The REACH Project
Reducing alcohol-related harm by embedding brief interventions in Victorian general practices

Research Summary

MONASH University

Monash Health

Health Issues Centre
Consumer voices for better healthcare

Griffith UNIVERSITY
Queensland, Australia

enliven
ENHANCING SOCIAL HEALTH

phn
NORTH WESTERN MELBOURNE
An Australian Government Initiative

HSCU
Health Social Care Unit

UNSW
SYDNEY

VicHealth

Authors

Elizabeth Sturgiss[1], Jenny Advocat[1], Suzanne Nielsen[2], Lauren Ball[3], Chris Barton[4], Tina Lam[2], Nilakshi Gunatillaka[1], Danielle Mazza[4], Renee O'Donnell[5], David Jacka[6], Grant Russell[4], Helen Skouteris[5], Michael Tam[7]

Statistician: Cathy Martin[8]

Affiliations

1. School of Primary and Allied Health Care, Monash University
2. Monash Addiction Research Centre, Monash University
3. Menzies Health Institute Queensland, School of Allied Health Sciences, Griffith University
4. Department of General Practice, School of Public Health and Preventative Medicine, Monash University
5. Health and Social Care Unit, School of Public Health and Preventive Medicine, Monash University
6. Monash Health
7. Faculty of Medicine, School of Population Health, University of New South Wales (UNSW)
8. Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University

Suggested citation

Sturgiss E. A. et al (2021) The REACH Project: Reducing alcohol-related harm by embedding brief interventions in Victorian general practices. Victorian Health Promotion Foundation, Melbourne.

Acknowledgement of Country

We acknowledge the traditional custodians of the land on which this research was conducted, the Wathaurung, Woi wurrung (Wurundjeri), Taungurung, Dja Dja Wurrung and Boonwurrung people. We pay respect to them, their culture and their Elders past, present and future, and uphold their relationship to this land.
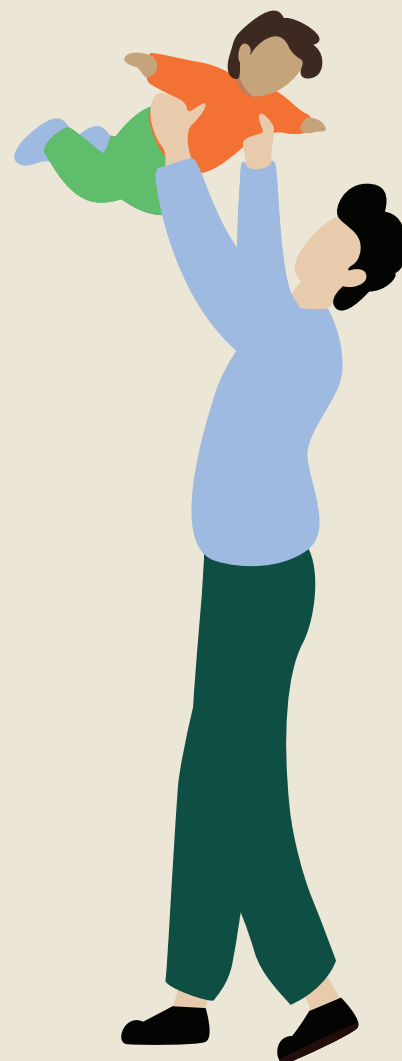
Executive summary

Alcohol is a major source of harm in the community. Primary care (including family doctor and general practice settings) can play a role in reducing harmful alcohol use. Research shows that when clinicians talk to their patients about alcohol use patients can reduce their weekly alcohol consumption. In the REACH project we worked with general practitioners (GPs), nurses and patients to design a new approach to delivering alcohol brief interventions, including new tools and resources to support GPs and nurses to ask more patients about their alcohol use.

Feedback from GPs and nurses indicated that the resources were useful. We found some difficulties with embedding the resources into practice, mostly influenced by the Covid-19 pandemic. Primary Health Networks have an opportunity to facilitate practices to engage with patients about their alcohol use by providing high quality resources in the languages spoken by patients, work with practices to know more about the patient data they capture, and work with the whole practice, including doctors, nurses, and administrative staff to raise awareness of the resources available to them.

One-page summary

Background

Each year in Victoria, alcohol contributes to 1200 deaths and 43,736 Disability Adjusted Life Years (DALYs) (Gao, O'Geil and Lloyd, 2014). Alcohol brief interventions provided by general practitioners (GPs) and nurses in community based primary care are effective for reducing risky drinking (Kaner et al., 2018). These involve assessing the amount of alcohol a person is consuming and offering individualised advice on how to reduce the associated health risks. As communities with socioeconomic disadvantage are at increased risk of alcohol-related harm (Roche et al., 2015), this project focused on reducing the alcohol-related harms that disproportionately affect the 13% of Victorians living in poverty (ACOSS and UNSW Sydney, 2018)

The overall aim of the Reducing alcohol-related harm (REACH) Project was to:

a. increase the screening for problematic alcohol use in general practice and
b. increase the application of brief interventions for use in general practice. This study focused on developing an approach that is acceptable, feasible and effective for low-income groups.

Key Findings

Phase 1 of REACH **identified barriers and facilitators**, recognised by both patients and clinicians, to **design a resource pack**. We found a need to:

- Raise community and clinician awareness about alcohol-related harms
- Implement practice-wide systems that prioritise and routinise talking about alcohol
- Develop supportive and accessible resources

Phase 2 trialled the co-designed **implementation** strategy and resource pack to increase the uptake of brief interventions in primary care. The pandemic had a significant impact on the ability of some practices to prioritise preventive care. Nonetheless, REACH resources were seen as useful and acceptable.

Recommendations

Using the evidence from REACH we have formulated some recommendations to achieve better implementation of brief interventions for alcohol in general practice.

There can be a **prominent and productive role for Primary Health Networks (PHNs)** to provide real-time data reports:

- Recommendation 1: Prepare practice level data prior to practice engagement to highlight individual practice need
- Recommendation 2: Optimise practice software to identify low income and disadvantaged populations in practice data

PHNs and practices could benefit from **educational videos and updates**:

- Recommendation 3: Circulate short online videos for both PHN and practices which clearly outline the aims and how to use REACH resources
- Recommendation 4: PHNs to circulate existing resources or develop educational updates using webinars or asynchronous material on brief interventions in the general practice consultation

Accessible REACH resource packs were well received:

- Recommendation 5: Use highly visual resources for patients as they assist with low literacy
- Recommendation 6: Translate materials into many languages, but be aware that some people may not be able to read in their primary language
- Recommendation 7: Prepare printed and electronic copies of all materials
- Recommendation 8: Provide printed materials including the poster, consultation room signs and pamphlets to practices

Project management expertise was important to enhance adoption in general practice:

- Recommendation 9: Identify a "practice champion" and at least one other team member who can set up processes to ensure a whole-of-practice approach to implementation
- Recommendation 10: Involve administration and reception staff as well as clinicians, to support implementation and keep staff engaged.

Sustainability is likely through **scale-up investment** and **regular refreshing of resources**:

- Recommendation 11: Invest in scale-up now because REACH is aligned with policy requirements like PIP QI and PHN key priority areas
- Recommendation 12: Refresh resources each year to ensure continued relevance and salience

Findings from using **SMS with patients** include an awareness of its limitations:

- Recommendation 13: Use SMS 2-way survey for feedback from the general population
- Recommendation 14: Engage with disadvantaged populations with interviews or paper-based surveys in a trusted setting

Research Report

Context

Alcohol is a major source of harm. Each year, the harmful use of alcohol contributes to 1200 million deaths and 43,736 Disability Adjusted Life Years (DALYs) in Victoria alone (Gao, O'Geil and Lloyd, 2014). Communities at socioeconomic disadvantage have a prevalence of problematic alcohol use and are at increased risk of alcohol-related harm (Roche et al., 2015). It is common for interventions that are developed for the general population to be more effective for advantaged populations, leading to increasing health disparity (O'Donnell et al., 2014). Our focus is on reducing alcohol-related harms that disproportionately affects the 13% of Victorians living in poverty (ACOSS and UNSW Sydney, 2018) by developing an approach that is most acceptable, feasible and effective for low-income groups.

