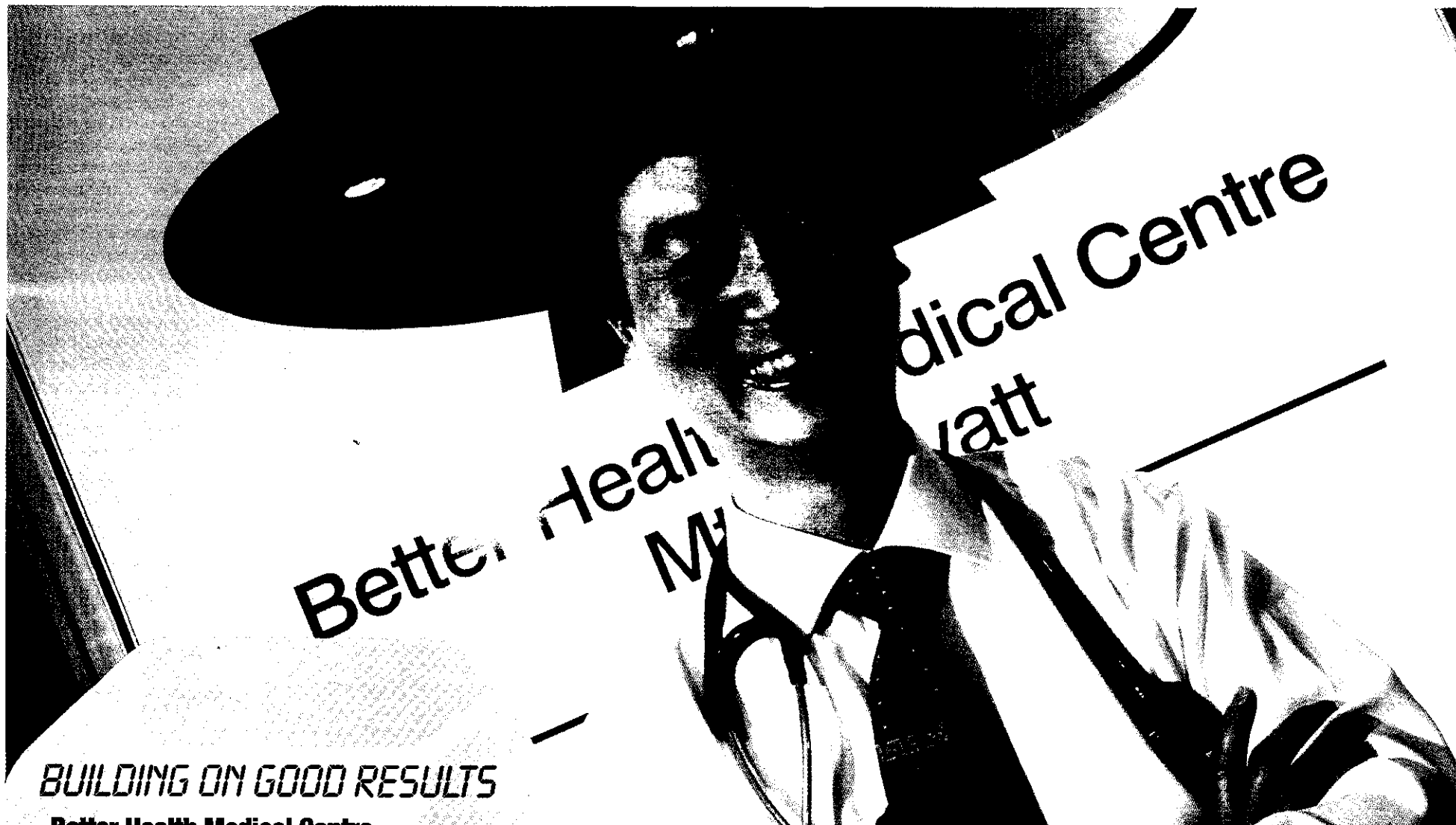


# In Practice

Your essential legal, ethical, business, financial and IT guide



## BUILDING ON GOOD RESULTS

### Better Health Medical Centre, Mount Gravatt, Queensland

AFTER successfully completing the program's first phase in his Brisbane practice, Dr Carlos Chan (above) decided to jump on board phase 2 in the hope of making even further improvements to his new practice in Mount Gravatt.

His practice manager at both surgeries, Ms Susan McAsey, says the practice team had "such a great outcome the first time that we wanted to build on what we learnt and try new techniques".

She says the Brisbane practice had great success after starting diabetes clinics, which were managed on a six-monthly basis or according to need, and building diabetes and CHD registers that allowed GPs to place patients in the correct file for the nurses to access when required.

