

A Success Story...

A PAPER BASED COLLABORATIVES JOURNEY: The trials and tribulations

CHD - Involving patients in delivering and developing care

Biota Street Medical Centre - QLD

The triumph for the Biota Street Medical Centre throughout the Collaboratives program has been to prove that an efficient paper-based system can be just as efficient, if not more so, than a computer-based system. They have no plans to move to a computer-based system.

This practice has managed the Program and their patient registers with relative ease, allowing them to focus on patient management rather than data management, an area where many computer-based practices become weighed down. I was quietly hesitant to recruit this practice, fearing that the submission of monthly measures would be a laborious task for them.

Fast forward 14 months and this practice has fully embraced the Program to the benefit of their patients and practice systems. They continue to be extremely positive about their experience with the Program, which has highlighted the efficiency of their systems and cemented their passion to treat and improve the management of their chronic disease patients.



Context

The practice is located in the relatively low socio-economic, urban area of Inala, within Brisbane South Division of General Practice, approximately 20km from the Brisbane CBD. The area has a high proportion of Aboriginal and Torres Strait Islander people and people with a non-English speaking background. The practice has approximately 4000 active patients, having been established in the area for around ten years.

Due to their patient demographics, the practice has a relatively high number of patients diagnosed with chronic disease, with 47 CHD patients and 79 Diabetic patients. The practice also counts Asthma as a significant problem for their patients. The age demographic of the practice is also wide and varied.

The Situation

Biota Street Medical Centre had often thought they were being left behind in the great race to become computerised. The Principal GP, Dr Sarada Vadlamudi, is passionate about providing the best possible patient care, particularly for the growing number of patients with a chronic disease attending her practice. She had heard about the success the national Collaboratives program was having in practices across Australia.

After making enquiries, Dr Vadlamudi learnt that the Program seemed to have a heavy focus on data management in general practice. Not being computerised, Dr Vadlamudi was curious as to whether a paper-based practice could become involved and still achieve great results for their patients.

The Situation *continued...*

She consulted some colleagues involved and was told it would be quite difficult to run the Program with a paper based system. After learning Brisbane South Division of General Practice was offering the chance to become involved in the Program locally, rather than travelling to Melbourne, she decided to seek more information.

It was at this time I visited Dr Vadlamudi, where we were to have an honest and lengthy conversation about the practice becoming involved. We discussed the possible enablers and barriers that need to be considered before committing, as well as the expectations of the Program in terms of monthly measures and the establishment and maintenance of current registers.

I outlined that being paper-based was going to be challenging as was the absence of a practice nurse. In her favour, I counted the fact she is a solo practitioner with one receptionist and her obvious passion and enthusiasm to become involved despite all else.

The Change

Dr Sarada Vadlamudi and Kathleen Hope (a practice team member) were very keen to have some clarity around trying to implement an improved system for dealing with their chronic disease patients. They searched all active patient records to establish their registers and were to update these opportunistically as patients were to attend. The reason this was done with ease was due to the only one staff member and one GP at the practice being involved in the Program.

They were extremely systematic with their approach to PDSA's. As they were not spending time on managing compromised data on a computer-based system, they were able to quickly move on to aspirin and HbA1c PDSA's. By establishing which patients didn't have current medical information, they were quickly able to work on their recall and reminder system to ensure these patients were reviewed. They have not once hinted at their paper-based system as being a disadvantage.

Since then, they have addressed all patients who have not had a flu injection or pneumovax injection. With the help of their CPM, they were also able to compile a plastic folder for each patient who attended for a GP Management Plan (GPMP) and/ or Team Care Arrangement (TCA). Each folder was customised with information specific to each patient.

The folder contained a copy of their GPMP/ TCA, healthy eating and physical activity guides, smoking cessation material if applicable along with an information sheet for diabetic patients emphasising the importance of the annual cycle of care. The sheet was also enclosed with reminder letters sent.



Dr Vadlamudi (centre) with other Local Collaboratives participants

"They have not hinted once at their paper based system being a disadvantage."



Dr Vadlamudi (right) at one of the Local Workshops

The Outcome

From the practice graphs attached (Figures 1 and 2), the visual improvement in patient measures from Baseline to July 2007 is obvious.

The practice has since employed an Exercise Physiologist and is currently looking for a Dietician to join them in the near future. This practice is an excellent example that a Collaborative can be applied in any practice context; it is the motivation and dedication of the staff and GP's in the practice that drives the Program and determines its success.

The practice has also sought feedback from patients directly affected by the Program i.e. their patients with CHD and Diabetes. The overall collective feedback indicates the patients are very happy with the enhanced level of care they are receiving at the practice. They specifically mentioned that they enjoy seeing the Exercise Physiologist without having to travel to another location. It was also mentioned that they noticed a different level of support from the practice in the last 12 months.

Biota Street Medical Centre will continue to apply the Collaboratives methodology in their practice in the coming months.

"The Collaboratives methodology is now embedded in our practice. Kathleen and I will continue with the Program after it has formally ended," said Dr Vadlamudi.

"We will be looking to apply our learnings to other areas of the practice such as asthma, immunisation and mental health."

Author: Rebecca Dunn
Brisbane South Division of
General Practice

Figure 1 - Practice graphs for CHD (July 07)

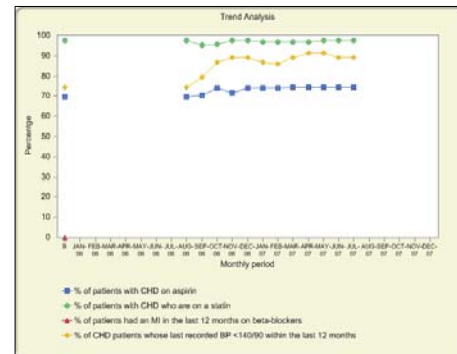
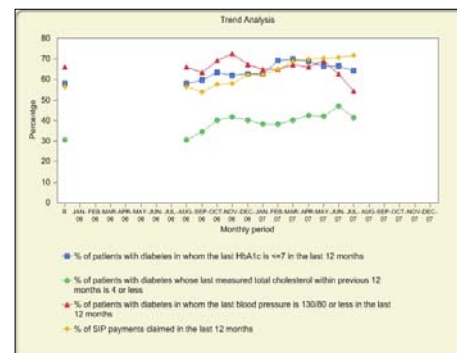


Figure 2 - Practice graphs for Diabetes (July 07)



The Collaboratives methodology is now embedded in our practice... We will be looking to apply our learnings to other areas of the practice such as asthma, immunisation and mental health."

Dr Vadlamudi, Biota Street Medical Centre

Published November 2007

