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Supplementary Material

Supporting primary care practitioners to promote dementia risk reduction in Australian general practice: outcomes of a cross-sectional, non-randomised implementation pilot study

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Supplementary file

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Contents

1 Materials

1.1 Waiting room survey

Here at xxx, we want to work with you to improve your future health. Completing this form can help. You do not have to complete this form if you do not want to.

Age ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60-64 ☐ Rather not say

Sex: ☐ Male ☐ Female ☐ Other ☐ Rather not say

Have you had your blood pressure, cholesterol, and blood sugar checked in the last three years? ☐ Yes ☐ No ☐ Not sure

Are you physically active (30+ minutes, most days)? ☐ Yes ☐ No ☐ Not sure

Is your diet high in vegetables and low in sugar, fat and salt? ☐ Yes ☐ No ☐ Not sure

For females, is your waist size 14 (80cm) or lower?
For males, is your waist size 37 (94cm) or lower? ☐ Yes ☐ No ☐ Not sure

Do you smoke? ☐ Yes ☐ No ☐ Not sure

Do you drink 10 or more alcoholic drinks a week? ☐ Yes ☐ No ☐ Not sure

Choose **one** area where you want to be healthier:


Health checks ☐


Physical activity ☐


Diet ☐


Waist size ☐


Smoking ☐


Drinking ☐

On a scale from 0-10, where 0 is not at all important and 10 is very important, how **important** is it to you to be healthier in this area?

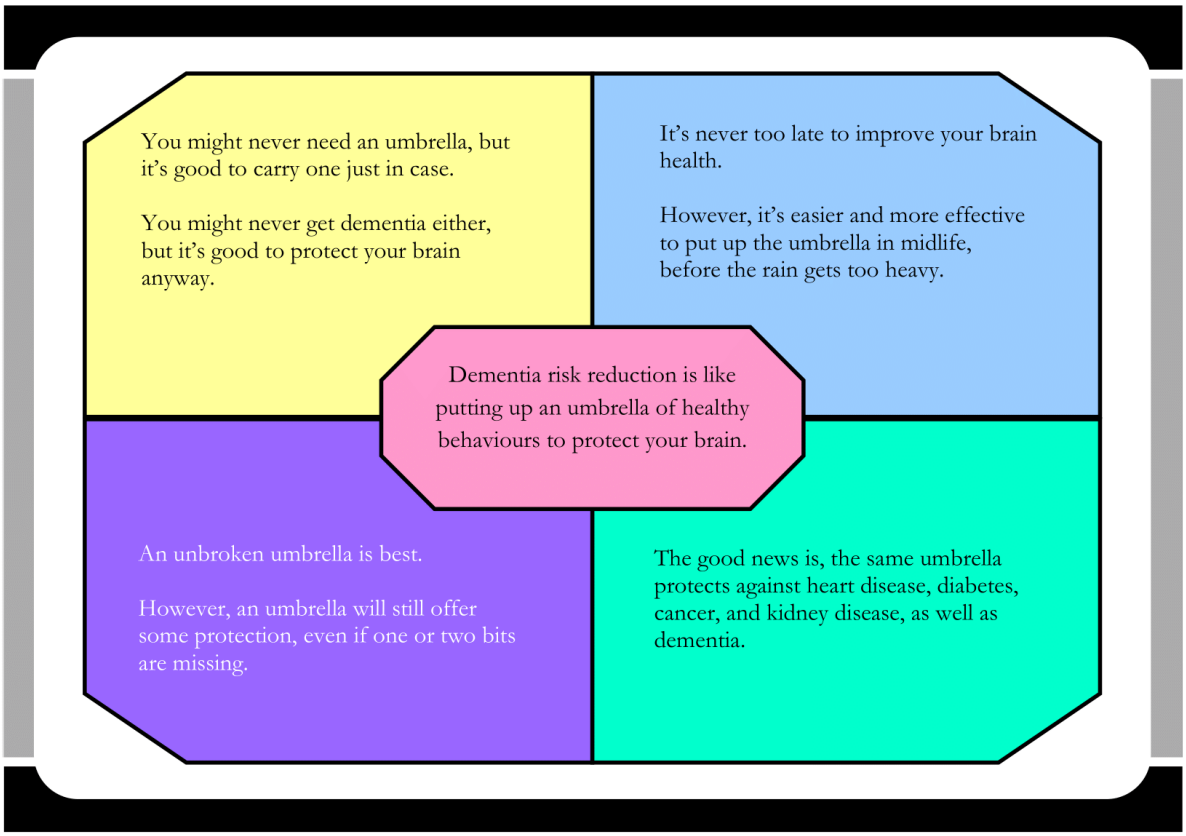
Importance: _____

On a scale from 0-10, where 0 is not at all confident and 10 is very confident, how **confident** are you that you can be healthier in this area?

Confidence: _____

Please give this form to your GP or nurse. If you do not want to discuss your responses today, you may simply return the form to reception.

1.2 Patient information cards



REDUCING YOUR RISK OF DEMENTIA

You can reduce your risk of dementia by quitting smoking, getting regular health checks, losing weight, being more physically active, improving your diet and reducing your drinking.

- Looking after your brain is important at any age.
- It is particularly important in middle age (40 to 65 years old).

What is dementia?

- Dementia is not a normal part of aging.
- Dementia is a term for a group of diseases that affect the way the brain normally works.
- People who have dementia often forget things or get confused, which makes it difficult to do everyday activities.
- A family history of dementia does not necessarily mean you will get dementia yourself. You can still reduce your risk of dementia.

Why are we discussing dementia?

- Dementia affects about 450,000 people in Australia.
- Dementia is the second biggest cause of death in Australia, after heart disease.
- Dementia affects 1 in 10 people over 65 years old, and 3 in 10 people over 85 years old.
- There is no cure for dementia, but you can reduce your chances of developing it.
- We want to make sure you know how to reduce your risk, and where to get help.

Reducing your risk of dementia

- Lifestyle changes could prevent up to 1 in 3 cases of dementia.
- The back of this card lists small steps you can take in your everyday life that can make a real difference to the health of your brain.
- These steps are also good for your general health. They can help lower your risk of other chronic diseases like diabetes, heart disease, cancer and kidney disease.

Find out more

Dementia Australia
www.dementia.org.au

Your Brain Matters
www.yourbrainmatters.org.au

National Dementia Helpline
1800 100 500

Sources: RACGP and peak bodies for dementia. © The PRECIPICE Project. The University of Melbourne. Ethics ID 1955339.1.

1. Get regular health checks

- Conditions that affect the heart or blood vessels can increase the risk of developing dementia.
- High blood pressure, high cholesterol, and diabetes often have no symptoms at first, so you might not know you have them.
- Get regular health checks to monitor your blood pressure, cholesterol, and blood sugar.

2. Be more physically active

- Regular physical activity increases blood flow to the brain.
- It also helps to build new brain cells and strengthen connections between them.

3. Improve your diet

- Your brain needs a variety of nutrients to function properly.
- A healthy diet will help reduce the risk of dementia.

"What's good for your heart is good for your brain"

You have about 100 billion brain cells. Each one needs a constant supply of oxygen and nutrients, and to get rid of waste.

The heart, blood and blood vessels work together to service your brain cells (and all your other cells).

4. Lose weight

- Being overweight can affect the blood supply to your brain.
- Obesity in midlife increases the risk of dementia.

5. Quit smoking

- Smoking tobacco damages the blood vessels going to your brain.
- Quitting smoking is one of the best things you can do for your brain and your body.

6. Reduce your drinking

- Drinking alcohol at high levels over time can cause alcohol-related brain damage.
- Sticking to fewer than 10 standard drinks per week will help reduce the risk of dementia.

Anything else?

- Staying mentally and socially active and getting enough sleep can improve your personal well-being.
- It could also help to improve your chances of delaying or avoiding dementia.
- Challenging the brain with new activities and sleeping well helps your brain cope better, even if some brain cells get damaged or die.

Sources: RACGP and peak bodies for dementia. © The PRECIPICE Project. The University of Melbourne. Ethics ID 1955339.1.

GETTING REGULAR HEALTH CHECKS

Getting regular health checks can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

What should I get checked, and how often?

There are often no symptoms of high blood pressure, high blood sugar or high cholesterol, so you need to have them checked regularly.

Most people should check their:

- blood pressure every two years from the time they are 18 years old
- risk of diabetes every three years from the time they are 40 years old
- absolute risk of cardiovascular disease every two years from the time they are 45 years old.
- cholesterol levels every five years from the time they are 45 years old.

Some people should have health checks more often than this (but never less often); we will let you know if this applies to you.

Blood pressure

Blood pressure is the pressure of your blood on the walls of your arteries as your heart pumps it around your body. Your blood pressure naturally goes up and down all the time, adjusting to your heart's needs depending on what you are doing. High blood pressure is when your blood pressure is persistently higher than normal. Blood pressure that's high over a long time is one of the main risk factors for dementia and heart disease.

Cholesterol

Cholesterol is a fatty substance that is carried around the body in the blood. When there is too much 'bad' cholesterol (low-density lipoprotein cholesterol) in the blood, it builds up in the walls of the arteries. Over time, this build up causes the arteries to harden. This can cause chest pain and/or a heart attack and serious circulatory problems.

Blood sugar

For your body to work properly, you need to convert glucose (sugar) from food into energy. A hormone called insulin is essential for the conversion of glucose into energy. In people with diabetes, insulin is no longer produced or not produced in sufficient amounts by the body. This is characterised by high levels of glucose in the blood, which can lead to serious medical problems with your heart, brain, eyes, circulation or kidneys.

<<Practice>> can help

1. We can check whether your blood pressure, blood sugar, and cholesterol readings are up-to-date.
2. We can ask about other risk factors for diabetes and heart disease such as your personal and family health history.
3. Once we know your risk factors, we can enter this information into web-based calculators to understand your risk of having diabetes, or a heart attack or stroke, in the next five years. Your calculator results will show whether you are at low, medium or high risk of having diabetes, a heart attack or stroke.
4. Depending on your results, we can encourage you to keep doing what you are doing, or give you advice, information and support to make healthy changes to your lifestyle. Changes might include modifying your diet, doing more physical activity, quitting smoking or reducing the amount of alcohol you drink.
5. If your cardiovascular risk level is high, we can prescribe medication to lower your blood pressure or cholesterol, or both.
6. If you are diagnosed with diabetes, we can prescribe medication to lower blood sugar.
7. We can send you a reminder when you are due for your next health check.

Find out more

Diabetes Australia
www.diabetesaustralia.com.au/risk-calculator

Australian absolute cardiovascular disease risk calculator
www.cvdcheck.org.au/calculator/

RACGP Preventive activities in middle age
http://bit.ly/DRR130

BEING MORE PHYSICALLY ACTIVE

Being more physically active can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

Physical activity

Regular physical activity has important benefits for physical and mental health. It reduces the risk of many health problems. Doing some physical activity is better than doing none at all, and increasing amounts of physical activity provide even more health benefits.

