An Introductory Guide to Population Health for General Practice Nurses
ACKNOWLEDGEMENTS

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The resource is funded by the Australian Government Department of Health.

The Australian Primary Health Care Nurses Association (APNA)
APNA is the peak national body for nurses working in primary health care, providing representation, professional development and support at a local, state and national level.

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First published March 2014

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Glossary of Key Terms

CHRONIC DISEASE
Chronic Disease is "characterised by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability, and in most cases, the unlikelihood of cure." (National Public Health Partnerships, 2001)

COMPREHENSIVE PRIMARY CARE
Comprehensive primary health care works from a social model of health which considers how wider determinants have an impact on health status. Improvements in health and wellbeing are achieved by addressing the social, behavioural, cultural and environmental determinants of health, alongside biological and medical factors.

POPULATION HEALTH
A discipline that focuses on promoting health, preventing disease and prolonging quality life through organised efforts and informed choices of society, organisations, public and private; communities and individuals.

GENERAL PRACTICE NURSE
A general practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. General practice nurses deliver primary health care in a general practice setting. The environment in which they work is often unpredictable and involves caring for a broad group of people from diverse backgrounds and at all stages of life. Australian Practice Nurses Association (2008). About practice nursing.

PREVENTION
A set of actions that enable individuals and communities to exercise greater control over their health; focus on the development of healthy behaviour and community action as well as the creation of environments and social policies beneficial to health.

CHRONIC DISEASE SELF-MANAGEMENT
Involves the person with the chronic disease engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes.
Aim

The aim of this guide is to provide general practice nurses and practices with an understanding of population health approaches that are workable from and within general practice settings, and guidance on implementing activities that have been shown to be effective.

This guide does not attempt to provide a comprehensive reference work on population health. It is a targeted resource that has been specifically designed for general practice nurses and practices to steer enhancements through population health activity.

Definition

For the purposes of this guide, population health is focused on understanding health and disease in community, and on improving health and well-being through approaches that address the disparities (unfair differences) in health status between social groups.\(^1\)

Population health recognises that to improve health, determinants outside health have to be tackled and health is maintained and improved not only through the advancement and application of health science, but also through the efforts and sound lifestyle choices of individuals.\(^2\)

Background

An ageing population and increasing rates of chronic disease are straining our health systems. Medical care and population health have largely operated in separate though sometimes intersecting realms in the past, however significant reductions in health disparities, morbidity and mortality, and consequent decreases in health spending have been reported to be achievable through improved cooperation between population health and personal health systems (i.e. addressing health and disease at the community and individual levels).\(^3\)

The general practice setting is ideally placed to develop and implement actions

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to support population health, including patient and practice focused disease prevention which works to avert disease in individuals and groups. When disease prevention efforts are coupled with effective secondary prevention to detect risk factors or signs of disease early and tertiary prevention which is aimed at better managing existing illness and preventing additional disease and disability, a comprehensive approach to population health, across all ages and stages, can be achieved. To be successful in population health, general practice works with the larger community context in mind, treating and supporting patients within their social, economic, and cultural environments. It establishes bonds with relevant community organisations, businesses and other institutions.

Primary Care versus Primary Health Care

Primary health care represents a more comprehensive approach than primary medical care (first medical contact) alone. It includes integration between primary care and secondary and tertiary care; encouragement of self-care and community involvement in health service planning and provision; collaboration between health and other sectors to address underlying causes of ill health; and a range of broader preventative programs, among others.


Useful Resources


Hurley C, Baum F, Johns J, Labonte R. Comprehensive Primary Health Care in Australia: findings from a narrative review of the literature. AMJ 2010, 1, 2, 147-152

interpersonal relationships and adhering to treatment regimes.
Population Health in Context

As an approach, population health is concerned with the underlying social, behavioural, environmental and cultural factors that influence health. It investigates differences in the presence of these factors in a population and applies the results in the design and implementation of actions to improve the health and well-being of those populations.

Population Health Approach

Outside biological and genetic influences, health is determined by complex interactions between a range of factors including:

- The social conditions in which people are born, live, and work (e.g. education, income, housing, social links, availability/access to health services)
- Behavioural (lifestyle choice - smoking, excess alcohol, poor diet, coping skills etc.)
- Environmental (climate, workplace etc.)
- Cultural factors (language, beliefs and customs etc.)
- Health organisations and other groups that support good health (availability and access)

It is the combined influence of the determinants of health that shapes health status and outcomes.

General Practice and Population Health

General practice and population health share a goal of supporting health and well-being. The link between general practice and population health was acknowledged as early as 1973 in the World Health Organisation’s Alma Ata Declaration and Health for All strategy which identified general practice as one of the most important means by which population health could be advanced.

Evidence shows that general practice not only helps prevent illness and death, it is associated with a more equitable distribution of health in populations.

In their investigation on the contribution of general practice to health systems and health, Starfield et al. identified six mechanisms that, alone and in combination, may account for the beneficial impact of general practice on population health. These factors are:

- Greater access to needed services.
- Better quality of care.
- A greater focus on prevention.
- Early management of health problems.
- The cumulative effect of the main general practice delivery characteristics.
- The role of general practice in reducing unnecessary and potentially harmful specialist care.

General Principles of Population Health in General Practice

Six key principles underpin the design and implementation of population health activities.

- A focus on preventative care, including encouraging and supporting healthy lifestyles

Preventive health care comprises of measures to prevent diseases, (or injuries) rather than curing them or treating their symptoms.

Supporting healthy lifestyles might involve encouraging people to eat a healthy diet and have an active lifestyle by advising people about health benefits such as disease prevention and longer life and giving people advice on how to achieve a healthy lifestyle within their daily lives.

Example: Management of chronic conditions includes the prevention of further deterioration as well as the management of existing symptoms.

- A Life Course Approach

A life course approach is taken in considering population health activities in general practice settings. This perspective understands health as the product of
risk behaviours, protective factors and environmental agents that are encountered across all stages of life and that individually or in combination have collective effects on health quality and outcomes.

Example: Children, adolescents, adults and the elderly are supported through relevant prevention activities, such as referral to childhood obesity prevention programs.

- **Patient centred**

Patient centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients.9

Despite the great improvements in average life expectancy achieved in recent decades, health gains have not been equally shared across the Australian population. One of the key Commonwealth Government priorities for general practice is to reduce inequities in health service access and health outcomes. Those most at risk of experiencing poor health status and healthcare access are our vulnerable population groups.

