PCP Integrated Chronic Disease Management - Case study template

Details of PCP contact

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Identified Partners

Partner Organisation	**Roles and responsibilities with regard to the project**	**Contact person details *(name, position)***
West Wimmera Health Service	Improvement Team Leader Improvement Team member Improvement Team member	Sarah Natali, Podiatrist Lesley Robinson, Diabetes Nurse Educator Janet Yong, Dietitian
Natimuk General Practice	General Practice working with West Wimmera Health Service	Dr Jim Thompson, General Practitioner
Wimmera Chronic Disease Network	PDSA working and learning group, part of Wimmera PDSA Chronic Disease Plan.	Donna Bridge, Agency Liaison Officer

Case Study Title	Big Changes at Little Natimuk (population 659)

Summary/Abstract (200 words)

The West Wimmera Health Service (WWHS) adopted the Plan, Do, Study, Act (PDSA) quality improvement methodology to improve communication with General Practice and to better coordinate the care of clients at the WWHS Natimuk campus.

Prior to this work communication and referrals between the Natimuk General Practice and WWHS were very low and the relationship between the health service and General Practice was not strong. Clients with chronic conditions had to travel to other centres to access the allied health services they needed.

Methodology

1. WWHS formed a quality improvement team at their Natimuk Campus
2. A suite of GP feedback tools was successfully trialled and WWHS expanded their communication practices in consultation with the general practice.
3. Developed a multi-disciplinary team day where the Diabetes Nurse Educator (DNE), Podiatrist and Dietitian and GPs available to provide consultations on the same day
4. Developing processes to ensure all clients that qualify have a complete cycle of diabetes care
5. Implemented a new model of care using the MBS Schedule.

Improving the communication practice with the GPs has led to a substantial increase in referrals to WWHS Allied health services and the professional relationship between the two organisations is now very strong. The General Practice now refers directly to the multi-disciplinary team who are regularly practicing in Natimuk and clients can have their appointments booked in after their GP consultation.

To address this increase in referral traffic and to improve client access, WWHS have utilised the MBS schedule to increase Allied Health EFT at Natimuk. This has also allowed the Allied Health professionals to develop their multi-disciplinary team day which now consults fortnightly and clients who have chronic conditions are now able to have their allied health visits scheduled on the same day. This has resulted in a more holistic approach of client care with the client at the centre, high client satisfaction in the level of their care, and a reduced level of sick leave in this community now only need to take minimal leave to see all health professionals together.

This work positively demonstrates the power of the PDSA quality improvement process as a successful way to implement change. Rural clients now have better access to service, improved processes to ensure they receive the care they need and better coordinated care.

Background

Name of Project	West Wimmera Natimuk Campus PDSA Improvements with General Practice
Target client group	Clients of: Natimuk General Practice & West Wimmera Health Service.
DHS ICDM expectations 2009-12	Enhancing the capacity of the local workforce to: • Provide coordinated, best-practice clinical care and support for self management, and • Plan, implement and measure service system improvements in particular improvements in communication and care planning practice. Developing local service systems to: • cover each point in the continuum of care (access & initial contact, initial needs identification, assessment, care planning, care delivery, liaison & referral, monitoring & review, transition & exit, and proactive recall and ongoing support); • clearly articulate inter-agency linkages and pathways between Natimuk General Practice and WWHS • clearly articulate communication and information sharing arrangements between Natimuk General Practice and WWHS. • Identify mixed models of care that utilise the MBS.
Background	**2007 – present** The Wimmera Primary Care Partnership (WPCP) facilitates and maintains the active engagement of partner agencies in a working group with identified priorities and a plan for Integrated Chronic Disease Management (ICDM). This *Wimmera Chronic Disease Network* identified Improving Communication between Health Services and General Practice as one of its priorities for the region 2009-2012.

