

Putting prevention into practice

A guide for the implementation of
prevention in the general practice setting

1st Edition 1998


Prepared by the National Preventive and Community Medicine Committee
of the Royal Australian College of General Practitioners



The Royal Australian
College of General
Practitioners

ACN 000 223807

The Royal Australian College of General Practitioners



Published by RACGP, Melbourne, 1998

© Copyright: The Royal Australian College of General Practitioners, Melbourne, Victoria, Australia. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means – electronic, mechanical photocopying, recording or otherwise, unless the permission of the publisher has been given beforehand.

ISBN: 0 86906 096 1

Printed by the RACGP, Melbourne

Foreword

Recent evidence suggests prevention does reduce morbidity and mortality and the general practice setting is vital to the delivery of preventive activities. *Putting Prevention into Practice* is a plainly written evidence-based monograph that should assist GPs to be more effective in the implementation of preventive care in the practice setting. It complements the previous RACGP publication *Guidelines for Preventive Activities in General Practice* (the Redbook) which provides a summary of recommended evidence-based preventive activities.

This exciting RACGP initiative is relevant to all aspects of clinical practice as it incorporates many interventions that have been shown to be effective in improving quality of care. The interventions were included both because evidence supports their efficacy in the Australian general practice setting and because they are feasible to implement within the context of mainstream general practice.

The book is divided into two main sections. The first section outlines a clear and realistic **framework** for providing prevention. Emphasis is on planning and coordination of all the practice components that can contribute to better delivery of preventive care. The second section covers the **range** of effective strategies to improve preventive activities. Designed to address organisational issues, these strategies can be adopted by GPs in any practice setting.

The book illustrates how GPs can formulate a prevention plan that involves realistic and achievable steps. It provides a practice prevention inventory and a patient prevention questionnaire to assist GPs to determine the level and extent of prevention in their practice, the needs of their patients, and the potential to increase their delivery of preventive activities through a systematic evaluation of their practice.

It will only achieve what the dedicated group who have presented it to you intend if you use it.

The National Preventive and Community Medicine Committee has produced a valuable addition to the range of available services to members and to the wider community.

Dr Peter Joseph
President
RACGP

Acknowledgments

This monograph was produced by the National Preventive and Community Medicine Committee of the Royal Australian College of Practitioners.

John Litt (SA), with the assistance of Janice Duffy, wrote the various drafts, collated input from the literature and various individuals and piloted the handbook nationally.

The other members of the National Preventive and Community Medicine Committee, Paul Mercer (Qld), Mark Harris and Elizabeth McMaugh (NSW), Jim Dickinson and James Chong (WA), Gerard Connors (Vic), Carmel Martin (ACT), Michael Sladden and Arjun Von Caemmerer (Tas), contributed to the editing and identification of GPs to participate in the study. Marina Helsdingen from the RACGP Secretariat provided valuable administrative assistance.

During the preparation of this book, the Committee had the advantage of multidisciplinary input. Some provided specialist assistance in their areas of expertise. The committee would like to thank Teng Liaw for guidance on patient held records, Oliver Frank for contributions on computers in general practice, Kathryn Featherstone from the Health Promotion Unit at the Flinders Medical Centre for advice on waiting room organisation, Alison Heywood for advice about Health Summary Sheets, and Merelie Hall, Andrew Pattison, David Oberklaid and Colin Jacobson for practical tips on putting prevention into practice. The practice prevention inventory was developed from an instrument initially developed by the University of New South Wales Department of General Practice for an integrated GP health promotion project in South West Sydney.

The Committee would also like to thank those who commented on the various drafts, often at short notice. These include: the RACGP National Informatics Committee, Jenny Pry, Sharyn Watts of The Flinders University of South Australia, Catherine Hurley from SA Health Plus, Helen McIntosh from Southern Domiciliary Care, Theresa Burgess from the RACGP, Robyn Miller (Western Division of General Practice), Pauline Curtis (Southern Division of General Practice): Anne Mirams and Dr Robert Hall provided valuable advice about content and clarity. Lucio Nacarella, Nancy Huang, Jane Gunn, Jenny Thomson and Anne Southorpe at the Public Health and Health Promotion Unit SERU commented on earlier drafts.

Many thanks to all the GPs who participated in the pilot study.

Brian Kable

Chairman of the National Preventive and Community Medicine Committee
RACGP

Contents

INTRODUCTION

Why prevention?	1
Why GPs?	2
What is prevention?	2
Common difficulties associated with practising prevention	3
Getting started	4

A FRAMEWORK FOR PREVENTION IN THE PRACTICE SETTING: GETTING STARTED

The key processes for developing a prevention framework in your practice	
<i>Develop and adopt a prevention philosophy</i>	5
<i>Conduct a preventive needs assessment</i>	6
<i>Check the practice's capacity for implementing prevention: availability and range of practice resources</i>	8
<i>Devise a prevention plan</i>	9
<i>Appoint a practice prevention coordinator (PPC)</i>	10
<i>Identify roles, responsibilities and tasks</i>	10
<i>Use a range of organisational tools and strategies</i>	10
<i>Make prevention a routine part of your practice</i>	11
<i>Facilitate greater patient and practice staff involvement and partnership</i>	12
<i>Pay attention to sustainability</i>	12

PUTTING PREVENTION INTO PRACTICE: IMPLEMENTATION STRATEGIES

Practice staff	14
Waiting room	14
Noticeboard	16
Health summary sheets	19
Reminders	21
Computer information systems	25
Patient-held records	29
Patient education	30
Patient education materials	32

CONTROVERSIES

Screening/case finding	35
Traditional continuing medical education	36
Facilitator	36

BIBLIOGRAPHY	37
--------------	----

Contents

APPENDICES

1. Practice Prevention Inventory	41
2. Patient Practice Prevention Questionnaire	47
3. Local Prevention Contacts in Each State	49
4. Other RACGP Documents or Position Papers Supporting Prevention	50
5. Assisting patients with lifestyle changes: a guide to motivational interviewing techniques and brief behavioural interventions	51
6. Faxback comments on the Greenbook	60
7. RACGP Prevention-related practice assessment activities	62
8. Calendar of Health Event Weeks	63

FIGURES

Figure 1: Primary, secondary and tertiary prevention	3
Figure 2: Practice prevention system	9
Figure 3: Getting started: an initial plan	13
Figure 4: Patient education material – examples of layout	17
Figure 5: RACGP health summary sheet	19
Figure 6: Two types of casenote stickers	21
Figure 7: RACGP recall card and instructions	22
Figure 8: Example of the Personal Health Record	29
Figure 9: Example of a good patient education leaflet	34

Why prevention?

Prevention is worthwhile

There is clear evidence that many preventive activities do reduce the morbidity and mortality associated with a number of diseases. Immunisation has eliminated smallpox and is likely to eradicate polio by the year 2000. Early recognition and management of hypertension, hyperlipidaemia, anti-smoking strategies and change in lifestyle have contributed to the decline in the morbidity and mortality associated with ischaemic heart disease. As many preventive activities can and do alter the natural history of disease, they deserve to occupy an increasing part of the GP's attention.

This handbook reviews the evidence for a range of **implementation strategies** to help you become more effective in providing preventive care to your patients. The key is to **organise** yourself and your practice for prevention as you have already done for your billing system.

This handbook has been dubbed the Greenbook as it will help to 'green' your practice towards prevention. The RACGP *Guidelines for Preventive Activities in General Practice* (the 'Redbook') has summarised the most effective and worthwhile preventive activities that you can offer your patients. This guide will describe the most effective and feasible ways of incorporating preventive activities into your practice setting. Specifically, the Greenbook will describe how these activities can be implemented.

The implementation strategies and recommendations are based upon a detailed synthesis of the available evidence. Studies were analysed according to the quality of their methodology (ie. systematic reviews, randomised controlled trials or quasi experimental designs) and their relevance to the Australian general practice setting. The feasibility and cost of the strategies were also considered.

Prevention incorporates both health promotion and disease prevention. Health promotion is: 'a process of enabling people to increase control over and improve their health. Individuals must be able to identify and realise aspirations, satisfy needs and change or cope with their environment'. Disease prevention, on the other hand, involves identifying and reducing specific risk factors with a view to ameliorating the impact of disease, disability and premature death.

Introduction

Why GPs?

GPs are a key resource in the delivery of preventive care

- GPs and health authorities see prevention as an important part of the GP's role¹
- Patients view the GP as a key, first contact and credible source of preventive advice
- There are many opportunities for prevention in general practice
- GPs are effective in providing prevention
- GPs are in an ideal position to link prevention with comprehensive, continuing and holistic care
- GPs provide a range of services that span the health care continuum from prevention of illness through to treatment and rehabilitation.

GPs have indicated that prevention is a core part of their role. Eighty-five percent of the population visit their GP at least once a year with a median number of five visits per person. When patients present with symptoms and concerns they are more receptive to advice about how to minimise or avoid illness.

Because you are a trusted expert, patients are more likely to follow your advice. A recommendation from you about a variety of preventive activities is the **most potent influence** on patients accepting and carrying out the activity. An integrated, holistic approach to care is an efficient process that is very attractive and meaningful to patients.

What is prevention?

Prevention can be divided into three categories (*Figure 1*). Primary prevention reduces the likelihood of disease occurring. Secondary prevention is aimed at early detection of disease before it becomes symptomatic. Many screening activities fit under this category, for example, Pap smears, checking blood pressure. Tertiary prevention, which GPs practice every day, is the attempt to prevent or minimise the complications or disability associated with established disease.

¹ The Commonwealth Health Department, through the Health Insurance Commission, has acknowledged the role of GPs in prevention through their endorsement of the RACGP Guidelines for Preventive Activities in General Practice as the appropriate standard for what preventive activities are acceptable. The RACGP has also included a number of standards relating to prevention in the recently released Entry Standards for General Practice, 1996.

Introduction

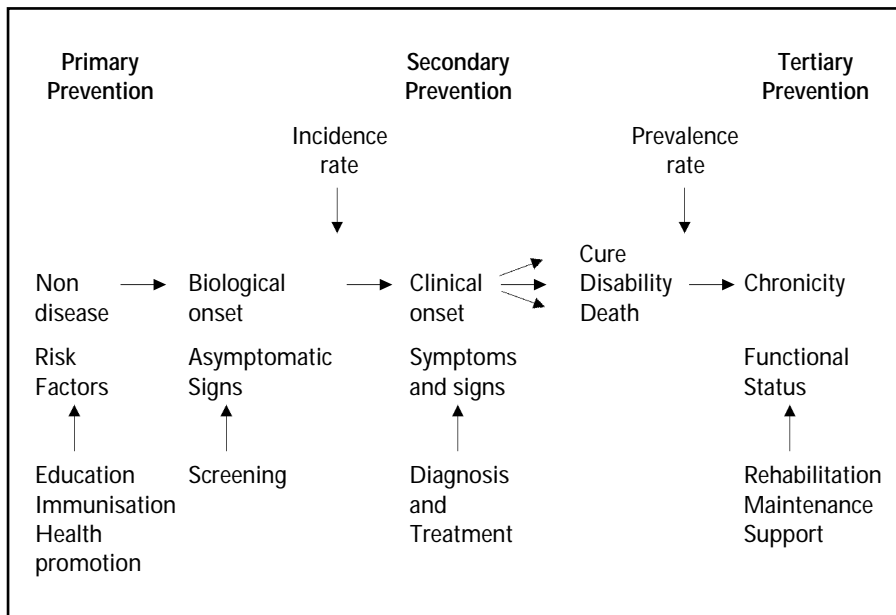


Figure 1: Primary, secondary and tertiary prevention.

Common difficulties associated with practising prevention

While GPs generally believe that practising prevention is an important part of their role, making it happen effectively without disrupting the 'flow' of the surgery can sometimes be problematic. A number of factors below may relate to your practice or experience. It is worthwhile thinking about all of them to help you overcome any potential or real difficulties.

The barriers to prevention relate to the GP, the patient, the preventive activity, the practice setting and the health care setting.

GP

- Attitudes/beliefs: not a role, not effective/low yield
- Perceived lack of clinical and lifestyle counselling skills
- Lack of time.

Patient

- Fears and concerns
- Not really interested/lack of motivation
- Difficulty carrying out preventive activity
- Lack of perceived benefit.

Introduction

Preventive activity

- Lack of consensus about what is effective
- Perceived costs outweigh benefits.

Practice setting

- Lack of coordination
- Lack of resources and support

Health care setting

- Financial disincentives
- Illness orientation.

The framework and the implementation sections will outline strategies that address these barriers and difficulties.

Getting started

An easy way to get the ball rolling is to hand out the practice prevention questionnaire (PPQ) to a number of patients (20–30) and complete the practice prevention inventory (PPI) which provides you with a ‘stocktake’ of your current implementation strategies.

The first section of the Greenbook outlines a framework for practice prevention. As there are a number of fundamental differences between the provision of clinical care as opposed to preventive care, it is important to consider a framework that combines a prevention philosophy with planning and coordination of a range of implementation strategies. The final section outlines each of these implementation strategies in detail.

A framework for prevention in the practice setting – getting started

Putting prevention into practice consists of two interconnected tasks. The first task relates to the development of a supportive framework for prevention in your practice. The focus is on processes. All of these processes will help make the various implementation strategies more effective. Remember to focus on preventive activities that have strong evidence for their adoption. If you are not sure what preventive activities are worthwhile, have a look at the RACGP *Guidelines on Preventive Activities in General Practice*, 4th Edition, 1996.

The implementation section addresses the second task by describing each of the preventive components that can help in the more effective **delivery of prevention**. This section concentrates on specific activities.

Developing a prevention framework in your practice

There are several key areas that can assist in the development of a prevention philosophy in your practice. They are:

- Develop and adopt a positive attitude towards prevention
- Conduct a preventive needs assessment
- Check the practice's capacity for implementing prevention
- Devise a prevention plan
- Appoint a practice prevention coordinator (PPC)
- Identify roles, responsibilities and tasks
- Use a range of organisational tools and strategies
- Make prevention a routine part of your practice
- Facilitate greater patient and practice staff involvement and partnership
- Pay attention to sustainability.

Develop and adopt a positive attitude towards prevention

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

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

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

A framework for prevention in the practice setting – getting started

Conduct a preventive needs assessment

Conducting a preventive needs assessment in your practice will determine:

- The preventive activities you are currently doing well
- The areas that need improving.

This assessment involves being able to step back and take a ‘helicopter’ view of what you do in your practice. You may have a good idea about your prevention needs already (especially if you hand out a practice prevention questionnaire (PPQ) or intermittently review your case notes). Your Division may also have some of this information (through a local needs survey).

