

USING INFORMATION MANAGEMENT TO IMPROVE DIABETES CARE

Platinum Medical Centre, Chermside, Queensland

GP Partners

DIABETES CHANGE PRINCIPLE 3

Be Systematic and Proactive in Managing Care

Summary

Platinum Medical Centre (MC), while operating a successful holistic health care service, acknowledged their lack of standard systems which could improve their services even more. Diabetes is a strong focus for the clinic and through the APCC Program, the team at Platinum MC were able to successfully establish a strong diabetes care plan, through data cleansing and building their registers and well as employing a chronic disease specialist nurse.

Background

Whilst offering a unique and holistic approach to health care, through their involvement in the APCC Program, Platinum MC realised that they did not have standard systems in place. Operating with two full time and two part time GP's, plus Registrars, the practice saw a need to ensure that standard systems and processes were in place, in order to provide more systematic care for their patients with diabetes.

Diabetes was a particular focus for Platinum MC because of the increase of this disease in the community and the escalating problem of childhood and adolescent obesity, as precursors of the disease. The practice principal also has a strong interest in diabetes and ongoing involvement in diabetes education. The establishment of a nurse-led diabetes clinic was seen as a positive step towards improving patient outcomes in this area.

Platinum MC felt that by offering proactive and preventive care, such as patient education, and encouraging positively focused lifestyle changes, they could help patients reduce the risk or avert the development of type 2 diabetes.. For those patients that already had type 1 or type 2 diabetes,

continuity of care and timely care were paramount in achieving optimal health outcomes and reducing complications associated with diabetes.

Process

After attending the APCC workshops, particularly the sessions relating to diabetes, Platinum MC were clear on the steps and tools needed to establish consistent standards and implement uniform strategies. Using PDSAs, Platinum MC was able to analyse what they were doing on a day-to-day basis and from this, form a plan of action to target the following gaps:

- A valid and up-to-date diabetes register.
- A recall and reminder system.
- The ability to identify, capture and complete the annual cycle of care for patients.

Outcomes

- The practice principal is a GP on the Advisory Council on Diabetes, which educates GPs nationally on type 2 diabetes early intervention and insulin therapy.

*“To begin with the APCC work seemed daunting and too difficult to accomplish... However, it taught us to **THINK** about what we were doing and how we were delivering our healthcare. We soon saw gaps that were making our jobs unnecessarily complicated”*
- Moira, Practice Nurse



Outcomes continued

- The team learnt how to disseminate skills and knowledge from the practice principal and facilitate the development of an effective diabetes management program.
- Practice Expansion – The addition of a Chronic Disease Management (CDM) specialist registered nurse was a key part of the diabetes management program.
- Other registered nurses now employed by the practice are encouraged to attend workshops and seminars hosted by the Division - GP Partners, to increase their skills and knowledge in order to more effectively provide a team based holistic health care program.
- Data Cleansing - Improved recall and reminder system – Chronic Disease registers for both diabetes and chronic heart disease (CHD) were established. This allowed the CDM registered nurse (RN) to focus on patients who required more specific and more frequent interventions and follow ups.
- The establishment of these registers enabled the medical centre to be more vigilant in its monitoring of patient HbA1c's, blood pressures and medications.
- Platinum MCs 'Annual Cycle of Care' brochure was updated to include patient's goals and measures, and has been used by 87 patients so far.
- The practice principal's vision was for total client health care, incorporating all on-site allied health professionals (including podiatry, medical massage, counselling and acupuncture), therefore an effective communication process between all providers was needed. In-house discussions and reciprocal referral arrangements have been developed with written feedback (as required) and informal patient progress meetings occurring on an 'as needs' basis.
- Improved communication with patients
 - Patients are contacted according to outstanding tests or abnormal results. In addition to this; personal information gained

during GP Management Plans and reviews, identify gaps in patient knowledge about self-management which alerts practitioners to the need for closer monitoring or altered interventions to maintain optimal health outcomes for the patient.

- The CDM RN evaluates patient knowledge of diabetes and embarks on a patient oriented teaching program. GP's and allied health practitioner's work together with the patient to achieve optimal health outcomes. This close partnership with shared goals instils a sense of empowerment and ownership where patients feel they are genuinely valued and are happier and healthier as a direct result.

Looking Forward

In 18 months, Platinum MC has implemented real changes and made significant improvements in monitoring the progress of diabetic patients. With guidelines and management protocols in place, the practice is now well placed to continue managing its level of diabetic patient care and expand these protocols to CHD, asthma, osteoporosis/ osteoarthritis.

Conclusion

Using the skills and tools learnt through the APCC Program, Platinum MC have been able to make tangible differences to the way they run the practice and the level of care provided. Patients with diabetes are now closely and effectively monitored. Quality data analysis was the cornerstone of the improvement process, without which identification of the target groups would not have been possible.

