

Wimmera PCP ICDM - Case study

Improving communication and care planning practice with health services and General Practice in the Wimmera.

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	Project Implementation	Martha Karagiannis, Community & Allied Health Manager
Wimmera Health Care Group	Project Implementation	Denise Hooper, Primary Care Manager
Rural Northwest Health	Project Implementation	Pam Clugston, Community Health
Edenhope & District Memorial Hospital	Project Implementation	Meredith Finnigan, Director of Nursing
Dunmunkle Health Services	Project Implementation	Dianne Knoll, Community Health Nurse
Grampians Community Health	Project Implementation	Marianne Hendron, Direct Care Manager
West Vic Division of General Practice	GP Liaison, supporting agencies in communication improvements	Joanne Martin, Health Promotion Manager

Case Study Title	Improving communication and care planning practice with health services and General Practice in the Wimmera.
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Summary/Abstract (200 words)

Six Wimmera PCP Health Agencies have been making significant improvements to the way they communicate with General Practitioners and in also in Care Planning during 2011. In order to improve care coordination and health outcomes for their clients, Wimmera Health Care Group, West Wimmera Health Service, Dunmunkle Health Services, Grampians Community Health, Edenhope Hospital & Rural Northwest Health undertook Plan, Do, Study, Act (PDSA) quality improvement cycles aimed at improving feedback to GPs and in developing best practice care plans.

The PDSA Model for Improvement framework is a tool used to plan and manage change by breaking it down into manageable chunks which can then be tested to ensure things are

improving.

At the start of the project agencies undertook file audits to understand how they were communicating with GPs and Care Planning. Practice was found to be inconsistent, varying in quality and did not meet best practice standards.

At the end of the project, this had changed dramatically with agencies providing consistent, quality communication with GPs that meets the Victorian standards. Care Planning practice improved dramatically with complete care plans in place for clients with chronic and complex conditions which meet best practice guidelines.

All agencies involved in the project have committed to making further service system improvements using the PDSA approach and have signed up to a Wimmera wide plan to do this work in 2012.

Background

Name of Project	Improving communication and care planning practice – Using the PDSA model for improvement in the Wimmera.
Target client group	<p>Clients of:</p> <ul style="list-style-type: none"> • West Wimmera Health Service Natimuk campus • Wimmera Health Care Group HARP, Diabetes Self Management program and Subacute TCP program • Rural Northwest Health Primary Care Department • Edenhope & District Memorial Hospital Community & Allied Health departments • Dunmunkle Health Services Murtoa Medical clinic • Grampians Community Health Counselling team <p>who have chronic conditions.</p>
DHS ICDM expectations 2009-12	<p>Enhancing the capacity of the local workforce to plan, implement and measure service system improvements in particular improvements in communication and care planning practice.</p> <p>Developing local service systems to: clearly articulate inter-agency linkages and pathways between General Practice and the health services, and clearly articulate communication and information sharing arrangements between General Practice and the above health service departments.</p>
Background	<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 2009-2012.</p> <p>In 2010 the Department of Health provided opportunities to fund rapid Plan, Do, Study, Act (PDSA) quality improvement cycles aimed at improving feedback and care planning to general practice from community health on services provided to their patients and recommended follow up treatments and</p>

	<p>services.</p> <p>All six health services in the Wimmera worked together and successfully applied for the <i>Plan, Do, Study, Act (PDSA) Model for Improvement Project</i> funding as a region as the project aligned perfectly with our major ICDM priority.</p> <p>A Memorandum of Understanding was developed and signed by all health services, the West Vic Division of General Practice and Wimmera PCP with the purpose of documenting the roles and responsibilities of each party to support the project. The <i>Wimmera Chronic Disease Network</i> has operated as the key consultative group for the project.</p> <p>All agencies agreed to provide some of their project funds to the Wimmera PCP ICDM worker position as a central resource for the project and to support agencies in their PDSA improvements, interpretation of data and development of regional evidence during the project.</p> <p>The Department of Health <i>Plan, Do, Study, Act (PDSA) Model for Improvement Chronic Disease Incentive Project</i> commenced on 1 November 2010 with approximately 50 agencies participating across Victoria. In the Wimmera, of our six agencies participating, three have been making improvements in communication with General Practice and three in improving care planning practice, particularly with General Practice.</p>
Objectives	<p>To implement the PDSA Model for Improvement approach to:</p> <ol style="list-style-type: none"> 1. build an improvement team 2. analyse current practice through file audits 3. trial improvements 4. embed practice <p>in communication and care planning with General Practice.</p>

