# Every single patient
# Every single time

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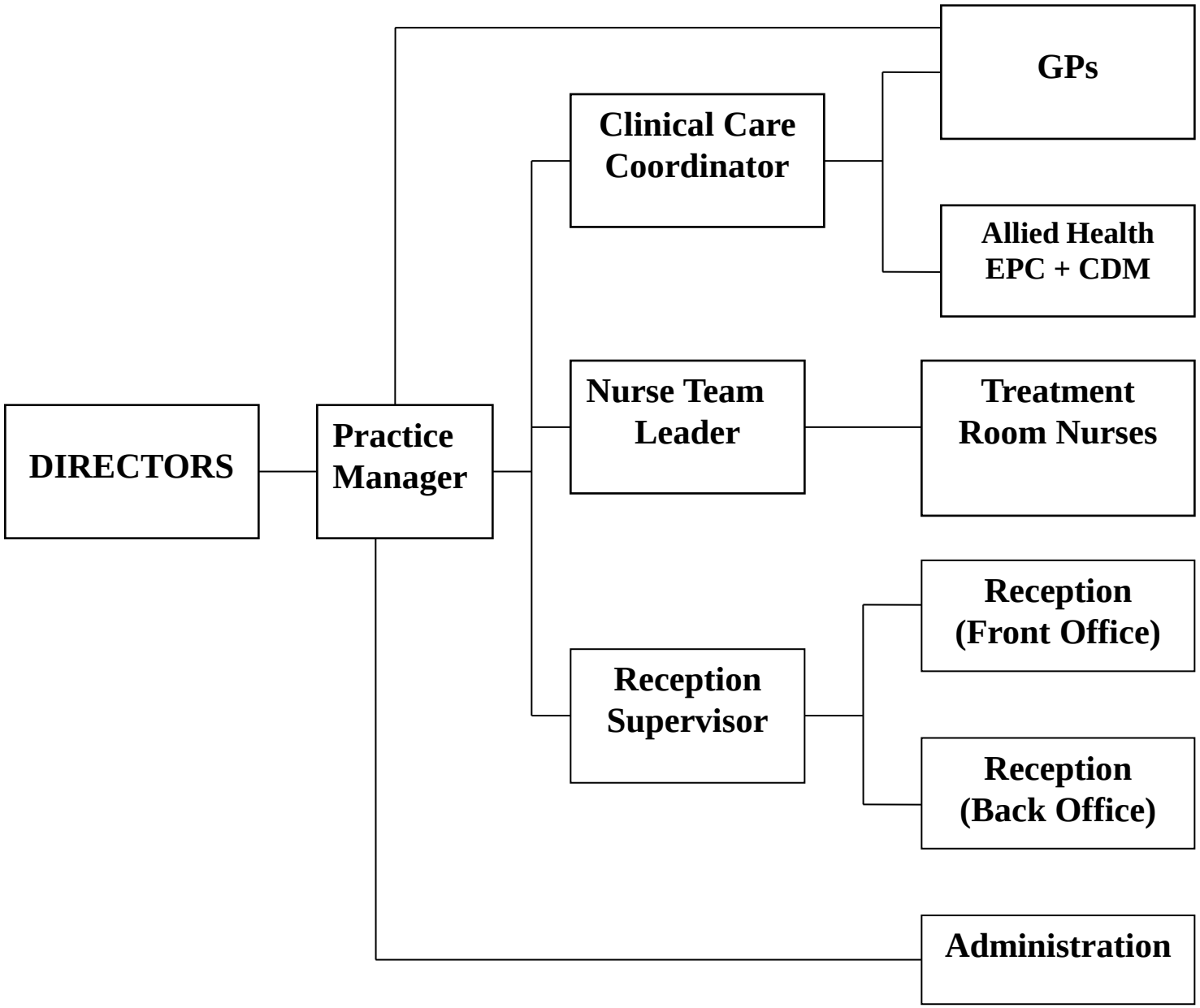
# Practice Profile

