Bone health group clinic

A multidisciplinary, preventative care model for chronic disease management

What?

Group appointments allow patients to come together with a team of healthcare professionals to receive education about a specific disease or medical condition. Group sessions include the patients' GP, however they are usually coordinated by the practice nurse and can involve a variety of allied health practitioners or external partners. An important feature is the peer-to-peer interactions, which are facilitated by bringing groups together. Patients are supported and encouraged to be more active and effective partners in their own health care.

This group appointment model strongly aligns with the principles of the Patient Centred Medical Home (PCMH) model of care. Sharing care responsibilities throughout a clinical team to provide a comprehensive and integrated service for patients, is rapidly evolving to become the future of primary health care in Australia and internationally. Within a general practice operating as a PCMH, team members can be tailored to suit the needs of each practice and their patients.

Why?

Australia has an ageing population and an increasing number of people with multiple chronic conditions. This is leading to rising and unsustainable health costs - for individuals, communities and the health system. Most people with chronic conditions receive treatment from many health providers – often working in different locations and in different parts of the health system. This can make effective communication between the health 'team' challenging and inconsistent.

Osteoporosis is a rarely identified chronic condition, yet it is estimated that two out of three Australians aged over 50 years have low bone mass and are therefore at high risk of associated fractures.

A group approach that focuses on prevention can help to increase disease awareness, identification and treatment, leading to reduced fracture risk. It also has other potential benefits including:

- patients develop the knowledge, skills, and confidence to be engaged in their own health care
- patients feel empowered to take measures to reduce their risks of falls and fractures by shifting the focus from episodic treatment to long-term support, management and prevention strategies
- nurses and GPs have a heightened awareness of the seriousness and under-diagnosis of osteoporosis, facilitating enhanced identification and screening of at-risk patients
- practices up-skill and multi-skill their staff to work as a stronger team unit
- by refining their data quality processes, practices embed continuous quality improvement.

How?

The bone health group clinic was one of thirteen initiatives supported by COORDINARE. It was part of a project, designed to build the capacity and capability of the region's general practices to move towards the PCMH model of care.

With funding from COORDINARE, Marima Medical Clinic was able to provide group education sessions involving nurses, GPs and allied health staff. The aim was to educate and empower patients over 70 years of age, about how to recognise and/or avoid the health complications of osteoporosis.

Patients played a key role as active participants in an initial focus group. They had the opportunity to provide feedback which helped shape the program structure, ensuring it was consumer focused and met patient needs.

The program was structured into three sessions:

1. Osteoporosis education, facilitated by the practice nurse and GP. If appropriate, patients were referred to a local radiology service for bone densitometry screening.
2. Patients set goals for their bone health, they were also given the results of their bone densitometry test and referred to the GP if they received a diagnosis of osteoporosis or osteopenia.
3. Two allied health providers (a dietitian and exercise physiologist) provided practical information on small lifestyle changes participants could make to improve their bone health.

To help enhance practice capacity, a number of receptionists were upskilled as part of the project. The receptionists completed formal training to become Medical Practice Assistants, and were involved in all stages including administration, testing and evaluation.

The practice found the model highly beneficial and has since implemented a number of other shared appointment programs.

> *"It was very satisfying to be able to work on prevention of disease and make an impact on patients' future health outcomes, empowering them to take control of their health and reduce the risks of falls and fractures." – GP, Marima Medical Clinic.*

Want to get involved?

At different times COORDINARE offers funding to support initiatives such as this. Practices which do not apply or are not selected for funding can still work with us and explore other opportunities. If we are outside of a funding round, we have resources to support practices on their change journey.

For further details on the steps involved to implement this model of care, visit http://bit.ly/MOCbonehealthclinic. For more information or support contact your Health Coordination Consultant, or phone 1300 069 002.

This initiative is supported by funding from COORDINARE – South Eastern NSW PHN through the Australian Government's PHN Program.