The practice built stronger relationships with allied health providers and changed the appointment system to accommodate walk-in patients and ensure GPs received lunch breaks.

"We became more proactive and developed a newsletter, made courtesy calls if patients missed an appointment, did mail-outs ... We're now managing patients rather than just treating them when they come in," she says.

Dr Chan says these changes will now be automatically built into the Mount Gravatt practice, with the hope of building them further.

# SECOND HELPING

GPs say the collaboratives program has improved both patient outcomes and practice efficiency. Now a new group of GPs is about to embark on phase 2 of the program.

BY CHRISTINA ANASTASOPOULOS

IT has been hailed as one of the biggest success stories in general practice, achieving substantial improvements in patient access and in the treatment of diabetes and coronary heart disease.

GP leaders are calling it an "exciting approach" to improving general practice, while GPs are surprisingly happy to put in the extra hours required of a program that has taken the UK by storm and is now looking set to make dramatic changes to

the Australian primary care system.

The National Primary Care Collaboratives program, which has been renamed the Australian Primary Care Collaboratives, has already made its mark.

Data from phase 1 show the number of diabetic patients with HbA1c levels below 7% has almost doubled, the number of CHD patients with blood pressure readings below 140/90mmHg is up 50%, and the number of CHD patients taking aspirin has increased by 28% (see box, page 46).

Some practices have even reported efficiency savings of \$100,000 a year.

And while these results haven't come easy for the 600-plus practices involved in phase 1, it seems all the extra workload has been well worth it.

Now, as the second phase of the program is being rolled out, *Australian Doctor* talks to practices on their experiences with phase 1 and the expectations of practices set to embark on phase 2.

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## Recent study has confirmed that dermoscopy increases melanoma detection\*

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\*Dermoscopy compared with naked eye examinations for the diagnosis of primary melanoma: meta-analysis of studies performed in clinical setting. M.E. Vestergaard, P. Macaskill, P.E. Höll and S.W. Menzies, British Journal of Dermatology 2008

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## WHAT IS THE COLLABORATIVE PROCESS?

THE Australian Primary Care Collaboratives program is based on a US model where practices submit key chronic disease data and share innovations with other participating practices.

It was adapted for use in the UK in 2000 involving about 6000 practices and 32 million patients. The model has reduced cardiovascular death rates by 40% in participating UK practices.

The Australian model aims to reduce CHD deaths by 30%, increase to 50% the

proportion of diabetic patients with HbA1c levels below 7% and improve patient access to GPs.

The program pays practices up to \$8200 for a GP and practice nurse or manager to attend workshops to brainstorm ideas and devise a plan to take them through the plan-do-study-act cycle. The cycle involves taking a plan, implementing it, analysing the results and then acting to remedy any problems.

Results are submitted to

the APCC each month, which shares them with other practices across Australia via divisions of general practice and the program's web site.

### What is phase 2?

THE second phase of the program will involve seven state-based waves.

To the end of June, 159 practices had enrolled in phase 2, which is being implemented by Improvement Foundation Australia, a not-for-profit organisation that provides expertise in developing and

delivering quality improvement programs.

The collaboratives program was due to end in December last year after three waves of practices completed phase 1. However, a second phase was launched after the then Coalition Federal Government extended funding for another three years.

Despite its demonstrated improvements in health outcomes, the new Labor Government's recent budget cut the program's funding by almost half.

The Improvement Foundation had hoped to increase practice involvement

**Budget cuts mean the program can only afford to take through another 600 practices instead of 1000.**

in the program from 9% in phase 1 to 20% by the end of 2011. However, its chief operating officer, Mr Colin Frick, says the budget cuts mean the program can only afford to take through another 600 practices instead of 1000, and only 50% of divisions of general practice.

Despite this setback, he says practices can still expect improvements in the program.

GPs will spend less time out of their practices because the requirement to attend national meetings in Melbourne has been removed, and the data reporting process will be simplified as data analysis and extraction tools are improved through updated software.

Australian General Practice Network former CEO Ms Kate Carnell says the program will also continue to evolve as the new funding round includes a requirement that the government be advised on potential new target areas.

"A number of divisions have already started to use the model in other areas such as immunisation ... so there will be a process to determine what the next areas are," she says.

"But there's no doubt that for practices that have been involved it's an exciting approach that improves patient care and you can really see improvements graphically."

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# Where's Prius?