Vulnerable populations include the economically disadvantaged, the homeless, Aboriginal and Torres Strait Islanders, people with disabilities and those with chronic health conditions, including severe mental illness. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as poor access to health care. Their health and healthcare problems intersect with social factors, including housing, poor or no social capital and inadequate education. The health and non-health service needs of these populations are important, with social disadvantage likely compounded by poorer general health than the more advantaged and vice versa.

Example: A patient with mental health problems who is also homeless and/or unemployed and/or non-English speaking and/or alcohol dependent, suffers from multiple disadvantages i.e. is affected by a number of determinants (outside genetic makeup) that adversely impact health.

- **Appropriate and high quality, with a focus on continuous quality improvement**

Continuous quality improvement is an approach by which better health outcomes are achieved through analysing and improving service delivery processes.10 The approach includes measuring existing service/activity and its outcome, then applying potential improvements and re-measuring outcome. Continuous quality improvement is an essential aspect of primary health care delivery.

Example: Approaches in general practice settings that are relevant to this principle include general practice accreditation, CPD audits and programs such as the Improvement Foundations - Australian Primary Care Collaboratives Program.

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**Activity One**

What is the immunisation coverage rate within your general practice? How do the immunisation coverage rates compare to national targets?

Consider ways in which you may improve these rates within your general practice?

For example, how would you provide opportunity for those who are late or require catch up vaccinations? Who within the practice can assist you?

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
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Further information can be found in The Australian Immunisation Handbook


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• **Supportive of health literacy**

Health Literacy is the reasoning and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.\(^{11}\)

Health literacy is important because it affects people’s ability to:

- Navigate the healthcare system, including locating providers and services
- Fill out health questionnaires
- Share personal and health information with providers
- Engage in self-care and chronic disease management
- Adopt healthy behaviors, such as exercising and eating a healthy diet
- Act on health-related news and announcements

There are a growing number of health literacy information resources and measurement tools available to inform and support general practice settings.\(^{12,13,14,15}\)

Beyond these resources, non-English speaking patients often require additional support to fully understand health related information and advice.

• **A strong commitment to partnerships**

All parts of the system need to work in partnership to maximise access and enable person centred holistic care through multiple health and social care specialty support.

Examples: The chronic disease management Medicare Benefits Schedule (MBS) items enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers.\(^{16}\)

Comprehensive health and social service directories that are locally developed by and available from all Medicare Local websites are a convenient and accessible resource to support partnerships and the coordination of patient care. They provide detailed information on available services and include details such as eligibility criteria and opening hours.

**Preventive Health Care**

Promoting health and preventing disease are key components of population health. Preventable health problems place a substantial burden of suffering on individuals, families and communities, as well as place a heavy burden on society as they draw on scarce health care resources. Prevention is often defined as having three levels:

Primary prevention helps people avoid disease. It includes the promotion of health and the prevention of illness e.g. maintenance of healthy weight, immunisation, making physical environments safe etc.

Secondary prevention modifies risk. It is aimed at treating a disease after its onset, but before it causes serious complications.

Secondary prevention includes identifying individuals with established disease, and treating those individuals in a timely way so as to prevent further problems (e.g., mammography screening to detect and treat breast cancer in its earliest stages, blood pressure and cholesterol monitoring, cervical screening etc. It is possible to reduce the impact of illness once a risk is identified. Major avoidable disease risk factors are obesity, lack of fruit and vegetables, physical inactivity, smoking, excessive alcohol consumption, hypertension, illicit drug use, high blood cholesterol, hazardous occupational exposures and unsafe sex.

Medicare rebates are available to general practice for a number of prevention/early detection activities which include:

- Conducting Health Assessments for Aboriginal and Torres Strait Islanders
- Health Assessments for 75 years and over
- 45 – 49 year old health check incorporating the AUSDRISK tool

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**Tertiary prevention** focuses on delaying or stopping disease advancement, reducing impairments and disabilities, minimising suffering caused by health or illness, and/or supporting adjustment to chronic conditions, e.g. administering a foot check to a person with diabetes to identify infections that could require amputation if left untreated. Major causes of mortality, such as cardiovascular disease, chronic obstructive pulmonary disease, cancer and diabetes are amenable to tertiary prevention.

Medicare rebates are available to GPs for a number of tertiary prevention type services including (but not limited to):

- Preparing a management plan for a patient who has a chronic medical condition with or without multidisciplinary care needs (Medicare Benefits Schedule (MBS) Item 721)
- Coordinating preparation of Team Care Arrangements for a patient who has a chronic medical condition and requires ongoing multidisciplinary team care of at least three health/care providers (Item 723)

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National Health Services Directory

The NHSD is a consolidated and comprehensive national directory of health services and provider information. It covers all Australian jurisdictions with services across the public and private sector.

Implemented by Healthdirect Australia on behalf of all Australian Governments, it aligns with and supports current health reform activities in Australia.

The NHSD has been built by extending and enhancing the software already used for the Victorian Human Services Directory.

Access to the directory is available through a variety of websites and a mobile application. Searchable services include General Practice, Pharmacist, Hospital and emergency departments.

Further information can be found by visiting the national health services directory website http://www.nhsd.com.au/
Accountability

Responsibilities for the different levels of prevention are shared among primary and specialty care providers, public hospitals and health services, and community organisations.

General practice has responsibilities that fall within all levels of preventive care, including primary preventive services, such as immunisation and health risk counselling for behaviours such as smoking; secondary preventive care services, such as disease screenings; and tertiary preventive care services, such as treating diabetes and high blood pressure.

Activity Two

List further examples of primary, secondary and tertiary prevention activities that can be applied in your work setting?

Primary Prevention examples ____________________________________________________________

Secondary prevention examples __________________________________________________________

Tertiary prevention examples ___________________________________________________________

How would you go about implementing some of these activities?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Useful Resources


Commonwealth of Australia (2009) A healthier future for all Australians, final report of the National Health and Hospital Reform Commission, Australian Government, Canberra


Population Health Support

Policies and Organisations

Population health activity is undertaken by the wide variety of professionals and organisations including government, academic, non-government, medicine, nursing, allied health and other health workers, health promotion, and others.

Population Health Support

Government

Australian governments at the National and state level steer population health through the following functions:

- Facilitate the development of national and state population health policy.
- Facilitate ongoing planning, monitoring, reporting, research, training and evaluation of population health activities.
- Facilitate the development of consistency in policy standards, legislation and regulation, workforce competencies and disease prevention methods.
- Foster and initially finance innovation in population health programs.
- Develop strategies for new and emerging population health problems and conduct population health programs.
- Identify and report population health status and issues through epidemiological surveillance.
- Conduct, in consultation with other partners, Australia’s international responsibilities and obligations in population health.

