APCC Australian Primary Care Collaboratives Pioneering Change

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CASE STUDY: MADDINGTON VILLAGE GENERAL PRACTICE

Preventing chronic disease through a team approach to care

Joining the APCC Program helped the practice team at Maddington Village General Practice develop a stronger team approach by holding regular team meetings and improving communication. The practice team has successfully implemented a number of changes that benefit both the patients and staff. By 'getting to know' their patients, the staff are able to provide a more efficient and proactive service to their community.

Location: *Maddington, Perth, WA.*

Staff: *3 GPs, 3 receptionists, 2 administrators a registered nurse and a state enrolled nurse.*

Patients: *Approximately 8,000 active patients.*

Aim: *To improve patient care through working more efficiently as a team, building morale and improving the working environment.*

BACKGROUND

Before joining the Program, the staff at Maddington Village General Practice (GP) felt very little time was being allocated for team building. Those staff members who had been involved in the previous wave of the APCC Program knew that building and maintaining the practice team was a good way to start improving efficiency in the practice setting, which would also help to improve staff morale.

PROCESS

Initially, the team focused their energy on data and register cleansing. Having an accurate database allows the team to focus on their current patients and helps to efficiently identify those patients who require a risk assessment. All of the staff at the practice were responsible for archiving patients who were deceased, had left the practice or had not visited the practice in the past two years. Part of the database cleansing involved updating patient information including: smoking status, height, weight, BMI, waist circumference, blood pressure and Aboriginal and Torres Strait Islander status.

In order to gain this information about their patients, the administration staff created a new patient questionnaire. Once a questionnaire was completed by a patient, the receptionists and nurses were responsible for transferring the data from the questionnaire into the patient's record.

The GPs were also encouraged to update and record patients' height, weight, BMI, waist measurements, blood pressure and smoking status, via friendly visual reminders placed discreetly on their computer screens.

Maddington Village GP staff used the **Model for Improvement** and **plan, do study, act (PDSA) cycles** to test their changes before implementing them. The majority of their improvement work was focused on getting to 'know their population', through cleansing, building and maintaining their databases.

'At risk' registers were developed as a result of the practice team utilising the Australian Diabetes (AUSDRISK) and Absolute Cardiovascular Risk Assessment Tools. The reception staff started targeting patients who presented at the reception desk between the ages of 40 and 49, by giving them the AUSDRISK Assessment Tool form to fill out while waiting for their appointment. From this

form, patients are appropriately added to either the 'low risk', 'medium risk' or 'high risk' register. Patients are then proactively cared for, through evidence based and patient centred interventions, education and lifestyle modification programs.

The team also implemented monthly staff meetings, with 15 minutes dedicated to discussing the APCC Program, including reviewing their data and results. The meeting is held during lunch so everyone can attend and lunch is provided.

OUTCOMES

Since participating in the Chronic Obstructive Pulmonary Disease and Chronic Disease Prevention & Self Management wave of the Program, the staff at Maddington Village GP have seen several improvements to their team morale and patient care. These improvements include:

- Reviewing their monthly data (**click here** for a full list of data measures) allows the team to assess their progress and benchmark against their peers. The monthly feedback graphs are presented at each staff meeting to highlight 'a job well done' or what areas need improving, without passing judgement, the team discuss how this might occur and their future direction.
- The team is stronger and morale has improved. Staff feel comfortable and their roles are clear in terms of what is required of them through involvement in the APCC Program.
- Nurse led clinics have generated additional income of approximately $33,000 over an eight month period.
- 'At risk' registers have been developed for both diabetes and coronary heart disease, which supports proactive care for those patients flagged as at risk of developing a chronic disease. Patients identified as 'high risk' receive referrals to lifestyle modification programs and increased patient education about chronic disease prevention and self management.
- Staff are more motivated to try and make improvements at the practice since using the Model for Improvement and PDSA cycles. By planning, trying, observing and then acting on what has been learnt, the staff can review and discuss the outcomes and develop ideas for improvement, or see the positive results in action.
- Having experienced the APCC Program before, the team were confident in developing their own objectives, **change ideas** and key tasks in order to achieve their objectives.
- Verbal patient feedback has been positive, particularly in regards to the introduction of nurse led clinics.
- Data cleansing occurs once a month now, so that all patient registers are kept up-to-date and accurate.

CONCLUSION

After taking the opportunity to be involved in the latest wave of the APCC Program, staff at Maddington Village General Practice have improved their patient care, which they attribute to their improved team approach to patient care and increased team morale. The entire team were responsible for cleansing the patient database and they have since developed 'at risk' registers for patients at a 'high, low or medium' risk of developing a chronic disease. The registers help the practice team to provide systematic, proactive, and interventional care.

> ***"The APCC Program gives us a fresh approach to improving outcomes. The 'systems approach' improves our overall quality management framework, which includes quality assurances, quality improvement and risk assessment and management. We get it right much more often. We ensure timely diagnosis and effective communication through a team approach."***
>
> **- Dr Ivor DeSouza, Maddington Village General Practice Principal GP**

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