Aim to be active most days, preferably all. Try to accumulate 2½ to 5 hours of moderate intensity physical activity each week. Moderate intensity means that the activity requires some effort, but you can still talk while doing it. Examples of moderate intensity activities include:

- Brisk walking
- Recreational swimming
- Social tennis
- Cleaning the windows at home.

Muscle strengthening

Muscle strengthening activities improve the strength, power, endurance and size of skeletal muscles. This helps to manage blood pressure, blood sugar and blood cholesterol levels, and manage weight. As you gain muscle, your body burns more energy when at rest.

Aim to do muscle-strengthening activities on at least 2 days each week. Examples of muscle-strengthening activities include:

- body weight exercises (push-ups, squats or lunges)
- using free weights (dumbbells, barbells and kettlebells, medicine balls or sand bags)
- doing tasks around the house that involve lifting, carrying or digging.

Inactivity

Even if you meet guidelines for physical activity and muscle strengthening, there are still risks associated with sitting too much. It's not good for your health to be sitting or lying down for long periods during waking hours. Adults who sit less throughout the day have a lower risk of early death, particularly from heart disease. Sedentary behaviour is associated with increased risk of being overweight, type 2 diabetes, and heart disease.

Regular interruptions from sitting (even as little as standing up) may help to reduce your risk factors for developing heart disease.

<<Practice>> can help

1. We can check whether your levels of physical activity and sedentary behaviour have been measured in the past two years (or more often if you are at higher risk of not meeting the guidelines).
2. We can discuss the type, intensity, frequency and duration of bouts of physical activity that you do. We can also explore barriers to, and facilitators of, physical activity, and your motivation and confidence to be more physically active.
3. We can support you to set goals and develop problem-solving skills to overcome barriers to increasing physical activity. We can offer sessions of physical activity advice or counselling
4. We can write you an exercise prescription. We might suggest you use a step tracker as part of your prescription, or that you use a logbook for self-monitoring.
5. We can refer you to physical activity programs or classes run by local community organisations. Or, we can suggest you access telephone advice or counselling.
6. If you have a health condition that puts you at higher risk during moderate intensity physical activity, we can provide clinical assessment and supervision. We might also refer you to an accredited exercise physiologist or physiotherapist for further support.
7. We can send you a reminder every 3 –6 months for a review of your physical activity.

Find out more

Australia's Physical Activity & Sedentary Behaviour Guidelines for Adults (18-64 years)
http://bit.ly/DRR137

Heartmoves
www.heartmoves.org.au

Sport Australia
www.sportaus.gov.au

Exercise & Sports Science Australia
www.essa.org.au

parkrun Australia
www.parkrun.com.au

IMPROVING YOUR DIET

Improving your diet can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

By following the dietary patterns recommended in the Australian Dietary Guidelines, you will get enough of the nutrients essential for good health and also help reduce your risk of chronic health problems.

Fruit and vegetables

Eat at least 2 serves of fruit and 5 serves of vegetables every day. A standard serve of fruit is about 150g (350kj); a standard serve of vegetables is about 75g (100-350kj). Avoid fruit and vegetables with added sugar or salt.

Grain foods

Have 6 serves (4 serves for women over 50) of grain foods per day, mostly wholegrain and/or high cereal fibre varieties. A standard serve is 500kj.

Protein

Eat 2-3 small serves of lean protein every day. A standard serve is 500-600kj. Limit red meat to 3-4 times per week and keep processed meat to a minimum.

Fish

Aim to include 2-3 servings of fish per week, totalling about 1750–3500mg of omega-3 fatty acids (labelled as EPA and DHA). Fish with the highest levels of omega-3 include fresh or canned salmon, herring, sardines, and tuna.

Dairy

Have 2-3 serves (4 serves for women over 50) of dairy or a dairy-alternative every day. A standard serve is 500-600kj. Full fat cheeses should be limited to 2–3 serves per week, and varieties which are lower in salt are preferable.

Salt, fat and sugar

Limit salt to <5g/day (approximately 2,000 mg sodium). Keep fat intake to <30% of total calorie intake, and saturated fat to less than 10% of your total energy intake. Keep sugar to less than 10% of total energy intake. Avoid all sugary drinks like soft drinks, cordial, fruit drinks (less than 98% fruit) and sports and energy drinks.

Overall energy intake

If you are overweight, aim for a daily energy deficit of 2500kj or 600 kcal (taking physical activity into account).

Vitamin supplementation

There is no evidence that vitamin supplementation is necessary in individuals without signs or symptoms of deficiency disorders.

Sources: RACGP and the Australian Dietary Guidelines.

<<Practice>> can help

1. We can help you set goals and learn how to monitor your behaviour (including reading food labels) and progress
2. We can help with problem-solving, relapse prevention and management. We can help you recognise and plan to avoid triggers that prompt unplanned eating.
3. We can refer you for self-management support, coaching in an individual or group-based diet, or support from an allied health provider (e.g. dietitian, psychologist).
4. We can arrange to see or telephone you again every 2-3 months to provide support, monitoring and relapse prevention.

Find out more

Australian Dietary Guidelines
www.eatforhealth.gov.au

Energy needs calculator
www.eatforhealth.gov.au/webform/daily-energy-requirements-calculator

Dietitian Association of Australia
www.daa.asn.au / 1800 812 942

LOSING WEIGHT FROM YOUR WAIST

Reducing the size of your waist can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

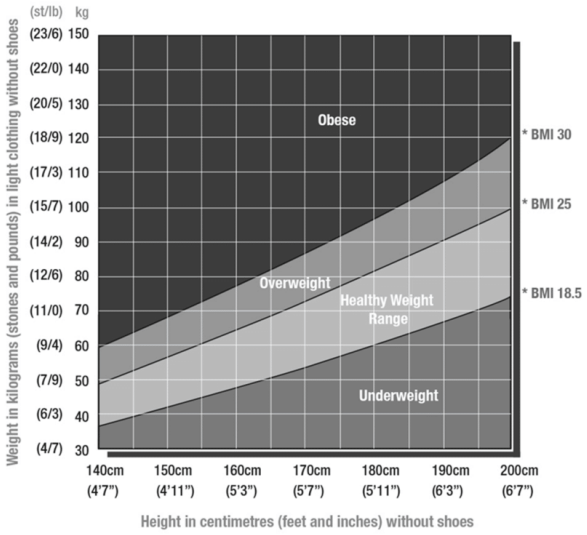
Caucasian males should aim for a waist circumference under 94 cm (37 inches), or under 90 cm (35 inches) in Asian males. For females, the target is under 80 cm (31.5 inches, or size 14).

The correct place to measure your waist is halfway between your lowest rib and the top of your hipbone, roughly in line with your navel. Measure directly against your skin. Breathe out normally. Make sure the tape is snug, without compressing the skin.

Waist circumference is a stronger predictor of health problems such as dementia, cardiovascular disease, diabetes and metabolic syndrome CVD and diabetes than weight alone.

On its own, body mass index (BMI) may be misleading, especially in older people and muscular individuals. To minimise your health risks, you should aim for a healthy waist size and a body mass index (BMI) between 18.5 and 25 kg/m2.

Having a healthy body weight and waist circumference lowers the risk of heart problems and can help lower blood pressure and cholesterol.



<<Practice>> can help

1. We can check whether your weight and waist circumference have been measured in the past two years (or the past 6 months if you are overweight).
2. We can discuss any concerns you have about your weight and whether you have tried to lose weight in the past.
3. We can help you set goals, such as an initial target of 5% weight loss and specific measurable changes to diet and physical activity.
4. We can arrange to see or telephone you again in two weeks to see whether your goals are being met.
5. We can re-assess your weight and waist circumference three months after you start trying to lose weight. If there has been no change (less than 1kg/1cm), we can discuss alternative approaches with you, such as referral to lifestyle programs or coaching.
6. If there is still no change, we can explore starting you on a very low energy diet under medical supervision.
7. If your BMI is >35 kg/m2 and you have another condition (e.g. diabetes) that is expected to improve with weight reduction, we can explore the possibility of bariatric surgery with you.
8. Once you have achieved initial weight loss, we can help you develop a maintenance program that includes support, monitoring and relapse prevention. We can arrange 12-monthly reviews for five years.

Find out more

Heart Foundation

www.heartfoundation.org.au/your-heart/know-your-risks/healthy-weight

Better Health Channel

www.betterhealth.vic.gov.au/healthyliving/weight-management

QUITTING SMOKING

Quitting smoking can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

Smoking affects the vessels that supply blood to your heart and other parts of your body. It reduces the amount of oxygen in your blood and damages blood vessel walls.

Smoking also contributes to atherosclerosis, which occurs when there is narrowing and clogging of the arteries which reduces blood supply, and the amount of oxygen available, throughout the body.

Smoking increases the stiffness of the blood vessels making it harder for them to expand and contract as needed and more likely to split. These changes to the arteries can cause a heart attack, stroke or angina. Smokers have more heart attacks, strokes and angina than non-smokers, and at a much younger age.

One year after quitting, your risk of a heart attack or stroke is reduced by half. In 5 to 15 years, your risk of stroke and coronary heart disease returns to that of someone who has never smoked.

There is insufficient evidence for acupuncture, acupressure, laser therapy or e -cigarettes in supporting quitting. The best chance of quitting is with a quit specialist and prescription medication.

Give yourself the best chance to quit

<<Practice>> can help

1. We can help you examine the pros and cons of quitting compared with continuing to smoke. If you are still unsure about quitting, we might suggest a follow-up visit to discuss it further.
2. When you are ready to quit, we can assist you to:
   - agree on a quit date
   - identify smoking triggers and discuss quitting strategies
   - access self-help materials
3. We can refer you to a quit program such as the Quitline. Quit programs increase your chance of quitting successfully.
4. We can discuss medications such as varenicline (Champix), bupropion, or nicotine-replacement therapy.
5. We can arrange to see or telephone you again within one week and again after one month of stopping smoking, to help increase your long-term chance of quitting.

Find out more

Quitline
www.quit.org.au

Better Health Channel
www.betterhealth.vic.gov.au/healthyliving/smoking-and-tobacco

REDUCING YOUR DRINKING

Reducing your drinking can help reduce your risk of developing dementia as you get older. It can also reduce your risk of heart disease, diabetes, cancer, and kidney disease.

The lifetime risk of harm from drinking alcohol increases with the amount consumed. The risk of an alcohol-related problem increases dramatically with an increase in the number of drinks consumed.

