



HEALTHY WEIGHT TOOLKIT

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INTRODUCTION

Obesity is fast becoming Australia's biggest public health challenge

Across Australia, two in three adults and one in four children are either overweight or obese. For many people in our community, unhealthy weight is a pathway to chronic disease.

Rates of overweight and obesity are higher in rural and regional areas compared to metropolitan areas.

Research shows that tackling obesity and unhealthy weight requires a multifaceted approach, as the causes of weight gain may relate to a range of physiological, social, genetic, environmental and psychological factors.

Hunter, New England and Central Coast Primary Health Network (HNECCPHN) is developing a model of care for General Practice to support people to reach a healthy weight and reduce their risk of chronic disease.

The model will take an inclusive approach to interventions, with multiple sectors and organisations included in the initiative to support people to reach and maintain a healthy weight.

The State of the Nation

RISK FACTORS	LATEST AUSTRALIAN DATA	LATEST INDIGENOUS DATA	2025 TARGET
 Adults who are overweight or obese	63.4%	71.4%	61.1%
 Adults who are obese	27.9%	41.7%	24.6%
 Adults not meeting physical activity recommendations	44.5%	65%	40%

NSW	Narrabri LGA	Narrabri LGA	Australia Gender	Australia Rates
Adults - Overweight 34.6%	Adults – Overweight 34%	Adults – Overweight or Obese 75.4% or <2 in 3 adults	Adults – Overweight or Obese 70.8% Men 56.3% Women	Adults – Overweight or Obese 18-24 yrs. 38.9% ↓ 55-64 yrs. 74.7%
Adults - Obese 26.4 per 100	Adults - Obese 41.1 per 100			

