

# PCP Integrated Chronic Disease Management - Case study template

## Details of PCP contact

<b>Name of PCP</b>	Wimmera Primary Care Partnership
<b>Contact Person</b>	Donna Bridge
<b>Position/Title</b>	Agency Liaison Officer
<b>Phone No.</b>	03 5362 1221
<b>Email Address</b>	<a href="mailto:donna.b@grampianscommunityhealth.org.au">donna.b@grampianscommunityhealth.org.au</a>

## Identified Partners

<b>Partner Organisation</b>	<b>Roles and responsibilities with regard to the project</b>	<b>Contact person details (name, position)</b>
West Wimmera Health Service	Project implementation	Martha Karagiannis, Community & Allied Health Manager
West Vic Division of General Practice	Input into planning phase, GP liaison if required	Leanne Jeffrey, Clinical Team Leader
TriStar Medical Practice	GP liaison	Renche Riordan, Practice Manager

<b>Case Study Title</b>	Improving Communication with General Practice for better coordination and care of clients with chronic conditions
-------------------------	---

## Summary/Abstract (200 words)

In order to improve care coordination and health outcomes for their clients, West Wimmera Health service (WWHS) undertook Plan, Do, Study, Act (PDSA) quality improvement cycles aimed at improving feedback to general practice and recommended follow up treatments/services from their Allied and Community Health Department (Dietetics and Counselling).

The program involved WWHS and Wimmera Primary Care Partnership staff attending PDSA training workshops delivered through General Practice Victoria and Department of Health; analysing current communication practice and processes of referral between general practitioners (GPs) and WWHS; leading the PDSA cycles and changes within WWHS; working with TriStar General Practice in implementing and trialling changes and embedding new communication practice.

A template and agreed practice for communication between the general practice and WWHS were developed and tested jointly and this is now the preferred feedback mechanism for the GPs. This improved communication model has led to better coordination of care of patients between organisations.

Referrals from general practice to dietetics and counselling increased during the project and indicates that clients with chronic conditions are now referred to the appropriate service at the right time and thus able to maximise their health and wellbeing and quality of life. GPs have also gained a greater understanding of the range of services provided by the WWHS allied health department and an expanded knowledge of the service system.

This work will be expanded during 2010-2011 using the PDSA model to improve care planning practice, particularly with general practice and to further improve care for clients

with chronic and complex conditions.

## Background

<b>Name of Project</b>	Improving Communication with General Practice for better coordination and care of clients with chronic conditions
<b>Target client group</b>	Clients of the TriStar Medical Practice and West Wimmera Health Service who have chronic conditions.
<b>DHS ICDM expectations 2009-12</b>	Developing local service systems to: clearly articulate inter-agency linkages and pathways between General Practice and WWHS, and clearly articulate communication and information sharing arrangements between General Practice and WWHS.
<b>Background</b>	<p>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 <i>Wimmera Chronic Disease Network</i> identified Improving Communication between Health Services and General Practice as one of its priorities for the region and members of the network agreed that GPs are pivotal in addressing the needs of people with a chronic condition.</p> <p>A file audit by West Wimmera Health Service (2009) had revealed that referrals from the TriStar Medical Clinic, co-located at West Wimmera Health Service (WWHS) were low for clients with chronic conditions and that communication between the service and clinic was not strong.</p> <p>In 2009 the Department of Health provided an opportunity to fund rapid Plan, Do, Study, Act (PDSA) quality improvement cycles aimed at improving feedback to general practice from community health on services provided to their patients and recommended follow up treatments/services. WWHS was funded to undertake this <i>Community health and General Practice engagement PDSA Project</i> to make these improvements.</p> <p>WWHS supported staff to undertake the project with support from the Wimmera PCP. The West Vic Division of General Practice was involved in project planning.</p> <p>The project focused on the referral feedback mechanism to General Practitioners (GPs) once the GP had sent through a referral to the Counselling or Dietetics Departments.</p> <p>This work aligns closely to the Wimmera PCP's Strategic Plan and the goal of "Improving the service system for clients with chronic conditions" (WPCP<sup>1</sup>)</p>
<b>Objectives</b>	To strengthen WWHS Community & Allied Health's engagement with general practice to improve care coordination and health outcomes for clients.

To implement the PDSA approach to:

1. build an enthusiastic team to undertake this work
2. analyse current referral and acknowledgement practice
3. trial improvements
4. embed practice

### **Project participants**

- Project Partners (as listed in Identified Partners section)
- Donna Bridge, Agency Liaison Officer (ICDM & HP), Wimmera PCP
- General Practitioners at TriStar Medical Clinic, Nhill
- Clients of the TriStar Medical Clinic & WWHS

### **Methodology and approach**

Project planning commenced in April 2009 with WWHS, Wimmera PCP, Department of Health Grampians Region and WestVic Division of General Practice.

WWHS identified key staff that would be responsible for driving the program and the Wimmera PCP offering a supporting role through the ICDM worker.

WWHS Staff and Wimmera PCP staff members actively participated in three PDSA training workshops delivered by GPV and Department of Health in May, July & August, in Melbourne.

After attending the introductory workshop, WWHS's first area for improvement focused on building an enthusiastic team at the health service to undertake this work. Once this PDSA cycle had been completed, the next area for improvement was indentified as the quality, quantity and timeliness of communication with the general practice.

