preventive care to the consultation, assess your own abilities and capacities, and ask about and facilitate your patient's abilities and capacities. One useful strategy is motivational interviewing strategies and patient education.

It is important to acknowledge that the patient's behaviour is their own personal choice – ambivalence, nonadherence and lack of acceptance of GP advice are normal and your patient's decision may be well researched. Patients are less likely to adhere to treatment if they perceive that there is little or no benefit to them or if the regimen is difficult to follow.

An effective initial approach is to allow the patient to decide how much of a problem they have by exploring both the benefits and costs associated with the behaviour. Change is more likely when a patient's behaviour conflicts with their values and what they want. The aim of

motivational interviewing is to encourage this discrepancy and increase a patient's motivation and confidence to change.

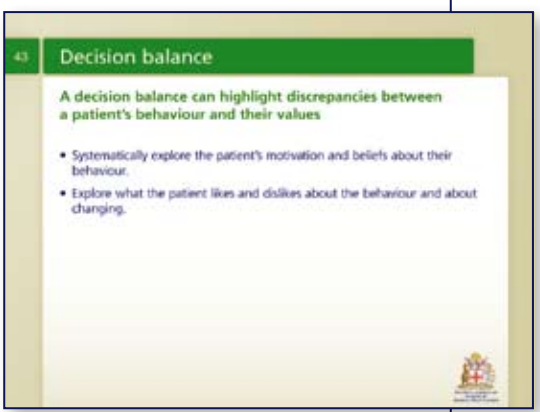
Patients should be encouraged to manage their own health, including lifestyle, health related behaviour and chronic diseases, in conjunction with the GP. An interactive patient centred discussion of the costs and benefits helps the patient understand their health condition, be involved in decision making, follow agreed plans for health care, monitor symptoms and manage the impact of the condition.

Strategies that promote better patient adherence include regular clarification and summarising of health information, the use of empathy and humour, simplification of the treatment regimen, receptivity to patient questions, listening to patient concerns and clear, concise and nonjudgmental advice. General practitioners should also make change incremental, achievable and realistic.

Above all, avoid arguments and confrontation. Making judgments or moving ahead of the patients can generate resistance and tends to entrench attitudes and behaviour. Accept that some patients may be contrary to suggestion.

SLIDE 43 Decision balance

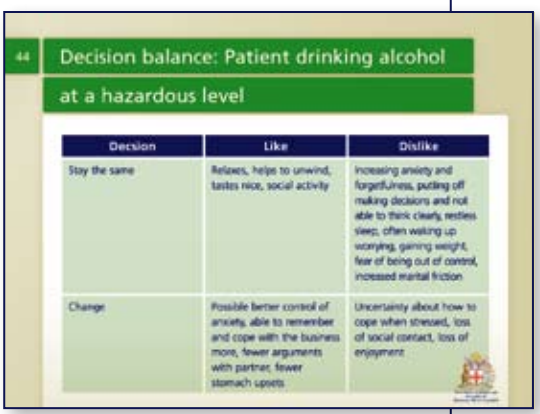
A decision balance is a useful tool to highlight discrepancy. It can be used to systematically explore a patient's motivation and their beliefs about a particular behaviour.



Slide 43

SLIDE 44 Decision balance: patient drinking alcohol at a hazardous level

The table shows an example of what a patient likes and dislikes about drinking at a hazardous level. Highlighting discrepancy encourages a sense of internal discomfort and helps to shift the patient's motivation.



Slide 44

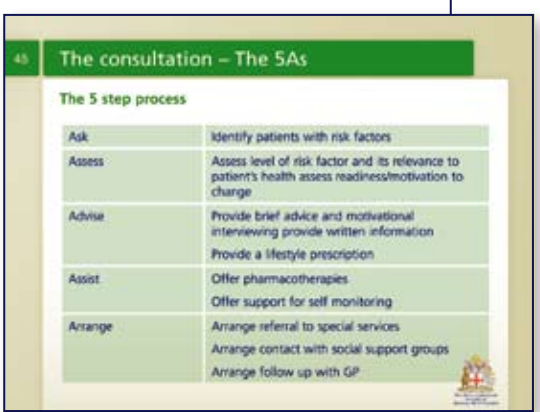
SLIDE 45 The consultation – the 5As

The 5A framework can help formulate lifestyle intervention strategies into activities that can be achieved in less than 1 minute or in 1–5 minutes.

The 5As framework includes:[5]

- asking every patient about their risk factors to identify those at risk
- assessing the level of risk and the relevance of the risk factor to the individual's health
- assessing the patient's willingness or motivation to change
- advising behavioural change by motivational interviewing, providing written information or a lifestyle prescription
- assisting patients with treatment and support
- arranging follow up contacts and referrals.

The *SNAP guide* and Lifescripts resources (assessment tools, prescriptions and 5As guidelines) can assist health professionals to conduct brief interventions on lifestyle risk factors.



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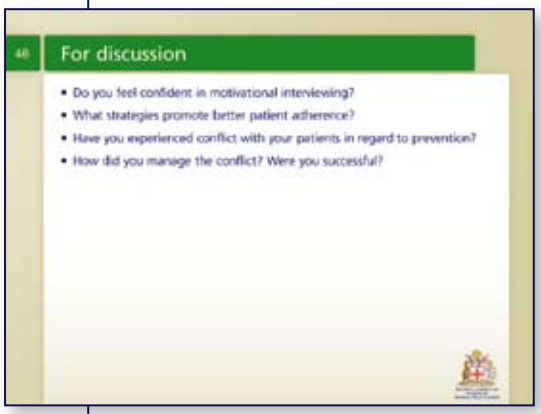

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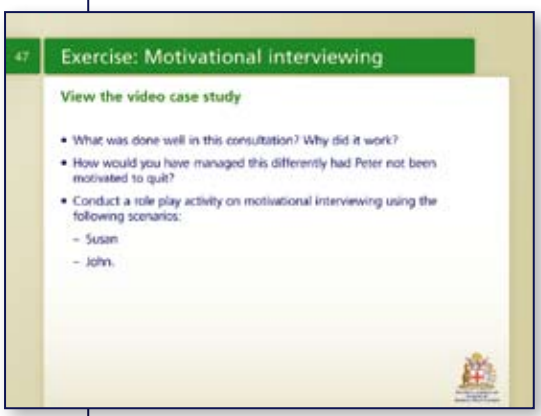


Slide 47

SLIDE 46 For discussion

SLIDE 47 Exercise: Motivational interviewing – video case study

Note: The video case study is the smoking example on the Lifescripts CD-ROM.

Question

What was done well in this consultation? Why did it work?

Answer

The GP used the 5As approach effectively:

Ask: The GP asked about smoking status and whether Peter was happy to discuss this. He also linked the presenting symptoms to smoking.

Assess: The GP assessed Peter's motivation and confidence in quitting, and discussed any barriers.

Advise: The GP advised Peter to quit, taking a nonjudgmental approach.

Assist: The GP assisted Peter by providing patient information and suggesting he contact the Quitline, and issued a Lifestyle prescription to provide a written summary of the discussion.

Arrange: The GP arranged a follow up appointment.

Question

How would you have managed this differently if Peter had not been motivated to quit?

Answer

- Avoid argument and confrontation.
- Explore both the benefits and costs associated with the behaviour as perceived by the patient.
- Explore with Peter how to increase his motivation and confidence to change.
- Avoid moving ahead of the patient as this can generate resistance and entrench attitudes and behaviour.
- Highlight any discrepancy, allowing the patient to make the connection (change is likely when a person's behaviour conflicts with their values and what they want – by encouraging this confrontation within the patient (not with the GP), a sense of internal discomfort may help to shift the patient's motivation).
- Offer brief advice on the risks of smoking and encourage him to consider quitting.

Using the following scenarios, conduct a role play with one person taking the part of the GP and another person taking the role of the patient.

Scenario

Susan, aged 32 years, is an office worker who presents with symptoms of tiredness and nausea. She lives alone and goes out drinking with friends or colleagues 4–5 times each week. She reports drinking about 5 drinks on each occasion, often more on weekends. She says that she does not enjoy being at home alone and goes out in order to stay in touch with people.