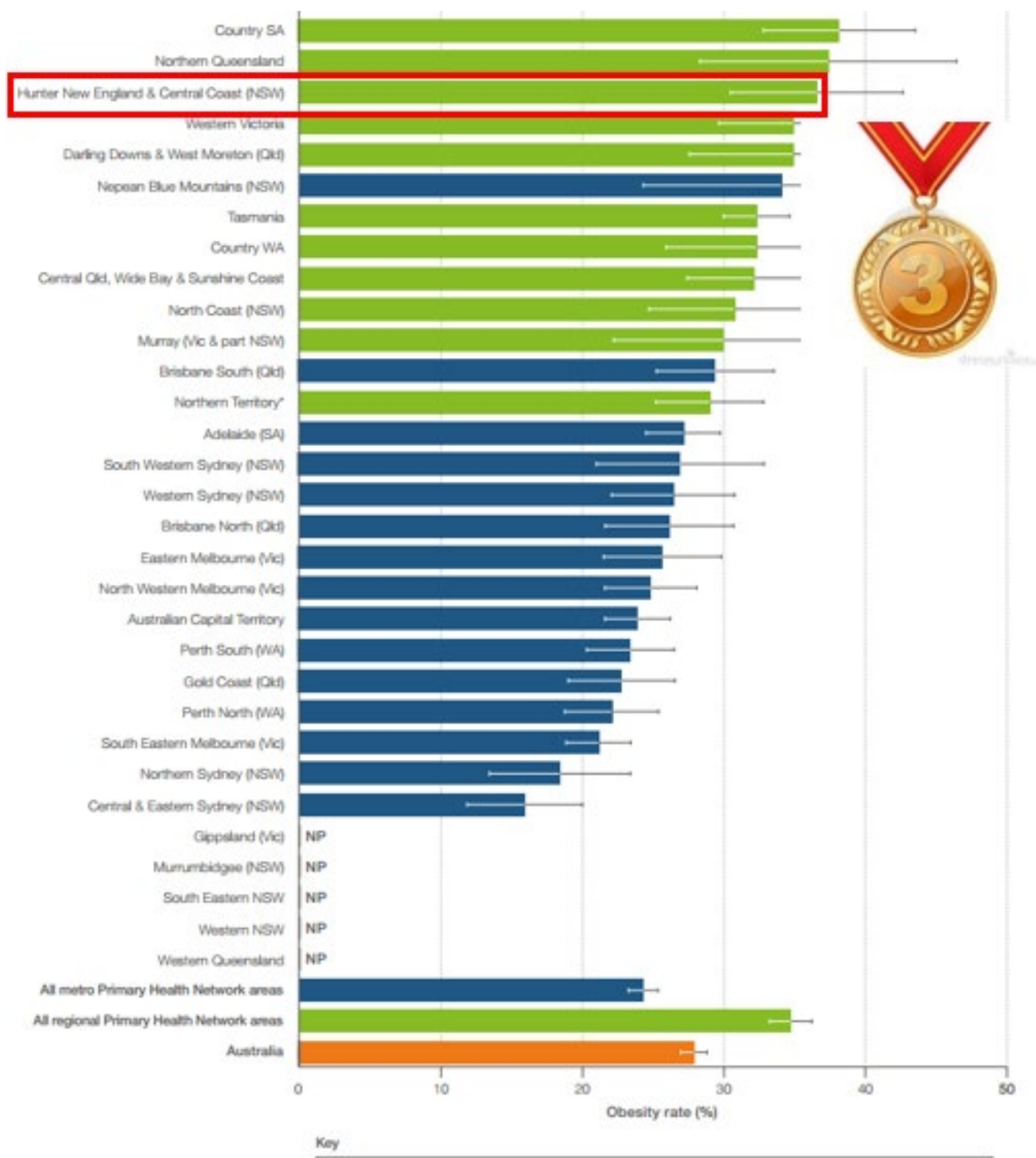
Source: Australia's Health Tracker 2017

Obesity - a PHN priority health issue

In 2014-15, 4.9 million adults (1 in 4) obese in Australia; 5th highest of OECD countries.

- HNECC PHN has 3rd highest rate of adult obesity across Australian PHNs
- Regional & Rural PHN's have significantly higher obesity than metro PHNs
- COAG benchmark - 2018 - 41.9% at healthy weight (currently at 35%)

(AIHW Healthy Communities Report, 2016)





Healthy Communities: Overweight and obesity rates across Australia, 2014–15

Published 8 December 2016

This report presents, for the first time, overweight and obesity rates in adults by Primary Health Network (PHN) areas across Australia.

Being overweight or obese can have serious negative health consequences, and the effects of overweight and obesity are a leading health concern in Australia.¹ Carrying extra weight can lead to cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis, and some cancers. These conditions cause premature death and substantial disability.¹

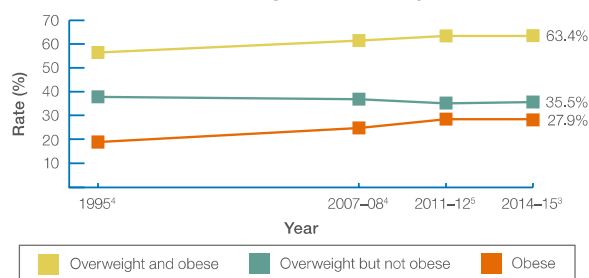
Overweight and obesity rates in Australia are some of the highest in the world.² In 2014–15, 11.2 million Australian adults were overweight or obese, equivalent to a national rate of 63.4%.³

National rates of overweight and obesity have increased in recent decades, up from 56.3% in 1995.⁴ This has been driven by an increase in obese adults, with the percentage of adults who were overweight but not obese remaining similar in that time (Figure 1).

