Wimmera Primary Care Partnership – Rural Northwest Health

Streamlining Initial Needs Identification for Chronic & Complex Clients leads to Care Planning

The Wimmera region of Victoria is a predominately rural area with a high proportion of ageing population and also high levels of chronic conditions such as diabetes, respiratory disease, cardiovascular disease and cancer. Rural Northwest Health (RNH), between their three campuses at Warracknabeal, Beulah and Hopetoun provide a comprehensive range of acute, aged, and primary health services to the local community. To respond to the rising rates of chronic disease in their catchment, RNH is focusing on strengthening early detection and early treatment, and integration and continuity of prevention and care – working closely with consumers to identify their needs early.

The Community Health Team at RNH has been using a quality improvement approach with the Wimmera PCP over the last 12 months to implement and embed the new Department of Health Community Health Indicators. This approach showed that RNH could improve the way that consumers enter and access their service - especially for those with chronic and complex conditions.

The team meet monthly with the Wimmera PCP, utilise the Plan, Do, Study, Act model for improvement which means small cycles of change are implemented, tested, improved and embedded. With more consumers with chronic conditions accessing services at RNH, prioritising client appointments, managing waiting lists and coordinating appointments was becoming increasingly demanding. A review of the RNH Intake process recognized that identifying consumer's needs through Intake and general screening was required to direct consumers to the most appropriate service at the right time, especially if there was a waiting list.

The RNH team have developed a new intake process with assistance from Department of Health Grampians Region and the Wimmera PCP; reception staff and the key intake coordinator work together to organise appointments utilising the Chronic & Complex Conditions screening tool and DH Priority Tools. Initially the Single page screener for health and social needs was used to identify a consumer's broad health needs however after trialling, the Chronic & Complex conditions screener has been implemented as it better reflects and captures the needs of the consumers who present at RNH. Each consumer is contacted by the Intake Coordinator prior to their first appointment and the screening is undertaken by phone.

The new intake process has provided consumers with a way of indicating what they feel their health issues and needs are, and they are supported and empowered to participate in their initial needs identification process. The Intake Coordinator has been able to determine the consumer's needs and provide opportunities for information provision and early intervention. This process also informs the urgency and type of assessments required. Many referrals have been activated for other services such as counselling whilst the consumer is placed on a waiting list to access their original referral for service– such as physiotherapy or podiatry. Making improvements to the intake process has also assisted with identifying incorrect referrals – clients are now directed to the services they need – saving time, reducing frustration and increasing efficiency. The extra emphasis on an efficient initial needs identification process has assisted RNH to manage demand for services. This has been much needed as the service has been struggling to recruit staff to fill podiatry and physiotherapy positions.

Feedback from clients has been positive: *"Wow… I didn't realise until we discussed things more in-depth that I actually self-identified that I actually am isolated from my community and peers".* Another client experience has been *"I knew it! I thought I needed to see a dietician and counsellor as well as the physiotherapist and exercise physiologist to address my social and emotional well-being and my nutritional needs".*

Comments from the staff also indicate that the process is providing benefits to clients – *"As the Intake Worker I have found this process to be very productive in receiving appropriate information to filter what is required (treatment) for the client".* Staff have also indicated that the process "*Works well, inputting information to this is user friendly and identifies the urgency of the needs of the clients. This also fits in very well for the Chronic Complex Care clients we all support within Allied Health, again identifying*

support mechanisms for positive, fruitful client outcomes". It has helped clinicians bridge some of the difficult conversations with clients about the need for certain services like dietetics, social work and counselling as the client is made aware of these options through the initial needs process in a non-judgemental or invasive way.

The main clinical outcomes of this approach have been that staff are supported to explore the initial requirement of the referral or episode and are then able to identify with the client other complex issues that are impacting on the presenting issue for treatment. Clients are then able to access services that they may not have considered and therefore having an improved holistic and preventative approach. Furthermore, the Intake Coordinator has also added some ABI screening into the Intake process.

So what are the next steps for this dynamic team? This new intake model provides a strong foundation for developing a care plan for those clients with a chronic condition or who are complex. The Chronic and Complex Conditions screening tool enables the team to determine the appropriate key worker and share the client's information with other team members. They have now identified that they will now convene a fortnightly care coordination meeting and will work on improving their care planning processes, so that their community can remain healthy.