Answer

- Engage Susan in a discussion about her drinking levels, remaining nonjudgmental.
- Link Susan's symptoms to her lifestyle.
- Assess Susan's motivation and confidence to reduce her alcohol intake.
- Provide advice to reduce Susan's alcohol intake.
- Assist Susan by providing information and discussing ways that she can reduce her intake such as alternatives to drinking with friends and other social activities
- Arrange a follow up appointment.

Scenario

John, aged 57 years, was diagnosed with diabetes 2 years ago. He is overweight (BMI 31) and his blood sugar control has been inconsistent. He attends the practice infrequently and has not attended follow up appointments in the past. He presents complaining of fatigue and tells you that he is unable to keep up with his young grandchildren.

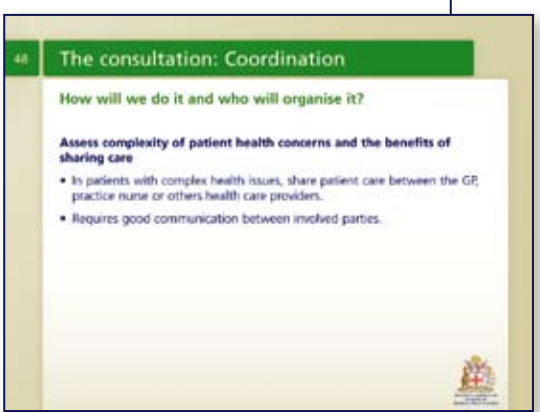
Answer

- Ask John about lifestyle factors such as diet, physical activity and diabetes management that may be affecting his health.
- Allow John to make the link between his fatigue and the poor management of his diabetes.
- Examine the benefits of improving John's lifestyle and improving his self management of his diabetes.
- Highlight any discrepancies.
- Assess John's level of motivation and confidence to change his lifestyle and manage his diabetes.
- Advise John to make changes to his lifestyle.
- Assist John with information on nutrition and diabetes self management.
- Arrange referral to additional services that may assist, eg. dietician, diabetes educator, exercise programs.
- Arrange a follow up visit.

SLIDE 48 The consultation – Coordination

Coordination issues in the consultation arise where patient care is shared between the GP, practice nurse and others external to the practice or when patients have complex health issues. The practice nurse is an excellent candidate for the role of prevention coordinator.

Effective coordination requires good communication between the parties, including adequate referral mechanisms and documentation, and a clear plan with clarification of roles and responsibilities.



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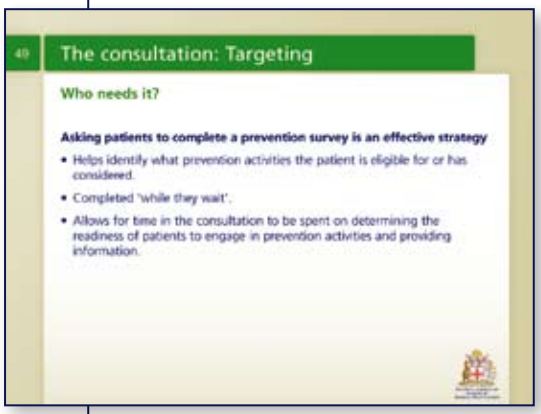

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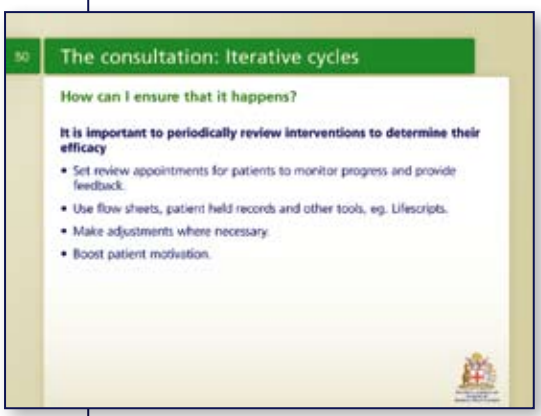

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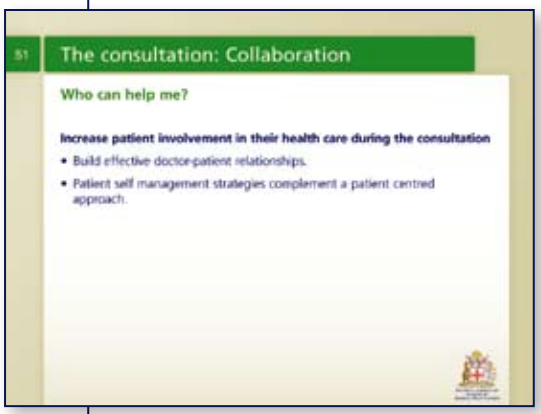


Slide 51

SLIDE 49 The consultation – Targeting

An effective strategy for effectively targeting priority patients for preventive care is to ask patients to complete a prevention survey in the waiting room before they see you. The time in the consultation is therefore better spent providing information, exploring concerns or negotiating for a separate appointment if the prevention issue is likely to take more time. As the time a patient waits to see the GP is a significant predictor of their level of satisfaction, getting them to provide you with this important information while they wait is beneficial.

The patient practice prevention survey included in the green book (*Appendix 4*) can be completed by patients in less than 5 minutes and contains appropriate prevention activities indicated by current evidence. You may also wish to directly ask patients whether they have considered particular prevention activities.

SLIDE 50 The consultation – Iterative cycles

It is important to periodically review prevention strategies to determine whether they are helping patients. Regular review appointments to monitor progress provide the opportunity for feedback and reflection. Most behaviour change involves a cyclical process with many patients relapsing after attempting to make changes. Patient motivation also fluctuates with time and may require boosters and additional discussion to clarify their interest in changing.

SLIDE 51 The consultation – Collaboration

Encouraging more active patient involvement and inclusion in the consultation has a number of benefits. There is clarification of what is expected of you by the patient and stronger patient autonomy, patient responsibility and patient self management. As a result, there is increased patient and GP satisfaction and better adherence to the agreed prevention activities and therapeutic regimens.

A number of factors contribute significantly to the building of effective doctor-patient partnerships:

- responding to affective cues
- being empathetic
- providing ongoing support
- ensuring open and clear communication.

These activities also contribute to the development of trust, which also contributes to greater patient satisfaction and adherence.

Patient self management strategies complement a patient centred approach. Key self management principles include:

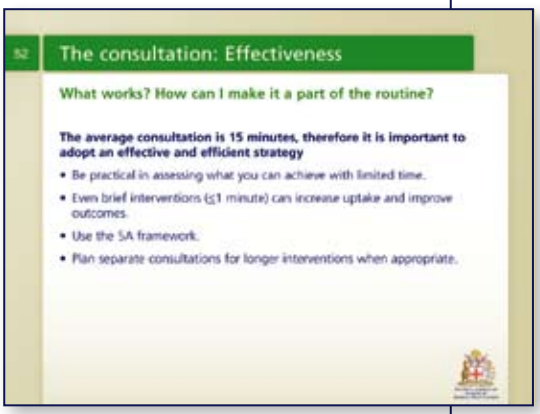
- engaging the patient in decision making and management of their illness, including working with them to set appropriate goals
- using evidence based, planned care
- improving patient self management support (eg. enlisting other health professionals and supports, and better linkages with community resources such as seniors centres, self help groups, skills and support programs)

- a team approach to managing care. Make use of GP Management plans and team care arrangements.

SLIDE 52 The Consultation – Effectiveness

The average general practice consultation takes around 15 minutes,[6] therefore it is important to choose a strategy that is likely to be both effective and efficient. It is vital to be practical in assessing what you can achieve in the limited time frame of a consultation. Think about what strategies will provide the best return on effort.

Remember that you can still achieve a significant amount with brief interventions. Evidence suggests GP recommendations or brief advice (even 1 minute or less) is one of the most potent influences on both patient intentions and prevention related behaviour and can increase uptake and improve outcomes. One minute interventions can be achieved using the 5A framework. Arrange separate consultations for problems requiring longer interventions when appropriate.