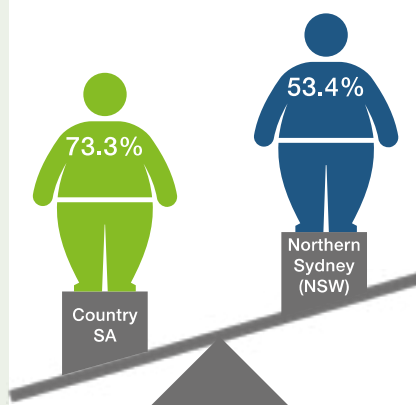
At the local level in 2014–15, the percentage of overweight or obese adults varied across the PHN areas that could be measured, ranging from 53.4% in Northern Sydney to 73.3% in Country SA. Overall, adults in regional PHN areas were more likely to be overweight or obese than their city counterparts.

Obesity by itself showed wider variation across PHN areas, ranging from 16.0% in Central and Eastern Sydney to 38.1% in Country SA. Overall, regional PHN areas also had higher obesity rates than metropolitan PHN areas.

Figure 1: National adult overweight and obesity rates



Overweight and obesity rates varied across Primary Health Network areas, ranging from:



What is a Primary Health Network?

Primary Health Networks (PHNs) are organisations that connect health services over local geographic areas. There are 31 PHNs in Australia. See the back page for more information.

Visit www.myhealthycommunities.gov.au for more detailed results

Sources and references can be found in the Technical Note at www.myhealthycommunities.gov.au/publications

WHAT IS QUALITY IMPROVEMENT?

The RACGP Standards for General Practice describes quality activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards recommend practices engage in quality improvement activities that review structures, systems and processes to aid the identification of required changes to increase the quality of healthcare delivery and safety of patients.

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Engaging in quality improvement activities is an opportunity for the practices' GPs and other staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team.

Standards for General Practice - 5th Edition

The RACGP 5th Edition Standards have been released with a new module specifically identified for Quality Improvement. Criterion QI 1.1 identifies four indicators that relate to Practice based activity around Quality Improvement and reference a team-based approach. The criterion recommends having at least one team member responsible for leading quality improvement in the practice, which establishes clear lines of accountability. Please refer to the guidelines.

Criterion QI 1.3 relates to improving clinical care, specifically practice use of relevant patient and practice data to improve clinical practice. Establishing and utilising robust reminder and recall systems could be a focus under this criterion.

The Quality Improvement process is divided into two manageable steps, the "thinking" and "doing" part. This process allows ideas to be broken down into management sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing on a larger scale.

The 'Thinking' part

The thinking part consists of three fundamental questions that are essential for guiding improvement.

1. What are we trying to accomplish?

By answering this question, you will develop your aim for the activity.

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation Understanding what the problem is and thinking about why there is a problem helps in developing your aim.
- Set realistic objectives which are specific, have a defined timeframe and are agreed (SMARTA). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.

2. How will we know that change is an improvement?

By answering this question, you will develop measures for tracking your goal.

Without measuring, it is impossible to know whether the change you are testing is an improvement.

- Communicate to the team what you are measuring, how, when and who is responsible (see 'Measuring Success').
- Make the measurement as simple as possible.
- Only collect the data that is required.

3. What changes can we make that will result in an improvement?

By answering this question, you will develop ideas for change.

Encourage the whole team to contribute ideas. Be creative. Think outside the box.

- You know your General Practice and your patients best. Keep this in mind and use your knowledge and experiences to guide your ideas.
- Adapt from others.
- Think small and test. Think about testing a change with one GP or a select group of patients. This will assist in determining if the change had the desired effect and suitable for wider implementation.

FOR EXAMPLE - your General Practice may decide to focus on Weight Management.

You may have an aim like this:

To increase participation in weight management of patients aged between 18-65 years.

Your response may be:

We will measure through CAT4:

- The number of eligible patients aged 18-65 with a BMI > 25 in our practice
- The number of patients who have a chronic disease which could be improved with weight management strategies
- The number of patients which have a BMI > 25 who do not have a chronic disease.

Your outcome may include:

- Use CAT4 to extract the number of patients aged 18-65 with a BMI > 25
- Provide training to ensure both clinicians and non-clinicians have the necessary skills and confidence to discuss weight management with patients
- Routinely weigh all patients
- Ensure patients weight, waist circumference and BMI are recorded in the correct location in Clinical Software (no free text)
- Send weight management invitation letters to eligible patients.