Project participants

- Project Partners (as listed in the Identified Partners section)
- Donna Bridge, Agency Liaison Officer (ICDM & HP), Wimmera PCP
- Geoff Witmitz, Agency Liaison Officer (SC & HP), Wimmera PCP
- General Practitioners in the Wimmera
- Clients of participating health services and GP practices

Methodology and approach

All six health agencies in the Wimmera have made a strategic decision to implement quality improvement activities through this project. Three have been making improvements in communication with General Practice and three in improving care planning practice, particularly with General Practice.

High level project aims were set:

Communication with GPs – 100% of eligible clients have feedback provided to General Practice which is consistent, timely and appropriate throughout the course of care.

Care Planning – 80% of eligible clients have all elements of a care plan documented

The project was stepped through a set of change principles:

- Build an improvement team at each agency
- Build an understanding of all aspects of either: communication with GPs or Care Planning
- Change your business – be systematic and proactive in managing care and communication
- Involve clients in developing communication feedback pathways with GPs and in delivering and developing care
- Adapt a multi-skilled, multi-agency approach to ensure effective communication and care coordination.

Agency improvement teams, Wimmera PCP and WestVic Division staff attended a suite of five Department of Health PDSA project workshops from November 2010 – August 2011.

Each agency also collected Indicator Data for tracking progress towards the aim of the quality improvement area of focus (Communication or Care Planning) as follows:

- Project Commencement – baseline data (elements of feedback templates or care planning templates) and file audit: 7 March 2011
- Interim 1 – 9 May
- Interim 2 – 1 August
- Project End – 19 September

This continuous improvement project has seen agencies drive their own specific activities using the PDSA Model for Improvement framework. Each agency has identified their own key issues and prioritised them, set SMART goals, tested ideas, measured progress of each goal and implemented improvements.

Agencies were supported closely by Wimmera PCP ICDM and Service Coordination staff and this project has strengthened service coordination practices, policies and protocols particularly in systematic referral and feedback to general practice, acknowledgement of referrals and providing feedback to GPs about referral outcomes. There have also been impressive changes in care planning practice, use and sharing of care plans and embedding of the SCTT care coordination plan.

The project progress has been an agenda item at each Wimmera Chronic Disease Network Meeting during 2011 and the Wimmera PCP ICDM worker has employed a range of communication strategies to ensure that agency management and Quality staff are kept abreast of the improvements made.

The West Vic Division of General Practice has worked closely with each agency and has facilitated meetings and communication with GPs when required. This has been invaluable to ensure that the GPs understood the purpose of the project, had some input into the process and were receptive to the changes implemented.

Results

Service improvement and innovation

The WHCG Diabetes Self Management & WHCG HARP programs have implemented Care Coordination plans for all clients. They are also ensuring that the goals and objectives identified by clients are recorded and a time frame for attainment is noted in the care plan. Clinicians have found these new processes mean that they are working together with clients in a much more coordinated way and helping their clients reach their goals. They have set up a new documentation policy where Outpatients Medical Records now have an approved divider for care coordination plans which is accessible to all clinicians. Clinicians in other departments can now see who else is working with the client and also the clients' goals.

Rural Northwest Health have improved staff knowledge and education around providing feedback using the one page template they have trialled successfully with General Practice. They provided education and implemented a new policy to encourage all staff in Community Health to use the new improved feedback templates routinely. The GPs really like these new changes and there has been a gradual increase in referrals to Allied and Community health programs.