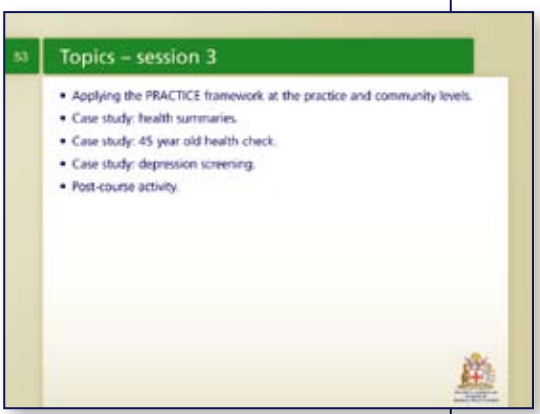


Slide 52

SLIDE 53 Topics – session 3

At the completion of this session, you will be able to:

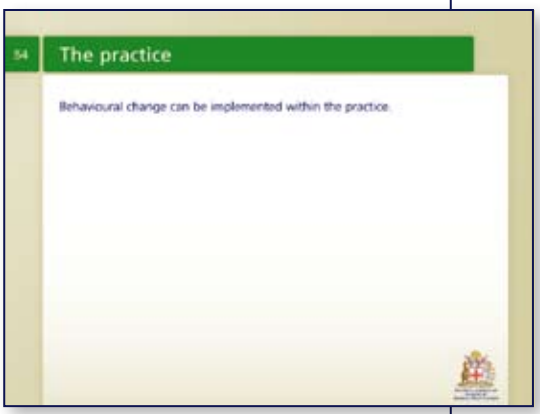
- understand the application of the PRACTICE framework at the practice and community levels
- develop, plan and implement prevention activities
- reflect on your practice and implement successful prevention programs.



Slide 53

SLIDE 54 The practice

Preventive care and behavioural change can be implemented within the health care team in general practice.



Slide 54

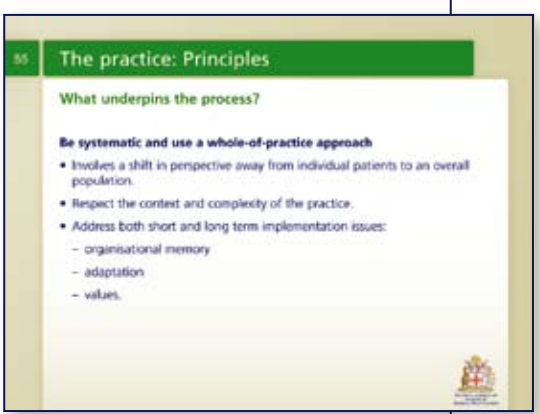
SLIDE 55 The practice – Principles

The approach to the implementation of preventive care should be systematic and whole of practice orientated. This involves a shift in perspective for many practitioners who are used to focusing on individual patients and their needs.

Implementation of prevention activity should respect the context and complexity of general practice. Improvement of care is not necessarily improved by the removal of variability.

The process should address both short and long term implementation issues. Much effort is expended in setting up programs and activities without paying attention to sustainability. Factors associated with practice routine include:

- organisational memory – reflects the shared interpretations of past experiences that are relevant to current activities (includes social networks, paper based manuals and computerised memory)
- adaptation – implementation strategies need to be adapted to local context and circumstances (such a process also facilitates engagement and ownership)
- values – the program should reflect the collective values and beliefs of the practice.



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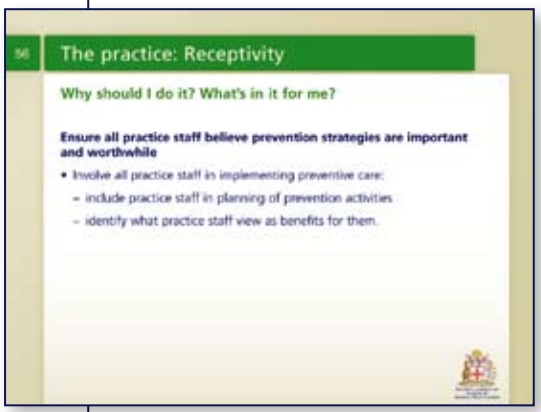


Slide 56

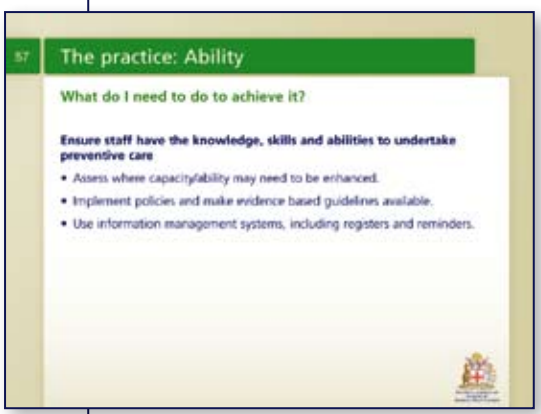
SLIDE 56 The practice – Receptivity

Despite the benefit and value of providing preventive care, it may be more of a challenge to persuade all practice staff to be involved. Barriers to greater practice staff involvement include:

- questioning the need for change
- additional work in an already busy schedule without any additional resources
- not seen or believed to be part of their role/responsibility
- lack of training.

It is important to involve all staff in the planning and implementation of preventive care. Ensure that implementation strategies are consistent with the practice and staff goals. Studies show the benefits for practice staff being actively involved in the implementation of preventive care include:

- increased effectiveness and efficiency
- opportunity to contribute directly to the practice goals and values
- enhanced team work and job satisfaction.



Slide 57

SLIDE 57 The practice – Ability

It is imperative that all practice staff have the knowledge, skills and abilities to undertake preventive care. Assess the areas where capacity may need to be enhanced:

- understanding and knowledge – regular staff meetings, bulletins and a practice manual may help to consolidate understanding of what is required
- skills – further training may be required for GPs and practice staff (eg. counselling skills, motivational interviewing techniques, self management strategies, specific clinical knowledge, setting up practice registers, searching clinical databases):
  - Lifescripts CD-ROM provides information on motivational interviewing and case studies incorporating some techniques
  - the RACGP *SNAP guide* provides a list of resources for smoking, nutrition, overweight and obesity, alcohol and physical activity
- practice policies – a common and useful strategy to promote and standardise a range of activities (eg. a no smoking policy, a range of health promotion materials in the waiting room, immunisation for GPs and practice staff)
- accessible and evidence based guidelines
- information management and information technology components (eg. practice registers, reminder systems, screening and information gathering systems, data storage, electronic linkage of pathology, imaging and discharge summaries)
- alternative ways of delivering prevention activities (eg. delegation to a practice nurse, multidisciplinary clinics, groups and referral options).

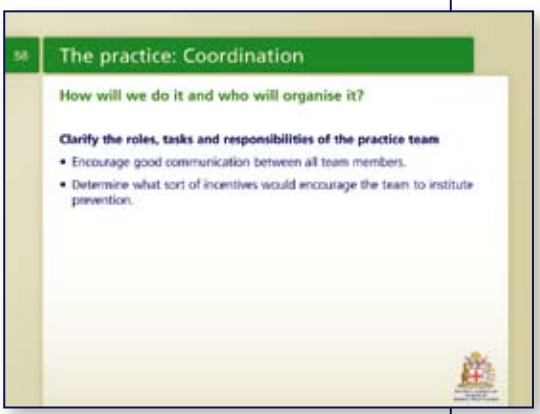
Tip

Make use of your clinical software, eg:

- asthma – it is simple to generate a list of patients with asthma. This can be used to generate reminders and recalls
- diabetes – many software packages combine relevant information to allow you to review a patient's progress, generate recalls, and conduct an audit of your diabetic patients. You could also set up a prompt and recall system to track whether items in the annual cycle of care have been completed.
- document procedures and protocols, eg. procedure for handling recall information for immunisation such as automatic letter generation, telephone call. Outline protocols such as who enters the data, sends letters and follows up.[3]

SLIDE 58 The practice – Coordination

Practice based prevention activities will require coordination. Clarify the roles, tasks and responsibilities of each member of the practice team. Good communication between all team members is essential. Determine how the team copes with change and what types of incentives would encourage the team to institute prevention.