The growing recognition of the role of prevention in reducing the risk factors for chronic disease is reflected in the release of Australia’s first National Preventative Health Strategy in 2009 which recommended a range of measures to limit the consumption of alcohol and tobacco and reduce overweight and obesity.

The Australian National Preventive Health Agency was established in early 2011 to strengthen Australia’s investment and infrastructure in preventive health and provide national capacity to drive preventive health policy and programs.

The Agency has a focus on alcohol, tobacco and obesity, which are all significant lifestyle risk factors associated with chronic disease, and is providing policy leadership and establishing partnerships with community health promotion organisations, industry and primary health care providers. The Agency is working with Medicare Locals to embed prevention and health promotion action at the general practice level and to analyse and disseminate information for a wide range of sectors and communities to promote the effective adoption of prevention and health promotion actions.

Within states and territories there are a large number of local government bodies that support population health in a variety of ways with different emphasis from State to State, as determined in the respective Health Acts and Local Government Acts. Local councils vary with respect to the type (rural or metropolitan), the role they play, and the extent to which they respond to local needs.

For example local government ‘health’ services include, but are not limited to: municipal waste services; food inspection; (in some states) the provision of maternal and child health centres; immunisations; programs run by councils to encourage community health and fitness, such as nutrition awareness programs, and healthy weight loss programs; the establishment and/or maintenance of sports and recreation facilities, bicycle paths, and walking tracks.
Academia
A large number of universities and academic institutions in Australia offer training programs that support the health workforce in understanding and applying population health approaches which involve a strong orientation towards evidence based health practice. There are also specific research institutions which play an important role in population health research efforts in Australia including national centres which focus on HIV/AIDS, immunisation and drugs and alcohol.

Non-Government
Non-government organisations have a significant role in promoting health in communities. Individual organisations generally focus on specific issues (e.g. heart disease, asthma, diabetes, cancer), or on specific population groups (e.g. people with Diabetes, those living with HIV/AIDS, and the aged). They therefore have specific knowledge, experience and access to individuals and communities.

The larger organisations (e.g. the National Heart Foundation19, the various State and National Cancer Councils20, and the Asthma Councils21) have designated funding for population health activities and health promotion, and well-established reputations with community and government.

Professional Groups
A range of professional organisations (e.g. the Australian Public Health Association, the Australian Primary Health Care Nurses Association, the Australasian Faculty of Public Health Medicine of the Royal Australasian College of Physicians) play significant roles in promoting the health of the Australian population. Their roles include workforce advancement through journals and specialised education, resource and policy development and intersectoral networking.

Activity Three
Look up your local council website and list some of the health related services that are available.

Consider how you would incorporate this information to your current practice?

Royal Australian College of General Practitioners
SNAP Guide
One important resource developed by the Royal Australian College of General Practitioners is the SNAP Guide which helps practice staff tackle behavioural risk factors that affect the health of the Australian community. The Guide provides a summary of the evidence of harm associated with smoking, poor nutrition, excess alcohol consumption and a sedentary lifestyle and helps General Practices to systematically target patients and offer treatment appropriate to their needs. This guide is designed to assist practice staff to effectively work with patients on reducing the adverse lifestyle risk factors.

19.  www.heartfoundation.org.au
20. www.cancer.org.au
21. www.nationalasthma.org.au
Primary Health Care Organisations
Medicare Locals\(^22\) provide a range of health promotion programs for defined population groups. Medicare Locals contribute to community understanding and support for government public health policies and have a role in promoting health through their access to key groups in the community and knowledge of the local community and its needs. A growing number of general practices are successfully working with Medicare Locals, local and other government sectors, community and non-government organisations in population health efforts.

Health Consumers and Carers Organisations
Consumers Health Forum of Australia\(^23\) is the peak organisation providing leadership in representing the interests of Australian healthcare consumers. Consumers Health Forum is made up of member organisations from around Australia. These members include state peak health consumer organisations and networks dedicated to particular health conditions and objectives.

Carers Australia\(^24\) is the national peak body representing Australia’s carers. The organisation takes a leadership role and responds to carers’ needs and those of the people for whom they care. Carers Australia advocates on behalf of Australia’s carers to influence policies and services at a national level and works collaboratively with partners, member organisations and the Network of state and territory Carers Associations, to deliver a range of essential national carer services.

Funding
Medicare Benefits Schedule
A significant number of Medicare Benefit Schedule (MBS) items have been introduced over the last fifteen years aimed at increasing support for the range of options available to general practice for the provision of population health activity. These items focus on the prevention and management of chronic disease, and support a more integrated and accessible approach to healthcare provision, including full financial coverage for patients and shared care opportunities across providers.

Chronic disease management items enable general practitioners and general practice nurses to plan and coordinate the health care of patients with chronic conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers; Health Checks; Screening; Better Start Disability Services For Children; telehealth and Medicare items for general practice nurses.

Medicare rebates are also available where general practice nurses (or Aboriginal/Torres Strait Islander health workers) provide specific types of services on behalf of a general practitioner. These items include the provision of monitoring and support for a person with a chronic disease; provision of follow-up services for Aboriginal and Torres Strait Islander people who have received a health check; Healthy Kids Check for children receiving or having received their four-year-old course of immunisation; patient-end consultation during a telehealth consultation with a medical specialist.

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23. https://www.chf.org.au
Practice Nurse Incentive Program

The Practice Nurse Incentive Program (PNIP) provides incentive payments to eligible general practices to offset the costs of employing a general practice nurse and support an expanded role for nurses working in a general practice that is accredited under the Royal Australian College of General Practitioners Standards. For further information refer to the Australian Government Department of Human Services Practice Nurse Incentive Program Guidelines http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp

e-health

e-health initiatives have the potential to improve population health. The Australian Government’s eHealth record system is an electronic summary of a patient’s key health information which is expected to deliver significant benefits to general practice providers and patients. For patients who regularly see multiple healthcare providers, having an eHealth record will help general practice to coordinate care and keep track of the health and medical treatment a patient receives, providing greater continuity of care as patients negotiate the health system.

Having online access to current information about a patient’s health helps to reduce risks in diagnosis and treatment decisions, including medication management, and reduce unnecessary repeat tests, hospitalisations, and follow-up specialist visits. Local eHealth enablers include: secure messaging of discharge summaries from hospital to general practice; medical management software for exchange of information between providers; and supportive tools such as ehealth enabled health pathways and the Royal Australian College of GP’s Oxygen program.

Useful Resources


26. 2009-14 Commonwealth of Australia
27. eHealth.gov.au Page last updated 12 December, 2013
Data and Information

Population health starts from an understanding of, and then improving, the health status of a population. It depends on the availability and ready use of population health data and other relevant information at national, state, local and general practice levels.