Dunmunkle have provided staff orientation and training on new care planning processes. They amended client data on the patient management system so that accurate information is auto-populated. Care Plans at Dunmunkle are stored electronically and Dunmunkle now scan wound care plans into their client management system. This allows other types of care plans to be accessed by clinicians at any of their three sites.

Edenhope have reviewed referral processes with GPs and a way to prompt GPs to identify other care needs for their clients. They are currently working with West Vic Division of GPs so that referrals can be sent electronically. Edenhope have also now set up a Chronic Disease Management Committee to formalise their commitment to making improvements in working with clients with Chronic conditions.

West Wimmera Health Service has successfully trialled a suite of GP feedback letters and the GPs have found these extremely useful and the GPs are now communicating much more effectively. They are finally at the stage of trialling electronic communication with the Natimuk GP Surgery. WWHS have started a multi-disciplinary team day at the Natimuk campus with the Natimuk GP Surgery. The Diabetes Nurse Educator and GP are running an afternoon clinic once a month and the Podiatrist and Dietician will be there on the same day so patients can have all their visits in one day....so very holistic and patient centred.

Grampians Community Health has trialled their new primary care Counsellors Care Plan Tool at the Horsham and Stawell sites successfully. They have been using the tool with every new intake and extending this to existing clients. The process has been extremely valuable and has given counsellors an additional sense of the value of their work. Counsellors feel part of a whole care team and seeing the client more fully in the context of their care.

Collectively

Agencies have been able to share their work at the PDSA Workshops and also at the Wimmera Chronic Disease Network – much like a peer learning group. This has been valuable as agencies have been able to gain change ideas from others, share tools developed and learn from others.

