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Supporting Information

Supplementary methods and results

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Webster R, Usherwood T, Joshi R, et al. The prevalence and impact of unprofessional behaviour among hospital workers: a survey in seven Australian hospitals. *Med J Aust* 2021; doi: 10.5694/mja2.51030.

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1. Pilot testing of the intervention

Prior to the main trial, the proposed intervention was tested in a pilot phase (about 6 months) to determine any improvements required.

Four general practices were recruited from sites previously involved in the Torpedo study.[1] One practice subsequently withdrew because of factors unrelated to the intervention. Three practices were paired with three partner pharmacies for the pilot trial in July and August 2016.

All general practitioners were trained in use of the required software, including Topbar, HealthTracker and the Argus secure messaging software, as well as in how to refer a patient for the Pharmacy Adherence Support Service. Pharmacists were trained in the use of the PASS tool. Polypills were not provided during the pilot phase because of the limited time available for starting and ceasing medications.

After 6 months of trialling the system, we undertook qualitative interviews with GPs and pharmacists about their experience of the system.

Several problems were identified, most technology-related:

1. General practice:
    a. Technology components not fully set up prior to training, which affected training;
    b. Older version of HealthTracker installed (without polypill tab);
    c. Study technology use affected by practice technology problems unrelated to study components;
    d. HealthTracker did not always appear for eligible patients;
    e. Fidelity data not initially captured in data extracts;
    f. Practice forgetting to start Topbar at beginning of the day (not set up for automatic start-up).
2. Pharmacy:
    a. Initial tablet set-up difficulties with security key and Windows updates problems;
    b. Some doctors not listed on Argus, so that linking the PASS program to the doctor for sending letters was not possible;
    c. Bugs in the PASS program prevented progress to end of the program;
    d. Fidelity data could not initially be viewed.

Positive feedback was received from GPs in relation to the clinical usefulness of HealthTracker, mainly with respect to using it for patient communication. GPs recommended additional information that could be provided to patients, including posters for the waiting room and pamphlets about the PASS program. GPs also said that novel interventions required time for sustained uptake.

For pharmacists, in-person training with case studies was valued, but workflow was not clear in the app. Overall, pharmacists said that it could be a useful tool, but did not fully encompass all aspects of a full medication review (an alternative program subsidised by Medicare). Pharmacists predicted challenges that would affect delivery of the intervention, including time pressures in busy pharmacies, lack of private areas for consultations, and lack of patient follow-up because scheduling follow-up appointments is difficult (outside the usual workflow of community pharmacists).

Actions following the pilot phase:

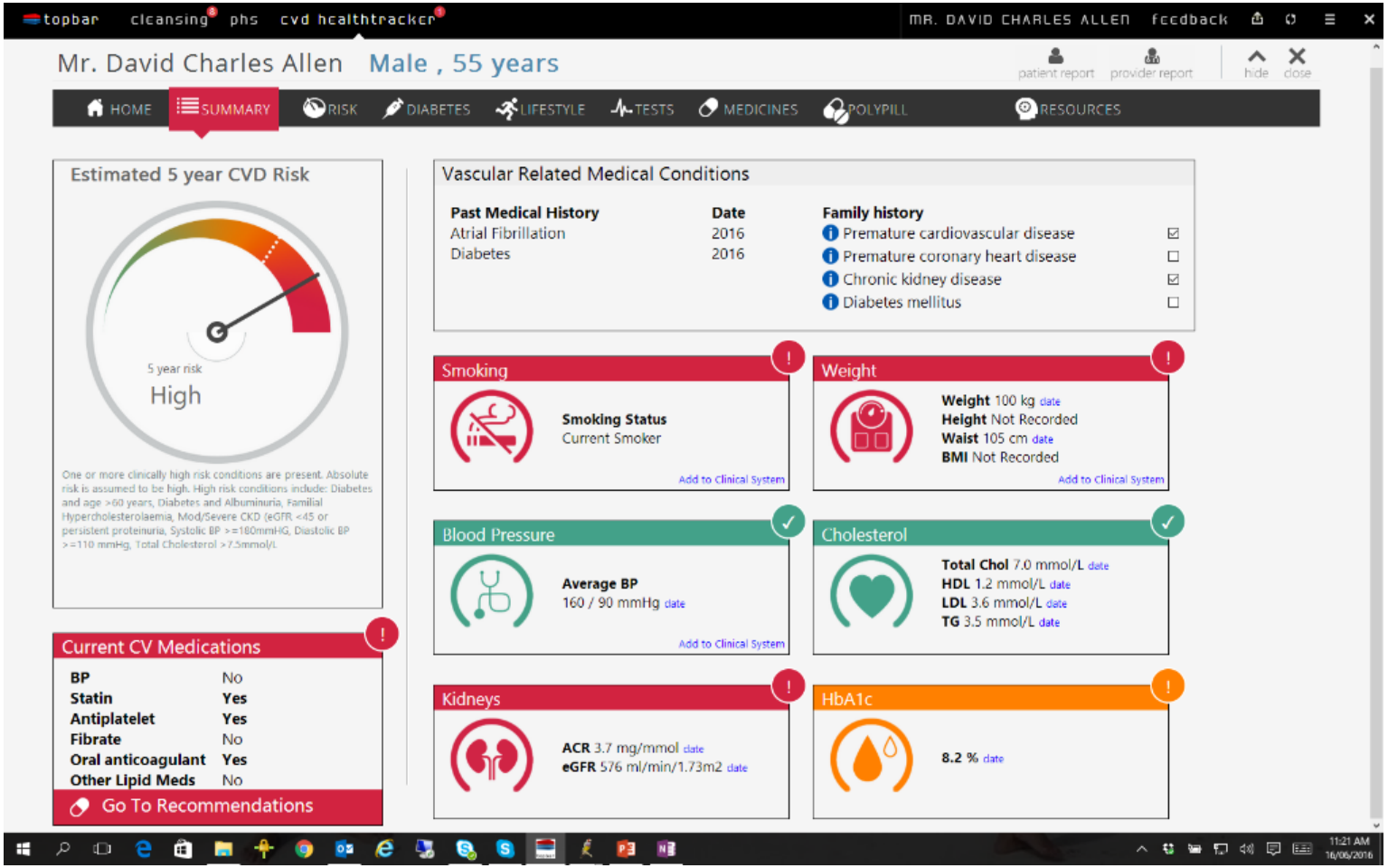
Following the pilot phase, the technology aspects were amended as follows:

- PASS program upgraded to improve the workflow and interface;
- Pen Computing systems consulted regarding solutions for Topbar (and therefore HealthTracker) that facilitate automatic start-up when a practice opened their electronic medical record system;
- Improved checklists for technology set-up to ensure systems were installed and working prior to study staff training;
- Argus consulted to overcome problem of unregistered GPs, including pro-actively ensuring they were registered prior to technology set-up.