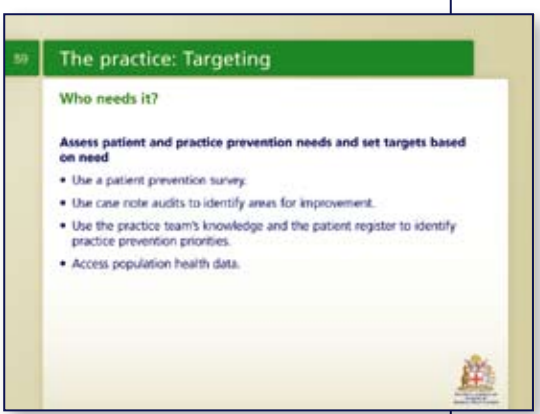
Slide 58

SLIDE 59 The practice – Targeting

Patient prevention surveys and case note audits can be used to identify areas for improvement. Use your practice team's knowledge and your patient register to identify trends and practice prevention priorities. The practice can gather and summarise information in priority prevention areas to develop a practice population profile covering burden of disease, socioeconomic disadvantage, risk factors for common chronic diseases, age and sex distribution, distribution of Aboriginal and Torres Strait Islander peoples and those from other cultural backgrounds and consumer/patient expressed needs. Divisions of general practice can also help with this.

Example

A practice asks patients to complete a prevention questionnaire while waiting to see the GP. The practice team has found that this occupies the patient's time and distracts them from the process of waiting. It also signals that the practice has a holistic perspective about the patient's health and thereby assists with patient receptivity. General practitioners find that it also allows them to target prevention activities more easily, as information is provided by the survey and patients can be referred to the practice nurse where appropriate. The waiting room is also used as a prompt to patients about a range of prevention areas, using the noticeboard and information brochures. Overall, the practice's ability to provide preventive care is enhanced.



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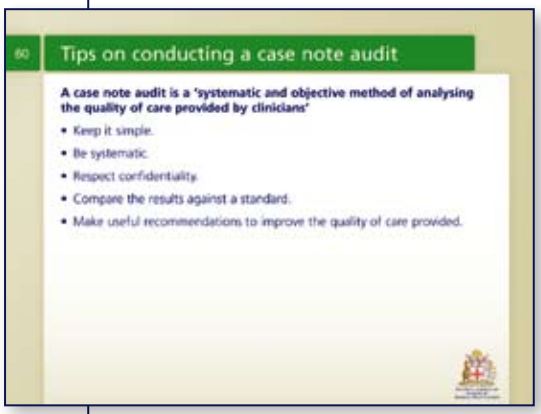


Slide 60

SLIDE 60 Tips on conducting a case note audit

When conducting a case note audit, the fewer number of goals or objectives the better. Keep the process systematic and be thorough in your search. Be sure to respect the confidentiality of patients – any presentations of audit results should be should be free of personal details. It is important to compare the results of the audit against some standard, either implicit or explicit. When making recommendations, do not criticise or make complex suggestions just for the sake of it – if you have no major changes to propose then make a simple recommendation such as improving documentation.

Slide 61

SLIDE 61 Exercise: Case study – health summaries

Scenario

Your practice is preparing for accreditation against the RACGP *Standards for general practices* (3rd edition).

Your practice principal wants to ensure that the practice meets the following standards:

- at least 90% of our active patient health records contain a record of allergies in the health summary
- at least 50% of our active patient health records contain a health summary. A satisfactory summary includes, where appropriate:
  - adverse medicines events
  - current medicines list
  - current health problems
  - past health history
  - risk factors
  - immunisations
  - relevant family history
  - relevant social history.

You note that active patient records are defined as patients who have attended three or more times over the past 2 years.

Question

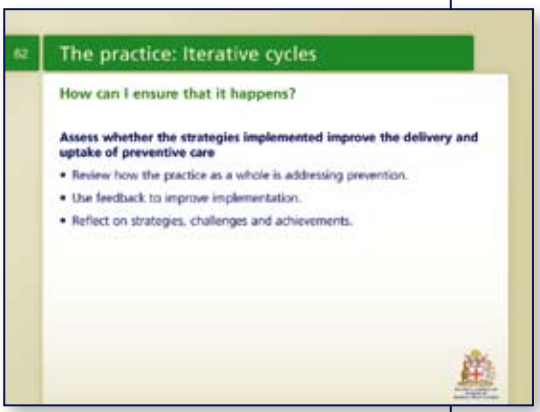
How would you check your current status against these standards?

Answer

Review records or conduct a case note audit, eg. during one session, record whether patients seen have health summary and allergies recorded.

SLIDE 62 The practice – Iterative cycles

Part of the cycle of the improvement process is to see whether the various implementation strategies are improving the delivery and uptake of a prevention activity. Some form of measurement is required to provide an accurate indication of progress. Periodically review how well your practice as a whole is addressing prevention. Examine if it is cost effective and reasonable from a GP's point of view. Do other practice staff feel the changes have been worthwhile and are there benefits to patients? Use team meetings to discuss how to build quality systems for review of the prevention activity.



Slide 62

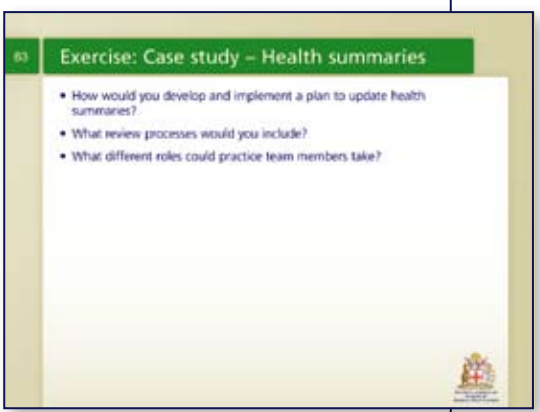
SLIDE 63 Exercise: Case study – health summaries

Scenario

Review of the practice register shows that allergies are not adequately recorded, and that many health summaries are incomplete.

Question

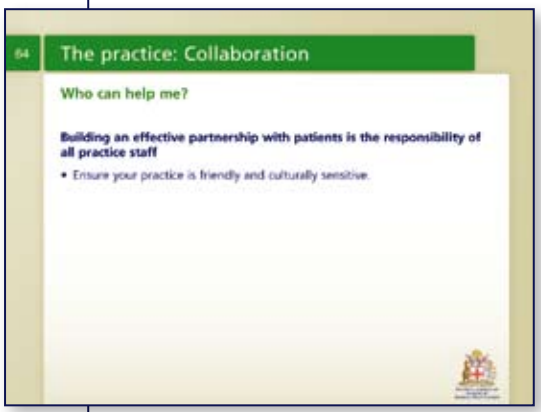
How would you develop and implement a plan to update health summaries? What review processes would you include? What different roles could practice team members take?



Slide 63

Answer

- Use the plan, do, study, act (PDSA) cycle.
- Use practice prevention survey or have GPs or practice nurses ask each patient at visits.
- Reception staff could provide allergy surveys to all patients and ask them to give it to the GP for discussion and recording.
- Use reminder systems and standardise procedures.
- Use patient information: posters in waiting room or a handout reminding patients to tell GPs of any allergies – engage patients in the process.
- Address any barriers, eg. ease of entering into electronic record, time, resources.
- Consider what, if any, additional resources are required.
- Involve practice nurses in the process.
- Develop a process to ensure that this information is always recorded for new patients, eg. use an RACGP new patient form.
- Review after 1 month. Look at the proportion of patients seen in that month with up-to-date records, how to improve the process and what could be done differently.
- Note importance of recording 'no known allergies' rather than assume this in the absence of a record.
- One practice has taken a step-by-step approach to this, focusing on one aspect of the health summary for a period of time and changing the focus at regular intervals (see green book, *page 46*).



Slide 64

Slide 65

SLIDE 64 The practice – Collaboration

Building an effective partnership with patients is the responsibility of the practice as a whole. As the first point of contact, administrative staff play a vital part in establishing the overall relationship with the patient. Practice staff who are friendly and helpful and who respond appropriately to cultural differences, language barriers, and literacy problems make a significant impression on patients.

SLIDE 65 Exercise: Case study – health summaries

Scenario

One of the part time GPs complains that she doesn't have time to check her patient's health summary and record the information.

Question

What strategies would you take to ensure team members are more receptive?

