

Patient Assistance Tool (PAT)

Web-based program to improve
Chronic Disease Management

Designed By Dr Patrick Byrnes


www.patsoftware.com.au



PAT is a 3 stage process

1. **Nurse** checklist for series of basic tasks. e.g. weight, BP (15 mins)
2. **Patient** section of interactive questions can be done in 3 ways (15 mins)
 - a) nurse reading out the questions
 - b) patient reading the nurse's screen and nurse clarifying as needed
 - c) **patient using a touchscreen tablet in the waiting room (significant cost saver)**
3. **Doctor** section (average 30 mins)
 - a) Google Chrome speech recognition reduces typing to a minimum during the editing process.
 - b) PAT runs a side by side screen with your Medical software so easy to work with both simultaneously.

At the end a GPMP and TCA is automatically generated and exported to practice software.



PAT's waiting room shows progression through the 3 stages

Waiting Room - PAT

https://demo.patsoftware.com.au

Patient Assistance Tool 3.0.41

Waiting Room

Open Patient

Resources

Export

Settings








Feedback

Help


Log out

+ Add patient


Remove

Clinic	Started	Patient	 Patient section	 Staff checklist	 Doctor section
 General GPMP expanded	4:34 pm	Gavin Smith900 (DOB 13/09/1960)			

PAT assists in managing these future challenges for General practice

1. **CDM**. Increasing demand for Chronic Disease Management with the aging of the population.
 2. **Costs**. Practice rent and nursing staff costs rising faster than the Medicare rebate.
 3. Need for **co-operative management** with multiple Allied Health providers.
 4. PAT's **audit** ability via a download into Excel allows for 'Continuous quality improvement' required by the new PIP.
 5. Coping with the explosion of **guidelines** (PAT hyperlinks to each relevant guideline).
- 

How does PAT help the first two major challenges: CDM & costs?

- **CDM.** Automatic data, results and diagnosis extraction from practice software.
 - Disease specific templates then integrated into the one GPMP.
 - This GPMP is then subsequently updated with each review or cycle of care, streamlining long term management.
 - **Costs.** The patient using a tablet running Google Chrome in the waiting room saves nurse time.
 - Thus the waiting room becomes a “virtual consulting room” freeing up consulting rooms.
- 

General GPMP structure

Core checks

- Adherence, Absolute CV risk, Sleep apnoea
- Depression, Anxiety, Dementia, Falls , Home assistance, AHD
- Osteoporosis and CKD

Prevention

- Recommended preventive health programmes (e.g. Bowel screen)
- Recommended immunisations (e.g. Pneumovax)
- SNAP

Disease Specific

- Based on extracted data from your Medical software active problem list, disease specific questions (sub-clinics) are integrated into the GPMP
- Each of the 33 common chronic BEACH conditions are searched for.



GAVIN SMITH900

58 years old • male • born 13/09/1960



Issues



Outline



Care Team



Care Plan

Preview
PDF

CLINICS



PAT automatically selects sub-clinics based on the patient's medical history. This is a new feature. As PAT does not cover all chronic conditions, you must check the health summary for any conditions PAT has not extracted and add them to the plan manually.

Active condition from health summary	Sub-clinics
COPD	COPD
Ischaemic heart disease	CHD
Lower back pain	Back pain
Osteoarthritis	Arthritis osteoarthritis

Matched sub-clinics



Add more sub-clinics

- AF
- Anxiety
- Aortic aneurysm
- Asthma
- Back pain
- Bipolar

Option to add more

Built-in care plans and interactive patient education

Select clinic

General GPMP



General GPMP



Age 45 to 49 health assessment



Age 75 health assessment



Asthma cycle of care



Chronic pain GPMP



COPD cycle of care



Diabetes cycle of care



Opioid initiation

Resources

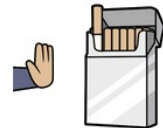
Questionnaires



Chronic pain



Exercise



Smoking



Weight



Insulin
concerns

Other



Search...

A typical patient question



Pat Test · 68 years old · male
Question 25/29

Send feedback



Blood pressure **varies all the time**. It is also, on average, 10 points higher in the morning than in the evening.

We like **12 to 14 readings**, half in the morning and half later in the afternoon, to work out an average each time we review you.

Therefore, it is very convenient for you to own a blood pressure monitor.

It is also important to use a wider BP cuff if your arm is larger.

Do you own a BP monitor?

Yes

No

Unsure



Back

Next



SNAP Interactive patient education wizards triggered by patient answers



Gavin Smith900 · 58 years old · male
Question 3/4

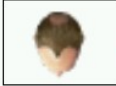
Send feedback



These pictures are specific body parts that can be affected from smoking.
Please touch **any box** that you want the doctor to explain about in more detail



Eyes: macular degeneration



Hair loss



Skin: ageing, wrinkles, wound infection



Brain: stroke



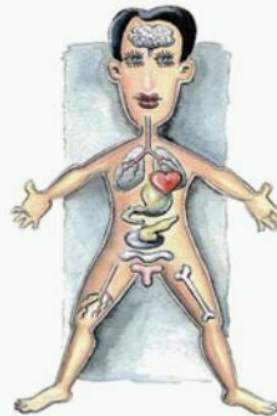
Mouth and Pharynx: cancer, gum disease



Lungs: cancer, emphysema, pneumonia



Heart: coronary artery disease



Stomach: cancer, ulcer



Pancreas: cancer



Bladder: cancer



Women: cervical cancer, early menopause, irregular and painful periods



Men: impotence



Arteries: peripheral vascular disease



Bone: osteoporosis




Back


Next





A typical doctor screen


GAVIN SMITH900 58 years old · male · born 13/09/1960


Issues


Outline


Care Team


Care Plan


Preview PDF

HOME BP WITHIN NHF LIMITS

 Home systolic BP average: **145**

After checking the target BP do you want to alter BP treatment?

