

## CASE STUDY: PLATINUM MEDICAL CENTRE

# Using Information management to improve diabetes care

Platinum Medical Centre (MC), while operating a successful holistic healthcare service, recognised that by introducing standard systems they 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 as well as employing a chronic disease specialist nurse.

**Location:** Chermside, Queensland

**Staff:** 2 full time GPs, 2 part time GPs, registrars and reception staff

**Goal:** To introduce standard systems that will assist in proactively managing the care of patients with diabetes

### Background

Whilst offering a unique and holistic approach to healthcare, 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 their 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.

The team at 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 their

risk of developing 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 Plan, Do, Study, Act (PDSA) cycles, Platinum MC had the ability 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

Since joining the APCC Program, the practice has seen a number of outcomes occur. Some of these outcomes are included below:

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

- The team learnt how to spread the skills and knowledge from the practice principal to the rest of the team and facilitate the development of an effective diabetes management program.
- Practice expansion – the practice employed a chronic disease management registered nurse (CDM RN) who plays a key role in the diabetes management program.
- More registered nurses have been employed by the practice. All staff 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, healthcare program.
- Data cleansing & improved recall and reminder systems – chronic disease registers for both diabetes and chronic heart disease (CHD) were established. This allowed the CDM RN to proactively focus on patients who required more specific and more frequent interventions and follow ups.
- The establishment of registers enabled Platinum Medical Centre to be more vigilant in its monitoring of patient's HbA1c, blood pressure 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 healthcare, 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; information gained during GP Management Plans and reviews identify gaps in patient's knowledge of self-management. This 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 instills 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 patients with diabetes. With guidelines and management protocols in place, the practice is now well placed to continue managing its level of patient care for diabetes, and expand these protocols to CHD, asthma and 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.

To learn more about Platinum MC, visit their website at:

<http://www.platinummedical.com.au/>

**“To begin with the APCC work seemed daunting and too difficult to accomplish – especially the PDSAs and monthly reporting measure. 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**