Overview

Population health data includes, but is not limited to:

- Health status (incidence, prevalence, morbidity, mortality)
- The demographic mix of people in a community or population e.g. according to age, gender and other characteristics such as Aboriginal and Torres Strait Islander status.
- Risk factors: behavioural (smoking, excessive alcohol, overweight, etc), environmental (second hand tobacco smoke, workplace exposures, air pollution etc.)
- Socioeconomic characteristics, specifically those that are risk factors for poor health, such as low socioeconomic status, low education levels etc
- Screening and other early intervention rates
- Rates of chronic diseases
- Health service availability and use

Population health data is important because it allows an understanding of:

- The current situation
- Changes and trends
- Population group comparisons (gaps, inequities etc.)
- Effects of interventions

……and provides a sound basis for the initiation of prevention and management programs.

Health Status Terminology

Incidence: The number of new cases of a health problem diagnosed within a certain population over a particular period of time.

Prevalence: A measure of all those suffering from a particular health problem in a population at one point in time.

Mortality: The number of deaths due to a particular health problem in a population at one point in time.

Morbidity: The disease state (i.e. having a particular health problem).

National and State Data
Given the broad range of health data sources and possible applications, national and state level data collections, which aggregate health data, are needed to develop the requisite guiding strategies to address existing gaps and needs to achieve greater health outcomes nationally. Various population health data sources at these levels are described in Table 1.

Local Community Data
Population health data and information about the local community, including the health needs of local communities, can be accessed through the Medicare Local that serves local general practices. Medicare Locals have been established to coordinate primary health care delivery and tackle local health care needs and service gaps. They will provide and seek advice from practices to demonstrate they are continuing to develop their awareness of their local population. More information about Medicare Locals is available at www.medicarelocals.gov.au

General Practice Data
General practice is a source of population health data that provides insights into local health and wellbeing at a level that is not available from mainstream sources. A good understanding of patient data can help primary care practices engage in preventive care, improve the quality of care, and ultimately, improve health outcomes. Examining the extent and quality of care provided to patients is an opportunity to assess gaps in care, and to begin discussions about how to address them.

Practice data can support population health in general practice settings in a number of ways:
• Allow providers to track the care of all patient groups, rather than limiting attention to the patients who make appointments.
• Identify subpopulations of patients to target the group of patients that requires preventive care or tests.
• Examine detailed characteristics of identified subpopulations e.g. narrow down the subpopulation of patients to determine which patients might want to participate in group educational sessions.
• Supports an ability to systematically target particular age groups in care projects to keep appointment numbers or clinic bookings to a scale that is easy to manage.
• Inform the care of patients with complex chronic disease management needs.
• Locate patients who would need to be notified in the case of a health check or to find patients who might be eligible to participate in a clinical trial.
• Gain an understanding of the provision of care relative to best practice guidelines or a prior period etc.

A better understanding of the patient population could also inform decisions about appropriate practice staffing levels or identify areas where continuing professional development would be most valuable for staff and patients.

Furthermore, as practices learn about their patient populations through the data they accumulate on each individual patient, data from a general practice may in turn inform analyses on the health of the broader community. For example, data originating from general practice can complement morbidity data from other sources such as hospital admissions data to describe the burden of disease in the local community and how this varies among different socio-economic and ethnic groups.

General Practice Support
Examples available to support General Practice in population health data capture include:
Canning Tool: Provides the ability to retrieve lists of patient populations; has the ability to rank patients by important measures; send data elsewhere; and open patient file from a patient list.

Pen CAT Tool: Allows for complex searches (use of multiple filters to drill down to specific populations and important measures); can view data by GP; and interacts with the sidebar to enable prompts when the patient file is opened.

Practice Health Atlas: Produces comprehensive practice & population profiles incl. epidemiological maps based on practice, ABS & other data sources; and multidisciplinary care provider mapping.

Identifying the area of focus

Basic population health profiling at the practice level might seek answers to questions such as:

- Which are patients at risk of a particular health problem e.g. smokers?
- How many patients have a particular health problem e.g. diabetes?
- Which of the patients with a particular health problem have had a health check in the past three months?

Example from the field: Health Checks

A general practice nurse identifies the need to assess how many 75 year olds attending her practice over the past year have had a health check. The general practice nurse engages the practice manager to look at the Medicare billings for health checks in the target group and identify that only a small proportion have had a check. They organise a team meeting to discuss and plan appropriate action to improve the current low screening levels in this group. Together the team identifies the establishment of a nurse led clinic would be best action to target the group. The general practice nurse researches how to fund the clinic using MBS items to make it financially sustainable.

A whole of team approach is developed with the nurse inviting eligible patients and the practice receptionist booking appropriate timed appointments, with the general practice nurse and GP, as patients respond to the invitation. The general practice nurse identifies any health issues of each 75 year old patient and refers to the GP. If needed the patient is then moved onto a chronic disease pathway with appropriate recalls for review and annual health assessments; vaccinations; two yearly eye check and Allied Health Practitioner referral/s as required.

Examples Questions - Diabetes

- Did all patients with diabetes undergo an annual cycle of care to prevent complications associated with diabetes?
- Did patients with diabetes receive any kind of education since diagnosis?
- What proportion of patients with diabetes been managed according to current clinical management guidelines?
- Have all eligible patients with diabetes been referred to a podiatrist in the last 12 months?
- Which population groups are most affected? (e.g. age, gender, socioeconomic status)

Activity Four

Find out what tools you have available in your practice to identify patients who have diabetes?

Provide dot points on how you may go about improving the proportion of patients with diabetes who have completed all the requirements of an annual cycle of care.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please refer to the RACGP Diabetes Management in General Practice – guidelines for type 2 diabetes
Steps Involved in Utilising Practice Data

1. Detail the problem or issue you are trying to improve.
2. Define the area of interest or specific patient population e.g. current smokers who are eligible for a health check or new quit smoking program.
3. Decide on the actual data to be collected.
4. Design a method for gathering data including deciding how many patients to include in the investigation e.g. measure only a sample or all patients?
5. Educate all involved to ensure data are collected consistently (this may require a whole of team approach).
6. Identify the time period to investigate e.g. last 12 months?
7. Trial the method to help ensure useful data is collected.
8. Analyse and discuss the findings to determine if change is required.

Data may come from a variety of sources within the practice including patient records, log books, reminder systems, appointment books, electronic data systems and others. Of course not all data is available in number form, feedback from patients and families are essential if the practice is to provide effective and appropriate interventions.