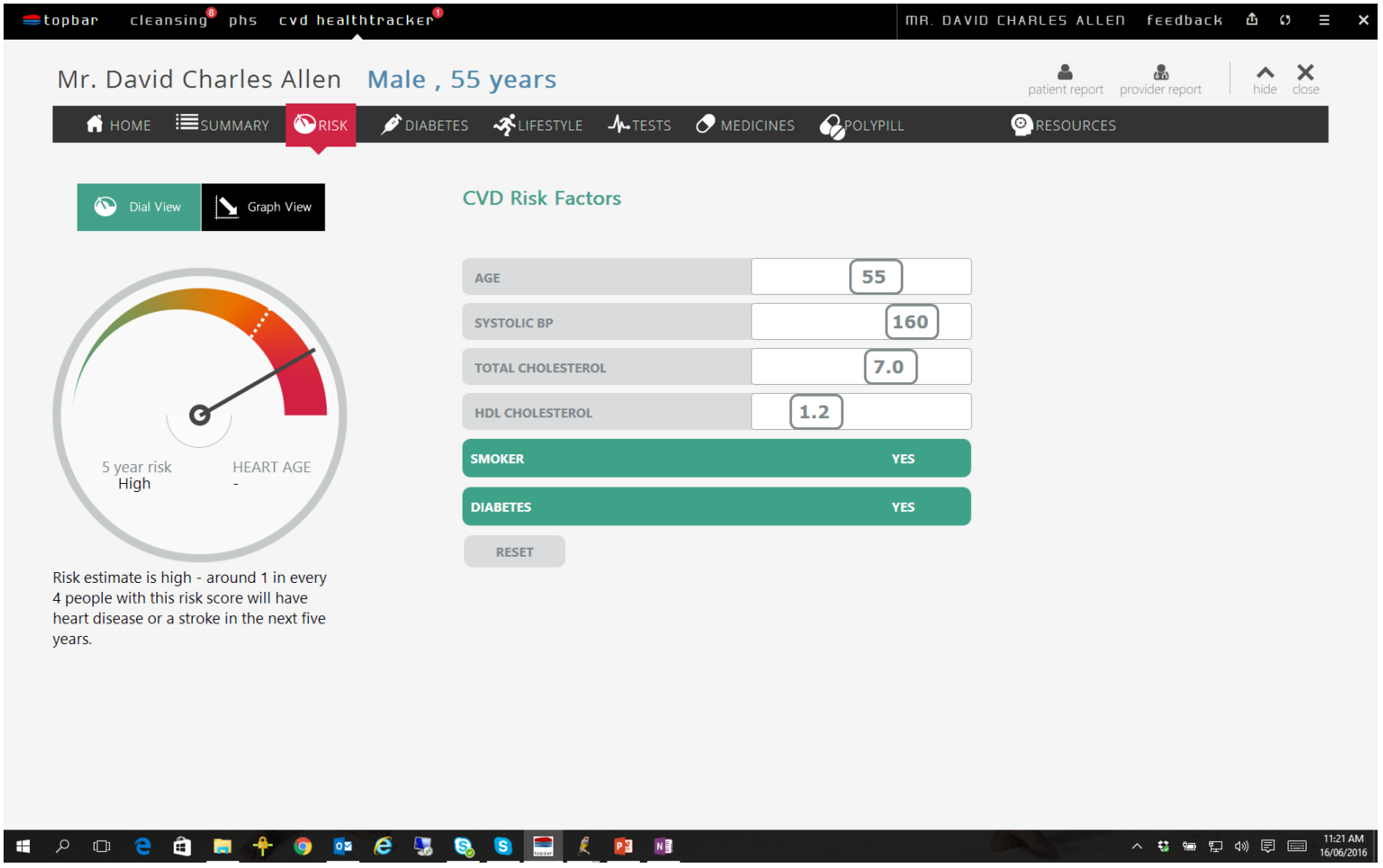
Training materials were also modified, and additional informational materials for patients developed.

Figure 1. Screenshots of the HealthTracker electronic decision support tool (fictitious patients)

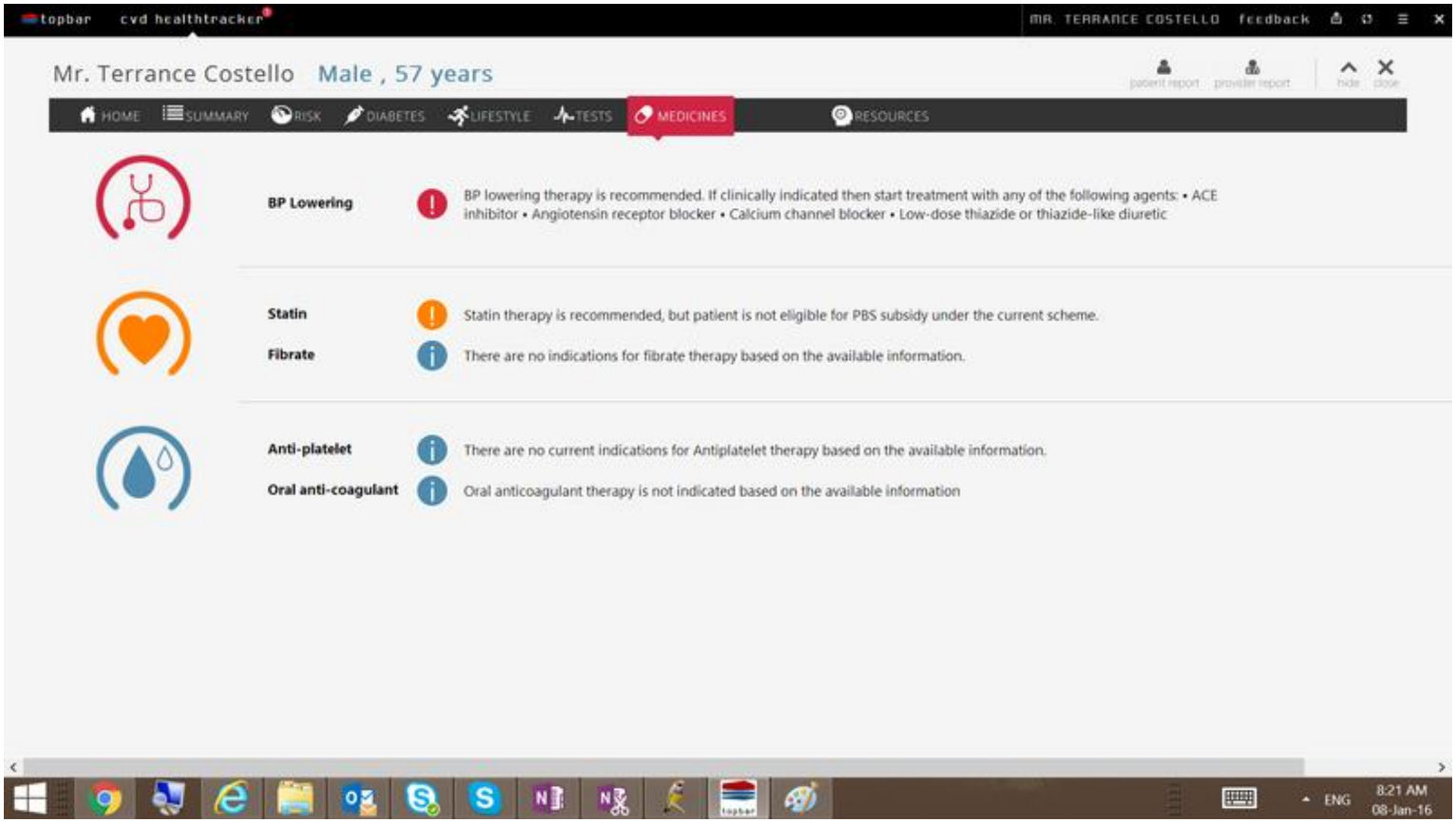
A. Risk factor summary and absolute risk calculation