The effect of alcohol on the body is complex. Low levels of alcohol (i.e. within the recommended levels) raise high-density lipoprotein cholesterol and reduce plaque accumulations in arteries. Alcohol can also have a mild anti-coagulating effect.

However, alcohol can also raise blood pressure and increase the risk of arrhythmias, shortness of breath, some types of cardiac failure, stroke and other circulatory problems. High levels of alcohol causes high triglycerides and low HDL ("good") cholesterol.

New guidelines recommend healthy adults drink no more than 10 standard drinks a week to reduce the lifetime risk of harm from alcohol-related disease.

A note on alcohol dependence

If you are dependent on alcohol, reducing your drinking could cause withdrawal symptoms. Speak to your GP about managing withdrawal either at home or in a detox unit or hospital. Your GP can prescribe medication to manage withdrawal symptoms and help you avoid relapse.

Alcoholic beverage	Std drinks
Full strength beer (4.9% alcohol)	
1 can or stubbie	1.4
285mL glass (pot)	1.1
425mL glass (schooner)	1.6
570mL glass (pint)	2.2
24x375mL cans or stubbies	34
Wine (9.5%–13% alcohol)	
100mL glass	1
Restaurant serving (150mL)	1.4 to 1.6
750mL bottle	7 to 8
4-litre cask	36 to 43
Spirits (37%–40%)	
1 nip (30mL)	1
700mL bottle	22
Pre-mixed spirits (5%–7% alcohol)	
1 can (375mL)	1.5–2.1
1 bottle (275mL)	1.1–1.5

<<Practice>> can help

1. We can discuss any concerns you have about your drinking and whether you have tried to reduce your drinking in the past. We might also ask about your motivation and confidence to reduce your drinking.
2. We can administer a questionnaire such as the AUDIT, AUDIT–C, or the WHO Severity of Alcohol Dependence Questionnaire to better understand your drinking patterns and level of dependency.
4. We can try to reach an agreement with you about the number of drinks per day and alcohol-free days per week.
5. We can help you to identify high-risk situations and encourage you to avoid these.
6. We can give you some self-help material and information about available support services. We can help you to enlist the support of friends or family to reduce your drinking.
7. We can arrange to see or telephone you again two weeks after your first visit, and again after 1-3 months, to provide support, monitoring and relapse prevention, and review your goals.
8. If you are still drinking at unsafe levels, we can discuss referring you to a local drug and alcohol counsellor or service. We can also refer you for an individual psychological intervention that focuses specifically on alcohol misuse.

Find out more

Australian guidelines to reduce health risks from drinking alcohol
http://bit.ly/DRR135

Alcohol Use Disorders Identification Test (AUDIT)
http://bit.ly/DRRaudit

Severity of Alcohol Dependence Questionnaire
www.drinksafely.soton.ac.uk/SADQ

BEING SOCIALLY AND MENTALLY ACTIVE

Being socially and mentally active might help reduce your risk of developing dementia as you get older.

Compared to other healthy behaviours, we don't have as much evidence that being socially and mentally active reduces your risk of dementia. That's partly because it is difficult to test scientifically.

Still, there are good reasons to think it might help build new brain cells and strengthen connections between them. This helps to give the brain more 'reserve' or 'back up' so that it can cope better and keep working properly if any brain cells are damaged or die.

There are many brain training games available on the market. Some of these have been shown to lead to some improvements to the brain functions they were designed to train. However, we do not yet know if they reduce the risk of dementia.

Enjoying social activity

Most of us are social beings and usually prefer the company of others. It can be more fun doing things with other people, to share experiences like going to the movies or a concert, taking a trip somewhere or discover a new restaurant.

To help look after your brain health, it's important to be social with people whose company you enjoy and in ways that interest you.

Social engagement has been found to have benefits for other health factors related to cognitive functioning, such as vascular condition and depression.

Research suggests that social activities that involve mental activity and physical activity (e.g. dancing and team sports) provide even greater benefit for brain health and reducing the risk of dementia.

Mentally challenging your brain

Keeping your brain active is important to keep it functioning well. As we grow older we tend to prefer doing the things we've always done, and tasks that we are familiar with.

But, the brain benefits by having to tackle something it doesn't know. This could be learning a new language, taking up a new sport, or doing a course in something you're always wanted to do.

Higher levels of mental activity throughout life are consistently associated with better brain function and reduced risk of cognitive decline and dementia. Increased complex mental activity in later life is also associated with a lower dementia risk.

Challenge yourself often and keep learning new things throughout life.

<<Practice>> can help

1. We can discuss the type, intensity, frequency and duration of social and mental activity that you do. We can also explore barriers to, and facilitators of, being socially and mentally active.
2. We can support you to set goals and develop problem-solving skills to overcome barriers to increasing social and mental activity.
3. We can write you a prescription for social or mental activity, and follow-up with you on your progress.
4. We can signpost you to local clubs, associations, community groups, adult learning programs or classes.

Resources

Australian Men's Shed Association
https://mensshed.org/

Adult Learning Australia
https://ala.asn.au/

Meetup
http://www.meetup.com

Neighbourhood Houses Victoria
https://www.nhvic.org.au/

University of the Third Age
http://www.u3avictoria.com.au

NORMAL AGEING vs DEMENTIA

How dementia is different from normal ageing

Many of us get a little more forgetful as we get older. Most people will need a bit longer to remember things, get distracted more easily or struggle to multi-task as well as they once did. This may become noticeable, particularly from middle age.

These changes are normal, but they can be a nuisance and at times frustrating. However, you may worry that these things are an early sign of dementia. It's important not to worry too much about this. For most people, these changes will be the result of normal ageing and won't be down to dementia.

Don't use this information to try to 'spot' dementia in yourself or someone else. Dementia can only be diagnosed by a qualified and experienced health professional.

If you are worried about yourself or someone close to you, talk about your concerns with your GP.

What are the symptoms of dementia?

For a doctor to diagnose dementia, a person's symptoms must have become bad enough to significantly affect their daily life, not just be an occasional minor irritation. This means having new problems with everyday activities about the house, in the community or at work. For example, starting to have problems paying household bills, using the phone, managing medicines, driving safely or meeting up with friends.

If a person has symptoms that are worse than would normally be expected for a healthy person their age, but are not severe enough to significantly affect their daily life, a doctor may diagnose mild cognitive impairment (MCI). This is not a type of dementia, though some people who have MCI will go on to develop dementia.

The signs of normal ageing and dementia

The back of this card lists some of the possible changes due to both normal ageing and early dementia. However, it is important to remember that everyone is different and not everyone with dementia will have all of these changes.

Other conditions may also account for some of them. For example, a person with depression can have problems making decisions, get confused easily and appear withdrawn or irritable.

Less common types of dementia may lead to early changes that are not shown in the table. These changes could be visual hallucinations (seeing things that are not really there) or very disturbed sleep, in dementia with Lewy bodies. Or they could be early changes in personality or behaviour, in frontotemporal dementia.

Possible changes due to normal ageing	Possible changes due to dementia
Sometimes forgetting people's names or appointments, but remembering them later	Forgetting the names of close friends or family, or forgetting recent events (e.g. visitors you had that day)
Occasionally forgetting something you were told	Asking for the same information over and over
Misplacing things from time to time (e.g. mobile phone, glasses, TV remote) but retracing steps to find them	Putting objects in unusual places (e.g. house keys in the bathroom cabinet)
Being a bit slower to react or think things through	Getting very confused when planning or thinking things through
Getting less able to juggle multiple tasks, esp. when distracted	Having a lot of difficulty concentrating
Making a bad decision once in a while	Frequently poor judgement with money or when assessing risks
Occasionally making a mistake when doing family finances	Having trouble keeping track of monthly bills
Having a bit of trouble finding the right word sometimes	Having frequent problems finding the right word or frequently referring to objects as 'that thing'
Needing to concentrate harder to keep up with a conversation	Having trouble following or joining a conversation
Losing the thread if distracted or many people speaking at once	Regularly losing the thread of what someone is saying
Getting confused about the day/week but figuring it out later	Losing track of the date, season and the passage of time
Going into a room and forgetting why you went there, but remembering again quite quickly	Getting lost or not knowing where you are in a familiar place
Vision changes related to cataracts or other changes in the eyes, such as misty or cloudy vision	Problems interpreting visual information (e.g. difficulty judging distances on stairs, misinterpreting patterns such as a carpet)
Sometimes being weary of work, family and social obligations	Losing interest in work, socialising or hobbies
Sometimes feeling a bit low or anxious	Getting unusually sad, anxious, frightened or low self-confidence
Developing specific ways of doing things and becoming irritable when a routine is disrupted	Becoming irritable or easily upset at home, at work, with friends or in places where you are comfortable, or familiar places

1.3 Change plan template

CHANGE PLAN

Date: I am going to work on:	 *Health checks*	 *Physical activity*	 *Diet*	 *Weight*	 *Smoking*	 *Alcohol*
	○	○	○	○	○	○

The changes I want to make are: *(include what, when and how)*

The reasons why I want to make these changes are:

Please turn over

The steps I plan to take in changing are:

I will know that my plan is working if:

Some things that could interfere with my plan are:

If the plan isn't working, I will:

I will have a follow-up appointment with _____

in _____ weeks / months (circle one)

1.4 Reception notice

Today, the following doctors and/or nurses are participating in an activity to improve how we care for our patients.

_____

_____

_____

_____

If you are a patient of one of these doctors or nurses, you may be invited to answer a confidential patient form in the waiting room. The goal of this activity is to provide better support for people to reduce their risk of chronic disease.

We thank you for considering your participation in this activity.

1.5 Educational materials for primary care practitioners (PCPs)

10 STEPS FOR GPS AND NURSES

You can skip, rearrange, or modify steps according to your clinical judgement.

Part 1: Leading up to a discussion about dementia risk reduction

1. Ask about the patient's waiting room form

- Quantify "yes" responses
  - E.g. "You've said you're physically active most days. That's great! What kind of activity do you do?"
- Clarify "not sure" responses
  - E.g. "You're not sure whether you've had your blood sugar checked recently. Let me check our records."
- Follow-up "no" responses
  - E.g. "You're drinking at least 10 alcoholic drinks a week. What do you drink on a typical day?"
- Ask about importance and confidence
  - [See Motivational Interviewing Card]
- Ask open questions to elicit patients' priorities and motivation to change
  - [See Motivational Interviewing Card]

2. Decide whether to discuss dementia risk reduction today

- Explain what you want to do
  - E.g. "I want to support you to improve your health and reduce your risk of things like heart disease and dementia"
- Option 1 (enough time): Ask the patient when they would like to discuss dementia risk reduction
  - E.g. "We can talk about this now, if you like, or we can make another appointment, where we can focus on [health priority]? Which would you prefer?"
- Option 1 (*not* enough time): Ask the patient to make another appointment to discuss dementia risk reduction
  - E.g. "Unfortunately, we don't have enough time now to talk about this properly. Would you like to make another appointment, where we can focus on [health priority]?"

