

CASE STUDY: BUSBY MEDICAL CENTRE

Building on established initiatives to improve patient care

To provide proactive care to their patients with a chronic disease, the team at Busby Medical Centre adopted a 'cycle of care' plan. The care plan assists patients in managing their own condition as well as planning their care thoroughly with the practice team, utilising a whole-of-team approach. Access was also improved dramatically by modifying their existing duty doctor initiative, which lightened the workload for the GPs and provided greater capacity for 'on the day' appointments.

Location: 123 Howick Street, Bathurst, NSW.

Staff: 9 permanent GPs, 1 registrar, 7 allied health professionals, 5 nursing staff (sisters) and 10 administration staff.

Patients: approximately 15,000 on their database.

BACKGROUND

Busby Medical Centre joined the APCC Program after feeling the pressure of demand on patient appointments, as well as wanting to introduce a chronic disease model, but with little experience in how to develop one. They also wanted to further develop the integrated care they provided to their patients.

PROCESS

After attending the first APCC workshop, two lead GPs and the practice manager met with the rest of the practice team and shared their thoughts on the Program and their ideas for progression. From this meeting, three micro-teams were established, one for each of the Program topics of diabetes, coronary heart disease (CHD) and access & care redesign. The micro-teams consisted of two GPs, one sister and administration staff.

The diabetes micro-team discussed their thoughts for improving diabetes care, and, in keeping with Medicare guidelines, suggested a diabetes 'cycle of care' be implemented. They presented this to the rest of the team who agreed to a trial.

The cycle of care is now implemented whenever

a new patient is diagnosed with diabetes. It is coordinated by the chronic disease sisters, who make an appointment with the patient to discuss and plan their care, over 24 months. Patients are given a **picture** of the cycle of care model, and have the opportunity to discuss its requirements with the sisters as well as booking their follow-up appointment in three months time. They are given a folder with information about diabetes, a picture of the GP Management Plan and cycle of care models, and other useful information. It is recommended that the patient brings their folder to each visit.

The practice team also felt that patient access to care could be improved. While they already had a system in place for 'on the day' bookings, it didn't seem to be as efficient as it could be. Their existing system had one GP scheduled on each day as the 'duty doctor'. This GP maintained a normal schedule of appointments, with the exception of five appointments that were blocked out and allocated for 'on the day' bookings. In addition, the duty doctor also assisted other GPs who were not available to take phone calls or write prescriptions.

In order to improve access to care, the access micro-team brainstormed ideas for improvement. They decided to trial a change in the duty doctor system. The duty doctor now only takes appointments that are booked on the day. This was a concern at first for the GPs, as they were worried the appointments might not fill, but they soon realised the bookings filled up quickly for patients wanting to get in on the day.

OUTCOMES

Since joining the Program the entire practice team at Busby Medical Centre now hold a regular 'Collaboratives meeting'. This meeting has a structured agenda, where each of the Program topic areas are discussed, as well as new projects on the horizon. Each staff member is involved in the meeting. At the end of the meeting, a guest speaker is invited to talk to the team about issues and activities occurring in the community. A dietician, occupational therapist, acupuncturist and an exercise physiologist have now joined the practice team as a result of speaking at one of these Collaboratives meetings.

Other outcomes for the practice team include:

- After seeing the success of the diabetes cycle of care, the team used the same model to successfully implement a cycle of care for patients with CHD.
- Through the cycle of care model, patients are much more in-tune with what expectations they have for themselves and of the practice for their care. There is a greater response to recalls, which is likely to be a result of better patient education.
- Access has improved tenfold. In the majority of cases, patients are finding they can ring up and get an appointment on the day without hassles or negotiations. Over the course of the 18-month Program 'wave', the practice team were able to improve their appointment demand by meeting 80% more appointment requests.
- The new duty doctor system encourages patients to feel comfortable with all of the doctors at the practice and not just the one or two they usually see. Patients have more exposure to build a rapport with other doctors who might be the duty doctor that day, which opens opportunities for future appointments as patients feel more comfortable going back to see a doctor they have seen before.
- The reception staff were trained and up-skilled on triaging patients, which assisted the improvements in access, particularly for 'on the day' bookings.
- The practice now has an integrated care structure. While it is still in the early stages, the team can see that collaboration and working with allied health

providers offers patients a better service. They now see better attendance at referrals to those allied health providers that are within the same establishment.

- The patient database continues to improve. The practice manager will regularly print out the latest clinical software data and request the practice nurses check the registers for accuracy and amend where necessary.
- Busby Medical Centre was joint winner of the AGPAL Quality and Safety 2009 award for exceeding overall expectations of what was required through the standards of accreditation, in regards to safety and quality.

LOOKING FORWARD

There are a number of projects on the horizon for the team at Busby Medical Centre. They have recently introduced a therapy group for patients with chronic care issues. The group therapy sessions are well attended and appreciated amongst patients. The team hopes to continue these sessions and improve on them, as well as introducing more group discussion opportunities and events in the future.

CONCLUSION

In order to improve their care for patients with a chronic disease, the practice team implemented a cycle of care model. This model is utilised for those patients diagnosed with either diabetes or CHD and supports proactive care for the patient, as well as comprehensive education about the disease. To improve access to care, the team modified their 'duty doctor' initiative by blocking out the entire day for 'on the day' bookings, as well as up-skilling the reception staff on triaging patients.

"Just by having us all sit in the one room and collaborate I feel that our team is much stronger. For me that is very rewarding and I'm sure that the team would agree with me that we're all here trying to achieve the same goal, we just have different roles. We're a team and I think that's been strengthened through the APCC Program."
- Louise Warry, Practice Manager