Alcohol brief interventions provided by general practitioners (GPs) and nurses in community based primary care are effective for reducing the number of episodes of risky drinking and the average amount of alcohol consumed over a week among people with problematic alcohol use (Kaner et al., 2018). Brief interventions involve assessing the amount of alcohol a person is consuming and offering individualised advice on how to reduce the associated health risks. It is important for GPs and nurses to be aware of the patient's personal health history and current living circumstances to be able to provide individualised advice (Kaner et al., 2018). For example, women planning pregnancy should be advised not to drink and there are medical conditions that make alcohol less safe (Boffa, Tilton and Ah Chee, 2018)

Objective

The overall aim of the REACH Project was to:

- increase the screening for problematic alcohol use, and
- increase the application of brief interventions for alcohol use in general practice.

This study specifically focused on developing an approach that is effective for low-income groups.

REACH involved two phases. Phase 1 involved co-design with stakeholders to inform the development of new resources for brief interventions for alcohol use in general practice. Phase 2 was the implementation trial of the new resources in six general practices. Both are described below and in the published protocol (Sturgiss et al., 2021a).

Phase 1: Co-design with stakeholders

Approach

Overview:
We began by co-designing a new approach to increase the uptake of brief interventions (BI's) for alcohol use in general practice with patients and practitioners. Phase 1 was completed in 2019, prior to the Covid-19 pandemic. Our team sought to identify factors that influence whether alcohol BIs are used in consultations from the perspective of clinicians and patients. We then developed appropriate clinical resources to:

- increase patient screening for alcohol use in a way that is acceptable and appropriate for patients.
- increase practitioner engagement with existing BI strategies such as motivational interviewing, patient education and awareness raising, and goal setting.
- provide appropriate clinical resources to brief interventions.

Participants:
Our qualitative study used semi-structured interviews and focus groups (face-to-face and virtual) of primary care clinicians working in the greater Melbourne metropolitan region and patients from across Australia.

Recruitment and sample:
General practices were recruited via a mail-out, newsletters and social media platforms including Twitter and GP-specific Facebook groups. Patients from low-income groups were engaged via social listening (where discussions are had on social media platforms such as Facebook) and through advertisements on social media or peer-to-peer alcohol support groups. We conducted 6 in-person focus groups (practice visits) and 3 virtual focus groups and 19 semi-structured interviews (Table 1).

Analysis:
Field notes were made from audio-recordings and themes were identified using a matrix based on the question structure.

Data collection method	Participant group and number(s) recruited			
	General practitioners	Nurses	Other practice staff	Patients
In-person focus group (practice visit)	24	5	2 (1 practice manager, 1 receptionist)	–
Virtual focus group	6	2	–	–
Semi-structured interview	4	1	–	14

Table 1: Data collection methods and participant sample used in Phase 1 of the REACH Project.

Results

A summary of key themes identified from our qualitative study into factors influencing the use of alcohol brief interventions from the perspective of patients and clinicians is presented below:

Patients felt that talking to patients about alcohol was part of the GPs role due to the implications of alcohol on a person's health (e.g. indicating underlying mental health conditions) and medical care (e.g. possible interactions with medications). Most respondents said they had a good relationship with their GP and had spoken to their GP about alcohol. Often, it was the GP who had initiated the discussion about alcohol. Respondents identified several factors that made it more difficult for them to talk about alcohol with their GP. These included being asked about alcohol alongside recreational drugs, feeling that they were taking up too much time, fear of judgement, or concern that a GP wouldn't know how to help them.

GPs and nurses identified the following situations in which they would ask patients about their alcohol use: (1) when there is a clinical indication e.g. high blood pressure, weight gain, abnormal liver function tests, anxiety or depression; (2) or the patient comes in for a health assessment. Time constraints were identified as a barrier for discussions around alcohol use. GPs and nurses felt that the discussions happen after the patient's reason for visiting has been addressed. They stated that they found it difficult to quantify how much their patients are drinking because of limited awareness of what a standard drink is, and they were concerned that patients might not accurately disclose how much they are drinking. GPs and nurses mentioned that they were more comfortable talking about alcohol if they felt that they had good referral options.

We used these findings to develop an ecological model (Figure 1). Several factors influenced the use alcohol brief interventions in general practice settings. These were categorised into barriers and facilitators as follows:

Barriers
- Australian drinking norms
- Inconsistent public health messaging
- Patients not identifying general practice as a place to go for help
- Community stigma
- General practice culture around preventative health
- Limitations of clinical software
- Limitations in current patient resources

Facilitators
- Raising community awareness of the health harms of alcohol;
- Building a practice culture around prevention;
- Resources to support discussion about alcohol use and strategies to reduce intake

To increase the uptake of brief interventions in general practice, respondents felt patient resources should include:

- visual depictions of the health harms of alcohol
- clear advice on safe limits for alcohol intake (including how to quantify intake)
- practical strategies for reducing alcohol intake and information on where to seek help
- easy to understand English resources, and
- translation into community languages.

The complete findings have been published in Family Practice (Sturgiss et al., 2021b). These practical recommendations were then used to develop the REACH resources for the implementation trial.
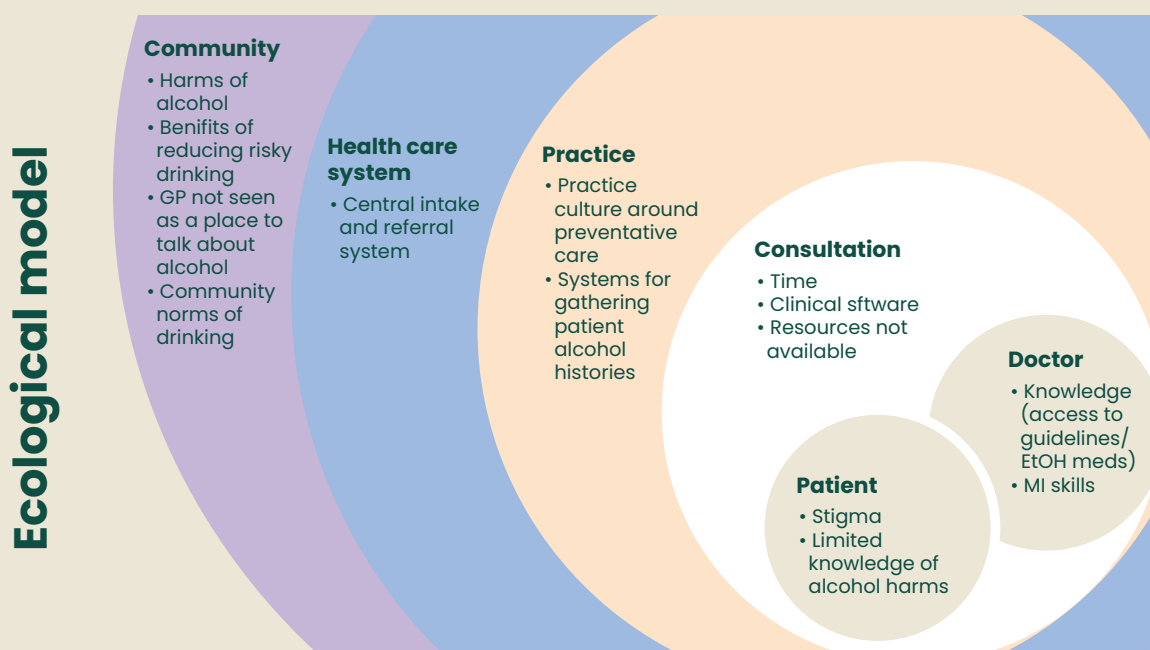

