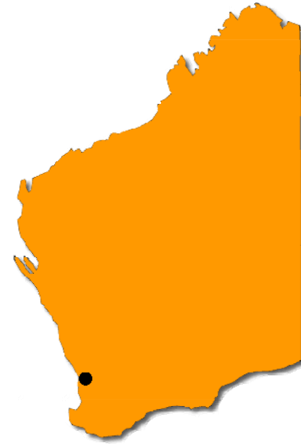
A Success Story...

AT STREET LEVEL

CHD and Diabetes: Be systematic and proactive in managing care

The Street Doctor (Perth and Hills DGP) - WA

The Street Doctor team at Perth and Hills Division of General Practice have faced some unique challenges throughout their Collaboratives journey. Being a mobile GP service and catering largely for homeless and disadvantaged patients, the team have had to come up with individualised and appropriate ways to undertake chronic disease management.



While other practices began setting up register/recall systems and speaking to their regular patients about annual cycles of care, the Street Doctor team were busy trying to find ways to locate patients who had no fixed address, faced social, legal and relationship issues as well as medical problems, or couldn't access health care for financial reasons.

The Street Doctor team's Collaboratives journey, along with every other challenge they have faced, has been about thinking outside of the square and doing whatever it takes to provide quality care to patients that most general practices will never encounter.

Context

The Street Doctor is a mobile GP service that caters for marginalised population groups in the Perth inner city and north eastern suburbs. The service operates from a bus (overleaf), which visits various locations including the city train station and the suburbs of Midland and Morley. Currently there are approximately 350 patients on the Street Doctor books. The GPs who work with the Street Doctor work on a rostered basis, with one GP, one Nurse and an outreach worker at every clinic session. The GPs all work full time in other practices in addition to their evening work with Street Doctor.

Patients who access the Street Doctor usually do so because they have particular barriers to accessing a conventional GP surgery. These barriers include homelessness (an increasing issue for unemployed and low income earners in Perth due to the steep rise in housing costs related to the mining boom), the cost of accessing medical care, co-morbidities, such as alcohol and illicit drug use and mental health disorders. Around 80% of patients who access the Street Doctor have either diagnosed or undiagnosed mental health disorders.

There are also legal issues, as many Street Doctor patients have been incarcerated or have records for criminal offences and cultural and social issues related to language barriers, marginalised populations and difficulties engaging with the health care system.

"The team realized that by making small changes and managing their data more effectively, they could improve the care they were providing to their patients"

Context *cont...*

Issues such as these affect a patient's capacity to access a regular GP, and in addition make it very difficult for health professionals to provide ongoing care for patients with chronic diseases such as diabetes. Many patients are unreliable in their attendance either for follow up appointments with the GP or for allied health and specialist referrals.

The Street Doctor mobile van

Chronic disease management for these patients takes priority only after issues such as shelter (temporary accommodation), drug and alcohol rehabilitation or other immediate concerns have been addressed. Trust is also a difficult thing to achieve, with many of these patients having suffered trauma or being on the fringes of society and unable to interact with more mainstream health services.

The Situation

The Street Doctor team was introduced to the NPCC in June 2006, when they joined as a Wave 3 practice. Eight GPs, one Practice Nurse and an outreach worker attended the introductory NPCC meeting, with one GP and one nurse unable to attend. While the practice team were receptive to the idea of being involved in the Program, some concerns were raised about the impact it would have on time spent with the patients, and also the extra work involved with collecting data, doing Plan-Do-Study-Act cycles and tracking progress.

The main issue that the Street Doctor team faced was how to be systematic and proactive in managing patient care, whilst acknowledging the unpredictable nature of their work, which would not change. While most other practices could generally encourage their patients to engage in care plans or cycles of care, the Street Doctor patient population were much harder to engage. Patients who attend the Street Doctor often do so irregularly and infrequently, and cannot always be easily contacted by mail or telephone. They also usually presented with multiple problems, not all of which were strictly medical in nature.

The idea of a 'register/recall system' seemed impossible. Patients were followed up using a variety of methods, such as talking to family or friends on the local 'grapevine', making calls to temporary accommodation centres or a nurse literally walking the streets looking for a particular patient. When asked how patients were followed up, several Street Doctor team members responded with "just however we can."

Adding to the problem of keeping in touch with patients was the fact that their medical histories, and even their personal details, were often 'sketchy', and were usually gathered over the course of several visits.

The Change

The main change the Street Doctor team made during their NPCC journey was to become much more systematic in the way that they approached patient care, in spite of the very un-systematic way that many patients approached their own care.

While it was never going to be possible to make chronic disease management and information systems their top priorities, the team realised that by making small changes and managing their data more effectively, they could improve the care they were providing to their patients.

The team initially put a lot of effort into setting up Diabetes registers. Painstakingly collated medical histories needed to be translated into systematic coding of patient records. Pathology results were obtained to assist with Diabetic information and patient records were coded accordingly. For the first time, the team started using care plans for their diabetic patients, and also sourced a diabetes Service Incentive Payment template.

The Change *cont...*

Six-weekly team meetings and a communication book were also introduced so that the team could work more effectively together. It was hard to get the whole team together often, due to the fact that only three staff members worked together at any given time, but the team committed to communicating regularly and keeping each other up to date with PDSAs they were working on, as well as progress with their data measures.

The Outcome

The Street Doctor team feel that they have benefited from their involvement in the NPCC, because they now have systems in place to provide better care to their patients with chronic disease. They now feel confident that they can provide chronic disease management to patients who attend the service regularly. Although the actual number of patients completing the diabetic cycle of care is low (2.6% of 77 patients as at August 2007), the Street Doctor team feel that just having the systems in place to perform a cycle of care is a tremendous achievement, given the challenges they face with recalling patients and keeping regular contact with them.

Communication within the team has also improved, and staff members continue to meet regularly to discuss their progress and to discuss new ways to improve their systems and chronic disease management. They find that, when changes are required, breaking things down into small steps works well, and that with this method they can achieve better outcomes than they did previously.

One major challenge for management of chronic disease is establishing strong links with Allied Health Providers in the area. The Street Doctor team continue to work on this task and believe that they are making progress. Previously, Allied Health Providers have been reluctant to see Street Doctor patients given that they are unreliable in their attendance, and sometimes have trouble with Medicare billing issues. It is hoped that gradually this situation will improve, and a good working relationship can be established with these providers.

Despite so many challenges that the team face, they continue to submit data and PDSAs monthly, and their measures have improved slowly but steadily. The team feel that, while it could be discouraging to benchmark themselves against others, their continuing steady progress from baseline to the present is something they are very proud of. They also feel that the Collaborative methodology is something that is firmly embedded in everything they do, and that this will be sustained long-term.

Author: Alicia Bakewell

Perth and Hills Division of General Practice

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