

# Client Coordination: The YDHS Journey

## Details of PCP contact

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## Identified Partners

<b>Partner Organisation</b>	<b>Roles and responsibilities with regard to the project</b>	<b>Contact person details (name, position)</b>
YDHS	Establishment of Primary Care Client Coordination Meetings at YDHS	Julie-Anne Walters Care Coordination Worker
WPCP	Support role	Jo Cockwill Executive Officer

<b>Case Study Title</b>	Client Coordination: The YDHS Journey
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## Summary/Abstract (200 words)

YDHS have recognised the need for improvement in care coordination across the organisation and have researched evidence based best practice guidelines. Client centred care is best practice so YDHS set about establishing a primary care coordination committee which meets fortnightly.

Relevant practitioners are invited to a case conferencing meeting for clients with complex needs. A care plan is developed and recorded in line with the SCTT Care Coordination Plan. Decisions are recorded on the care plan, which is then distributed to relevant health care providers with the original kept in a central file. Ongoing cases are presented for review and outcomes/plans are recorded.

Project outcomes thus far include:

- Improved communication and collaboration internally and externally
- Improved client involvement in own care
- Improved communication between clients and service providers

Challenges and limitations include:

- Funding constraints
- Time constraints
- Increase in the number of clients
- Need for improved electronic communication
- Increase in efficiency of gaining patient consent

As the trial is only looking at complex clients at this stage, the plan for the future will be to extend the type of clients who receive a care plan with a focus on the Active Service Model and goal setting.

**Future Developments**

- Investigate available funding opportunities to support integrated care and self-management
- Ongoing quality improvement and review strategies to monitor project outcomes for further development
- Implementing Active Service Model

**Evaluation Methods:**

- Meeting records
- Number of care coordination plans written
- PDSA cycle – results will be analysed and changes trialled

**Background**

<b>Name of Project</b>	Establishing a Primary Care Client Coordination Committee at YDHS
<b>Target client group</b>	YDHS Clients with complex needs
<b>DHS ICDM expectations 2009-12</b>	<p>3.1</p> <p>a. Develop and review local agreements, implementation plans, and supporting resources to improve chronic disease care by:</p> <ul style="list-style-type: none"> <li>• Providing coordinated, best practice clinical care and support for self management and</li> <li>• Planning, implementing and measuring service system improvements, including evaluation of impacts and outcomes for consumers</li> </ul> <p>b. Developing local service systems that provide coordinated, best practice clinical care and support for self management:</p> <p>(PCP, Revised Program Logic, July 2009: page 5)</p>
<b>Background</b>	<p>Best practice care for clients with complex needs requires a coordinated person centred approach, evidence based care, support for self management and regular review and follow up.</p> <p>The Active Service Model (ASM) is a quality improvement model that focuses on building the capacity of some HACC clients to live in the community as independently as possible, encouraging clients to become involved in their care.</p> <p>YDHS have recognised the need for improvement in care coordination across the organisation and have begun their journey on establishing a client coordination meeting and introducing the ASM into YDHS services.</p> <p><b>Vision</b> To enable and maximise the health and independence of complex clients of the Yarram &amp; District Health Service (YDHS) and their carers.</p> <p>‘Complex’ clients may have multiple health needs and difficulties in their daily lives. Clients are suitable to be discussed at this meeting if a coordinated approach is required to meet their goals and provide holistic care, for example:</p> <ul style="list-style-type: none"> <li>• The client is experiencing a deterioration of their</li> </ul>

chronic condition or health, which is impacting upon their daily activities, e.g. medical condition, cognitive impairment, mental health

- The client has a current care plan that is not working due to an exacerbation or change in their circumstances
- Breakdown of carer/family support has/may occur
- Social isolation puts client at risk
- Current or expected future service level unlikely to maintain client at home.
- The client has reoccurring inpatient admissions
- The client requires an advanced care plan

### **Membership**

The Care Coordinator or delegate attends each meeting as the chairperson and scribe.

Other professionals involved, or potentially involved, in the client's care are invited to meetings. These professionals could include:

- HACC Coordinator (delegate for home and personal care staff)
- Community Nursing Coordinator (or delegate)
- Allied Health
- Social Worker
- General Practitioners
- Youth and Family Services
- Acute Nursing Coordinator (or delegate)
- Latrobe Community Mental Health Service
- Other relevant service representatives

These or other professionals could also be invited to a meeting to provide information or consult on a client's condition or needs, even if the person is not a current client.