The needs assessment will help you to develop clear goals about what you want to achieve. Discuss these goals at your practice management meeting and negotiate a set of objectives that are:

- Clear
- Achievable
- Measurable
- Agreed upon by all the relevant parties.

There are two components to the needs assessment.

Practice needs assessment. This will enable you to identify the nature and extent of the various strategies that you currently use and could adopt to implement prevention in your practice. Completing the practice prevention inventory (PPI) will help you to achieve this (*Appendix 1*).

Patient needs assessment. This will enable you to survey your patients to determine the prevention coverage in your practice and what prevention information patients would like. Use the PPQ (*Appendix 2*).

Practice needs assessment

The PPI can help you review all of the implementation strategies used to put prevention into practice. Questions to consider:

- How is prevention provided in the waiting room?
- Does someone review the material pinned up on your noticeboard?
- Are there any items on the noticeboard that relate to prevention?
- Does the material on your noticeboard correspond with local and national Health Department campaigns, for example, Diabetes Week, Influenza Awareness Week, World No Tobacco Day and National Alcohol Awareness Week?
- Are your staff involved in any preventive tasks, such as, handing out patient questionnaires, promoting your practice newsletter or putting stickers on case notes?

A framework for prevention in the practice setting – getting started

- Are the health education leaflets and booklets organised to ensure they are relevant, informative, accessible and up to date?
- What organisational tools and resources are available and used for prevention within the practice?

You or the practice prevention coordinator can complete the PPI.

Patient needs assessment

Rather than looking only at an individual patient, you also need to look at the various groups of patients (eg. diabetics, elderly) who make up your practice population. Ask your practice staff to give patients a PPQ to complete before they are due to see you. The PPQ will help to:

- Highlight both your patients' needs and your level of coverage for preventive activities
- Identify the priority areas for various target groups.

Remember that some patients may find it difficult, or be reluctant, to fill out a questionnaire because of their language or literacy skills. They may need assistance from family or a practice staff member.

Use the needs assessment to help tailor prevention activities for your patients. This is probably quicker than the alternative of conducting an audit of your case notes.

While most of the items in the prevention questionnaire address issues that you believe are medically important, the patient may wish to raise other areas, for example, stress management or healthier eating. Including an open-ended section at the end of the questionnaire where patients can identify their own health needs will help to guide the selection of patient education material to stock the practice.

Placing a white sticker on the case notes with the date that the patient was surveyed will help to flag those patients who haven't completed the questionnaire.

The patient needs assessment is desirable for a number of reasons.

- It acts as a cue to patients to think about prevention
- It provides feedback to you (and individual patients) about how you are doing
- It saves you time asking these questions during the consultation (when time is at a premium)
- It is appreciated by patients who see it as a broader interest in their health and well-being
- When collated, it contributes to the construction of a practice denominator²
- It helps to identify your strengths and weaknesses in the delivery of preventive care.

² Assembling a practice denominator register is essential if you wish to evaluate how well you are doing. For example, to determine your performance in influenza vaccine coverage in the elderly, you need to have a list of all the eligible elderly patients in your practice. The use of practice denominators and practice registers is described in the section on reminders.

A framework for prevention in the practice setting – getting started

The information in the questionnaire can be reviewed with each patient during the consultation. Patients will have thought a little about the various prevention areas when they complete the questionnaire so they are more likely to be receptive to advice. Negotiate with the patient to tackle an area that you both feel is worthwhile. To prevent the information from being lost it is helpful to record most of the patient's responses on a health summary sheet (HSS). This can be done by your practice staff or when you see the patient.

It is easy to feel overwhelmed by patients with multiple needs. If time is pressing, be realistic and stagger the preventive activities over a number of consultations so that you can ensure that you have enough time to review areas that you and the patient have selected. Devising a 'plan' with the patient can ensure that all of their preventive needs are addressed.

Patients appreciate being asked about a range of health issues. They feel that the doctor is being holistic and "looking-out" for their overall welfare. Both of these contribute to patient satisfaction and may increase 'loyalty' to the practice. They are also a good way of showing your value and marketing your practice to patients.

The PPQ will help to focus your preventive activities by highlighting both where you are doing well and where improvement may be needed. For example, are your elderly patients getting their influenza injection each year? Are smokers being identified and receiving advice about options for quitting?

Handing out the PPQ again, about 12–18 months after putting a number of the implementation strategies in place, will provide you with feedback about whether the situation has improved and whether you have met your objectives.³

Your local Division may have already conducted a needs assessment in conjunction with consumers. This information should provide a more general overview of the needs of patients in your area.

**Check the practice's capacity for implementing prevention:
availability and range of practice resources**

After completing the PPI, review the nature and extent of the resources you have for prevention. It is useful to distinguish which prevention activities need to be done by you and which ones can be incorporated into other parts of the patient's visit to the practice. Your PPC can help to coordinate the latter.

Remember that there are other groups of health professionals who are also committed to prevention (which often forms a significant part of their role). Don't forget about resources outside the practice. The Health Departments, through various media campaigns, health policy initiatives and supporting health promotion units, are also involved in disseminating preventive information together with other groups such as the Anti Cancer Council and the

³ This process can also provide you with practice assessment points in the RACGP Quality Assurance Program (see Appendix 7)

A framework for prevention in the practice setting – getting started

National Heart Foundation. They can often provide leaflets, posters and other handout material in a variety of prevention areas. Your local hospital or population health unit may have a health promotion unit with staff skilled in health education and delivering health promotion programs (see *Appendix 3* for a list of Health Department contacts in each State).

Coordination of effort will reduce duplication and relieve you of some of the tasks involved in prevention. Awareness of various current prevention and media campaigns will help you to address prevention issues that patients may raise as a result of the campaign. Divisions of General Practice provide a vehicle to help coordinate and integrate the prevention activities that GPs provide to the community.

Devise a prevention plan

The PPI, the PPQ and the assessment of your resources will have highlighted what preventive activities you currently provide, the activities you may need to improve and what your patients want in prevention. Simply believing that prevention is important doesn't make it happen – you need to have a plan. Prevention can be improved if you **plan it around the practice as a whole**. Look at all the practice activities that may contribute to the delivery of preventive care. This means thinking about your practice as a system that is made up of a number of components. These components include: the waiting room; practice staff; computer systems in the practice; your case notes and other organisational tools such as reminder systems; health summary sheets, practice registers and patient education. You will be more effective if you consider all of the components (*Figure 2*). These strategies will be discussed in Section 3.

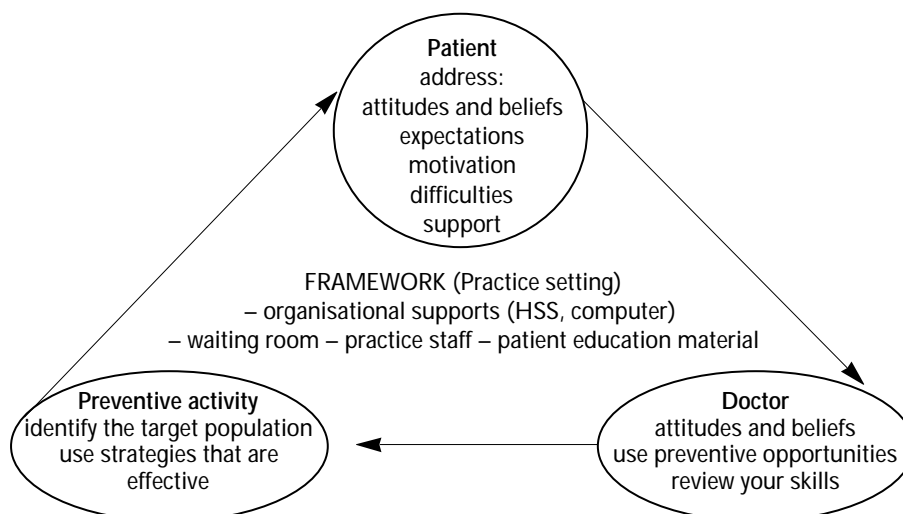


Figure 2: Practice prevention system. A systems approach to preventive care: key elements of the prevention plan

A framework for prevention in the practice setting – getting started

While most practices have a well thought out billing system, preventive care tends not to be coordinated. It can be haphazard, fragmented and episodic. There is often no clear goal about what you want to achieve or a plan to realise the goal. The task of putting prevention into practice is more effective when there is a clear plan. The plan should consider all the components within the practice environment that may contribute to prevention and describes how they relate to each other.

- Start this process by completing the practice prevention inventory
- Include prevention in your practice management meeting agenda⁴
- Review the prevention plan regularly to see if you are making progress.

Appoint a practice prevention coordinator

Coordinating the various components is made easier if one of your practice staff has the responsibility for this and works with one of the GPs. The practice prevention coordinator (PPC) doesn't have to be the doctor. In fact one of your practice staff is likely to have more time than you to organise prevention.

The main role of the PPC is to oversee the **coordination of prevention**. The PPC should be responsible for clarifying the preventive roles and responsibilities of each of the staff and making sure that the various activities happen.

Identify roles, responsibilities and tasks

Clarify the roles and responsibilities of the various practice staff who are helping to put prevention into practice. This is a useful starting point for your PPC. It will help to ensure that:

- Implementation is a coordinated process
- All the relevant tasks will get done.

Use a range of organisational tools and strategies

Organisational strategies such as health summary sheets, practice registers and reminder systems, case note stickers and ideally, a computer (that can provide all of these tools in one), can greatly assist your delivery of preventive care. These organisational tools have a number of advantages. They can help you to:

- Focus on your practice population by providing a complete list of various target groups, for example, all patients 65 years and older, all diabetics
- Ensure that the preventive activities are offered in a systematic manner
- Free up your time to focus on the aspects of prevention that you are best suited to do
- Facilitate the assessment of how well you are doing.

⁴ If there are no practice management meetings the coordination and opportunity for planning any practice activity is made more difficult.

A framework for prevention in the practice setting – getting started

Even if you are motivated to make prevention a routine part of your day-to-day practice, you will still need to use all the available and relevant resources in the limited time that you have available. Thinking about how your practice is organised and using the suggested tools will help to facilitate this process.

Make prevention a routine part of your practice

Prevention is more likely to become a part of your practice culture if you routinely use the various **preventive opportunities** that arise. GPs tend to only consider the time that they spend with the patient and discount or do not consider other opportunities. There are a number of these ‘opportunities’ every time a patient comes to the practice.

Patient opportunities

Sitting in the waiting room (often for up to 15 minutes) provides time to:

- Browse practice ‘library’ (leaflets, books and videos for loan)
- Read accessible and eye catching patient education material
- Complete PPQ.

Practice staff opportunities

Practice staff may be able to:

- Hand out practice newsletter
- Inform patients about various practice prevention activities (ie. hand out a prevention questionnaire)
- Place stickers on case notes
- Collate and check reminder systems.

GP opportunities

In the consultation.

Think about the opportunity for prevention in every consultation. Realistically, you may only be able to consider prevention if there is a little extra time left in the consultation with the patient. If there is no time for prevention, ask the patient to make another appointment so that the prevention area is not ignored. If you believe that this is important, and outline the reasons to your patients, they are more likely to value the need to return and address the issue. Linking the preventive activity with the patient’s presenting complaint will help to increase the relevance (and the acceptability) of the preventive activity.

Think about underlying recurring themes that may relate to prevention areas, for example, hazardous drinking in a patient who has repeated presentations for insomnia, fatigue, gastroenteritis, and anxiety.

A framework for prevention in the practice setting – getting started

Organising and coordinating the preventive activities in your practice will also help to ensure that prevention is timely, systematic and efficient. Priority should be given to mechanisms that facilitate routine inquiry about prevention. On average patients see you five times over the course of a year, so preventive activities can be spread over a number of visits, especially if the patient has multiple problems. Tackle only one or two preventive activities at a time. For example:

- Merely raising a preventive issue may be sufficient to prompt the patient to think about it
- Raise at least one prevention item with each patient
- Hand out patient education leaflets.

Facilitate greater patient and practice staff involvement and partnership

Patients are more likely to carry out preventive activities if they:

- Feel that you have listened to, and understood their fears and concerns
- Believe that the preventive activity is important and relevant to them
- Believe that you recognise their autonomy and treat them as an equal partner in the consultation
- Believe that they can choose from a range of options
- Have articulated the reasons for change (in their own words)
- Perceive that the benefits of change outweigh the costs
- Receive clear and specific advice from you
- Feel confident and able to carry out the preventive activity.

Appendix 5 expands on these issues and provides a pragmatic approach to addressing a patient's motivation.

Including practice staff is an essential ingredient as it helps to **share the workload** involved in providing more comprehensive preventive activities. It also provides you with more time to do the preventive activities that are best done by you, for example, raising the issue, giving brief advice complemented with pertinent patient education leaflets.

Pay attention to sustainability

Finally, a number of factors help to **sustain the prevention** process.

- Are the various prevention implementation strategies tailored to your needs and setting?
- Are the results of your preventive efforts visible?
- Are the patients, your colleagues and practice staff supportive?
- Do you get a feeling of satisfaction or some sense that you have been effective?
- Do you regularly arrange to get feedback from patients and your practice staff about how things are going?
- Do you regularly review how you are putting prevention into practice?

A framework for prevention in the practice setting – getting started

While you cannot see the results from many preventive areas directly, you can monitor your patients' progress through reviewing the health summary in their case notes, collating the results of the PPQ, or simply asking them how they are doing.

Similarly, reviewing your prevention plan at the practice meeting together with feedback from the various participants will help to ensure that the process is systematic and patient focused (*Figure 3*).

Investigate which of your local health professionals are also committed to prevention and where it may be feasible to work together. Many Divisions are also involved in assisting GPs in the delivery of preventive care.

- Needs assessment: handing out patient prevention questionnaire to all patients attending the surgery; complete PPI
- Prevention plan: consider it at the next practice meeting.
 - focus on (three) main areas identified from PPQ
 - review performance 3 months after various strategies are put in place
- Appoint PPC: Jan Davis, practice manager will collate PPQ and report to the next practice management meeting.
- Identify role responsibilities and tasks: Sue Graham receptionist to check noticeboard once a fortnight.
- Organisational tools: Case note stickers ordered (influenza, diabetes). RACGP Health Summary Sheets to be inserted in the notes of all attending patients. Age-sex register considered.
- Patient education material: Review priority areas and obtain leaflets. Dr Sarah Jones to review.
- Sustainability: Get health calendar with dates of health campaigns and events (Appendixes 3 and 8)

Figure 3: Getting started: an initial plan.