B. Risk communication tool



C. Tailored medication recommendations



D. Tailored recommendations about eligibility for polypills

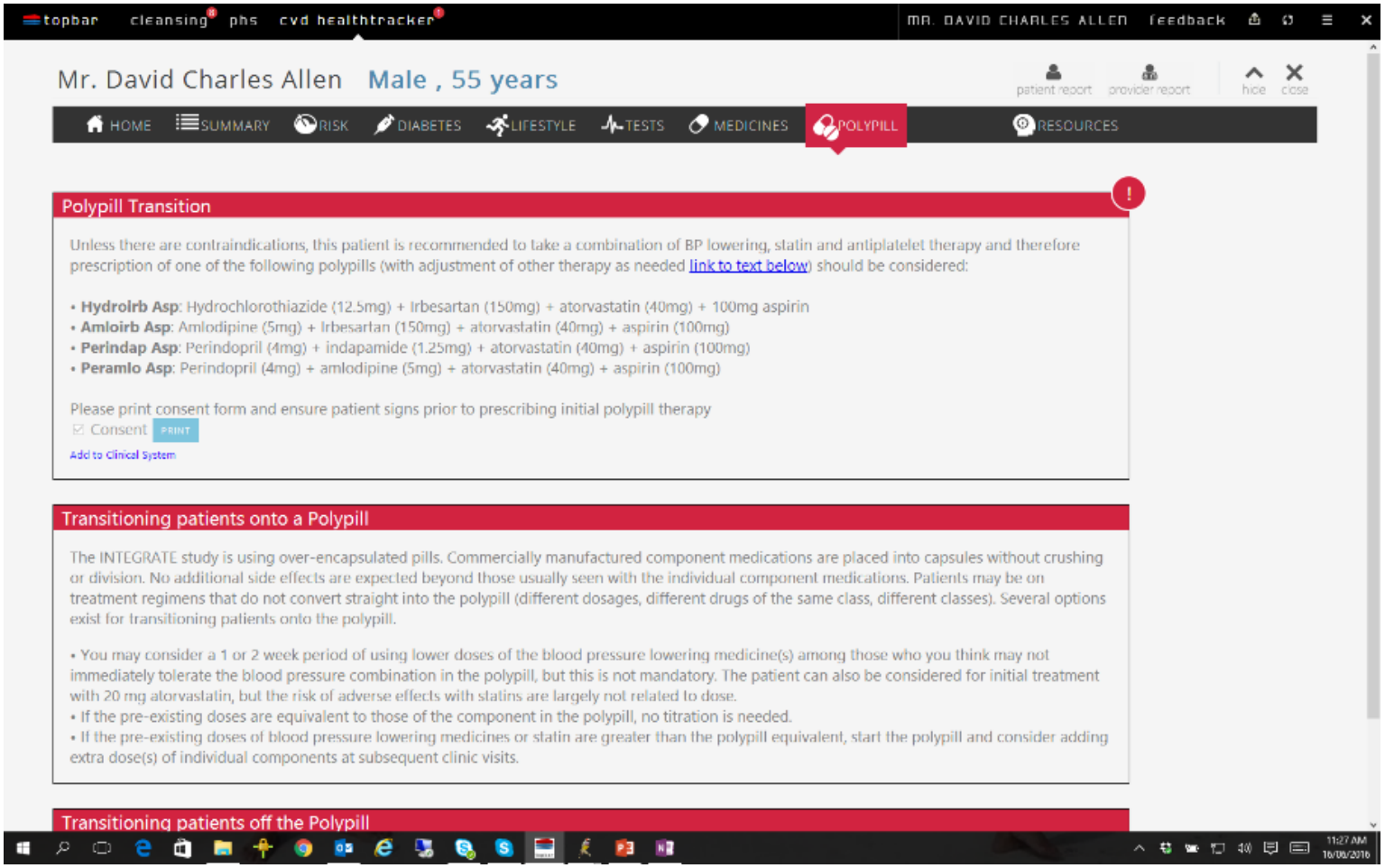


Figure 2. Population health audit tool with re-identification facility for reminder systems

Note: Patient is fictitious.

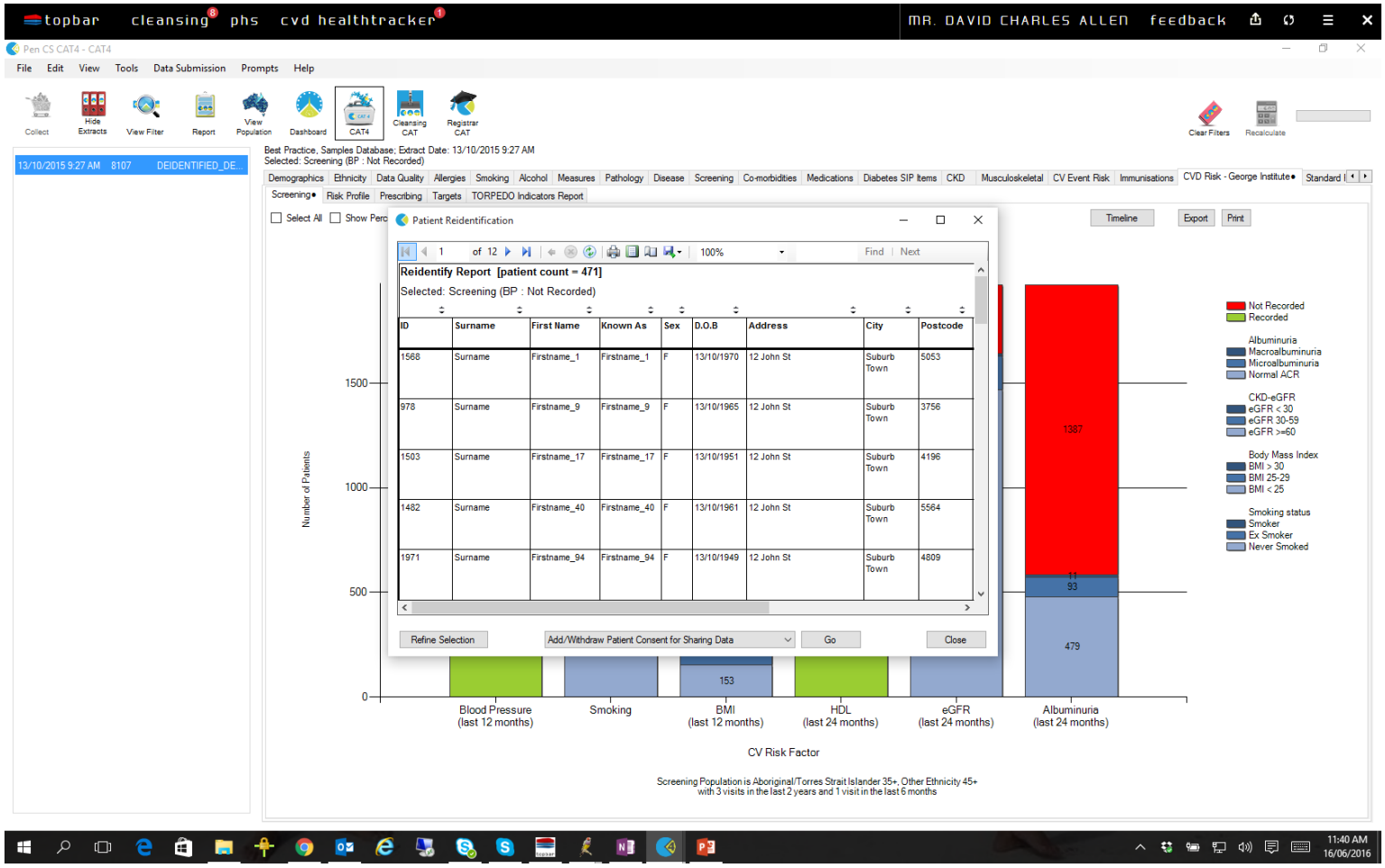


Figure 3. Sample benchmarking report, provided at 3-monthly intervals to participating practices