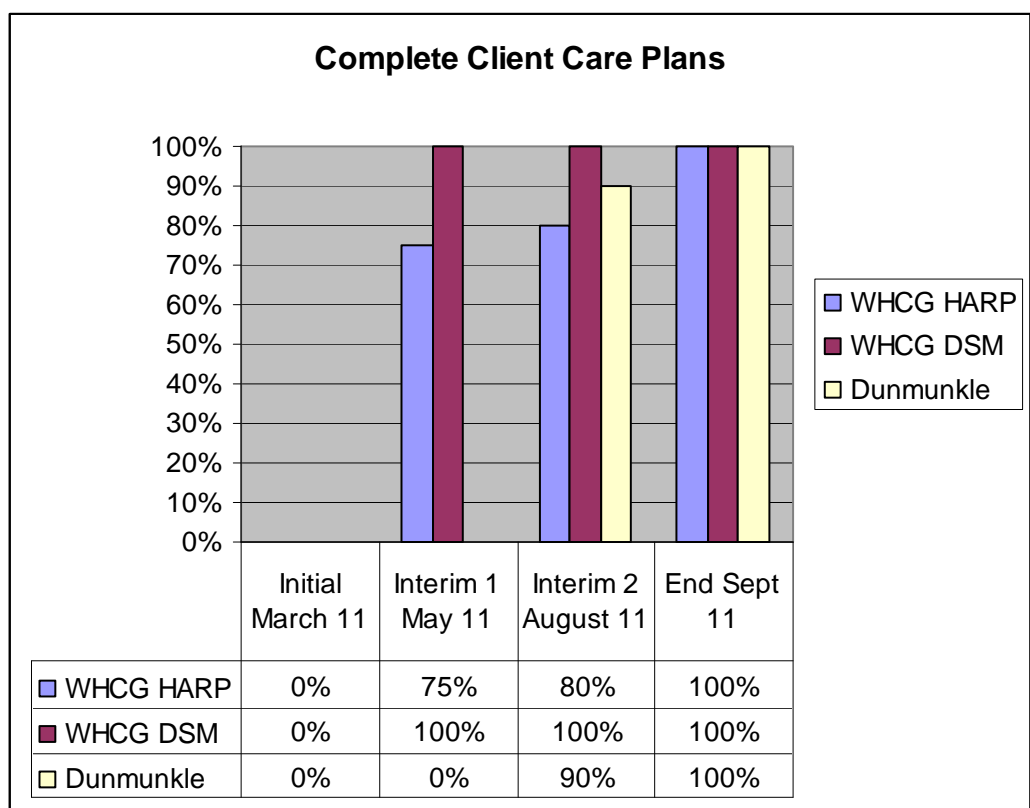
Outcomes

The results from baseline audit and final audits are as follows:

Edenhope GP Communication	Initial March 11	End Sept 11
Communication template completed	0%	100%
GP contact details recorded	69%	100%
GP referral acknowledgement sent within 2 day	0%	100%
GP referral acknowledgement sent within 7 day	0%	89%
Initial assessment report sent to GP	0%	100%
Discharge report sent to GP	56%	0%

WWHS GP Communication	Initial March 11	End Sept 11
Communication template completed	69%	100%
GP contact details recorded	58%	100%
GP referral acknowledgement sent within 2 day	0%	100%
GP referral acknowledgement sent within 7 day	0%	100%
Initial assessment report sent to GP	8%	100%
Discharge report sent to GP	0%	100%

RNH GP Communication	Initial March 11	End Sept 11
Communication template completed	62%	100%
GP contact details recorded	70%	90%
GP referral acknowledgement sent within 2 day	0%	0%
GP referral acknowledgement sent within 7 day	0%	86%
Initial assessment report sent to GP	20%	80%
Discharge report sent to GP	0%	n/a



Improvement Teams – All health services now have chronic disease improvement teams.

Built Capacity – We now have clinicians in our region who are able to determine areas for improvement and can implement change and monitor their work into the future.

GP Communication - Health services are now routinely communicating and providing feedback to GPs. The GPs are now responding to this and are communicating more freely with agencies and referral rates are increasing.

West Wimmera have audited their GP referral rates during this project and the improvements can be seen below:

Number of referrals received at Natimuk		
Discipline	Mar-Dec 2010	Jan-Sept 2011
Podiatry	2	40
Dietetics	0	11
Diabetes Ed	5	45

Status and sustainability

All agencies involved in the project have indicated that they will continue to make service system improvements using the PDSA approach.

The Wimmera PCP ICDM worker has developed a plan for taking this work further: The Wimmera 2012 PDSA Improvement Plan has all agencies identifying their service improvement focus for the coming year. This is a 12 month plan of action that has been endorsed and signed off by all health service managers and the Wimmera PCP Executive.

The Wimmera PCP ICDM worker ran a conference poster workshop on 12 October. All agencies were invited to attend to write up this work into a conference grade A0 size poster. Four of the six agencies have completed these posters (see Appendix) and three of these have been presented at the Australian General Practice National Conference in November 2011.

The results of this project will also be presented at the 2012 Australian Disease Management Association conference and written up as a conference poster for other relevant conferences and meetings.

Conclusions

This project positively demonstrates the power of the PDSA quality improvement process as an approach to changing practice around communication, referral and feedback between general practice and health services; as well as care planning practice, use and sharing of care plans and embedding of the SCTT care coordination plan.

Key success factors included: DH delivery of the PDSA project and support; agencies had some prior understanding of the PDSA Model; our regional focus on service system improvements particularly with GPs; and a strong partnership approach where all health services, PCP and GP Division were involved in the project.

Key challenges: taking on board new ideas for some staff and competing time pressures.