Answer

- Consider benefits to both patients and GP in having a good health summary that includes:
  - assist the patient's own GP, other GPs in the practice, locums, registrars, and students to rapidly obtain an overview of all components of the patient's care
  - reduce the risk of inappropriate management including medicine interactions and side effects (particularly when allergies are recorded)
  - assist with health promotion by highlighting lifestyle problems and risk factors (eg. smoking, alcohol, nutrition, physical activity status)
  - help disease prevention by tracking immunisation and other preventive measures
  - assist with a patient centred approach
  - recording allergies reduces the risk of adverse events
  - it can also save time when making referrals – an up-to-date health summary can populate referrals in some medical software
- Understand benefits of prevention as well as importance of accreditation.
- Goals and results are easily measurable.
- Work out ways to limit the amount of time this takes, eg. effective use of practice nurses in data collection.
- Break summary down into components, eg. current medical history and medications and allergies at this visit, past medical history, preventive health at subsequent visits.

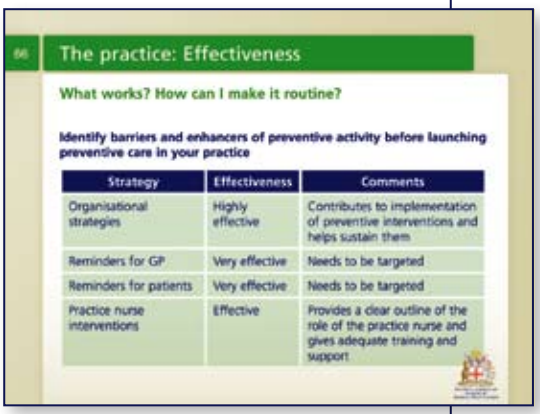
Question

How can updating these health summaries assist in future prevention activities?

Answer

- Highlights lifestyle problems and risk factors (eg. smoking, alcohol, nutrition, physical activity status).
- Tracks immunisation and other preventive measures.

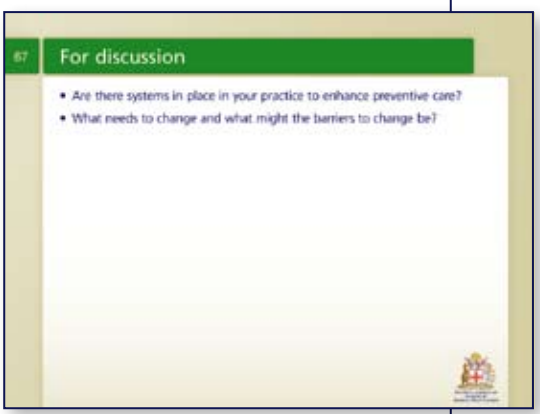
- Enables reviews of electronic records when targeting specific patient population groups for preventive activities.
- Assist in identifying prevention priorities.
- Reduces risk of missing important information, eg. not following up for at risk factors.
- A robust reliable system may reduce the risk of medicolegal problems in the future.



Slide 66

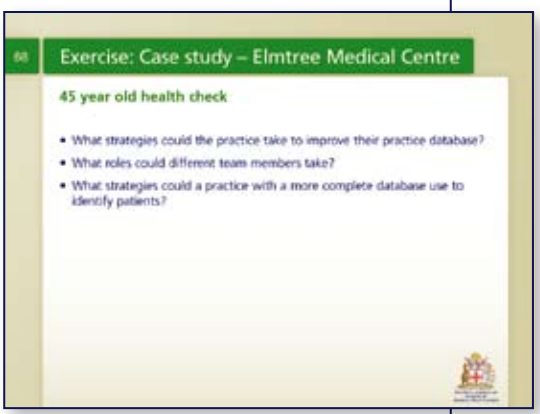
SLIDE 66 The practice – Effectiveness

The effectiveness of implementation strategies in improving prevention in the practice vary. Passive strategies most preferred by clinicians often have the least impact for example, lectures and traditional continuing medical education evenings have minimal impact in improving prevention. More active approaches such as reminders and educational outreach are more likely to be effective but are also more costly. Interventions based on an assessment of potential barriers to change are most likely to be effective. Multifaceted interventions targeting different barriers are likely to be more effective than single interventions.



Slide 67

SLIDE 67 For discussion



Slide 68

SLIDE 68 Exercise: Case study – Elmtree Medical Centre

Scenario

The practice team at Elmtree Medical Centre decides to target patients eligible for the 45 year old health check. The team consists of four GPs, two practice nurses, a practice manager and reception staff.

Knowing that patients must be aged 45–49 years inclusive and have an identifiable risk factor for chronic disease, practice nurse, John, looks at the practice database to identify eligible patients. At the next team meeting, John reports that it is not easy to identify eligible patients. Although age, gender and current medications are recorded, weight is only identified in 50% of patients, and many of these do not have height or body mass index recorded. Smoking status and alcohol consumption are recorded less than 50% of the time, and diet is recorded in less than 10% of patients.

Question

What strategies could the practice implement to improve their practice database?

Answer

- Provide all patients with the patient prevention survey and enter the data into the database.
- Use Lifescripts assessment tools.
- Standardise procedures for entering data for new patients and update existing records when patients visit.

Question

What roles could different team members take?

Answer

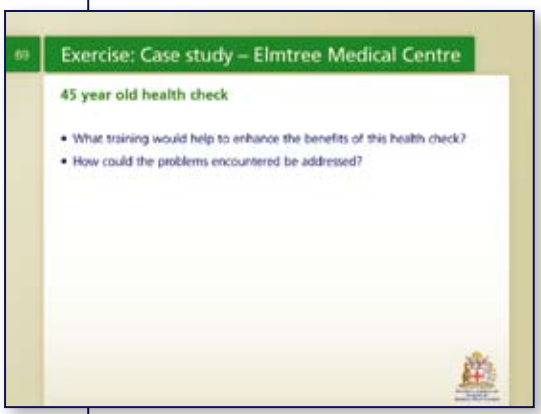
- Roles could include practice nurses collecting and recording information from patients, receptionists asking patients to complete practice prevention surveys, practice manager overseeing data management in IT system.

Question

What strategies could a practice with a more complete database use to identify patients?

Answer

- Use the practice's medical software to identify eligible patients and develop a form letter to inform patients of the health check and ask them to make an appointment if they think they have a risk factor. Sample letters are available on the RACGP website.
- Flag eligible patients and opportunistically discuss the health check when they visit the practice for other reasons.
- Reminder systems.



Slide 69

SLIDE 69 Exercise: Case study – Elmtree Medical Centre

Scenario

The practice team at Elmtree Medical Centre decides to identify patients eligible for the 45 year old health check as they come into the practice for other reasons. Reception staff flag patients visiting the practice who are within the eligible age range, and a practice nurse then asks them to complete the green book's patient practice prevention survey to identify risk factors. Their responses are later entered into their electronic record. If risk factors are identified, patients are then provided with information on the health check and how it may benefit them, and they are invited to return for the health check on another day. A brief information sheet about the health check is prepared for patients to take home with them.

The practice uses the RACGP checklist as the basis of the health check, and one of the GPs and a practice nurse work together to perform the health check. The practice nurses collect information such as BMI and waist circumference, and assess the SNAP factors and provide advice where required. The GPs undertake the remainder of the assessment, provides further advice and answers any additional questions.

Question

What training may be helpful to enhance the benefits of this health check?

Answer

- In many cases, the advice provided to patients undergoing the health check will require behavioural change to reduce the impact of risk factors. General practitioners and practice nurses may wish to refresh their knowledge and skills on assessing how ready patients are to change their lifestyle and assisting behaviour change.
- The 'stages of change' model may assist in determining the best management approach. For patients who are not confident about their ability to succeed, information and reassurance about their likelihood of success and the support available should be given. For patients who are ready to make a change, time can be spent explaining and planning how to make that change. The RACGP *SNAP guide* and green book, and Lifescripts CD-ROM provide guidance on assessing readiness to change and how to approach motivational interviewing.

Scenario

One month after the implementation of this program, the practice team meets to discuss any problems. The following problems are identified:

- a number of patients undertaking the health check would benefit from referral to support services in the local area. While staff are aware of these services, it can take some time during the visit to locate the information to give to the patient
- it was noted that some patients who had visited had been asked to complete the survey more than once.