Reminder

If booking a health assessment: (i) check eligibility, (ii) explain the health assessment process and its likely benefits, and (iii) obtain consent.

Part 2: Discussing dementia risk reduction

1. Elicit patient's understanding about the relationship between healthy behaviours and dementia risk

[See Motivational Interviewing Card]

2. Seek permission to provide information about reducing dementia risk

[See Motivational Interviewing Card]

3. Provide information about healthy behaviours and dementia risk

- Show the Umbrella Card
- Explain the umbrella analogy

4. Give the patient the dementia risk card, and discuss

- Key messages:
  - Dementia is not a normal part of ageing
  - Adopting a healthy lifestyle can reduce risk of dementia
  - One-third of cases of dementia might be avoided through adopting healthier lifestyles
  - What's good for the heart is good for the brain

5. Give the patient the relevant health behaviour card, and discuss

- Key messages
  - How the behaviour relates to reduced risk of disease
  - Guideline-concordant behaviour to work towards
  - How the clinical care team can help
  - Services to access for further information and support

6. Elicit patient response to the information and advice

[See Motivational Interviewing Card]

7. Give the patient the change plan card, and discuss

- Support the patient to write something under each heading

8. Arrange a follow-up appointment

Reminders

Relate discussions to the patient's understanding.

Ask the patient to return the waiting room form to reception.

RESOURCES for the MANAGEMENT OF RISK FACTORS

	RISK FACTOR	Guidelines	Link
	Smoking	RACGP SNAP	bit.ly/DRR101
	Overweight and obesity	RACGP SNAP	bit.ly/DRR102
	Nutrition	RACGP SNAP	bit.ly/DRR103
	Alcohol	RACGP SNAP	bit.ly/DRR104
	Physical activity	RACGP SNAP	bit.ly/DRR105
	Type 2 diabetes	RACGP Diabetes RACGP Red Book	bit.ly/DRR106 bit.ly/DRR106b
	Blood pressure	RACGP Red Book	bit.ly/DRR107
	Cholesterol	RACGP Red Book	bit.ly/DRR108
	Absolute CVD risk	National Vascular Disease Prevention Alliance	bit.ly/DRR109

LIST of RELEVANT MEDICARE ITEMS

Health assessments	Frequency of service	Medicare Items	Rebate	Link
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years	701 (<30 mins) 703 (30-44 mins) 705 (45-59 mins) 707 (60 mins+)	$60.30 $140.10 $193.35 $273.10	bit.ly/MBSAN036 bit.ly/MBSAN037
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only	701 (<30 mins) 703 (30-44 mins) 705 (45-59 mins) 707 (60 mins+)	$60.30 $140.10 $193.35 $273.10	bit.ly/MBSAN036 bit.ly/MBSAN038
Aboriginal and Torres Strait Islander Health Assessment	Once every nine months	715 (no time requirements)	$215.65	bit.ly/MBSAN043 bit.ly/MBSAN045 bit.ly/MBSAN046
Heart health assessment *Note: cannot be claimed if a patient has had a health assessment service in the previous 12 months (all the above item numbers)*	Once a year to adults aged 45 years and above, or Aboriginal or Torres Strait Islander persons aged 30 years and above.	699 (20mins +) Must include calculation of absolute cardiovascular disease risk	$86.95	bit.ly/MBSAN142
Provision of appropriate preventive health care	As indicated	B-23 (<20 mins) C-36 (21-39 mins) D-44 (40 mins+)	$38.20 $73.95 $108.85	bit.ly/MBSAN09

MOTIVATIONAL INTERVIEWING (MI) INFORMED PRACTICE

Importance
What makes the importance a …. and not a … [lower number]?
What would it take to increase the importance to a … [higher number]?

Confidence
What makes your confidence a …. and not a … [lower number]?
What would it take to lift your confidence to a … [higher number]?

Open questions to elicit patients' priorities and motivation to change

Stem
How…
What…
Why…
Tell me about…

\+

Change talk
- Want, like, desire, prefer
- Able to do, can do
- Reasons for, think
- Important, need, have to
- Will, intend to, doing
- Ready to, willing to
- Have done, started to

\+

Behaviour
- Get regular health checks
- Be more physically active
- Improve your diet
- Reduce your waist size
- Quit smoking
- Reduce your drinking

= Question
- Why is it important to you to be healthier?
- What do you think would help you to start being healthier?
- What do you want to be able to do?
- Tell me about what you've done in the past that's helped when you've wanted to drink less?
- How can you build on the walking that you do now?

Source: Aus J of Gen Prac. 2018;47(1-2):8-13. bit.ly/DRR-MI.

MOTIVATIONAL INTERVIEWING (MI) INFORMED PRACTICE

Elicit–provide–elicit framework for giving information and advice in motivational interviewing

Elicit
Ask patients about their ideas and what they know, understand or think.
By first eliciting what the patient knows, you can:
- Hear the patient's language and use this language in offering advice
- Listen for incorrect or missing information in the patient's understanding, and find ways to help them to understand
- Hear their ideas and reinforce what is helpful on the basis of evidence

What do you understand about… ?

What ideas do you have about making a change … ?

What would you most like to know about …?

Seek permission
Provide
- Information and a range of options, where possible
- Clarification of any misinformation
- Confirmation of patient's understanding or knowledge

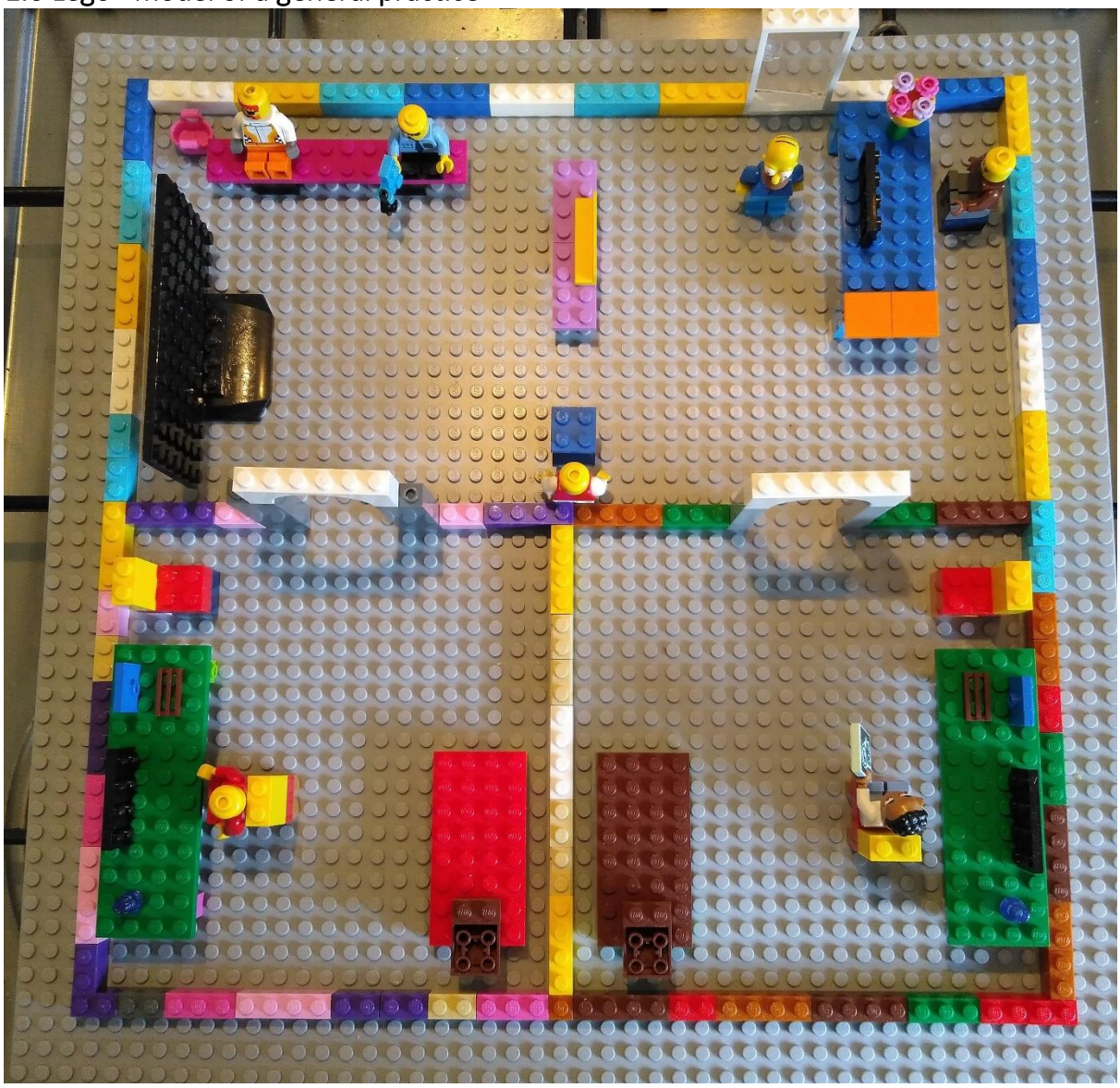
Would it be okay if I provide you with some information that might be helpful?

Elicit
- Ask patients what they think and feel about the information discussed
- Ask patients what they might do

Given all we've discussed, what are your thoughts now?

What might you do?

1.6 Lego® model of a general practice



1.7 Group meeting discussion guides

Meeting 1

Part 1: Set up (10 minutes)

1. Coffee / lunch distribution
2. Consent form for focus group
3. Survey about barriers to promoting dementia risk reduction (DRR)

Discussion: How important is it to discuss DRR with your middle-aged patients?

Part 2: Umbrella project procedures (15 minutes)

Let's have a think about some ways we can promoting DRR here.
No right or wrong answers. Democratic discussion about how we might do it here. [Share Lego model and kits of cards]. Here are the 10 proposed steps. What would you add into this picture or take out if you could?

Part 3: Explanation of evaluation procedures (5 minutes)

Counts of waiting room forms and patient information cards
PCP perspective

- Role-play interview with champions
- Online discussion group
- One more group meeting at the end of Cycle 1
- Interview with Practice Manager at the end of the project

Patient perspective

- Telephone interviews

Part 4: Consensus discussion (15 minutes)

1. How do you feel about promoting DRR?
2. How do you feel about the "Umbrella" intervention? Is it a good fit for you? Your patients?
3. Who needs to do what, and when, to make it successful here?
4. Are there challenges to effective implementation you can foresee, that we can address proactively?
5. Who wants to sign up to give the intervention a go?
6. Who will be a champion?