Putting prevention into practice: implementation strategies

This section discusses each of the implementation strategies. They have been included because:

- There is strong evidence for their effectiveness
- They are feasible and cost-effective to adopt immediately
- They are appropriate to the Australian context.

Practice staff

All of your practice staff can help with prevention by:

- Handing out the practice prevention questionnaire (PPQ)
- Placing case note stickers on the front of the patient's medical record
- Filing relevant details in the practice reminders and recall systems and checking when follow up by phone or personalised letter is due
- Contacting patients overdue for preventive activities
- Transcribing the information from the PPQ onto the patient's health summary sheet (HSS).

Other tasks that could be delegated to the practice prevention coordinator (PPC) or spread over several staff members include:

- Keeping the waiting room up to date, for example, changing posters, reviewing the noticeboard
- Organising patient education material so that it is accessible and easy to locate for all practice staff
- Reordering patient education leaflets when stocks are low
- Raising prevention issues at the practice management meeting.

The practice staff are more likely to take an active interest if all the GPs in the practice see prevention as an important part of their role.

Waiting room

The waiting room has enormous potential for cuing many preventive activities. Patients are a 'captive' audience, spending up to 15 minutes (or more) in the waiting room. A well presented waiting room can increase the patient's awareness of a range of preventive issues and lead to enhanced knowledge and motivation. Eye-catching displays, an organised noticeboard, a practice newsletter, health programs television and pertinent health leaflets are all useful methods of engaging the patient's attention. Cuing them in the waiting room increases the likelihood of their raising preventive issues during the consultation, saving you time (and concern) about raising the issue.

Completing the PPQ will also raise their awareness, especially if the relevant patient health education/information brochures or practice newsletters are available to address common questions that arise while completing the questionnaire.

Putting prevention into practice: implementation strategies

Does your practice have an organised system to keep relevant material displayed and identify when leaflets should be re-ordered? Think about where the patient education material is located in your practice.

Material left in the waiting room should act as a prompt for patients to raise an issue with you or direct them to other sources. Waiting room leaflets need to be clear, concise and simple. Sensitive material or issues that patients may not want to raise with you directly should also be kept in the waiting room (or in the patients' toilet).

Most of the leaflets are best kept in a centralised area. Keep ones that you regularly use in your consulting room to complement the advice that you give patients.

A separate health section with the opportunity for patients to borrow more expensive books or videos will complement the existing reading material. Advertise their availability on your noticeboard or a notice area on the reception desk.

A number of features can assist in priming the patient's interest and recall of prevention messages in the waiting room.

- Use posters and other health education material to link the practice in with broader community health programs. A health promotion events calendar summarising the nature and dates of the main preventive campaigns is available in most States (*Appendix 5*).
- Ensure that the colour scheme is conducive to information absorption (not too 'hot' or too 'cold'). For example, warm colours such as apricot and pink are better than bright colours or cold colours such as blue.
- Make the waiting room child friendly. Provide some play equipment such as a small table, chairs and a blackboard (very small toys are not recommended because children may put them in their mouths which distracts the parent). Parents are more likely to look at the noticeboard or leaflets if they don't have to constantly keep an eye on their child. Make sure the noticeboard and displays are out of the reach of toddlers.
- Keep the waiting room tidy – if you are going to provide magazines, don't put them on the table near the seats. Most patients will automatically reach for the magazines. Display materials that offer a health focus rather than the weekly magazines (if the latter are necessary). Place them away from the seats and patients will be more likely to look at the prevention material.
- Check to see if the leaflets/posters are available in other languages and gear your selection to the ethnic and language mix of your practice population.
- Place some patient leaflets (and your practice newsletter if you have one) on the reception counter where they are visible to patients.

Putting prevention into practice: implementation strategies

Noticeboard

Add prevention notices to your noticeboard. You can improve the impact by:

- Choosing a surface on which you can put velcro for easy attachment of material and safety for children.
- Ensuring it doesn't look too messy – don't go over the edge of the board with notices and avoid overlap of flyers and posters – less is more.
- Picking out the most important message you want people to receive and strive to make it what people see first.
- Ensuring that you grab the passer-by's attention within one or two seconds. If they have to search for the message you will lose them – simple messages are better.
- Planning how the information will fit together rather than merely putting it in an ad hoc manner
- Thinking about the display in terms of shapes and colours. You may need to separate or connect the elements with something like a paper frieze.
- Keeping your board up to date. It needs to contain the most important messages you want people to receive. For example, announcing the availability of influenza vaccine, targeting at-risk groups such as older women who are not presenting for mammograms.
- Checking the material to see that it is culturally appropriate and caters to the language mix in your practice and does not offend or discriminate.
- Checking with your local Division and/or Health Promotion unit to see if they can assist you with materials, layout or ideas for your noticeboard.

People become habituated to messages on noticeboards. Keep your noticeboard up to date. It is more likely to attract attention if:

- The notices and posters are changed regularly
- The material is relevant and up-to-date
- You (and your practice staff) encourage patients to read it
- It contains the most important (two or three) messages you want people to receive.

Focus on posters or notices that raise awareness, for example, flyers targeting women who are overdue for a Pap smear (*Figure 4*). Cut down on costs by taking advantage of the free leaflets that are provided as part of health promotion and media campaigns.

Putting prevention into practice: implementation strategies



Figure 4: Patient education material – examples of layout.

Putting prevention into practice: implementation strategies

Practice vignette

Dr Andrew Pattison runs a small group practice in suburban Melbourne. Dr Colin Jacobson has a solo practice in suburban Adelaide. Both have structured prevention as a routine aspect of their practice. Dr Merelie Hall works in a group practice in Queensland with three other doctors. She has identified 'windows of opportunity' during the consultation that can be used to do opportunistic preventive activities.

The waiting room

The waiting room is a wonderful area to start patients thinking about prevention. While some posters that come into the GP's surgery are useless, others are ideal for the noticeboard. However, they need to be regularly turned over. A well-placed brochure display is also useful but the information needs to be of a general nature. Topics on immunisation, for example, are good as are health tips for those going overseas. Other examples include; brochures on mental health, nutrition, breast self examination, men's health and smoking cessation.

Practice newsletter

A practice newsletter is a useful way of informing patients about a number of issues. It is nothing fancy, just a simple A4 sheet but it covers topics such as the Pap smear tests or the latest on cholesterol.

Reminders

The practice recall and reminder system is also very important. It is used to remind patients about screening and even things such as skin lesion checks for certain patients. Once again this is overseen by a designated staff member and a doctor.

Windows of opportunity

Scenario 1: A 31 year old patient, 'Elizabeth', has come in for a repeat of her oral contraceptive. She mentions this will probably be the last time she needs it as she is getting married and hoping to become pregnant soon after.

Suggestions: Offer her a Pap smear if it is due within 6–12 months because it is better to do this before she becomes pregnant. Check rubella antibodies because many of the girls immunised in high school have low antibody levels in their thirties. Offer her general lifestyle advice. For example, tell her that now she will have a partner to exercise (walk) and give up smoking with.

Scenario 2: Elizabeth's mother mentions that her husband is about to retire. Because you have not seen him for years his wife presents a good opportunity to 'reach' him.

Suggestions: Mention to Elizabeth's mother that retirement will give them more time together. Suggest that this may be a good time for him to come in for a checkup before he starts to play golf more regularly. Also mention the possibility of arranging healthier meals now she knows he will be home more often for dinner.

Putting prevention into practice: implementation strategies

Health summary sheets

Health summary sheets (HSS) prompt you about the need for preventive activities and succinctly summarise this information.⁵ Opportunities to address prevention issues within the consultation are more effective and efficient when you are aware of a patient's prevention needs (Figure 5).

Figure 5: RACGP health summary sheet (front sheet).

1. IDENTITY		2. HISTORY & RESIDENCE		3. SURNAME Birth		RECORD NUMBER 027488	
Date Completed 1 July 1992		Health Summary		GIVEN NAME Jane Anna			
DATE of BIRTH 10 / 6 / 1940		COUNTRY of BIRTH Australia		ADDRESS 22 Newbold St			
MARRIAGE STATUS married		SEX F		MARRIAGE at age husband, Richard			
OCCUPATION Sales Assistant		RELIGION C of E		RESIDENCE Randwick, NSW			
EMPLOYER or Medical Grace Brothers		BLOOD GROUP C Rh		HYPERALB None		Sex F	
A. IMMEDIATE FAMILY				B. ALLERGIES / DRUGS		C. LIFESTYLE RISK (Patient)	
				Eradim / Rash		Alcohol 160g/week Tobacco 4000 Physical Activity Regular Other	
Date		No.		Date		Type	
1971		1		Cholestyramine		ADT	
1982		1		Angina, (60, M, 62)			
1984		1		Angina, (60, M, 62)			
D. ACTIVE PROBLEMS last date reviewed				E. INVESTIGATION & TREATMENT		F. PHYSICAL MEASUREMENTS	
hypertension 1988 obesity 1982				amlodipine 10 mg twice		Height 160 cm Weight 70 kg BMI 22 BP 160/90 Tobacco 4000 Alcohol 1600 Hypertension Diabetes Cholesterol 5.6 (mmol/L) Triglycerides F.B.L. S.B.L. Diet Sex Cultural Menopausal 1980 Pop. 1980 -HARD Other	
				CAPOTEN 20mg TABLETS			

5 The RACGP has recognised this by incorporating a Health Summary Sheet as an essential part of their prevention standards in the RACGP Entry Standards for General Practice, 1996.

Putting prevention into practice: implementation strategies

Page No.		11. Preliminary Notes GPI ACPE PROGRAM - CONTINUED		SURNAME Smith	PHONE NUMBER
				GIVEN NAME Jane Anne	
DATE	TYPE No.	PROBLEMS (Subjective, Objective, Assessment GPI ACPE PROGRAM - CONTINUED)	EX	PLANS (Preventive, Therapeutic, Educational & Other Measures)	
17/92		menorrhagia ibuprofen		ultrasound gynaecology referral	
		check BP - 180/90		lipid profile	
12/298		vaginal dryness post hysterectomy			
		BP 140/85		diabetic control consult	
10/284		insurance medical		mammogram	
		BP - 180/90		low fat diet	
				advice re drinking & BP	
		PHYSICAL EXAMINATION			
		System eg. Neck (Normal)			
Date	to	10/29/94			
Abdom		2-4 day			
Throat		normal			
Pupils/		reactive 4 to 6mm			
Reflex		30m/s x 3 week			
Height		160		advice re low fat diet	
Weight		65			
HR		72			
BP		180/95			
ECG		NA			
Urea					
Albumin					
Hematin					
Smear					
Cholesterol		5.2			
Triglyceride					
HDL		1.0			
HDL					
Spacer					
BP					
Diabetes					
Mammogram		1992			
Pop.		NA			
Other					

Figure 5: RACGP health summary sheet (back sheet).

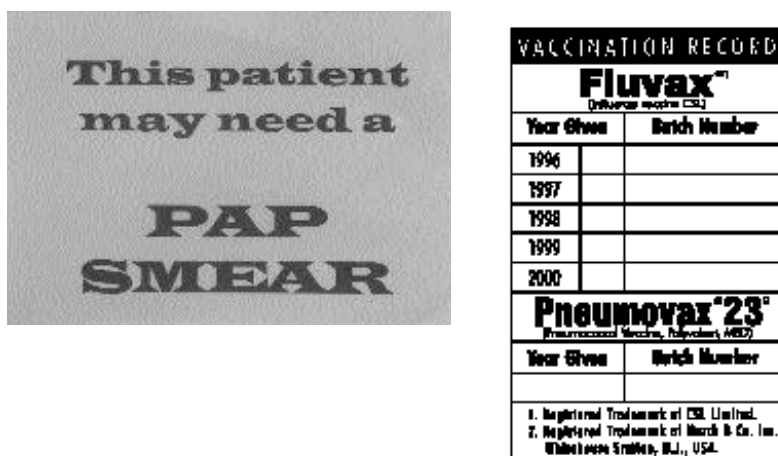
The information identified in the PPQ can be readily transferred to the HSS by someone like the PPC. Alternatively you can use the HSS as a prompt to raise an issue with the patient in the consultation. One useful strategy is to arrange a subsequent consultation with a new patient to fill it in (along with other relevant information such as allergies or medication) as part of getting all the patient's medical details.

Health summary sheets are a useful prevention aid because they can identify what has been done and what needs to be done. Tackling one (or perhaps two) items in a consultation is a more realistic strategy to bring the HSS up to date.

Putting prevention into practice: implementation strategies

Used in conjunction with case note reminders, the HSS significantly increases opportunistic identification of many preventive issues. Using different coloured stickers helps you to readily identify the most urgent of your patient's preventive needs and which activities need to be performed on a regular basis (Figure 6).

Figure 6: Two types of case note stickers



Reminders

Reminders can be either opportunistic (HSS, prompt by a computer or case note stickers) or pro-active (letter or a phone call to patients). They may be used to:

- Initiate prevention (call – invite patients to attend for a preventive activity)
- Opportunistically prompt during the patient visit
- Follow up a preventive or clinical activity (recall).

As noted earlier, a partly completed HSS serves as a useful opportunistic reminder. It highlights what preventive activities are due and what has been done.

Reminders are especially effective when they are coupled with a practice register. A practice register is merely a complete and ordered list of patients in the practice. It contains their date of birth, address, gender and any conditions that need follow up. It is assembled on two sets of cards (one for each gender) or, preferably, on a computer. The computer and associated software have greatly simplified this task. The various billing packages contain most of the required demographic information and can be used to provide a practice register.

There are several forms of the register:

- Age-sex register, for example, patients 65 years and older, children under five years of age, women over 50 years

Putting prevention into practice: implementation strategies

- At-risk register, for example, abnormal Pap smear, those on anticoagulants
- Prevention register, for example, extending the age-sex register to include appropriate prevention activities like Pap smears, immunisation
- Disease register, for example, asthma, diabetes, hypertension.

The various practice registers help you to systematically target all of the patients in a particular group (eg. patients over 65 years in the case of influenza and pneumococcal vaccinations). After you have assembled your register, the next step is to flag when a preventive activity is offered (and accepted). At an appropriate time interval you can check the register to see who is overdue for a preventive activity. You can then decide whether to send the patient a reminder to follow them up or deal with it opportunistically at the patient's next visit (*Figure 7*). Combining the reminder system with a practice register ensures that the system is geared to the practice population. Computers can also help here by providing automated reminders to GPs and generating mailing lists of those overdue for preventive activities. They also help to minimise the repeated data entries that may occur with manual registers and reminder systems.