Ecological model

Community
- Harms of alcohol
- Benifits of reducing risky drinking
- GP not seen as a place to talk about alcohol
- Community norms of drinking

Health care system
- Central intake and referral system

Practice
- Practice culture around preventative care
- Systems for gathering patient alcohol histories

Consultation
- Time
- Clinical sftware
- Resources not available

Doctor
- Knowledge (access to guidelines/ EtOH meds)
- MI skills

Patient
- Stigma
- Limited knowledge of alcohol harms

Figure 1: Ecological model showing factors influencing the use of alcohol brief interventions in general practice (Sturgiss et al., 2021b)

REACH intervention and resources

REACH resources were designed in partnership with enliven Victoria. They are adapted from internationally accepted evidence-based resources (Heather et al., 2008; Saunders et al., 1993; Saunders, 1993; Canadian Center on Substance Use and Addiction, 2019). The REACH team worked with enliven to design easy English resources (Kincaid et al., 1975) and test them for acceptability with consumer representatives. Polaron Translation Services translated the patient brochures into the two most spoken community languages in Australia – Arabic and Chinese (Simplified). Since the project was completed the patient brochures have also been translated into Greek, Italian, Traditional Chinese and Vietnamese.

The REACH resource pack includes resources for patients, clinicians, and consultation processes.

Patient priming materials

- Waiting room poster illustrating the health harms of alcohol and naming GPs at the practice who have a special interest in alcohol management.
- Waiting room survey patients can fill in while they wait for their doctor or nurse which includes questions about smoking, nutrition, alcohol and physical activity. Patients and clinicians use it as a way of starting a discussion about alcohol.
- "Talk to me about alcohol" signs displayed in doctors' and nurses' offices encourage patients to discuss alcohol use during their consultation.

Clinician resources

- Brief interventions flowchart and standard drinks guide show the steps to delivering an alcohol brief intervention
- Alcohol intake and health risks charts show how the risk for cancer (breast, prostate, colorectal) and stroke increase with increasing alcohol intake.
- Podcast featuring Dr. Liz Sturgiss, Dr. Hester Wilson and Dr. Paul Grinzi speaking about brief interventions for alcohol in general practice

Consultation resources

- Patient brochures present the national recommendations on alcohol intake (NHMRC), the health harms of alcohol use, the benefits of reducing alcohol intake, practical strategies, a standard drinks guide, and where to go for more help.

REACH implementation included planned, regular meetings between the PHN relationship manager and the practice participants. Due to the pandemic, REACH resources were adapted and made available online and for use during telehealth consultations. We partnered with "GoShare", an online portal that allows clinicians to email or SMS resources to their patients. REACH resources were uploaded in packages to allow easy transfer of information between clinicians and patients. The GoShare team offered on boarding and training to each of the practices. For the implementation trial, the GoShare licence cost was paid by the North Western Melbourne Primary Health Network (PHN) and the research team covered the SMS costs.

Phase 2: Implementation trial

Approach

We undertook a mixed-methods evaluation of the uptake of alcohol brief interventions in general practice clinics serving low-income communities in Melbourne, Australia. Our approach was informed by the Consolidated Framework for Implementation Research (CFIR) and Normalisation Process Theory (NPT). Our full protocol was published and is available freely online.

Recruitment:
Our partner, North Western Melbourne PHN was integral in the recruitment process and they used their usual EOI process for identifying practices who would be interested in participating through their newsletters and email blasts.

Participating practices:
Six general practices were recruited with five from the North Western Melbourne PHN catchment, and one from the south –east. The practice from the south-east was the only one involved in phase 1 and they were very keen to participate as they have a primary focus on AOD and serve a disadvantaged community.

The basic features of the practices are outlined in Table 1 and all practices served a significant number of disadvantaged patients. When asked about how many patient records would contain an alcohol history, four practices estimated >50% of records, one was unsure and one didn't answer. One practice reported that they had learning opportunities about alcohol for clinicians in their practice.

Prior to REACH, all practices used new patient registration forms and the clinical software to support alcohol history taking. To support alcohol related consultations, all practices had access to online pamphlets, one had posters in the waiting room, and a couple had printed pamphlets in either the waiting room or consultation rooms.

Table 2 shows the patient and clinician characteristics of the six intervention sites. This information was collected using a pre-intervention survey completed by practice manager (n=3), GP (n=1), or nurse (n=1). The sixth practice site did not complete the pre-intervention survey.

Table 2: intervention practice features as reported in a pre-intervention survey

Clinic	Patient characteristics					Clinician characteristics		
	No. of regular patients	Healthcare card (%)	Unemployed (%)	Pension (%)	Low income household (%)	No of GPs (FTE*)	No. of practice nurses (FTE*)	Practitioner with interest in AOD^?
1	1050	>50%		>50%	>50%	1.6	1	Yes – one OMT# prescriber with an interest in alcohol dependence
2	8500	10-29%	10-29%	10-29%	10-29%	6	2.5	Yes
3	3000	<10%	<10%	10-29%	Unsure	4	1	Yes – nurse AOD^ course
4	1500	>50%	>50%	>50%	>50%	1	1	Unsure
5	3057	>50%	10-29%	>50%	>50%	3.5	4	Yes – co-morbid and complex cases
6	This sixth intervention site did not complete the pre-intervention survey or qualitative interviews							

*FTE – fulltime equivalent ^AOD – Alcohol and Other Drug   #OMT – opioid maintenance therapy
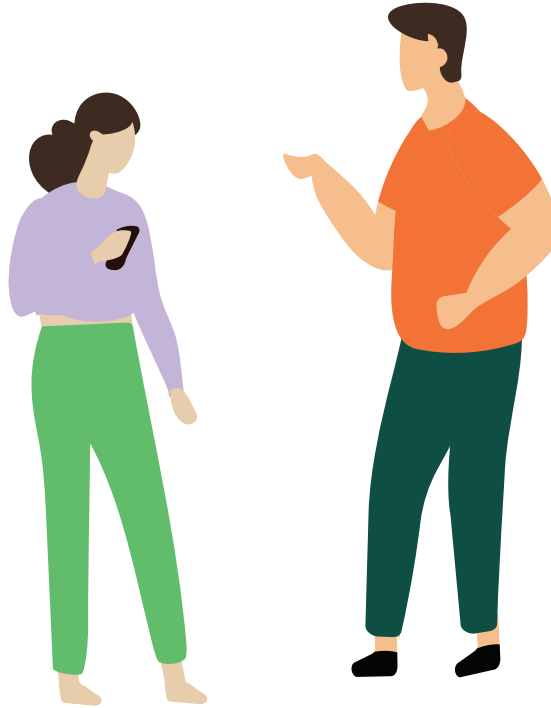
Representatives from each practice were invited to participate in an in-depth, semi-structured interview conducted via zoom or telephone near the end of the REACH project. Interviews were conducted by a research fellow from May-August 2021, lasted 15-60 minutes and focussed on the REACH resources, processes of implementation and their relationship with the PHN.

Table 3: Sampling for practice Interviews

Practice	Interview	Position	Length of time in the practice
1	P1GP	General Practitioner	18 months (since opening)
	P1PM	Practice Manager	18 months
	P1PN	Practice Nurse	18 months
2	P2GP	General Practitioner	4 years
	P2PN	Practice Nurse	6.5 years
	P2CEO	Chief Operating Officer	7 months
3	P3GP	General Practitioner	7 years
	P3Rec	Receptionist	12 months
4	P4GP	General Practitioner	23 years
	P4PN	Practice Nurse	9 years
5	P5PM	Practice Manager	3 years
	P5CC	Care Coordinator	26 years

PHN staff involved in REACH were also invited to participate in an in-depth semi-structured interview to talk about their experiences of participating in REACH. Seven PHN staff were interviewed between the end of April-June2021, including 6 Relationship managers (practice support) and one director.

