

PCP Integrated Chronic Disease Management - Case study template

Details of PCP contact

Name of PCP	Wellington PCP
Contact Person	Jo Cockwill
Position/Title	Executive Officer
Phone No.	5143 8843
Email Address	Jo.Cockwill@cghs.com.au

Identified Partners

Partner Organisation	Roles and responsibilities with regard to the project	Contact person details (name, position)
CGHS	Establishment of care coordination model at CGHS	Jude Deedman Care Coordination Project Worker
Wellington Primary Care Partnership	Steering Committee Member	Jo Cockwill Executive Officer

Case Study Title	Care Coordination Pilot
-------------------------	-------------------------

Summary/Abstract (200 words)

The Care Coordination Project's aim is to enhance the health and wellbeing of people with chronic illness and or complex health care needs through access to a highly coordinated health care and community support system.

Central Gippsland Health Service has introduced the Care Coordination model under the framework of action research. This form of Pilot was introduced as the preferred method so as to monitor, review and implement alternative processes to address identified issues.

Key project activities thus far have included:

- Training a significant number of clinical and non-clinical staff in Care Coordination objectives and principles;
- Recruitment and training of a Care Coordinator;
- Identification and introduction of a number of key processes such as a new referral system and in particular developing a Service Delivery Plan for each patient;
- Ongoing updates of Care Coordination Position Descriptions to reflect learning outcomes from the Pilot;
- Identification of existing staff to transition into the roles of Care Coordinators and Intake Officers as the project is expanded;
- Identification of capability development needs to support staff to successfully transition into roles

The Pilot has had a number of challenges:

- Turnover of significant staff associated with the project
- Staff coming to terms with a significant change in practice
- Ensuring effective relevant communication has been provided to staff
- Implementing the model without the other major component of the model – that is, a centralised Intake system
- Development of a capability development framework to ensure staff gain the relevant skills and knowledge to undertake new roles
- Engaging external services and ensuring they have a clear understanding of the Care Coordination Project objectives
- Orienting staff to “new language” – such as care coordination (not discharge planning), capability development (not training), person centred care (not health service driven).

Background

Name of Project	Early Intervention into Chronic Disease: CGHS Care Coordination Project
Target client group	<p>The targeted geographical area will be the Wellington Shire and those clients who access services at Central Gippsland Health Service.</p> <p>As this project is focussed initially on sustainable organisational systems change, the key target group initially is health and other professionals who contribute to client care.</p> <p>Following on from that, the target population will be clients with chronic disease and/or complex needs as the project progresses.</p>
DHS ICDM expectations 2009-12	This project aligns with 3.1 b) Developing local service systems (focused on a common client cohort) that provide coordinated, best-practice clinical care and support for self-management (PCP, Revised Program Logic, July 2009: page 5).
Background	<p>In late 2008, the final round of Early Intervention Into Chronic Disease Funding was announced in the Wellington Shire.</p> <p>The two main care providers in Wellington were invited to submit a project plan to receive funding under this program. Yarram & District Health Service (YDHS) and Central Gippsland Health Service (CGHS) applied for this funding and were both successful. WPCP also received a small amount of funding to support both agencies in the implementation of their projects.</p> <p>In 2009, a very broad stakeholder consultation was conducted over a twelve month period at CGHS. This process had four layers of consultation, which included:</p> <ul style="list-style-type: none"> • one on one • face to face meetings • focus group meetings; and • community group meetings. <p>Discussions and outcomes from these consultation sessions provided direction for the CGHS Strategic Plan 2009, which required care coordination to be a very high priority. This is</p>

	<p>being achieved through a major change project that will impact across the breadth and depth of CGHS. The Care Coordination Project is facilitated by the CGHS Chief Executive Officer with support from a Project Officer and Steering Committee consisting of:</p> <ul style="list-style-type: none"> • Executive Staff • Managers • CGHS staff • Consumer Advocate • General Practitioner; and • PCP Management.
Objectives	<ol style="list-style-type: none"> 1. To support the development of a coordinated care system where the client: <ul style="list-style-type: none"> ➤ Is at the centre of decision-making and care planning ➤ Has access to the required information to make informed decisions ➤ Receives care/services in a timely manner balancing clinical need within expectations. 2. To enable access for all service providers to required client information to maximise coordination and minimise duplication. 3. To enable staff to maintain or develop comprehensive care coordination capabilities. 4. To place service planning and care coordination ahead of program funding whilst ensuring we are fully accountable to our funding bodies.

