

# A Success Story...

## ESTABLISHING A NURSE LED HEART CLINIC

Coronary Heart Disease

### Reservoir Medical Group - Vic

**U**sing the Collaboratives methodology, the Reservoir Medical Group developed a nurse-led Heart Clinic for its 400 (approx) active Coronary Heart Disease (CHD) patients. Prior to the Collaboratives program, the practice had an existing nurse-led Diabetes Clinic, so they utilised the Program to develop a Heart Clinic, which incorporated:

- Developing an accurate CHD Register
- Developing computerised checklists for patient review appointments
- Sourcing web-based and other education materials
- Liaison with local community service providers
- Developing computerised templates
- Formalising internal practice systems regarding patient review processes



They have subsequently used their Heart Clinic experiences to further refine their Diabetes Clinic systems, and it will become a model for other chronic disease clinics in the future.

### Context

**R**eservoir Medical Group is a large and very busy urban practice located in an established, lower socioeconomic area of Melbourne, approximately 12 kilometres from the CBD, and operating across two sites.

The practice sees patients across the age spectrum, but is highly skewed towards the 70 years and over age group, reflecting the demographic, with an emerging 'baby' population as increasing numbers of younger people move into the area.



*Reservoir Medical Group*

It has had paperless patient records since 1996, and has a reputation for embracing change. The staff profile when the practice began the Collaboratives program included seven GPs (4 FTE) a Practice Manager (0.9 FTE), three Practice Nurses (2.5 FTE) and ten reception staff (6.0 FTE).

Associated co-located services include three Podiatrists, a Physiotherapist, a Dietician, a Psychologist, an Optometrist, on-site pathology and a pharmacy across the corridor.

"The Change Principles within the Program provided a structured pathway for the practice to follow."

## The Situation

**T**he practice already had an effective nurse-led Diabetes Clinic, and because of the increasing numbers of older patients, it wanted to address their cardiac health in a more proactive and systematic way.

The Change Principles within the Program provided a structured pathway for the practice to follow, and the CHD measures gave clinical guidelines regarding what needed to be achieved.

## The Change

**D**irect Program involvement was initially focussed on one GP, the Practice Manager, the Cardiac Nurse and two Reception staff with computer skills.

Using the PDSA methodology, the practice began by building its Heart Disease Register, increasing from 191 at baseline to 384 three months later, as free-texted diagnoses were converted to coded diagnoses, patients on cardiac-related medications were cross-referenced with the Register of known names, and electronic files of deceased patients and those who had not been seen at the clinic for several years were inactivated.

The lead GP and Practice Nurse clarified their Cardiac Clinic model and processes, including appointment content, GP/nurse coordination, review frequency, and Diabetes Clinic coordination.

The Practice Nurse attended a cardiac-related education program, and visited local service providers who could benefit their cardiac patients, including local hospitals, the local leisure centre and local walking groups. She collated patient education materials and resources from pharmaceutical company representatives, the National Heart Foundation, and others.

All practice staff were notified that the clinic was about to commence, and following an initial trial with three patients and some improvements, (including the development and implementation of Cardiovascular and Care Plan Checklists), all cardiac patients living independently in the community were informed about the clinic, and invited to make an appointment. At the same time, they were asked to confirm whether they were taking aspirin as a means of updating their electronic patient files.

Some patients did not see a need to attend the clinic, claiming that they “had had their heart attack but were better now,” and others lacked an understanding of their risk status. One was concerned about a nurse having access to their medical history.

Despite these early concerns, the number of patients seen in the clinic has gradually increased, with the GP and nurse using the checklists to easily identify problems and flag outstanding issues e.g. blood tests or BMI to be done, etc.

Learnings from the establishment of the Heart Clinic lead to a review of their Diabetes Clinic processes, and clinical improvements have been noted among these patients as well.

“[The practice] has developed much stronger relationships with its local providers.”

## The Outcome

The graph in Figure 1 highlights the improvements made for the CHD measures. In addition, the number of GP Management Plans (GPMPs) and Team Care Arrangements (TCA) increased, and more Home Medication Reviews are being undertaken.

The practice's internal processes regarding its GPMP/TCA reviews have become more robust and formalised.

Practice capacity has improved by shifting some work, (for example, making patient appointments, recalling the patients) from the nurses to the administrative support staff.

Patients with heart disease are now able to access health information from two sources, their GP and the Cardiac Nurse. Feedback from patients has been positive. As the patient/nurse relationship has strengthened and nurse contact has increased, the GPs are reporting fewer interruptions and being less stressed.

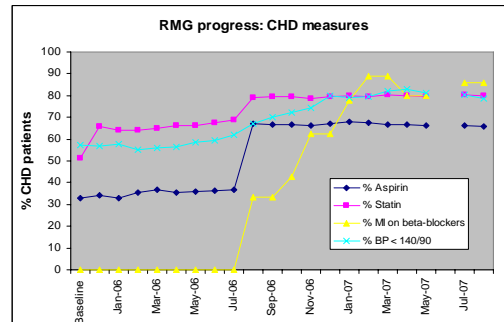
The increased 1:1 patient time with a health professional has led to the identification of other health issues (e.g. mental health problems) and the implementation of appropriate management strategies.

The practice has also employed another nurse (making a total of four nurses), and intends to utilise the Division's resources related to the Better Outcomes in Mental Health initiative.

It has developed much stronger relationships with its local providers, with some (e.g. the local leisure centre) referring patients without GPs into the practice for care.

There has been a change in practice culture particularly among the GPs, and plans to establish Clinics in other clinical areas (for patients with asthma and mental health) are underway. A 45 to 49 year preventative health clinic is about to start.

Figure 1 - CHD trend graph



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Published November 2007