Results

Recording of drinking status

The main outcome was the change in proportion of patient records with information on alcohol status (drinks alcohol; does not drink alcohol) as a proxy marker for where a brief intervention (BI) is likely to have occurred. A successful outcome would be to reduce the number of patients where drinking status was not recorded.

Using an interrupted time series analysis, we were able to show that although the rate of non-documented drinking status was reducing prior to the intervention at an estimated rate of 0.5% per month, we were able to amplify this rate of reduction with the REACH intervention. After implementing REACH in 5 practices, the rate of non-documentation of alcohol use status continued to decline approximately twice the rate (1% per month) (Figure 2). The comparison of slopes (i.e. the rate of change) was significantly different after the REACH intervention was implemented compared to prior (slope ratio = 0.994 (95% CI: 0.993, 0.995), p <0.001).

We identified outlying data during the analysis, as seen in the sharp peak between Jan 2020 and July 2020 in Figure 2. We discussed this finding with the PHN as this analysis was carried out using routinely collected administrative data, and they confirmed that this peak was a data extraction error. As at December 2021, the PHN is working with their practice auditing software provider to identify the cause of the outlying data and correct any data errors. Out results will be updated once corrected data is available. We anticipate that this will flatten the pre-intervention trend line but will not change the overall outcome of the time series.
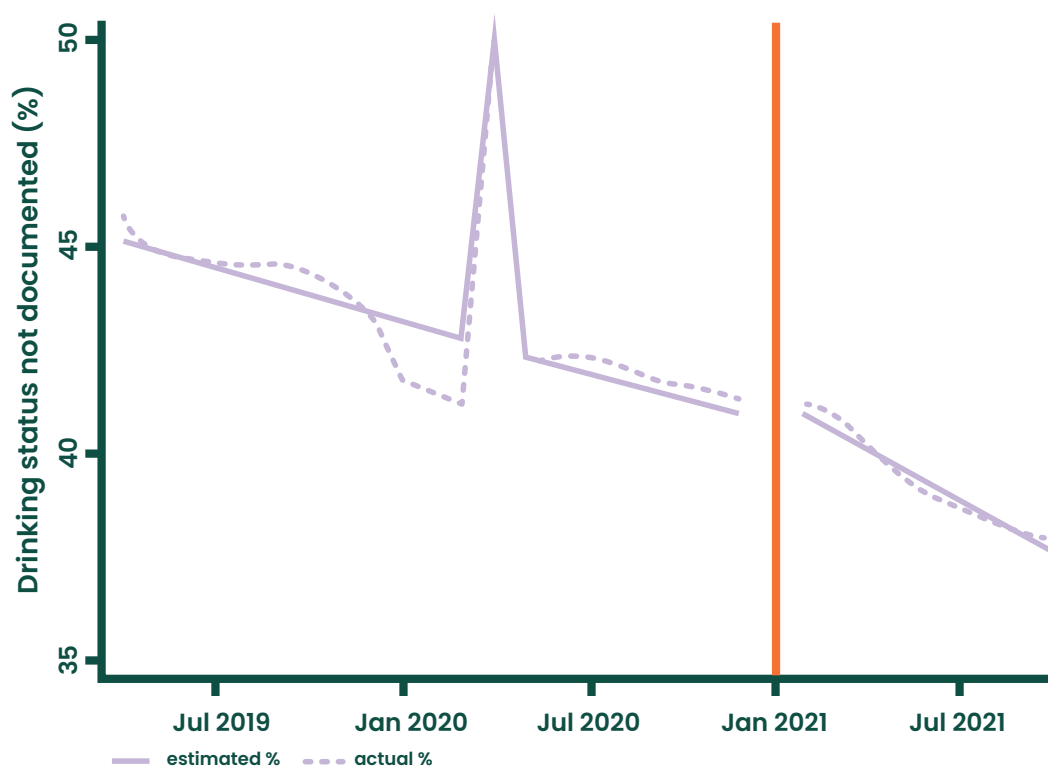
Recommendation 1

Prepare practice level data prior to practice engagement to highlight individual practice need

Recommendation 2

Optimise practice software to identify low income and disadvantaged populations in practice data

Impacts of the Pandemic

The period of the REACH study coincided with the Covid-19 pandemic in Australia. The North Western Melbourne PHN catchment area, where the REACH implementation trial was based, had 12,171 confirmed Covid-19 cases by 1 March 2021. At that time point, this was 59% of the total Victorian cases and 42% of all Australian cases. The REACH implementation trial occurred in the hot zone of the Australian pandemic.

North Western Melbourne PHN has recognised the particular challenges of the demographic diversity of the region, plus the complexity of a poorly integrated healthcare system during the pandemic which meant general practices were under extreme stress (North Western Melbourne Primary Health Network, 2021). During the REACH study, practices in the North Western Melbourne PHN region needed to balance their practice needs and those of their patient populations during the pandemic with the systemic issued identified.

Most practices indicated that the timing of the intervention was difficult as it coincided with the Covid-19 pandemic. The stress within some practices took energy away from their ability to engage with anything other than responding to immediate patient needs.

> *"...whilst there would be not a clinician here who would question the value of an alcohol prevention or healthy use alcohol program, trying to get people's time and attention has proven to be very challenging."* (P2CEO)

> *"...a lot of focuses were taken off things that we would normally do, and put onto Covid. So, I found that a lot of our preventative health was put on hold through the pandemic."* (P4PN)

A practical outcome of the pandemic on general practice was that in some practices, waiting rooms were no longer being used and any materials that patients may have had access to in waiting rooms were no longer available.

> *"... they took all the leaflets and pamphlets out of waiting rooms when we had the lockdowns going on. You had people not really going into practices for a huge amount of time as well."* (PHN Staff 1)

We had anticipated this loss of the waiting room and increase in telehealth and had adapted the resources for GoShare. Unfortunately, the GoShare feature was universally unused in all practices. A range of disadvantage, including older age, financial disadvantage and lack of English language skills prevented some patients at different practices from being able to engage with REACH resources over email or SMS.

For one practice who reported that the pandemic had not been a barrier to implanting REACH, a few elements stood out as important, including practice size and community connections that build trust and staff continuity.

> *"When you have a smaller and cohesive team with high levels of trust I think you can work through adversity better, whatever that is, so it doesn't just have to be the pandemic."* (P1GP)

This is consistent with the primary care literature that highlights the importance of team cohesion, trust and good leadership with implementing new innovations in care (Miller et al., 2010).

PHN and Practice Understandings of Brief Interventions and REACH

There was a general understanding across both PHN and practice staff about the premise of the study and how to use the resources. When asked how to describe REACH many replied with a variation of the following:

> *"It's using tools to help discuss alcohol consumption with patients"* (P1 Practice Manager)

However, not all participants had the same understanding about brief interventions. Some thought that they were best used for patients who had already been identified as having specific problems with drugs or alcohol use.

> *"...the REACH project is about reaching out to specific population and that is alcohol and drug, with drug and alcohol problems or drug and alcohol abuse."* (PHN Staff 2)

> *"if [patients] were all coming in with alcoholism, I probably would have gone to the REACH stuff and looked it all up and stuff because I was seeing it all the time. Alcohol's always there in the background, I recognise that but it just hasn't been a priority really."* (P3GP)

Some clinicians will require new knowledge and upskilling to ensure they are appropriately and effectively using BIs. There are existing resources online via professional colleges (e.g. Royal Australian College of General Practitioners and Australian Practice Nurses Association) or PHNs could engage with local clinicians to develop materials to specifically suit their community.

