

# A Success Story...

## EFFECTIVE USE OF CHD REGISTERS

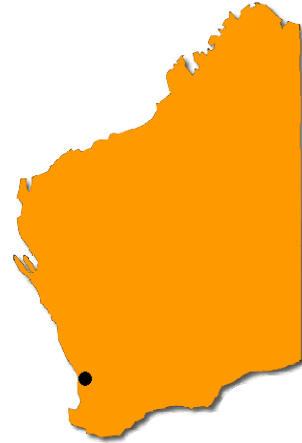
Establish a system for creating, validating and updating registers

### Fulham Medical Centre - WA

**F**ulham Medical Centre identified a lack of uniformity in diagnosis classification, particularly in CHD. This meant there was no comprehensive patient register, and no easy system to extract the data.

The practice adopted a team approach to create an umbrella CHD code (IHD), weekly checks of the register, data cleansing, and reminders at GP meetings to code correctly. They were systematic & proactive in managing care. This included regular recall of patients and involving them in their own care. Factors in their success included setting aside protected time, using PDSAs, and multi skilling.

The outcomes include an accurate register of patients with CHD, increased ability to recall patients for review, an effective practice team, and an easier method of extracting data for internal quality activities and NPCC reporting. There was also an improvement in health outcomes (cholesterol and blood pressure) and increased use of chronic disease management items and empowerment of practice nurses



### Context

**F**ulham Medical Centre is located in Cloverdale, 8 km east of Perth and close to the Perth Airport. The practice is in a middle class area and predominately bills patients privately.



*Fulham Medical Centre*

A large proportion of its 9000 active patients are elderly with chronic disease.

The practice consists of ten GPs (eight FTE), four Practice Nurses, eleven Receptionists, a Practice Manager and an Accountant.

Fulham was one of first practices in Canning Division to join NPCC. The practice Principal, Dr Shiong Tan, was the initial Chair of the NPCC CHD Expert Reference Panel.

"There is now an accurate and up to date patient register that is easily accessible by all GPs...patients are empowered and confident they are looked after."

## The Situation

**F**ulham Medical Centre was already paperless prior to NPCC participation and had a forward thinking principal who was keen to try new ideas and initiatives, and who already had assembled a positive team around him. The practice already had a long term view to use better information management to drive change, and were utilising it for primary prevention activities such as immunisation. They already knew their barriers and had weekly GP meetings to discuss systems and clinical issues.

### The Problem

The practice's software package, MedTech32, allows the use of non-standard classifications for diagnoses (J-codes). Each time a new diagnosis was entered by a GP it became one of the options in the drop down box. Even when subsequent GPs only used items in the drop down box, it meant they were actually using incorrect classifications created by other GPs.

This led to a lack of uniformity in classification (GPs used individual codes for CHD diagnoses), which resulted in a lack of a comprehensive patient register, especially for CHD. Given that there was no register, and a large variety of different codes, there was no easy system to extract the data for NPCC reporting purposes, or for internal review of patients within the practice.

### The Need for Change

The GPs understood that for effective chronic disease management to take place, an accurate patient register was very important so they knew who the patients needing intervention were. To report monthly statistics for NPCC and to provide feedback for their own quality activities, an easy way to extract the data needed to be identified and put into practice. To establish a patient register, patients had to be classified using the correct codes.

## The Change

**T**he first step was a dinner meeting run by the Principal to explain NPCC principles to all GPs and all staff. The practice worked closely with Mark Strickland and Ian Peters from Canning Division to commence problem solving to sort out IT problems and the lead nurse joined the weekly doctors meetings and included NPCC items on the agenda to promote cooperation.

In attempting to solve the problem, two main challenges became evident:

1. Gaining the GPs trust. Some GPs were sceptical that by changing the way patients' diagnoses were classified, that it would create an incorrect diagnosis. They needed to be convinced that the objective of the change was to add a "CHD umbrella classification", not change their diagnoses.
2. There was an overwhelming amount of data to be pulled for each classification.