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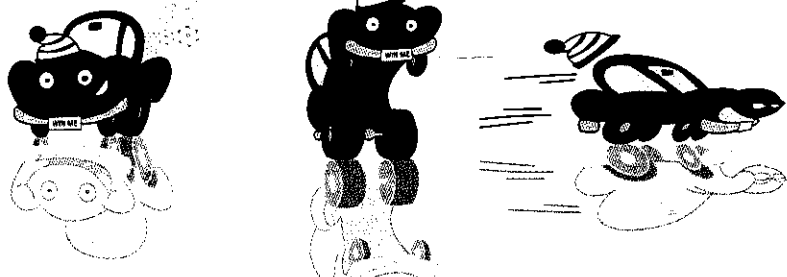
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## PHASE 1

### RESULTS

#### Coronary heart disease:

- 28% increase in CHD patients on aspirin medication
- 26% increase in CHD patients on a statin
- 52% increase in patients who have had an MI in the past 12 months on beta blockers
- 50% increase in patients whose last recorded blood pressure was below 140/90mmHg
- 45% increase in patients on CHD register

#### Diabetes:

- 97% increase in patients with HbA1c levels equal to or below 7%
- 132% increase in diabetes patients with cholesterol readings below 4mmol/L
- 101% increase in patients with blood pressure equal to or below 130/80mmHg
- 4% increase in patients on diabetes register

#### Access:

- 7% increase in patients seen by a GP on preferred day

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# PHASE 1 FLEXIBILITY IS THE KEY

**Brunswick Heads Medical Centre, Queensland**

AS the solo GP in a rural town of about 3000 people, Dr Marc Heyning was keen to improve patient access.

He had already made changes to his practice when his local division asked if he wanted to become involved in the collaboratives program.

The financial incentives offered were enough to get him interested, but he had to do quite a bit of "back-peddaling" to bring his changes into line with the collaboratives process.

"It was actually quite good because it was putting structure to the changes. It was more scientific," Dr Heyning says.

"We found that supply could equal demand if we were more flexible with our appointment system and in the hours and way that we worked."

Dr Heyning and his team of practice manager, receptionists, registrars and medical students met and agreed not to book appointments too far ahead and leave space for last-minute patients.

He also used his medical students to manage the follow-up treatment of chronic disease patients to free up much of his time.

"Medical students are such an underused and free resource and they really take the pressure off a practice," Dr

Heyning says.

"Some practices hire nurses but there's no need because medical students are really enthusiastic and patients are generally happy because they spend extra time with them."

The changes resulted in a dramatic reduction in waiting times from up to three weeks to most patients getting same-day appointments, or the next day at latest.

"It taught us how to introduce change and measuring it has been good," he says.

Dr Heyning admits the changes did not come easily, but the end result made it worth the effort.

"Mothers with children loved it because our policy is that children must be seen on the same day they call. But some pensioners didn't like that they couldn't book out every fourth Thursday morning at 10am, for example, months ahead. They were used to their routine," he says.

The changes were hardest on practice staff because they were tasked with explaining the new rules to patients. They also had to determine which patients could be exempted from the rules.

However, Dr Heyning warns other practices that a key element to succeed in the program is complete support from all practice staff.

"The biggest learning curve for us was the need to have regular staff meetings because confusion and frustration creeps in and it's important that everyone's talking to each other," he says.

Dr Heyning estimates the process added an extra 1-2 hours of administration work a week. He also feels the program is too limited in the areas it allows GPs to bring about change.

However, he says the concept of making it easier for GPs to make changes and to be able to build on other practices' ideas is "really quite good".

# PHASE 2

## PROGRESS IN SMALL STEPS

**Busby Medical Practice, Bathurst, NSW**

DR Richard Medbury and his practice manager, Mrs Louise Warry, have just returned from their first two-day workshop in Sydney and they're "excited".

"This program provides the perfect framework to improve on patient care and stepping up what we've been trying to achieve in the practice," Mrs Warry says.

The practice decided to become involved in the program after being approached by the local division.

Dr Medbury says teamwork will be the key to succeeding in the program and all nine GPs, four nursing sisters, practice manager and eight administration staff are 100% behind the move to make improvements in diabetes, CHD and patient access.

The practice plans to make small incremental changes in all three areas so as to not make the task too daunting and unachievable.

As the first step, its diabetes register will be "cleaned up" to ensure it is up to date and a standardised data input method will be introduced for practice-wide consistency.

In the area of CHD, the practice wants to set up a register of all relevant patients.

But Dr Medbury says before that can happen, all the GPs must agree on a coding system to ensure there is a common definition of CHD so only appropriate patients are included.