*THE RECALL PROCESS**

1. Fill in the Recall details and give your patient their copy (yellow copy).
2. The doctor or staff should complete the details in the stippled area of the Recall Reminder (white copy).
3. The Recall Reminder can be filed with the history or with the Recall Card (Pink File Copy) in the index box.
4. The Recall card is filed by month and year and can be colour coded.
5. At the time required, the history is checked and if still relevant, the stippled area on the Recall Reminder (white copy) is separated and discarded, prior to posting the Recall Reminder.
6. Action taken and outcome can be listed on the Recall Card.

* The RACGP Recall Card is one example of a follow up reminder system. The term reminder is used as it encompasses initiation, opportunistic activities and follow up whereas recall only relates to follow up.

Figure 7 : RACGP recall card and instructions.

Putting prevention into practice: implementation strategies

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	19 _____
Name _____ File No. _____												PATIENT COPY
Address _____												
Postcode _____												
REASON FOR RECALL _____												
<p>You will remember we agreed to notify you to make an appointment for review at this time.</p> <p>Please ring the surgery to make an appointment or to notify that this service is no longer required.</p> <p>Yours sincerely,</p> <p>Please advise name, address or phone changes.</p>												
APPLY PRACTICE STAMP												
												
"Move it or Lose it"												


Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	19 _____	Colour Code for Type of Recall	
Name _____ File No. _____												RECALL REMINDER	Initial Consultation Date: _____	
Address _____													Tel. Hm: _____	
Postcode _____													Wk: _____	
REASON FOR RECALL _____													(Code: _____)	
<p>You will remember we agreed to notify you to make an appointment for review at this time.</p> <p>Please ring the surgery to make an appointment or to notify that this service is no longer required.</p> <p>Yours sincerely,</p> <p>Please advise name, address or phone changes.</p>													e.g. PAP, BP, Cholesterol, Skin check, Breast Mammography, Diabetes, Immunisation, etc.	
TESTS OR OTHER SERVICES TO BE PRE-ARRANGED: _____													Doctor: _____	
Give details of type of test and how long before consultation, e.g. MSU 2 weeks													Consultation Preferred: _____ Best A, B, C or D	
OFFICE USE: LETTER: (date) _____ Verbal: (date) _____ Phone: (date) _____														
Comment on Recall Problems: _____														
 RECALL PROCESS OUTCOME _____													DATE: _____	

Figure 7 : RACGP recall card and instructions.

Putting prevention into practice: implementation strategies

Advantages of reminders

Reminders have several advantages.⁶

- They double the level of prevention coverage (efficacy)
- They identify the target population: clarify who is in an at-risk group
- They facilitate follow up of patients
- They are acceptable to patients, RACGP,⁷ and Health Insurance Commission
- They provide a denominator for quality assurance.

The RACGP and the Health Insurance Commission have indicated that patient recall and reminder notices are an appropriate and acceptable method for promoting preventive care. Reminders are also acceptable to patients who view them as an expression of interest on the part of their GP.

While Australian data are not available, overseas experience indicates that not all your patients attend the practice in a 12–24 month period. Attendance varies widely between practices, ranging from 60 to 90%. This sets an upper limit on the possible extent of coverage by passive reminder systems, even if every patient coming to see you was offered preventive activities that were appropriate to them.

While some patients have a number of visits that provide regular preventive opportunities, others may be relatively infrequent attenders. It is especially worthwhile flagging this group and offering them preventive activities whenever they present to the practice.

Problems associated with reminder systems

Several problems have been associated with reminder systems.

- Time and resources required to set up and maintain
- Alleged over-servicing/medicalising health
- May foster dependence
- Plateau/ceiling effect
- Cost-effectiveness uncertain.

First, considerable initial effort is required to identify the target (at-risk) population. Australian general practitioners without a computer in their practice do not, in general, have an accessible list of their general practice patients indicating age and sex. Most pathology practices can help you out by

⁶ A recent medicolegal opinion obtained by the RACGP indicated that reminders were seen as an essential part of the practice and strongly urged GPs to have some form of reminder system in place.

⁷ See RACGP policy on patient recall, RACGP Guidelines for Preventive Activities in General Practice, 4th edition, 1996, p. 8

Putting prevention into practice: implementation strategies

providing a complete list of your patients who have attended for a pathology test and who need follow up in a number of areas, for example, abnormal Pap smears, lipid profile or INR monitoring for those on anticoagulants.

Second, some GPs view the practice of sending reminders as over-servicing or even 'medicalising' aspects of health that should be best left to the patient. They express the concern that they may be taking on a responsibility that should be left to the patient. **This is not the case.** You should obtain the patient's consent to send reminders after explaining the nature and extent of both your and the patient's responsibilities. This consent should include both the method and frequency of contact.

In addition, it has been suggested that reminders may foster dependence – with both patients and doctors coming to rely on them. Careful consideration should be given to the timing of active reminders so that the patient's own efforts (and responsibility) to obtain preventive services are not undermined. Furthermore, patients may become habituated to frequent reminders, leading to the development of a ceiling or plateau of prevention coverage. Unfortunately this may be below the desirable level of coverage. For similar reasons when reminders are withdrawn, prevention coverage rates may decline to pre-reminder levels.

Finally, while active (call and recall) reminders may result in greater improvements in prevention coverage, they require a lot more work and tend to cost more to implement than opportunistic reminders. The latter have the advantage of being timely. The patient may be more receptive to the preventive activity when they see and get a specific recommendation from you. Passive reminders (HSS, computerised prompts and case note stickers) have the advantage of being simple to initiate and require 'minimal' maintenance. They may be less efficient at targeting patients who are both infrequent attenders and those who need a number of preventive activities.

Computer information systems

Information systems have two particular advantages over manual organisational methods. They minimise the time spent in accessing and sorting information.⁸ They are also more efficient in helping you to be more systematic in your approach to prevention.

Information systems in general practice have a number of components that can contribute to better preventive care.

⁸ Contact your local RACGP Informatics Committee for information about which computer system will best suit your needs.

Putting prevention into practice: implementation strategies

Advantages of using a computer in the practice

- Storing and organising information (accounts, databases, prevention registers)
- Cuing and recall systems
- Generating health education information for patients
- Assisting with decision making through algorithms and clinical decision-making and guidelines packages
- Accessing information, for example, information databases like Medline, the Cochrane Library and email.⁹

Storing and organising information

Computers are good for storing and organising large amounts of patient information, for example, laboratory results, disease databases, and health screening questionnaires. This information does need to be entered into the computer initially. It can then be arranged and used for prevention in a number of ways. Software programs can provide information that you have collected on patients to identify target groups or at-risk groups, for example, those overdue for childhood immunisations, infrequent attenders (no visits in the past 2 years), patients 65 years and older.

Computer programs also facilitate more systematic preventive care to all your patients through the assembly of age–sex, prevention and disease registers. Finally, the patient's prevention information can be systematically organised on the computer. It is easy to read and can be assembled into a readily accessible summary. Because information only has to be entered into the computer once, both duplication and the staff time required for doing things manually (eg. reminder cards and age–sex register) are reduced.

Cuing and recall systems

Automated reminders can prompt you to address preventive tasks that may be due or overdue for patients seeing you for other reasons. With automated cuing the guidelines for various conditions are pre-programmed into the computer. These guidelines then prompt you automatically when the patient attends the surgery and a preventive activity is due. It has the additional advantage of being both timely and operating independently of the doctor remembering which preventive activities are due. A number of packages can do this for childhood immunisation. In addition, the Australian Childhood Immunisation Register (ACIR) provides prompts to GPs and parents about overdue immunisations.

⁹ The Cochrane Library is part of an international network of centres established to coordinate the Cochrane Collaboration – a network of individuals preparing, maintaining, and disseminating systematic reviews of research on the effects of health care. The Australasian Cochrane Centre can be contacted on: phone: (08) 820 45399; fax: (08) 820 44690.

Putting prevention into practice: implementation strategies

In a similar manner, you can be prompted to send a reminder to patients who visit the practice infrequently or who fall due for some preventive activity and where a consultation with the GP is unlikely in the next few months.

The use of computer-generated prompts during patient consultations has significantly improved immunisation rates and the delivery of other preventive tasks such as cancer screening by up to 50%. A computer-based information system can be used to increase opportunistic screening by prompting the GP to offer a range of relevant prevention activities.

Generating health education information for patients

Computers with preventive-based software can be used as an interactive tool to interview the patient and provide personalised, timely and tailored feedback based upon the information collected. Up to date guidelines, preventive tips and suggestions can be printed out during the consultation, personalised and given to the patient to take home and read. This feedback can be in the form of a patient health summary or a complete patient health record. Computer generated patient education leaflets (eg. Edu-cate or John Murtagh's 'Patient-Education') are available on a wide range of health topics.¹⁰ Increasingly, computers are a useful tool for health risk appraisal where patients are given tailored advice based upon their responses to a variety of prevention questions. These can then be compared to a population database.

Assisting with clinical decision making and quality of care

Computers can assist with taking a patient history, prescribing medication, and making clinical decisions. Guidelines and databases (such as the Cochrane library) can be stored on computer and accessed when needed to help with monitoring the quality of care provided by GPs. Computerised practice registers also greatly facilitate the evaluation of the quality of care provided to patients and the monitoring of health outcomes.

Accessing information and email

Computers can contribute to your continuing education by providing quick access to a range of computerised databases and the Internet.¹¹ Email is a quick and efficient way of communicating with your colleagues, the local hospital (eg. for pathology results, discharge summaries etc.) and the Health Department (eg. infectious disease outbreaks and alerts, health promotion campaigns, calendar of health events).

¹⁰ Contact your local RACGP Informatics Committee member about the range of IT packages available and where they can be found.

¹¹ For example, Health on the Net (<http://www.mel.hcn.net.au/info/intro/htm>), the RACGP homepage (<http://www.racgp.org.au/index.htm>), and the Health Communication Network (<http://www.hcn.net.au>).

Putting prevention into practice: implementation strategies

In summary, computers provide the GP with efficient, powerful and flexible data and information management systems that can collate prevention registers and generate reminders. These activities are essential elements of an effective practice population-orientated prevention system.

For those who don't have or don't plan to use computers here are some practical tips:

- Use local pathology groups to provide lists of your patients who are due for a preventive activity, for example, Pap smears, lipid profile
- Use case note stickers to prompt you to do opportunistic screening
- Use a HSS to provide an easily accessible patient prevention profile
- A noticeboard that is kept current with health event weeks may prompt patients to ask you about their prevention status
- Use the RACGP manual recall system (*Figure 7*) or alternatively a simple diary with columns for due date, patient name, reason for recall, when recalled, method of recall such as phone or letter, and signature (using 2 months per page).

Dr Oliver Frank is a partner in an Adelaide suburban general practice. He uses a computerised record system coupled with an automated reminder system that is generated at each patient contact.

Our computer medical record system has been enhanced by the addition of programs designed to make use of the many opportunities to increase preventive care in each consultation. These programs allow the computer to automatically search the patient's medical record at the beginning of each consultation and find the most recent performance, if any, of each preventive procedure which is indicated for that patient.

For each preventive activity that is due or overdue, the system displays a reminder message which shows when the procedure was last done, what the result, finding or action was, and when that procedure was due to be done again. It also writes the reminder messages into the progress note.

This system saves time and effort because I don't have to leaf through pages of case notes or screens of data to ensure that I know which procedures are due for the patient. This leaves me more time and energy to deal with the patient's current health problems.

Because most of our patients attend several times each year, using the preventive care opportunities in each consultation allows most indicated care to be delivered without recalling those patients.

The system also generates statistics which provide information about how well relevant preventive care is being delivered. This provides a reward in satisfaction when I can see the delivery of care is improving or being maintained at an acceptable level.

Putting prevention into practice: implementation strategies

Patient-held records

Patient-held records:

- Are acceptable to patients
- Can promote better knowledge about prevention and illness
- Can contribute to increased patient responsibility for their health
- Can promote both continuity and quality of care.

Patient-held records are especially useful in:

- Chronic illnesses such as diabetes, asthma
- Multiple illnesses
- Situations where medication is being regularly reviewed such as anticoagulants, anticonvulsants
- Patients with hearing, memory and language problems.

Patient-held records help to facilitate patients taking a more active interest in their own health, and to empower them to become more involved in the management of their own illness.

Patient-held records are acceptable to patients, provide personalised information and contribute to their knowledge about prevention and other health topics.

They provide tangible evidence of your 'instructions'. These are more likely to be followed by patients as they can refer back to them frequently.

Patient-held records act as prompts and facilitate continuity of care and, subsequently, quality of care in an environment where some patients see a number of primary medical care providers. Examples of common patient-held records are: the diabetic diary, the child personal health record, asthma management plans and the personal vaccination card (*Figure 8*).


		RECOMMENDED SCHEDULE CHILDREN UNDER 15 2, 4, 4, 12 months Diphtheria, Tetanus and Whooping Cough (Pertussis) (DTP or Triple Antigen) Hib (Haemophilus influenzae type b) Poliovaccine (oral) Measles—Mumps—Rubella ----- 9-11 years 4th year Poliovaccine (oral) prior to school entry Diphtheria, Tetanus and Whooping Cough (DTP or Triple Antigen) *DTaP is recommended until 6 years of age. Measles—Mumps—Rubella ----- 15-18 years prior to leaving school Poliovaccine (oral) Diphtheria and Tetanus (ADT) ADT booster every 10 years Measles—Mumps—Rubella All women under 45	Personal Vaccination Record  SURNAME _____ GIVEN NAMES _____ ADDRESS _____ _____ _____ DATE OF BIRTH _____ Keep this card with the personal health record (PHR)
Vaccine	Vaccine		
Batch No.: Vaccine	Batch No.: Vaccine		
Batch No.:	Batch No.:		

Figure 8: Example of a personal health record.
 Reproduced with permission from the South Australian Health Commission

Putting prevention into practice: implementation strategies

The most efficient way to produce a patient-held record is to use a computer coupled with a computerised medical record. This avoids the problems of double entry, legibility and outdated records.

A good way to ensure that the record doesn't get lost is to suggest to the patient that they keep it with their first-aid box.

Patient education

Patient education is provided in a number of ways in general practice, usually during the consultation or through a range of brochures, information and educational material. Most patient education leaflets are more effective when they are offered directly to the patient as part of the advice that you give them during the consultation. The elements of a good patient education leaflet will be discussed in the next section. This section will focus on relevant communication and counselling skills.

