Referral parameters to initiate older adults into exercise programmes

I recently read the article ‘Objective benefits, participant perceptions and retention rates of a New Zealand community-based, older-adult exercise programme’ in the June edition of the Journal of Primary Health Care. As a physiotherapist of nearly 10 years, and in this age of evidence-based practice, I always find it pleasing to read studies that support and reinforce the beneficial aspects of exercise.

I’d like to highlight the authors’ comment that additional studies in this area are needed to further identify the factors that are associated with older adults initiating and adhering to these programmes; also the comment that general practitioners (GPs) and other allied health professionals in New Zealand should consider promoting programmes such as the never2old Active Ageing programme to their older patients. I feel that health professionals should have an integral role in encouraging and initiating older adults into exercise programmes, but there isn’t always a clear guide of when to do so.

GPs are the consistent health professionals in patients’ lives. They make the majority of referrals and receive the discharge plans and management recommendations. They refer to cardiac rehabilitation after a myocardial event and to a diabetes educator after a diagnosis of diabetes; but what clinical marker should spark a GP or any other health professional to refer to an older adult exercise programme?

From a quality and safety point of view, and in a world where structures and systematic processes such as clinical care pathways are becoming increasingly prevalent, it seems reasonable that the creation of a guideline matrix for when to refer for exercise might be a topic for further discussion. This could increase referral rates, creating greater access, appropriate care, and ultimately lead to a population that is more active, healthier and less of a burden on our acute health system.

We already have a good understanding of what barriers prevent older adults exercising, but as the authors discussed, more research into initiation and adherence factors is required to achieve appropriate referral parameters. In particular, research that looks at what individual patient factors translate into good benefits from these programmes is needed, so that a rationale and guidelines can be created to assist health professionals with when to initiate timely and appropriate referrals. In the meantime, it would be great to see programmes such as the never2old Active Ageing programme continue to expand.

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References

General practitioners’ role in nutrition care

I was with great interest that I read ‘Direct observation of the nutrition care practices of Australian general practitioners’ in the June edition of the Journal of Primary Health Care. It was with great interest that I read ‘Direct observation of the nutrition care practices of Australian general practitioners in the June edition of the Journal of Primary Health Care’. It is a

General practice is considered to
be the ideal place for nutritional advice, weight management, and for referrals to specialist dietetics services. Despite this key role, Ball et al. state that ‘their role in providing nutrition care is unclear’. Other articles provide further insights into this role discrepancy, whereby some doctors do not consider nutrition to be their role, some provide basic nutrition information or advice, and others include providing nutrition care as standard practice. This raises issues of the quality of nutrition care that patients are receiving, or indeed, may not be receiving, from their GP. How can GPs have different opinions on their role within nutrition care when specific components of nutrition assessment, advice and requirements for care are clearly established within guidelines set by the Royal Australian College of General Practitioners (RACGP)? The GP’s role within nutrition care is accepted by patients and is clearly set out in RACGP guidelines. Given the issues of clinical practice variations and the difference of opinion from GPs regarding their role and scope in providing nutrition care, I am not convinced that all patients are receiving accessible and equitable nutrition care from general practice. Congratulations to the GPs discussed in Ball et al. who are addressing nutrition care within their consultations. When will all GPs rise to the challenge of adhering to preventive guidelines and fulfil their key role in improving the nutritional status of all patients?

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A crisis pregnancy service within a general practice setting in New Zealand

Women may undergo termination of pregnancy when they perceive there is no other choice. The choices can seem particularly limited for those who are economically or socially disadvantaged. Providing choice to women in this situation is an area of unmet need in our primary health care system and an important factor in our high rate of induced abortion. We run a free general practice–based crisis pregnancy service in Nelson, which aims to address this unmet need in our community.

New Zealand has a high rate of induced abortion, with a total number of 14 745 in 2012. The general abortion rate (abortions per 1000 women aged 15–44 years) in 2012 was 16.1. This compares to abortion rates of 8.5 in the Netherlands, 12.0 in Scotland, and 16.4 in England and Wales.

An important contributing factor to the high rate of abortion in New Zealand is the way in which unplanned pregnancy is managed in the primary health care sector. When a woman with an unplanned pregnancy presents to the general practitioner (GP), there is usually limited time to deal with the situation. Adequate counselling is difficult to achieve in the time available and, typically, an urgent referral is made to secondary care.

We felt our approach to patients with unplanned pregnancy was inadequate and that we were not providing these women with enough time and support to properly assess their situation and consider their options. There was a risk that many were simply having an induced abortion because they felt they had no other choice.

Primary health care teams lacked a viable referral pathway for women who wished to explore other options. A new primary care–based service was needed and we decided to explore how this could be done. We sought input and support from our local community, presenting the need at various meetings and developing a list of volunteers and resources. From this we formed Crisis Pregnancy Support (CPS), Hapai Taumaha Haputanga, based at St Luke’s Health Centre, a general practice in Nelson.

A volunteer, acute response care coordinator (nurse, counsellor or midwife) meets with each woman, exploring with her the issues that make her pregnancy stressful. A woman in this situation needs a ‘window of time’ where she can recover from the acute shock and begin to process the multiple life changes she faces. We work in partnership with the woman, aiming to draw on her own resourcefulness and decision-making skills to allow an informed choice. Together, we assess her needs and options for support, empowering her to make her decisions in the knowledge that practical support and ongoing care is available to her. We work collaboratively within a multidisciplinary...
team, including existing community support agencies and primary care providers.

Support varies from providing for practical needs, such as accommodation or transport, to more complex needs, such as accessing restraining orders or advocating at family group conferences. Care is also offered for those suffering from post-abortion grief.

Little can be found in the literature describing similar services in New Zealand. In 1992, Brett and Brett published a report of a primary care–based pregnancy centre, but we were not able to contact the authors of that report. The advantages of a service within general practice include client anonymity, skilled receptionists, waiting room facilities and professional standards of care, which integrate well with other primary care services.

CPS has now been operating for 12 years, with 132 women registered in the service so far. Many have chosen to continue their pregnancy. Empowered to overcome difficult situations, they have built positive futures for themselves and their child. Often the unplanned pregnancy has opened a new and better chapter in their lives, with more robust social support resulting. We receive referrals from diverse sources, with 54% coming from general practice teams, sexual health clinics or midwives. Many clients come from groups that are socially and economically disadvantaged. The ethnic distribution broadly reflects that of our local community, with 8.4% being Māori, 3.3% Pacific, and 6.1% Asian.

CPS helps to meet an unmet need in our community for women facing an unplanned pregnancy. It is particularly helpful to the socially disadvantaged, and is well accepted by women from diverse social and ethnic groups. The service has arisen in partnership with the local community and offers greater choice to women, helping improve the social determinants of health in vulnerable groups. In these ways, it fits well within the principles of the Primary Health Care Strategy.

We believe similar services should be provided throughout New Zealand and have demonstrated that these services fit well within a general practice environment.

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