Project participants

Care Coordination Project Team
Community members who would benefit from care coordination
Multi-disciplinary Team
CGHS Chronic Disease Network
General Practitioners and Specialist Services
WPCP

Methodology and approach

Key project activities:

- Recruitment of Steering Committee members and Project Coordinator
- Identification and description of current processes in detail
- Development of Care Coordination and Intake Models and Position Descriptions
- Development of Communication Strategy
- Implementation of the Care Coordination Pilot
- Ongoing monitoring and evaluation
- Regular reporting to project partners

Resources Used:

- Central Gippsland Health Service, Workforce capability framework 2009
- Wagner Chronic Care Model Early
- Intervention into Chronic Disease Funding (Department of Human Services)
- Community of Practice Forums – regional and state wide

Reporting processes are in place to communicate the projects' progress to Board of Management.

The Care Coordination Project will align organisational structures, practices, procedures and systems in an integrated fashion so that clients:

- are at the centre of service delivery;
- experience a seamless, supported and integrated response from the Health Service (and beyond);
- have access to the services they need and will benefit from; and
- can take advantage of opportunities for early intervention and secondary prevention.

As we improve our care coordination processes, an important “by-product” will be a significant improvement in the efficiency and effectiveness of our service delivery as people will receive the right service or intervention by the right person(s), at the right time, in the right setting, to achieve the best outcome. This demonstrates evidence based best practice (Chronic Care Model, 1998).

The Chronic Care Model emphasises the importance of self-management support, delivery system design, decision support, and information systems. All of which are included in the Care Coordination Project at CGHS.

As CGHS continue to trial system improvements, they are building a supportive environment and community through empowering individuals to take an active role in their health care through best practice care coordination. This will lead to informed activated clients, and will lead to a supportive community (Chronic Care Model 1998).

CGHS redesigning their service system is a large project and the project activities will be an important part of improving the client journey at CGHS. Care coordinators will play a key role in the coordination of the client’s care and will influence the client’s experience with the health service. All of which is relevant to service coordination, chronic disease management, and health promotion.

Regular Care Coordination Project Progress reports are written and distributed to:

- Care Coordination Project Team members after each meeting,
- CGHS Department Heads with the recommendation for further distribution to staff.

Consecutive sets of story boards have been produced and positioned for public viewing at all CGHS sites, located at:

- Sale Hospital entrance foyer,
- Community Services Reception, Sale,
- Community Rehabilitation Centre Reception, Sale,
- Loch Sport Community Health Centre waiting area,
- Rosedale Community Health Centre waiting area,
- Heyfield Hospital foyer, and
- Maffra Hospital foyer.

Verbal reports have been provided at the following monthly meetings;

- CGHS Continuum of Care meetings,
- CGHS Community Liaison Group meetings; and
- CGHS Chronic Disease Network meetings.

Additionally, verbal reports have been presented at bi-monthly meetings for CGHS Division of Community Services meetings and at external forums such as the Wellington Chronic Disease Network meetings. Also a regular one-page emailed Communiqué is distributed to all CGHS staff.

- The Care Coordination Project Steering Committee has a Community Representative who also fulfils the role of Consumer Advocate for CGHS.
- Presentations have been delivered at the Rosedale and Heyfield Annual General

Meeting's, as well as at Stratford Planned Activity Groups.