The 'Doing' part

The doing part is made up of rapid, small Plan, Do, Study Act (PDSA) cycles to test and implement change in real work settings.

Not every change is an improvement, but by making small changes, you can test the change on a small scale and learn about the risks and benefits before implementing change more widely. Several PDSA cycles may be required to achieve your improvement goal.

You will find through PDSA cycles some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

Step One: Plan

A well-developed plan includes what, who, when, where and your predictions and what data is to be collected.

Make your plan as clear and as detailed as possible:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will we collect to know whether there is an improvement?

Step Two: Do

Write down what happens when the plan is implemented (both negative and positive) and other observations.

Collect any data you identified in the plan phase.

Step Three: Study

Reflect on what happened.

Think about and summarise what you have learnt. Analyse the data collected and compare with your initial predictions. If there is a difference in the data and predictions, consider what happened and why.

Step Four: Act

Considering the results from your tests; will you implement the tested change or amend and test or try something else?

Write down the next idea you will test. Be sure to start planning the next cycle early to keep up the momentum of change.



FOR EXAMPLE - your General Practice may decide to focus on Weight Management.

Idea	Use CAT4 to extract the number of patients aged 18-65 who are eligible for a weight management program.
Plan	<p>What: Use CAT4 to extract data</p> <p>Who: Practice Manager</p> <p>When: Wednesday 3 November 2019</p> <p>Where: General Practice</p> <p>Data to be collected: Extract or record the number of patients 18- 65, with a BMI>25.</p> <p>Prediction: Expect 67% of eligible patients to have a BMI>25 (National Health Survey, 2018).</p>
Do	Practice Manager extracted data as planned using CAT4 recipe to ensure correct data was extracted.
Study	Percentage of patients with BMI>25 was as expected.
Act	Data presented to practice team to discuss weight management strategies that could be implemented within the practice.



HELPFUL TIPS

- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data (PEN CS and clinical database audits, near misses and patient and/or staff feedback)
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute
- Utilise the Readiness Tool to assist identify ideas and areas for improvement
- No PDSA cycle is too small; keep it simple
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles
- Set aside protected time to complete the agreed upon tasks
- Document your PSDA cycles and present findings at team meetings
- Improvement is a team effort.

See Criterion C4.1 – [Health Promotion and Preventative Care RACGP 5th Standards](#)

READINESS TOOL

There are many ways to improve patients' participation in Weight Management.

This Readiness Tool is designed as a starting point to encourage General Practice to generate ideas and strategies in weight management that may be applied to a quality improvement activity. This may assist with the 'thinking part' of the quality improvement cycle.

In working through the Readiness Tool, start by identifying if the practice or clinicians are undertaking activity in the identified area. In the action column you could document any ideas or processes that may need to be introduced or changed.

Weight Management Quality Improvement Readiness Tool

General Practice Name:	
Completed by:	
Trained Health Practitioner:	

AREA: Weight Management Change Readiness	Yes/No	Action/Comment (what, when, who)
1. There is an active focus on weight management eg. discussed at practice meetings, reminder/recall systems, nominated clinician champions.		
2. You/your practice currently provides weight management screening activities as per The National Health Medical Research Council Clinical Practice Guidelines for the management of overweight and obesity in adults, adolescents and children in Australia.		
3. Within your patient population, have priority populations been identified?		

AREA: General Practice Systems	Yes/No	Action/Comment (what, when, who)
1. You/your practice utilise a standard anthropometry recording?		
2. The patient's anthropometry is updated and recorded in clinical software?		
3. Regular data cleansing activities are undertaken to establish up to date lists (registers) of patients eligible for weight management.		
4. Practice software is utilised for actions/prompts for the GP/Nurse to ask about weight management?		

