Treating alcohol misuse under the SNAP framework: (Smoking, Nutrition, Alcohol and Physical Activity)

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Overview

- Background
- Morbidity and GP role
- SNAP
  - Objectives
  - Framework
  - Outcome areas
  - Organisation
- Some key principles
- 5A's

Background

- Australian Government prevention policy (2001)
  - Joint Advisory Group on Population Health
    - Report
    - Conference
    - Review of the GP effectiveness in population health
  - Lifestyle Prescription project (2003)
    - Conference
    - Lifestyle assessment: barriers and tools
  - Practice Nurse program (2001)
    - Rural and remote GPs
    - Asthma 3+ plan
    - Diabetes cycle of care
  - Sharing care: chronic disease self-management program (2001)
- RACGP
  - Guidelines for prevention (‘Red book’)
  - Guidelines for implementation of prevention (‘Green book’)
  - Smoking, Nutrition, Alcohol and Physical Activity (SNAP)

Figure 1: Attributable risk factor DALYs as a proportion (%) of total DALYs (AIHW, 2000)

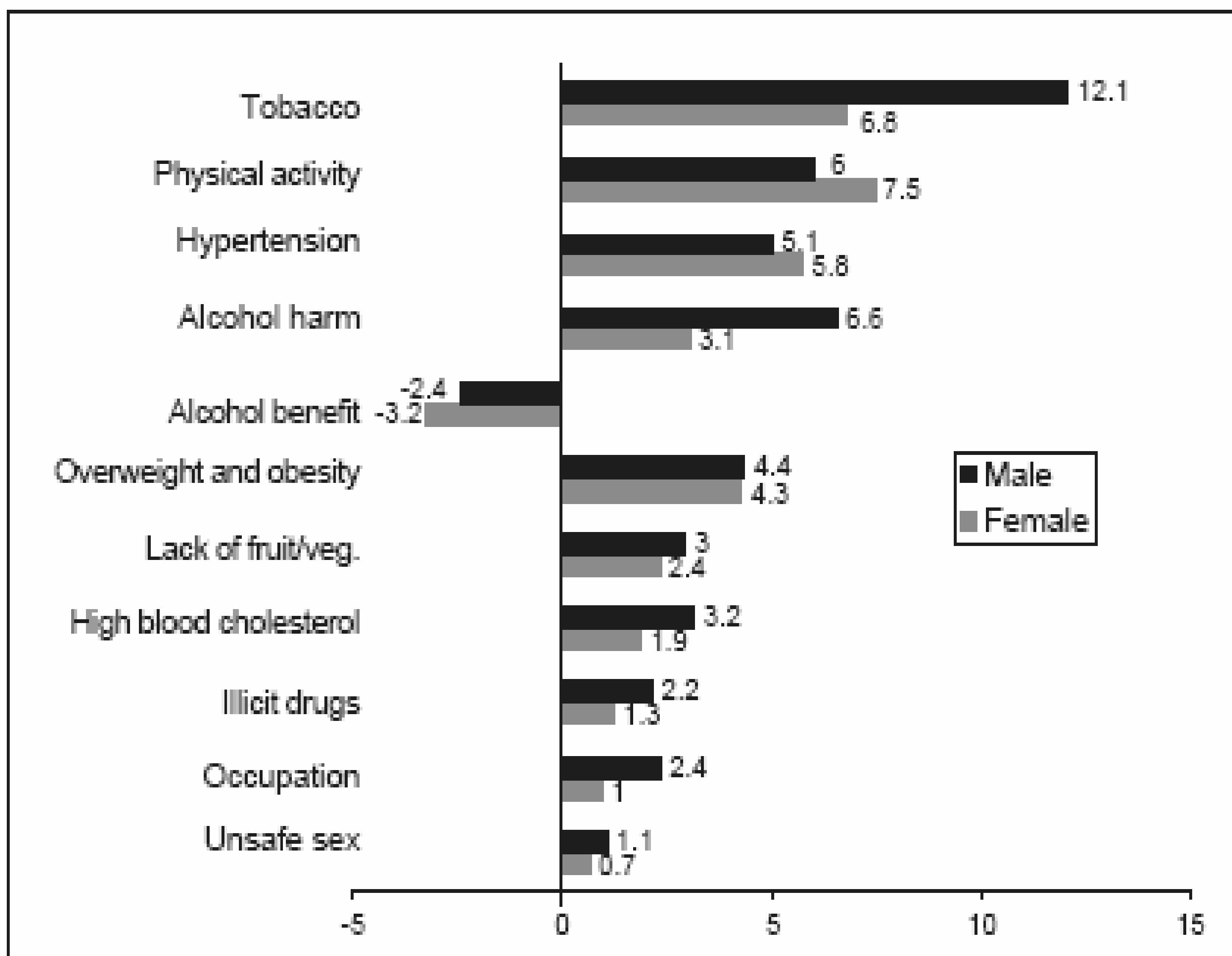
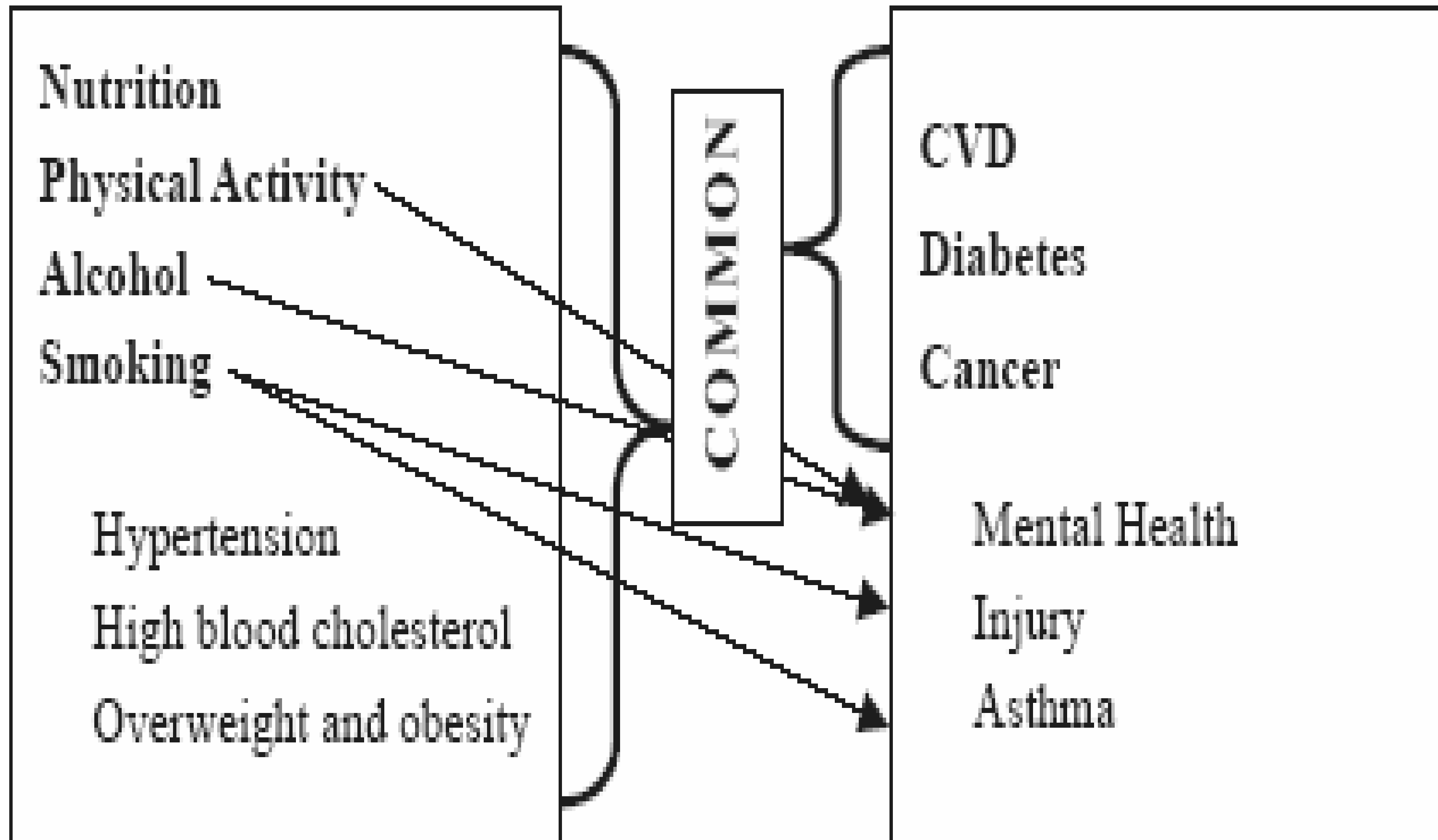


Figure 3: SNAP risk factors and the National Health Priority Areas



GP effectiveness (1)

Target area	GP time	intervention	NNT
Smoking[1]	3 – 5 mins	Brief behavioural counselling	1 in 12
Hazardous drinking[2]	3-5 mins	Brief behavioural counselling	1 in 10
Exercise[3]	3-5 mins	Brief behavioural counselling	1 in 10
Falls prevention in the elderly[4]	10-15 mins	Multi-component: medications, balance, exercises, home envt	1 in 8
Hyperlipidaemia[7] with 1% risk of CHD[8]	6-10 mins	Lipid lowering agent for 5 years	1 in 67
Screening for colorectal cancer[5]	3-6 mins	Haemoccult, appropriate Rx and follow up	1 in 1374
Mild HT in middle age[9]	6-10 mins	Prescription of an antihypertensive	1 in 2500