- Woodend in the Macedon Ranges Shire – rural Victoria (1 hour drive from Melbourne & 1 hour drive from Bendigo)
- 14,000 active patients
- 13 part-time reception & administration staff
- 10 part-time GPs
- Practice Manager
- Clinical Care Coordinator
- 9 Registered nurses (Treatment Room) part-time
- 2 Diabetes Educators (DE) part-time
- 1 Asthma Educator / Smoking Cessation Nurse part-time
- 1 Dietitian part-time
- 1 Exercise Physiologist part-time
- 2 Health Assessment / Chronic Disease nurses part time
- Other Health Professionals private practice – physiotherapist, podiatrist, psychologist, audiologist & ENT surgeon
- Diagnostic services – radiology & pathology


DIRECTORS
Practice Manager
GPs
Clinical Care Coordinator
Allied Health EPC + CDM
Nurse Team Leader
Treatment Room Nurses
Reception (Front Office)
Reception Supervisor
Reception (Back Office)
Administration

# Aim

To systematically provide:

- The right care
- To the right patient
- At the right time

# To meet our aims:

- Need to know patient population
  - Identify, validate & document ► register
- Use evidence based practice
  - Eg. RACGP / Diabetes Aust Type 2 Diabetes care guidelines
- Ensure services are provided at right time
  - Use register or data collection tools to track what is done & when

# 1st PDSA: How we started

PDSA to construct the register

- Plan: Identify all patients w diabetes
  - with a diagnostic code of diabetes
  - prescribed insulin & oral hypoglycaemics
- Do: search our patient data base for patients with code or meds

# 1st PDSA cont.

- Study phase
  - Many patients found
  - A number have Diabetes (prescribed insulin or oral hypoglycaemics) but do not have a diabetes code
  - We don't think we have enough patients on register
- Action
  - Record all on register
  - Ensure all have a diabetes code
  - Need to discuss with all clinical staff to put code for Diabetes patients
  - ► new PDSA to see if we have more eligible patients

# 2nd PDSA

- Plan & Do: Get lists of all patients who've had HbA1c tests done in last 18 months & compare with register (path labs)
- Study: found 57 patients not already on the register
- Act: Look at some patients – we think they should be on register but:
  - Some with HbA1c test don't have diabetes
    - ► new PDSA

# 3rd PDSA

- Plan: Are the 57 patients eligible for the register?
- Do: Diabetes Educators investigate file notes
- Study:
  - 27 have diabetes but it's not coded
  - 18 have pre-diabetes
  - 2 have neither
  - 10 have moved or are deceased
- Act:
  - Diabetes patients ► give a code & add to register
  - Discuss with clinical staff re use of HbA1c test in those not diagnosed with Diabetes
  - Archive medical records where appropriate
  - Pre-diabetes ► another story!

# 4th PDSA – mysterious register intruders!

- Register found to have Pre-diabetes patients!
  - Team discuss► come to a shared agreement – one system for the practice – **write up protocol**
- New PDSA
  - Build a register for patients with Pre-diabetes
  - Aim: to provide systematic care as per RACGP / Diabetes Aust General Practice Guidelines

# A team approach

- Reference group (represent all teams)
- Aim to build clear protocol with procedures
  - Who is responsible for what?
  - How to ensure new patients get on register?
  - How to facilitate care within timeframes?
  - How to ensure continuing care?
- Discuss & get feedback from whole team
- Allow for reflection and refinement over time

# Agree on a system of care

- Use guidelines for best practice care
  - RACGP / Diabetes Aust.
  - Medicare Diabetes Cycle of Care
- Allocate a key DE (even for patients seeing GP only)
- Decide on a system to document care and
- Decide on a system to identify those who have not had their baseline care
  - Use of recall and reminder system
  - Register report shows who is missing care
- Document the system ► written protocol

# Maintaining the register

Building a register is **not** a once only event

- Need to revisit the process (6 monthly?)
  - Patients who are new to the practice
  - Patients who are newly diagnosed
  - (may need coding as well as adding to register)
- Remove patients where required
  - Archive patients
  - Shift patients from pre-diabetes to diabetes register
    - Remove one code and give another

# Facilitating access

- Recall & reminder – part of protocol for care
  - good for systematic care and risk management BUT
- Does not guarantee the patient will use the service
- What can we do to make ourselves more receptive to the needs of our patients?

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