Nurse Led Clinics

Learning Outcomes

1	At the end of this session, participants will be able to specify some of the key elements for establishing and maintaining a nurse led clinic
2	At the end of this session, participants will have gained some useful ideas about how to establish and maintain systems and processes that ensure a successful nurse led clinic

Jean Beriki

Dianella Community Health / Hume GP Super Clinic

HUME G.P. SUPER CLINIC

42-48 COLERAINE STREET,
BROADMEADOWS

MEDICAL PRACTICE STAFF

- 1. 8 Doctors, Full/part time
- 2. 1 Practice Manager
- 3. 1 Practice Nurse
- 4. 7 Reception Staff- Full and Part time.

VIRTUAL NURSE LED CLINICS

- 1. STEPPING UP ONTO INSULIN
- 2. DIABETES CYCLES OF CARE
- 3. CHRONIC DISEASE MANAGEMENT CARE PLANNING.

ISSUE

- Large number of patients with HbA1c out of target
- Patient files reviewed – many needed insulin
- Process for insulin was refer out – inefficient and too long (>6 months)

STEPPING UP.

- 1. PATIENT identified with PEN
- 2. HBa1c elevated > 7.5 for the last 6 months
- 3.On maximum dose of oral therapy.
- 4. Patient called in for care plan and reviewed by GP
- 5. Check NDSS status
- **KEEP IT SIMPLE FOR THE PATIENT**
- 6. DOCTOR GIVE SCRIPT (LANTUS)
- Initiate insulin using the "Stepping Up Protocol"

PROCESS

- Training 2 lots of 4 hours
- Mentoring from a DNE
- GP trained in insulin initiation
- 6 patients called at a time
- Then as needed

PATIENTS

- Patients loved the program
- Often met each other at reviews
- Lunch organised for participants

PERSONAL REFLECTIONS

- Enjoyed the process
- Enjoyed the extended scope of practice
- Great outcomes
- Got to know patients really well
- See the improvements

OUTCOMES

- People with HbA1c >9% went from 15% to 4%
- Patients very happy program
- Doctors thrilled with success
- Protocol is now usual care

ONGOING CARE.

- FOLLOW WITH A GP MANAGEMENT PLAN
- 3 monthly review of GPMP/TCA on recall
- PICKING UP THE AREAS OF NEED AS PER THE PATIENT AND GP.
- Diabetes cycle of care done annually,
- Checking Podiatry done, eye care, weight and BP
- And any medication change.
- BLOODS HBa1c 3 monthly

Australian Primary Care Collaboratives
Pioneering Change

improvement foundation

Michelle Cordes

Harding Street Medical Centre

Harding St Medical Centre

- Over 10,000 active data base
- 310 diabetic type 2
- 15 Gp's FTE 6.5
- 3 practice nurse dedicated to chronic disease and preventative health
- 2 treatment room nurses – job share
- Onsite pathology, dietician, exercise physiologist, podiatrist and psychologist
- 3 sites

Harding Street
MEDICAL CENTRE

Before you start

- What is the clinic about?
- Where is it going to run?
- Time allocation
- What support do you have?
- What do you want to achieve?
- How will you measure success?

Before you start

- Acquire a range of educational materials and other resources
- Access referral pathways and develop relationships with local services
- Attend educational sessions- relevant to chronic disease targeting
- Use your pharmaceutical reps
- Liaise with other nurses
- Disease Foundations- Diabetes Australia, Heart Foundation, Lung Foundation, Diabetes Australia, etc, etc