Data may be collected retrospectively (look back at events that already have taken place), concurrently (as something happens) or prospectively (setting up a system to capture data on something that is expected to occur).

Practice staff or teams can discuss the findings of data investigations during regularly scheduled meetings; in extraordinary meetings; via memo or other correspondence or other means. Aims and objectives for improvement should be agreed and ideas for testing changes that will result in improvement can then be developed. Ideally a leader is designated to take responsibility for coordinating or undertaking the improvement process.

Example from the field: Immunisation

Immunisation to prevent the flu in elderly patients with chronic respiratory problems was often provided in an ad hoc manner in the practice. This left the patients at risk of hospitalisation with serious exacerbation of their respiratory problems. A discussion took place at the weekly staff meeting and a decision was made to investigate the problem further. The findings were to be discussed at the next meeting.

The general practice nurse was charged with leading the investigation and office staff supported the process. The nurse devised a simple tally sheet and a list of patients identified from the patient database was investigated for:

- The date of the last influenza immunisation
- Time between the last and previous influenza immunisation
- Whether a reminder had been sent to attend the practice for the influenza immunisation
- Whether a reminder had been acted on by the patient and the timeframe for the patient to return to the practice
- Whether any of the unimmunised patients had experienced hospitalisations due to respiratory flare-ups.

The findings of the investigation, which found a large number of unimmunised elderly patients with chronic respiratory problems, were discussed at the next staff meeting and several strategies were agreed, including immediately sending letters to all eligible patients to ensure they understood why they needed to be immunised each year and the need to return to the practice; planning to run immunisation clinic* on certain days; posters in the waiting room and alerts applied to patient records.

* see AML Alliance Nurse Clinics in Australian General Practice

The following table provides an overview and web links to a range of population health data sources in Australia.

Table 1: Population Health Data Sources

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Bureau of Statistics</td>
<td>Provides statistics on a wide range of economic, social, population and environmental matters, covering government, business and the community. The five-yearly Census of Population and Housing is the largest statistical collection undertaken by the ABS <a href="http://www.abs.gov.au">www.abs.gov.au</a></td>
</tr>
<tr>
<td>Australian Institute of Health and Welfare</td>
<td>Major national agency set up by the Australian Government to provide reliable, regular and relevant information and statistics on Australia's health and welfare <a href="http://www.aihw.gov.au">www.aihw.gov.au</a></td>
</tr>
<tr>
<td>Australian Research Centre for Population Oral Health</td>
<td>Provides a broad range of dental and oral health statistics for Australia <a href="http://www.arcpoh.adelaide.edu.au">www.arcpoh.adelaide.edu.au</a></td>
</tr>
<tr>
<td>National Diabetes Services Scheme</td>
<td>The Australian Diabetes Map is the only national map monitoring the spread of diabetes in Australia. It shows the numbers of people diagnosed with diabetes in all parts of Australia with information on age, gender and type of diabetes <a href="http://www.ndss.com.au">www.ndss.com.au</a></td>
</tr>
<tr>
<td>Public Health Information Development Unit</td>
<td>Provides information on a broad range of health determinants across the life course. A major emphasis is on the development and publication of small area statistics for monitoring inequality in health and wellbeing. The online atlases, graphics and data sheets enhance access to a wide range of data to support a population health approach to planning activities and service delivery <a href="http://www.publichealth.gov.au">www.publichealth.gov.au</a></td>
</tr>
</tbody>
</table>
Population health is the focus of many different organisations and groups, many of which have developed publically available resources and tools to support population health programs and services. The following table provides an overview and web links to a range of information and service directories that support population health in Australia.

## Table 2: Population Health Information and Service Directories

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active and Healthy Directory</td>
<td>Directory of Exercise Programs in local areas</td>
</tr>
<tr>
<td>Healthy Living Network</td>
<td>The Healthy Living Network is a registration portal that provides a list of</td>
</tr>
<tr>
<td></td>
<td>quality registered activities, providers and programs in local areas. Only</td>
</tr>
<tr>
<td></td>
<td>Healthy Living service providers and programs that have met the quality</td>
</tr>
<tr>
<td></td>
<td>standards of the Healthy Communities Quality Framework are available from</td>
</tr>
<tr>
<td></td>
<td>the Website <a href="http://www.healthylivingnetwork.com.au">www.healthylivingnetwork.com.au</a></td>
</tr>
<tr>
<td>Healthinsite</td>
<td>Healthinsite provides a wide range of information on important health</td>
</tr>
<tr>
<td></td>
<td>topics such as diabetes, cancer, mental health and asthma through links to</td>
</tr>
<tr>
<td></td>
<td>some of Australia’s most authoritative health organisations and their</td>
</tr>
<tr>
<td>Infoxchange Service Seeker</td>
<td>The Infoxchange Service Seeker is Australia’s most extensive electronic</td>
</tr>
<tr>
<td></td>
<td>health and welfare directory providing access to thousands of health,</td>
</tr>
<tr>
<td>Lifeline Service Finder</td>
<td>The Lifeline Service Finder is a directory of free or low cost health and</td>
</tr>
<tr>
<td></td>
<td>community services available in Australia. Allows a search for relevant</td>
</tr>
<tr>
<td></td>
<td>services in local areas <a href="http://www.justlook.org.au">www.justlook.org.au</a></td>
</tr>
<tr>
<td>Measure Up</td>
<td>The national Measure Up website provides easy to follow tips and guidelines</td>
</tr>
<tr>
<td></td>
<td>to help individuals decrease risk of chronic disease by reducing weight</td>
</tr>
<tr>
<td>National Health Services Directory</td>
<td>The National Health Services Directory is a consolidated and comprehensive</td>
</tr>
<tr>
<td></td>
<td>national directory of health services and provider information. It covers</td>
</tr>
<tr>
<td></td>
<td>all Australian jurisdictions with services across the public and private</td>
</tr>
</tbody>
</table>
Table 2: Population Health Information and Service Directories (Continued)

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrient Reference Values</td>
<td>Nutrient reference values are a set of recommendations for nutritional intake based on currently available scientific knowledge. This website allows health professionals to determine nutritional needs without having to consult complex tables for every nutrient. Provides access to recommendations, based on scientific evidence, about how to optimise what to eat in order to reduce the risk of chronic disease <a href="http://www.nrv.gov.au/">http://www.nrv.gov.au/</a></td>
</tr>
<tr>
<td>Nutrition publications</td>
<td>The Commonwealth Government website provides guidelines and recommendations for Australians to encourage healthy eating that will minimise the risk of the development of diet-related diseases within the Australian population. <a href="http://www.health.gov.au">http://www.health.gov.au</a></td>
</tr>
<tr>
<td>Physical Activity Australia</td>
<td>Physical Activity Australia is a national independent not-for-profit organisation which promotes physical activity, active living and the reduction of sedentary lifestyles by engaging with the fitness industry, building best practice instructor standards and program accreditation, and rigorously applying research and evidence to develop engaging physical activity initiatives <a href="http://www.physicalactivityaustralia.org.au/">www.physicalactivityaustralia.org.au</a></td>
</tr>
</tbody>
</table>

Useful Resources


de Lusignan S, Hague N, van Vlymen J, Kumarapeli P. Routinely-collected general practice data are complex, but with systematic processing can be used for quality improvement and research. Inform Prim Care. 2006;14 (1):59-66.