	2010-2011 All six health services in the Wimmera participated in the Department of Health *Plan, Do, Study, Act (PDSA) Model for Improvement Project.* This improvement work aligned perfectly with our major ICDM priority. Significant improvements were made at each agency during this project and all agencies involved indicated that they would continue to make service system improvements using the PDSA methodology. **2012** To support and further embed this improvement methodology, the Wimmera PCP ICDM Coordinator developed the *Wimmera 2012 PDSA Improvement Plan.* This is a twelve month plan of action where agencies make further improvements in their respective workplaces and then share their learnings, processes and ideas at each Wimmera Chronic Disease Network Meeting. West Wimmera Health Service (WWHS) has worked very closely with the Natimuk General Practice from 2010 through to 2012 (and ongoing) using the PDSA approach very effectively to deliver coordinated care to clients in a rural community.
Objectives	• To improve GP referrals from Natimuk General Practice by 50% in the fields of Dietetics, Diabetes Education and Podiatry at West WWHS by December 2011 • To ensure that by December 2012 WWHS will have a process for ensuring all clients that qualify have a complete cycle of diabetes care.

Describe the project and evaluation methodology and approach

WWHS made a commitment to use the PDSA Model for Improvement and to form a quality team at their Natimuk Campus in 2010. The team have used the PDSA approach to improve communication with the general practice at Natimuk. They successfully trialled a suite of GP feedback tools and expanded their communication practices in consultation with the general practice.

This led to a dramatic increase in GP referrals and to development of a multi-disciplinary team day where the Diabetes Nurse Educator (DNE), Podiatrist and Dietitian along with the general practice are available to provide consultations on the same day.

Further improvements have led to the trialling of the GP and the Diabetes Educator consulting in the same room at the same time. Recommendations for treatment made by the Diabetes Educator are discussed instantaneously with the GP and the patient and then implemented immediately increasing time efficiency as well as effectiveness of care.

The WWHS improvement team are currently developing a process to ensure all clients that qualify have a complete cycle of diabetes care. They have developed and are currently trialling an improved client file process, consistent service coordination principles with the SCTT (INI, consent), recall and reminder systems, education of staff to embed practice and also the provision of consistent information for clients with diabetes. This work is about improving the journey for clients with diabetes so that they now have access to best practice diabetes care.

WWHS have also been implementing a new model of care using the MBS schedule. With the increase in referrals from the Natimuk General Practice, WWHS have used the MBS Schedule to assign more Allied Health EFT to their Natimuk Campus – offering a comprehensive service to this rural community where there were previously no public or private allied health practitioners.

The WWHS Improvement team have been meeting regularly from 2010 onwards, developing their improvement cycles, testing ideas, planning what they will do, studying the results and acting on what happened. As part of the 2012 Wimmera PDSA Improvement plan they have submitted regular PDSA report templates to the Wimmera PCP and have shared and modelled their work with the Wimmera Chronic Disease Network at bi-monthly meetings. The team are now adept at conducting audits on their practice and using this information to make further improvements in their work.

Evaluation of WWHS Improvement team objectives:

Increasing GP referrals	*Process for ensuring clients have a full diabetes cycle of care*
File audits from 2010 through to 2012	Sufficient staff available at WWHS Natimuk Campus to deliver cycle of care Number of new clients accessing services – podiatry, dietetics & Diabetes Educator File audit on file contents/patient information Patient satisfaction survey 2012

The WWHS Improvement team's relationship with the Natimuk General Practice has grown since the start of the PDSA Project in 2010 and these two organisations now work closely together. The GPs are using the PDSA Model for Improvement in their own work.

Feedback from consumers at the WWHS Natimuk campus on the new multi-disciplinary team days was collected and has informed this work.