5. There are policies and procedures in place that include reminders and recalls for weight management programs? (review/develop policy for recall/reminders).		
6. The practice sends targeted reminders to patients (e.g. letters, SMS, email or phone calls) for weight management progress reviews.		
7. Have you developed a workflow to manage and monitor weight management in your practice?		
8. The practice is participating or preparing to participate in the HNECC PHN Healthy Weight Program. (Patient information and Clinician education)		

AREA: Patient Centred Care	Yes/No	Action/Comment (what, when, who)
1. Patient BMI is identified in health assessments and opportunistically raised?		

AREA: Aboriginal and Torres strait Islander (715) Health Assessment	Yes/No	Action/Comment (what, when, who)
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1. The practice undertakes health promotion activities for weight management?

Patient information such as location of community weight management opportunities are identified in areas of;;

Healthy Eating ☐ Physical Activity ☐ Lifestyle ☐

2. Patients provided with quality information on weight management utilising patient info, including access to resources in other languages and for Aboriginal and Torres Strait Islander communities?		
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3. Your practice routinely identifies Aboriginal and Torres Strait Islander patients?

4. Your practice routinely identifies CALD patients/ language spoken and utilises Telephone Interpreter Services where appropriate?		
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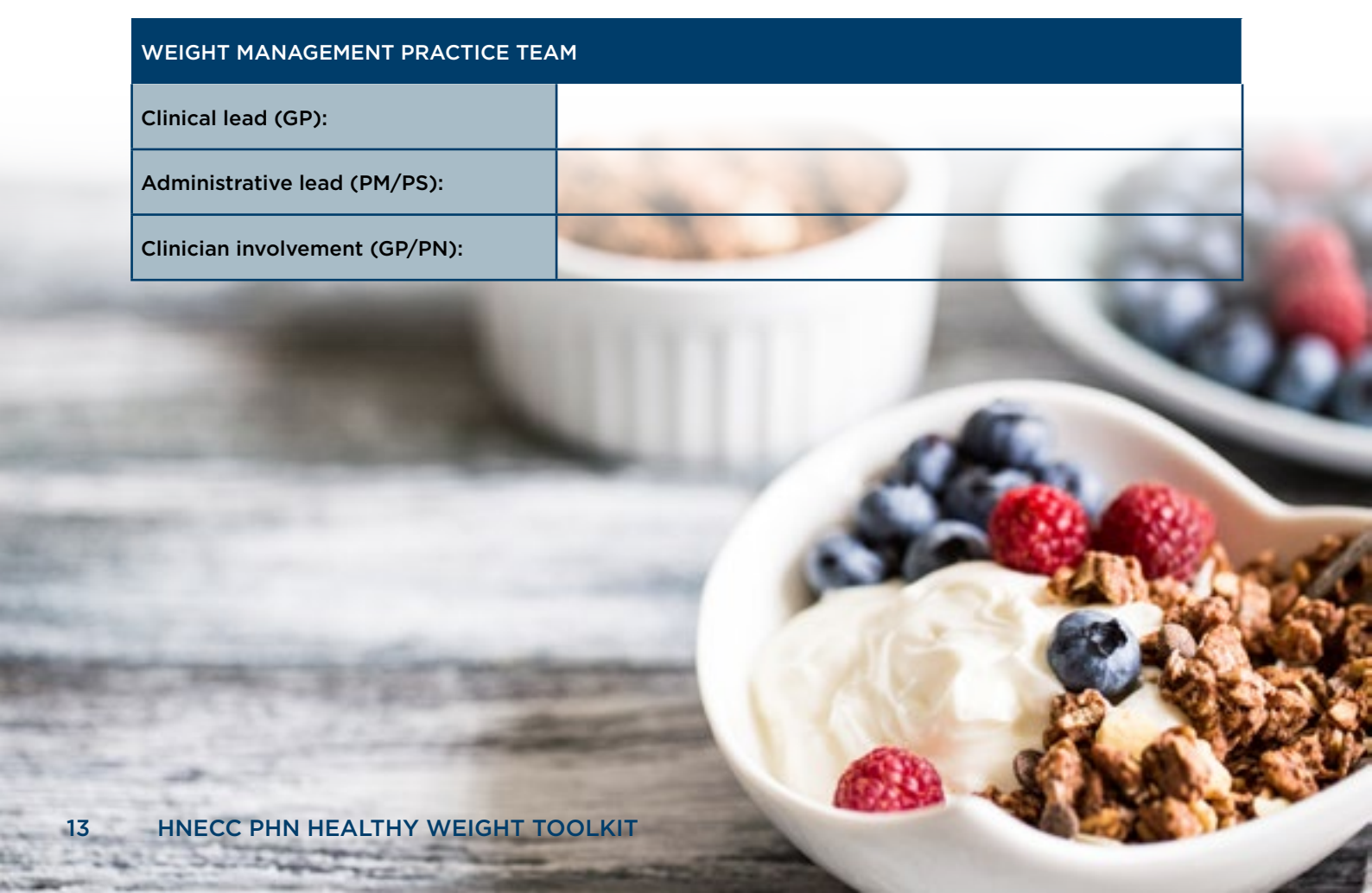
5. Each clinician is registered for the National Translator and Interpreter Service?
(Visit www.tisnational.gov.au)