Videoconference or teleconference facilities can be arranged as necessary to include other professionals, for example, medical personnel from key hospitals in Melbourne.

Family members and clients are not be invited to the case conferencing meeting. If required, a separate family meeting will be scheduled, either by the Care Coordinator or Key Worker.

The WPCP Strategic Plan has two priority areas:

1. The Client Journey – improving coordination of care.
2. Improve the health and wellbeing of communities most in need in Wellington; small & remote, Indigenous, Socioeconomically disadvantaged.

The project aligns with the WPCP strategic priority *Care Coordination – Improving the Client Journey*. YDHS are working to improve the client journey by conducting case planning meetings to improve care coordination for clients with complex needs.

### **Objectives**

- To provide a holistic approach to client care.
- To coordinate client care and services provided by YDHS.
- To facilitate and review progress towards client goals
- To identify need for further assessment and/or

### **Project participants**

- Director of Primary care
- Care coordinator
- HACC Coordinator (delegate for home and personal care staff)
- Community Nursing Coordinator (or delegate)
- Allied health professionals
- Social worker
- General Practitioners
- Youth and Family Services
- Acute nursing coordinator
- Latrobe Community mental health service
- Other service representatives as deemed relevant

### **Methodology and approach**

When it was decided that YDHS were introducing client Coordination meetings, the Care Coordinator set about researching other agency models of team care across the region. Terms of Reference were developed prior to the first meeting (attached).

Criteria for selection of clients for presentation:

- Complex needs
- Requires multiple services/support

The Case Plan Presentation includes:

- Reason for referral/review
- Basic personal details
- Workers view of the services/support needed
- Discussion and input from other disciplines
- Level of client involvement in their care
- Care Plan developed

### **Meetings**

Two meetings of 30 minutes duration are scheduled fortnightly on a Thursday morning. Additional meetings may be scheduled if urgent cases arise and there is no availability within the required timeframe. Meeting times may need to be flexible if external professionals are travelling to attend the meeting.

Clients to be discussed at a meeting are identified by a client's Key Worker and the following information forwarded to the Care Coordinator, at least one week prior to the meeting:

- Name, UR
- Issues to be discussed
- Suggested invitees
- Urgency for meeting
- Other relevant information, e.g. client goals

On receipt of a request for a meeting, the Care Coordinator sends an Outlook meeting request to all invitees, including the Key Worker, with a copy of the above information. Invitees will then accept or decline the Outlook request to inform the Care Coordinator of attendees.

Prior to the meeting, the Key Worker will contact the client to obtain consent for the meeting to occur. It is preferred that consent is obtained in written format using the SCTT consent form, however verbal consent is also acceptable.

Each invitee brings their running file to the meeting, including their current care plan. A SCTT Care Coordination Plan will be completed or reviewed during the meeting. This plan documents goals, action plans and progress for each identified issue. Actions including a timeframe will be allocated to relevant health professionals. A review date will be set during the meeting and a follow-up meeting scheduled if required.

Following the meeting, the Care Coordinator will develop an electronic version of the SCTT Care Coordination Plan and forward via email to the Key Worker to ensure the information contained in the document accurately reflects the discussion during the meeting. If changes are required, the Key Worker will feedback to the Care Coordinator for correction.

Once any amendments to the SCTT Care Coordination Plan are made, the Key Worker will discuss this with the client and obtain further consent for each action to be taken, as appropriate. Upon attaining consent, the Key Worker will inform the Care Coordinator of any further changes. Once these are made, the Care Coordinator will forward the finalised version via email to each invitee, for action of care plan items as allocated. The SCTT Care Coordination Plan will be reviewed on the review date scheduled during the original meeting.

Following the client's discharge from the Care Coordination service, a paper copy of this plan plus other relevant documentation will be filed in the client Community Based File.

The terms of reference for the care coordination committee will be reviewed annually.

**Key Project Activities:**

- Establishment of Care Coordination meetings
- Development of Terms of Reference
- Fortnightly meetings occurring and documented
- Key partnerships developed internally and externally
- Reporting to partners

**Resources Used:**

- Service Coordination Tool Templates
- Victorian Service Coordination Practice Manual
- Chronic Care Model

YDHS are trying to improve the service delivered to clients with complex needs so that the clients receive the right service at the right time. This demonstrates evidence based client centred care (Chronic Care Model, 1998).

