



TEAMWORK RESEARCH STUDY

Enhancing The Role Of Non-GP Staff In Chronic
Disease Management In General Practice



7th July 2009

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Enhancing The Role Of Non-GP Staff In Chronic Disease Management In
General Practice



Presented on behalf of
North West Slopes Division of General
Practice

and

Peel Health Care

by

Tanja McLeish

Team Leader – Chronic Disease - GPNSW

Geographical Intro



First Steps

- Recruitment
 - Sales & marketing
 - Understanding the product
 - Demonstrating value
 - Combating the negatives – what are they?
How will this research help? What's the buy in?
 - Selling the concept prior to recruitment phase
 - Show me the evidence

Understanding 5 Key Elements to Team Building



1. Clear Goals with measurable outcomes
2. Division of labour
 - Definition of tasks & assignment of roles
 - What tasks routinely performed by GPs can non-GP staff take on?
3. Communications
 - Build Structures ie: routine communication (eg: email), regular team meetings
 - Formulate processes ie: procedure for giving feedback – procedure for conflict resolution

Understanding 5 Key Elements to Team Building



4. Clinical and administrative systems
 - Who does what? When? How? = Written procedures
5. Training
 - Training for each team member
 - Cross training to allow for absences or periods of heavy demand

Assess readiness of change throughout process

The Key Players



- NWSDGP
- PHC
- GPNSW

Lyn – The Practice Manager for Peel Health Care



Daniel – GP – Peel Health Care



Alicia – The Practice Nurse – Peel Health Care



NWSDGP CEO – Graeme Kershaw



Findings



- Data collection provided evidence of the need for data cleansing and a focus on improved data entry

NWSDGP Diabetes Clinic Model



When	Practice Activity
Initial GP Appt (opportunistic)	<ol style="list-style-type: none"> 1. Refer Patient to Diabetes Clinic 2. Order relevant pathology (Patient to complete prior to next visit) 3. If required, GP Refers for Home Medicines Review and patient booked for 5/6 weeks for return to complete the medication management plan (item 900)
1st Month (PN/GP)	<ol style="list-style-type: none"> 1. GPMP and/or TCA & Diabetes Template MedTech 32 2. Commence Annual Cycle of Care 3. Review of pathology 4. Tell PN if TCA required and service providers to collaborate with and then get patient back in about one week 5. Separate long GP consultation for patient return for Medication Management Plan (Item 900) - if required
6th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 7th month appointment—reception staff b) or at time of GP consult
7th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Review of GPMP and/or TCA 3. Review of pathology
12th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 13th month appointment—reception staff b) or at time of GP consult
13th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Annual Cycle of Care 3. If required, GP Refers for Home Medicines Review and patient booked for 5/6 weeks for return to complete the medication management plan (Item 900) 4. Allied Health Medicare Referral Form if required 5. Review of pathology
18th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 19th month appointment—reception staff b) or at time of GP consult
19th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Review of GPMP and/or TCA 3. Review of pathology
24th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 25th month appointment—reception staff b) or at time of GP consult
25th Month (2 years) (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Annual Cycle of Care 3. New GPMP and/or TCA 4. Review of pathology 5. Allied Health Medicare Referral Form if required

What were the Benefits to the Practice?



- **“The main benefit was the motivation to actually get the Diabetes Clinic happening. We had the thought but had not actioned it until the research project began. The other benefits were that it made us look at a team care approach, I’m not sure whether this would have happened if the clinic had of commenced without the research component”** *Practice Nurse + Practice Manager, PHC*

Did it help your Practice to make changes?



- **“Yes – we created the Diabetes Clinic Model, PN and GP clinic (nurse led) because of the research project. This clinic has improved patient outcomes, has saved the GPs time and has increased the % of annual cycle of cares/GPMPs/TCAs being completed”**

Practice Nurse

Did being part of the UNSW CPHCE
Research Project help your practice
assess how you work as a team?
Would you have looked at this
anyway?



- **“Yes it did help, probably wouldn’t
have looked at this otherwise”** *Practice Nurse +
Practice Manager*

Any changes that you made because of the Research have they been sustainable and are they being reviewed and improved upon?

- **“Yes, Diabetes Clinic Model continues to grow and develop. Every session sees improvement and this is discussed between GP and PN. Increased patient compliance and self management reflected also in improved HbA1c. Processes being reviewed 6 monthly and as required. Currently in the process of starting other GPs in the practice in using the model. This model can be adapted to all Chronic Diseases.”** *Practice Nurse*

Peel Health Care



- Newly amalgamated
- Newly re-located to accommodate:
 - 7 Reception Staff
 - 1 Practice Manager and 1 Office Manager
 - 5 Practice Nurses
 - 8 GPs
- **Diabetes Clinic Model Continues to Grow**



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For Further Information



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