Results

Service improvement and innovation	Prior to this improvement work, the majority of referrals from the Natimuk General Practice to Allied Health were to practitioners outside of Natimuk. Clients would have to book their appointments and then travel to other centres for their appointments (closest town is 26km away) or wait for the scheduled visit of Allied Health professionals from WWHS Nhill campus. Now, the General Practice refers directly to the multi-disciplinary team who are regularly practicing in Natimuk and clients can have their appointments booked in immediately. Improving the communication practice with the GPs has led to a dramatic increase in referrals to WWHS Allied health services and the professional relationship between the two organisations is now very strong. To address this increase in referral traffic and improve client access WWHS have utilised the MBS schedule to increase Allied Health EFT at Natimuk. This has also allowed the Allied Health professionals to develop their multi-disciplinary team day which now consults fortnightly and clients who have chronic conditions are now able to have their allied health visits scheduled on the same day. This has resulted in a more holistic approach of client care with the client at the centre, high client satisfaction in the level of their care, and a reduced level of sick leave in this community now only

need to take minimal leave to see all health professionals together.

Clients with diabetes can choose to have their GP and Diabetes Educator consultations scheduled together. Recommendations for treatment regime or medication changes are discussed between the Diabetes Educator, GP and patient - and then implemented immediately increasing time efficiency as well as effectiveness of care.

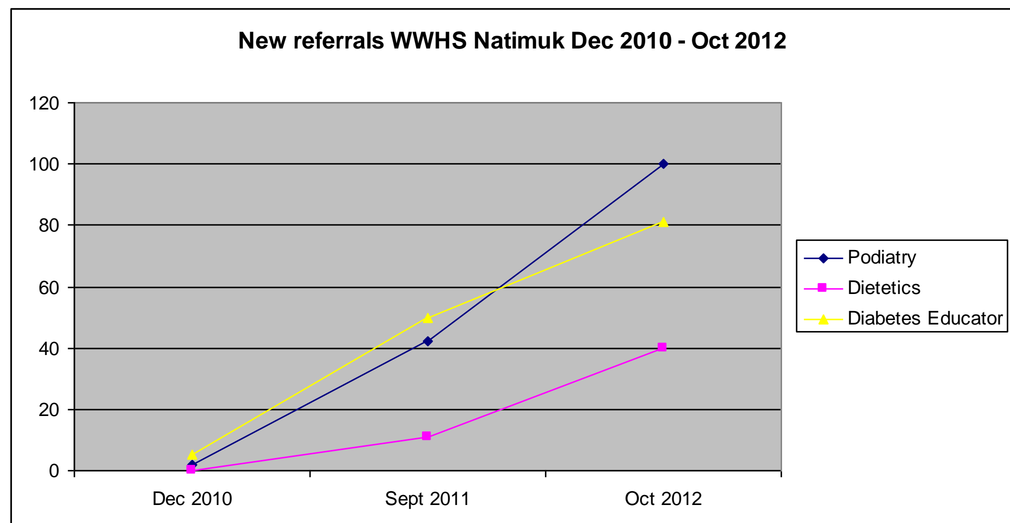
The improvement team have gone on to develop processes for client information, file systems and tracking. This is saving clinician's time in locating and accessing client information and it also ensures that any diabetes client receives a full diabetes cycle of care. The team are continuously aiming to improve and are currently gathering and compiling data to form a database (relevant biochemistry results such as HbA1C, lipid profiles, U + E's; as well as other health indicators such as weight and BMI) to demonstrate the improvements made in diabetes care and that the improvements are having a direct impact on the health of the community.

These changes have been implemented with the support of immediate and senior management.