Note: Multiple graphs were provided including Proportion of undertreated high risk patients with up to date screening of systolic blood pressure and lipids (including total, low-density lipoprotein [LDL] and high density lipoprotein cholesterol), proportion of high risk undertreated patients on guidelines recommended treatments including blood pressure-lowering medications, lipid-lowering medication ± aspirin), and proportion of undertreated patients at high CVD risk reaching their blood pressure and LDL cholesterol targets.

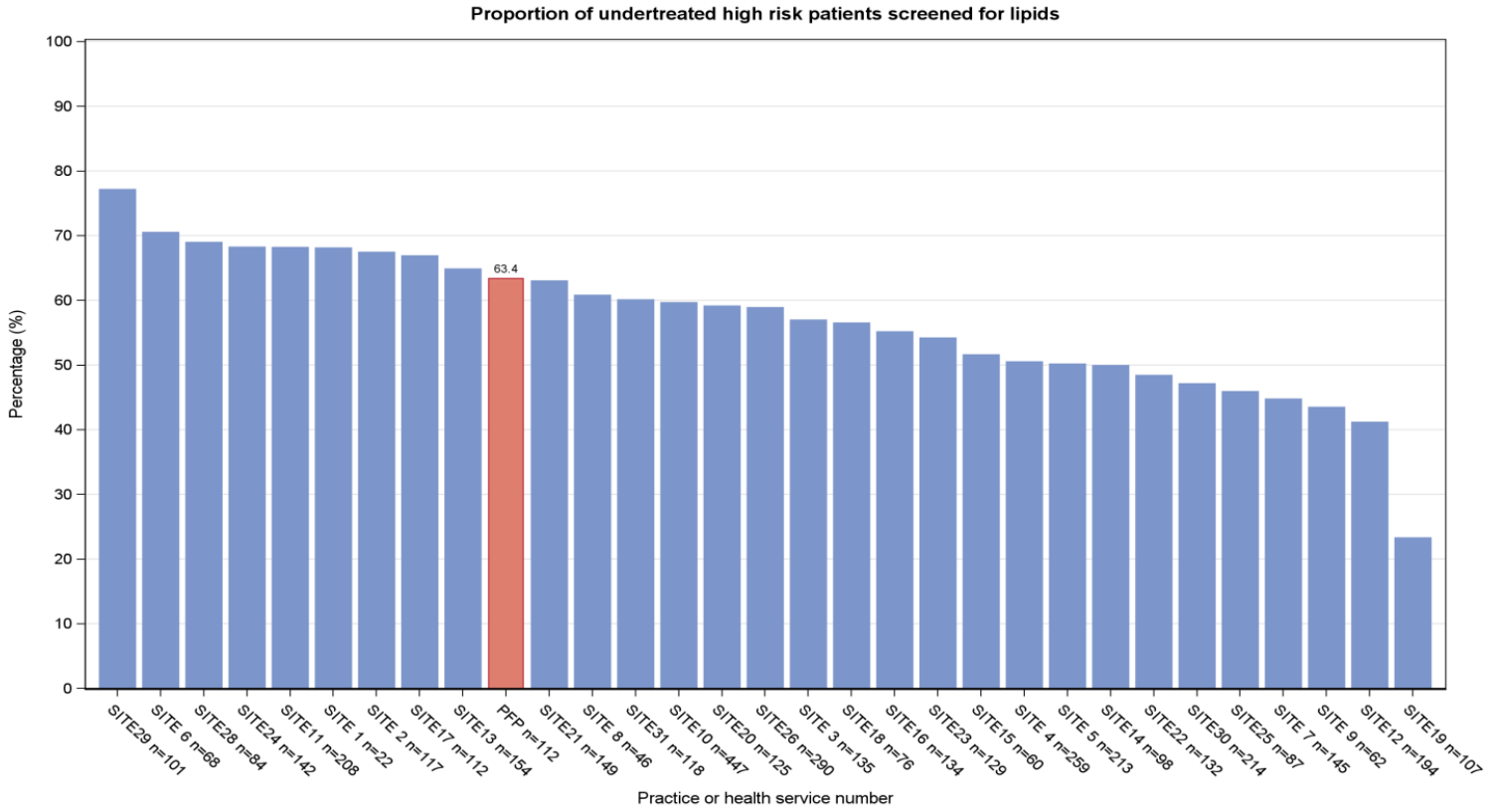


Table 1. Polypills available during the study

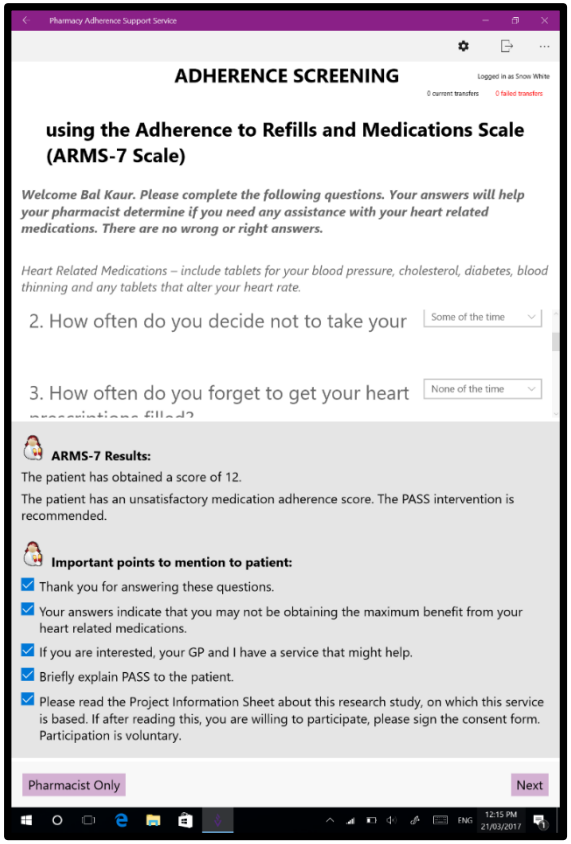
Polypills were manufactured specifically for the study at a local Therapeutic Goods Administration (TGA)-approved, Good Manufacturing Practice (GMP)-certified over-encapsulation company (PharmPackPro).

At the time of the study, the Pharmaceutical Benefits Scheme co-payment equivalent was between $6.10 and $6.30 for a patient with a concession card, and between $37.70 and $38.80 for other patients. Four pharmacies provided a discount to their general patients, as the cost of generic equivalent medications was lower than the co-payment amount of $37.70 – $38.80.