 [BP targets](#)

 [Home BP monitoring chart](#)

 [Hypertension Guidelines 2016 - National Heart Foundation](#)




Value entered in nurse section

Brief summary

Links to full guidelines

Answering yes immediately generates an editable problem

Yes

No

Issue & Goal


BP outside range

Uncomplicated hypertension =135/85 home. Complicated hypertension = 125/75 home.

Heart / Brain ✕

Treatment plan

If within 5mmHg use lifestyle measures if possible. Otherwise see every 4 weeks with escalation of dose until control.

 please speak slowly & clearly, to stop click here or say 'stop dictation'

Note (not included in printed care plan)

Action planned

Commenced / continuing

Refer

Completed

Defer

Delete

+

▼

Use Google speech recognition
or type

At the end of each problem timing and responsibility are allocated

Status
Action planned ▼
For
GP ▼
Reminder January 6, 2019 (7 days) ▼

Allied health referrals from your own contact list

FOOT STRUCTURE CHECK

Examine feet for deformities: skin, such as corns or calluses, toe nail dystrophy or bony/joint deformity.

Are the feet structurally normal?

Yes

No

Issue & Goal

Foot care

Educate more on foot care.

Blood sugar ✕

Feet ✕

Treatment plan

intermediate risk feet
foot protection program including podiatry referral

Note (not included in printed care plan)

Status

Referred

For

Podiatrist

Bartoletti, Nico

START TYPING TO ADD A NEW CONTACT

Bartoletti, Nico

Bergstrom, Keon

Bode, Brant


Bruen, Jerrod

Connelly, Fausto

+

▼

A custom treatment plan for a particular issue can be saved as an auto-fill

Search... 

Categories: [Blood sugar](#) | [Feet](#) | [General](#) | [Heart / brain](#) | [Lifestyle](#) | [Medications](#) | [Men's health](#) | [Prevention](#) | [Psychology](#) | [Smoking](#) | [Social](#)

Blood sugar

Issue & Goal

Diabetic cycle of care required


Complete an annual cycle


Blood sugar ✕


▼


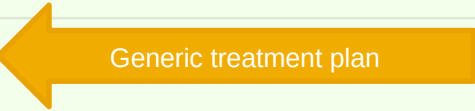
Treatment plan

Enter data and arrange reminders for next part cycle

 custom treatment

 speech recognition

 history



Relevant pathology extracted from practice software

CKD PRESENT

Review the path results for microalbuminuria (ideally a First Void urinary ACR), the eGFR, and any PH kidney problems to determine if CKD (Chronic Kidney disease) is present.

Are the kidneys normal?



Test	Value	Date
Albumin/Creatinine ratio	4.7 mg/mmol	1 month ago
eGFR	>90	1 month ago



[Classification of grades of Chronic Kidney Disease \(Kidney Health Australia\)](#)

Yes

No



GPMP ends with positive feedback & Medicare compliance

Doctor - Here are some things I think are going well

Here are 2 very important questions we need you to answer about the list of proposed changes above

Question	On a scale 0 to 10
How IMPORTANT is the above plan to you?	8 <input type="button" value="▲"/> <input type="button" value="▼"/>
How CONFIDENT are you that you can do it?	8 <input type="button" value="▲"/> <input type="button" value="▼"/>

Copy of GPMP and TCA offered to patient?	<input checked="" type="checkbox"/>
Consent obtained and copy/or relevant parts of GPMP and TCA supplied to other providers?	<input checked="" type="checkbox"/>
Referral forms for allied health services completed?	<input checked="" type="checkbox"/>
Review date (6 months)	20 January 2018

One-click generation of EPC form with care plan for pasting into referral letters

Care Plan Preview



1 of 3 100%

For Physiotherapist

Problem	Goal	Treatment Plan
Physio assessment	Design of a personalized home exercise program.	Physiotherapy for right knee osteoarthritis <i>referred - Rosie Torp</i>

For GP

Problem	Goal	Treatment Plan
COPD review	Evaluate & manage COPD	Review in 3 months <i>action planned - reminder 22 Oct 2019</i>
BP outside range	Uncomplicated hypertension: 135/85 at home	Work-up for new hypertension diagnosis <i>action planned - reminder 31 Jul 2019</i>

Referral material (click to copy to then paste into your letter-writing software)

- [Physiotherapist](#)
- [Podiatrist](#)



Patient section	12 minutes
Checklist section	6 minutes
Care plan section	18 minutes
Total	36:27



Copy clinical note (changes only)



Save & Close



Print



Edit