

## CASE STUDY: HOPE ISLAND MEDICAL CENTRE

# Adopting new systems to improve preventative care

Hope Island Medical Centre has improved preventative care and planned chronic care of their patients by adopting more systematic and efficient work processes. The practice nurses played a key role in instigating the focus on preventative care, and were able to devote their time into actively seeking out those patients who were at a high risk of developing a chronic disease, and encouraging them to proactively address risk factors.

**Location:** Hope Island, Northern Gold Coast, Queensland.

**Staff:** 8 GPs (7.5 FTE), 5 nurses (3 FTE) and 7 administration staff (5 FTE).

**Patients:** Database of approximately 9,500 active patients.

**Aim:** To further develop preventative patient care systems and expand chronic disease management services around COPD.

### BACKGROUND

Hope Island MC staff and GPs work collaboratively with visiting allied health professionals including physiotherapists, psychologists, an audiologist, exercise physiologist, dietitian and podiatrist. Before formally participating in the APCC Program, the practice team had been exposed to the Collaboratives methodology through local activities run by their Division. As a result of these Divisional events, they developed systems for comprehensive management of patients with chronic diseases, including diabetes, coronary heart disease (CHD) and asthma. However, the GPs and practice nurses decided they needed to focus more on preventative care and so they joined the APCC Program. Their aim was to expand their chronic disease management (CDM) services, particularly in relation to Chronic Obstructive Pulmonary Disease (COPD).

### PROCESS

In order to take a prevention focus, all five of the practice nurses (PNs) are responsible for opportunistically recording and updating basic patient information while they wait for scheduled appointments. The information taken is based on those measures required by the **Doctors Control Panel**, which include blood pressure, height, weight, waist measurement, smoking status, alcohol status and physical activity status. This data is then updated by the nurse in the patient's records accordingly. The nurses also highlight which preventive care items need to be addressed by the GP, e.g. when the patient is due for pathology, or pap smear, etc. This helps the GPs identify and manage basic risk factors comprehensively through establishing action plans that address lifestyle issues.

After joining the APCC Program, the PNs re-introduced **Lifescrpts** - an initiative which provides general practice with tools and skills to help patients address the main lifestyle risk factors for chronic disease: smoking; poor nutrition; alcohol misuse; physical inactivity; and unhealthy weight. The initiative assists nurses and GPs with the provision of tailored advice to patients on modifying their lifestyle, and can be used in conjunction with motivational interviewing training.

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Together with the GP and the patient, the nurse establishes an action plan to address the lifestyle issues present and the patient is flagged for continual monitoring and review. This has enabled them to devote more time into actively indentifying patients who are at a high risk of developing a chronic disease.

## OUTCOMES

Since commencing the APCC Program in late 2009, the practice team has achieved the following results:

- Increased identification of patients with COPD.
- Increased frequency of data cleaning - patient information is now reviewed and updated monthly.
- A 31% increase in spirometry tests for patients on the COPD register.
- A 12% increase in pneumococcal vaccinations for patients on the COPD register.
- A 57% increase in smoking status assessments over the past 12 months for existing patients on the COPD register.
- Increase in absolute cardiovascular risk assessments from 1% to 14%, of the patient database aged between 45 and 74.
- BMI is now recorded in 47% of all patients who are over the age of 18.
- Communication among the team has been strengthened and a team approach to service delivery and information sharing has been adopted.
- The team has improved their motivational interviewing techniques; spirometry training and utilisation; and risk factor identification and management.

## LOOKING FORWARD

Hope Island MC have developed resources to assist clinicians at the practice in supporting their patients, which they will continue to use. The resources include a procedure manual for management of chronic diseases, like COPD, and a procedure manual for health assessment services with a focus on prevention and grouping of information relating to local self management support programs.

## CONCLUSION

Hope Island Medical Centre has improved preventative care and planned chronic care for their patients by adopting more systematic and efficient work processes. The practice nurses now play a key role in recording vital information about their patients which assists the GPs in taking a more proactive approach to chronic disease care. By re-introducing their Lifescripts program and embracing motivational interviewing techniques, the practice team incorporate a whole-of-team approach in proactively caring for their patients.



*Members of the Hope Island practice team*

***“The APCC Program helps you improve the systems that support patient care and assist you to benchmark your performance against other practices...it is a rewarding experience for all of the practice team.”***

***- Anthea, Practice Manager.***