Aims of SNAP

- Improve health outcomes in the community
- Reduce level of competing pressures
- Maximise common prevention methods
- Provide practical support tools
- Provide a structure for integration across primary health care
  - Promote partnerships
  - Greater clarification of roles

Framework

- Consistent with Preventing Chronic Disease: a strategic framework (NPHP & AHMAC)
- System wide approach to identifying and managing behavioural risk factors
- Acknowledge role of socio-economic factors
- Focus on individuals with existing disease eg IHD, diabetes, PVD, cerebrovascular disease
- Actions for 7 broad outcome areas

Actions for 7 broad outcome areas

- Organisational structures and roles
- Financial systems
- Workplace planning, education and training
- Information management and information technology
- Communication, community awareness and patient education
- Partnerships and referral mechanisms, and
- Research and evaluation

Objectives (1)

- **To strengthen support provided by organisational structures**

- **To increase the availability of appropriate remuneration and incentives to support sustainable SNAP activities**

- **To increase GP and practice staff knowledge about EB integrated approaches to behavioural risk factor management**

Objectives (2)

- **To improve clinical IM/IT support systems for GPs to provide SNAP activities eg**
  - **clinical decision support tools,**
  - **patient registers, patient recall and monitoring systems, and**
  - **data collection and analysis systems**
- **To raise awareness amongst GPs, their patients and the broader community about the impact of the SNAP risk factors**
- **To encourage increased networks and referrals to community support professionals**
- **Facilitation of research into appropriate evidence based interventions, data collection and evaluation of SNAP activities**

Organisation

- 5 levels
  - GP and patient
  - Practice
  - Division and local community
  - State
  - National
- Core components
  - Behavioural approach: 5A's
  - Practice organisation
  - Resources and referral

SNAP

Smoking
Nutrition
Alcohol
Physical activity

A population health guide to behavioural risk factors in general practice

SNAP manual launched at RACGP Annual convention, October 2004
Workshops and further support tools to be developed in the next 3-6 months

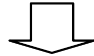
Some key principles relating to effectiveness

- Effort-performance paradoxes
  - Dose response curve varies ie impact is not necessarily a linear function of effort
  - Need to be strategic ie least preferred may be most effective
  - Less is more ie bigger gains can often be obtained by paying attention to coverage
  - Improvement is harder at the extremes of performance ie Newton's first law, Pareto principle / ceiling effect
- Be aware of aggregation to the mean
  - Systematic reviews provide information about average effect not variability

The "Reality Pyramid"