Population Health Implementation

The chapter explores the opportunities for general practice nurses to increase population health activity at the practice level.

Foundation Stones

There are a number of broad approaches that, when effectively adopted, have been shown to assist population health efforts. These are summarised below.

Planning

All population health planning should ideally be aligned with the core business activities, values, capacity and commitment of staff in the practice. The general recommended steps to be followed in the population health planning process are outlined below:

- Through an investigation of available data and other information (such as asking staff and patients for ideas about what needs to be improved), identify potentially feasible population health interventions that fit with the operational activity in the practice.
- Prioritise key opportunities for improvement.
- Select one specific population health intervention at a time on which to focus efforts.
- Determine the population group and number to be targeted by the intervention.
- Ascertain potential funding and support opportunities e.g. from the Medicare Local.
- Look at general practice initiatives that support a population health approach e.g. Practice Nurse Incentive Program, Practice Incentive Payments and Service Incentive Payments and Chronic Disease Management items.
- Determine the staff who should be involved in the development and implementation of the intervention, including staff from external organisations.
- Establish a process to manage the implementation and evaluation of the intervention.
- Evaluate the implementation at various intervals to identify if changes to the approach are required.
- If applicable, integrate the intervention into practice procedures and processes, for example interactions with practice accreditation.

Activity Five

Review the Practice Incentive Payments (PIP) and the Service Outcomes Payments (SOP) and identify which ones can be accessed to improve your practice population health?

Practice Incentive Payment guidelines can be found on the Australian Government Medicare website http://www.medicareaustralia.gov.au/provider/incentives/pip/
Practices can actively seek opportunities to build population health interventions into existing clinical and other practice activities. In addition to this, practice staff can take the opportunity while planning a population health intervention to build the practice culture that seeks to reduce health inequities and emphasise health promotion and disease prevention.

**Activity Six**

Design some simple activities, that allow all staff to participate and will promote a culture of population health in the practice.

**Tips for Promoting a Culture of Population Health**

- Educate staff about population health and provide them with the skills to participate in population health processes.
- Set a routine schedule for monitoring and reviewing data and population health activities.
- Communicate results from population health projects, such as rates of immunisations throughout the practice and local community.
- Display data and information where patients can see them.
- Convey the value of population health in meetings.
- Provide opportunities for all staff to participate in population health teams.
- Place an item in the practice newsletter that highlights the population health work of the practice for staff and patients.

**Partnerships**

Primary care cannot produce comprehensive improvement in the health of individuals or populations alone. The wide-ranging determinants of health recognise the importance of partnerships in adequately supporting holistic health care.

A partnership is a relationship which is based on agreements that reflect common responsibilities to progress shared interests. Partnerships in primary care may take many forms, ranging from partnerships between region wide Medicare Local Organisations to local partnerships between non-government and community groups, private clinicians and businesses, academic institutions to publically funded hospitals and health services. Partnerships may vary in terms of activity to the sharing of resources and information to collaborative programs and integrated services.

However, all partnerships have one thing in common; they have come about because both partners believe they have something to gain from the partnership.

### Table 3: Potential Partners in Population Health Activities

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Health**            | • Hospitals (public and private)  
                         • Community Health services and clinics (public and private)  
                         • Aged care services (public and private)  
                         • Non-government health groups  
                         • Medicare Locals  
                         • Local Health Networks  
                         • Private health insurance providers                                    |
| **Education and Training** | • Schools  
                         • Community Colleges  
                         • Professional groups  
                         • Universities                                                               |
| **Research**          | • Universities                                                              
                         • Private institutions and groups                                             |
| **Government Sectors** | • Local Government  
                         • Transport  
                         • Housing  
                         • Gaming and Racing  
                         • Policing  
                         • Family and community services                                              |
| **Local Communities and Groups** | • Support groups  
                         • Religious organisations  
                         • Cultural groups  
                         • Sporting groups                                                           |
| **Private Sector**    | • Business and corporations                                                  
                         • RSL and other social clubs (private)                                       |

### Patient and Carer involvement

Patient and carer (health consumer) involvement in general practice is fundamental to ensuring an effective and responsive system. There is considerable evidence that patient and carer involvement can contribute significantly to improvement in individual and community health outcomes; health service delivery; and policy development.\(^{32}\)

To ensure general practice gains the maximum benefit from this evidenced based approach, general practices should support and encourage individual and community capacity to participate fully in practice improvement decisions.

The Australian Commission on Safety and Quality in Health Care has made Partnering with Consumers a key standard to help protect the public from harm and to improve the quality of care provided by health service organisations.

Standard 2 requires leaders of a health service organisation to implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Links to this and other useful resources are available on the Commission’s web site: www.safetyandquality.gov.au

### Evidence Based Population Health in General Practice

Population health activity in general practice should be underpinned by decisions that have been informed by one or more of the following areas:

- The best available research evidence
- Reliable data and information systems
- Robust investigations from partner organisations

- Information gained from patients and/or community members
- An understanding of the context in which the activity is to be implemented, including resources and expertise

A number of population health evidence and information sources to support the design and development of population health activity are provided in table 4.

