

A Success Story...

LOOKING 'OUTSIDE THE SQUARE' FOR OTHER SYMPTOMS IN PATIENTS WITH CHD

CHD: Create, validate and update a register

Yarra Health - Vic

Yarra Health is a Community Health Centre. From the onset of the Collaborative program they looked at 'fundamentals' first. This included developing disease specific registers and also validating their patient database.

One of the activities they had always wanted to undertake was to clean up their database – which was difficult as the centre has been running at two major sites. Getting into the Program was easy, but the challenge for the practice was cleaning up their very large database, of data accumulated over the last 50 or more years.

The practice began to see things 'out of the square'. It was time for a change in data management. Out of this a small and reasonably quick activity materialised, to look at other symptoms relating to Coronary Heart Disease (CHD), such as smoking and alcohol. At almost their third PDSA cycle, the challenge was on.



Context

The Yarra Health Community Health Centre is a large multi-site entity located in the Eastern suburbs of inner Melbourne. The practice is a member of the Melbourne Division of General Practice. There are a couple of GP leaders who have been champions for diligent usage of medical software and fairly well backed by administration staff that support the front desk. Their patients are predominantly from Greek and Italian origin (around 40%) and are of mixed professions, including around 25% being University students. Their current patients database is around 24,000 patients.

The centre has six FTE GPs at each site (including a Clinical Medical Director for both sites), three nurses, three part time reception staff, and allied health care including podiatry and psychologists. An Occupational Therapist on four-day roster is housed at the same location.

The Situation

The centre's current CHD data represented only 0.66% of total patients according to the results from the latest version of the Canning Division extraction tool. The centre's concern is that this number could be higher as they also have a large portion of elderly patients.

There are 160 or so patients that show up as CHD patients, which roughly matches with some other search query performed through medication/prescription data. This tool looks for a set measures criteria, the chances are some patients with high risk factors could have slipped unnoticed and therefore not included in the register. Some of these could be very high-risk patients. The two diagnoses identified were smoking and alcohol. These are recordable codes in the Medical Director software application and hence search queries can be applied. The search found 43 patients who had excessive smoking habits and/or high-level abuse for alcohol.

The Situation *continued...*

The file was exported in an Excel format and given to each of the GPs at the two centres to consider if any of the 43 identified were at risk for CHD and, if so mark as CHD patients and individually apply a reminder recall letter to attend for elaborate examination.

Once this is complete the patient's details will be attached to the basic register, including, medications (especially Aspirin, Statin and Beta blockers), BP measures and smoking and alcohol status.

The Change

As users of Medical Director (MD), one of the first issues that grappled them was the number of patients in their database. Some time before participating in the NPCC program they had considered cleaning their data.

An opportune time again arose when certain flow charts (created by the Melbourne CPM and now available as a general resource) were produced in consultation with the Clinical Medical Director at the centre.

Initially they had around 25,000 patients. The first phase of data cleansing reduced the number to around 24,000 and it is anticipated that the numbers will go down slightly in coming months when they devote protected time for office management around the holiday period.

The team included Practice Managers and Nurses, but the motivation mostly came from the Clinical Medical Director. The larger part of this learning curve was the constant reminder to GPs to code appropriately. In relation to this particular activity - the subject of this case study - was taking that extra effort to note the status of smoking and alcohol habits.

The next step was to develop a PDSA that would list all CHD patients and literally check each file on MD to ascertain if the smoking/alcohol status was recorded. The practice found that 75% of the records had coding. This certainly encouraged the Clinical Medical Director to take the next step with alcohol usage/abuse, using the Lifescripts assessment tool.

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The Outcome

The success of this story is not necessarily one for the champagne! However, it is a straight forward excerpt of what is essential in the course of the change cycles. Regardless of how computerised the practice may be, the practice demonstrated the ability to understand the precursor change to look from 'outside the square' and to ask the prima facie question: "What else?"

Even in the few fully paperless practices, the key question which must be asked is whether the paperless system is being used efficiently to manage and track chronic diseases, to influence useful data to find solutions, to better manage practice systems and provide optimum care to patients. While many practices are computerised, surprisingly little effort is taken to then develop an efficient recall reminder system. In many cases it would be like a conventional car without wheels!

The Outcome *continued...*

The crucial outcome for the Yarra Health centre has been the following:

- Identification of CHD patients – via the NPCC extraction and software tools
- History of all CHD patients were reviewed by the Practice Nurse and GPs
- 163 patients were coded – that left 55 to be followed up by the Practice Nurse
- 43 patients smokers were encouraged to the Quit program and similarly alcoholics/alcohol abuse patients were referred to Eastern Drug and Alcohol Service – housed in one of their centres

The change therefore is as Einstein once said: 'The system will give the results for which the system was designed'. In my own words it means if one does not take heed of the fundamentals and run through something similar to a PDSA process – then it is also correct to assume that the practice may not have a 'comprehensive' patient register. It is the next few steps of actually 'doing' from the ground up, which have produced noticeable change.

Results may highlight some remarkable impact (number, medication data and gaps with lots of free text!) on some kind of chronic disease care but as the practice found, a search result may not be good if it has not to focussed on issues such as who are the potential CHD patients (or any other disease category).

It is safe to say that most GPs would have some training in a clinical software and safer still that most Practice Managers may have some idea about data management. But what about the other staff including Practice Nurses? This is where the division's handy 'How To' series was most beneficial to the practice. The Practice Nurse was oriented to the search technique (in this case Medical Director) and location of coding styles through use of this simple but effective 'cheat sheets'. It is believed that this practice has a copy of these sheets in every consulting room. Only a simple PDSA could have produced such a result!

The practice also had a second dose of 'alerting' GPs to special needs. In this case they created an awareness campaign for the practice (the GPs got a little pink sticker added to their already busy and colourful edges of the computer screen with 'post it' notes). Most importantly the patients benefited from the referral to the two programs. Prior to this exercise very few referrals were proactively channelled – now Yarra Health claim to have 20 patients a month going through these programs.

The next steps for the practice are to look for all patients who are heavy smokers and high-risk abusers of alcohol in the 24,000 strong patient databases. This is a huge task and will need a progressive approach to develop a preventative health promotion.

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