Polypill	Statin	First blood-pressure-lowering	Second blood-pressure-lowering	Anti-platelet	Number prescribed
All					107
1	10 mg rosuvastatin	4 mg perindopril erbumine	5 mg amlodipine	100 mg aspirin	17 (16%)
2	10 mg rosuvastatin	4 mg perindopril erbumine	5 mg amlodipine	-	15 (14%)
3	10 mg rosuvastatin	4 mg perindopril erbumine	1.25 mg indapamide	100 mg aspirin	11 (10%)
4	10 mg rosuvastatin	4 mg perindopril erbumine	1.25 mg indapamide	-	10 (9%)
5	10 mg rosuvastatin	12.5 mg hydrochlorothiazide	40 mg telmisartan	100 mg aspirin	9 (8%)
6	10 mg rosuvastatin	12.5 mg hydrochlorothiazide	40 mg telmisartan	-	11 (10%)
7	10 mg rosuvastatin	5 mg amlodipine	40 mg telmisartan	100 mg aspirin	14 (13%)
8	10 mg rosuvastatin	5 mg amlodipine	40 mg telmisartan	-	20 (19%)

2. Pharmacy Adherence Support Service

Patients could be referred by trial doctors, or pharmacists could independently initiate the program among identified patients from the partner practice. Potential medication-related problems were communicated directly to the prescribing doctor's EMR via an integrated secure messaging system.



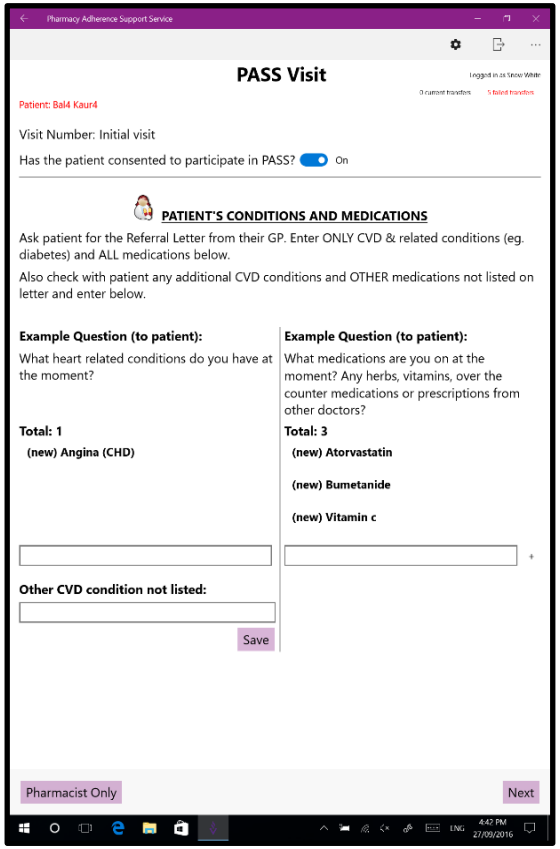
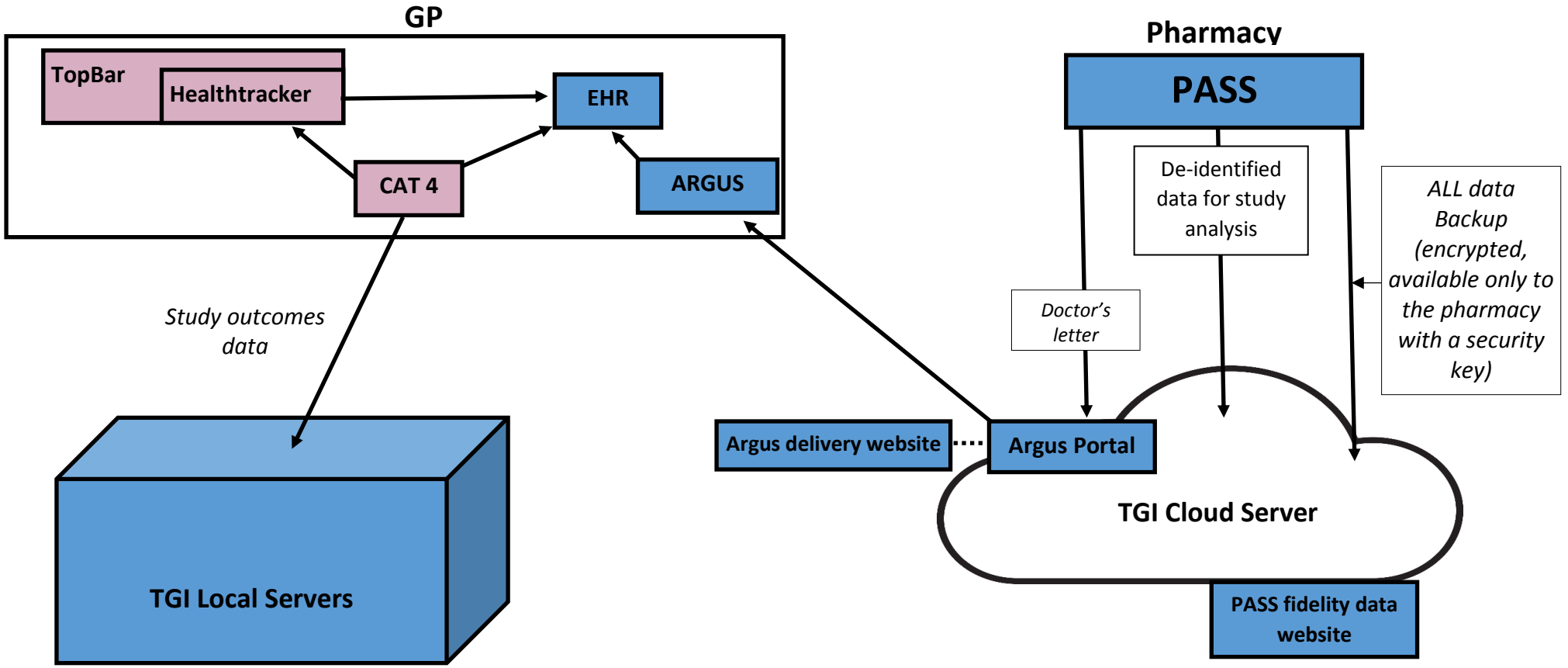


Figure 4. Architecture of trial intervention



GP = general practice, HER = electronic health record, CAT 4 = Clinical Audit Tool 4, ARGUS = proprietary secure messaging system, TGI = The George Institute, PASS = Pharmacy Adherence Support Service.

General practice:

EHR is the general practices' electronic health record system.

TopBar is a third party software owned by PenCS that provides access to data in the electronic health record to populate HealthTracker.

HealthTracker is the George Institute bespoke electronic decision support tool used in this study, and sat within Topbar.

CAT4 is a third party data extraction tool owned by PenCS, and provided data extracts from the electronic health record (outcomes data).

Pharmacy:

PASS is the pharmacy adherence support service, a digital tool incorporating the Adherence to Refills and Medications Scale (ARMS7) and the Brief Medication Questionnaire 1 (BMQ1).

Upon completion of a PASS visit, a doctor's letter was generated and transmitted by the Argus Secure Messaging System to the doctor's inbox in their electronic health record software.

3. Hierarchic matching strategy

Firstly, duplicate patient records with matching site ID, date of birth, and sex were removed.

