

BUILDING A NEW PRACTICE FROM SCRATCH WITH A FOCUS ON DIABETES MANAGEMENT

Cleve Medical Practice, SA
Eyre Peninsula Division of General Practice

CDPSM CHANGE PRINCIPLE 6

Adopt a multi-skilled, multi-agency approach to ensure effective coordination of the care of people with diabetes

Summary

Cleve Medical Practice undertook a change in ownership from a solo GP privately owned business to public ownership. This caused many issues for the practice and meant it had to build the practice from the ground up. Through the APCC Program and assistance from Country Health SA, the practice was able to grow into a successful business with a focus on diabetes care and management.

Background

In late 2007, Cleve Medical Practice (MP) changed ownership from a privately owned solo GP practice, to publicly owned Country Health SA – Eastern Health & Aged Care (EEHAC). The practice services the town of Cleve and the surrounding cereal and sheep farming districts. Currently, Cleve MP has 2300 patients on their database. Staff consist of a GP, practice manager, practice nurse, practice office manager and reception staff. Patients also have access to weekly female women's health GP as well as a range of visiting or resident allied health professionals and specialists.

Cleve MP joined the APCC Program in August 2008. This corresponded with the employment of the first resident GP and installation of new clinical software. With all of the changes to the practice, including the new public ownership, Cleve MP had the opportunity to develop close relationships with other EEHAC community health services and to develop, from scratch, a system of care for patients with diabetes.

The Process

Cleve MP's original aims through the APCC Program were centred around improving service delivery to diabetes patients in particular, and to improve communication and integration with other EEHAC services. In order to meet their overall aims, Cleve MP set some more specific targets including:

- 80% of patients with diabetes to be managed via a GPMP (GP Management Plan).
- All practice staff to be able to clearly articulate their role in the care of patients with diabetes.
- Staff will clearly understand and utilise the systems for referral to, and reporting from, the wider multidisciplinary EEHAC Community Health team.

In order to develop effective diabetes management plans for their patients, Cleve MP needed to build a strong relationship with their parent body, EEHAC. By utilising this relationship as outlined below, their care to diabetes patients continues to improve.

- When attempting to extract the original diabetes register from the previous clinical software, the Diabetes Educator at EEHAC compiled a new register based on their records.
- With the new ownership of the practice, the EEHAC Diabetes Educator's role changed from coordination of the care for diabetes patients in the Cleve and surrounding areas, to provision of education and advice by working together with other health professionals, as part of a multi disciplinary team. Due to this, the GP and practice nurse have taken on the responsibility of coordinating diabetes patient care.

Process Continued

- The practice staff create and maintain documentation of the specific roles of the GP, practice manager and nurse, and reception staff in their care, recall and billing systems associated with diabetes patients.
- The practice conducts regular staff meetings as well as regular meetings with EEHAC to ensure consistent approaches to referral pathways and tools for data collection, particularly in relation to chronic disease self management.
- Relevant staff attend ad hoc meetings with EEHAC and Division staff to set targets, plan and review improvements for the continuous care of diabetes patients.
- Cleve MP provides a 'one stop shop' for diabetes patients at the practice by giving them information, access and referral to relevant allied health services. These include: a physiotherapist, diabetes educator, podiatrist, dietician, optician and an ophthalmologist, who may be employed by Eastern Eyre Health or visit Eastern Eyre on a regular basis. Transport can be arranged to regional centres as needed for specialist health care.
- They have established and built upon a working relationship with visiting accredited pharmacists, which enables them to provide medication management reviews.
- The Healthy Living Project officer at EEHAC has been nominated as the officer responsible for receiving referrals from the practice to the EEHAC Healthy Living team, and also for the return of all reports about patients back to the practice.
- The Healthy Living team at EEHAC have taken on responsibility for most of the educational, lifestyle and health promotions and activities in the area, including CDSM via the Flinders and Stanford models, which frees up time for the practice to fulfil their clinical roles. The

Healthy Living Team is made up of a Lifestyle Advisor, Chronic Disease Self Management Coordinator, Health Promotion Coordinator and Youth Development Coordinator who provide a planned approach to healthy living across population groups and communities.

- The practice has organised group diabetes education sessions (similar to a diabetes clinic), when the waiting times for individual sessions becomes excessive.

Outcomes

Since joining the APCC Program, under their new public ownership, Cleve Medical Practice has made a lot of progress in building a successful clinic, with a focus on diabetes management. As they were unable to extract their clinical data from the old clinical software, they started the Program with no disease registers, patient histories or pathology records.

Along with EEHAC, the APCC Program has helped Cleve MC establish:

- a database of over 2300 patients
- a diabetes register of 101 patients
- a current GPMP for over 80% of diabetes patients
- HbA1C and BP records for over 90% of diabetes patients in the last 12 months
- over 50% of diabetes patients have a record of HbA1C ≤ 7 .

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Outcomes Continued

The practice staff also gained a number of personal skills and developments through the Program, including:

- How to establish and maintain disease registers.
- How to establish and maintain recall and reminder systems.
- Effective care planning procedures.
- Tracking and billing the diabetes cycle of care.
- Understanding the various CDM/CDSM tools and programs so they could be effectively allocated to practice staff or the wider EEHAC community health team.
- Chronic disease self management empowers the client to take responsibility for their own well being and staff have been trained to interview and coach clients to achieve goals that they set for themselves.
- How to establish effective care pathways.

Cleve Medical Practice designed and distributed an extensive patient satisfaction survey in 2009, to gather information regarding the community perception of the services offered by the 'publicly owned' practice and to gather information pertinent to further improvements.

The survey was posted directly to all patients on their database that were over 16 years of age. Approximately 400 surveys (38%) were returned. The results of the survey showed that of the 100+ patients on a GPMP that responded to the survey, 81% reported improved confidence in managing their condition as a result of the care planning process.

Looking Forward

The patient survey gave Cleve Medical Practice a number of ideas for improvements, which has resulted in:

- Increased media to promote services available to women.
- Recruitment of a Womens Health GP to provide a weekly service.
- Reception staff have completed training in Front Line customer service.
- Installation of a privacy screen and seating in reception area.
- Written information developed on out of pocket expense.
- Fold Down Baby Change Table installed.
- Signage developed and displayed in relation to waiting times; communication with GP; and type of appointments required eg short/long consult.

The practice also plans to extend their relationship with all of the EEHAC community health and hospital staff, to continue an integrated multidisciplinary approach to patient care.

Conclusion

Through the help of the APCC Program, the Division and EEHAC, Cleve Medical Practice successfully changed ownership from private to public, while developing a strong focus on diabetes management and ultimately improving the overall care for their patients. The practice has a strong reputation amongst their patients, and by continuing to communicate with them, they will continue to evolve and improve the services they offer.

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