Things you should consider when providing patient education

- What are the patient's needs?
 - What is their current understanding of the preventive area?
 - What does the patient want to know?
 - Does the information relate directly or indirectly to the presenting complaint?
 - Is the information congruent with their language and culture?
 - What skills are needed?
- Is the information relevant to the patient's existing knowledge, preferred learning format, reading level, beliefs, circumstances and prior experience?
- Does the patient understand and remember what was discussed during the consultation?
 - Are the agreements negotiated between GP and patient, clear, simple and in language that the patient understands?
 - Does the patient comprehend what action they need to take?
 - Does the patient remember your instructions and the information that you discussed in a weeks time?
- Is the patient ready to hear the information and accept the procedure or make the necessary changes?
 - Has the inquiry about a preventive area been supported by a clear rationale about why it is important to this patient?
 - Is their autonomy respected?
 - What are their expectations, fears and concerns about the preventive activity?

Putting prevention into practice: implementation strategies

- Does the patient have an opportunity (and encouragement) to ask questions and give feedback? Many patients miss this chance in the face of large amounts of information and are often hesitant about raising concerns. Telling patients what to do is often not effective. Getting them to identify their concerns and expectations assists them to articulate the arguments for change and helps to hand decision making processes back to them.
- What are the costs and benefits of carrying out the preventive activity?
 - Do the perceived benefits exceed the perceived costs? Assess the patient's motivation before you provide advice.
 - Are the benefits perceived as worthwhile and achievable by the patient? Start with the patient's perceptions of the costs and benefits associated with a prevention activity rather than your appraisal of the apparent costs and benefits. Brief motivational interviewing techniques can be used successfully with patients who express ambivalence about changing.¹²
 - Are all the available options explored, with the patient in control of the choices? While you may not agree with some of the patient's choices, respect their right to choose.
- Is the patient both confident and able to make the necessary changes?
 - Is the information relevant and tailored to suit the patient?
 - What are the existing and anticipated difficulties and barriers that may make it hard for the patient to accept or carry out the preventive activity?
 - Are the changes required under their control? Unless the patient believes that their efforts (such as changing their diet or stopping smoking) have a good chance of being successful, they are unlikely to persist in their attempt to change.
- What support(s) does the patient have to help them?
 - Are there mechanisms for support and feedback of the planned preventive activity? Do you review the issue at the next visit and provide reinforcement about the planned patient activities? Attempts to improve the patient's knowledge without assessing their environment and assisting them to gain the necessary skills are unlikely to be successful.

How GPs can be more effective

- First understand and address the concerns, issues and expectations of the patient (which is not always what you may think they need to know)
- Provide options to patients, allowing them the opportunity to choose alternatives and work on the 'risk' area of their choice

¹² Further information and reading on motivational interviewing techniques in the GP setting is provided in the bibliography and Appendix 5.

Putting prevention into practice: implementation strategies

- Structure the information in a form that addresses the patient's needs and recognises their preferred methods of learning
- Check that the patient has understood what has been said
- Adjust the pace, amount and type of information according to the patient's readiness to change and their level of comprehension
- Reinforce the message with personalised written materials, behavioural strategies and offer follow up to review the patient's progress.

Patients on average remember up to four things within a consultation. Written instructions and up to date relevant patient education materials (leaflets, brochures and books) are useful to reinforce the main messages of the consultation and offer details to be read at leisure.

Highlight the specific areas relevant to the patient's needs and concerns. When you add personalised messages to existing leaflets you also help to tailor the material to the specific needs of the patient. Putting the patient's name on the leaflet decreases the 'throw away' rate.

Patient education materials

Patient education materials can be used to:

- Raise awareness of a health issue
- Provide specific advice and information about a health topic.

When specific advice is needed, it is more effective to give patients health information/education pamphlets directly at some relevant point in the consultation. The information needs to be clear, concise, relevant to the patient, up-to-date and practical.

Be discerning. Choose leaflets carefully. Some factors you should consider are:

- **Audience**
 - Who is the material written for?
 - Does it target specific readers (eg. older people, people with diabetes)?
- **Needs**
 - Does it clearly explain its purpose?
 - Does the range of patient education materials reflect the most important prevention areas that you and your patients have identified?
- **Content**
 - Is it written in a way that the meaning is both clear and concise?
 - Does it discuss issues relevant to common misconceptions (eg. immunisation, HIV/AIDS)?
 - Is the content updated on a regular basis?

Putting prevention into practice: implementation strategies

- **Source**
 - Is the source of the information unbiased?
 - Is the leaflet readily available and accessible?
 - Is the information valid and evidence-based? Some patient education leaflets may promote a limited range, less effective, or even inappropriate therapeutic options.
 - Is it topical? Current issues and controversies are more likely to catch people's attention.
 - Is the material up to date? Check the latest edition date.
- **Presentation**
 - What factors will affect the patients' understanding and acceptance of the information? (eg. literacy, reading level, language, specific cultural practices and beliefs, knowledge of the topic)?
 - Is the print of adequate size for the elderly or sight impaired?
 - Is action or a response asked for in the leaflet (eg. smoking cessation)?
- **Clarity**
 - Does it read well?
 - Is sufficient detail provided for the patient to carry out the required activities?
- **Location**
 - Are sensitive topics discreetly displayed?
 - What is the best location for the material? Put simple awareness raising issues in the waiting room and keep more specific or detailed information for your consulting room.
- **Style**
 - Is it positive (not blaming)?
 - Is the physical presentation simple but 'catching'?

See *Figure 9* for a good example of a patient leaflet.

Putting prevention into practice: implementation strategies

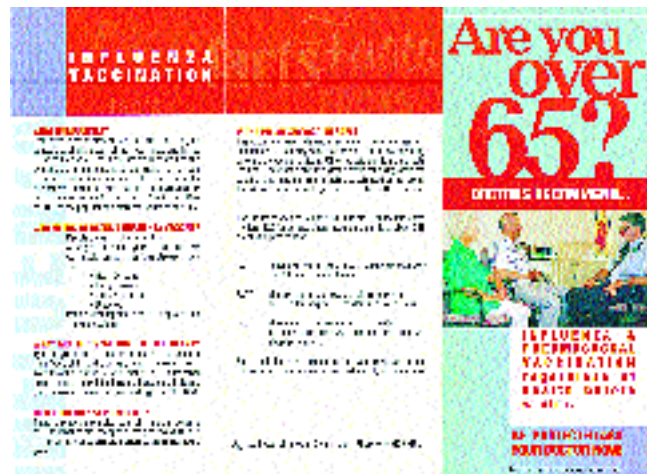


Figure 9: Example of a good patient education leaflet. Reproduced with permission from the South Australian Health Commission.

A system is needed to keep relevant material displayed and identify when more leaflets should be ordered. The PPC should delegate one person to regularly review the material (every 4–6 weeks) and update the leaflets.

The range of patient education materials that you can display and store will be dictated by your resources such as space and cost. Various computer software packages, (eg. Edu-cate, John Murtagh's Patient Education) provide patient education on a range of topics. They can also save you space as they can be printed off when needed.

Appropriate targeting to the main prevention areas of your particular practice will help.

Review the content and popularity of the patient education material at the practice meeting. Patient responses to the PPQ can help to identify areas that patients want more information about.

You may find it useful to use an 'expand a stand' to help keep leaflets tidy and organised. This interlocking perspex material provides the maximum versatility and is reasonably cheap. Monitor the condition of leaflets – replace them if they bend or start looking tatty. Leaflets about sensitive issues (eg. sexual) could be discreetly positioned – in one spot so that some people are not deterred. It is also useful to put leaflets in a holder next to a poster on the same topic. Don't forget the back of the toilet doors, above the wash basins, reception desks and surgery windows as convenient locations to display pertinent material for patients.

Other forms of patient education

While audiovisual strategies such as video and television programs, practice newsletter and other methods of educating patients (eg. practice health libraries) look promising, they have not been subjected to rigorous evaluation.

Screening/case finding

Screening is the systematic identification of all individuals within a target population with a clinical activity (examination or investigation) to determine whether they have the condition of interest.

The RACGP Guidelines for Preventive Activities in General Practice (the Redbook) has recognised only a handful of screening activities for which there is enough quality scientific evidence to support that the intervention does more good than harm (eg. mammography and Pap smears). Case finding refers to screening that occurs in the practice environment rather than at population level. Screening aims to identify disease early in its natural course so that effective intervention can be offered to reduce the associated morbidity and mortality. To be effective, all of the target population needs to be offered the screening procedure. This is difficult to do in the absence of a computerised practice register which facilitates identification of all the subjects in the target group.

The computerised register will need to contain an accurate and complete listing of the target population. A number of practice computer systems are looking at automating the prompting to help GPs identify individuals in the target population as they attend the practice to see the GP.

In the case of screening the following criteria should be met:

- The condition must have a significant effect on the quality or length of life
- Acceptable methods of treatment must be available
- The conditions must have an asymptomatic period during which detection and treatment significantly reduce morbidity and mortality
- Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear
- Tests to detect the condition in the asymptomatic period must be able to discriminate well between those who have the condition and those who do not
- The tests must be acceptable to patients and must be available at reasonable costs
- The incidence of the condition must be sufficient to justify the costs of screening.

Needs assessment has been used rather than screening or casefinding as the latter terms tend to generate confusion and controversy. GP and patient needs assessment emphasises a partnership and goes beyond an epidemiological interpretation suggested by casefinding and screening. It is also the starting point for any quality assurance activity by helping to ensure that any interventions or practice programs are based upon established need.

Controversies

Traditional continuing medical education

Lectures that simply tell you how to provide more effective prevention are unlikely to result in improvement. Educational methods of improving prevention activities, such as attending CME functions or reading a journal article are necessary but rarely result in changes in the doctor (or the practice).

Change requires a number of practice-related activities:

- Assessment of current performance and need
- Coordination
- Planning
- Using a number of strategies together.

Turn back to *Figure 2* to review the main ingredients that are necessary to be more effective.

Facilitator

There is substantial overseas evidence for the effectiveness of primary care facilitator/nurse educators in improving the delivery of preventive services in the general practice setting.

In most of these settings the GP shares a small part of the cost of employing the facilitator. While, PPCs are not an affordable option for most GPs in the current Australian setting, the advent of the Divisions and the possibility of a Division-based prevention coordinator may make the introduction of facilitators into Australian general practice more feasible.

To overcome this financial hurdle many of the coordination tasks of the facilitator have been incorporated into the role of the PPC. It is worth considering contacting your local Divisions to discuss the possibility of a Division-based prevention coordinator who could service a local cluster of practices in your area.

Tasks that they could do include:

- Identify and send out good quality patient education material for Division members
- Provide information technology advice about a range of computer systems (hardware and software)
- Assist in completing the practice prevention inventory
- Help inform and train your practice to organise the practice and assist your preventive efforts.

Bibliography

Audit

Humphrey C, Hughes J. Audit and development in primary care. Medical Audit Series 5. Kings Fund, 1992.

Humphrey C, Hughes J. Medical audit in general practice: a practical guide to the literature. Kings Fund, 1990.

Mugford M, Banfield P, O'Hanlon M. Effects of feedback information on clinical practice: a review. *Br Med J* 1991; 303: 398–402

Computers

Sullivan F, Mitchell E. Has general practitioner computing made a difference to patient care? A systematic review of published papers. *Br Med J* 1995; 311: 848–852.

Education: GP

Davis D, Thomson M, Oxman A, Haynes R. Changing physician performance: a systematic review of the effect of continuing medical education strategies. *JAMA* 1995; 275: 700–705.

Oxman A. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *Can Med Assoc J* 1995; 153 (10): 1423–1431.

Rush B R, Powell L Y, Crowe T G, Ellis K S. Substance Abuse Facilitator Model: Health Promotion Training for Family Physicians. *J Cont. Educ. Health Prof.* 1995; 15:106-116.

Solberg L I, Kottke T E, McBride P, et al. Using continuous quality improvement to increase preventive services in clinical practice – going beyond guidelines. *Prev Med* 1996; 25 (3):259–267.

Stott N C H, Pill R M. 'Advise yes, dictate no'. Patients' views on health promotion in the consultation. *Fam Pract* 1990; 7 (2): 125–131.

Wiggers J H, Sanson-Fisher R. General practitioners as agents of health risk behaviour change: Opportunities for behavioural science in patient smoking cessation. *Behav Change* 1994; 11 (3): 167–176.

Education: Patient

Kahn MD. Computer-based patient education: A progress report. *MD Computing* 1993; 10 (2): 93–99.

Knowlden S, et al. Process evaluation of computerised patient education leaflets in general practice. Final report. School of Community Medicine – UNSW, Department of General Practice – Fairfield Hospital, October 1995.

Stott NCH, Pill RM. 'Advise yes, dictate no., Patients' views on health promotion in the consultation. *Fam Pract* 1990; 7 (2): 125–131.

Facilitator

Dietrich A J, Sox C H, Tosteson T D, Woodruff C B. Durability of improved physician early detection of cancer after conclusion of intervention support. *Cancer Epid Bio Prev* 1994; 3: 335–340.

Bibliography

Fullard E, Fowler G, Gray M. Promoting prevention in primary care: controlled trial of low technology, low cost approach. *Br Med J* 1987; 294: 1080–1082.

Feedback

Buntinx F, Winkens R, Grol R, et al. Influencing diagnostic and preventive performance in ambulatory care by feedback and reminders: a review. *Fam Pract* 1993; 10: 219–228.

Framework

Baric L. The settings approach-implications for policy and strategy. *J Instit Health Educ* 1993; 31: 17 – 24.

Bass M J. Dissemination research in primary care: Impacting the real world of the practitioner. *Can J Pub Health* 1996; 87 (suppl 2): S71 – S74.

Berwick D M. A primer on the improvement of systems. *Br Med J* 1996; 312: 619–622.

Cohen S, Halvorson H, Gosselind C. Changing physician behaviour to improve disease prevention. *Prev Med* 1994; 23: 284–290.

Grol R. Quality improvement by peer review in primary care: a practical guide. *Qual Health Care* 1994; 3: 47–152.

Grol R. Beliefs and evidence in changing clinical practice. *Br Med J* 1997; 315: 418–421.

Jaen C, Stange K, Nutting P. Competing demands of primary care: a model for the delivery of clinical preventive services. *J Fam Pract* 1994; 38 (2):166–171.

McGinnis J M. Put prevention into practice. *Arch Int Med* 1996; 156: 130–132.