6. Patient experience of weight management is measured? (Identify patient reported outcome and experience measures for prevention in General Practice through patient feedback).		
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<p>AREA FOR ACTION (Go to PDSA template in your toolkit or see suggested PDSA activities)</p> <p>1.</p> <p>2.</p>
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WEIGHT MANAGEMENT PRACTICE TEAM	
Clinical lead (GP):	
Administrative lead (PM/PS):	
Clinician involvement (GP/PN):	

Clinical lead (GP):	
Administrative lead (PM/PS):	
Clinician involvement (GP/PN):	



CHANGE IDEAS TO CONSIDER

These ideas are suggestions only.

Idea: Encourage person centred care by encouraging overweight and obese patients to discuss weight management with their GP.

- Display weight management promotional material in the waiting room.
- Have the reception team give eligible patients a flyer asking them when they last assessed - the patients then take the flyer into their appointment with them, opening the door for a discussion with their Doctor or Nurse about weight management programs.

Idea: Engaging the General Practice Team - Develop and maintain an effective recall and reminder system: staff education.

There is often a lot of work that needs to be done to improve how practices use software to maintain effective recall and reminder systems. Staff education is the first step towards improvement. Ask your Primary Care Improvement Officer to provide a short information session to staff and provide "Weight Management Reminder and Recall" resource manuals.

Idea: Appoint a staff member who is responsible for creating and maintaining a database/ healthy weight register, add this role to their job description.

This staff member may become the Practice Weight Management Champion. Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

Idea: Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care.

(eg. by linking multiple recalls such as weight management recall, GP Management Plans, Health Assessments etc together)

Dedicate some time at a staff meeting to discuss how health assessments can include healthy weight prompts. Review health assessment templates to ensure that healthy weight and weight management questions are included.

Idea: Draft a written procedure for recall and reminder systems.

If your practice has a policy/procedure for recalls and reminders, check that there is a process for healthy weight management. If there is not a current policy, contact GPA or AGPAL as a starting point to generate conversation and development of a policy.

Idea: Send weight management reminder letter to eligible patients due for assessment.

- Following the establishment of your healthy weight patient register, identify patients due for assessment.
- Healthy Weight Initiative suggests two key times where Practice reminders can really value add:
 1. For patients who have never been assessed
 2. On a patient's actual re-screen due date.
- Utilise the suggested template reminder letter available through your Primary Care Improvement Officer.

RESOURCES FOR UNDERTAKING QUALITY IMPROVEMENT

Quality Improvement Goal Setting

1. What are we trying to accomplish?

By answering this question, you will develop your goal for improvement.