Recommendation 3

Circulate short online videos for both PHNs and practices which clearly outline the aims and how to use REACH resources (available online)

Recommendation 4

PHNs to circulate existing resources or develop educational updates using webinars or asynchronous material on brief interventions in the general practice consultation

Implementation

The Covid-19 pandemic meant that REACH was often not implemented as expected. Still, practice staff and clinicians generally found the REACH resources very helpful and, although not seen as entirely unique, they fit into existing practice routines and their presentation and availability as a package were seen as valuable additions to preventive practices and raised awareness of the topic for patients and staff.

> *"Because we had them up in our treatment room, so sometimes when people were coming in for dressings they would look up at the picture of the posters with how alcohol harms your health, and so they would be like, "Oh, I didn't realise it caused this and this." ...so it did generate a bit of talking....So I think it did heighten awareness"* (P2 Practice Nurse)

Each practice had its own ways of adapting the intervention to local needs, using the survey and brochures in different ways to meet the needs of the practice staff and perceived needs of patients.

> *"Some [changes] are just small steps, like adding a survey when they come here. Some of them are more system-wide, where we add actual information from REACH to our website, making it more available to everyone that visits our website."* (P5 Practice Manager)

The survey was used by some as a waiting room survey, provided by receptionists.

> *"So any incoming individual to see our GP or nurses, [our reception team will] ask them to fill out the survey, and once they have done that, then my nursing team would ask them, "Hi, how are you? Have you filled out the survey? Do you want to talk about it?" Majority of the patients are very active at saying, "Yeah, actually I didn't know about that,"* (P5 Practice Manager)

Then, as part of the care planning process, the survey is used by the nurse or care coordinator prior to the patient seeing the GP and if a need is indicated the care coordinator will follow up.

> *"Before they see the doctor, they...will see the nurses, they will do their blood pressure, they will do their BMI tracking, and then also trying to update the alcohol and smoking status. And that's where we've targeted it for them to start a conversation about the REACH project. But if the patient decided to talk in detail – because that's only 15, 10 minutes' time, it's not much time - but if the patient thinks that they want a referral...then we pass that on to the care coordinator."* (P5 Practice Manager)

In another practice, the questionnaire was similar to what the practice nurse already asked through the care plan but she found it helped her to "be a bit more specific...to nut out what they think is just a bit of a social drink is actually more regular than that" (P1 Practice Nurse)

While some practices found they did not need to adapt the resources at all to make them useful, for a few practices with patients with languages other than English, the resources needed to be translated. Although, the infographics were seen to be useful for everyone, especially for patients who did not read in their primary language.

> *"I remember the practice managers saying, 'that's a shame. We wanted to use these great resources, but they don't come in the languages of our patient base.' I think that one kind of fizzled out a bit. I'm not sure if they ever withdrew."* (PHN Staff 4)

In a small practice, with just one GP and one PN, it was easier to incorporate the resources into usual practice. The waiting room survey was provided to "everyone that came in" and they took the completed survey in to the GP. If necessary, the GP would give the survey to the PN who would "either discuss it or send an SMS [with the resources]" or print them out for the patient. (P4 Practice Nurse)

One practice manager articulated that their expectations had been met across three key areas.

> *"Number one, a material that we can use to give away to a patient. So even if they're not here, they have something to read or to consider. So I think for me, that has been achieved.*
>
> *Number two, trying to utilise the waiting time of my patients....That helps out, absolutely, because we keep them busy while waiting for the doctor. So for me that's been addressed.*
>
> *Number three is measuring our data through motivational talks to patients, to monitoring it and recording it. So for me, it's been satisfied as well because...in terms of graphs, it's been increasing. And if they have plateaued, then why has it plateaued, maybe we need to do more. So in terms of data cleansing, it's been achieved as well."*
> (P5 Practice Manager)

Recommendation 5
Continue to use highly visual resources for patients as these assist with low literacy

Recommendation 6
Translate materials into many languages, but be aware that some people may not be able to read in their primary language

Recommendation 7
Prepare printed and electronic copies of all materials

Recommendation 8
Provide printed materials including the poster, consultation room signs and pamphlets to practices

Whole-of-Practice Approach

REACH was set up to be coordinated by the PHN who recruited practices then were to provide resources, data reporting back to practices and ongoing advice as required. Six relationship managers within the PHNs practice engagement team each had one practice to work with on REACH.

The PHN perspective on successful implementation involves a whole-of-practice approach which recognises the effectiveness of engaging all practice staff and taken into account practice context and capacity in order to achieve practice improvement (Upham et al., 2016). Some practices took a whole-of-practice approach with REACH, and others did not.

> *"…[O]ne of the things that we know was successful around these projects is having a whole-of-practice engagement around the project, and I think looking at the protocol, we set [a] project team as well as a project champion who then went back to the team. And unfortunately, that's where some of it I think has also fallen down.…[O]ne or two people from the practice team who knew about it and it was their responsibility to pass on some of that information, but if that didn't happen and then that person left or that person moved to another role, then that continuity of the practice team still continuing with the activities and being clear on what they needed to do was lost.* (PHN Staff 7)

In some practices there was only one person in the practice who was involved in REACH and in practices where that occurred, the demands of the pandemic and other stresses on the practice such as staff turnover, made their participation in REACH untenable.

> *"And then because I was struggling to use all the stuff because I was a bit pandemic focused and a bit distracted and then there was no one else but me doing it. I don't know, in the end I think I lost my mojo a bit really."* (P3GP)

Leadership, Networks & Communication

In two practices GPs led practice involvement in REACH and it was not really implemented in either practice. In one practice, the GP was overwhelmed by the Pandemic and did not implement REACH. In the other practice, the GP felt unsupported and, as she stated, "own my own" (P3GP) in implementing REACH.

The lack of communication about REACH across the practice was thought to be related to staff shortages or staff turnover.

Q: *"[do] you have opportunities to reflect on REACH or discuss how it's going?*

A: *I think we are - I don't know what other practices are like, and I know it's not an excuse, but we're just very short on doctors, so there hasn't been a second to even take time to meet the nurse to talk about it or any of that.* (P3 Receptionist)

Staff turnover was an issue for practices where organisational memory might not enable interventions like REACH to continue when key staff members left.

> *"I've only been here a year, so there might have already been something in place, but I think a lot of the clinical stuff around here isn't communicated to management or to admin staff, I think they know what they're doing, and they do it. I think in the past admin has not got involved in things like that."* (P3 Receptionist)

In other practices where there was more than one person at the practice involved in implementing REACH, it was more integrated into the practice. Staff, other than just GPs, including practice nurses and managers, were also involved and this led to the practices being more active in their involvement.

Practices described their approach to within-practice communications and REACH was rarely on the agenda in formal meetings. However, in smaller practices, communication seemed to be easier and less formal as REACH was communicated across practice staff.

> *"Because it's just me and him [PN and GP], if we need to discuss something, either I go into his room or he comes into my room, and we just discuss it"* (P4 Practice Nurse)

Some practices had key individuals who were driving the intervention forward across the practice, which was seen as an effective approach to participation. In one practice this was a practice manager who brought the project to a meeting and then followed through with staff informally.

> *"we include REACH in any of the meetings. Me, in particular, with my meeting with my nurses - or sometimes all I have to do is I'd go out to my reception and say, "How are we doing with the survey? Make sure everyone is provided the survey, and ask them if they have questions. They can talk to the nurses and all." So we come up with that kind of - you know, a very simple but so far effective way of making sure that we're integrating REACH project information into our daily clinical operation."* (P5 Practice Manager)

The REACH intervention included regular meetings between the practices and their PHN relationship manager and this was an essential engagement tool to communicate data recording with practices.