Pommerenke F, Dietrich M D. Improving and maintaining preventive services part 1: applying the patient model. *J Fam Pract* 1992; 34 (1): 86–91.

Sanson-Fisher R W, Bowman J, Leeder S. Prevention in clinical practice. *Med J Aust* 1992; 156: 397–404.

Solberg L I, Maxwell P L, Kottke T E, et al. A systematic primary care-based smoking cessation program. *Fam Pract* 1990; 30: 647–54.

Thompson R S, Taplin S H, McAfee T A, et al. Primary and secondary prevention services in clinical practice. *JAMA* 1995; 273: 1130–1135.

Walsh J, McPhee S. A systems model of clinical preventive care: an analysis of factors influencing patient and physician. *Health Educ Quart* 1992; 19: 157–175.

Woolf S H, et al, 'Methodology', Adapted from the report of the Canadian Task Force on the Periodic Health Examination. The Canadian Task Force on the Periodic Health Examination: 1989 update part 1. *Journal of Clin Epidemiol* 1990; 43: 891-905

Guidelines

Belcher D W, Berg A O, Inui T. Practical approaches to providing better preventive care: Are physicians a problem or a solution? *Am J Prev Med* 1988; 4 (suppl 4): 27–48.

Bibliography

Davis D A, Taylor-Vaisey A. Translating guidelines into practice. *Can Med Assoc J* 1997; 157: 406–416.

Grimshaw J M. Achieving health gain through clinical guidelines II: ensuring guidelines change medical practice. *Qual Health Care* 1994; 3: 45–52.

Grimshaw J M, Freemantle N, Wallace S, et al. Developing and implementing clinical practice guidelines. *Qual Health Care* 1995; 4: 55–64.

Hutchinson B G, Abelson J, Woodward C A, Norman G. Preventive care and barriers to effective prevention. How do family physicians see it? *Can Fam Physician* 1996; 42: 1693–1700.

Pels R, Bor D, Lawrence R. Decision-making for introducing clinical preventive services. *Ann Rev Public Health* 1989; 10: 363–383.

Smallwood R A, Lapsley H M. Clinical practice guidelines; to what end? *Med J Aust* 1997; 166: 592–595.

Worrall G, Chault P, Freake D. The effects of clinical practice guidelines on patient outcomes in primary care; a systematic review. *Can Med Assoc J* 1997; 156: 1705–1712.

Health behaviour

Alonzo A A. Health behaviour: issues contradictions and dilemmas. *Soc Sci Med* 1993; 37 (8): 1019–1034.

Health summary sheets

Belcher DW, et al. 'Practical approaches to providing better preventive care: Are physicians a problem or a solution?'. *Am J Prev Med* 1988; 4 suppl 4: 27–48.

Cheney C, Ramsdell JW. Effect of medical records' checklist on implementation of periodic health measures. *Am J Med* 1987; 83: 129–36.

Fullard E, Fowler G, Gray M. Promoting prevention in primary care: controlled trial of low technology, low cost approach. *BMJ*; 1987, 294: 1080–82.

Heywood A, et al. Final Report on Preventive Care Management in General Practice. A Pilot Project Funded by the General Practice Evaluation Program. December 1994.

Marsh GN, Channing DM. Narrowing the gap between a deprived and an endowed community. *BMJ* 1988; 296: 173–76

McPhee SJ, et al. Promoting cancer prevention activities by primary care physicians: Results of a randomised trial. *JAMA* 1991; 266 (4): 538–44.

Pommerenke MD, Weed DL. Physician compliance: Improving skills in preventive medicine practices. *AFP* 1991; 43 (2): 560–68.

Rich EC, et al. Influence of a preventive care educational intervention on physician knowledge, attitudes, beliefs, and practice. *Prev Med* 1989; 18: 847–55.

Weingarten MA, Bazel D, Shannon HS. Computerised protocol for preventive medicine: A controlled self-audit in family practice. *Fam Prac* 1989: 120–24.

Bibliography

Motivational interviewing

Miller W, Rollnick S. Motivational interviewing. Preparing people to change addictive behaviour. New York: Guilford Press, 1991.

Needs assessment

Bauman A, Mant, A, Middleton, L, Mackertich, M, Jane E. Do general practitioners promote health? A needs assessment. *Med J Aust* 1989; 151: 262–269.

McMenamin J P. Health screening in a general practice by opportunistic recruitment. *N Z Med J* 1992; 105: 495–497.

Opinion leaders

Silagy C, May F, et al. A systematic review of current practices of academic detailing and opinion leader education in Australia and internationally. Commissioned report for the Department of Health and Family Services, August 1997.

Organisational strategies

Carney P, Dietrich A, Keller A, et al. Tools, teamwork and tenacity: an office system for cancer prevention. *J Fam Pract* 1992; 35: 388–394.

Dickey L, Kamerow D., The put prevention into practice campaign: office tools and beyond. *J Fam Pract* 1994; 39: 321–323.

Frame P, Werth P. How primary care providers can integrate cancer prevention into practice. *Cancer suppl* 1993; 72: 1132–1137.

McPhee S, Detmer W. Office based intervention to improve delivery of cancer prevention services by primary care physicians. *Cancer* 1993; 72: 1100–1112.

Snell J, Buck E. Increasing cancer screening: a meta-analysis. *Prev Med* 1996; 25: 702–707.

Reminders

Austin S, Balas F, Mitchell J, et al. Effect of physician reminders on preventive care; meta analysis of randomised clinical trials. *Proc Annu Symp Compt Appl Med Care* 1994: 121–124.

Balas F, Austin S, Mitchell J, et al. The clinical value of computerised information services: a review of 98 randomised clinical trials. *Arch Fam Med* 1996; 5: 271–278.

Buehler S K, Parsons W L. Effectiveness of a call/recall system in improving compliance with cervical cancer screening: a randomised controlled trial. *Can Med Assoc J* 1997; 157: 521–526.

Appendix 1: Practice prevention inventory practice organisation

1. Is prevention discussed at the practice meeting? (Please tick)

- often sometimes rarely never
 not applicable, don't have a practice meeting.

Needs assessment

2. a. Do you hand out a questionnaire to patients to gauge the needs of your practice? Yes No

b. If yes, does this include questions on prevention? Yes No

3. In the past **two weeks** how often did you use the following resources for patient education?

	Percentage of patients seen who were given resources					
	Not at all	1-20%	21-40%	41-60%	61-80%	81-100%
Pamphlets/leaflets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagrams and handwritten personalised drawings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Videos/films	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. In the past **two weeks** how often did you give your **patients written educational material** on the following issues during the consultation?

	Never	Sometimes	Frequently
a. Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Immunisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Injury prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Sun exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Others – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 1: Practice prevention inventory practice organisation

5. Do you have a person in the practice responsible for (tick all that apply):

	Yes	No
a. Reviewing and updating the noticeboard and waiting room reading material	<input type="checkbox"/>	<input type="checkbox"/>
b. Reordering patient education material	<input type="checkbox"/>	<input type="checkbox"/>
c. Regularly checking the patient reminder systems	<input type="checkbox"/>	<input type="checkbox"/>
d. Overall coordination of prevention activities	<input type="checkbox"/>	<input type="checkbox"/>

6. Do you use a Health Summary Sheet to act as a prompt to discuss prevention with your patients?

- often
 sometimes
 rarely
 never
 not applicable, don't have a HSS

7. Do you use a computer for any of the following tasks?

	often	sometimes	rarely	never
a. Word processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Storing and organising information				
- patient files	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- accounting/billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- at-risk/disease register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- age/sex register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- other – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>				
c. Computers as a clinical assistant				
- patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- obtaining medical history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- scheduling appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- computerised prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- other – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>				
d. Cuing and surveillance				
- generating patient reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- GP reminders eg. prompt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- automated reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- other – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 1: Practice prevention inventory practice organisation

Patient reminders

8. Do you have a reminder system to prompt patients for any preventive activities? Yes for what conditions

	target every patient in relevant group	target selected patients	not systematic (ie. ad hoc)
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

No go to question 10

9. What form does the patient reminder take?

	frequency			
	always	often	sometimes	rarely/never
Personalised and handwritten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personalised and word processed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non personalised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone call	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GP reminder

10. Do you use case note stickers to flag any of the following conditions (tick all that apply)

a. Specific diseases

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> allergy | <input type="checkbox"/> chronic illness |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> asthma | <input type="checkbox"/> patient medication |

b. Patients at risk

- | | |
|---|---|
| <input type="checkbox"/> influenza | <input type="checkbox"/> abnormal Pap smear |
| <input type="checkbox"/> FH eg. Breast cancer, bowel cancer | |
| <input type="checkbox"/> other, please specify _____ | |

c. Patient medication

- | |
|--|
| <input type="checkbox"/> on anticoagulants |
| <input type="checkbox"/> other, please specify _____ |

11. Do you have a noticeboard or other type of display that includes information on prevention?

- yes how frequently is this reviewed? _____
- no

Appendix 1: Practice prevention inventory practice organisation

Feasibility and priority of implementation

12. Which of the following prevention strategies are feasible to implement in YOUR practice? (1 = least feasible, 5 = most feasible). What priority do you place on this activity for your practice? (1 = top priority – 5 = lowest priority) (please circle)

	Feasibility	Priority
a. Have one staff member coordinate prevention activities (PPC)	1 2 3 4 5	1 2 3 4 5
b. Regularly discuss prevention activities at practice meetings	1 2 3 4 5	1 2 3 4 5
c. Clarify practice staff role, responsibilities and tasks in prevention	1 2 3 4 5	1 2 3 4 5
d. Design and implement a prevention plan	1 2 3 4 5	1 2 3 4 5
e. Hand out a patient survey to assess preventive activities	1 2 3 4 5	1 2 3 4 5
f. Regularly review the prevention questionnaire with the patient	1 2 3 4 5	1 2 3 4 5
g. Regularly review and update the waiting room notice board	1 2 3 4 5	1 2 3 4 5
h. Regularly review and update the patient education material in the practice	1 2 3 4 5	1 2 3 4 5
i. Implement a regular patient newsletter containing some preventive activities	1 2 3 4 5	1 2 3 4 5
j. Have a completed health summary sheet on regularly attending patients	1 2 3 4 5	1 2 3 4 5
k. Use a patient reminder system	1 2 3 4 5	1 2 3 4 5
l. Use a computerised		
– age/sex register	1 2 3 4 5	1 2 3 4 5
– at risk/disease register	1 2 3 4 5	1 2 3 4 5
– cuing and reminder system	1 2 3 4 5	1 2 3 4 5
– patient education leaflet	1 2 3 4 5	1 2 3 4 5
– information database	1 2 3 4 5	1 2 3 4 5
m. Incorporating case stickers on the notes to prompt preventive activities	1 2 3 4 5	1 2 3 4 5

Appendix 1: Practice prevention inventory practice organisation

13. Which of the following prevention strategies are you likely to implement in YOUR practice?

Target Area	already in place	immediately	in the next 3 months	in the next 12 months	not at all
a. Have one staff member coordinate prevention activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Regularly discuss prevention activities at practice meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Clarify practice staff roles, responsibilities and tasks in prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Provide practice staff training to help put prevention into practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Discuss and implement prevention plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hand out a patient survey (needs assessment) to assess preventive activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Review the prevention survey with the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Regularly review and update the waiting room notice board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Regularly review and update the patient education material in the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Implement a regular patient newsletter containing some preventive activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Have a completed health summary sheet on regularly attending patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Use patient reminder system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 1: Practice prevention inventory practice organisation

Target Area	already in place	immediately	in the next 3 months	in the next 12 months	not at all
m. Use a computerised					
– age/sex register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– at risk/disease register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– cuing and reminder system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– patient education leaflet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– information database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Incorporating case stickers on the notes to prompt preventive activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Schedule specific appointments for preventive activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Systematically organise some preventive activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 2: Patient practice prevention questionnaire

NAME _____ DATE OF BIRTH _____

Please tick or write your response. Please answer all the questions.

Don't worry if you don't know the exact date when something was done.

Put down approximately the month and year when you think it happened.

RECALL/REMINDER

Would you be happy to be contacted if, on the basis of any of your responses it is felt to be necessary by the doctor?

yes don't know no

FAMILY HISTORY

Do you have a family history of any of the following? (Tick all that apply)

alcohol problems heart attack diabetes
 bowel cancer breast cancer

BLOOD PRESSURE

When was your blood pressure last taken?

Date _____ not sure never

LIPIDS

When were your cholesterol and triglycerides (fats in the blood) last tested?

Date _____ don't know never

SUN PROTECTION

How often do you use the following to protect yourself from the sun when outdoors?

	always	often	sometimes	rarely	never
Protective clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunscreen creams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SMOKING

Do you smoke?

yes no, ex-smoker → date quit _____ no

Amount per day? _____

Do you wish to quit? yes undecided no

IMMUNISATIONS

When was your last tetanus booster?

Date _____ don't know never had one

Have you had three doses of the polio vaccine (drops or injection)?

yes don't know no

FOR THOSE 65 YEARS AND OLDER

When was the last time you were immunised?

Influenza? date _____ not sure never

Pneumococcal pneumonia? date _____ not sure never

Appendix 2: Patient practice prevention questionnaire

EXERCISE

How often do you engage in any regular exercise or activity, eg, brisk walking, dancing, active gardening, long enough to work up a light sweat (at least 30 minutes)?

- 3 or more times a week 1 – 2 times a week seldom never

ALCOHOL

On how many days a week do you usually drink alcohol?

- never → non drinker
 less than monthly 1 – 2 days a month 1 – 2 days a week
 3 – 4 days a week 5 – 6 days a week every day

On a day do you drink alcohol, how many drinks do you usually have?

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often when you have six or more drinks on one occasion?

- never less than monthly monthly
 weekly daily or almost daily

Do you have any concerns about your drinking?

- yes unsure don't know

MEDICATIONS

Are you taking any medication not prescribed for you by this doctor, for example, pain relievers, vitamins or minerals, tranquillisers to calm you down (eg. Valium, Serapax), laxatives, sleeping pills, cough and cold medicines or antihistamines (for allergy)? Please indicate how often you take the medication.

- | | Medication | how often do you take these |
|---|------------|-----------------------------|
| <input type="checkbox"/> yes → please specify | | |

- no

WOMEN'S HEALTH

GERMAN MEASLES

Have you ever had German measles or the German measles (rubella) vaccine?

- yes, immunised had German measles don't know no

PAP SMEAR

When was your last cervical smear (Pap) test?