Meeting 2

Part 1: Set up (5 minutes)

Coffee / lunch distribution

Part 2: Feedback from Cycle 1 (15 minutes)

1. Responses to survey about barriers to promoting DRR
2. Counts of waiting room forms and summary of patient responses
3. Contributions to the online discussion group
4. Direct feedback from Cycle 1 champion
5. Implementation facilitator observations

Part 3: Consensus discussion (15 minutes)

1. Do you want to continue using the intervention here for another month?
2. How do you feel about the "Umbrella" intervention now? Is it a good fit for you? Your patients?
3. Are there challenges to effective implementation you can foresee, that we can address proactively?
4. Who wants to give the intervention a go in this next cycle?

Part 4: Refresher on Umbrella project procedures for PCPs participating in Cycle 2 (5 minutes)

1.8 Champion role-play interview guide

Here is the waiting room survey for [a recent patient]. Imagine I am [him/her]. I came in with the survey in my hand. Show me what happened next.

Prompts (if needed):

1. Interpreting the patient survey
2. Assessing and documenting patient risk factors
3. Providing the DRR information card
4. Discussing DRR
5. Making a plan to address risk factors
6. Arranging a follow up appointment
7. Arranging an alternative time to address risk reduction

Additional questions/prompts to be used if not covered in the role-play interview
(Note: Questions are a guideline only and prompts may be used to elicit relevant information if needed.)

• Can you tell me about the usability of the intervention? Prompt: look; feel; functionality
• How do the components of the intervention fit into the workflow of the consultation? Of the practice?
• Is there additional information or training that you need, to deliver the intervention?
• Do we need to change anything, moving forward?

1.9 Online peer discussion

Please discuss your experiences in implementing the Umbrella Project.
How do you feel about the materials and procedures? What have you discovered? Do you have any questions? Can you offer any advice? Should anything be changed?
The materials and procedures under discussion can be accessed at the project website, https://blogs.unimelb.edu.au/umbrella-project/. In particular, check out the 10 Steps for GPs and GPNs (in the drop-down menu, top right).

1.10 Practice assessment tool

1. How many active patients aged 40-64 are registered at your practice? Include only those patients seen at least 3 times in the past 2 years
2. From January 2020 to April 2020, who will work for your practice? Please provide names and roles.
3. Who do you bulk bill?
    - Everybody
    - Nobody
    - Medicare card holders
    - Student card holders
    - Senior card holders
    - Health care card holders
    - OSHC (Overseas Student Health Cover) card holders
4. Which clinical audit tools do you have installed? (i.e., Canning, PenCAT, Practice Health Atlas, CDMnet, POLAR)?
5. What are recalls and reminders used for?
6. How do patients receive reminders or recalls?
7. How is the recall and reminder process managed?
8. Please describe any CHRONIC DISEASE MANAGEMENT AUDITS you have undertaken, or your practice has participated in, over the past six months
9. Please describe any QUALITY IMPROVEMENT PROJECTS you have undertaken, or your practice has participated in, over the past six months.
10. Please describe any OTHER RESEARCH PROJECTS in which you, your practice, or individual GPs/GPNs have participated in, over the past six months
11. How are changes in clinical policy managed in your practice? E.g., follow-up between meetings; who manages/maintains systems
12. Please describe your practice's data cleaning policy.
13. For how many active patients do you have a record of...
    - Smoking status
    - Weight classification
    - Alcohol consumption status
    - Blood pressure
    - Total and HDL cholesterol
    - Diabetes status
    - Blood glucose

1.11 Staff survey regarding implementation barriers

1. What is your primary role?
2. Do you work full-time or part-time?
3. Which days do you work, in a typical week?
4. How many years have you been in your primary role? Include years you have been in this role at other General Practices
5. Do you have a special interest or expertise in any of the following areas?
    - Dementia
    - Diabetes
    - Cardiovascular disease
    - Mental health
    - Health promotion and primary prevention
    - Quality improvement
    - Implementing new practices at work
6. With which gender do you identify?
7. How old are you?

The Umbrella Project is all about promoting DRR in primary care. To promote DRR in primary care…

1. Invite patients to discuss DRR with you
2. Identify middle-aged people with risk factors for dementia
3. Discuss DRR with patients who are at elevated risk
4. Manage risk factors for dementia
5. Signpost patients to local and online support services
6. Follow up DRR at subsequent visits

In the Umbrella Project, we focus on six healthy behaviours to reduce the risk of dementia:

1. Getting regular health checks
2. Being more physically active
3. Losing weight
4. Improving diet
5. Quitting smoking
6. Reducing drinking

These six behaviours are supported by new guidelines from the World Health Organization (WHO) and the NHMRC Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People.
Here are 19 factors that other GPs and General Practice Nurses have identified as positive influences on promoting DRR. Please indicate the extent to which you agree or disagree with each statement. 1=strongly disagree, 5=strongly agree.

1. There is enough evidence that reducing risk factors prevents or delays dementia.
2. There is enough evidence that promoting DRR with my patients is effective.
3. I know how to promote DRR with patients.
4. It is part of my role to discuss DRR with my adult patients.
5. I should be promoting DRR with more of my adult patients
6. I have been seriously thinking about promoting DRR with more of my adult patients.
7. I'm confident that I can help patients reduce their risk factors for dementia.
8. My patients and I have a strong bond, and we agree on health goals and tasks.
9. I focus on psychosocial risk factors for poor health (e.g., diet; exercise) just as much as biomedical risk factors (e.g. blood pressure; cholesterol).
10. As a practice, we have clear goals about promoting DRR.
11. GPs and nurses in our practice have enough time to promote DRR.
12. As a practice, we can tell how well we are promoting DRR.
13. The computer systems in our practice are set up to support us in promoting DRR.
14. We have high quality and productive communications systems in our practice. (For example, we have effective team meetings; GPs and nurses talk to each other; patient risk factors are noted properly.)
15. Our practice has adequate educational materials for patients about DRR.
16. There are adequate supports (online and/or in our community) for people who want to reduce their risk of dementia.
17. I have adequate access to education and training about DRR and how to promote it with patients.

18. The existing workflows and systems in our practice prioritise patient needs. (For example, we encourage non-acute appointments; we offer after-hours appointments; we follow-up frequently with patients attempting to make lifestyle changes.)
19. Our practice has effective strategies to attract and involve patients in discussions about DRR.

Now, here are 5 factors that other GPs and General Practice Nurses have identified as negative influences on promoting DRR. Please indicate the extent to which you agree or disagree with each statement.

1. It is enough to promote a generally healthy lifestyle. There is no need to mention dementia specifically.
2. There is not much point in promoting DRR with patients.
3. I'm burned out. (This can include feeling depleted of energy, feeling exhausted, increased mental distance from your job, feeling negative or cynical about your job, and/or reduced professional efficacy.)
4. In our practice, promoting DRR takes a backseat to other preventive activities (e.g., promoting cardiovascular health).
5. The Medicare billing system makes it difficult to promote DRR in our practice.

If you wish to expand on any of your responses, or describe other influences on promoting DRR, please do so here.

1.12 Patient interview

1. Is English your first language?
2. Are you of Aboriginal or Torres Strait Islander origin?
3. How much would you say you know about dementia?
4. What do you know about what increases someone's risk of getting dementia?
5. What do you know about how someone can reduce their risk of getting dementia?
6. How do you know this information? Did you find this out during your recent appointment at XXX practice or were you aware before?
7. How much do you agree or disagree with the following statement? "There is nothing anyone can do to reduce their risk of getting dementia."
8. How likely are you to adopt a healthier lifestyle specifically to reduce your risk of developing dementia, or does it make no difference?
9. Did you recall if your GP or nurse mentioned dementia at all during your appointment last week?
10. Can you tell me what was covered in the discussion about memory/dementia?
11. Which of the following things did the doctor or nurse say during your appointment last week?
12. What did you think about this information?
13. How useful was the discussion about dementia/DRR? What was most useful? Least useful?
14. Did you receive any written information about lowering your risk of dementia?
15. Have you looked at the information?
16. When did you look at the information?
17. What did you think about the written information?
18. Did the doctor or nurse point out other services you could access for support to lower your risk of dementia?
19. Which other services (did the doctor or nurse point out that you could access for support to lower your risk of dementia)?
20. What did you think about the doctor or nurse pointing out these other services?
21. What impact do you think the discussion about DRR will have on your behaviour?
22. Why do you think that is?
23. Were you satisfied with the answers to your questions about dementia?
24. How much do you agree or disagree with the following statement? "I felt uncomfortable when DRR was mentioned last week."
25. Can you tell me how the doctor/nurse approached the subject? (e.g., direct question about concerns? Knowledge of signs/symptoms? Linked to ways to reduce risk? Linked to cardiovascular disease risk factors?)
26. How did you feel about the way they approached it? Were you happy about the approach?
27. Sometimes when a doctor or nurse introduces the subject of DRR, people feel that it isn't relevant for someone their age. Did it feel that way for you? Does it still feel that way?
28. Do you think a waiting room form and discussion about dementia should be included as standard for all patients your age in general practice?
29. What would you change about the risk survey and discussion about dementia? What would you keep the same?

1.13 Practice manager interview

1. How did you feel about being involved in the Umbrella Project?
2. How did your staff feel about it? Your patients?
3. What went well? Why do you think that is?
4. What could have gone better? Why do you think that is?
5. We had some group meetings and an online discussion as part of the project. How did you feel about those?
6. Did different staff approach the project differently? If so, in what way?
7. How important was the project in your practice? What impact do you think it had?
8. We were targeting patients aged 40-64 in this project. Do you think that was the right age group? Why/why not?
9. If we did this project here again, this time next year, what should we do differently?

1.14 Facilitator field journal template

Site
Date of visit
Time arrived
Time departed
Names of staff on reception
Names of participating PCPs working today
Touched base with the practice manager? Y/N. If not, why not?

Patients:
Behaviours observed
Questions/comments
Facilitator response

Staff:
Behaviours observed
Questions/comments
Facilitator response

Appearance of public spaces
Study materials in view
Potential barriers/facilitators to implementation outcomes

2 Characteristics of included participants

2.1 Characteristics of participating general practice staff

Across the participating practices, 66 staff members were eligible to participate in the Umbrella intervention or implementation strategies (see Table 1).

Table 1: General practice staff across the five participating practices

	A	B	C	D	E	*Total*
GPs	4	3	3	4	12	26
GPNs	0	2	1	2	4	9
Practice Managers	1	0[†]	1	1	1	4
Reception staff	2	4	4	7	10	27
Total	7	9	9	14	27	66

[†]The practice was managed by one of the GPs
GP = general practitioner. GPN = general practice nurse

Sixteen of the 35 PCPs completed the survey about implementation barriers. Characteristics of these PCPs are summarised in Table 2.