> *"And we went through that and data – showing practices or clinicians data is like – they love it. They love it. They want to know where they can improve. I find clinicians very competitive. So data as a tool to encourage is really great. ...They want to know where they sit against others and things like that because I think everyone wants to do their best. So that's been really helpful."* (PHN Staff 6)

Practices which had more regular meetings and feedback with the PHN seemed more motivated to improve alcohol recording, particularly when there were two or more people involved, including one clinician. This further supports the whole-of-practice approach.

Recommendation 9

Identify a "practice champion" and at least one other member of the team who can set up processes to ensure a whole-of-practice approach to implementation

Recommendation 10

Involve administration and reception staff as well as clinicians, to support implementation and keep staff engaged

External Facilitators

REACH clearly aligned with the Practice Incentive Program Quality Improvement (PIPQI) incentive which commenced in general practice on 1 August 2019 (Department of Health, 2021). To receive the PIPQI payment, practices must provide a "PIP Eligible Data Set" to their PHN as well as complete QI activities. Alcohol recording is one metric that is captured in the PIPQI. PHNs support practices to use software to monitor data recording that is linked to PIPQI incentive payments. The North Western Melbourne PHN has seen particularly poor recording of alcohol histories and this is consistent with national data.

> *"We've just started giving these PIP QI reports back to practices less than – We've had two reports, so six months ago was the first report. This shows them 10 measures, and one of them is looking at recording of alcohol, and it's particularly poor across the whole PHN. So that's something that practices need to address."* (PHN4)

Practice staff were also aware of their data needs for PIPQI and REACH provided a platform for engagement with that system and feedback from the PHN.

> *"[The software for data extraction provided by the PHN] helps us a lot because it helps us monitor how we're progressing and our performance in doing data cleansing, in updating our record for indexes for PIPQI, which includes alcohol level and smoking level."* (P5PM)

REACH is aligned with PHN key performance indicators through the national priority areas that are set by the federal Department of health. Currently, one of the seven priority areas is Alcohol and Other Drugs (Department of Health, 2018). One of the PHN staff was clear in the alignment between REACH and their quality improvement framework.

> *"… we were just interested in providing a project like that to the general practices in our region, as the objective of the project was, it aligned well with what we were doing and the, the topics that we focus on like, disease prevention or systems improvements."* (PHN4)

One participant believed that having an academic partner more closely involved with meetings between the PHN and practices would promote practice involvement.

> *"….So if Monash were already involved in those meetings more so, they would have maybe promoted those resources more so, I guess, because it's your resources……it would have been good if we did it as a team, …. I think sometimes in general practice, if it's Monash University doing a project, their ears prick."* (PHN Staff 5)

While an in-depth, ongoing involvement of a research team is not possible for scale-up, ensuring that future practices are aware of the academic roots of the project may be important.

Sustainability and the role of the PHN

REACH was designed to be implemented via the PHN to enable national scale-up via existing structures. Due to staff turnover, miscommunication and pandemic complications, engagement meetings focussed on the REACH project between the PHNs and practices did not occur as often as was intended. One practice felt well-supported by the PHN during the pandemic.

> *"[The] PHN, I have to say…they're the best they've been, probably, the last 18 months, two years. That's probably the best that they've been with interacting and helping and things like that"* (P4 Practice Nurse)

But other practices had less successful experiences regarding support for implementing REACH.

> *"Look, [the PHN] might have tried to [help]. They might have tried to. I can't honestly say that they haven't engaged, but I don't remember certainly anyone emailing me or - like you're the only person that I had any knowledge that there was a meeting planned or anything. "* (P2GP)

This highlights the critical role of the PHN and practice meetings for REACH to be successfully implemented.

One example of existing PHN infrastructure is HealthPathways. HealthPathways is an online portal that offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care. HealthPathways Melbourne is a collaboration between Eastern Melbourne PHN and North Western Melbourne PHN. The REACH resources have been added to HealthPathways and made available for all practices in the region which will enable use into the future for clinical practice and education.

> *"… GPs use HealthPathways at the point of care…. we actually use HealthPathways in a lot of our care education materials, so any of the webinars or education sessions that we're running. We underpin all of our content with the information that's in HealthPathways. So that's another way to get the message out."* (PHN Staff 7)

While the online resources were useful, many practices still would like to receive ongoing paper-based resources from the PHN.

> *"The only probably downfall for us is we can't print in colour, so when we're doing the paper ones, obviously, it's not as attractive as being in colour…so if we're sending it to the phone, it's in colour, but printing the paper, it's not in colour, so that's the only downfall to using the resources…"* (P4 Practice Nurse)

This suggestion for attractive, paper-based resources needs to be factored into scale-up via the PHNs. Our findings indicate the acceptability of the REACH resources. Evidence on salience shows that resources need to be updated and renewed over time to ensure ongoing interest as novelty is one aspect of the resources that will draw participant attention back to them over time (Dolan et al., 2010).

Recommendation 11
Invest in scale-up now because REACH is aligned with policy requirements like PIP QI and PHN key priority areas

Recommendation 12
Refresh resources each year to ensure continued relevance and salience

Engaging with program users through SMS survey methods

Often surveys about new programs and innovations have very low response rates from the community. Usually, surveys are distributed on paper or via email. We were interested in whether surveys sent by two-way SMS would have superior response rates while also being feasible and acceptable for patients from disadvantaged groups.

Each general practice that participated in REACH were asked to send an SMS to patients in their practice. The SMS contained a link to a general survey about REACH, and also asked participants to volunteer to receive 3-monthly SMSs about their alcohol intake and contact with their GP.

Of the six participating practices, four were able to send the initial SMS survey link to their patients. One practice was not able to due to IT issues, and another chose not to as their patient group was very culturally and linguistically diverse. We instead placed a QR code with the survey link in their waiting room.

Each two-way SMS survey had five separate questions, each was answered by a number between 1 and 5.

The responses to the survey links and SMSs are outlined in Figure 3. There was a large variation in the number of patients that the practices were able to send the SMS to, this was related to:

- Practice consent processes: one practice required specific consent from the patient to be able to send the SMS;
- IT issues: one practice could only send the SMS to all active patients in the system, rather than ones who had recently visited; another had software that didn't allow for past patients to be contacted, only presentations from that specific day.

Overall, the response rate to the initial SMS survey was low and this reflects the large number of patients who were sent the survey from a couple of practices. The practice that used the QR code in the waiting room did not have any responses.

