



Strengthening The Chronic Disease Team

Processes that work



Changes in Primary Care

- It is no longer about General Practice
- What about the concept of primary care alliances
 - GP
 - Pharmacy
 - Other AHP's

Changes in GP

- The GP numbers are changing
- The new graduates are different, skill sets are different, diseases are different
- We are no longer “just” GP’s
 - We are managers of chronic disease
 - Which leads to a tug of war for us – our time and our resources



Getting the most out of your chronic disease patients

- The patient health management model
- The business model



Does it have to be a tug of war?





The Chronic Disease Tug Of War

Business Model

- Time
 - Resources
 - Knowledge
 - Skills
 - Systems
- = Costs

Patient Model

- Chronic
- Complex needs
- Multiple people
- Multiple meds

And it all takes

- time ,
resources,
systems

Changes in the Australian Population

Name of Division of General Practice	Population 2006(b)	Estimate number of Indigenous persons	% of population that is indigenous	% of population > 65 years	CALD group prevalence
South East Alliance of GP (Brisbane)	335036	5435	1.6%	11.82	8.70%
Brisbane South Division of General Practice	290235	5029	1.7%	11.49	16.90%
Logan Area Division of General Practice	291648	7043	2.4%	7.74	10.00%
GPpartners Ltd	599099	7875	1.3%	10.88	8.10%
Gold Coast Division of General Practice	461965	5257	1.1%	13.90	8.80%
Redcliff Bribie Caboolture Division of General Practice	192761	4572	2.4%	14.83	4.80%
Ipswich & West Moreton Division of General Practice	192659	6521	3.4%	10.42	5.40%
GP Connections	160650	4917	3.1%	13.32	3.30%
Central Queensland Rural Division of General Practice	75569	3884	5.1%	7.47	2.20%
Mackay Division of General Practice	132613	5253	4.0%	9.80	3.30%
Townsville Division of General Practice	161327	9739	6.0%	8.80	11.60%
Cairns Division of General Practice	134238	13251	9.9%	8.68	UA
Southern Queensland Rural Division of General Practice	177688	9469	5.3%	13.60	3.30%
North & West Qld Primary Health Care	113229	15409	13.6%	12.11	UA
Far North Queensland Rural Division of General Practice	111791	25918	23.2%	11.50	UA
Sunshine Coast Divisions of General Practice	334506	4793	1.4%	15.98	4.50%
Capricornia Division of General Practice	135079	6600	4.9%	11.86	2.80%
Wide Bay Division of General Practice Association Inc	184927	5793	3.1%	17.61	3.50%



Turf Wars - Yours, mine, ours

- GP's no longer have to do it all.
 - If the system is set up right
 - If we have confidence in the people we interact with and rely upon
 - If we have knowledge about their skill set and are comfortable in their ability to deliver what our patient needs.
- Who decides: we do.

Managing Chronic Disease As the Leader of the Team

- Systems in place
- Attitude shift for the GP
 - Delegate
 - Give clear direction/instruction
 - Make your expectations understood





Getting the most out of our chronic disease patients

- Disease model centred outcomes
- Patient centred outcomes
- Business centred outcomes

The Disease Model Outcome Model

- Decide on the outcomes you want to measure and achieve
- e.g. Diabetes:
 - Clinical: A1c, BP, Cholesterol (easily measured)
 - Anthropometric: weight, waist (easily measured)
 - Knowledge: Patient knowledge etc (less so)
 - ACOC
 - Medication adherence
 - Complications
- All of these can be measured and this model allows you to select and target for change
 - e.g. Increasing number of patient with a chronic disease who have had a HMR, or involved the pharmacist; Benefits ++ for the disease, outcomes and the patients; DMAS



The Patient Centred Outcome Model

- Decide on the outcomes you want to measure and achieve
- e.g. Diabetes:
 - More understanding, empowerment, self management. Health literacy is an issue in chronic disease. < 50% of people < 55 years old have literacy skills that are good enough to manage day to day in chronic disease states. < 20% of people > 65 years of age have skills adequate enough to manage with chronic disease states.
 - Well being
 - Decreased complications
 - Some can be measured, others are qualitative
 - What do we do? Measure, identify, select strategies for change – with a team (delegate this task)





The Business Model

- Successfully achieving outcomes in either model you are looking at costs, whether it be in absorbed costs (our time) or paid costs (nurse, staff, AHP etc)
- The business model addresses this aspect by helping us get the most out of the current funding structures.

Chronic Disease Management – The Example for Diabetes	Item Number	Medicare Rebate
General Practitioner Management Plan (GPMP)	721	\$124.95
Team Care Arrangement (TCA)	723	\$98.95
Review GPMP	725	\$62.50
Review TCA	727	\$62.50
Home Medication Review	900	\$140.20
Service provided to a person with a chronic disease by a practice nurse (x 5 events @ \$11.00)	10997	\$55.00
Measurement of ankle: brachial indices and arterial waveform analysis,	11610	\$50.00
Incentive for completion Annual Cycle of Care		\$40.00
TOTAL ABLE TO BE GENERATED PER DM PATIENT PA		\$634.10
<i>TOTAL GP TIME TO ACHIEVE THIS IS LESS THAN 1 HR PER PATIENT (THE REST IS BY STAFF AND NURSE)</i>	= \$650 per hr	

This equates to 80 x \$634.10 per average GP = \$50700 pa, per GP. If the practice does not have a nurse, she will pay for herself.