---

Table 4: Population Health Evidence and Information Sources

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Primary Health Care Research and Information Service</td>
<td>A national primary health care organisation which provides a weekly eBulletin information service that delivers primary health care news via email. The eBulletin is designed to inform you of recently published articles and reports, news items, media releases, upcoming conferences and courses, research grants, scholarships and fellowships, PHCRIS products and services and new and/or relevant websites in the primary health care field. The eBulletin also provides direct links to further relevant information. <a href="http://www.phcris.org.au/ebulletin/">www.phcris.org.au/ebulletin/</a></td>
</tr>
<tr>
<td>The Cochrane Library</td>
<td>More than 5,000 systematic reviews are published in the Cochrane Library, including clinical and population-based interventions and economic evaluations. The Cochrane Public Health Group produces reviews on the effects of population health interventions. <a href="http://www.ph.cochrane.org">www.ph.cochrane.org</a></td>
</tr>
<tr>
<td>The Campbell Collaboration</td>
<td>This international research network produces systematic reviews in education, crime and justice, and social welfare.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.campbellcollaboration.org">www.campbellcollaboration.org</a></td>
</tr>
<tr>
<td>Guide to Community Preventive Services</td>
<td>The Task Force on Community Preventive Services has systematically reviewed more than 200 interventions to produce evidence-based recommendations on population-level interventions. Topics currently include adolescent health, alcohol, asthma, birth defects, cancer, diabetes, health communication, health equity, HIV/AIDS, sexually transmitted infections and pregnancy, mental health, motor vehicle injury, nutrition, obesity, oral health, physical activity, the social environment, tobacco use, vaccines, violence, and worksite health.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.thecommunityguide.org">www.thecommunityguide.org</a></td>
</tr>
<tr>
<td>Cancer Control P.L.A.N.E.T</td>
<td>The P.L.A.N.E.T. portal walks practitioners through an evidence-based process for cancer control, providing easy access to data and evidence-based resources. Topics include diet/nutrition, physical activity, tobacco control, and more. Step 4 includes practical details on interventions such as time and resources required and suitable settings. <a href="http://cancercontrolplanet.cancer.gov">http://cancercontrolplanet.cancer.gov</a></td>
</tr>
</tbody>
</table>
Evidence Based Population Health Interventions

Population health interventions in general practice can occur at the individual, practice and community levels as the following diagram illustrates. The value of general practice accrues from the services provided to individual patients, but also from practice and community level efforts that support improved health of targeted groups and improvements in the overall functioning of health care systems.

Figure 2: Population Health Examples - Individual, Practice and Community Levels

A range of intervention examples that have been found to be effective in research can be found in tables 5, 6 and 7.
Table 5: Examples of Evidence Based Population Health Interventions at the Individual Level

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Screening (individuals)</td>
<td>Health screening targeted to individuals at increased risk due to age, gender, family or personal history, or other factors (e.g. pap smears; skin cancer checks; referral to breast cancer screening; etc)</td>
</tr>
</tbody>
</table>
| Collaborative Care Programs     | Identification and referral of all practice patients, with an eligible chronic condition, to a local collaborative care program coordinated and sponsored by an external health organisation (e.g. public health system or non-government organisation etc). Typically these programs have case managers, who support general practice staff with functions such as:  
  - Patient education, counselling and social support Patient follow up to track improvements, outcomes and adherence to treatment  
  - Adjustment of treatment plans for patients who do not improve  
  General practice staff are usually responsible for:  
  - Routine clinical screening and diagnosis  
  - Clinical treatment  
  - Referring patients to specialists as needed  
  - Coordinating care e.g. Coordinated Veterans Care Program  
  These processes are frequently coordinated by technology-based resources such as electronic medical records, telephone contact, and provider reminder mechanisms. |
| Referral                        | Practice data examination and mail out to all current smokers providing information on early warning signs for lung cancer and encouraging/endorsing the Smoking Quitline.                                           |
| Counselling and Health Coaching | Counselling discussions between general practice clinicians and patients about ways that changes in personal behaviour can reduce risk of illness or injury. The goal of which is to educate patients about their health risks as well as to provide them with the skills, motivation, and knowledge they need to address their risk behaviours (e.g., 5A framework for tobacco cessation: Ask, Advise, Assess, Assist, Arrange). |
| Information systems             | Clinical decision-support systems (computer-based information systems designed to assist health care providers at the point of care) to support improved screening for CVD risk factors and referral to CVD-related preventive care services. |

Example from the field: Improving Blood Pressure Control

After interrogating the practice data for information on patients with cardiovascular disease, the clinical staff noted how many patients had unstable blood pressure. After discussions at the regular staff meeting, they agreed that a multidisciplinary team approach was needed to improve the quality of patient blood pressure management. Several local pharmacists and a community based healthy lifestyle not-for-profit group were contacted to complement the activities of the practice in this health promotion exercise.

All groups actively engaged patients in their own care by providing them with education (about blood pressure medication or lifestyle), understanding and adherence support (for medication and other management approaches), and tools and resources for self-management (including health behavior change). Where the partnering groups identified health issues, they referred the patient to the practice for a follow-up and provided relevant and timely information to the GP or nurse coordinator. The practice checked whether the clinical support provided was in line with the latest evidence-based clinical management guidelines and established regular, structured follow-up mechanisms to monitor patients’ progress and schedule additional visits as needed. This was enabled via the utilisation of practice medical software for reminding patients. The practice also updated their waiting room posters and patient materials.
Example from the field: Chronic Disease Management

Lois Mitchell was awarded the MSD Best Practice Nurse Award for Chronic Disease Management for her work in setting up the innovative weight management program ‘Change of Life’. She began to tackle the issue of obesity in her work with Nexus Healthcare Group in early 2011. Drawing on her considerable skills and experience in chronic disease management and the promotion of behavioural change through neuro-linguistic programming technique, she designed the Change of Life program. The program involves an initial patient screening visit, where they are educated about energy imbalance and their readiness to attempt behavioural change is assessed. Patients who show a commitment to the program are invited to continue the 12-week program. Education and motivation is provided throughout the program by the nurse, with the assistance of the GP, and where appropriate, a dietician and/or exercise physiologist.

Source: APNA Media Release, Thursday 16 May 2013

Table 6: Examples of Evidence Based Population Health Interventions at the Practice Level 36,37,38,39

<table>
<thead>
<tr>
<th>Level</th>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice population (all or groups)</td>
<td>Nurse clinics</td>
<td>• Health screening and immunisation clinics targeted to groups at increased risk due to age, gender, family or personal history, or other factors (e.g. pap smears; skin cancer checks; influenza vaccine; etc). Includes health promotion and lifestyle education etc.</td>
</tr>
<tr>
<td></td>
<td>Referral</td>
<td>• Practice data interrogation and regular mail out to all current smokers providing an invitation to have a check-up and information about the Smoking Quitline.</td>
</tr>
<tr>
<td></td>
<td>Group Education</td>
<td>• Small group Diabetes self-management education (teaching people to manage their diabetes) the goals of which are to control blood sugar levels, prevent short and long term health conditions that result from diabetes.</td>
</tr>
<tr>
<td></td>
<td>Recall and Reminder Systems</td>
<td>• Patient reminder and recall interventions involving reminding members of a target population that vaccinations are due (reminders) or late (recall). Reminders and recalls differ in content and are delivered by various methods—telephone, letter, postcard, or other. Most reminder systems involve a specific notification for a specific patient, and may be supplemented by educational materials regarding the importance of immunisation.</td>
</tr>
</tbody>
</table>

Box 7: Example from the field: Aboriginal Women’s Health

Congratulations to local nurse Sandy Anderson who has been awarded the Best Practice Nurse Award for Sexual Health. Sandy was one of five nurses recognised for outstanding contribution to best practice and enhancing patient health in primary care as part of the 2012 Australian Practice Nurse Association National Conference. Sandy’s strategy included developing a permission form, opportunistic discussion during appointments, new patient screening, in women’s health assessments, concerted follow-up, community newsletters and education through Koori women’s health days. In building the Pap test history, from what at times can be a very mobile population, her team was greatly assisted by the responsiveness of the Pap registry.

