CASE STUDY: SEVILLE DRIVE MEDICAL CENTRE

Working collaboratively to implement new systems to improve diabetes care

Seville Drive Medical Centre has improved its processes and systems to ensure all patient data and information is correctly recorded in the clinical software, which allows for more proactive care of patients with chronic diseases. The practice now prides itself on its diabetes care, provided by a whole-of-team approach.

Location: *Seville Grove, Western Australia.*

Staff: *5 full time GPs, 4 part time GPs, 2 FTE practice nurses, 4 FTE receptionists and 1 practice manager.*

Patients: *Approximately 12,000 active on the database.*

Aim: *To work collaboratively to implement new systems for identifying, diagnosing and recalling diabetes patients, in order to provide more efficient and proactive care.*

BACKGROUND

Seville Drive Medical Centre (Seville Drive) was established in July 2005, when a number of GPs and other practice staff transferred from a nearby corporate medical centre. In 2009 Seville Drive commenced the Chronic Obstructive Pulmonary Disease (COPD), and Chronic Disease Prevention and Self Management (CDPSM) wave of the APCC Program, as the GPs identified a need for improved diabetes care and systems for diagnosing diabetes. Seville Drive expected that the information supplied and the interaction with other practice teams sharing the same goals and desires, through the Program, would help motivate and lead them to improve their community's awareness and education of diabetes, as well as improving patient care.

PROCESS

Through their involvement in the Program, the team at Seville Drive have become more aware of the increasing risk of diabetes within the community. Due to their low numbers on the diabetes register, the practice decided to actively seek out uncoded patients (patients who were not identified on the system as having either diabetes type 1 or type 2). This was achieved by running reports that identified patients who were currently taking diabetic medication and cross-checking this against those patients currently on the diabetes register. Those who were on the appropriate medication but not recorded on the system as a patient with diabetes were then recorded correctly and added to the diabetes register.

Through their diabetes register cleansing work, the team identified that some patients with diabetes who were under specialist care were not being coded as a patient with diabetes, on the database – this was progressively corrected upon receipt of specialist letters, which often included the results of pathology tests done by them.

Another initiative the practice team undertook was to randomly screen patients from the waiting room using urinalysis – this was done opportunistically when the nurses had time.

The practice team works collaboratively in identifying, recalling and caring for patients on the diabetes register. Staff members in all areas are required to update any information that they gather or receive regarding the patients in their clinical software. Once patient records are updated, they are checked by the nurses for any codes that allow patients to receive additional services, such as a diabetes educator, podiatrist or GP Management Plan. This helps the patient proactively manage their condition, and is more financially viable for the practice.

In order to engage the entire practice team, Seville Drive holds regular team meetings. They have also installed a staff noticeboard on which they post their monthly APCC Program result graphs. The noticeboard is a good way to keep all team members informed and engaged in their improvement work, and highlights what areas are being focused on by the team. Monthly results are eagerly awaited by staff so they can see how they have improved over the past month and how well the practice is doing, compared to the average of all other practices in their wave. The result graphs encourage the team to strive for further improvements.

Practice manager Jeanette Bailey says "The assistance from the Canning Division of General Practice cannot be understated, they are always ready to help and motivate. In addition to the support provided by the Division, the ability to share ideas with others in the Program and "steal shamelessly" has been an essential part of the process."

OUTCOMES

Through changes to their systems and a refreshed approach to patient care, Seville Drive now have:

- Accurate and up-to-date registers, which allows for better management of chronic disease care.
- Improved procedures for identifying uncoded patients with diabetes – cross checking reports on a regular basis i.e medication list vs diabetes register.
- Improved database recording processes for patients with a chronic disease, which means they are correctly identified, diagnosed and recalled, as required.
- Confidence in their level of patient care due to improved systems and processes.
- A whole-of-team approach to identifying and recalling patients, rather than individually.
- Increased income due to completing more care plans and coding correctly.
- Increased income has enabled them to employ a new nurse, whose primary role is to develop care plans, as well as provide practice support during busy periods and annual leave.
- Confidence that information sent to specialists and allied health workers is accurate, as patient records are correctly entered and kept up-to-date on the practice's clinical software.
- Increased patient education and knowledge leading to more proactive patient self management of chronic disease.
- Newly diagnosed patients with diabetes are being identified regularly as a result of routine checking of specialist letters, new patient information forms, transferred files, and recording the data in the clinical software.
- Regular assessments are being carried out by nurses and GPs to ensure patients that are at a risk of developing a chronic disease are identified and proactively cared for.
- A greater awareness of the increasing risk of diabetes in the practice's patient population, and improved systems to manage these risks.
- Seville Drive has received positive feedback from patients regarding the improved systems of care. They have expressed appreciation for the extra care they are now receiving and say they feel special and cared for at the practice.

CONCLUSION

The knowledge Seville Drive Medical Centre has gained through peer-to-peer learning at the Program workshops has assisted the practice team to thoroughly cleanse and update their patient database, and implement new systems for identifying, diagnosing and recalling patients with diabetes. As a result, improved systems have led to better care for all of the practice's patient population.

"Patients have verbally expressed their appreciation and tell us they feel better informed and cared for, which is demonstrated by their increased physical activity, better diets and improved HbA1c readings."

- Jeanette Bailey, Practice Manager

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The Australian Primary Care Collaboratives Program is funded by the Australian Government Department of Health and Ageing and delivered by Improvement Foundation Australia. © Improvement Foundation 2010.