- CGHS Chronic Disease Network has been formed to provide direction to the Project on how community members who live with Chronic Disease can benefit from streamlined Care Coordination processes.
- CGHS CEO Frank Evans and members of the Executive team provide regular education and updates of the Project to Medical Registrars and General Practitioners.
- Dr. David Monash, Board Member of East Gippsland Primary Health Alliance, Physicians Dr. Howard Connor and Dr. Krishna Mandaleson receive regular progress reports of the Project and their engagement in the Project is welcomed.

Results

Service improvement and innovation

The CGHS Care Coordination model supports the identification of patients and clients with complex care needs at point of entry to the health service. In August 2010 the introduction of the Care Coordination model commenced in the form of a Pilot (Action Research Model) on the medical ward, Sale Hospital campus.

In the absence of a centralised Intake system, which is in the process of being established, patients with complex care needs are identified at point of admission to the medical ward. This identification is achieved by the ward nurses completing the Nursing Assessment form which has Care Coordination screening questions embedded.

Care Coordination processes place the patient at the centre of their care and ensures they are the driver of the decision making process. This is achieved by coordinating services so that the right services are delivered at the right time, by the right people and in the right place in order to maximise the potential for people with complex needs to achieve their goals and aspirations. Care Coordination is also about, continuity of care, avoiding duplication of effort and breaking down program boundaries so that they do not hamper service providers in meeting people's needs.

Patients have had positive experiences of Care Coordination as CGHS values patient determined goals and works in accordance with the principles of the Active Service Model. Care Coordination respects the contribution the person can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs. The person in turn respects the contribution of the multidisciplinary team who contribute their professional expertise, skills and knowledge to the best of their ability.

Outcomes

Key outcomes:

- Ongoing strong engagement of the steering committee
- Extreme goodwill from staff across the board who have provided significant feedback to address issues and collaboratively implement solutions to enhance the ultimate aim of the project
- Expansion and introduction of the care coordination model to other departments
- Development of resources to support care coordination processes
- Engagement with GP's and medical clinics

	<ul style="list-style-type: none"> • Improved communication with external services <p>Evaluation methods:</p> <ul style="list-style-type: none"> • Continuous consultation and communication with staff • Ongoing reporting to stakeholders
Status and sustainability	<p>The expansion of the Care Coordination model across the whole of organisation is approaching. Staff have been identified to fulfil Care Coordination positions. Training to support these staff to transition into their new role is being developed. Learning's from the Pilot are continually being monitored and evaluated to guide the project into the future.</p> <p>The project officer continues to be an important part of the Wellington CDM Network, and her reports are highly valued by the members. This project is a priority at meetings and this will continue into the future. The network provides peer support for the project worker and enables other agencies to hear about the learning from such a large project.</p>

Conclusions

Key success factors:

- Growing enthusiasm across the organisation
- CEO driving the project with full support from the Board of Management and Executive Team
- ELiCD funding has provided the opportunity to make big changes
- Support from large steering committee – large representation across CGHS and from external partners
- PDSA – trialling small changes first

Key challenges and Limitations:

- Change in organisational culture
- Supporting and education staff who may be resistant to change
- Progress in implementing new model
- Technology – sufficient computer system/programs to support reporting/recording requirements

The care coordination project is included in the WPCP Strategic Plan and is reported against at all PCP Business Meetings. Improving the client journey – coordinating care is a strategic priority for the PCP, and also for CGHS. This shared priority is relevant to all PCP partners, and the general community.

Strengthened partnerships between CGHS, General Practitioners, Specialist services and external community services has commenced and will continue to transpire as the project progresses.

With the Pilot of care coordination well underway, learning's will be used to refine the project. Evaluation of the Pilot is continually being conducted and all relevant stakeholders are notified with regular updates. These findings will be used to inform future direction of the project.

The service system at CGHS will further develop as technology solutions are sought.

CGHS are implementing a huge change in the way the organisation works. While there have been teething problems it is important to note how much the project has achieved to date. Organisational change is difficult and slow to implement, and WPCP will continue to support the project, including providing training and support to CGHS as required.

References (optional)

List any key references used in the case study, using the Harvard system of referencing. If you are planning to present your case study at a conference, this section can be structured to meet the conference requirements.