Outcomes

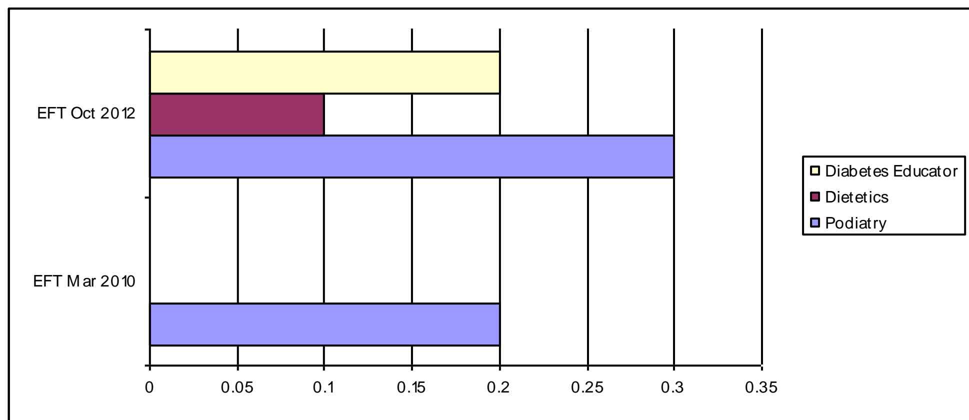
WWHS have been more than able to meet their objective of improving referrals by 50% by December 2011 and on into 2012.

Number of new referrals at WWHS Natimuk Campus			
Discipline	***Mar-Dec 2010***	***Jan-Sept 2011***	***Oct - Oct 2012***
Podiatry	**2**	**40**	**58**
Dietetics	**0**	**11**	**29**
Diabetes Educator	**5**	**45**	**31**



The impact of this increase in referrals has been the commencement of a multi-disciplinary allied health team at Natimuk and the availability of service to the community of Natimuk.

Allied Health Practitioners at WWHS Natimuk Campus		
Discipline	**EFT Mar 2010**	**EFT Oct 2012**
Podiatry	**0.2**	**0.3**
Dietetics	**0**	**0.1**
Diabetes Educator	**0**	**0.2**



The improvement team are developing processes (client information, file systems and tracking) to ensure that any diabetes client receives a full diabetes cycle of care. This is ongoing work and the file audit undertaken in September 2012 indicates that there is further improvement to be made and another audit will measure progress in 2013. *Results are in Appendix A.*

Clients of the Natimuk multidisciplinary Diabetes Clinic were surveyed in October 2012 and results indicate that clients find the clinic beneficial, that they like being able to schedule their appointments on the same day, they are satisfied with the service, that their concerns about diabetes management have been addressed, that the clinic has helped clients meet their goals and improved their understanding about diabetes and that they would recommend others with diabetes to attend the clinic.

Improvements to client files and the filing system mean that the clinicians don't waste 10 minutes each day chasing information. This saves approximately 32 hours of clinician time each year (approximately $2,500 - $3,000 of staff time). This frees the team up to spend more direct time with clients at the WWHS Natimuk campus.

Client experience vignette

Sandra is a newly diagnosed diabetes patient. She now needs to see a wide variety of health professionals to assist her with her diabetes. Sandra lives on a farm 11km from Natimuk and her GP at Natimuk GP clinic has referred her to the diabetes educator, Dietitian and Podiatrist at the WWHS Natimuk campus. She is able to have her appointments scheduled for the multi-disciplinary team day after she has seen her GP. Sandra is able to see the relevant allied health professionals all on the same day.

"It's so good to have these services in Natimuk – I can't think how hard it would be if I had to drive to Horsham or Nhill and whether I could have my visits on the same day. The Dietitian has been fantastic in helping me in my decisions about food – I probably wouldn't have gone to see a Dietitian if they weren't in Natimuk, just because its something I didn't think I needed" Sandra

"Everyone is very happy with the way their visits are coordinated. There is less waiting and people who work can do all their appointments in a single day" Norma Hudson, Natimuk General Practice Receptionist

Status and sustainability

The WWHS Improvement Team at Natimuk Campus will continue to use the PDSA Quality Improvement process in their future chronic disease management work. The team see this work as a continuous cycle of improvement and a successful way to implement change.

	The team have modelled their work to other health services in our region through the Wimmera Chronic Disease network and as part of the *Wimmera 2012 PDSA Improvement Plan.* The Wimmera PCP ICDM worker ran a conference poster workshop at the end of 2011. WWHS attended and were able to write up their work into a conference grade A0 size poster. The poster has been presented at: • The Australian General Practice National Conference in November 2011 • Grampians Region Community of Practice meeting November 2011 • Department of Health PDSA Model for Improvement Project Final Workshop The team will write up their 2012 improvements in another conference poster (as part of the *Wimmera 2012 PDSA Improvement Plan)* in November with the aim of presenting this at the Australian Disease Management Association meeting in 2013.