Then patients were matched by patient ID at 49 of 70 sites. Patients without matching patient IDs at study end were removed.

Technical problems with patient IDs at 21 of 70 sites meant that patients were hierarchically matched by date of birth, sex, and at least one matching variable from a list of 20 unique variables with associated dates:

a. If CHD = Y and CHDdate = the same from baseline to EOS
b. If stroke = Y and strokedate = the same from baseline to EOS
c. If CHF = Y and CHFdate = the same from baseline to EOS
d. If CKD = Y and CKDdate = the same from baseline to EOS
e. If DM = Y and DMdate = the same from baseline to EOS
f. If GDM = Y and GDMdate = the same from baseline to EOS
g. If PVD = Y and PVDdate = the same from baseline to EOS
h. If AF = Y and AFdate = the same from baseline to EOS
i. If smokerquitdate is the same from baseline to EOS
j. If waist number and waist date are the same from baseline to EOS
k. If weight and weight date are the same from baseline to EOS
l. If ACR and ACRdate are the same from baseline to EOS
m. If height and heightdate are the same form baseline to EOS
n. If LDL and LDLdate are the same from baseline to EOS
o. AlbEx = Y and AlbExDate are the same from baseline to EOS
p. Creatinine number and Creatinine date are the same from baseline to EOS
q. FBG number and FBG date are the same from baseline to EOS
r. GTT number and GTT date are the same from baseline to EOS
s. HbA1c number and HbA1c date are the same from baseline to EOS
t. LVH = Y and LVHdate are the same from baseline to EOS

CHD = coronary heart disease, EOS = end of study, CHF = chronic heart failure, CKD = chronic kidney disease, DM = diabetes mellitus, GDM = gestational diabetes mellitus, PVD = peripheral vascular disease, AF = atrial fibrillation, ACR = albumin creatinine ratio, LDL = low density lipoprotein cholesterol, AlbEx = albumin excretion, FBG = fasting blood glucose, GTT = glucose tolerance test, HbA1c = glycated haemoglobin, LVH = left ventricular hypertrophy

The suffix ‘date’ indicates the date the variable was documented in the medical record.

4. Statistical analysis

We estimated that 70 practices (35 per arm) would provide 80% power (2 α = 0.05) with a mean cluster size of 60 to detect a relative risk of $\geq$ 1.35 in the proportion achieving blood pressure and low-density lipoprotein cholesterol targets (intervention *v* control). We assumed an intra-class correlation of 0.01 and that 10% of control group patients would achieve the blood pressure and low-density lipoprotein cholesterol targets by study end. Three groups of patients were available for analysis: all eligible patients; eligible patients who had high cardiovascular disease risk at baseline; and eligible patients who had high cardiovascular disease risk at baseline and were undertreated at baseline.

The association between the primary outcome and the use of HealthTracker (intervention arm only) has been assessed by the hierarchical log-binomial model described in the main text, adjusted for potential confounders.

The primary approach was complete case analysis, including only non-missing target outcome data. We performed two sensitivity analyses based on how missing outcomes were imputed. One was based on imputation of missing outcomes as "target not achieved". The second used multiple imputation by chained equations with full conditional specification (employing linear regression models for continuous variables and logistic models for binary variables) and pooling the results of 20 imputed datasets.

For each subgroup, the primary analysis was repeated with the addition of the subgroup variable and its interaction with intervention. Assessment of heterogeneity was based on the statistical significance of the interaction term.

We made no formal adjustments for multiple testing, but findings have been interpreted in the light of the number of comparisons made.

All statistical analyses were performed in SAS Enterprise Guide 7.15.

A detailed statistical analysis plan has been published elsewhere.[2]

Table 2. Characteristics of participating practices and pharmacies

Characteristic	Intervention	Control
Practices	35	35
State		
New South Wales	19 (54%)	21 (60%)
Queensland	3 (9%)	3 (9%)
Victoria	8 (23%)	8 (23%)
Western Australia	5 (14%)	3 (9%)
Practice size (under 500 patients)	2 (6%)	2 (6%)
GPs, median number (IQR)	7 (4–10)	6 (3–9)
GP, sex (women)	127/238 (53%)	112/216 (52%)
Practice nurse available	33 (94%)	30 (86%)
Registered training practice	23 (66%)	24 (69%)
Proportion of patients bulk-billed, median (IQR)	95% (80–100%)	95% (80–100%)
Sessions per week worked by GPs, median number (IQR)	6.9 (4.7–7.8)	6.6 (5.0–8.0)
Other allied health services	15 (43%)	22 (63%)
Ownership (MyHealth)	13 (37%)	16 (46%)
Pharmacies	36*	—
Type of ownership		—
Franchise	7 (19%)	
Large chains	14 (39%)	
Independent	15 (42%)	
Pharmacists, median number (IQR)	3 (2–4)	—
Sex (women)	63/126 (50.0%)	—
Pharmacy assistants, median number (IQR)	4 (2–8)	—

IQR = interquartile range.

***** One GP site had two practices with a joint database (counted as one GP site), but each practice partnered with a separate pharmacy for geographic reasons (counted as two pharmacy sites).

Practice information is taken from final practice survey data.

Table 3. Baseline characteristics of all participants

Characteristic	Intervention	Control
Number of patients	**72 880**	**70 374**
Age (years), mean (SD)	45.8 (18.5)	46.8 (18.4)
Women	42 693 (58.6%)	41 516(59.0%)
Current smoker	9085/63 722 (14.3%)	9189/61 336 (15.0%)
Diabetes	6037 (8.3%)	5887 (8.4%)
Body mass index (kg/m^2), mean (SD)	28.3 (6.6) *N=35836*	28.2 (6.4) *N=34 871*
Systolic BP (mmHg), mean (SD)	124.0 (16.7) *N=58 307*	124.7 (16.4) *N=57 122*
Diastolic BP (mmHg), mean (SD)	77.2 (10.7) *N=58 263*	77.8 (10.4) *N=57 058*
Total cholesterol (mmol/L), mean (SD)	5.0 (1.1) *N=42 101*	5.0 (1.1) *N=42 150*
HDL cholesterol (mmol/L), mean (SD)	1.4 (0.4) *N=37 120*	1.4 (0.4) *N=37 681*
LDL cholesterol (mmol/L), mean (SD)	2.9 (0.9) *N=36 398*	3.0 (1.0) *N=37 173*
Triglycerides (mmol/L), mean (SD)	1.5 (1.0) *N=41 128*	1.5 (1.0) *N=41 015*
Creatinine (µmol/L), mean (SD)	74.6 (29.9) *N=49 492*	73.9 (26.3) *N=48 068*
HbA1c (%), mean (SD)	6.1 (1.3) *N=15 258*	6.1 (1.3) *N=14 877*
Risk unable to be calculated	39 035 (53.6%)	36 021 (51.2%)
High CVD risk	9253 (12.7%)	9240 (13.1%)
History of CVD	3695 (5.1%)	3673 (5.2%)
High-risk condition	4619 (6.3%)	4692 (6.7%)
High calculated risk	939 (1.3%)	875 (1.2%)

SD = standard deviation; BP = blood pressure; CVD = cardiovascular disease; HDL = high- density lipoprotein; LDL = low-density lipoprotein.

