

CASE STUDY: PROSPECT MEDICAL CENTRE, TASMANIA

New care program improves outcomes for patients with diabetes

Prospect Medical Centre (MC) developed a care program for patients with diabetes, which required correct data input, registers and more specific programming. The practice extended its allied health and nursing services - which now 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.

Location: *Launceston, Tasmania.*

Staff: *9 GPs (5.4 full time equivalent), part time chronic disease nurse, general nurse coordinator, diabetes nurse coordinator, 5 practice nurses; practice manager, office manager, an allied health manager/nurse administrator, and 8 part time reception staff.*

Patients: *Broad patient demographic spreading over Launceston and surrounding areas.*

Goal: *To provide more comprehensive, systematic and proactive care for patients with diabetes.*

BACKGROUND

Prospect MC uses a specific framework as part of their management system whenever they undertake planning and development. The framework focuses on the following six areas of the business: Human Resources; Clinical; Financial Facilities; Patient Management System; Management; and Future Planning.

If all of these areas are considered in terms of the changes being made, then practice development and implementation of ideas will be a smoother process.

PROCESS

In order to achieve their aim of providing more comprehensive care for patients with diabetes, the team at Prospect MC discussed and decided on a number of goals. The lead APCC GP, Dr Vanderslink,

and practice manager, Cecily, have been actively participating in the APCC Program so they have a large amount of input into the practice's chronic disease development. **The following goals were developed:**

- Ensure all diabetic patients are correctly coded, have been offered a GP Management Plan and completed their annual cycle of care.
- Have an accurate diabetic register.
- Ensure correct item numbers are being billed and increase Service Incentive Payments (SIP) to continue funding the diabetes program.
- Ensure that the team care arrangements (TCAs) are complete to allow access to the appropriate allied health workers. The arrangements ensure access as the patient is then eligible to a total of five visits to allied health, which is covered by a Medicare rebate, making it financially more viable for these patients to access a continuity of care.
- Develop programming and initiatives with allied health providers to improve patient care and appoint a practice nurse responsibility 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.

To achieve their goals:

- Dr Vanderslink and Cecily organised a meeting to educate clinical staff on correct diabetic coding to ensure that registers were accurate. It was agreed that the correct data boxes within the medical director clinical system would be utilised. Previously many of the doctors were free typing, so the data was not identifiable for registers.
- HbA1c results were obtained from pathology and cross-referenced with the practice's diabetes register. Doctors could then identify patients not on the diabetes register who should be.
- The general nurse coordinator was allocated additional hours in order to undertake the diabetic patient work and manage the diabetes program. The practice has since employed a nurse for two days a week to coordinate diabetic care.
- The diabetic educator 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 patients with diabetes and assist them to develop plans to better control their condition with nutrition, exercise and medication.
- The chronic disease coordinator cross-referenced the established GP Management Plan patient spreadsheet against the diabetic register to identify diabetic patients without a GP Management Plan.
- An exercise physiologist has joined the practice, currently working one day a week. Patients with diabetes are advised to see the exercise physiologist to assist them with their care. Often this is done through the TCAs.
- After completing a Plan, Do Study, Act worksheet and listening to a presentation at an APCC workshop, the practice begun checking with patients to ensure they are on the National Diabetes Services Scheme (NDSS) and if not, adding them.

- The practice correlates patient records as to when cycles of care were completed, reviews were done, GP Management Plans, TCAs, and medication reviews in spreadsheets and then compares their benchmarks through both General Practice North and their APCC data to track diabetes patient care.

OUTCOMES

Through systematic identification of the steps that needed to be taken, Prospect MC 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 an increase in SIPs.
- 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 MC 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 team intends to continue building their diabetes program and is looking into developing allied health workshops.

CONCLUSION

Through being aware of their practice and some of its limitations, Prospect Medical Centre have systematically worked through their plan and made positive changes. Patients have commented that access to allied health workers within the practice is fantastic. They also appreciate the time given by staff to care for chronic disease patients through their GP Management Plans and the whole of team care.