Question

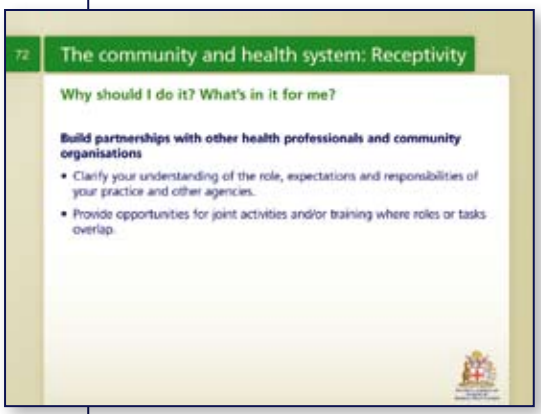
How could these problems be addressed?

Answer

- It may be useful to investigate what services are available in the local area and how accessible they are to patients. A directory of referral information within the practice should include counselling and self help groups for smoking cessation, dietician referral information, drug and alcohol counsellors and self help groups, local programs and services for physical activity, and more specialised services such as diabetes services. Divisions of general practice will be able to provide some information. The RACGP *SNAP guide* and the Lifescripts practice manual include contact details for a number of national services for behavioural risk factors, such as QUIT.
- When patients complete the survey and undertake or decline the 45 year old health check, it should be noted in the medical record so they are not asked again. Where follow up is required, this should be noted for reminders or recalls.

Slide 70

Slide 71



Slide 72

Slide 73

SLIDE 70 The community and the health system

Divisions of general practice, and regional, state and national health organisations can provide support for health activities at the local level through various programs. Linking with other organisations can provide the general practice with different perspectives, knowledge and expertise, publications, publicity and other supports. Working collaboratively with local organisations can add value for patients, particularly those who are disadvantaged or have complex care needs. To work effectively with organisations, it is important to have a systematic method of referral when sharing patient care, and a realistic understanding of what the practice can do when working on activities such as health promotion events.

Community involvement needs careful consideration as it is naive to assume that shared care is less time consuming than individual patient management. Careful planning is essential for successful outcomes.

GP management plans and team care arrangements may be useful tools.

SLIDE 71 The community and the health system – Principles

The principles of being patient centred, adopting a population approach and addressing health inequalities and disadvantage are considered to be very important by most state, national (and many international) health services, organisations and agencies. Other pertinent principles include focusing on what GPs and the practice are interested, competent, prepared and able to do and acknowledging the GP as one of the key players in an effective primary health care system.

SLIDE 72 The community and the health system – Receptivity

The attitude of health workers influences how clinical care is provided. Build community partnerships based around community campaigns and practice based skills, knowledge and competencies, and the known needs of patients. When creating partnerships with community or other health care agencies, clarify your understanding of the roles, expectations and responsibilities of your practice and those of other agencies. Provide opportunities for joint activities and/or training where roles or tasks overlap.

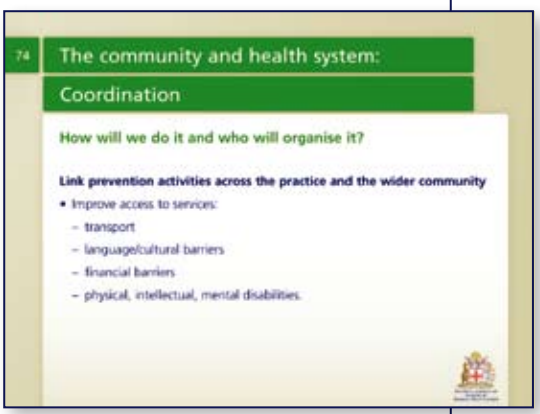
SLIDE 73 The community and the health system – Ability

Not all practice staff will be equally comfortable networking with other agencies and groups in the community. It is important practice staff understand the purpose of the activity and how it could benefit patients,

GPs and the practice. It will take time to identify and explore barriers to extending networks and partnerships and how these can be overcome. Establishing a good team environment in your practice will provide a sound basis for building broader partnerships in the community. Adequate knowledge, awareness, skills, time and incentives are also important. Many divisions of general practice provide support, opportunities and/or skills training for participating in community and national campaigns. The Australian Practice Nurse Association has networks in each state through which practice nurses can support each other and share ideas. Many divisions of general practice also run practice nurse networks.

SLIDE 74 The community and the health system – Coordination

Evidence suggests that socioeconomically disadvantaged patients can make effective use of preventive services if barriers to their participation are addressed. Consideration should be given to issues such as transport to and from services, carer responsibilities of participants, financial barriers, and language and cultural barriers.



Slide 74

SLIDE 75 The community and the health system – Targeting

Identifying partners who have a shared interest in finding ways to improve health outcomes is encouraged.

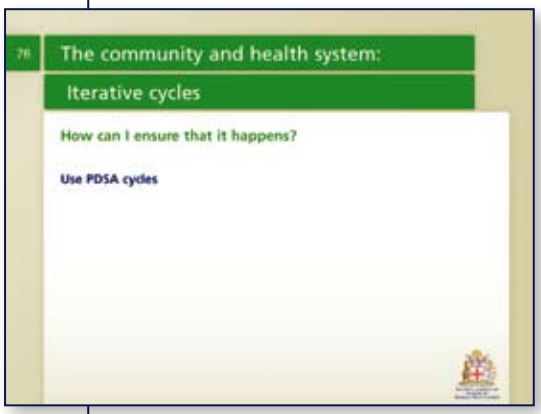
The Australian Government has eight health priority areas including:

- asthma
- diabetes
- cardiovascular health
- cancer
- mental health including depression
- injury prevention
- arthritis and musculoskeletal conditions
- dementia.

Other national initiatives include public health programs such as cervical and breast screening and immunisation and the 'SNAP' and Lifescripts programs, targeting the priority risk behaviours of smoking, nutrition, alcohol and physical activity.

Certain populations experience greater inequality in health care than other groups. Health care inequality is more common among Indigenous Australians, people of lower socioeconomic status, people living in rural and remote areas, people with disabilities, and refugees and asylum seekers. Divisions of general practice, community organisations and local groups may have identified target population groups, and be willing to work with GPs to improve the health needs of these groups.

Slide 75



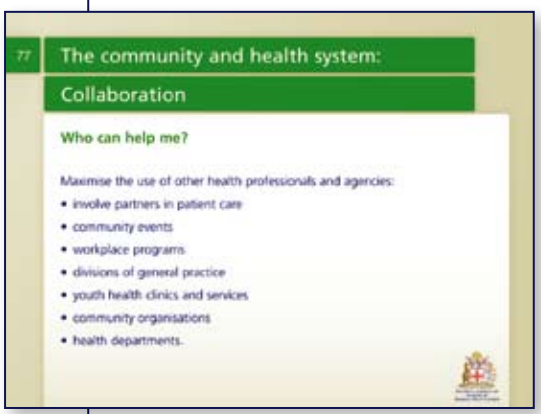
Slide 76

SLIDE 76 The community and the health system – Iterative cycles

Quality improvement approaches should involve cycles of problem identification, research, implementation and review.

In 2004, a structured approach to quality improvement was initiated through the National Primary Care Collaboratives Program. The approach provides a considered and systematic approach for general practices and divisions of general practice to work together. The approach is based on the PDSA cycle.

The purpose of the National Primary Care Collaboratives Program is to develop ways to enable participating general practices to create sustainable improvements in the quality of care for their patients. It entails practices linking into a process for gathering existing best practice and trialling new methods. A series of workshops share successful and less successful strategies and repeat the PDSA cycle. The collaboratives program offers practices and GPs the opportunity of improving patient care, continuous professional development, improvement in practices strengths and minimising weaknesses, the learning of useful general skills, better organisation of work time, and increased professional satisfaction.



Slide 77

SLIDE 77 The community and the health system – Collaboration

Other service providers within the health system are natural partners for general practice, as it can be difficult for individual practices to provide a full range of health services.

Conditions that affect collaborative action with external organisations include:

- the necessity to work together
- opportunities to gain support from the wider community or to build on existing policy initiatives
- the capacity of those involved to take action (commitment, knowledge, skills)
- strong relationships between participants
- well planned action
- provision for sustained outcomes.