Table 2: PCP characteristics

	Count	Percent
Sex		
Female	13	81
Male	3	19
Age		
<35	5	31
35-44	3	19
45-54	2	13
55-64	6	38
Hours worked		
Full-time	9	56
Part-time	7	44
Experience (years)		
<10	9	56
10-20	5	31
20-30	2	13
Areas of special interest[†]		
Dementia	7	44
Diabetes	7	44
Cardiovascular disease	7	44
Mental health	8	50
Health promotion and primary prevention	12	75
Quality improvement	8	50
Implementing new practices at work	3	19

[†]Total percent does not sum to 100 because PCPs could select more than special interest area

2.2 Characteristics of participating patients

Across the participating practices, 159 patients participated in the Umbrella intervention. Patient characteristics are summarised in Table 3.

Table 3: Patient characteristics

	All (n=159)		Interviewed (n=16)	
	Count	**Percent**	**Count**	**Percent**
Sex				
Female	67	42	8	50
Male	36	23	8	50
Missing	56	35	0	0
Age				
40-44	24	16	5	31
45-49	26	17	3	19
50-54	31	20	2	13
55-59	40	26	4	25
60-64	32	21	2	13
Risk areas (no or unsure)				
Health checks	11	7	1	6
Physical activity	50	31	2	13
Diet	54	34	5	31
Waist size	75	48	12	75
Smoking	9	6	0	0
Drinking alcohol	14	9	3	19
Number of risk areas				
0	40	25	2	13
1	52	33	8	50
2	41	26	3	19
3	25	16	3	19
4	1	1	0	0
Focus area[†]				
Health checks	37	24	0	0
Physical activity	72	46	10	63
Diet	41	26	4	25
Waist size	42	27	6	38
Smoking	4	3	0	0
Drinking alcohol	7	4	0	0
High importance (9-10/10)	96	63	6	38
High confidence (9-10/10)	43	29	5	31

[†]Total percent does not sum to 100 because 19% of all participants selected more than one focus area

A subset of 16 patients completed semi-structured interviews. Seven interviewed patients (44%) said they knew “not very much” about dementia. Twelve patients (75%) agreed that DRR was possible. Four patients (25%) said they were a little more likely to adopt a healthier lifestyle specifically to reduce their risk of developing dementia; 7 patients (44%) were much more likely to do so.

3 Penetration of the Umbrella intervention, by practice

This section presents the penetration of the Umbrella intervention by practice, for patients (Table 4), PCPs (Table 5) and reception staff (Table 6). The intervention reached an average of four eligible patients per day (159 patients over 38 intervention days). There were only four days on which an individual PCP reviewed more than five completed waiting room surveys. Qualitatively, some staff attributed low penetration to few patients aged between 40 and 64 years presenting to the practice. *"I think measured against how many patients were getting per session, it's very high. We're getting really good take up." (GP, Practice E)*.

Table 4: Penetration of the Umbrella intervention among patients

PRACTICE	A	B	C	D	E	TOTAL
Participating patients	17	30	6	64	42	**159**
Eligible patients	686	455	624	997	1801	**4563**
Percent	2	7	1	6	2	**3**

Table 5: Penetration of the Umbrella intervention among PCPs

PRACTICE	A	B	C	D	E	TOTAL
Participating PCPs	2	5	2	3	6	**18**
All PCPs	4	5	4	6	16	**35**
Percent	50	100	50	50	38	**51**

Table 6: Penetration of the Umbrella intervention among reception staff

PRACTICE	A	B	C	D	E	TOTAL
Participating staff†	2	3	2	4	1	**12**
All reception staff	2	4	4	7	10	**27**
Percent	100	75	50	57	10	**44**

†An unknown number of additional reception staff handed out waiting room surveys under the direction of their Practice Manager

4 Fidelity to the Umbrella intervention

4.1 Count of patient information cards removed

Only some PCPs requested replenishment of patient information cards during the study; we could only count the number of cards that had been removed from replenished kits. Table 7 shows the count of cards that were removed from six kits, 35 days (on average) after distribution. Table 7 also shows the number of cards that were expected to be removed from these kits during the same period, based on the number of waiting room surveys returned and the priority health areas that patients selected on these surveys. There was a tendency to remove more information cards than expected. Field notes and meeting transcripts suggested this may have been due to several factors, including: (1) PCPs providing patients with information cards on additional, non-priority health areas; (2) PCPs removing the information cards for other purposes (e.g. self-education, information for patients ineligible for the study); and (3) PCPs providing information cards to patients who did not return their waiting room surveys (e.g. patients opting out; reception staff misplacing completed forms).

Table 7: Count of patient information cards removed

	A (31 days, 1 PCP)			B (44 days, 2 PCPs)			D (37 days, 1 PCP)			E (29 days, 2 PCPs)			**Total**		
	Actual	Expected	%	Actual	Expected	%	Actual	Expected	%	Actual	Expected	%	Actual	Expected	%
Dementia	8	9	89	22	27	81	60	59	102	27	35	77	117	130	90
1. Health check	3	2	150	0	6	0	12	17	71	5	4	125	20	29	69
2. Physical activity	7	5	140	19	10	190	18	30	60	15	14	107	59	59	100
3. Diet	11	3	367	24	9	267	14	13	108	13	8	163	62	33	188
4. Waist size	5	3	167	14	7	200	5	10	50	18	14	129	42	34	124
5. Smoking	2	0	-	1	1	100	3	1	300	2	1	200	8	3	267
6. Alcohol	2	0	-	2	0	-	4	1	400	8	2	400	16	3	533
Change plan	0			19			4			25			48		
Social and mental activity	0			1			10			5			16		
Normal aging vs dementia	0			2			17			3			22		

4.2 Champion role-play interviews

Table 8: Components of the Umbrella intervention spontaneously demonstrated by champions during the role-play interview, by practice

	A	B	C	D	E
Ask about the patient's waiting room form					
Quantify "yes" responses *E.g., "You've said you're physically active most days. That's great! What kind of activity do you do?"*	X	X	X		
Clarify "not sure" responses *E.g., "You're not sure whether you've had your blood sugar checked recently. Let me check our records."*		X			
Follow-up "no" responses *E.g., "You're drinking at least 10 alcoholic drinks a week. What do you drink on a typical day?"*			X		
Ask about importance and confidence					
Ask open questions to elicit patients' priorities and motivation to change	X				
2. Decide whether to discuss DRR today					
Explain what you want to do *E.g., "I want to support you to improve your health and reduce your risk of things like heart disease and dementia"*	X	X			
Option 1 (enough time): Ask the patient when they would like to discuss DRR *E.g., "We can talk about this now, if you like, or we can make another appointment, where we can focus on [health priority]. Which would you prefer?"* **or** Option 2 (not enough time): Ask the patient to make another appointment to discuss DRR *E.g., "Unfortunately, we don't have enough time now to talk about this properly. Would you like to make another appointment, where we can focus on [health priority]?"*			X		X
3. Elicit patient's understanding about the relationship between healthy behaviours and dementia risk			X		
4. Seek permission to provide information about reducing dementia risk	X				
5. Provide information about healthy behaviours and dementia risk					
Show the Umbrella Card					
Explain the umbrella analogy					
6. Give the patient the dementia risk card, and discuss					
Give the patient the dementia risk card	X	X		X	X
Convey that dementia is not a normal part of ageing				X	
Convey that adopting a healthy lifestyle can reduce risk of dementia					
Convey that one-third of cases of dementia might be avoided through adopting healthier lifestyles					
Convey that "what's good for the heart is good for the brain"					
7. Give the patient the relevant health behaviour card, and discuss					
Give the patient the relevant health behaviour card	X	X			X
Convey how the behaviour relates to reduced risk of disease	X	X	X		
Advise about behaviour that is concordant with current guidelines	X				
Convey how the clinical care team can help					

Signpost to services to access for further information and support	X				
8. Elicit patient response to the information and advice				X	
9. Give the patient the change plan card, and discuss					
Give the patient the change plan card		X			X
Support the patient to write something under each heading					
10. Arrange a follow-up appointment	X	X			

4.3 Patient recall of a discussion about dementia

Table 9: Remembered phrases

Remembered phrases	***Count***	***Percent***
Dementia is not a normal part of ageing	3	19
Adopting a healthy lifestyle can reduce risk of dementia	9	56
One-third of cases of dementia might be avoided through adopting healthier lifestyles	2	13
What's good for the heart is good for the brain	2	13
You can reduce your risk of dementia by…		
quitting smoking	5	31
getting regular health checks	6	38
losing weight	8	50
being more physically active	8	50
improving your diet	8	50
reducing your drinking.	5	31
mentally challenging your brain	0	0
enjoying social activity	4	25

5 Penetration of the implementation strategies

Table 10: Penetration of the implementation strategies among PCPs

PRACTICE	A	B	C	D	E	TOTAL
Participating PCPs	2	4	2	4	5	**17**
Eligible PCPs	4	5	4	6	16	**35**
Percent	50	80	50	67	31	**49**

6 Fidelity to the implementation strategies

Table 11: Engagement in educational meetings and contributions to the online peer discussion

Practice	Type	Meeting 1	Meeting 2	Online discussion group (posts)
-	Implementation facilitator	●	●	● (19)
A	Champion GP	●	●	● (8)
A	GP	●	●	
A	PM	●	●	
B	Champion GP	●		● (2)
B	GP	●	●	● (2)
B	GP registrar		●	
B	GPN	●	●	● (2)
C	Champion GP	●	●	● (8)
C	Nurse	●	●	
C	PM	●		
D	Champion GP	●		
D	GP	●		
D	Nurse	●		
D	Nurse	●	●	
D	PM	●	●	
F	Champion GP	●	●	● (5)
F	GP	●	●	
F	GP	●	●	
F	Nurse	●	●	
F	Nurse	●	●	
F	PM	●	●	

Pink = missed. Grey = not applicable to practice managers. GP = general practitioner. GPN = general practice nurse. PM = practice manager

