PCP optional case study template 2015

Name of PCP	Wimmera Primary Care Partnership

Case Study Title	**PLAYING THE LONG QUALITY GAME IMPROVES CHRONIC DISEASE OUTCOMES FOR RURAL PATIENTS**
Which PCP program Logic domain does your case study relate to?	☒ Early intervention and integrated care ☐ Consumer and community empowerment ☐ Prevention
What was the need?	For the past five years, West Wimmera Health Service (WWHS) has been working with Wimmera Primary Care Partnership (WPCP) in using the Plan, Do, Study, Act (PDSA) quality improvement methodology to better coordinate the care of clients at the WWHS Natimuk campus and to improve communication with the Natimuk/local General Practice. Natimuk is a small rural town in Western Victoria and prior to this work, communication between the General Practice and WWHS was poor, resulting in low rates of referrals. Local clients with chronic conditions were bearing the consequences and had to travel to access allied health services. Due to long travel times, lack of public transport and lack of understanding of intended health benefits, many missed out on a holistic multidisciplinary care.
What was the aim of the initiative/action?	To improve access, processes and coordinated best practice diabetes care.
Who was the target group?	Clients who have diabetes who attend the Natimuk General Practice co-located at the WWHS Natimuk campus.
What was the setting?	As above
Who did you work with?	WWHS Allied Health Team (Diabetes Educator, Podiatrist & Dietitian) Natimuk General Practice (General Practitioner)
How did you do it?	WWHS and WPCP formed a quality improvement team at Natimuk and trialled a suite of GP feedback tools. The service then expanded communication practices with the general practice and over time developed a multi-disciplinary team day when the Diabetes Educator (DE), Podiatrist and Dietitian and GPs are available to provide consultations on the same day. Processes to ensure all qualifying clients have a complete cycle of diabetes care were then implemented, as well as a new model of care using the MBS Schedule.
What was achieved? (Consider whether results were benefits for clients and/or for service providers and/or for the system)	Improving the communication practice with the GPs has led to a dramatic increase in referrals to WWHS Allied Health services. To address this increase in referral traffic and improve client access, WWHS utilised the MBS schedule to increase Allied Health EFT at Natimuk. This has also allowed the Allied Health professionals to run a multi-disciplinary diabetes clinic on a fortnightly basis and clients are now able to book several appointments on the same day thus reducing extra travel for rural clients. Following the PDSA cycle, further study identified that the GP and the DE could consult in the same room at the same time. Recommendations for treatment regime or medication changes are discussed between the DE, GP and client and then implemented immediately increasing time efficiency as well as effectiveness whilst providing patient centred care. Clients no longer

	need to travel to access best practice diabetes care and they now have a care plan that maps out their care. Clients' diabetes-related biochemistry results indicate improvements in diabetes management which is likely to have been brought about through improvement in diabetes care provided by the multi-disciplinary team. Also, to accommodate the increase in service, a whole new Allied Health wing has been constructed at the WWHS Natimuk campus.
What is the status and sustainability?	The WWHS & WPCP quality improvement team continues to meet and future work will focus on improving processes for capturing patient goal achievement in their care plans (which aligns with the Community Health Indicators). This work was presented as an oral presentation at the 2014 ADMA National Conference and has been shared at PCP Statewide Forums as it has progressed over the years.
What was the specific role of the PCP?	The WPCP ICDM Officer saw an opportunity to use the PDSA quality improvement approach with WWHS in 2009. WWHS were keen for WPCP to lead this work with their staff. At each meeting, WPCP produces a one page report which outlines who is going to do which tasks before we meet again. WPCP sets the next meeting, provides examples of ways we could solve problems/issues, researches best practice and keeps the team motivated. WPCP shares the work through the Wimmera Chronic Disease network (coordinated by the WPCP) so that others can learn from the challenges and also good practice. WPCP has provided the WWHS Team with skills in problem definition, data collection, conference abstract writing and poster development.
What lessons have you learnt?	The PDSA quality improvement process has proven to be a successful way to implement change with organisations. This work has encouraged other WPCP agencies to improve their own services – and it gives us a simple framework to assist this. The agencies value the links to quality and provides good buy in for investing in Integrated Chronic Disease work by their staff.

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