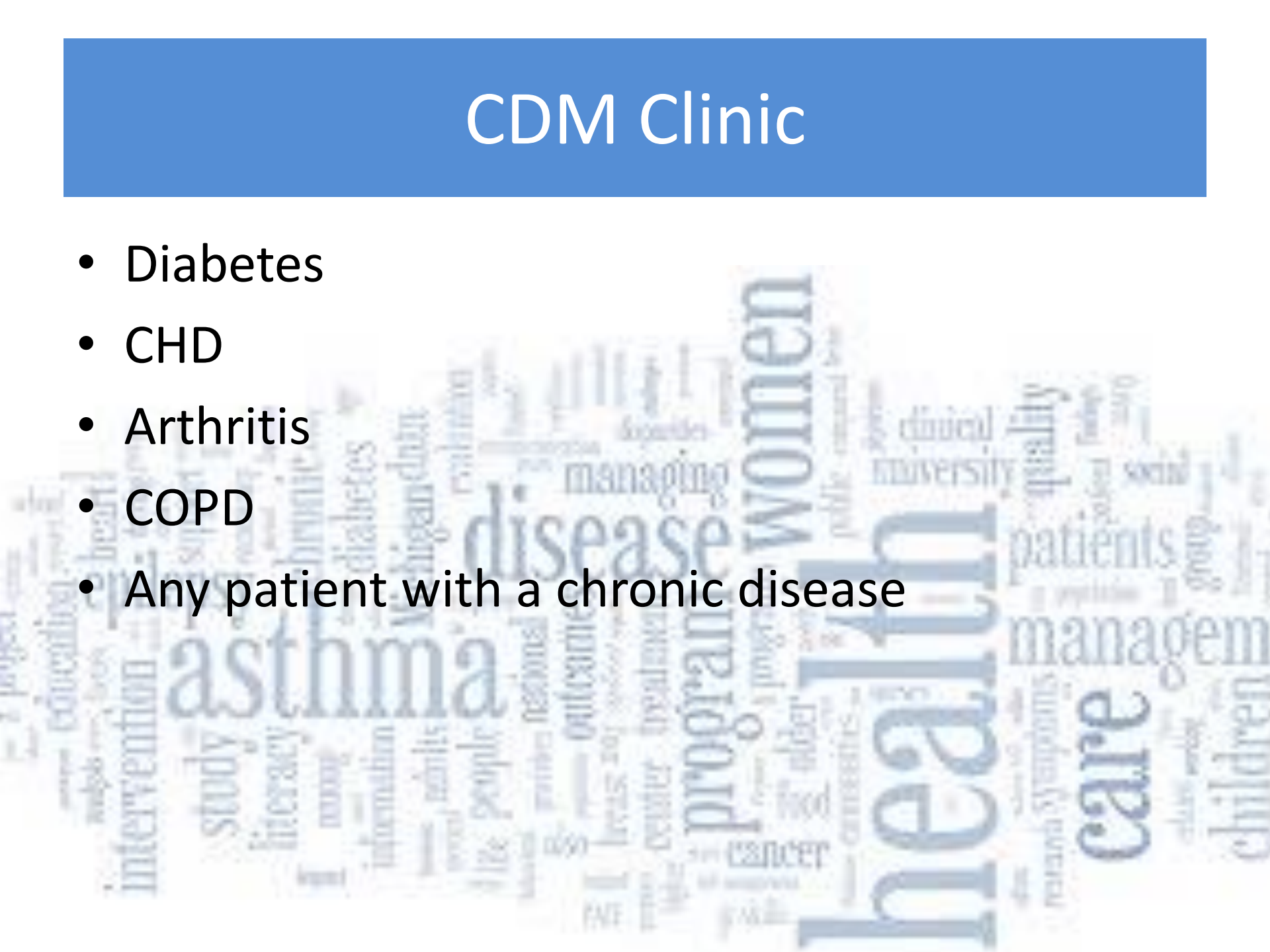
Mission and Aims

- What do you want to achieve?
  - Involve patients in there own care and help them understand disease process
  - Promote better health outcomes
  - Provide better patient care
  - Promote lifestyle modification
  - Promote disease prevention
  - Chronic disease management
  - Achieve best practice clinical management

What are we doing now?

CDM Clinic

- Diabetes
- CHD
- Arthritis
- COPD
- Any patient with a chronic disease



Why?

- Improve patient outcomes
- Improve patient care
- More holistic approach to patient care
- Encourage patients to actively take part in self management
- Improve revenue to practice

How do we get the patient involved?

- Education sessions for all staff – GPs, Nurses and reception staff
- Provide prompts in histories
- Ask GPs to recommend visit with nurse
- Advertise clinic
- Decide how to do you contact clients – letters, phone calls etc
- If resistance work with the team players

Logistics

- Patients seen off site from main practice
- This ensures no interruptions
- We offer after hours appointments
- Home visits for patients where needed