Once patients had agreed to be sent ongoing SMSs, the response rate was good at approximately 50%. This was particularly surprising as these patients did not have any ongoing contact from the REACH team.
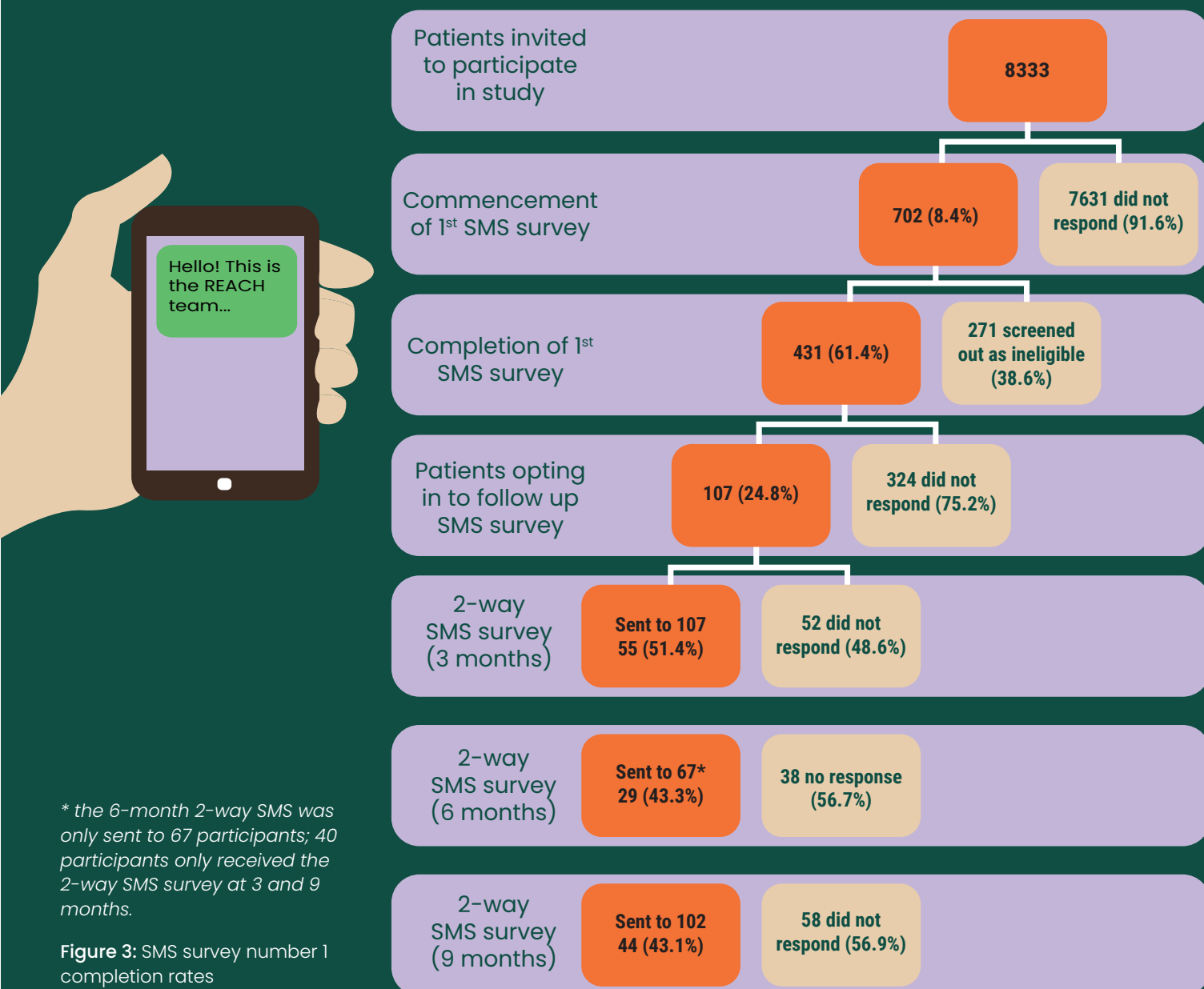

Hello! This is the REACH team...

* the 6-month 2-way SMS was only sent to 67 participants; 40 participants only received the 2-way SMS survey at 3 and 9 months.

Figure 3: SMS survey number 1 completion rates

Patients invited to participate in study	8333	
Commencement of 1st SMS survey	702 (8.4%)	7631 did not respond (91.6%)
Completion of 1st SMS survey	431 (61.4%)	271 screened out as ineligible (38.6%)
Patients opting in to follow up SMS survey	107 (24.8%)	324 did not respond (75.2%)
2-way SMS survey (3 months)	Sent to 107 55 (51.4%)	52 did not respond (48.6%)
2-way SMS survey (6 months)	Sent to 67* 29 (43.3%)	38 no response (56.7%)
2-way SMS survey (9 months)	Sent to 102 44 (43.1%)	58 did not respond (56.9%)

However, the SMS surveys did not reach the most disadvantaged patients and some practices gave us detailed feedback about why SMS surveys were difficult for their patients. Some were related to access to smartphones:

> "But we have to also remember not everyone is tech-savvy. I have to say, some of my patients still have the flip-flop phones, not smartphones. So if we send - it definitely can receive a text message, but it's not adaptable to QR codes, to links, those things." (P5 Practice Manager)

The patient could also have no data on their phone, no access to WIFI or could be hesitant to use their phone credit on returning SMS surveys.

There were also difficulties with language and understanding in culturally and linguistically diverse patient groups:

> 'Yeah, I think from the patient's perspective, there were some struggling, because we have 80% non-English speaking people here, so I think they struggled with the text messages." (P1GP)

This also held true for some patients who were conversant but unable to read in their primary language.

Other patients had co-morbidities, especially mental health disorders, which made them worried or even paranoid about SMSs from unknown numbers. Others have blocked unknown numbers or are worried about whether they are from the police.

Finally, practices mentioned that patients with visual difficulties, manual dexterity problems or intellectual disability may find accessing SMS surveys more difficult. These all reflect the known literature on the digital divide that describes easier mHealth and eHealth access for the more advantaged patients in our communities.

Practices had several suggestions for how to reach more disadvantaged patient groups:

- Using paper-based surveys distributed at a place the patient knows and trusts
- Face to face interviews for patients who are not literate or able to access online surveys
- Incentives to complete the surveys, such as $10 vouchers

Recommendation 13
Use 2-way SMS survey for program feedback from the general population

Recommendation 14
Engage with disadvantaged populations with interviews of paper-based surveys in a trusted setting

Implications

Primary Health Networks

Evidence from the REACH trial suggest a **prominent role for PHNs** in relation to data collection:

> • **Recommendation 1:** Prepare practice level data prior to practice engagement to highlight individual practice need
>
> • **Recommendation 2:** Optimise practice software to identify low income and disadvantaged populations in practice data

The REACH Alcohol Brief Intervention resource packs were well received:

> • **Recommendation 5:** Continue to use highly visual resources for patients as these assist with low literacy
>
> • **Recommendation 6:** Translate materials into many languages, but be aware that some people may not be able to read in their primary language
>
> • **Recommendation 7:** Prepare printed copies of all materials in addition to technological solutions
>
> • **Recommendation 8:** Provide printed materials including the poster, consultation room signs and pamphlets to practices

Sustainability is likely through investment in scale-up and ongoing salience of the resources would be improved through regular refreshing of resources

> • **Recommendation 12:** Refresh and renew resources each year to ensure their continued relevance and to keep attention on their use

PHNs and General Practices

We found that PHNs and practices could benefit from **educational videos and updates**:

> • **Recommendation 3:** Circulate short videos for both PHN and practices which clearly outline the aims and objectives of the REACH resources and how they can be used (available online)
>
> • **Recommendation 4:** PHNs to circulate existing resources or develop educational updates using webinars or asynchronous material on brief interventions in the general practice consultation

We found evidence on the importance of **project management expertise** to enhance the use of Alcohol Brief Interventions in general practice:

> • **Recommendation 9:** Identify a "practice champion" as well as at least one other member of the team who can set up processes to ensure a whole-of-practice approach to implementation
>
> • **Recommendation 10:** Involve administration and reception staff as well as clinicians, to support implementation and keep staff engaged.

Commonwealth Department of Health

> • **Recommendation 11:** Invest in scale-up now because REACH is aligned with policy requirements like PIP QI and PHN key priority areas

Organisations involved in evaluation

Findings from using **SMS with patients experiencing disadvantage** include an awareness of its limitations:

> • **Recommendation 13:** Use 2-way SMS survey for program feedback for the general population
>
> • **Recommendation 14:** Engage with disadvantaged populations with interviews or paper-based surveys in a trusted setting

Health Equity

The practices that were involved in the REACH implementation trial each served a high percentage of disadvantaged patients, including: people living with financial insecurity, poor general literacy and/or health literacy, as well as people with a refugee background. Throughout the implementation trial we focused on exploring barriers that may have been augmented for those patients in disadvantaged groups. We can consider these issues at different layers of the system.