2. How will we know that a change is an improvement?

By answering this question, you will develop measures to track the achievement of your goal.

3. What changes can we make that can lead to an improvement?

List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal.

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

Describe the idea you are testing.

IDEA

Must include what, who, when, where, predictions & data to be collected.

What:

Who:

PLAN

When:

Where:

Data to collect/record:

What do we think will happen?

Was the plan executed? Document any unexpected events or problems.

DO

Record, analyse and reflect on the results.

Extract same data to measure for improvement:

STUDY

What will you take forward from this cycle (next step or next PDSA cycle)

ACT



Measuring Success

The overall aim of undertaking a weight management quality Improvement activity is to increase participation in screening.

Choosing an activity or idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know when the change has occurred.

Applying a SMARTA (Specific, Measurable, Attainable, Realistic, Timebound and Agreed) goal setting process will assist you.¹

When reflecting on the Weight Management Activity identified on page 11, where you have undertaken a data analysis utilising CAT4. This has shown the percentage of active patients who have a BMI>25. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For this example, you may like to set a goal to increase recording of BMI status and waist circumference measurement by 10%. When this has been implemented, within a set time frame, you can then repeat the data analysis to see the change in status has increased.

SMARTA Goal Setting

- **Specific.** Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.
- **Measurable.** Ideally goals should include a quantity of 'how much' or 'how many' for example drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.
- **Achievable.** Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only if the person can achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.
- **Relevant.** The goal should seem important and beneficial to the person who is assigned the goal.
- **Time-related.** 'You don't need more time, you just need a deadline.' Deadlines can motivate efforts and prioritise the task above other distractions.
- **Agreed.**

¹Health Direct November 2016 <https://www.healthdirect.gov.au/smart-goals>

An Example of Measuring Success

Practice X has 600 active male and female patients aged between 18-65 years. Of these patients, following the use of CAT4, 200 males and females in this age group have a recorded BMI and waist circumference that puts them at risk of developing a chronic disease.

Numerator: The number of male and female patients aged 18-65 years, with 3 or more visits in the previous 2 years, who have a BMI>25.

Denominator: The number of active male and female regular clients aged 18-65 years.

$$[\text{Numerator of 200}] \div [\text{Denominator of 600}] = 30\%$$

Practice X then decides as a QI activity to undertake a data cleansing and improvement activity for weight management. The measurement of change will be the increase in recording of 10%. This could be a measure after 3 months as this is a measurement of data management and system change.

Measurement for Weight Management

Waist Circumference Measure

NUMERATOR	The number of clients aged 18-65 years, with 3 or more visits in the past 2 years, who have not had a waist circumference measurement within the previous 2 years.
DENOMINATOR	The number of clients aged 18-65 years, with 3 or more visits in the previous 2 years, who have had a waist circumference measurement recorded within the past 2 years.

BMI Measure

NUMERATOR	The number of regular clients aged between 18-65 years, with 3 or more visits within the previous 2 years, who have not had their BMI calculated within the previous 2 years.
DENOMINATOR	The number of regular clients aged between 18-65 years, with 3 or more visits within the previous 2 years, who have had their BMI calculated within the past 2 years.

24 Hour Food Diary

NUMERATOR	The number of male and female patients aged 18-65 years, with a BMI>25, with 3 or more visits in the previous 2 years, who have completed a 24-Hour Food Diary in the last 2 years.
DENOMINATOR	The number of regular clients aged between 18-65 years, with 3 or more visits within the previous 2 years, who have completed a 24-Hour Food Diary within the past 2 years.

Physical Activity: Average steps per week

NUMERATOR	The number of active female clients aged 18-65 years, who have had their steps recorded over a 1-week period within the previous 2 years.
DENOMINATOR	The number of regular clients aged between 18-65 years, with 3 or more visits within the previous 2 years, who have had their steps recorded over a 1-week period within the past 2 years.

NOTES:

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