DIABETIC IMPROVEMENTS THROUGH DATA ANALYSIS AND ALLIED HEALTH PARTNERS

Prospect Medical Centre - TAS

General Practice North TAS

Diabetes Change Principle 3

Be systematic and proactive in managing care

Summary

Prospect Medical Centre (MC) developed a care program for patients with diabetes, which required correct data input, registers and more specific programming. The practice had also extended its allied health and nursing services (which includes a dietician, diabetic educator, podiatrist, mental health nurse, exercise physiologist, psychologist, and their chronic disease nurse manager and diabetic nurse coordinator), to provide both preventative and health management measures for patients with diabetes.

To develop the program further and offer more comprehensive care, the practice utilises a framework as part of their management system, focusing on six areas of the business, within which, changes made would have a direct impact on diabetes care:

- Human Resources
- Clinical
- Financial
- Facilities
- Patient Management System
- Management & Future Planning.

Prospect Medical uses these six areas whenever the practice is undertaking planning and development. If all of these areas are considered in terms of the changes being made, then it will assist with smoother practice development and implementation of ideas.

Background

Prospect MC is situated in Launceston, which has a population of approximately 105 445 people, however the practice sees patients from a much wider area of Tasmania, with patients currently distributed over 95 different postcodes. The practice currently has nine GPs, 5.4 FTE, a part time chronic disease nurse, a diabetes nurse coordinator and five practice nurses who work various part time hours to take care of their daily appointment schedule. They also employ a practice manager, an office manager, an allied health manager/nurse administrator, and eight part-time reception staff.

The Process

In order to achieve their aim of providing more comprehensive care for diabetes patients, Prospect MC discussed and decided on a number of goals they wanted to reach in order to achieve their overall aim. The goals were, and continue to be developed by, the GPs, practice nurses, chronic disease coordinator and the practice manager. Dr Vanderslink one of the practice's GPs and Cecily, the practice manager, have been actively participating in the Collaboratives Program so they have a large amount of input into the practice's chronic disease development.

The goals developed are as follows:

- Ensure all diabetic patients are correctly coded.
- Have an accurate diabetic register.

- Ensure all diabetic patients had completed their annual cycle of care.
- Ensure correct item numbers are being billed.
- Increase SIP payments to continue funding the diabetes program.
- Ensure all diabetic patients had been offered a GP Management Plan.
- Ensure that the team care arrangements are complete to allow access to the appropriate allied health workers. These arrangements increase access as the patient is then eligible to a total of five visits to allied health services, which is covered by a Medicare rebate. Therefore it is financially more viable for these patients to access additional care, and continuity of care is increaseed through improved communication between the GP and allied health worker.
- Develop programming and initiatives with allied health providers to improve patient care.
- Appoint a practice nurse responsible for the continued development and implementation of the diabetes program.
- Educate patients with diabetes to make their condition clear and known when calling the practice, so that they can then be triaged accordingly as in some cases this may increase the urgency of the required appointment.
- Educate reception staff on triage of patients with diabetes and to encourage the patients to feel comfortable in identifying themselves to triaging staff.

To achieve the above goals:

- Clinical staff were educated on correct diabetic coding to ensure that registers were accurate. Dr Vanderslink and Cecily organised a meeting for the doctors and nurses, where it was agreed that the correct data boxes within the medical director system would be utilised, as many of the doctors were free typing so the data was not identifiable for registers.
- HbA1c's were obtained from pathology and cross-referenced with the practice's diabetes register. The practice used their program officers from General Practice North to assist with some information that they had collated through the Collaboratives process. Doctors then identified patients not on the diabetes register who should to be. This has resulted in a more accurate and complete diabetes and pre-diabetes register.
- The general nurse coordinator was working additional protected time in order to undertake the diabetic patient work and took on responsibility of managing the diabetes program. The practice has since changed this arrangement and now employs a nurse for two days a week to coordinate diabetic care within the practice.
- The diabetic educator (a specialised nurse with additional training in diabetes care), and a dietician, are now running specialised diabetes clinics to encourage patients to be proactive with their own care. They provide a clinical service for care and support of people with diabetes and assist patients to develop plans for better control of diabetes with nutrition, exercise and medication.
- The chronic disease coordinator cross referenced the established GP Management Plan patient spreadsheet with the diabetic register, to identify patients without a GP Management Plan.
- An exercise physiologist has joined the practice, currently working one day a week, however they may work more days when

demand increases. It will be recommended to patients with diabetes to see the exercise physiologist to assist them with their care, often this is done through the team care arrangement.

- The practice will be checking with patients to ensure they are on the National Diabetes Services Scheme (NDSS) and if not, add them. NDSS is a free of charge Australian Government program, which offers a range of approved products and information to people who register, in order to assist them to manage their condition. The practice decided this would be beneficial after doing a PDSA on this prior to the third workshop in Sydney, and in addition, attending an information session on this during the third workshop.
- The practice will correlate patient records as to when cycles of care were completed, reviews were done, GP Management Plans, Team Care Arranagements (TCA), and medication reviews in spreadsheets and they will compare their benchmarks through both General Practice North and their Collaborative data to track diabetes patient care.

Outcomes

Through systematic identification of the steps that needed to be taken, Prospect Medical Centre has been able to achieve a number of its aims under the business area framework:

- Human Resources –increased team involvement in diabetes care. A policy and procedure manual on chronic care has been developed.
- Clinical – patients with Diabetes receive more systematic care and have a greater awareness and tracking of self management.
- Financial – there is a forecast increase in SIP payments.
- Facilities – a room has been allocated for allied health services and clinics.
- The practice now has an accurate diabetes register that is constantly updated and monitored.

Looking Forward

With a number of successful steps taken, Prospect Medical Centre now has a motivated workforce who is engaged in the process of change and will continue to support the achievement of their aims.

The practice intends to continue building their diabetes program and is looking into developing allied health workshops.

Conclusion

Through awareness of their practice and some of its limitations, particularly in the field of data accuracy, Prospect Medical Centre have systematically worked through their plan and have been able to make positive changes. Patients have commented that access to allied health workers within the practice is fantastic and they appreciate the time given by staff, to care for chronic disease patients through their GP Management Plans and the whole of team care.

> ***" 'An idea that is developed and put into action is more important than an idea that exists only as an idea'* (Buddha)*...the APCC Program assists practices to achieve this."***
>
> *- Cecily Igglesden, Practice Manager Prospect Medical Centre, uses this quote from Buddha in her business plan.*

The Australian Primary Care Collaboratives Program is funded by the Australian Government Department of Health and Ageing and delivered by the Improvement Foundation