Smoking Cessation Interventions

GP Uptake



Effectiveness

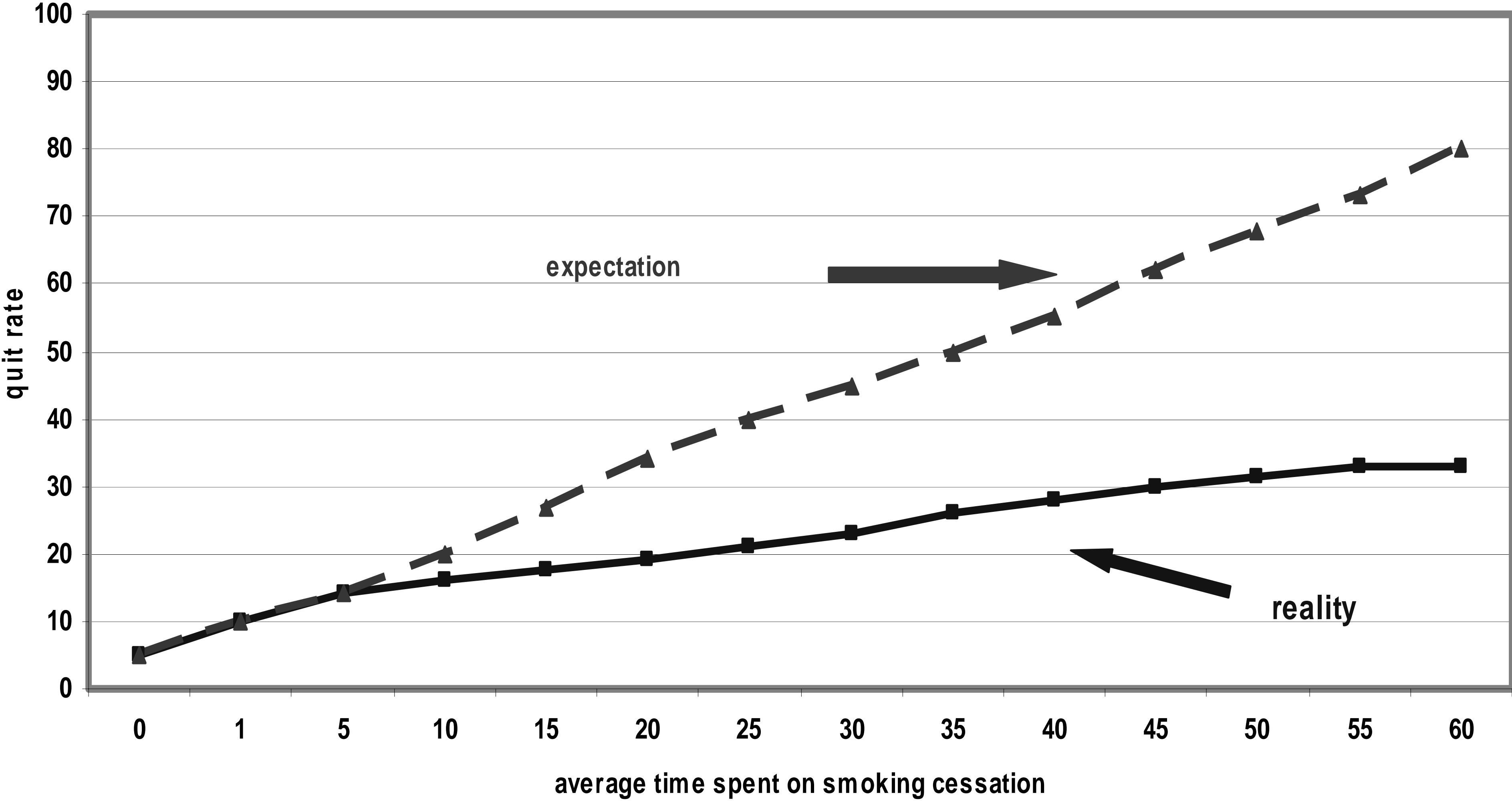
> 5 mins
Explore motivation, confidence, ambivalence. NRT/Zyban. Develop a quitting plan. Offer ongoing support and/or referral.
GP Uptake: 5 - 15% | Effectiveness: 5-7 fold

2 to 5 minutes
Explore motivation, confidence, ambivalence. Offer ongoing support and/or referral.
GP Uptake: 20-40% | Effectiveness: 4 fold

< 1 minute
Discuss smoking status. Affirm decision to quit. Provide brief advice and support. Self help materials and referral to the Quitline.
GP Uptake: 30-60% | Effectiveness: 3 fold

Supportive organisational infrastructure
Smokers routinely identified, self help materials and Quitline promoted within the setting.
GP Uptake: 60-100% | Effectiveness: 2 fold

Reframe efficacy as 'return on effort'



Quit rate as a function of the average time spent by GPs

Effectiveness = efficacy +(reach +uptake)

	reach	*efficacy*		*effectiveness*	efficiency
Time spent per smoker	Number counselled per 100 smokers	Effectiveness (Quit rate)	Total time spent (mins)	Number of quitters	Time spent per quitter
< 1 min	60	10%	60	6	10.0
3 mins	25	12%	75	3	25.0
10 mins	10	16%	100	1.5	67.0
60 mins	3	34%	180	1	180.0

Ask

- **Ask about drinking, including:**
  - quantity,
  - frequency
  - alcohol free days

- **Be alert to sensitivity about enquiry**
  - link the enquiry to the presenting complaint
  - establish common ground

Assess

- interest in cutting down
- barriers to cutting down
- (dependence on alcohol)

Assess

- **Rating motivation and confidence**
  - rate motivation on scale of 1 to 10
    - for score < 5: ask what would need to happen to ↑ score to a higher rating eg 8-9?
    - for score > 5: why x and not 2-3?
  - rate confidence on scale of 1 to 10 and repeat exploration of the score
  - systematically explore likes (benefits) and dislikes (costs) of current drinking (and cutting down) from the patient's perspective using the decision balance

DECISION BALANCE

	LIKES	DISLIKES
Continue current pattern of drinking		
Cut down		

Advise

- Provide clear, non judgmental advice to cut down
- Work with the patient to set a realistic goal (limit to number of drinks)
- Provide personalised feedback based upon your medical assessment
- Highlight other potential benefits of cutting down

Assist

- Enlist support where possible
- Identify high risk situations and work with the patient to develop a strategy to deal with them
- Use Practice nurses (where they have had appropriate training and support)
- Provide a booklet on strategies to help with cutting down

Arrange

- Follow up
- Referral to local Drug and Alcohol counsellor