

A Success Story...

PROACTIVE DIABETES CARE IN A LARGE RURAL PRACTICE

Diabetes: Systematic and proactive care

Breed Street Clinic - Vic

This case study outlines the process Breed Street Clinic undertook in developing a coordinated systematic approach to managing diabetes and coronary heart disease (CHD) patients within a large rural practice.

A Practice Nurse Coordinator was employed to coordinate the diabetes registers. Having such large patient numbers required a lot of time and dedication to establishing clean patient data. Having accurate diabetes registers was seen as a crucial element in the process of being able to deliver good diabetes care.

Other areas the practice focused on were, developing protocols, using practice specific templates, active recall and reminders, undertaking diabetes clinics and utilising practice nurses in the delivery of diabetes care. With hard work and persistence the practice has had excellent improvement in all aspects of their diabetes care and are looking forward to providing innovative self management strategies to their patients to further enhance their health outcomes.

The Collaborative program provided Breed Street with focus, motivation and structure to implement changes and ultimately improve patient outcomes.



Context

Breed Street Clinic is located in Traralgon (population 28,402), a regional city in the Latrobe Valley in the Gippsland region, south-east of Victoria. Latrobe Valley is home to most of Victoria's power generation facilities and the economy is still heavily reliant on the power industry and the paper mill for employment.

Breed Street Clinic is a Wave one Collaborative practice and are one of 32 practices within the Central West Gippsland Division of General Practice and are a RRMA 4 practice. Within Central West Gippsland Division there is a high incidence of cancer, cardiovascular disease and respiratory system disease compared to Country Victoria and Australia (PHIDU, March 2007).

Breed Street has a patient population of 14,500, with a current diabetes register of 498 patients and a current CHD register of 528 patients. They use Medical Director 3 clinical software. The practice is accredited with AGPAL and is a teaching practice for the GetGP regional training program, as well as Monash University for Medical Students. The practice employs six full time GPs, three part time GPs, four Practice Nurses, a Practice Nurse Coordinator, a Practice Manager and associated administrative staff.

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The Situation

Breed Street Clinic are a large rural practice with a commitment to quality improvement. With a large diabetes register of 714 patients the practice wanted to ensure that all of their diabetic patients were receiving best practice care, however to achieve this they recognised the need for a more coordinated approach.

The practice had already recognised the need to move towards good diabetes management; however there was room for improvement in tracking diabetic patients. The practice felt they were floundering a little and needed a framework to progress the practice into a more structured and coordinated approach.

The directors decided as a group to employ a Nurse Coordinator to develop chronic disease management systems, however it was a further seven months from initial advertising before a suitable candidate was employed.

The practice was involved in the Better Health Care in Gippsland Project that developed better referral systems to allied health professionals for patients with diabetes. It made good sense to become involved in the Collaboratives and run the two projects consecutively.

Breed Street identified the Collaboratives as an opportunity to help them develop systematic care for patients with chronic conditions, test PDSA ideas, monitor progress, develop team focused care and to further enhance the good work already undertaken by the practice.



Dr Paul Brogham and Heather Scott

The Change

Lead GP, Dr Paul Brougham and the newly appointed Nurse Coordinator, Heather Scott headed up the diabetes practice team. One of the critical areas to achieving success was to have dedicated people driving the change. Fortnightly reports back to the clinical team via practice meetings were used as the vehicle to engage the whole of practice and discuss any arising issues.

The initial PDSA was to scrutinise the diabetes database of 714 patients to include only current patients, thus reducing the register from 714 to 498 patients.

Another PDSA was to develop a working database utilising extracted data exported into an Excel spreadsheet, incorporating different categories of patients which was colour coded to assist in prioritising needs.

Residents in Aged Care facilities and patients who were under the care of an Endocrinologist were highlighted. Patients who had both diabetes and CHD were also highlighted to prevent duplication of assessments.

GP Management Plans (GPMP's) and annual cycle of care were also included to enable the practice track accurately which patients were receiving what treatment.

Time was the biggest factor impeding the change process. To obtain clean valid data for so many patients was a labour intensive process. Working through the first two to three Change Principles in diabetes required a lot of time and effort.

However, once the database was clean, work systems were then established and practice nurses then took on a partnership role with the GP in diabetes care.

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The Outcome

An important outcome was that Breed Street recognised that systems change can be a relatively slow process, especially in a large practice, and that it must be regularly monitored. Whilst smaller practices involved in the Collaboratives achieved rapid improvement in a shorter timeframe, for a larger practice it takes time to achieve, but is well worth the time and effort.

Practice protocols have been developed, such as uniformity in doctors coding diabetic patients as type 1 and type 2. Also protocols were developed for validating the database, such as inactivating patients who have not attended the clinic in a specific period of time.

Understanding patient profiles is another valuable outcome to the practice. This ensured that patients didn't 'fall through the cracks', and that all patients, in particular those with diabetes, could be monitored closely helping them achieve optimal care for their condition. Improvement in patient outcomes is reflected to some degree in clinical indicators measures. The HbA1c ≤ 7 measure now sits at 44% compared to a baseline figure of just 8%, while the cholesterol $< 4\text{mmol/L}$ measure is at 24%, up from a baseline of 5%.

The Excel spreadsheet has provided the practice with the ability to track where patients are at in their diabetes care. Located on the server the GPs and nurses have access at any time to their patient's status.

The greater utilisation of practice nurses in diabetes care, such as contributing to care plans and diabetes assessments has resulted in better coordinated care and importantly created a 'practice team approach'. There is also the added benefit to the GP of being able to see other patients in the time taken to review all elements of the annual cycle of care.

As well as patient outcomes there were also financial benefits for the practice in the form of Service Incentive Payments (SIPs) and GPMPs undertaken on diabetic patients. The SIP measure has improved from a baseline figure of 31% of patients receiving the annual cycle of care to 65%, which equates to 325 patients.

After almost 2 ½ yrs in the Collaborative program Breed Street continue to demonstrate the success of the Collaborative as their data shows constant improvement.

Breed Street have recently renovated which has provided valuable room and practice facilities to explore new approaches and tailored programs to suit specific consumer groups. We are looking to extend the successful diabetic approach to Cardio-vascular disease and Asthma. There will be dedicated rooms for Practice Nurses to use for chronic disease management and streamline the process to make it more efficient for doctors and patients.

Support Material

- Excel spreadsheet incorporating exported data and colour coded patients
- Diabetes patient recall letter
- Practice graphs documenting improvement in clinical measures.

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