Patient groups

We identified issues with general literacy and health literacy and attempted to overcome this with translated resources and highly visual materials:

> *"So, the brochure that's got the standard drinks has been helpful because it's very pictorial. A lot of our clients don't speak English, so it's not like we would hand out the questionnaire to our clients, but it's more that we can show them in a consultation what is a standard beer, or what is a wine, or spirits, so that they are more informed about what is a standard drink."* (P1 Practice Nurse)

The digital divide was evident for the SMS components of both the intervention and research surveys, our attempt to overcome this with QR codes was unsuccessful.

> *"But we have to also remember not everyone is tech-savvy. I have to say, some of my patients still have the flip-flop phones, not smartphones. So if we send – it definitely can receive a text message, but it's not adaptable to QR codes, to links, those things. "* (P5PM)

Cultural differences have not often been considered in available resources on alcohol use. One practice was very aware of the different types of alcohol consumed by some patient groups which may have made some previous resources inappropriate for discussions.

> *"A lot of our clients actually make their own alcohol, so it's really potent. So, they make it from rice, and so, one mouthful blows your head off. Yeah, you really need to narrow down exactly what it is that they're drinking because it probably doesn't fit into the standard drink stuff. So, it's probably a lot stronger if they're making their own."* (P1 Practice Nurse)

The following recommendations relate to the visual resources which were co-designed with our partner enliven to make them accessible for patients despite differing abilities and literacy levels.

> - **Recommendation 5:** Use highly visual resources for patients as these assist with low literacy
> - **Recommendation 6:** Translate materials into many languages, but be aware that some people may not be able to read in their primary language
> - **Recommendation 8:** Provide printed materials including the poster, consultation room signs and pamphlets to practices

Our findings prompt a recognition of the ongoing digital divide that continues to disadvantage our most vulnerable populations.

> - **Recommendation 7:** Prepare printed and electronic copies of all materials
> - **Recommendation 13:** Use 2-way SMS survey for feedback from the general population
> - **Recommendation 14:** Engage with disadvantaged populations with interviews or paper-based surveys in a trusted setting

Healthcare system

General practice does not routinely collect information related to disadvantage, apart from healthcare card status. This lack of data relating to disadvantage makes it difficult to track inequitable health outcomes. This has also been recognised in the international literature with some groups looking to screen for disadvantage in primary care (Pinto et al., 2019).

> - **Recommendation 2:** Optimise practice software to identify low income and disadvantaged populations in practice data

References and bibliography

- Canadian Centre on Substance Use and Addiction. (2019) Knowing your limits with alcohol. Available at: https://www.ccsa.ca/sites/default/files/2019-08/CCSA-Knowing-Your-Limits-with-AlcoholGuide-2019-en_0.pdf (Accessed: 12/2021).

- Boffa, J., Tilton, E. and Ah Chee, D. (2018) 'Preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities: The experience of an Aboriginal Community Controlled Health Service in Central Australia', Aust J Gen Pract, 47(12), pp. 851-854.

- DOI: 10.31128/AJGP-08-18-4661

- Department of Health (2018) PHN Program Performance and Quality Framework, Canberra: Commonwealth of Australia. Available at: https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-performance-and-quality-framework-phn-performance-and-quality-framework.pdf (Accessed 12/2021)

- Department of Health (2021) PIP QI Incentive guidance. Canberra Australian Government Department of Health. Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance (Accessed: 22 November 2021).

- Dolan, P., Hallsworth, M., Halpern, D., King, D. and Vlaev, I. (2010) MINDSPACE

- Influencing behaviour through public policy, U.K.: Institute for Government. Available at: https://www.bi.team/wp-content/uploads/2015/07/MINDSPACE.pdf.

- Gao, C., O'Geil, R. and Lloyd, B. (2014) Alcohol's burden of disease in Australia, Canberra: FARE and VicHealth in collaboration with Turning Point. Available at: https://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/alcohol%20misuse/Alcohols-burden-of-disease-in-Australia.ashx.

- Heather, N., Girvan, M., Kaner, E. and Cassidy, P. (2008) A final report on research funded by the Tyne and Wear Health Action Zone. Newcastle upon Tyne: Northumbria University.

- Kaner, E. F., Beyer, F. R., Muirhead, C., Campbell, F., Pienaar, E. D., Bertholet, N., Daeppen, J. B., Saunders, J. B. and Burnand, B. (2018) 'Effectiveness of brief alcohol interventions in primary care populations', Cochrane Database Syst Rev, 2(2), pp. Cd004148. DOI: 10.1002/14651858

- Kincaid, J. P., Fishburne, R. P., Rogers, R. L. and Chissom, B. S. (1975) Derivation of new readability formulas (automated readability index, fog count, and flesch reading ease formula) for Navy enlisted personnel. Research Branch Report 8–75. Institute for Simulation and Training.

- Miller, W. L., Crabtree, B. F., Nutting, P. A., Stange, K. C. and Jaén, C. R. (2010) 'Primary care practice development: a relationship-centered approach', Ann Fam Med, 8 Suppl 1(Suppl 1), pp. S68-79; s92. DOI: 10.1370/afm.1089.

- O'Donnell, A., Anderson, P., Newbury-Birch, D., Schulte, B., Schmidt, C., Reimer, J. and Kaner, E. (2014) 'The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews', Alcohol Alcohol, 49(1), pp. 66-78. DOI: 10.1093/alcalc/agt170

- PHN North Western Melbourne (2021) Covid-19 Response to recovery, Parkville, Victoria: NWMPHN. Available at: https://nwmphn.org.au/wp-content/uploads/2021/07/RA997a_NWMPHN_WhitePaper_CoVid19_Response_v17-1.pdf (Accessed: 11/2021)

- Pinto, A. D., Bondy, M., Rucchetto, A., Ihnat, J. and Kaufman, A. (2019) 'Screening for poverty and intervening in a primary care setting: an acceptability and feasibility study', Family practice, 36(5), pp. 634-638. DOI: 10.1093/fampra/cmy129.

- Roche, A., Kostadinov, V., Fischer, J., Nicholas, R., O'Rourke, K., Pidd, K. and Trifonoff, A. (2015) 'Addressing inequities in alcohol consumption and related harms', Health Promot Int, 30 Suppl 2, pp. ii20-35. DOI:10.1093/heapro/dav030

- Saunders, J. B., Aasland, O. G., Amundsen, A. and Grant, M. (1993) 'Alcohol consumption and related problems among primary health care patients: WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption I', Addiction, (88), pp. 349-362. DOI: 10.1111/j.1360-0443.1993.tb00822.x.

- Saunders, J. B. e. a. (1993) Drink less program resources. Available at: https://jbsaunders.net/resources/drink-less-program/ (Accessed: December 2021).

- Sturgiss, E., Gunatillaka, N., Ball, L., Lam, T., Nielsen, S., O'Donnell, R., Barton, C., Skouteris, H., Tam, C. W. M., Jacka, D., Mazza, D. and Russell, G. (2021a) 'Embedding brief interventions for alcohol in general practice: a study protocol for the REACH Project feasibility trial', BJGP Open, 5(4). DOI: 10.3399/BJGPO.2021.0037.

- Sturgiss, E., Lam, T., Russell, G., Ball, L., Gunatillaka, N., Barton, C., Tam, C. W. M., O'Donnell, R., Chacko, E., Skouteris, H., Mazza, D. and Nielsen, S. (2021b) 'Patient and clinician perspectives of factors that influence the delivery of alcohol brief interventions in Australian primary care: a qualitative descriptive study', Family Practice. DOI: 10.1093/fampra/cmab091

- Upham, S. J., Janamian, T., Crossland, L. and Jackson, C. L. (2016) 'A Delphi study assessing the utility of quality improvement tools and resources in Australian primary care', Med J Aust 204(7). DOI: 10.5694/mja16.00115

- ACOSS and UNSW Sydney (2018) Poverty in Australia 2018, Sydney. Available at: https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS_Poverty-in-Australia-Report_Web-Final.pdf (Accessed: 11/2021)