- Date _____ don't know never had one not applicable
(have had a hysterectomy)

ABNORMAL PAP SMEAR

Have you had an abnormal cervical smear (Pap) in the last 5 years?

- yes don't know no

WOMEN 50 YEARS OR OLDER ONLY

When was your last mammogram (breast X-ray to detect cancer)?

- Date _____ don't know never had one

HEALTH INFORMATION

Please list any health areas about which you would like more information.

Appendix 3: Local prevention contacts in each state

QUEENSLAND

Senior Project Officer
Public Health Services
Queensland Health Department
GPO Box 48
Brisbane 4000
ph: (07) 3234 0111
fax: (07) 3221 0951

TASMANIA

Health Promotion Policy Officer
Department of Community
Services and Health
GPO Box 125B
Hobart 7001
ph: (03) 6233 3551
fax: (03) 6233 2899

VICTORIA

General Practice Unit
Health Enhancement unit
Department of Human Services
16th Floor/120 Spencer Street
Melbourne 3000
ph: (03) 9637 4021
fax: (03) 9637 4077

NORTHERN TERRITORY

Manager
Casuarina Community Care Centre
Territory Health Services
PO Box 40596
Casuarina 0811
ph: (08) 89 227 301
fax: (08) 89 227 477

WESTERN AUSTRALIA

The Director
Health Promotion Services
Health Department of WA
Ground Floor, C Block
189 Royal Street
East Perth 6004
ph: (08) 8226 6421
fax: (08) 8226 6133

SOUTH AUSTRALIA

Manager
Health Promotion Unit
Health Commission
Box 6
Rundle Mall PO
Adelaide 5000
ph: (08) 8226 6421
fax: (08) 8226 6133

NEW SOUTH WALES

Manager
Health Promotion Branch
NSW Health Department
Locked Mail Bag 961
North Sydney 2059
ph: (02) 9391 9000
fax: (02) 9391 9579

Appendix 4: Other RACGP documents or position papers supporting prevention

Guidelines for Preventive Activities in General Practice,
4th Edition, 1996, RACGP.

Position Statement

- The RACGP has a number of position (policy) statements that are relevant to prevention
- RACGP and Prevention
- Immunisation
- Information Technology
- GPs and Community Health Workers

Entry standards for General Practice, RACGP, 1996

A number of implementation strategies are highlighted in the entry standards for general practice including:

- Practice services (1.3.1)
- Health summaries (1.4.2)
- Medical records (1.4.3)
- Linking with local health campaigns (1.6.1)
- Patient education material (1.6.2)
- Providing opportunistic prevention (1.6.3)
- Reminder Systems (1.6.4)
- Practice staff training (3.1.2 , 3.1.3)
- Practice management (3.1.4)
- Practice resources (3.1.5)
- Follow up and recall systems (4.2.4)
- Practice facilitator (5.1)
- Occupational health and safety (5.1.8–5.1.15)
- Practice equipment (5.2)
- Vaccine cold chain (5.2.4)

Other relevant documents

- Running a successful general practice, RACGP 1st edition, 1995.
- Sterilisation/disinfection guidelines for general practice, RACGP 1994.
- RACGP Health Record and Operating Manual, 1996.
see sections: 13, 23, 24, 27, 28, & 29.

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

Hazardous Drinking

Alcohol is often implicated as a contributory factor in a large number of common problems that present to the GP, for example, heartburn, insomnia, anxiety and depression. GPs are in a position to identify and address the early effects of alcohol-related harm in their patients. There is good evidence that a number of hazardous drinkers want to cut down their drinking and more frequently seek help from GPs than other health care providers. Brief intervention strategies are effective, realistic, efficient and flexible and accommodate the significant time constraints that exist.

1. RAISING THE ISSUE

Enquire about alcohol as a routine part of your history taking. You should certainly ask about a patient's drinking whenever their presenting symptoms or problems may be related. As some patients may be sensitive to your enquiry it is important to use a non-judgemental approach in these situations. Provide a clear rationale for why you are asking about their drinking and avoid labels like alcoholic and problem drinker.

Patients are more likely to be responsive to changing their drinking if:

- they see a connection between their drinking and health symptoms or problems.
- they believe that things will get better if they change
- they believe they can change

2. MOTIVATIONAL INTERVIEWING (Preparing people for change)

Motivation can be viewed as the sum of factors that influence a person to act in a specific way. It can be assessed by systematically exploring the costs and benefits of a particular behaviour. It is strongly influenced by the attitude of the doctor and the interaction between them and the patient.

The main aims of motivational interviewing is to explore the ambivalence associated with behaviour and encourage the patient to express their reasons for concern and arguments for change.

There are four key principles:

(1.) Regard the person's behaviour as their personal choice

By acknowledging that there are two sides to a behaviour and that the patient is making a choice which is rational to them, you help to increase their sense of responsibility for their behaviour.

Appendix 5:

Assisting patients with lifestyle changes:

a brief guide to motivational interviewing and brief behavioural

In a similar manner, when you systematically explore both the benefits and costs associated with a 'problematic' behaviour you involve the patient more directly in decision making. This process helps to enhance their sense of autonomy and encourages them to take responsibility for their actions.

(2.) Let the patient decide how much of a problem they have

Systematically explore benefits and costs that the patient associates with the problematic behaviour. This helps the patient to convince themselves of any need for change as the issues raised are meaningful to them.

It is important to recognise that ambivalence about many behaviours is normal and that when you 'label' someone you are likely to increase their resistance to change. Some obvious labels are alcoholic and problem drinker. Other more subtle labels include- smoker, asthmatic. If you start with the benefits of the behaviour you help to defuse some of the tension associated with the need to change. It is then easier to look at the subsequent costs without generating as much resistance.

A useful way to assess both motivation and confidence to change is to ask the patient to rate motivation on a scale from 1 to 10. Then get them to indicate what things would need to happen to increase the rating from where they are (eg. 4 or 5) to a higher rating (eg. 8 or 9). Repeat the exercise for confidence. Tune in for any self-motivational statements where there is evidence of problem recognition, concern, intention to change or optimism. Self-motivational statements are an indication that the patient is ambivalent and thinking about the need to change.

(3.) Avoid argumentation and confrontation

Confrontation within the patient is the goal. The aim is to generate conflict internally, and not between the GP and patient which tends to lead to resistance.

Resistance is likely if there is a mismatch between the GP and the patient's assessment of their readiness to change. Eliciting resistance tends to entrench the patient's current behaviour. Use your 'antennae' to pick up whether the patient has tuned out.

(4.) Encourage discrepancy

Change is likely to occur when a person's behaviour is seen to conflict with their personal goals. Highlighting the discrepancy makes the contrast more visible eg using a decision grid. Work through each section with your patient. If time is short, get the patient to complete the grid before their next visit. Include the completed version in your casenotes.

Appendix 5: Assisting patients with lifestyle changes:

Decision grid

	stay the same	change
Costs		
Benefits		

Discrepancy generates patient self-reflection and internal discomfort, motivating the patient to change. For example: what will happen in the next 6 (12) months if things stay as they are? How will things be if you change your behaviour? Contrast the discrepant statements generated by the decision grid.

Summarise the motivational interview

Try and include the following

- patient's own perception of the problem as reflected in his or her self-motivational statements
- sum up the patient's ambivalence: include the positives related to the problem behaviour but focus on the patient's concerns
- review and personalise the objective evidence (from your assessment) and describe how it relates to risks and problems
- re-state any indications the patient has offered of wanting, intending or planning to change (self-motivational statements)
- revisit the patient's motivation and confidence to change (has there been any shift?)

Doing a motivational interview

- Examine the good things about the target behaviour
- Ask about the less good things and compare the two
- Systematically explore how much of a concern the negatives are
- Ask the patient: How does this concern you? Why does this concern you?
- Look to the future. Is the good/not so good balance going to change?
- Highlight any discrepancies
- Get the patient to rate both their motivation and confidence on a scale from 1 to 10
- Summarise

Interventions and the stages of change

Precontemplator

- provide personalised feedback
- give printed (educational) material
- offer follow up
- flag case notes

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

Contemplator

- motivational interviewing techniques
 - good, less good
 - outline concerns
 - decision matrix
 - highlight discrepancy
 - assess motivation and confidence (on 1 to 10 scale)
 - avoid labelling and generating resistance
- provide written reinforcement
- consider self-monitoring
- make follow up arrangements

Action

- range of behavioural strategies

Maintenance

- follow up
- attention to high risk situations
- enlist social support
- reinforce self rewards
- ongoing review of goals and expectations

3. BRIEF INTERVENTION

Behavioural intervention strategies are effective in addressing hazardous drinking in the general practice setting.

Before using these strategies you need to check the prerequisites for behaviour change.

Prerequisites for behavioural change

Strategy

- recognise that current behaviour is a concern or a problem
 - increase awareness, for example, self-monitoring
 - assess pros and cons of behaviour change
 - provide context and opportunity for change
- believe that they will be better off if they change
 - personalise the benefits for the patient
 - provide information about the advantages of change, for example, decisional balance

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

- believe that they are able to change
 - set achievable goals
 - foster self-efficacy
 - identify support
 - learn strategies to deal with high risk situations and relapses; avoid reactance
 - motivational interviewing techniques

The following six behavioural strategies provide a framework for helping the problem drinker change their behaviour.

(1) Personalised feedback

The most important feedback you can give a patient relates to problems (particularly medical problems) that may have been caused or exacerbated by their drinking. The types of problems you should discuss include:

- their immediate alcohol related health problems
- problems in their history which may be alcohol related; and
- problems that are likely to occur in the future if they continue to drink.

The next step is to feed back to the patients the benefits they are likely to see if they moderate their drinking. These include:

- benefits specifically related to the health problems just discussed.
- benefits of a general nature, for example, more spending money, weight loss and less strain on family and other relationships, improved intellectual functioning.

Feedback is more effective if:

- it is accurate, specific and non-judgemental
- the patient has time to absorb, reflect and respond

(2) Negotiated goal setting

Involving the patient directly in the setting of treatment goals has a number of advantages. Change is facilitated if goals are in small and achievable steps. Moderate agreement rather than abstinence will be both more appropriate and acceptable for most patients. Develop intermediate goals which move the patient towards the final goal in achievable steps. Assess the desirability and ease of implementation of each of the goals. Try to arrive at agreement about:

- a daily average and weekly total;
- a maximum number of drinks per session; and
- a number of alcohol free days.

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

(3) Provide written reinforcement.

Self-help booklets and pamphlets complement the information you provide directly to your patients. They assist the patient in digesting the amount of information that you may give in the consultation.

(4) Identify high risk situations and use a range of methods to cope with them

High risk situations are occasions where the patient is at significant risk from their drinking. They may be characterised by:

- physical location (eg. the pub or out to dinner)
- time of day (eg. after work)
- company (eg. drinking in a round with mates); and
- mood states (eg. boredom, anxiety or depression).

Identify and deal with the 'costs' associated with reducing their drinking eg less able to deal with social pressure, difficulty coping with negative feelings (tension, boredom, irritability).

Successful strategies include avoiding the situation or learning alternative ways of coping. The coping situation will depend on the situation but may include learning to refuse a round of drinks by using their medical condition as an excuse, or dealing with a negative emotion by talking to someone

(5) Enlist social support

Any behaviour change is more likely if it occurs in a supportive environment. Enlisting a significant other provides a further source of positive reinforcement.

(6) Monitor behaviour by measurement of drinking

Self monitoring of drinking behaviour, by using a diary, has also been shown to be a powerful tool in reducing consumption through direct feedback. It can be done formally through a diary completed daily and reviewed at each appointment. It provides a more accurate assessment of drinking and helps to identify high risk situations that require special attention.

4. FOLLOW UP

- monitor progress
- review goals
- provide reinforcement
- refer if needed

Appendix 5: Assisting patients with lifestyle changes:

5. REFERRALS

Referral should be considered if:

- The patient is drinking more than 10 standard drinks (100g) every day and therefore has a high risk of physical dependence).
- There is evidence of significant social disruption as a result of the patient's drinking.
- Brief intervention has proven to be ineffective.

These practical tips are an abbreviated version taken from a handbook written as a guide for alcohol problems in general practice, (Litt J C B, Ali R, White J. Dealing with alcohol problems in general practice, The Drug Offensive, 1993, currently being revised for a third edition).

Smoking Cessation

GPs are in a unique position to counsel patients regarding smoking – the question is how to best intervene with patients. A brief intervention program is outlined below.

What questions should be asked?

GPs should ask all patients whether they smoke.

GPs should ask this question at every opportunity especially if the presenting problem is related, for example, respiratory tract infection.

Smokers should be clearly identified on the medical record, for example, by attaching stickers to smokers' files.

It is better to ask about smoking in a non-confrontational way since this may allow smoking to be discussed more openly.

How do you feel about smoking?

Do you want to quit now?

Further management is dependent on the readiness of the smoker to quit. It has been estimated that at any one time 10% of smokers are ready to stop, 30% are unsure about quitting and 60% are not ready to stop.

For patients who are not ready to quit, lecturing will not be effective. These patients should be told to consider quitting and offered a self help booklet. Written material is available from the State Cancer Councils, the National Heart Foundation and QUIT. Intervention with these patients should be very brief but repeated at future consultations.

GPs should ask those who wish to quit if help is required.

Many patients are able to quit on their own, especially those who are not strongly psychologically or pharmacologically dependent (see the section on nicotine replacement). Smokers who do not want assistance should be offered self help materials and inquiries should be made about their progress at future consultations.

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

Those who need assistance to quit should be offered an intervention that addresses both the behavioural and the addictive aspects of smoking.

1. BEHAVIOURAL STRATEGIES

Inform smokers of the need to quit completely – not just reduce. Set a quit date.

Provide self help material to patients. These booklets enable patients to recognise their triggers for smoking and develop strategies to help them quit. GPs can increase their knowledge of smoking cessation techniques by reading these materials.

Discuss simple techniques to assist in the more difficult moments, for example, 4Ds.

- Delay acting on the urge to smoke – the intensity of the craving often settles after a few minutes;
- Deep breathe, breathe in slowly and deeply, then breathe out slowly;
- Drink water or citrus juice – drink it slowly and perhaps use a straw;
- Do something else to take your mind off smoking, for example, go for a walk

Discuss withdrawal symptoms (see the next section)

Remind patients of the need for motivation

Remember weight gain is an issue (especially for women). Suggest starting an exercise program and recommend low calorie substitutes.

Refer to the self help material for a more detailed list of strategies.