Conclusions

This project positively demonstrates that quality improvement processes and a committed team can dramatically improve the care available to rural clients with chronic disease and the crucial linkages between General Practice and State funded health services.

Key success factors included: A committed improvement team at WWHS, a General Practice willing to try new approaches in shared care, WWHS adopting the MBS schedule to make services available in a small rural community, staff who are skilled in using the PDSA approach (from the Department of Health project 2011).

Key challenges: staff changes in the improvement team, competing time pressures and problems in electronic referral/communication between WWHS and the GP practice.

Limitations of the project: The team had hoped to have implemented processes so that all clients of the multidisciplinary Diabetes clinic had completed a full diabetes of care during 2012. On developing these processes, the team realised that patient information systems required further work before this could be put in place.

Future directions: With the improvements in the patient information system, the team are now ensuring that all clients with diabetes are completing a full cycle of diabetes care. They have developed a database of relevant biochemistry results as well as other health indicators to demonstrate that the improvements in care are having a direct impact on the health of the community.

References (optional)

Department of Human Services, Primary Care Partnerships Revised Program Logic July 2009, Department of Human Services, Melbourne, Victoria.

Department of Human Services 2009, Victorian Service Coordination Practice Manual 2009, Victorian Government Department of Human Services, Melbourne, Victoria.

Department of Health 2010, The Plan Do Study Act (PDSA) model for improvement project workbook, Victorian Government Department of Health, Melbourne, Victoria.

Wimmera Primary Care Partnership 2009, WPCP Strategic Plan 2009-2012. Wimmera Primary Care Partnership, Horsham, Victoria.

Appendix A

File audit WWHS PDSA 2012

Date completed: September 2012
by Sarah Natali

	24297	12724	4912	52643	15592	21923	17741	13077	5421	18479	24799	52535	53036
	File 1	File 2	File3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File 11	File 12	File 13
Tracking card in use	100%	100%	100%	100%	100%	100%	100%	unable	100%	100%	100%	100%	100%
Allied Health Visit form present	100%	100%	0%	0%	0%	0%	100%	to	0%	100%	0%	100%	0%
Visit form tallys with visits since 20/7/12	0%	0%	n/a	n/a	n/a	n/a	100%	locate	n/a	0%	n/a	0%	100%
SCTT tool present	100%	100%	0%	100%	100%		100%	File 8	0%	100%	100%	100%	100%
SCTT tool completed fully	0%	100%	0%	100%	100%	0%	100%	?	0%	100%	out of date	100%	100%
Consent document completed	0%	100%	0%	100%	100%	0%	0%	Rainbow	0%	100%	100%	100%	100%
Income declaration completed	0%	100%	0%	100%	100%	0%	0%	patient?	0%	100%	0%	100%	100%
Bradma stickers present	0%	100%	0%	100%	100%	0%	100%		0%	0%	100%	100%	0%
and match info on SCTT	n/a	0%	n/a	100%	100%	n/a	100%		n/a	n/a	100%	100%	n/a
Separate practitioner sections	100%	100%	0%	50%	100%	100%	100%		100%	50%	0%	100%	100%
Notes arranged in reverse chronological order	50%	100%	0%	100%	100%	50%	66%		50%	100%	0%	0%	100%
GP initial feedback present for each practitioner	n/a	100%	100%	50%	100%	100%	50%		50%	0%	n/a	100%	0%
All pages firmly in file	100%	100%	100%	100%	100%	100%	100%			100%	0%	100%	100%
File correctly filed	100%	100%	100%	100%	100%	0%	100%			100%	100%	100%	100%
File correctly labeled	100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	100%