This project has benefited:

- **Patients/clients:** better coordination of care, not having to tell their whole story again, referred to appropriate service, goal setting is more client centered
- **GPs:** now read feedback & know what action is required of them; more aware when

patients have received service; better understanding of services offered by health services and greatly improved the relationships with health services

- **Health Services:** better relationship with GPs, increased referrals, improved care planning practices and goal setting with clients, and quality improvement work more sustainable
- **Clinicians:** saving time by using one page GP reports, GPs know who clinicians are now, improved relationships and staff feel more confident in setting client centered goals whereas previously goals were more clinically focused (and goal achievement is now higher).
- **Other services:** sharing the wins of PDSA approach as a way of improving practice.

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.

Appendices

Appendix A (see below)

Big Changes at Little Natimuk

Authors: Sarah Natali, Lesley Robinson, Morgan Sandeman, Bianca Jones and Martha Karagiannis

West Wimmera Health Service

Introduction

The Plan, Do, Study, Act (PDSA) Model for Improvement project has been a 12 month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice.

West Wimmera Health Service (WWHS) worked closely with the Natimuk General Practice to improve feedback, referral acknowledgement and communication between Allied Health and General Practitioners (GPs).

WWHS undertook small rapid cycles of quality improvement during 2011 using the PDSA Model for Improvement. A key feature of the approach was the use of data to measure change and effect.

WWHS has tested a variety of change ideas and worked closely with the GPs to grow and sustain work in chronic care systems improvement.

Methods

Building an improvement team

We systematically looked at the areas in which we were able to improve upon and developed our project aims. These were to improve communication with General Practice and to increase referrals at the Natimuk Campus by 50% by September 2011.

Understanding our business

Through liaising with General Practice we were able to ascertain the level and quality of feedback required and then developed a one page feedback form which complied with Victorian standards. This has now become an invaluable tool which has been essential in allowing General Practice to realise the scope of Allied Health services at West Wimmera Health Service.

Changing our business systematically and proactively

Following the process of the PDSA program our team met regularly and undertook small improvement cycles working closely with the Wimmera Primary Care Partnership (PCP) and West Vic Division of General Practice to test ideas and develop long term improvements across our health service.

Involving clients in developing pathways

We developed a multidisciplinary diabetes team which now consults fortnightly. This team includes the Doctor, Diabetes Educator, Dietitian and Podiatrist. This holistic approach has put the client at the centre of our practice and has improved health outcomes and access to services.



Lesley Robinson (DME), Dr Jim Thomson (GP), Sarah Natali (PhD) & Morgan Sandeman (Dietitian)

Adapting a multi-skilled, multi agency approach

The changes were implemented with the support of immediate and senior management and a protocol has been developed to ensure the work is not lost. The feedback tool has been rolled out over the five other sites of West Wimmera Health Service and across the Allied Health, Community Health and District Nursing departments.

"I reckon it's good; being able to come up here and not have to go into Horsham" Len Pilmore Natimuk resident and client.

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

Results

Plan, Do, Study, Act has significantly improved communication and relations with the Natimuk General Practice. We are now receiving written referrals rather than verbal and the quality and appropriateness of referrals have improved.

We have dramatically improved the availability of health services to Natimuk and have therefore improved health outcomes for a previously underserved area with a high risk farming clientele.

At Natimuk we are now providing 100% feedback to General Practice including failure to attend appointments. This is consistent, timely and appropriate throughout the course of care.

We are now receiving significantly more referrals as a result of this Project.

Number of referrals received at Natimuk

Discipline	Mar-Dec 2010	Jan-Sept 2011
Podiatry	2	40
Dietetics	0	11
Diabetes Ed	5	45

Discussion

Plan, Do, Study, Act has been a fantastic way of improving services to a town with a population of 460 people. We have knocked down walls, literally, to create a dedicated Allied Health treatment room which means that Allied Health are now able to consult in Natimuk every day rather than fighting for use of a shared room with the doctor.

Traditionally clients from Natimuk have travelled 26kms to the regional centre to access Allied Health services. From our PDSA improvements we are now finding this trend has reversed and people from local and neighbouring communities are travelling to our clinic at Natimuk to access the services we provide.

Our GP has embraced our improvements and has started using the PDSA cycle, making changes and improvements to his Team Care Arrangement form so that it is better suited for the Allied Health team.



