

## CASE STUDY: BROUGHTON CLINIC

# Using population health data to chart improvements and measure outcomes

Broughton Clinic joined the APCC Program to learn how to use their patient population health data more efficiently. Through regular data cleansing and analysis, they were able to more accurately define their patient population and measure health outcomes. The team is now more focused on making improvements and staff challenge themselves to find better ways of improving patient engagement, and provide systematic and proactive care.

**Location:** Port Broughton, South Australia.

**Staff:** At commencement of the Program in 2006 there were 2 GPs, 1 practice manager and 4 part time reception staff.

**Patients:** Approximately 3600 active patients.

**Goal:** To accurately define the patient population and measure outcomes by conducting regular data cleansing and review.

## BACKGROUND

Broughton Clinic is located at the seaside rural community of Port Broughton, about 170km north of Adelaide, in the mid north of the state. It is a private health service which has been operating for over 30 years. Originally operating with a solo GP, a second GP was employed to cope with population growth in the area.

At their commencement of the Program, the patient database had 5890 'active' patients, mainly consisting of senior citizens, retirees, fishing and farming families and holiday makers. Broughton Clinic joined the APCC Program to learn how to use the data that was being inputted into their system more efficiently. The health service staff felt that if their patient information and activity status was more organised, they could more accurately define their patient population and measure health outcomes, which would also help the team to identify other potential areas for improvement.

## PROCESS

A review of the patient database reduced the active patient number by around 40% down to a more realistic figure of about 3500 patients. This process involved archiving patients who were holiday makers, had left the practice or had not visited the practice, in the past two years.

Analysis of clinical data is conducted monthly to provide an ongoing focus on charting improvements and to challenge staff to find more efficient processes which will lead to improving patient engagement. Data is extracted from the clinical software, and feedback graphs are created. The report is evaluated by the chronic disease coordinator and then presented at team meetings, or discussed informally as time permits.

Broughton Clinic employed a practice nurse (PN) to help streamline some of the formal enhanced primary care approaches, take on a systematical management role and the monitoring of patient records. The decision to employ a PN was agreed on at a staff meeting. The nurse works closely with one of the reception staff to share the chronic disease co-ordination role. It is their job to ensure patients are up to date with their chronic disease management plans, bloods tests and other checks as appropriate. This, along with the administration team carrying out non-clinical tasks, such as making appointments and maintaining recall lists, has relieved pressure on the practice GPs.

## OUTCOMES

Cleansing their data has enabled Broughton Clinic to accurately define their population and measure health outcomes. For example the first data review suggested that less than 20% of patients with diabetes had a recorded Hba1c under 7%. However after tidying the database the figure was shown to actually be at 55%. Ongoing efforts with this group, including a focus on ensuring GPs correctly code patients, and encouraging patient involvement in managing their own condition, have improved the Hba1c <7 figure to near 70%.

Being involved in the Program clearly demonstrated to the practice opportunities for improvement that they were previously unaware of, including:

- The team has reviewed its approach to motivation and patient engagement with training in the Flinders Program (formerly the Flinders Model) - a tool for health professionals that provides a structured approach to self-management assessment and care planning.
- Patients with a chronic disease are now more engaged in their care. Almost all have care plans in place, are encouraged to make lifestyle modifications and be involved in the management of their conditions.
- appointment scheduling
- document scanning processes
- roles and responsibilities, to ensure the best person is doing each job
- a more inspiring waiting room has been created
- a stronger sense of teamwork within the staff group has been established.

One year after employing the PN, data evaluation of the 75+ health assessments showed a significant increase in the amount of these assessments being completed. These health assessments are for people aged 75 years and over, and help identify any risk factors exhibited by the patient that may require further health management. A random phone survey was completed on 20 patients, which aimed to gain feedback on these health checks, and the role of the PN, in particular. The results of the survey

indicated that patients perceived the overall service at Broughton Clinic as excellent and they welcomed the PN's involvement in the team.

The results of the survey gave the team confidence in the service they are offering and that they are moving in the right direction.

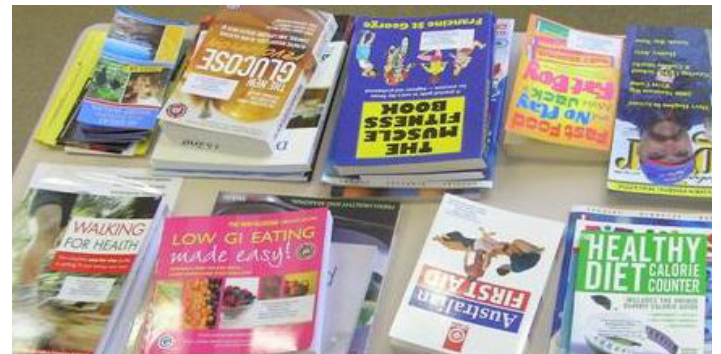
The health service team has found what gets measured, gets improved. Discovering a systematic approach to quality improvement has opened the way for the team to consider all areas of the practice for improvement.

## LOOKING FORWARD

The team at Broughton Clinic now embrace an ethos of continuous quality improvement. Embracing change and being open to alternate processes they plan to continue to review their systems and make improvements as necessary.

## CONCLUSION

Discovering a systematic approach to quality improvement has encouraged staff to consistently make small changes in order to make big improvements. It clearly demonstrated to the team opportunities for improvement across all areas, which has helped them to enhance the care they provide.



*The practice created a more inspiring waiting room with the inclusion of health related reading materials.*

**“We encourage any practice to become involved in the APCC Program. It has had a fundamental impact on how we work as a team, engage with our patients and work with them to improve their health outcomes...It was a life changing experience.”**

**- Dr Alison Edwards, lead GP.**