WPCP Integrated Chronic Disease Management - Case study

Details of PCP contact

<table>
<thead>
<tr>
<th>Name of PCP</th>
<th>Wellington Primary Care Partnership (WPCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person</td>
<td>Emily Durbridge</td>
</tr>
<tr>
<td>Position/Title</td>
<td>Chronic Disease Management Worker</td>
</tr>
<tr>
<td>Phone No.</td>
<td>5152 0022</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:EmilyD@glch.org.au">EmilyD@glch.org.au</a></td>
</tr>
</tbody>
</table>

Identified Partners

<table>
<thead>
<tr>
<th>Partner Organisation</th>
<th>Roles and responsibilities with regard to the project</th>
<th>Contact person details (name, position)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Gippsland Primary Health Alliance</td>
<td>Steering Committee Member</td>
<td>Dr. David Monash Board Member</td>
</tr>
<tr>
<td>Wellington Primary Care Partnership</td>
<td>Steering Committee Member</td>
<td>Jo Cockwill Manager</td>
</tr>
</tbody>
</table>

Case Study Title

Development of Care Coordination and Intake Models.

Summary/Abstract (200 words)

Following a successful funding submission, CGHS received Early Intervention into Chronic Disease money from the Department of Health. The development of the Care Coordination Project soon followed.

This project is focussing on sustaining organisational system change initially. Once the system is trialled and functioning, care coordination will be implemented.

Key project activities thus far include:
- Recruitment of Steering Committee and Project Coordinator
- Detailed mapping of current processes
- Development of Care Coordination and Intake Models and Position Descriptions

Key Outcomes thus far include:
- Engaged, enthusiastic steering committee
- Trial of care coordination model
- Improved communication across the organisation

The redesigning of the CGHS care system is a large project. The project activities will be an important part of improving the client journey at CGHS, which aligns with the WPCP Strategic Plan and regional priority areas.

The project has had some challenges:
- Change in organisational policy and culture
- Staff coming to terms with changing practice
- Information Technology needs

CGHS are conducting important, difficult work as part of this project and have a long way to go to achieve the project goals. It is important to reflect on the project thus far, to acknowledge the CGHS journey to date. The results of the care coordination trial will be
analysed and distributed to relevant project partners and the Department of Health.

**Background**

<table>
<thead>
<tr>
<th>Name of Project</th>
<th>Early Intervention into Chronic Disease: CGHS Care Coordination Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target client group</strong></td>
<td>The targeted geographical area will be the Wellington Shire and those clients who access services at Central Gippsland Health Service.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Following on from that, the target population will be clients with chronic disease and/or complex needs as the project progresses.</td>
</tr>
<tr>
<td><strong>DHS ICDM expectations 2009-12</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>In late 2008, the final round of Early Intervention Into Chronic Disease Funding was announced in the Wellington Shire.</td>
</tr>
<tr>
<td></td>
<td>The two main care providers in Wellington were invited to submit a project plan to receive funding under this program. Yarram &amp; District Health Service (YDHS) and Central Gippsland Health Service (CGHS) applied for this funding and were both succesful. WPCP also received a small amount of funding to support both agencies in the implementation of their projects.</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• one on one</td>
</tr>
<tr>
<td></td>
<td>• face to face meetings</td>
</tr>
<tr>
<td></td>
<td>• focus group meetings; and</td>
</tr>
<tr>
<td></td>
<td>• community group meetings.</td>
</tr>
<tr>
<td></td>
<td>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 being achieved through a major change project that will impact across the breadth and depth of CGHS.</td>
</tr>
<tr>
<td></td>
<td>The Care Coordination Project is facilitated by the CGHS Chief Executive Officer with support from a Project Officer and Steering Committee consisting of:</td>
</tr>
<tr>
<td></td>
<td>• Executive Staff</td>
</tr>
<tr>
<td></td>
<td>• Managers</td>
</tr>
<tr>
<td></td>
<td>• CGHS staff</td>
</tr>
<tr>
<td></td>
<td>• Consumer Advocate</td>
</tr>
<tr>
<td></td>
<td>• General Practitioner; and</td>
</tr>
<tr>
<td></td>
<td>• PCP Management.</td>
</tr>
</tbody>
</table>
The WPCP Strategic Plan has two priority areas:
2. Improve the health and wellbeing of communities most in need in Wellington; small & remote, Indigenous, Socioeconomically disadvantaged.