Sandy and the team’s approach showed significant statistical improvements to rates of screening in the last 12 months. Aboriginal and Torres Strait Islander women with a Pap test recorded increased by 17.3% and the ‘no Pap test recorded’ rate decreased by 18.9%. In May this year, of those women in the Baarlinjan Medical Clinic population, 63.1% had a Pap test recorded and of those 69.3% had been screened in the last two years.


Table 7: Examples of Evidence Based Population Health Interventions at the Community Level

<table>
<thead>
<tr>
<th>Level</th>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community (all or groups)</td>
<td>Workplaces</td>
<td>• General practice support in employer sponsored workplace influenza immunisation clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• General practice support in employer sponsored health risk assessments that identify employees at risk for early signs of chronic conditions (e.g. Type 2 Diabetes, heart disease, or hypertension) and refer those employees to their General practice for continuing care.</td>
</tr>
</tbody>
</table>
Useful Resources

http://www.thecommunityguide.org/index.html


Taylor EF, Machta RM, Meyers DS, Genevro J, Peikes DN. Enhancing the primary care team to provide redesigned care: the roles of practice facilitators and care managers. Ann Fam Med. 2013 Jan-Feb; 11(1):80-3

General Practice Nurses

General practice nurses enhance the provision of services offered in general practice and are integral to the provision of population health activities in these settings. The population health roles and functions of general practice Nurses will depend in large part on practice patient demographics (age, sex, health literacy levels etc.), workload and practice staffing.

Scope of Practice

A range of competency standards support the development and implementation of population health activities in general practice settings. The national Nursing and Midwifery Board competency standards for the registered nurse identify:

- “The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities.
- “The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individuals with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life”.
- The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes”.

Enrolled nurse competency standards also support population health activity. For example, they require the enrolled nurse to provide “accurate and appropriate education to individuals/groups related to the maintenance and promotion of health in consultation with the registered nurse”, among other relevant activities.

Specific competency standards for registered and enrolled nurses in general practice are available to support the provision of primary health care centred on individuals and groups, in accordance with their educational preparation, professional nursing standards, relevant legislation and general practice context.

Activity Seven

The Australian Nursing and Midwifery Federation website provides the competency standards for nurses in general practice.


Read through the competency standards and make reference to areas relating to population health activities.

Roles and Functions

General practice nurses work in collaboration with general practitioners and other health professionals to provide a range of population health services to patients at the individual and group levels, such as chronic disease management, health check reminders (e.g. pap test reminders), lifestyle and health education, health assessments across the lifespan, health promotion, immunisations and women’s, men’s and children’s health. General practice Nurses are often the key drivers of population health activity within their practices.

Figure 3: Population Health Supporting Roles and Functions of General Practice Nurses

Activity Eight

Identify specific general practice nurse activities for each of the areas in the diagram above.

Leadership in Population Health

While the application and opportunity to demonstrate nurse leadership in population health will vary across different general practices, there are a number of key factors that are likely to be important for all types of practices, including the need to:

- Have an awareness of how information about individual patients relates to the health status of the total population
- Develop a sound working knowledge of population health and implement activities that:
  - Address the health needs of patients
  - Aligns with evidence and key government health plans and policies e.g. MBS funding
  - Are acceptable to local services and providers
  - Fit with the local context
  - Are appropriate from the patient perspective
- Encourage an emphasis on health promotion and maintenance, in addition to the clinical management of disease or disability
- Mobilise teams to take action on population health issues and value working in partnership with shared responsibility and credit for collaborative work
- Implement effective techniques to ensure adequate patient engagement and feedback.
- Establish ongoing interaction and joint decision making with multiple health-related and non-health-related disciplines to address the health needs of population groups
- Draw on a wide range of workers and expertise from various disciplines and sectors to enable the development of innovative population health interventions
- Seek out evidence to support population health practice
- Identifies and undertakes continuing professional development in new approaches to population health in general practice.
- Possess change management skills
- Identify opportunities
- Advocate for population health activity

Effective population health also requires general practice nurse leaders to focus on the success of the practice overall. This often includes managing people by providing direction and motivating others, and managing resources i.e. knowing what resources are available and using their influence to ensure that resources are used efficiently and reflect population health needs.

At the organisational level, nurse leaders need to be supported by structures that assist the application of population health principles including:

- Population health activity is evidenced in plans, policies and accepted ways of working within the practice
- Position descriptions provide a mandate for population health activities
- Practice systems support inter-agency and intersectoral referral
- Professional development opportunities in population health approaches are prioritised and encouraged

The Australian Medicare Local Alliance has developed a learning module for general practice nurses “Leadership in Action”.


Learning objectives:

- recognise the difference between leadership and management
- identify the qualities of effective leaders/leadership
- identify personal leadership qualities
- recognise opportunities for nursing leadership in general practice
- develop an action plan for development as a leader at the personal, practice and professional levels
- locate resources that will assist in further leadership development.
**Professional Development**

General practice nurses maintain, improve and broaden their knowledge, expertise and competence through undertaking regular continuing professional development (CPD). More information is available on the CPD registration requirements of general practice nurses on the Australian Health Practitioner Regulation Agency (AHPRA) website (see below in the useful resources section).

There are a range of different agencies that provide CPD opportunities for general practice nurses which focus on population health, including (but not limited to):

- Australian Primary Health Care Nurses Association [www.apna.asn.au](http://www.apna.asn.au)

General practice nurses also have opportunities to undertake tertiary education in an area of nursing that is relevant to population health such as studies in health education, Aboriginal and Torres Strait Islander health, public health, and epidemiology.

**Activity Nine**

What type of education will enhance your knowledge of population health activities and where will you access it?

Consider utilising the self-assessment and professional development plan found in the Competency Standards for Nurses in General Practice toolkit as a guide.

**Useful Resources**

Australian Primary Health Care Nurses Association (APNA)
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Supporting nurses in primary health care