7 Results of the staff survey regarding implementation barriers (n=17)

	Rating (1= strongly disagree, 5 = strongly agree)				
	1	**2**	**3**	**4**	**5**
1. There is enough evidence that reducing risk factors prevents or delays dementia.	0%	0%	29%	35%	35%
2. There is enough evidence that promoting dementia risk reduction with my patients is effective.	0%	6%	35%	47%	12%
3. I know how to promote dementia risk reduction with patients.	0%	41%	41%	18%	0%
4. It is part of my role to discuss dementia risk reduction with my adult patients.	0%	0%	12%	59%	29%
5. I should be promoting dementia risk reduction with more of my adult patients	0%	12%	12%	29%	47%
6. I have been seriously thinking about promoting dementia risk reduction with more of my adult patients.	0%	24%	29%	41%	6%
7. I'm confident that I can help patients reduce their risk factors for dementia.	0%	24%	24%	41%	12%
8. My patients and I have a strong bond, and we agree on health goals and tasks.	0%	6%	18%	65%	12%
9. I focus on psychosocial risk factors for poor health (e.g. diet; exercise) just as much as biomedical risk factors (e.g. blood pressure; cholesterol).	0%	6%	12%	35%	47%
10. As a practice, we have clear goals about promoting dementia risk reduction.	0%	24%	47%	12%	18%
11. GPs and nurses in our practice have enough time to promote dementia risk reduction.	12%	12%	41%	29%	6%
12. As a practice, we can tell how well we are promoting dementia risk reduction.	6%	35%	47%	12%	0%
13. The computer systems in our practice are set up to support us in promoting dementia risk reduction.	6%	25%	50%	19%	0%
14. We have high quality and productive communications systems in our practice.	0%	0%	35%	6%	59%
15. Our practice has adequate educational materials for patients about dementia risk reduction.	0%	41%	41%	18%	0%
16. There are adequate supports (online and/or in our community) for people who want to reduce their risk of dementia.	0%	12%	76%	6%	6%
17. I have adequate access to education and training about dementia risk reduction and how to promote it with patients.	0%	24%	59%	12%	6%
18. The existing workflows and systems in our practice prioritise patient needs.	0%	0%	6%	47%	47%
19. Our practice has effective strategies to attract and involve patients in discussions about dementia risk reduction.	6%	24%	35%	24%	12%
20. It is enough to promote a generally healthy lifestyle. There is no need to mention dementia specifically.	35%	41%	12%	6%	6%
21. There is not much point in promoting dementia risk reduction with patients.	65%	18%	0%	12%	6%
22. I'm burned out	53%	12%	35%	0%	0%
23. In our practice, promoting dementia risk reduction takes a backseat to other preventive activities (e.g. promoting cardiovascular health).	24%	24%	18%	29%	6%
24. The Medicare billing system makes it difficult to promote dementia risk reduction in our practice.	6%	12%	24%	18%	41%

8 Acceptability of the Umbrella intervention

Component	*Rating*	*Supporting data*
Overall	Reasonable	"Better and easier than I thought it would be" (GP, Practice A) "It didn't have any negatives" (PM, Practice E)
Job satisfaction	Good	"This is valuable stuff they're delivering. So, from a job satisfaction point of view, it's also good." (PM, Practice E)
Waiting room survey		
Non-confronting	Good	"Nice easy questions. I don't think they were anything too personal or anything like that. I mean, you guys have kept it nice and light, and if you want to go further then we could have this conversation." (Patient, Practice C) "You couldn't be offended because everybody has the same offer. It wasn't as if they looked at you and thought, 'Oh, you look a bit odd, we'll target you'." (Patient, Practice E)
Optional	Good	"This is patient-driven. So, they're only going to come in with the form if they want you to do something." (PM, Practice E) "[The receptionist] gave me an option whether I wanted to or not. Which is really good." (Patient, Practice C)
Physical resource	Good	"This [survey] is good because it means you invest in something. You've got a piece of paper. Which is good." (GP, Practice E) *In one practice (C), patients brought the survey into the appointment still attached to the distinctive pastel-blue intervention clipboard, which was an extra visual cue to the PCP to ask about the survey.*
Brief	Reasonable	"It's pretty brief, which is kind of what you want to get an idea whether you need to actually go further with it, so I think it was fine… You don't want it to be too in-depth anyway, otherwise people would just get bored and be like, 'No, I don't want to do it.'" (Patient, Practice C)
Priming poster	Not included initially; then good	"This poster you've done is perfect. It's simple, eye-catching, and gets the point across without being too overwhelming. Love it." (GP, Practice C).
Patient information cards		
Content	Good	"They're really curious. They like to know exact figures, like how much salt" (GP, Practice A) "I love the literature, that little box." (GP, Practice E)
Physical resource	Reasonable	"The kit is good. Self-explanatory" (GP, Practice A) "We thought they were fabulous., Really well thought out, really easy, you know, user-friendly. Just engaging little cards that you could stick in your handbag. Yeah, thought they were fantastic." (PM, Practice E) "[If we printed it out as needed] it wouldn't be coloured, and it will be just another piece of paper we give to the patients… No, I love the idea of the box". (PM/GP, Practice B)
Education and advice		
Comfortable	Good	"It was picked up by patients as a real issue and concern for them and something they wanted to do something about… That was so refreshing. This has been a refreshing project, where people were really keen to do something about their health." (PM, Practice E)

		"People were willing to be involved in it. It was interesting. It wasn't one of those subjects like, oh, high cholesterol. Everybody knows about that, you know? It is an interesting subject." (PM, Practice A) "They're really keen to know" (GP, Practice D)
Focus on risk reduction for dementia	Good	"I was a little bit surprised that the medicos and all that fraternity are looking at trying to curb [dementia] in society now. It gets the alarm bells ringing, even harder, and then you may actually think, "Oh!". So, it motivates you more." (Patient, Practice B) "As much as we think we know something and have read it, it's being professionally reminded and the focus brought back onto it" (Patient, Practice E)
Integration with risk reduction for noncommunicable diseases more generally	Good	"It's very good, because it does not only cover the dementia. I can still talk about their cardiovascular risk, which we always do, and then I add this". (PM/GP, Practice B) "[It was useful] that it's all linked to general health rather than being specific. Not targeting [dementia] specifically but if you target the whole health, lose weight, more activity, it all feeds into it. That it's a bonus to a general healthy lifestyle. Rather than trying to worry about one particular thing". (Patient, Practice A)
Thoroughness	Good	"They like a doctor paying attention to everything, even if it's just they're coming in with a virus and you ask about cholesterol, ask about all that. They tend to like that you're a bit pedantic." (GP, Practice A)
Motivational interviewing and change planning using the Change Plan template		
Change Plan template	Mixed	"We went through the black "change plan" card… The questions there were brief and simple to fill out. This format is similar to motivational interviewing and takes elements of "SMART plan" goal setting. I particularly liked the way it allowed us to follow up over a time period of our choosing" (GP, Practice C). "To be honest, no, I haven't been using it… I feel like it may be a bit overkill… I think some patients would be OK with it, but it sounds very like a test-taking thing." (GP, Practice A).
Change discussion	Reasonable	"Some patients, they were very impressed with the cards that they were getting, with the plan to come back and talk to me." (PM/GP, Practice B) "It was made fairly simple. The discussion, it wasn't complex. The processes and the steps are simple, and it's just about beginning and engaging rather than just sitting back and waiting…. So, it's pretty easy to just make a change". (Patient, Practice A) "It's something that I often think about, but don't do much about. I think having that ownership and that checking in on what you said you were going to do or what you said was important, it sort of keeps me in check a little bit." (Patient, Practice E)

GP = general practitioner. GPN = general practice nurse. PM = practice manager.

9 Appropriateness of the Umbrella intervention

Characteristic	*Supporting evidence*
Patients	
Good health literacy	I think I'm very lucky in this clinic. It's people that are very health literate and very interested in their health. So, it's a bit easier (GP, Practice A)
English-speaking background	"There are some patients who are not from an English-speaking background. They might not understand." (GP, Practice D)
At elevated risk	"With regard to the health and physical activities I think I'm on the right track at the moment." (Patient, Practice D)
Already interested in changing lifestyle behaviours	I actually went in there to talk about exercise and weight loss and the physio that I was going to go to… Well, that wasn't the entire reason I was there, but it came up because of that pre survey at the front desk. (Patient, Practice E) "A lot of the patients kind of don't want to… like, aren't even in the contemplation phase" (GP, Practice A)
Not yet making lifestyle changes	"I already know I need to lose weight. I'm doing it anyway" (Patient, Practice E)
Unaware of DRR	I had one who wasn't interested. "Yeah, I know it". She's a biology teacher. (GP, Practice E)
Unaware of available support	You don't realize that going to the Medical Center and stuff like that, you can have access to dietitians. (Patient, Practice C)
Receptive to information	(It) depends on their personality and reception of these things. Especially prevention, preventive health. Some people are not very receptive. If you give (too much) information that will scare them off. (GP, Practice D) "No, there was so much on my list to get through and I had a little boy there at the same time." (Patient, Practice E)
Known to the PCP	Patients you already know are more receptive to health promotion (GP, Practice C) It's got to be your patients, really. (GP, Practice E)
Not ill	"If someone is really feeling really sick, probably they don't want to hear about the additional form" (Patient, Practice D) "I was healthy, I just needed a prescription, and it was kind of surrounding health and it was just hand in hand with that. Kind of naturally led into the conversation of what you guys are working on." (Patient, Practice C)
Few acute concerns	"Every patient I've had so far have only wanted to focus on their particular medical issue, instead of chatting about Umbrella Project" (GP, Practice C) I had so many things on my list to do so I was like tick tick tick and then yeah. So, we didn't really talk too much about dementia. (Patient, Practice E)
Willing and able to complete the waiting room survey accurately	Most of the time I don't see that they're telling the exact truth or maybe they are misinterpreting. Or they just don't want to face it… They're not accurate (GP, Practice D) "I know her well and I'm dealing with her alcoholism, but … she actually ticked no in the alcohol section." (GP, Practice A)
Not pregnant†	I found it hard talking (about DRR) to a 40yr old pregnant patient as diet and exercise would be different (GPN, Practice B)
Sufficient resources to pay for PCP time	"We're in a demographic where people are pretty happy to pay and see value in it, so in many respects probably it would have been easier for us than many practices." (PM, Practice E)
Sufficient resources to make changes	"Some of my housing patients, they can't afford to even buy fruits or vegetables so talking to them about eating two to three serves? They're not interested." (GP, Practice A)
Reception staff	

Full-time	(Receptionist 1) comes in in the afternoons. His primary role isn't as a receptionist, so he's doing us all a favour… So, we're not asking too much of him… And I don't think he'd be interested in doing it. (GP, Practice A) The casual girls, they're still a bit slack (GP, Practice D)
Patient-focussed	(Receptionist 2) probably didn't do it either. She's more very focused on herself, I guess. (PM, Practice A)
General practice staff	
Full-time	"(GP) is a good one, but the only problem is, she just started back after the baby. Only here two days… I really want to grab (GP), but I don't know how possible it is, because she's just started back." (PM, Practice D)
Not new	"We'll give him [GP registrar] the first month to settle in" "Yeah, he's still needing to learn. So maybe not the first month." (GPs, Practice B)
Practice owner	"(The champion) was really interested as an owner of the practice, was really keen to see where this could develop across the practice. (GP2) as an employed doctor was really just following directions." (PM, Practice E)
Longer appointments	"We have longer appointment times, so we normally do get through some of this [risk reduction], every time, anyway." (GP, Practice D)

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† The implementation facilitator responded to the post about pregnancy in the online discussion group as follows: "I hadn't anticipated much of an overlap between our target age group (40-64) and pregnancy (in 2017, there were just 15.4 births per 1000 women aged 40-44; https://aifs.gov.au/facts-and-figures/births-in-australia). I think that, while there is probably no harm in a pregnant woman completing the waiting room form, it might be more appropriate to frame the following conversation in terms of a healthy pregnancy, and defer the dementia risk reduction until after the birth and recovery."