We have had major issues with introducing electronic referrals due to IT complications. PDSA has allowed us to push for change and the GPs have agreed to change their email server so that this can be facilitated.

The PDSA approach has been so successful that West Wimmera Health Service will incorporate it into their future project planning in chronic disease management.

Conclusions

The Plan, Do, Study, Act improvement cycles have proved a successful way to implement change.

Support from the Wimmera PCP, the Department of Health and West Wimmera Health Service has been essential to the success of this Project.

Small changes lead to big things and by using PDSA to increase the number of referrals we have been able to create an Allied Health hub at the Natimuk campus.

Further information: www.wwhs.net.au

Contact: Sarah Natali, West Wimmera Health Service, snatali@wwhs.net.au

Photo acknowledgements: Melissa Powell, Sarah Natali



Improving Care Planning practice using PDSA

Authors: Cathy Newell & Janine Harfield
Wimmera Health Care Group

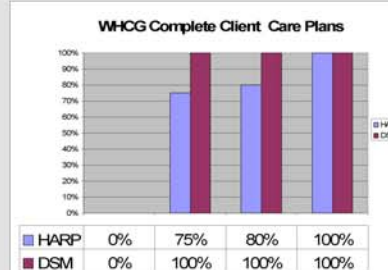
Introduction

The Plan, Do, Study, Act (PDSA) Model for Improvement project has been a 12 month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice.

Wimmera Health Care Group (WHCG) aimed to improve their Care Planning Practice within the Hospitals Admissions Risk Program (HARP) and the Diabetes Self Management Program (DSM).

WHCG undertook small rapid cycles of quality improvement during 2011 using the PDSA Model for Improvement. A key feature of the approach was the use of data to measure change and effect.

WHCG has tested a variety of change ideas, embedded good practice and worked hard to grow and sustain work in chronic care systems improvement.



Discussion

The success of the program has been in the staff uptake of the PDSA process in making small changes and seeing the results. We will use the PDSA approach to make further improvements and to introduce the care plan work we've undertaken into other departments at WHCG.

IT programs have not been useful in sharing care plans electronically across our health service. We would like to see improvement in this area in the near future.

We will use PDSA in 2012 to continue to audit and monitor the use of care plans and in further improvement work.

Next steps will be to liaise with the local general practices to gauge whether they feel receiving care plans from us will be beneficial in the care of clients.



"The PDSA cycles mean that our quality improvement work is much more sustainable — changes are embedded into practice and other staff members are involved as you are continually evaluating what you are doing and seeing whether it works"
Care Coordinator, HARP, WHCG

"The Care Planning improvements mean that the client's journey through HARP is much clearer and we can all work together on reaching the client's goals"
Care Coordinator, HARP, WHCG

Methods

Built an improvement team

The HARP program and Diabetes Self Management Program came together to form the Wimmera Health Care Group Improvement team in Care Planning.

Identified our key issues

We undertook a file audit across the above programs to determine the quality and quantity of care planning processes and understand our processes.

Implement Change

From this information we implemented small rapid cycles of change in our care planning practices.

- Found a tool for care planning that met all criteria in best practice care planning
- Started using the tool initially with new clients
- Reviewed files on a monthly basis to ensure all active clients now had a care plan
- Changed our practice in sharing Care Plans within each department and with other departments at WHCG.

Embedding Practice

- Educated staff in developing client focused goal setting and care planning
- Initiated a new policy where care coordination plans are accessible to all clinicians.

Management support

We have had significant management support from our Primary Care Management and the Wimmera Primary Care Partnership (PCP) to undertake these improvements.

Results

At the start of the project there was no consistent care planning tool used across our programs. We then identified that the SCTT Care Coordination Plan was the ideal tool to enable all elements of best practice care planning to be used.

Where the Care Plans were used at the start of this project, they were not used in a consistent manner.