2. NICOTINE REPLACEMENT

Nicotine withdrawal symptoms may prevent even highly motivated smokers from quitting. Withdrawal is characterised by craving, anxiety, hunger, restlessness, decreased concentration and sleep disturbance. These symptoms typically peak within the first 2–3 days and slowly diminish after 1–2 weeks of abstinence.

Nicotine dependence can be easily assessed. Nicotine replacement therapy should only be recommended to those who are ready to quit and are dependent on nicotine. Those who smoke more than 15 cigarettes a day have their first cigarette within 30 minutes of waking and/or have experienced strong cravings at a previous attempt to quit are likely to be dependent and require a nicotine substitute to assist them to quit.

Those smoking less than 10 cigarettes daily should not use pharmacotherapies as they are unlikely to experience withdrawal symptoms and hence can usually quit with counselling and behavioural and educational interventions.

Nicotine therapy can be offered either as nicotine patches or gum. Using these methods the smokers can get the nicotine they crave without the harmful effects of thousands of other chemical found in cigarettes.

Appendix 5: Assisting patients with lifestyle changes: a brief guide to motivational interviewing and brief behavioural

The patch should be recommended for most patients because it is generally well tolerated by patients. However the patch does not appear to be effective as the 4 mg gum for the very dependent smoker. Some smokers may benefit by using more than one patch and others benefit from using a combination of the patch and gum. Currently, however, indications for these interventions are not well defined.

Patients should continue with therapy for at least 8 weeks. The patch should be continued for longer periods in individuals where there seems to be a risk of relapse.

3. FOLLOW UP

When patients are aware that their progress may be reviewed their chances of quitting on a long term basis are increased. Most relapses occur in the first few weeks after quitting. Ensure follow up visits are scheduled in the first few weeks. These visits should be used to encourage quitters to abstain from cigarettes and can be used to discuss any problems and suggest further intervention strategies.

It often takes a number of attempts to quit successfully. Relapse or inability to quit should also be seen as part of the normal process of quitting. Each time intervention is offered to a smoker the seeds are planted for future attempt to quit.

4. REFERRAL

The health consequences for patients unable to quit are often disastrous and consideration should be given to patients experiencing difficulty with quitting. Options include being referred to GPs with an interest in smoking cessation, group quit programs such as Freshstart which have the benefit of group support or for hypnotherapy.

An important point to remember in counselling is that GPs should maintain a supportive and positive relationship throughout the many stages smokers pass on their way to quitting successfully.

Appendix 6: Faxback comments on the Greenbook

This handbook was produced by the RACGP in response to many requests from its members. Because research on the delivery of prevention in the Australian general practice setting is in its infancy, the process of production included a substantial review component of the successive drafts with a view to enhance relevancy to the 'real world' of general practice. A pilot trial of GPs as well as other consumers in the health field was conducted on an earlier draft and the comments were synthesised and integrated into this published product.

Research into prevention in Australian general practice is a burgeoning field and an ongoing task of the National Preventive and Community Medicine Committee is to update future drafts of this book. However, the Committee recognises that evidence is only one aspect of the factors that relate to intervention. It is expected that future editions will include responses to this edition based upon practical experience by GPs of the implementation of preventive activities using this handbook.

This appendix has been included to enable GPs: (a) to contribute to future modifications of the Greenbook by returning their comments; (b) to show their own successes and experiences in prevention.

Your success stories

- (1) What things (strategies, tips, ideas) have worked for you in improving the profile of prevention in your practice?

Review of the book

- (2) What were the most useful aspects of the Greenbook?

- (3) What aspects were least useful?

Appendix 6: Faxback comments on the Greenbook

(4) What would you change?

(5) What other things, if any, should be included (details)

Optional details

Name _____

Address _____

Phone/Fax _____

Age _____

Gender _____

Appendix 7: RACGP prevention-related practice assessment activities

There are three nationally approved prevention related practice assessment activities. These are listed below with the address of the RACGP contact

Preventive Care in Men

RACGP, Research and Health Promotion Unit
215 Payneham Rd
ST PETERS
SA 5069
Telephone: (08) 8362 9954

Preventive Care in Women

RACGP, Research and Health Promotion Unit
215 Payneham Rd
ST PETERS
SA 5069
Telephone: (08) 8362 9954

Preventive Practice Audit

RACGP Queensland Faculty
PO Box 1598
COORPAROO
QLD 4151
Telephone: (07) 3391 5200

In addition, there are a number of State based prevention-related practice assessment activities that may be relevant to prevention. Contact your local QA and CE committee for details.

Appendix 8: Calendar of Health Event

This is a list of health 'weeks' and 'days' suggested to tie in with your noticeboard displays. The dates vary from year to year and from State to State. Check in with your local health department in each State for an updated list (Appendix 3).

AIDS Awareness Week

Arthritis Week

Children's Week

Coeliac Awareness Week

Health Bones Week

Heart Week

Kidsafe Week

National Diabetes Week

National Skin Cancer Action Week

Sun Smart Week

- Coordinator (see Practice Prevention Coordinator)
- Costs
 - of the implementation strategies: 1, 4, 14, 16, 24 25, 31, 34, 35, 36, 38
 - and benefits to the patient: 51, 52, 56
- Counselling
 - lifestyle: 18, 51
 - skills: 3
- Cuing: 7, 14, 26, 42, 44, 45

- D
- Dependence
 - of patients on alcohol: 57
 - of patients on nicotine: 58
 - of patients on reminder systems: 24
- Diabetes
 - casenote stickers: 13
 - patient held records: 29
 - register: 10, 22
 - week: 6
- Disease Prevention: 1
- Disincentives, financial: 4
- Divisions of General Practice: 6, 8, 9, 13, 16, 36

- E
- Edu-cate (Patient Education Package): 27, 34
- Education
 - GP: 27, 36 37, 40
 - patient: 7, 9, 11, 12, 13, 14, 15, 17, 26, 27, 30, 32, 33, 34, 36, 37, 41, 42, 44, 45, 46, 50, 53, 58
 - staff: 9
 - computers: 42, 44, 46
- Elderly: 7, 8
- Email: 26, 27

- Evidence
 - clinical practice: 38, 39
 - facilitator: 36
 - patient alcohol use: 51, 57
 - patient education materials: 33
 - preventive activities: 1, 5, 14, 60
 - screening: 35

- F
- Facilitator: 36
- Feedback: 7, 12, 27, 31
- Framework for prevention: 4, 5, 38, 55

- G
- General practice
 - College (see Royal Australian College of General Practitioners)
 - Divisions (see Divisions of General Practice)
- GP
 - attitudes: 3, 5
 - influence: 2
 - role: 2, 3, 5, 10
 - skills: 5
- Guidelines
 - clinical practice and preventive care: . . . 39
 - computers: 26, 27
 - GP education: 37
 - Health education: 27
 - see also RACGP, Guidelines for Preventive Activity in General Practice

- H
- Health care setting: 2, 3, 4
- Health Departments: . . . 2, 6, 8, 9, 27, 49, 63
- Health Education (see education, GP, patient and staff)
- Health education leaflets: 7, 9, 11, 12, 13, 14, 15, 30, 32, 34, 41, 42, 44, 45
- Health Event Weeks Calendar: . . . 13, 15, 63
- Health Insurance Commission: 24
- Health Promotion: 1, 8, 16, 27

Index

- Health Summary Sheets (HSS): 7, 8, 9, 10, 13,
 19, 20, 21, 25, 27, 39, 42, 44, 45
- Health Records (see patient held records)
- Health videos: 34, 41
- Healthy Bones Week: 63
- Heart Week: 63
- HIV/AIDS: 32, 63
- Holistic Approach: 2, 8
- Hypertension: 1, 22, 41, 43
- I**
- Illness – orientation: 4
- Immunisation: 1, 3, 18, 22, 26, 27,
 29, 32, 41, 47, 50
 – Childhood Immunisation Register: 26
- Information Systems, computer: 25
- Influenza: 13, 43
 – Awareness Week: 6
 – vaccine: 7, 8, 16, 21, 22, 47
- Internet: 27
- Inventory
 (see Practice Prevention Inventory – PPI)
- J**
- K**
- Kidsafe Week: 63
- L**
- Language
 – non discriminatory: 16
 – other than English: 15, 16
 – patient education: 30, 33
 – problems with: 7, 29
- M**
- Mammogram(s): 16, 35, 48
- Medical Record(s)
 – checklists: 39
 – computer system: 28, 30
 – entry standards: 50
 – patient: 14, 28, 57
- Motivation, patient: 3, 9, 12, 14, 31
- Motivational Interviewing Techniques: 31, 40, 51
 – and lifestyle change: 53–9
- Murtagh, John
 – Patient Education: 27, 34
- N**
- National Alcohol Awareness Week: 63
- National Diabetes Week: 63
- National Heart Foundation: 9
- National Preventive and Community
 Medicine Committee: iv, 60
- National Skin Cancer Action Week: 63
- Needs
 – assessment, GP: 5, 6, 35, 40
 – assessment, patient: 5, 6, 7, 8, 35, 45
 – assessment, practice: 5, 6, 12, 41
 – patient: 8, 13, 21, 30, 32, 41, 45
 – patient education: 32
- Noticeboards: 6, 13, 14, 15, 16, 17,
 18, 28, 42, 43, 44, 45, 63
- O**
- Opportunistic
 – prevention: 9, 11, 18, 21, 22, 27, 28, 40, 50
 – reminders: 21, 25, 27
- Organisational
 – methods (manual): 25
 – resources: 7
 – strategies: 5, 10, 40
 – supports: 9
 – tools: 5, 7, 9, 10, 13
- Over-servicing: 24

P

Pap Smears: 2, 16, 18, 21, 22, 25,
 28, 35, 43, 48

Pamphlets: 32, 41, 56

Patient Education Material
 (see Education, patient)

Patient

- awareness Week: 63
- held records: 29
- opportunities: 2
- patient-centred approach: . . . 8, 12, 30, 31
- practice prevention questionnaire: 47

Philosophy: 4, 5

Plan (see prevention plan)

Pneumococcal pneumonia vaccine: . 21, 22, 47

Posters: 14, 15, 16

Practice:

- Assessment Points: 8, 62
- capacity: 5, 8
- denominator (see patient register)
- management meeting: . . . 10, 14, 41, 44, 45
- newsletter: 11, 14, 18, 34, 44, 45
- Registers: 7, 9, 10, 21, 22, 26, 27, 28
- resources: 8
- staff: 5, 7, 8, 9, 10, 11, 12,
 14, 16, 22, 44, 45, 50

Practice Prevention Coordinator

- practice: . 5, 7, 8, 10, 14, 20, 34, 36, 44, 45
- GP Divisions: 36

Practice Prevention Inventory (PPI): 4, 6, 7, 8,
 9, 13, 36, 41

Practice Prevention Questionnaire (PPQ): 4, 6,
 7, 8, 9, 11, 13, 14, 20, 34, 44

Practice Prevention System: 9

Primary care: 36, 37, 38, 39

Prevention

- culture: 5, 11
- definition: 1
- GP role: 2
- Plan: 5, 9, 10, 13, 44, 45
- primary, secondary, tertiary: 2, 3
- Register: 22

Preventive Activities: 1, 2, 5, 6, 7, 8, 9, 10, 12,
 14, 18, 19, 21, 22, 24, 25,
 27, 35, 43, 44, 45, 46, 50

Preventive Opportunities: . 2, 9, 11, 19, 24, 28

Prompts (see reminders)

Q

Quality of Care: 27, 29

R

Royal Australian College of General Practitioners (RACPG)

- documents or position papers supporting prevention: 50
- Guidelines for Preventive Activities in General Practice (Redbook): . . . 1, 4, 35, 50
- health summary sheets (HSS): . . 13, 19, 20
- prevention-related practice assessment activities: 62
- recall card: 22, 23, 24, 28

Readiness to Change: 32, 52

Recall (also see reminders)

- card: 22
- process: 22
- reminders: 24, 25, 47
- systems: 14, 18, 21, 24, 26, 28, 39, 50

Records

- computerised: 28, 30
- medical: 14, 30, 39, 50, 57
- patient: see patient-held records

Redbook (see Royal Australian College of General Practitioners)

Registers (see age/sex, age/disease, at-risk, practice registers)

Reminders

- advantages of: 24
- automated (computerised): . 21, 22, 26, 27,
 28, 40, 42, 44
- cards: 26
- casenote stickers: 21
- computerised: 21, 42
- dependence on: 25
- Health Insurance Commission: 24
- health summary sheets: 21

Index

- opportunistic: 21, 25
- overservicing: 25
- passive: 24, 25
- patient consent: 25
- personalised letter: 21, 22, 43
- phone call: 21, 43
- problems with: 24
- postcard: 43
- RACGP: 24
- recall (see Recall)
- systems: 9, 10, 11, 14, 18, 21, 22,
. 24, 27, 28, 42, 43, 45, 47, 50

Resources

- assessment of: 9
- availability: 5, 7, 8, 11, 34
- lack of: 4
- practice: 11, 50
- problems with: 24
- use of: 41

Risk factors (see also at-risk): 1

Rubella: 18, 48

S

Screening

- and computers: 26, 27
- casefinding: 18, 28, 35
- costs of: 35
- criteria for: 35
- definition: 35
- evidence for: 35
- needs assessment: 35, 40
- opportunistic: 27, 28, 40
- primary, secondary and tertiary prevention: 2
- questionnaires: 26
- recall/reminders: 18, 40
- tests: 2, 35

Smoking

- cessation: 1, 18, 31, 57-59
- patient education material: 33, 37, 38, 41
- patient questionnaire: 47
- World No Tobacco Day: 6

State Health Department: 9

Sunsmart Week: 63

Sustainability

- and prevention philosophy: 5
- and prevention process: 12, 13

T

Target population: 9

Tasks

- and computers: 27
- and practice staff: 6, 14 36,44
- and preventive framework: 5, 13
- and preventive plan: 10
- coordination of: 9
- identification of: 5, 10

Tetanus vaccine: 47

Time

- and computers: 25, 28
- and organisational strategies: 7, 10
- and practice staff: 10, 12, 26
- and preventive opportunities: 11
- and reminder systems: 24
- in the consultation: 7, 11, 14
- in the waiting room: 11
- lack of: 3, 8, 11, 52

U

V

Videos (see Health Videos)

W

Waiting Room

- and children: 15, 16
- and cuing patients: 14, 15
- and patient education material: 15, 18, 33,
. 42, 44, 45
- and patient opportunities: 11, 18
- and practice staff: 14, 42
- and prevention framework: 9
- and preventive activities: 6, 14

World No Tobacco Day: 6

Practice Notes



Practice Notes