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Project: Knowledge and attitudes of general practitioners and practice nurses to the Green Prescription Programme and Community-based Smoking Cessation programmes

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Introduction:

It is widely acknowledged that being physically active has many health benefits. The Green Prescription programme (GRx) was developed in the late-1990s as a tool for encouraging physical activity through phone-based intervention. GRx is accessible through a primary care referral pathway with a large proportion of referrals coming from General Practice clinicians. Baseline funding for GRx delivery allows providers to offer a phone consultation for each patient referred, and up to four months of phone follow-up support. Motivational support and information around physical activity options and nutritional habits are discussed. Here in Canterbury, extra funding from the CDHB and Pegasus Health allow the provision of face-to-face consultations and group activity programmes in urban centres. From 2013, the Ministry of Health invested further resourcing into GRx in response to the rising incidence of both type 2 and pre-diabetes in New Zealand, increasing referral targets. In order to make service improvements to ensure GRx is relevant to the needs of both patients and health professionals and to meet the increasing referral targets, it is important to understand factors that influence the referral of patients into GRx. A limitation of previous literature on GRx is the relative lack of investigation into low referring general practices and their reasons for not referring and this in particular was what the current study aimed to target.

Aim:

1. Understand referral models and processes
2. Understand the knowledge and attitudes of GPs and practice nurses to GRx
3. Guide the development of this (and other) programmes that support positive behaviour change
4. Improve the communication of these programmes by and to GPs and PNs within the primary care environment

Method:

This study used a qualitative methodology, performing eight 30 minute focus-groups with a mixture of high and low referring general practices. The ten highest and ten lowest referring general practices were identified by calculating referral rates to GRx using data from the two years prior to May 2015. Care was taken to include a mixture of both rural and city-based practices in the purposive sample in order to ensure a diverse range of backgrounds and opinions. Practice staff involved in lifestyle intervention and referral at the selected practices from this group were invited to participate. Thematic analysis was performed to determine the reasons for the differing referral rates and potential ways to improve the service.

Results:

There were a wide range of findings, many of which were interwoven. It was found that a practice's philosophy about the promotion of physical activity as part of their approach to the prevention and management of long-term conditions appears to be an important factor in the acceptance of GRx. The data indicated that high-referring practices expressed emphasis on physical activity far more than low-referrers. A practice's philosophy also seemed to be affected by the personal exercise habits of the health professionals who worked at that practice. Those who exercised themselves appeared to be more enthusiastic about physical activity intervention for their patients. Lack of knowledge about the GRx programme was evident throughout the focus groups, but was far more pronounced in low referring practices. Without knowing specifics about GRx, health professionals were not comfortable referring their patients to it. Some health professionals were unsure of the efficacy of GRx and in rural communities where only phone support is available, pessimism about the positive effects of that delivery model were expressed. An important factor in the underutilisation that presented in the data was the perception that patients were not engaging after the referral was made. This reportedly deterred health professionals from continuing to refer patients into the service. Data from the last twelve months shows that approximately 70% of patients referred to GRx engage with the service, however variations do exist between practices. The final key theme was physical access to the service. A number of rural communities do not have local access to face-to-face consults and instead, the phone-support model is used. This was reported as a major barrier to rural practices increasing their use of GRx, despite evidence supporting the efficacy of phone-based interventions.

Conclusions:

This study has provided a unique primary health care perspective on the reasons for, and barriers to, referring to GRx. Many factors were identified through our focus groups and the consequent analysis and many of them were heavily interwoven. GRx is an effective intervention to increase physical activity and may be an important tool that can be used to prevent the associated complications of the sweeping obesity and diabetes epidemic in New Zealand. Possible ideas that could improve service provision, and by extension improve referral rates, are to provide more information and education about GRx to health professionals; offer motivational interviewing and brief intervention training to primary health care professionals; create a participant information brochure that can be given to patients upon referral to increase likelihood of accepting the referral; strengthening the communication between general practices and the GRx staff; and to investigate the feasibility of offering face-to-face services in rural areas. Providing the right environment and structure to enable more referrals to GRx can only have a positive impact on the health of all New Zealanders. By delineating the current barriers to referral, it is possible to try and target these areas to improve access to Green Prescription, for both health professionals and patients.