However, at the end of the project in October 2011, care planning practice is now significantly improved (please see graph for more details).

Staff now feel more confident in setting client centered goals whereas previously goals were more clinically focused.

Conclusions

PDSA improvement cycles are a successful way to implement change in our organisation.

Staff involvement in this quality improvement process means they own the work and the changes are embedded into practice.

Building a good team to do this work at the start of the project is very important.

Having support from management and the Wimmera PCP has been invaluable.

Further information: www.whcg.org.au

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Improving Care Planning using the PDSA Approach

Author: Dianne Knoll, Dunmunkle Health Service

Introduction

The Plan, Do, Study, Act (PDSA) Model for Improvement project has been a 12 month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice.

Dunmunkle Health Services (DHS) aimed to improve their care planning practice and to embed consistent care planning processes with the General Practice which sits within the health service.

DHS undertook small rapid cycles of quality improvement during 2011 using the PDSA Model for Improvement. A key feature of the approach was the use of data to measure change and effect.

DHS has tested a variety of change ideas, embedded good practice and worked to grow and sustain work in chronic care systems improvement.

Results continued...

These small rapid changes have meant that we have been able to test ideas and see whether they worked. Staff feel more confident to implement changes and to try new approaches to improving their work.

This project has meant that we are now more aware of the opportunities to implement care plans for clients who we had not considered previously.



Staff have more skills in care planning practice and in identifying clients who may benefit from coordinated care and a care plan.

Methods

Built an improvement team

The Community Health and Primary Care nurses came together to form an improvement team which also included our Quality Manager.

Identified key issues

We undertook a file audit to better understand our care planning practice and to see if our care plan had all the elements of best practice. We looked at the quantity of care plans in place and the quality of these.

Implemented change

Once we understood our current practice we then looked at ways to improve. We implemented small rapid cycles of change in our care planning practice which included:

- Worked with the West Vic Division to implement changes to the client management system
- Date of care plan developed on front page
- Client signature on the care plan
- Added recall onto our client management system so that reviews were done when required
- Developed a process for checking for recalls
- Developed a new wound care plan and a way of communicating this electronically with general practice and other staff

Embedded practice

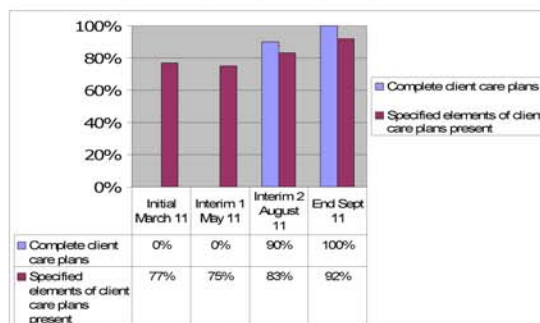
We also identified that to embed these new processes at our health service, we would need to provide education on our new care planning processes to staff at DHS.

Results

At the start of the project our care plans did not have all the best practice elements of a care plan. By the end of the project we had implemented 92% of the elements of a best practice care plan within our community and primary care departments.

The PDSA project has meant that we are now implementing care plans for our chronically ill clients in a much more consistent manner.

Care Plans at Dunmunkle



Discussion

Using PDSA means you start off analyzing your problems and thinking there is one solution but end up discovering that there are better ways to solve things.

PDSA breaks big problems down into manageable chunks and by working in small rapid cycles, big improvements can be achieved over time.

The PDSA approach has been successful and DHS will incorporate it into our future project planning in chronic disease management.

Conclusions

Anyone in an organization can use the PDSA approach to make significant improvements. Its not just for management and the Quality Manager, it's a process that all staff can be part of to make improvements.

We will use the PDSA approach again in 2012 to further improve the care we can provide for clients with chronic and complex conditions.

Collaborating agencies: West Vic Division of General Practice, Wimmera Primary Care Partnership and the Victorian Department of Health.