Appointments

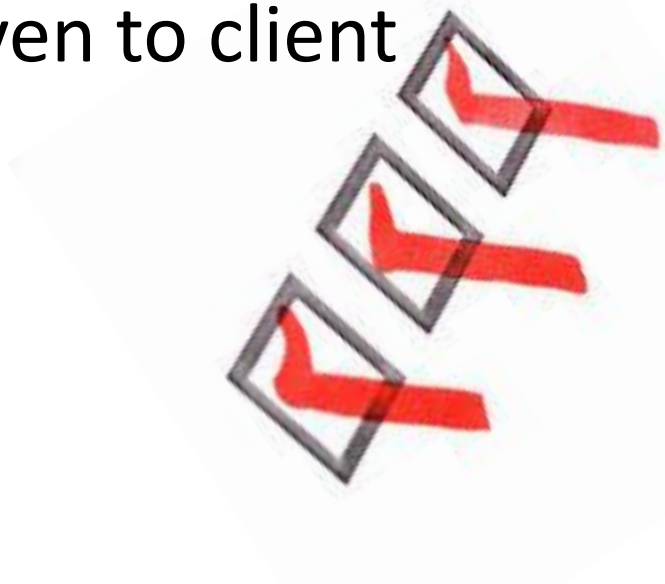
- Appointments are 1 hour each
- 3 nurses averaging 6 -8 appoints each per day
- Follow up appointment with GP to sign off and bill
- Recall with same nurse to ensure continuity of care

Session activities

- Record all patient measures
- Provide patient education
- “Mr SNAP”
- Check relevant pathology and order tests where necessary
- Promote emergency plans
- Commence GPMP
- Commence TCA where relevant
- Initiate referrals to allied health services where appropriate
- Create recalls
- Be holistic

Check lists and templates

- Create a template
- This will provide hard copy in patient's history
- Easily accessible to all GPs and nurses
- Can be printed off and copy given to client



Preventative Health

- 40 -49 Risk assessments
- 45-49 yo health checks
- 4 yo health checks
- Over 75 home health assessments
- Intellectual disability health assessments
- 50-60 yo health clinic (CD or family history)

Diabetes Management: 12 Months

- 1st Visit:
- Patients visit nurse
- Nurse creates GMPM MBS Item 721 +/- TCA MBS Item 723
- Refer for HRM if needed
- Refer allied health
- Back to GP to claim GPMP MBS 721 +/- TCA MBS 723
- 2nd Visit (3 months)
- Back to nurse to claim 10997 – ongoing education and support
- 3rd Visit (6 month)
- Back to nurse for review of GPMP MBS 732 +/- review of TCA MBS 732
- Claim 10997
- 4th visit (12 months)
- Nurse claim 10997
- Repeat GPMP MBS 721 +/- TCA MBS Item 723
- Then claim diabetes SIP 2517
- *During the 12 months ticking off Diabetes Cycle of Care Items*

Diabetes Management: Use of prompts/reminders

- Prompt GPs through clinical systems and remind them the patient
- Needs pathology
- Needs Referral: Consider community health if EPC has been utilised in calendar year
- Needs eye check
- Needs measures recorded
- If all diab sip requirements met claim item number

CHD Management

- Familiarise self with best practice recommendations
- Pathology, recording of all measures, discussion re medications, promote healthy diet and regular physical activity
- Create recalls

Remember think outside the box

- All patients with a chronic disease should should have a GPMP
- Also ask yourself:
  - Do they need / qualify for TCA?
  - Do they fit criteria for HMR?
  - Are they 40 -49 years?
  - Have they had 45-49 y.o. health check?
  - Are they over 75 years?
  - Are they ATSI?

Support

- Initially the practice priniciple plan to commence this initiative following APCC wave
- Stared this with 1 nurse and 1 GP
- Has taken over 4 years to get most Gp's onboard
- Work in progress

Marketing

- Power point presentation running in the waiting room
- Prompts in patient in clinical notes
- New patient information packs
- Website
- If it comes from GP then patients more inclined to participate initially
- Word of mouth

Results

- Patient outcomes - improvements
- Patient feedback – keen to return
- GP time – dramatically decreased
- Data improvements - ongoing
- Financial improvements –

  Continual increase

Ongoing improvement

- Provide regular reviews
- Share freely
- Continually share your journey
- Be systematic
- Baby steps
- KISS method
- Keep your data clean

Key Messages

- Work with the willing
- Set realistic goals
- Ensure all staff are aware of what you're trying to achieve
- Ensure the team share the same goals
- Continually monitor and conduct clinical audits
- Continually review service delivery
- Hold regular staff meetings
- Take small steps

Key Messages

- Clean data
- Develop accurate chronic disease registers
- Use PDSAs
- Acknowledge it’s a work in progress
- Whole of practice team involvement
- Use Extraction Tool to monitor, create registers and identify patients
- Marketing is essential

Conclusion

- All clinics are works in progress, therefore continually improve
- Talk to patients – what do they want?
- Always good to have new ideas and keep looking for things to do
- Use the APCC mailing lists and discussion boards – find out what other practices are doing

Acknowledgements

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