

CASE STUDY: CLEVE MEDICAL PRACTICE

Building a new practice from scratch with a focus on diabetes management

A change in ownership from a privately owned solo GP practice to public ownership meant Cleve Medical Practice had to rebuild from the ground up. They joined the APCC Program with an aim to improve service delivery, communication and integration with other community health services. Through their involvement in the Program, and with assistance from Country Health SA, the practice was able to grow into a successful business with a focus on diabetes care and management.

Location: Cleve, South Australia.

Staff: A GP, practice manager, practice nurse, practice office manager, reception staff, a weekly visiting female women's health GP.

Patients: There are approximately 2300 patients on their database from Cleve and surrounding districts.

Goal: To strengthen relationships with other health services in order to improve service delivery, with a focus on diabetes care and management.

BACKGROUND

In late 2007, Cleve Medical Practice (MP) changed ownership from a privately owned solo GP practice, to publicly owned Country Health SA – Eastern Health & Aged Care (EEHAC). Their joining of the APCC Program in August 2008, corresponded with the employment of the first resident GP and installation of new clinical software.

PROCESS

In order to meet their overall aims, Cleve MP set some more specific targets including:

- 80% of patients with diabetes to be managed via a GP Management Plan (GPMP).
- All practice staff to be able to clearly articulate their role in the care of patients with diabetes and clearly understand and use the systems for referral to, and reporting from, the wider multidisciplinary EEHAC Community Health team.

In order to develop effective diabetes management plans for their patients, practice roles changed and the relationship with EEHAC and external partners was strengthened.

- When attempting to extract the original diabetes register from the previous clinical software, the Diabetes Educator at EEHAC compiled a new register based on their records.
- The EEHAC Diabetes Educator's role changed from coordination of the care for patients with diabetes, to provision of education and advice.
- The GP and practice nurse have taken on the responsibility of coordinating diabetes patient care.
- The practice staff create and maintain documentation of their specific roles, in their care, recall and billing systems associated with diabetes patients.
- The practice conducts regular meetings with staff and the EEHAC, and occasionally with the Division. The meetings aim to ensure consistent approaches to referral pathways and tools for data collection, and to set targets, plan and review improvements for the continuous care of patients with diabetes and chronic disease.

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- Cleve MP provides a 'one stop shop' for patients with diabetes at the practice by giving them information, access and referral to relevant allied health services. These include: a physiotherapist, diabetes educator, podiatrist, dietician, optician and an ophthalmologist, who may be employed. Transport can be arranged to regional centres as needed for specialist health care.
- They have established and built upon a working relationship with visiting accredited pharmacists, which enables them to provide medication management reviews.
- The Healthy Living Project officer at EEHAC has been nominated as the officer responsible for receiving referrals from the practice to the EEHAC Healthy Living team, and also for the return of all reports about patients back to the practice.
- The Healthy Living team at EEHAC have taken on responsibility for most of the educational, lifestyle and health promotions and activities in the area. The Healthy Living Team is made up of a Lifestyle Advisor, Chronic Disease Self Management Coordinator, Health Promotion Coordinator and Youth Development Coordinator who provide a planned approach to healthy living across population groups and communities.
- The practice has run group diabetes education sessions (similar to a diabetes clinic), when the waiting times for individual sessions becomes excessive.

OUTCOMES

Along with the support of EEHAC and the APCC Program, Cleve MP has established:

- a database of over 2300 patients
- a diabetes register of 101 patients
- a current GPMP for over 80% of diabetes patients
- HbA1C and BP records for over 90% of diabetes patients in the last 12 months
- over 50% of diabetes patients have a record of HbA1C ≤ 7 .

In 2009 Cleve MP designed and distributed a patient survey to gather information and feedback regarding the community perception of the services offered by the practice. The results of the survey showed that of the 100+ patients on a GPMP that responded to the survey, 81% reported improved confidence in managing their condition as a result of the care planning process.

The practice has made a number of improvements as a result of the suggestions provided in the survey. Reception staff have completed training in Front Line customer service. A privacy screen and seating has been installed in the waiting area and a fold down baby change table has been installed in the practice bathroom. Signage has been developed and displayed in the waiting room in relation to waiting times; communication with the GP and the type of appointments required e.g short/long consult.

LOOKING FORWARD

The patient survey gave the practice a number of ideas for improvements. They are now looking to increase promotional activity to build up community awareness of services available to women, and recruit a Womens Health GP to provide a weekly service. The practice also plans to extend their relationship with all of the EEHAC community health and hospital staff, to continue an integrated multidisciplinary approach to patient care.

CONCLUSION

With the support of the APCC Program, the Division and EEHAC, Cleve Medical Practice successfully changed ownership, while developing a strong focus on diabetes management and ultimately improving the overall care for their patients. The practice has a great reputation amongst their patients, and by continuing to communicate with them, they will continue to evolve and improve the services they offer.

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