10 Feasibility of the Umbrella intervention

Characteristic	*Supporting evidence*
Characteristics that increased feasibility	
Easy	"Easy. So, that's not a problem". (GP, Practice B) "I think you've made it as simple as you could." (GP, Practice C)
Quick	"I read [the waiting room survey], and then discuss for maybe, roughly, I can say 5-10 minutes. Because she is a very busy doctor, but still she spares the time to discuss that one." [Patient, Practice D]. "I'm probably spending less than 5 minutes on it" (GP, Practice E). "I personally found the dementia risk reduction talk span roughly 5-7 minutes as well" (GP, Practice C)
Restricted target age bracket	"So, it's not necessarily too many patients really. So, it won't take too long."
Behaviours able to be performed over two appointments	"I found discussing the [change] plan on a different day is a good idea" (GP, Practice B). "[Is it possible] for the doctor to bring back that patient for another appointment? That'd be good as well. Probably one of the better ways of working." (PM, Practice C) *Reasons given for this included: (1) limited time in the initial appointment, (2) the need to obtain pathology results, (3) the ability to claim a second appointment against an appropriate Medicare item, and (4) only investing additional resources in patients motivated enough to return.*
Able to be integrated with a Heart Health Check	*Staff in one practice (E) integrated the Umbrella intervention with a Heart Health Check (Medicare item 699), inviting eligible patients to return for a follow-up preventative assessment and treatment planning with the GPN for a $20 out-of-pocket cost. The implementation facilitator provided a software template[357] to assist staff with this approach.*
Characteristics that decreased feasibility	
Distribution of the waiting room survey by reception staff	"Reception can get busy super quickly" (GP, Practice C) "Anything additional at that front desk is a bit of a struggle" (PM, Practice E) *To increase feasibility, PCPs or reception staff in some practices printed a list of booked patients each day and highlighted the patients who should receive the waiting room survey.*
Intervention only used sporadically	"Still not much of a flow yet. I think it's because we haven't done enough so it's still a second thought… It's been straightforward, but in terms of it becoming part of our system? Not yet."
Time needed to become familiar with the resources	"I told [the GPN] you need to spend time to read the cards… She won't be able to say anything if she doesn't know what is written inside the cards, so that's what took me a while" (GP, Practice B)
No Medicare rebate for nurses' time	"This is very economic, but we do have to pay for our nurses." "If we're going to involve the nurses, we have to work out an item number." (PM/GP, Practice E) *Half of PCPs (56%) felt the Medicare billing system made it difficult to promote DRR in their practice*
No Medicare benefits for allied health services	"Care plans are easier [than preventive care], because we can actually offer people services and refer them to services" (GPN, Practice E)
Non-integration with practice software	"We should probably set up a shortcut, too, so we could tick off the things as we do them" (PM, Practice E)

GP = general practitioner. GPN = general practice nurse. PM = practice manager.

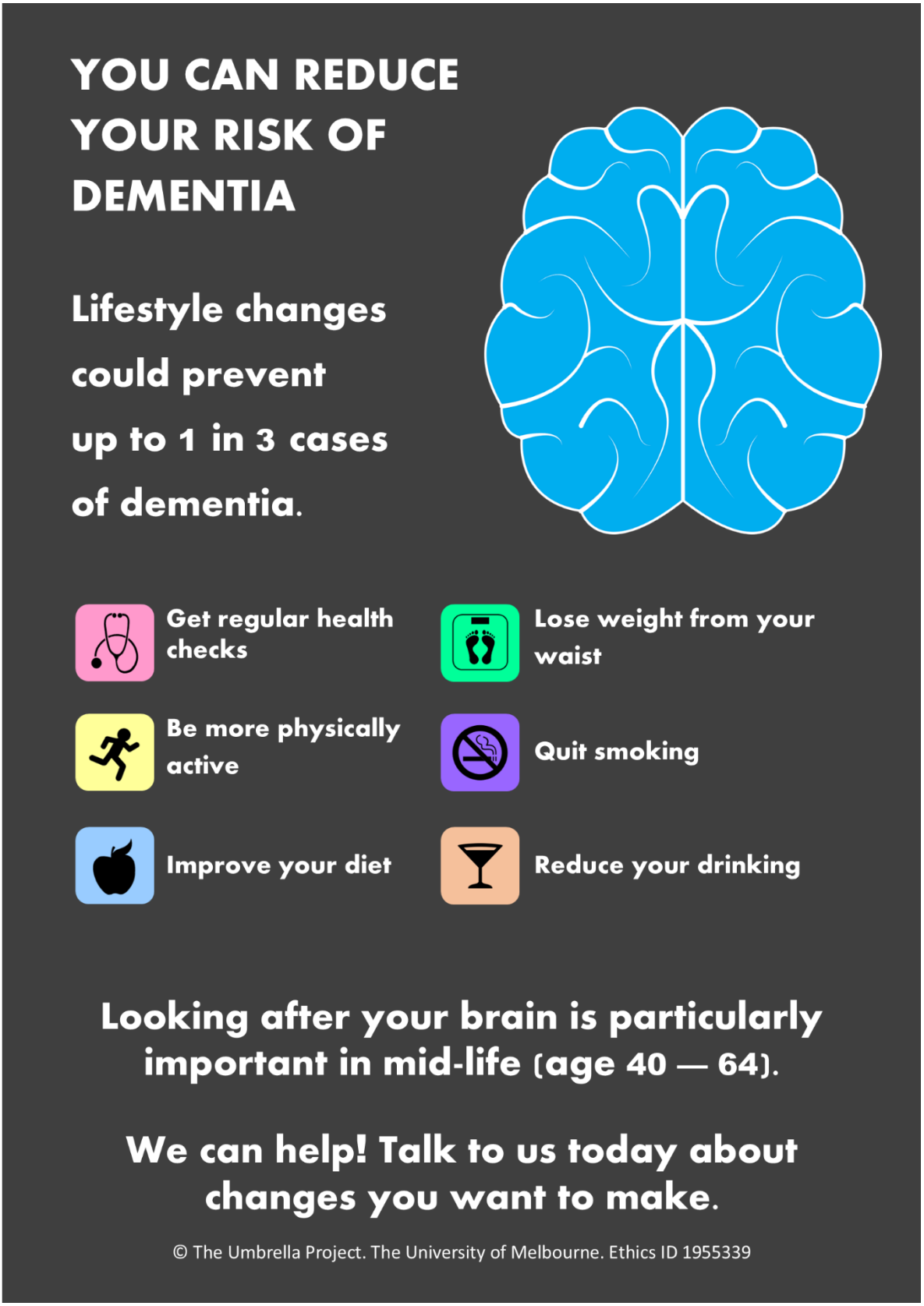
11 Acceptability of the implementation strategies

Component	*Rating and summary*	*Supporting data*
Incremental approach		
Two implementation cycles	Good.	"It was a lot to take in at that first stage. You know, what item numbers are we using, how are we going to… how's the flow going to work?" (PM, Practice A)
Subset of patients at first	Good	"So maybe for me, maybe just one a session." "I think one a session, see what [happens]" (GP/PM, Practice E)
Educational strategies		
Overall	Good	"We just found it easy to manage, you know. The resources you provided, and the backup of how to manage those resources, was so well delivered and well-researched that we really… it was all taken away from us, all the headache." (PM, Practice E)
Information cards	Good	"I think everything I need is here". [GP, Practice A) "You had it all covered. We just needed to absorb it all." (PM, Practice E)
Website	Reasonable	"When you're in a rush, and you're looking around for information, the website was good for that. But I didn't really look into it more than that." (PM, Practice A).
Lego model	Good	"Oh, that's so cool" (GP, Practice B) "I'm a visual person. So, Homer comes in…" (GPN, Practice C)
Outreach visits	Reasonable	"I think those meetings were necessary and very worthwhile." (PM, Practice E) "It's always good to meet together and if someone was a little bit, you know, lazy in doing things, he sees the rest are encouraged to do it" (PM/Champion, Practice B)
Relational strategies		
Champions	Good.	"I think having a champion is really important in this situation, especially in these larger practices" (PM, Practice E)
Peer discussion group	Poor	"No one was else was talking" (PCP, Practice A) "The other day I went and I wrote something and then I saw only one other comment and that's it… I didn't find this very helpful" (GP, Practice B)
Site visits from the implementation facilitator	Good.	*Site visits reminded reception staff and PCPs to focus on the project, and patients in the waiting room were interested in talking to the facilitator about the intervention.*

GP = general practitioner. GPN = general practice nurse. PM = practice manager.

12 Modifications intended to improve outcomes

12.1 Poster



12.2 Educational materials for reception staff

5 Steps for Reception Staff
Thank-you for being part of the Umbrella Project! Please read and sign the information and consent form for reception staff. Return the signed consent form to your Practice Manager or <<facilitator>> from the Umbrella Project Team.

Display the reception notice on days that participating GPs and nurses are working at your practice
Write the names of the participating GPs and nurses on the notice.

2. Give the waiting room form to 40-64 year old patients of participating GPs and nurses
You might like to check the appointment schedule for participating GPs and nurses at the beginning of the day and earmark forms for eligible patients. Do not include any identifying information on the form itself; the forms are meant to be anonymous.
Use the turquoise clipboards provided by the Umbrella Project team.
Waiting room forms are numbered in order at the bottom of the form (e.g., X1-A1, X1-A2, X1-A3). Be sure to hand out the forms in order.

3. After the patient's appointment, collect and date the waiting room form
Check that the patient has completed all the questions, including age and sex at the top of the form.
Write the date at the bottom of the form.
Add the form to the patient's electronic medical record as appropriate.

4. Check the back of the form to see whether the patient has opted out of sharing the form with the researchers
Keep a tally of patients who have opted out. There is an opt-out tally on the envelope containing the waiting room forms.
If the patient has opted out of sharing their form with the researchers, dispose of the form.

5. Store the completed forms securely until collection
<<Facilitator>> will visit weekly or fortnightly to collect the completed forms. The visit schedule for your practice can be viewed at the bottom of the Project Paperwork page.

If you have any questions or concerns about these steps, please speak to your Practice Manager or contact the Umbrella Project Team.