Further information:

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Ph: 03 5363 1200 email: dknoll@dunmunkle.com.au

Photo acknowledgements: Melissa Powell Photography



Implementing Care Planning at Grampians Community Health

Authors: Marianne Hendron & Sandra Mc Grath
Grampians Community Health

Introduction

The Plan, Do, Study, Act (PDSA) Model for Improvement project has been a 12 month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice.

Grampians Community Health (GCH) aimed to improve their care planning practice and to embed consistent care planning processes within the Primary Care Counselling Team.

GCH undertook small rapid cycles of quality improvement during 2011 using the PDSA Model for Improvement. A key feature of the approach was the use of data to measure change and effect.

GCH has tested a variety of change ideas, embedded good practice and worked hard to grow and sustain work in chronic care systems improvement.

Methods

Built the Team

We established a small team of 3 to drive the project. Our efforts were focused on working alongside the Primary Care Counselling Team, which was already embedding a focus on Early Intervention in Chronic Disease Management since increasing numbers of generalist clients are living with chronic disease..

Identified key issues

Building on the Social Model of Health philosophy that underpins holistic assessment within the counselling team practice and GCH more broadly, we clarified why care planning was relevant, appropriate and a service improvement for our clients. We undertook a file audit and determined that there were minimal care plans in place for current clients. Existing care plan tools were also inappropriate.

Implemented Change

- The Team Manager led the Team in developing a workable care plan tool, based on the SCTT template. This was modified 4 times throughout the PDSA cycle. We knew that if the tool wasn't right the staff would not be comfortable in using it.
- We held several discussions to clarify and address concerns the team had around confidentiality and sharing of client information.
- We aligned our PDSA project with another significant change process that was already in place in GCH, the Intake Review Reference Group, and ensured our objectives were complementary and in the context of best practice in service co-ordination.
- The Project overall was reviewed at every monthly team meeting and problems addressed systematically
- Wimmera PCP staff were extremely helpful in providing information and support to staff

Embedded practice

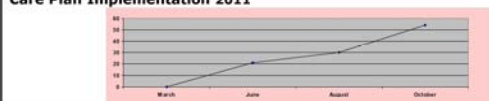
Care plans are now part of client file management and completed for new clients of the primary care team.

A new client database will be implemented in coming months which will incorporate care plans and this will embed the practice further.

Results

At the start of the project, documented care plans were not part of the Primary Care Team's file management process, nor were there consistent care plan tools in use by the team. The main outcome of the project was that the number of care plans in place for Primary Care clients went from zero to 54 during the life of the project! The team was also made more aware of the value of care planning and of holistic assessment in the context of psychosocial wellbeing.

Care Plan Implementation 2011



Discussion

The introduction of care planning was a significant change for the counselling team and generated much discussion about where the counselor's role begins and ends and how much information they and other partners in care need to know in order to work effectively and respectfully with the client.

An increasing number of our clients are having to make big life adjustments to deal with diagnoses of chronic disease and as Counsellors we can play a significant part in their psychosocial transition. Anger, denial, grief and loss are often factors in this change of life experience; we are helping the client move "from where I was then to where I am now..."

Care planning is a collaborative process for setting and achieving goals and helps to identify and co-ordinate the multiple services and professionals involved in the client's care and support.

This is the team.



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Conclusions

We found PDSA to be a simple and accessible model for change. It helped us to focus on the small steps necessary to take us where we wanted to go.

It was helpful that we weren't time pressured in terms of introducing this change so we could pace it to allow discussion and reflection as well as trial changes to the tool to make it more appropriate.

Effective Care Planning is about developing client focused goals to optimize client's physical, mental and emotional wellbeing. Our next challenge is to embed the practice across all of GCH and the Primary Care Team will play a lead role in this.

Further information: www.grampianscommunityhealth.org.au

Contact: Sandra McGrath, Counselling Team Manager. Ph (03) 5362 1200. Sandra.m@grampianscommunityhealth.org.au

Photo: Primary Care Team Planning Day, Halls Gap June 2011