And in the area of patient access, Mrs Warry says administration staff will conduct a review on current practice capacity and try to marry that with patient demand.

Dr Medbury says: "I'm quite excited about it. It has the potential to make the practice a whole lot better."

# PHASE 1 DOUBTS DISPELLED

**Broughton Clinic, Port Broughton, SA**

DR Alison Edwards admits she entered the first phase of the collaboratives program uncertain as to whether her practice in rural SA would gain anything from it.

But now she is encouraging other practices to get involved in a program that improved the care and health outcomes of her patients with diabetes, with real data to back up the results.

"It is great to have a much clearer idea about how well our diabetic patients are going," she says.

"It has motivated us to be more aggressive with BP and cholesterol management as well as lowering HbA1cs ... Our patients are maintaining improved parameters, which we expect will flow on to better health for longer."

Dr Edwards says it was important to get all practice staff behind the program and to work as a team because a key component of its success required cleaning up the diabetes database to ensure it was up to date.

"All the data was pretty much already in our [electronic] health records but not in an easily usable format," she says.

"We had to remove all the holidaymakers we had only ever seen once, and [close] those who were no longer with us. We did some double-checking to see if there was anyone on oral hypoglycaemics but didn't have a 'diagnosis' in the database.

"It did take up a bit of time, but the steps towards change were promoted in tiny bite-sized pieces so it was not as overwhelming as I presume setting up a database from scratch would be."

Dr Edwards says before engaging in the program, the practice had no means of monitoring visits by patients with diabetes and would review patients when they presented with other illnesses or for scripts.

"We now know with the click of a few buttons -- using the collaboratives extraction tool -- who has not been in for annual bloods and can actively chase them up," she says.

"We started getting more proactive with getting recalcitrant patients in for reviews, which didn't always get well received. But overall the patients enjoyed sharing in the improvements in the monthly graphs."

## Risk management

# Be e-aware

Put secure systems in place before using e-mail when referring patients.

**W**ITH the enormous increase in use of e-mail communications, it is inevitable that doctors will want to send patients' medical information via e-mail, either direct to the patient or to another medical practitioner.

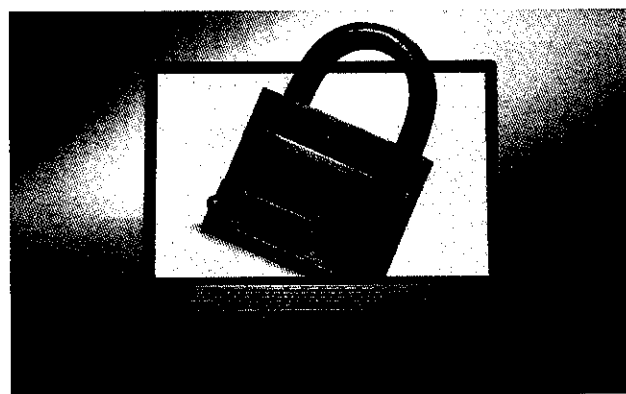
Medical defence organisations are often contacted by doctors concerned about whether they can send patient information in e-mails between GPs and specialists, either as a referral letter or a reply by the specialist to the GP with the results of the

consultation or investigations undertaken.

There is no doubt the patient has given an implied consent for information to be transferred between the two medical providers by agreeing to see the specialist the GP has referred them to.

But does this mean the patient has agreed to have their medical information transferred by e-mail?

Although rare, we all know of situations where we don't receive e-mails that have been sent to us. Occasionally, we accidentally press 'send' and off goes an e-mail to an unin-



tended recipient.

As e-mail is becoming the most convenient, cost-effective and immediate method of communication, is there a

way to avoid any medicolegal issues involving patient consent and e-mails going astray? The answer is yes.

First, it would be prudent

for the GP referring the patient to ask for specific consent to transfer their information via e-mail.

If consent is given, the referring doctor should include in the referral letter the advice that the patient has given explicit consent for their information to be transferred by e-mail.

Second, encrypt the text. There are now secure messaging systems that allow patient information to be sent by e-mail with encrypted text. Both the referring doctor and the specialist receiving the referral must have the encryp-

tion system in place to eliminate issues of privacy and confidentiality if an e-mail goes astray.

Encryption systems are available at no cost to the GP or the specialist, other than the time taken to install them.

As more and more medical information will be transported by e-mail in the future, safe and secure messaging systems should be put in place now.

As well as the need to send and receive encrypted text, patients' consent ensures it is safe to use e-mail for referrals.



**CHERYL McDONALD** is the medicolegal manager of Medical Insurance Group Australia (MIGA).