Table 4. Baseline characteristics for undertreated patients with high baseline risk of cardiovascular disease, by availability of follow-up data for the primary outcome

	Intervention		Control	
Characteristic	**With follow-up data**	**Without follow-up data**	**With follow-up data**	**Without follow-up data**
Total number of patients	2156	1432	2321	1256
Age (years), mean (SD)	67.9 (12.3)	67.9 (16.4)	68.1 (12.4)	67.2 (16.4)
Sex (women)	931 (43.2%)	657 (45.9%)	983 (42.4%)	575 (45.8%)
Diabetes	970 (45.0%)	443 (30.9%)	1049 (45.2%)	387 (30.8%)
Current smoker/quit within past 12 months	337/2015 (16.7%)	245/1263 (19.4%)	326/2160 (15.1%)	227/1144 (19.8%)
Body mass index (kg/m^2), mean (SD)	29.9 (6.5) *N*=1733	29.0 (6.6) *N*=963	29.4 (6.2) *N*=1741	28.3 (5.9) *N*=820
Systolic blood pressure (mmHg), mean (SD)	133.9 (18.4) *N*=2102	134.8 (19.8) *N*=1341	134.1 (17.8) *N*=2221	135.4 (19.3) *N*=1151
Diastolic blood pressure (mmHg), mean (SD)	78.0 (12.3) *N*=2105	79.0 (12.9) *N*=1337	78.4 (11.2) *N*=2217	79.6 (12.9) *N*=1150
Total cholesterol (mmol/L), mean (SD)	5.1 (1.4) *N*=2076	5.4 (1.6) *N*=1240	5.1 (1.4) *N*=2211	5.4 (1.6) *N*=1069
HDL cholesterol (mmol/L), mean (SD)	1.3 (0.4) *N*=2030	1.3 (0.4) *N*=1136	1.3 (0.4) *N*=2166	1.4 (0.5) *N*=984
LDL cholesterol (mmol/L), mean (SD)	2.9 (1.2) *N*=2006	3.1 (1.2) *N*=1091	3.0 (1.2) *N*=2130	3.2 (1.3) *N*=960
Triglycerides (mmol/L), mean (SD)	1.8 (1.2) *N*=2069	1.9 (1.7) *N*=1221	1.7 (1.0) *N*=2204	1.8 (1.3) *N*=1049

	Intervention		Control	
Characteristic	**With follow-up data**	**Without follow-up data**	**With follow-up data**	**Without follow-up data**
Creatinine (µmol/L), mean (SD)	86.6 (51.7) *N*=2100	93.6 (72.9) *N*=1296	84.6 (33.8) *N*=2240	93.3 (84.6) *N*=1142
HbA_{1c} (%), mean (SD)	6.6 (1.4) *N*=1349	6.6 (1.6) *N*=626	6.6 (1.4) *N*=1436	6.4 (1.5) *N*=577
High CVD risk				
History of CVD	788 (36.5%)	518 (36.2%)	838 (36.1%)	487 (38.8%)
High risk condition	1044 (48.4%)	701 (49.0%)	1163 (50.1%)	586 (46.7%)
High calculated risk	324 (15.0%)	213 (14.9%)	320 (13.8%)	183 (14.6%)

CVD = cardiovascular disease; HbA_{1c} = glycated haemoglobin; HDL = high-density lipoprotein; LDL low-density lipoprotein; SD = standard deviation.

Table 5. Additional secondary outcomes

Outcome	Intervention	Control	Outcome: intervention *v* control (95% CI)	Intra-class correlation coefficient
Patients at high CVD risk and undertreated at baseline				
Systolic blood pressure: change from baseline (mmHg), mean (SD)	–1.9 (18.9) *N*=3064	–1.4 (18.8) *N*=3080	MD, –0.33 (–1.44 to 0.78)	0.01
Diastolic blood pressure: change from baseline (mmHg), mean (SD)	–1.3 (12.2) *N*=3065	–1.1 (11.6) *N*=3069	MD, –0.08 (–0.84 to 0.69)	0.01
LDL cholesterol: change from baseline (mmol/L), mean (SD)	–0.3 (0.91) *N*=2102	–0.3 (0.93) *N*=2250	MD, 0.00 (–0.07 to 0.08)	0.02
All patients with high baseline CVD risk	4526	4598		
Achieved blood pressure and LDL cholesterol targets and taking antiplatelet (if CVD diagnosis)	1227 (27.1%)	1151 (25.0%)	1.09 (0.95–1.25)	0.02
Low and medium CVD risk at both baseline and end of study	15 029	15 275		
Received new prescription or escalation of blood pressure-lowering, statin, or antiplatelet therapy	1330 (8.8%)	1249 (8.2%)	1.05 (0.80–1.39)	0.02

CVD = cardiovascular disease; CI = confidence interval; LDL = low-density lipoprotein cholesterol.

Table 6. Outcomes: sensitivity analyses

	Imputing missing/non updated data as "target not achieved"			Multiple imputation of missing data		
Outcome	**Intervention**	**Control**	**Outcome: intervention *v* control (95% CI)**	**Intervention**	**Control**	**Outcome: intervention *v* control (95% CI)**
Undertreated patients with high baseline CVD risk						
Proportion achieving blood pressure *and* LDL cholesterol targets (**primary outcome)**	423/3588 (11.8%)	466/3577 (13.0%)	1.00 (0.76–1.31)	668/3588 (18.6%)	676/3577 (18.9%)	1.06 (0.87–1.28)
Achieved blood pressure target	2185/3588 (60.9%)	2153/3577 (60.2%)	1.02 (0.93–1.12)			
Achieved LDL cholesterol target	599/3588 (16.7%)	650/3577 (18.2%)	0.98 (0.78–1.24)			
Achieved blood pressure *or* LDL cholesterol targets	2361/3588 (65.8%)	2337/3577 (65.3%)	1.01 (0.93–1.10)			
All patients with high baseline CVD risk						
Achieved blood pressure and LDL cholesterol targets	1420/6757 (21.0%)	1368/6507 (21.0%)	1.02 (0.84–1.24)			
Achieved blood pressure and LDL cholesterol targets (for all patients) and taking antiplatelet (if patient had established CVD)	1227/6757 (18.2%)	1151/6507 (17.7%)	1.05 (0.86–1.28)			

CVD = cardiovascular disease; LDL = low density lipoprotein cholesterol.

Table 7. Associations between undertreated patients with high baseline CVD risk achieving the primary outcome and HealthTracker use, by approach to handling missing data*

	HealthTracker used		Relative risk (95% CI)	
Adjustment for missing data	**Yes**	**No**	**Unadjusted**	**Adjusted for baseline covariates†**
Patients excluded from analysis	59/266 (22%)	318/1660 (19%)	1.14 (0.88–1.49)	1.06 (0.79–1.42)
Patients deemed to have not met targets (imputed as negative)	59/347 (17%)	318/2889 (11%)	1.44 (1.09–1.90)	1.29 (0.94–1.76)
Multiple imputation	77/347 (22%)	529/2889 (18%)	1.20 (0.94–1.54)	1.18 (0.94–1.49)

CI = confidence interval; LDL = low density lipoprotein.

* Follow-up data for blood pressure or LDL-cholesterol not available.

† Baseline age, sex, body mass index, estimated glomerular filtration rate (pre-specified).