The advantage of collaboration is that each of the partners may contribute what they do best to deliver a better result, with less effort, for a particular group of patients. Factors important in the development of collaboration include:

- adequate expertise, motivation, support and resources
- sharing of planning and responsibility with clear roles and tasks
- decision making, problem solving and goal setting
- open communication, cooperation and coordination
- recognition and acceptance of separate and combined areas of activity.

It is vital to be specific about what your practice can contribute, bearing in mind that the role may vary with different patients. How all the relevant partners work together is crucial in successful collaborations. Once you have identified the issue and the target group have identified likely partners, consider the following:

- Are these potential partners interested in collaborating?
- What are the likely benefits in building links with these partners?
- Are there any existing relevant activities or interventions you could build on?

You may wish to discuss this with the practice team before the first meeting with potential partners.

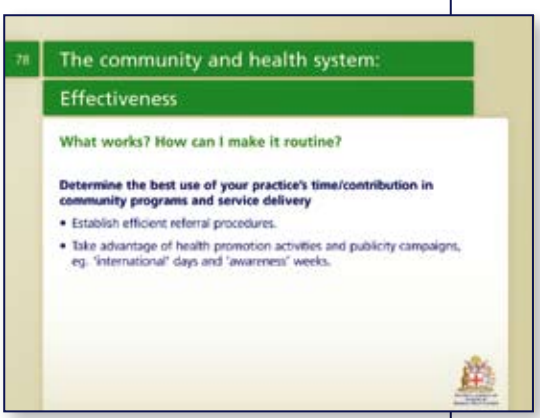
Groups that practices can effectively collaborate with to increase preventive care include:

- other health care providers (eg. specialists)
- local workplaces
- Divisions of general practice
- Youth health clinics and services
- community organisations
- health departments.

Example

Section 2.2.6: *Utilising available supports* of the green book (*page 21*) provides an example of how a division of general practice is supporting practices in their management of patients with chronic disease by collaborating with community health services and providing a range of services and strategies. These include an external diabetes register and recall program, a diabetes/asthma support program for practice nurses, and employing diabetes and asthma educators whose services are contracted to provide regular clinics.

SLIDE 78 The community and the health system – Effectiveness



Slide 78

Most successful ventures work best when there is partnership between funding bodies and community players with a fair degree of flexibility. Your practice's ability to be efficient with prevention will be enhanced substantially by establishing effective referral mechanisms and links to regional, state or national health promotion publicity programs.

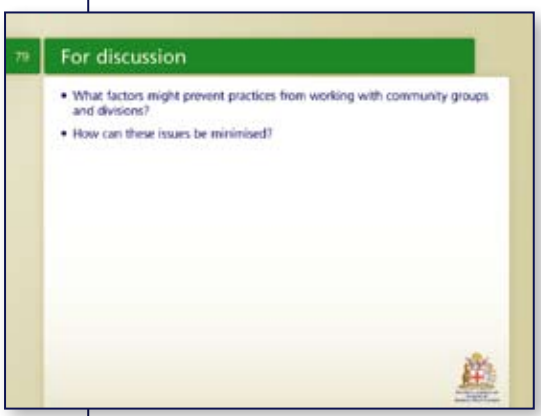
Major barriers to GPs engaging with other agencies to provide prevention, primary health and community support services include:

- GP uncertainty about the expertise and likely services that may be provide by such agencies
- GPs traditionally refer to an individual specialist who is known to them, rather than a service type
- feedback on new referrals may take longer
- increased time taken to identify new referral sources
- the lack of up-to-date information on referral sources.

Strategies that have worked for some divisions of general practice in addressing the above concerns include:

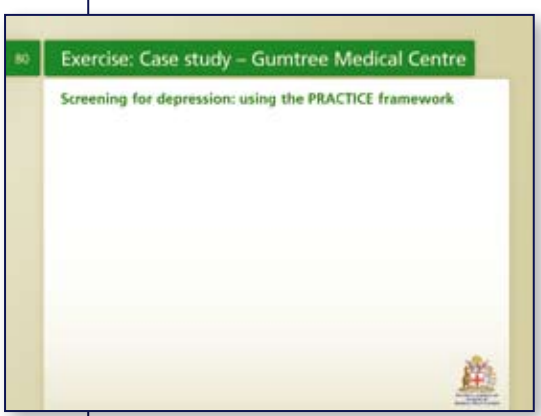
- creating a referral resource directory of quality services and supports that is easy to update
- identifying a set of central referral numbers (eg. The Cancer Council Australia) where the agency will identify the patient's needs and refer on appropriately
- establishing or advocating for access to a range of health support services for your region on behalf of vulnerable groups of patients.

Practices can take advantage of various health promotion activities and publicity campaigns being run by other groups. For example national programs such as cervical and breast screening and immunisation are ongoing national programs integrated with general practice to achieve prevention outcomes. International calendar days are set by the World Health Organisation to promote certain medical conditions. 'Awareness weeks' are more often local, state or territory initiatives (eg. Arthritis Week, Children's Week, Coeliac Awareness Week, Healthy Bones Week, Heart Week, National Diabetes Week, National Skin Cancer Action Week and Sun Smart Week). Some state or territory health departments publish 'events calendars' that can be a helpful guide. The Department of Health and Ageing publishes a national health events calendar online at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubs-calendar-index.htm.



Slide 79

SLIDE 79 For discussion



Slide 80

SLIDE 80 Exercise: Gumtree Medical Centre

Scenario

The Gumtree Medical Practice is in an area of low socioeconomic status (SES) and a large proportion of the practice population has low SES. Responses to a prevention survey show that patients see mental health as a priority area. Practice staff are conscious of the fact that patients with low SES are statistically more likely to have depression. Therefore, on the basis of these results, the practice team decides to implement a program to screen for depression.

After reviewing the evidence set out in the RACGP red book,[1] the team decides to focus initially on screening people at increased or high risk of depression, ie:

- people at increased risk of depression (eg. with a family history of depression, recent loss, postpartum women, people with poor social supports, un/under-employed people, young men in rural areas, mothers from low SES groups, people suffering from life stress) should opportunistically be screened for depression, and a high level of clinical awareness of those at high risk of depression should be maintained

- people at high risk of depression (eg. a past history of depression, multiple or unexplained somatic complaints, chronic illness/pain, alcohol and drug abuse, comorbid psychological conditions) should be screened every 12 months, and a high level of clinical awareness should be maintained at every encounter.

A team meeting is organised to discuss how the depression screening program will be implemented. One of the doctors conducts a quick search using the RACGP *MyGeneralPractice* desktop resources which enable quick access to the Cochrane database,[7] the National Guideline Clearing House[8] and Bandolier. Using search terms 'depression', 'screening' and 'primary care', she is able to read papers about this topic and learn more about the issues related to screening for depression. She reports to the team that depression guidelines did generally support case finding or screening for depression, but the literature only supports screening if the practice had a system in place to ensure that people suspected of having depression could be adequately assessed, treated and followed up.[8–10] She also notes that there is evidence that case finding is best focused on patients that have not been seen in the past 12 months.[11]

The team decides to use the PRACTICE framework to highlight areas that are currently being addressed, along with areas that need attention. You draw up a matrix as shown below to assist you in this.

Question

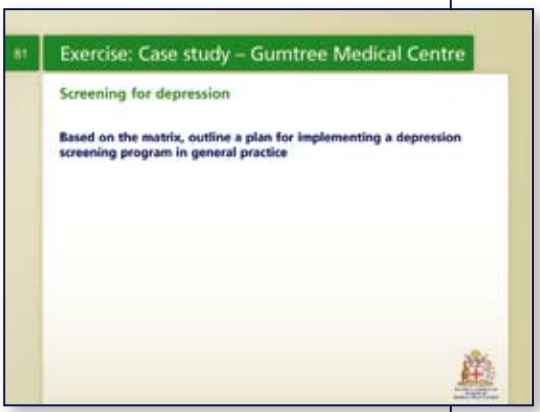
Using the PRACTICE matrix for the implementation of a prevention program to record height and weight of patients (included in the participant workbook) as a guide, complete the matrix to help you identify what may be required to implement a comprehensive prevention program designed to screen for depression. For each element, outline what needs to be done at each level of care.