By redesigning their service system, CGHS are addressing both strategic priorities of WPCP. More focus initially is on improving the coordination of care.

Care coordination is also a regional priority, with a large regional focus on care planning and referrals.

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
</table>
| 1. To support the development of a coordinated care system where the client:  
  - 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. |

<table>
<thead>
<tr>
<th>Project participants</th>
</tr>
</thead>
</table>
| - 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 |

<table>
<thead>
<tr>
<th>Methodology and approach</th>
</tr>
</thead>
</table>
| 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 statewide |
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.

The Better Health Self Management program is an example of a self-management program that CGHS have delivered. Programs are planned for 2011, and part of the care coordination process will be to refer appropriate clients into this program and other programs across CGHS.

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.

Three 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 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 two weekly one-page emailed Communiqué is distributed.

- 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 Director of Medical Service Dr. Ka Chun Tse 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 Mandaaleson receive regular progress reports of the Project and their engagement in the Project is welcomed.

Results

| Service improvement and innovation | The CGHS model for Intake and Care Coordination supports the identification of complex need at the entry point regardless of where that entry point is within the system. This is achieved through a standardized screening tool. Where complex need is identified the patient/client is referred to care coordination. A comprehensive assessment at this early point will confirm or otherwise the need for ongoing care coordination and a multidisciplinary, multi-service, service delivery plan.

Facilitating this efficient, effective system will have a direct positive impact on patients as their goals are identified, assessment are undertaken and agreed supports to will be determined at the earliest possible time.

Patients will experience a seamless, cohesive service system as individualised service delivery plans will be the result of a comprehensive interdisciplinary assessment process facilitated by the care coordinator. The care coordinator will ensure the right services or interventions by the right person(s), at the right time, in the right setting, to achieve the best outcome for the patient/client. Central to care coordination is the patient or client being at the centre of the decision making processes, thus encouraging self management.

Strengthened partnerships between CGHS, General Practitioners, specialist services and external community services will transpire as we work together, coordinating Client Service Delivery Plans which will mitigate duplication of effort. |
| Outcomes | Key Project Outcomes:
- Engaged, enthusiastic steering committee – large representation internally and externally
- Trial of care coordination model
- Position descriptions of care coordinators finalised
- Improved communication across the organisation
- Reduction in resistance to change across organisation
- Screening tool identifies clients suitable for care coordination

Evaluation Methods:
- Reports to various partners and committees
- Reporting to Department of Health
- PDSA cycle – results of care coordination trial will be evaluated |
**Status and sustainability**

The trial of care coordinators is currently underway on the medical ward at CGHS. The results of this trial will be analysed and used to guide the project into the future.

As the trial is not organisation wide at this point, this will be the plan for the future – to have a coordinated service for clients who enter CGHS at any point and who will receive evidence based best practice care at the right time every time.

The project officer is 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 will continue into the future. The network provides peer support for the project worker and enable other agencies to hear about the learnings from such a large project.

**Conclusions**

**Key success factors:**
- Growing enthusiasm across the organisation
- CEO driving the project with full support from the Board of Management
- EiICD 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 policy
- Change in organisational culture
- Staff resistant to change
- Slow progress in implementing new model
- Utilising existing staff – rostering changes and challenges to allow for project work
- Technology – insufficient computer system to manage clients

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 will transpire as the project progresses.

With the trial of care coordination underway, results from the trial will be used to refine the project. An evaluation of the trial will be conducted and distributed to relevant parties. The findings will be used to inform future direction of the project.

The service system at CGHS will further develop as technology solutions are sought for client management systems, files and referrals.

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)**

Improve Chronic Illness Care 1999, The Chronic Care Model, MacColl Institute for Healthcare Innovation, Seattle, Washington USA
BHSM    Better Health Self Management (Stanford University)
CDM     Chronic Disease Management
CGHS    Central Gippsland Health Service
EIICD   Early Intervention into Chronic Disease Project
ICDM    Integrated Chronic Disease Management
PCP     Primary Care Partnership
SM      Self Management
WPCP    Wellington Primary Care Partnership
YDHS    Yarram & District Health Service