Key data was collected on referrals received, GP details documented in clients file, feedback (other than referral acknowledgement) provided to GP, Referral acknowledgement provided to GP and whether acknowledged within 2 days (urgent) or 7 days (routine). WWHS gained an understanding of their current practice and areas for further improvements, which led to another PDSA cycle.

WWHS convened meetings with the TriStar medical clinic staff. The GPs indicated that information provided by WWHS on patients was too lengthy and because of this the GPs did not read the information, also the GPs did not receive routine acknowledgement of a referral. Furthermore, GPs did not understand the range of services provided by WWHS allied health department. Work was undertaken to determine what level of communication GPs required and changes were incorporated using PDSA cycles and trialled. A half page template for the feedback summary was developed and is now the preferred feedback mechanism of the GPs.

This continuous improvement process was implemented in May 2009 is still active in August 2010. This project has strengthened service coordination and has put in place a policy and procedure to support systematic referral and feedback to general practice, acknowledgement of referrals and providing feedback to GPs about referral outcomes (DHS 2009).

### **Results**

#### **Service improvement and innovation**

Improved communication between WWHS and TriStar clinic has led to better coordination of care of patients between organisations. GPs are more aware of whether a patient has

	<p>been treated at WWHS and any key action that the GP must follow up on. Patients are receiving treatment by health professionals who are sharing key information about their care – not having to retell their story over and over.</p> <p>Increased referrals into dietetics and counselling indicates the GPs increased knowledge of the service system. It also shows that clients with chronic conditions are now referred to the appropriate service at the right time and thus able to maximise their health and wellbeing and quality of life.</p> <p>Prior to the project, clinicians sent GPs a 3-4 page report which was laborious and GPs stated they did not have time to read this. Now communication with the general practice is more streamlined and succinct and is saving clinicians' time.</p> <p>The GP feedback summary template will be sustained and rolled out to all allied health departments as the preferred feedback mechanism.</p>
<p><b>Outcomes</b></p>	<p>1. WWHS Project Team</p> <p>WWHS built an enthusiastic improvement team who were, and remain, active participants in making changes to their practice.</p> <p>2. GP Feedback Template</p> <p>WWHS and the TriStar General Practice developed the GP feedback Template. The GPs determined the content and WWHS implemented the new process, which has in turn influenced how GPs communicate with WWHS. This new template alleviated the work load of the health practitioners as they would normally send a 3-4 page report instead.</p> <p>3. Implementing a new way of communication and monitoring</p> <p>A total of 25 referrals were received by the Dietetics department and 47 by the counselling department from GP's throughout the duration of the project. On completion of the project 100% of referrals from the GP to the departments were followed up with the ½ page feedback template from the health professional to the GP indicating the Assessment that had taken place and recommendations made. This indicates that this communication process has been embedded into practice.</p> <p>Referrals to the dietetics and counselling departments increased during the project. Both Dietitians and Counsellors indicate that this work has improved contact with the GPs with more telephone contact and face to face interaction, with GPs even initiating contact.</p> <p>4. Breaking down barriers</p> <p>Previously, communication between TriStar clinic and WWHS was not strong. After implementing this project, the GPs are happy with the level of communication with WWHS, and have indicated that they now would like further information included in the GP Feedback Template. The Allied and Community health manager has been invited to the GP staff meetings to discuss other Allied and Community Health services that are available and how referrals to these services can be made.</p>
<p><b>Status and sustainability</b></p>	<p>The feedback summary template will be sustained and rolled out to all of allied health departments as the preferred feedback mechanism with the GP clinic.</p>

This work and findings have been presented at the Wimmera Chronic Disease Network meeting on 29<sup>th</sup> April 2010. WWHS's project has inspired other organisations in the Wimmera to make improvements using the PDSA approach. Six Wimmera health agencies applied for and received funding from the Department of Health under the *"Plan, Do, Study, Act (PDSA) Model for improvement chronic disease incentive project"*. Agencies will use a partnership approach to undertake this work. WWHS will focus this next PDSA project on improving care planning with general practice.

## Conclusions

This project positively demonstrates the power of the PDSA quality improvement cycles as an approach to changing practice around communication, referral and feedback between general practice and health services.

Key success factors included: a champion for the PDSA approach for improvement at WWHS (Allied & Community Health Manager), management support and a proactive improvement team at WWHS, and training and support from GPV and Department of Health.

Key challenges included: travelling to Melbourne for workshops for two key staff members - a huge commitment for this rural health service (9 hours return) and competing time pressures for staff.

A project, like the one outlined in this case study is an important early step to improving communication and care coordination between health services and general practice, but there is much more work to do. Further improvements in Care Planning practice particularly with the general practice (again using the PDSA quality improvement cycles) will take place at WWHS during 2010 – 2011.

WWHS's work with general practice using the PDSA approach has inspired other Wimmera health services to apply for and receive funding for "Plan, Do, Study, Act (PDSA) Model for Improvement – chronic disease incentive project". Our region will have six health services using this approach to improve care planning practice, particularly with general practice and we hope to further improve care for clients with chronic and complex conditions.

## References

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.

Wimmera Primary Care Partnership, WPCP 2006-2009 Community Health Plan: ICDM Goals. Wimmera Primary Care Partnership, Horsham, Victoria.

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