Get the most out of your software

- Clinical Audit Tools (others will discuss)
- In diabetes:
 - Clean the data
 - Code
 - Create registers
 - If you don't know where to start – call pathology, get help from the division



Maximal output from the staff

- Non clinical staff can do some pseudo clinical duties to enhance the clinical time of the GP



Maximal output from the nurse

- Clinical assistant
- GPMP
- ACOC
- Review
- ABI
- ECG
- etc



Strategies to survive the changes that are coming

- What about clinical assistants?
- What about the nurse practitioners – we will all have an opinion.
- What about efficient use of GP time – the miniclinic



Establishing mini-clinics

- Miniclinics do not refer to hospital style clinics.
 - They refer to the process of using our time in GP in an organised time efficient manner for the management of chronic disease
 - You need no extra room
 - You can manage with existing staff, though nurses do support the business model more
- Steps 1-6



Steps for Miniclinics (1)

1. Find the patient base first

1. ICPC Codes within the practice software
2. Download list of all patients who have had a HbA1c test from pathology
3. Audit tools

2. Create the register

3. Find the undiagnosed

1. Look at the risk groups – audit tools
2. Flag them for testing

Steps for Miniclinics (2)

4. Establish how many days per week you need to run the miniclinic
 - ~ 60-80 per GP, seen 3-4 times a year mean about 250 to 300 consultations per year.
 - On average there will be 40 working weeks per year
 - This means about 6-8 consultations per week dedicated to diabetes
 - Allow 15-20 minutes for a dedicated diabetes consultation, 30 minutes for the annual cycle of care
 - This means 3-4 hrs per week for diabetes, less when the nurse is more proactive





Steps for Miniclinics (3)

5. Running the day

1. Patient arrives
2. Anthropometrics done by practice staff
3. Staff insure all pathology is available, flags GP re ECG, ABI, ACOC
4. Patient sees GP's
5. GP concludes consultation
6. Patient is booked for diabetes specific follow up with pathology in 14 weeks on the dedicated day
7. Actions from consultation are booked as a non diabetes follow up.

Steps for Miniclinics (4)

6. Follow up

1. GPMP is flagged
2. GPMP is booked
3. Nurse sees patient first
4. Nurse completes most of GPMP
5. GP sees patient for TCA
6. Patient sees nurse after completion for booking follow up visits as part of GPMP



And what will the model achieve for the patient?

Glycaemic Control		Current ABC Control
Mean HbA1c	6.6%	
< 7%	77.8%	50- 52% HbA1c < 7%
7.1 to 8%	17.2%	
> 8.1%	5.0%	
Blood Pressure		
BP <130	81%	53% have a BP <130/80
Lipids		
LDL <2.0	58%	
LDL > 2.6	19%	46% have LDL > 2.6
CKD		
Microalbuminuria	19%	



Evidence for the miniclinic model

- TRANSLATE Trial

TRANSLATE Trial

- **Target high risk patients:**
 - Identify and begin with patients at highest risk.
- **Registry**
 - Create a registry for data collection, reporting, and support.
- **Administration**
 - Set up administration to oversee changes in roles and responsibilities and enhance continuity during staff turnover.
- **Notify and remind**
 - Notify patients of targets and appointments. Remind providers at time of visit with patient-specific alerts.
- **Site coordinator**
 - Identify a coordinator to facilitate the clinic operations.
- **Local physician champion :**
 - Identify a lead provider to work with the coordinator and facilitate the intervention with colleagues.
- **Audit and feedback:**
 - Audit and review monthly. Provide feedback to improve progress.
- **Track:**
 - Track process measures, outcomes, and operational activity.
- **Education:**
 - Educate and update all staff in diabetes management techniques



TRANSLATE Trial

- The purpose of this study was to determine whether implementation of a multicomponent organizational intervention can produce significant change in diabetes care and outcomes in community primary care practices.



TRANSLATE

■ Outcomes:

- Foot examinations 35.0% ($P < 0.001$);
- Annual eye examinations 25.9% ($P < 0.001$);
- Renal testing 28.5% ($P < 0.001$);
- A1C testing 8.1% ($P < 0.001$);
- Blood pressure monitoring 3.5% ($P = 0.05$); and
- LDL testing 8.6% ($P < 0.001$).
- Mean A1C adjusted for age, sex, and comorbidity decreased significantly in intervention practices ($P < 0.02$).

- At 12 months, intervention practices had significantly greater improvement in achieving recommended clinical values for SBP, A1C, and LDL than control clinics ($P = 0.002$).

CONCLUSIONS—Introduction of a multicomponent organizational intervention in the primary care setting significantly increases the percentage of type 2 diabetic patients achieving recommended clinical outcomes.



What does it mean for the GP?

- TRANSLATE supports the miniclinic model and allows general practice to monitor and track changes.
- This was in diabetes, but the principle applies to all chronic disease.



You can't change what you don't know

- If nothing changes, nothing will change
- If you think you can you will
- If you think you can't you wont'



Breakout

■ Goal

- Manage the case
 - What are the issues
 - Identify goals
 - What is the patient contribution, the GP role, the AHP contribution
 - Develop a GPMP to better outline and achieve the above
- At a practice level,
 - What systems do you have to identify other patients like this.
 - Do you need to? Why wouldn't you?
 - What strategies can you implement?



Feedback

- What barriers did you identify
- What strategies did you identify
- What tools do you need
- What resources would you like to make it easier



Messages in conclusion

- Chronic disease is here to stay
- The team approach is here to stay and we need to learn to use it rather than be used by it.
- The business model will soften the “pain” and fund the outcomes
- Miniclincs – can be used in all chronic disease
- Tools to make transition and management “easier” exist – we just need to use them

Thankyou