The INTEGRATE participants

The George Institute for Global Health
- Jayanthi Mysore, Statistical Programmer
- Katie Goddard, Project Officer
- Pravin Siriwardena, Project Assistant

Site GP001: Powell St Medical Practice
- Alofivae-Doorbinnia, Olataga
- Sorial, Wendy
- Luu, Tan
- Ung, Andrew
- Eastwood, Anne

Site GP003: The Practice Bundanoon
- Rajendra, Indran

Site GP004: Macarthur General Practice
- McCroary, Kenneth

Site GP005: Bluestone Family Medical Centre
- Al Kamil, Mohammed
- Taliana, Lisa
- Abdul Karim, Inas

Site GP006: Select Medical Group
- Chia, Irmgard
- Pakthagurunathan, Manchula
- Wallace, Desi
- Maxwell, Loretto

Site GP007: Picton Family Medical Centre
- Pham, Anna
- Buckingham, Daniel

Site GP008: Villawood Medical Centre
- Samarasekera, Chandani
- Oei, Priscilla

Site GP011: Kogarah Railway Medical Centre
- Bazergy, Carl
- Mahadev, Anand
- Mahadev, Visawanathan

Site GP012: The Hastings Clinic
- Keillar, Peter
- Frew, Bradley
- Giannakakis, John

Site GP014: Old Princess Highway Surgery
- Xin Shi, Yong

Site GP015A/B: The Oaks Medical Practice/The Clinic
- Campbell, Ron

Site GP017: Daintree Medical Centre
- Varghese, Alfeen
- Datta, Chinmoy
- Gill, Ramanpreet
- Munamati, Rosemary

Site GP023A/B: Liverpool Medical Centre/ Greenvalley
- Singh, Pradyumn (Paddy)

Site GP025: MyHealth Central Park
- Au, Richard
- Ru Zhou, Angela
- Huang, Yao Chun
- Thiangtham, Achiraya
- Jeon, Glory
- Yee, Joo Faa

Site GP026: MyHealth Eastland / GP035 MyHealth Chadstone
- Liu, Shaojun
- Liu, Xiao Dan

Site GP028 / GP029 Mortlake Family Medical Practice / Hughes Street Medical Centre
- Keh, Frank

Site GP030: MyHealth Castle Towers
- Fang, Elliot
- Aitken, James
- Kabir, Fariya
- Pan, Eva

Site GP031: MyHealth Fountaingate
- Saluja, Sanjay
- Cheung, Melissa
- Zaidi, Huma

Site GP032: Belvidere Health Centre
- Xu, Daniel
- Ruan, Jian
- Ullah, Mohammed
- Kirupananther, Devaki
- Saeed, Shamaila

Site GP033: Curtin University Health Service
- Coombes, Fiona
- Palmer, Roger

Site GP034: Burslem Medical Centre
- Singh, Kanwal
- Smith, Nick
- Dennis, May Zin
- De Almeida, Sherina
- Brar, Satveer
- Doyle, Bianca

Site GP038: Granada Medical Practice
Vidyabhushana, Arosha
Site GP039: Captain Stirling Medical Centre
Benson, Michael
Site GP040: MyHealth Macquarie Centre
Mackun, Kenneth
Site GP041: MyHealth Oran Park
Samaranayake, Dimuthu
Muzammel, Saila
Khoury, Patrick
Simi, Arju
Ndhlovu, Austin
Tuxford, Joshua
Alvarez-Runio, Alma
Site GP042: MyHealth Point Cook
Solanki, Parul
Islam, Abu
Khan, Shamim
Gurung, Parbati
McAllister, Caroline
Ericson, Taylah
Site GP045: MyHealth Southland
Kaur, Raman
Site GP046: MyHealth The Glen
Harewood, Andrew
Site GP047: MyHealth Doncaster
Wong, Cora
Isaac, Shriti
Leong, Ee
Wong, Leighton
Ibrahim, Hanaa
Emmerson, Stuart
Ling, Grace
Ewert, Cameron
Cardwell, Lewis
Cervelli, Melanie
Site GP049: MyHealth Pacific Fair
Dickinson, Ian
Powers, James
Hayward, Kulbir
Site GP050: Myhealth Benowa
Chiu, Kevin
Site GP051: MyHealth Ashmore Plaza
Azadzamany, Farhad
O'Brien, Russell
Site GP052: Mount Hawthorn Family Practice
Kelly, Andrea
Site GP056: MyHealth Chatswood Chase
Hong, Henry
Site GP057: MyHealth Enfield
Lau, Mary-Ann
Site GP059: MyHealth Burleigh Waters
Lim, Phin
Site GP060: MyHealth Helensvale
Moshtagh, Hamid
Site GP061: MyHealth Corio
Odeleye, Olugbenga
Site GP062: Myhealth Box Hill
Ng, Frank
Tan, Irene
Louey, Janice
Teng, Tina
Wang, Lynn
Mok, Chee Ken
Site GP064: Aveley Medical Centre
Afilaka, Olugbenga
Weerasekera, Kanchana
Akter, Murshida
Sithole, Nqobile
Shaw, Daytinee
Poni, Lynda
Pindoria, Alpa
Kamran, Anam
Lee, Mei
Site GP066: Haynes Medical Practice
Jayatilake, Mithila
Site GP067: Richmond Road Family Practice
Bittar, Hani
Site GP068: Metella Road Family Practice
Nasr, Taleb
Saba, Therese
Site GP069: Mt Druitt Medical Centre
Lim, Kean Seng
Cochrane, Natalie
Kek, Teng-Kiong
Cabrera, Samantha
Sharma, Vivienne
Site GP071: Holroyd Medical Practice
Edwards, Peter
Site GP072: Camden Surgery
Venkatesan, Ramana

Site GP073: Faulconbridge Health Centre

Krzyszton, Andrew

Site GP074: Malvern Road Medical Centre

Poh, William

Site P001: Yagoona Medical Pharmacy

Chu, Linh

Pham, Tuyet

Site P006: Chemist Warehouse Princes Highway Dandenong (previously Pharmasave Moore's the Chemist)

Tahsin, Naveed

Site P008: Rochesters Pharmacy Villawood

Nguyen, Jenny

Do, Jennifer

Wu, John

Site P021: Lethbridge Park Pharmacy

Ghaly, Joshua

Site P030: MyChemist Castle Towers

Pham, James

Sok, Jennifer

Site P032: Belmont Family Pharmacy

Branchi, Christopher

Ayad, Michael

Site P033B: Acacia Pharmacy Bentley

Nguyen, Phuong

Weber, Rainer

Ho, Agnes

Wong, Nicole

Weber, Elisabeth

Site P039: Captain Stirling Pharmacy

Andrew, Tom

Benn, Sol

Webb, Christina

Barve, Priyanka

Chong, Michelle

Benn, Jack

Site P042: Sneydes Rd Pharmacy

Nguyen, Lee

Armellin, Lara

Site P043: Demarte's Amcal

Demarte, Joe

Wong, Lawrence

Site P050: Benowa Gardens Chempro

Fretten, Ben

Elliott, Amica

Fretten, Alicia Helen

Site P062: MyChemist Box Hill

Xiao, Harris

Wong, Mae

Lam, Grace

Yeung, Wan

Site P064: Friendlies Pharmacy Aveley

Pindoria, Alpa

Dodhia, Shilan

Site P067: Medicines Rx Chemist

Hanna, Bishoy

Saleeb, Ibram

Site P074: TerryWhite Chemmart Stanhope Gardens

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