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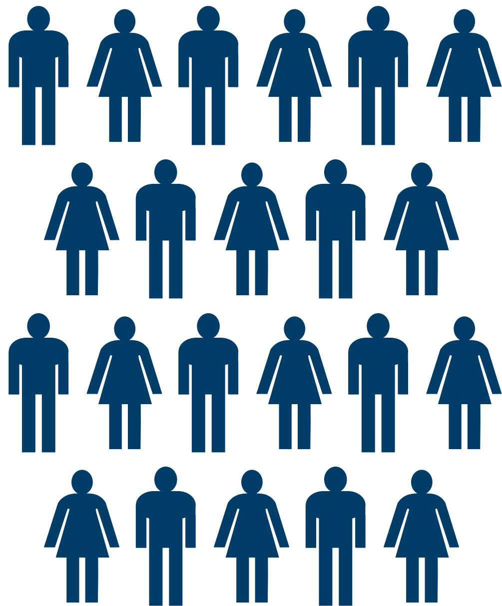
Outcomes

Figures sourced from Marima Medical Clinic PCMH final report.

Patient response



22 people over the age of 70 years attended the three sessions

100% of patients reported program satisfaction and willingness to refer

Increased patient empowerment

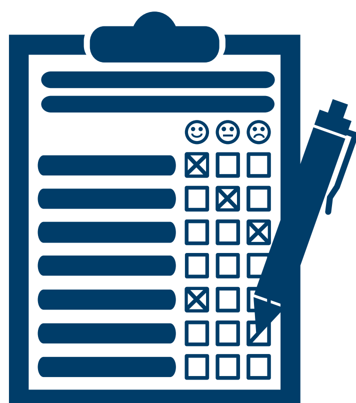
Self-reported sense of community from the small group environment

100% of patients completed the diary action plan

100% of patients proactively set a minimum of four personal health goals

Increase patient awareness

100% of patients reported learning something new about osteoporosis



100% of patients completed the falls risk survey

Perspective profiles

Practice Manager - Kim Weeks

For Marima Practice Manager Kim Weeks, the benefits of patient centred care, isn't always measured solely by patient clinical health measures…

"I think the education of the Medical Practice Assistants is probably singularly the most important part of what we have done. Nurse-led projects are wonderful, it gives your nurses a great sense of responsibility and achievement and it really sees them flourish in this environment. The education we gave to the nursing staff and the GPs meant that we were then able to go on and focus on some of our other patients who were at greater risk of osteoporosis, and prevent that from happening to them as well."

And the benefits of a shared medical approach to chronic disease continue to have systemic flow-on effects…

"Data cleanup has now become a habit rather than something that had to be specially done for a project. Better disease coding has been integrated into the GPs daily schedule, the Medical Practice Assistants have found new duties that they are able to do as patients come in, with the thought that that patient may end up being apart of a shared health project."

Practice Nurse - Geoff Loader

After his involvement in the bone health clinic, Geoff Loader - a practice nurse at Marima - is adamant that group appointments are the future for chronic disease management. Group visits allow more time and a relaxed pace of care, increased patient education and more opportunity for patients to ask questions. However it's the peer support, help and encouragement from other patients that Geoff felt was the greatest impact…

"I was a bit concerned to begin with about how the patients would adopt the shared medical appointment, but they really embraced it. And they talked about things I would never imagine they would talk about in a group. A lot of the information people got was from each other and the support that they gave was incredible."

The group approach also offers greater efficiencies by providing the health care providers with the opportunity to relay the same information to a group that might otherwise be delivered in several one-one-one appointments. For all these reasons Geoff would "like to see more people involved in group sessions because I see a lot of potential there."

Patient - Wendy Wise

The concept of 'activating patients' to be engaged in their own care is a key goal of the education provided in group appointments. Better coordinated, more comprehensive and personalised care and education empowers patients to actively participate in the development and self-management of their chronic disease. This is exactly the sentiments shared by Wendy Wise - a participant in the bone health clinic…

"We were very welcomed, it was very friendly and everything was very well organised. There were so many things I was not aware of - calcium intake, trip hazards and sunlight - and we did get a little action plan book to follow. I highly recommend it. Great fun, great people, I enjoyed it. I would like to thank Marima for giving us the opportunity to participate."

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