In Change Principle 1 (Establish a system for creating, validating and updating a register of people with CHD), the practice undertook:

- Data cleansing
- Umbrella CHD coding
- The GPs started to using standard codes only (K-codes).
- Weekly checks of the register to validate status of patients on CHD register
- Continuous reminders at weekly GP meetings to code correctly

"The practice already had a long term view to use better information management to drive change."

## The Change *cont...*

In Change Principle 2 (Be systematic and proactive in managing care) the practice used the query builder to regularly recall CHD patients for Cholesterol, blood pressure and weight or BMI checks. They also included INR clinics and ABI clinics.

In Change Principle 3 (Involve patients in delivering and developing care) the Practice Nurses educated patients on diet, medications, exercise, quitting smoking, falls prevention, the importance of blood testing (especially for cholesterol) and sometimes recommended Home Medicine Reviews. They also used information sheets on local activities in these areas.



*Cheryl Smith, Practice Nurse*

"Through the Collaboratives, I have gained a wealth of information on how to better manage Chronic Disease"

*Cheryl Smith,  
Practice Nurse*

In Change Principle 5 (Analyse your secondary care interface) the practice gained assistance from Canning Division with patient centred activities such as Ambulatory BP monitoring for many CHD patients, referring patients to HeartBeat and Team Care Arrangements.

The practice found that factors for success included:

- Only address one aspect at a time; to make it achievable.
- Set aside protected time each week: the most important success factor!
- Make use of PDSAs – good brainstorming tool
- Getting GPs on side – the key issue here was teaching them "Why" change was useful and not just "How".
- Have at least two people who can do data extraction

## The Outcome

**A**s a result of the changes, the patients are now able to be recalled for management planning when they are well, and not when they are in crisis. This results in better planning and implementation of holistic care.

Some patients have experienced a remarkable decrease in cholesterol levels (e.g. from seven to five), and decreases in blood pressure. The number of patients on statins increased markedly due to a quality activity which involved recalling patients from the register. Patients are empowered and confident they are looked after.

The GPs are now really involved in CDM – they do GPMPs and TCAs for a range of conditions, leading to an improved income for the practice. The GPs have embraced the computer; they now automatically code and BP figures are put in right places.

Involvement in NPCC also made the lead nurse (pictured above) confront her fears of computers and realise that her limitations were self imposed. She discovered that she was able to do a lot more as a nurse than she thought she could and increased her networking and self development opportunities due to the 'collaborative' nature of the Program. She gained more respect from the GPs and her peers and realised that there is a lot of room for improvement in health care.

The Outcome *cont...*

“As a Practice Nurse with 16 years experience I thought I knew all there was to know about Chronic Disease management,” she said.

“Through the Collaboratives, I have gained a wealth of information on how to better manage Chronic Disease and I now feel extremely proud to be a member of the huge family that is General Practice in Australia.”

There is now an accurate and up to date patient register that is easily accessible by all GPs. The net number of patients on the register did not change but there was a great deal of movement (i.e. approximately the same number of patients who shouldn't have been on it, came off as the number who went on). The other big difference in the register was the ease with which data could be accessed, due to the coding umbrella being instituted. The nurse provides regular figures for individual GPs on BP (and provides incentives for best performance).

Due to the close working relationship of this practice with Canning Division, the data extraction developer at Canning Division learned more about the intricacies of the Med Tech 32 database. As a result of this, and with encouragement from the practice, Canning Division incorporated MedTech32 into the October 2006 release of the Canning Data Extraction Tool.

The Canning Data Extraction Tool is currently in use in 44 Divisions around Australia (as at August 2007). All users of MedTech32 now have access to its data extraction and business planning capabilities.

In the future the practice plans to hold clinics for chronic disease management, such as diabetes and asthma, continue measuring quality improvement through PDSA cycles and continue to improve quality of care given to patients.

**Author: Campbell Anderson**  
**Canning Division of General Practice**

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