Note that this matrix can be used as a guide when developing a prevention plan, however, it may not be possible to address every aspect all at once. By considering all the issues, you will be able to prioritise your prevention activities and develop your plan based on your practice's priorities. Additional activities could be introduced at a later stage.

Answer

	The consultation	The practice	The community
Principles	Engage with individual patients to understand their social and family history and recent events that may impact on their mental health	Consider the use of a patient questionnaire to identify risk of depression	Ensure the practice is accessible to the community, especially at risk groups
Receptivity	Highlight the rationale for patient screening of at risk groups	Identify whether all practice staff agree that offering quality care for depression is important Provide waiting room information to inform patients that the practice is interested in psychological as well as physical health	Build partnerships with community based campaigns to promote mental health issues
Ability	Provide GPs with training to use counselling skills; educate patients about their disorder	Develop policies and guidelines for management and follow up Provide relevant training to all staff members	Use external agencies to provide education within the practice
Coordination	For those patients requiring shared care, ensure good communication between the GP and practice nurse	For practice based activities ensure practice team roles and responsibilities are clarified Have a care manager to coordinate and monitor ongoing care	Investigate local services that might improve patient access to services
Targeting	Consider the use of a patient questionnaire to identify risk of depression Address common potential or actual barriers, eg. stigma	Set up a practice register including patients with a past history of depression Develop a system to identify patients for screening such as those who attend less frequently	Identify partner organisations that can assist with support for patients
Iterative cycles	Arrange follow up appointments to regularly monitor patients at risk of depression Ensure all patients identified as possibly depressed have a full assessment and management plan, as well as appropriate review	Periodically review how well screening for depression is being carried out and provide feedback; develop strategies to overcome barriers and determine whether the project is worthwhile	Connect with other general practices undertaking similar projects to share your experiences and learn from each other
Collaboration	Work with the patient to treat depression, and provide empathy, understanding and information	Ensure familiarity with the mental health Medicare items to facilitate longer appointments and improved access to other services	Identify mental health professionals and community agencies that can help patients with depression
Effectiveness	Provide the most appropriate intervention for the patient using evidence based strategies	Implement strategies in the practice to help promote patient initiation of mental heath issues	Establish effective referral mechanisms and links with community mental health programs

SLIDE 81 Exercise: Case study – Gumtree Medical Centre



Slide 81

Question

Based on the matrix, outline a plan for implementing a depression screening program in general practice in your workbook.

Answer

Objective: To implement a depression screening program in patients aged ≥18 years who may be at increased or high risk of depression.

Achieve: Develop procedures for screening for depression.

Actions:

- Develop procedures and reminder systems for GPs to ask and record past history of depression, social and family history, and identify patients who may be at risk.
- GPs will ask at risk patients questions to screen for depression.
- GPs will record on the patient's file that they have screened for depression.
- Ongoing review to ensure patients identified by this process are offered appropriate care, barriers are overcome and strategies to improve the process are implemented.

Resources:

- Training is provided to practice nurses and GPs to enhance skills in this area.
- Local pathways for mental health care will be clarified.
- Resources will be on hand, eg. beyondblue consumer information, MoodGym for young people.
- Practice manager will investigate mental health item numbers available and provide a summary of the eligibility and requirements.
- Systems to support patients will be required, to ensure that people suspected of having depression are adequately assessed, treated and followed up.

When: The initial phase will be a 1 week period followed by review.

Who:

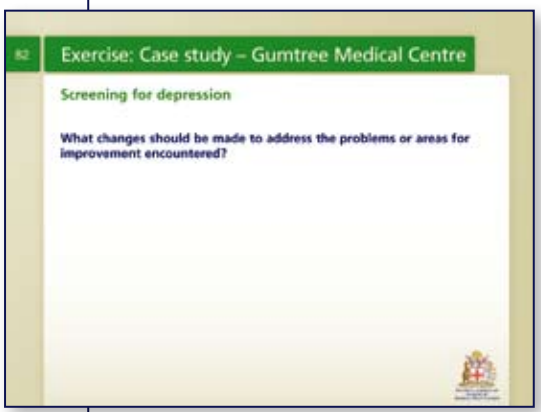
- GPs will be responsible for screening at risk patients.
- Practice nurse will review the records of patients.

How: Success of the program will be measured by:

- Proportion of patient records recording past, social and family history (eg. goal: 50% of records of patients seen in the initial phase).
- Proportion of patients screened (eg. goal: 10% of patient visits during the initial phase).
- Follow up of patients can be monitored by the use of outcome measures to assess patient changes over time. A number of depression outcome measures are available, such as the Patient Health Questionnaire (PHQ-9), Montgomery-Asberg Depression Rating Scale (MADRS), Hamilton Depression Rating Scale (HAM-D), Kessler Psychological Distress Scale (K10) and Depression Anxiety Stress Scale (DASS). The AGPN *Better Access initiative orientation manual* (*page 17*) has information on outcome measures available at www.primarymentalhealth.com.au/client_images/93571.pdf.

Possible barriers:

- Lack of time during consultations to incorporate preventive screening, as well as conflicting preventive priorities (eg. smoking, physical activity, weight).
- Additional time taken in the visit when depression is indicated.
- Cost and availability of referral services for patients.
- Clinical and emotional capacity, if numerous patients are identified.
- Patient concerns such as confidentiality, implications of a diagnosis of depression.
- Ability to adequately assess, treat and follow up patients.



Slide 82

SLIDE 82 Exercise: Case study – Gumtree Medical Centre

Scenario

The program was implemented. Procedures were developed for GPs to ask and record past, social and family history, and reminder systems set up to assist them. GPs asked those patients considered at increased risk of depression two questions: 'Over the past 2 weeks, have you felt down, depressed or hopeless?' and 'Over the past 2 weeks, have you felt little interest or pleasure in doing things?' GPs recorded on the patient's file when they screened for depression, so that they will know at future visits when the patient was last screened. After 1 week, practice nurses reviewed the records of patients seen during that period.

After 1 week, the practice team meets to review the success of the program, discuss their experience, and whether there has been any improvement. The GPs had difficulties in asking and recording all the information due to time constraints. In some cases relevant issues came up in the course of conversation during the consultation, and in other cases it was not always easy to ask. Where GPs assessed patients as being at increased risk of depression, they found that they were generally able to quickly ask the two screening questions, however, in some cases there was not enough time. Patients who answered yes to the depression screening questions required additional time to discuss further. General practitioners suggested a patient information pack would be a helpful resource to give patients. Practice nurses found it difficult to assess whether social and family history had been asked due to a lack of consistency in the reporting by GPs, as it was unclear whether a blank record meant that there were no relevant issues, or whether the patient had not been asked. It was also difficult to determine which of the at risk patients had been screened for depression.

Question

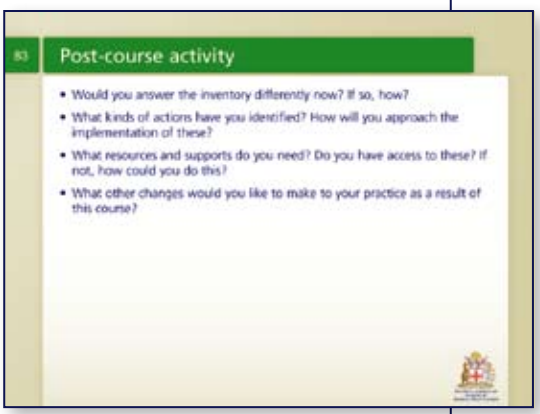
What changes should be made to address the problems or areas for improvement encountered?

Answer

- Posters were created for the waiting room explaining to patients that changes in their circumstances such as employment or family issues, can impact on their health and suggesting that they talk to their GP if there had been any changes to their circumstances.

- GPs will record 'none relevant' when they ask about past, social and family history but there is nothing to record.
- A consistent method of recording that depression screening has been undertaken was implemented.
- The practice decided to engage with their local division of general practice and gain access to their mental health resources and develop a mental health resources pack with available resources and support services, psychologists and referral list.

SLIDE 83 Post-course activity



Slide 83

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