The Chronic Care Model is a framework that supports agencies to implement continuous quality improvement activities. The framework describes the importance of information systems, delivery system design, self management support and decision support. YDHS will work to address the components of the model through the progression of the project.

**Results**

**Service improvement and innovation**

**Organisation Outcomes:**

- Improved coordination of care through improved collaboration and communication between health care providers
- Issues/problems discussed and solutions discussed in a collaborative environment

**Client Outcomes:**

- Increased opportunities for self management

	<ul style="list-style-type: none"> <li>• Involvement in own care</li> <li>• Improved communication with health care providers</li> </ul> <p>Clients will receive person centred care that is received at the right time, in the right place, with the right person. The service system will be improved so that it becomes seamless, and so that the client is at the centre of the decision making relating to their individual care.</p> <p>YDHS are working in partnership with external agencies to discuss shared clients and to improve communication between services and patients. Improved communication should see a reduction in duplication and effort and an increase in collaboration so that the best outcomes are achieved for each client.</p>
<b>Outcomes</b>	<p>As the initiative is in the early stages, it is difficult to measure outcomes at this stage. Once the process is established and there is more capacity amongst staff, the target group will be extended out.</p> <p>However, thus far early results indicate: Successful elements:</p> <ul style="list-style-type: none"> <li>• Increased communication and collaboration across YDHS</li> <li>• Coordination of care for clients with complex needs</li> <li>• Job satisfaction</li> <li>• Increased use of the SCTT Care Coordination tools</li> <li>• Team based approach to care</li> </ul> <p>Successful referral system</p> <ul style="list-style-type: none"> <li>• SCTT sent via internal electronic system PJB, email and via paper based referral</li> </ul> <p>Challenges/Barriers</p> <ul style="list-style-type: none"> <li>• Staff awareness</li> <li>• Time constraints</li> <li>• Change in organisational culture and work practices</li> <li>• Funding models</li> <li>• Limited GP involvement</li> <li>• Demographics of the district, e.g. ageing population</li> <li>• Understanding of client centred care</li> <li>• Limitations of electronic systems- PBJ not ideal as limited space in SCTT and no way for feedback along the way</li> <li>• Limited uptake by staff-invitee only at this stage</li> <li>• Staffing issues</li> <li>• ASM</li> </ul> <p>Evaluation Methods:</p> <ul style="list-style-type: none"> <li>• Meeting records</li> <li>• Number of care coordination plans written</li> <li>• PDSA cycle – results will be analysed and changes trialled</li> <li>• Reporting to Department of Health</li> <li>• Service Coordination/ICDM Survey</li> </ul>
<b>Status and sustainability</b>	<p>Currently, the care coordinator is looking at ways to increase the number of clients that are discussed as part of the care coordination meetings.</p>

As the trial is only looking at complex clients at this stage, the plan for the future will be to extend the type of clients who receive a care plan.

#### Future Developments

- Investigate available funding opportunities to support the integrated care approach and chronic disease self-management
- Ongoing quality improvement and review strategies are in place to monitor project outcomes and actions for further development
- Increase staff training opportunities and awareness
- Utilise the Plan Do Study Act Approach to trial changes
- Ongoing quality improvement
- Ensuring core attendees are at meetings
- ASM approach to meetings and more formal structure
- Investigate an electronic care plan system
- Await the results of the E-care plan pilot

#### Dissemination of findings:

- Reporting to the Department of Health
- Reporting to WPCP Steering Committee
- Reporting to WPCP CDM Network
- Communication methods with external providers and clients – eg newsletter, website

## Conclusions

Since 2011, care coordination meetings have been conducted on a fortnightly basis at YDHS to discuss clients with complex needs relevant to YDHS health care providers. Attendees include allied health, nursing, medical staff, GPs and HACC staff.

#### Project outcomes include:

- Improved communication and collaboration internally
- PDSA continual quality improvement
- Best practice

#### Challenges and limitations include:

- Limited GP involvement
- Time constraints
- Change in organisational culture and work practices
- Funding models
- Demographics of the district, i.e. ageing population

#### Sustainability of improvements:

- Ongoing improvement process
- Expansion of clients included in the care coordination process
- Expansion of Project partners to include outside referrers

#### Relevance of findings to PCP activity:

- Improving the coordination of care – the client journey: key PCP strategic priority
- Working towards service system improvements
- Continuous quality improvement

#### Future Directions:

- Further implementation and embedding of the Active Service Model

As the trial is only looking at complex clients at this stage, the plan for the future will be to extend the type of clients who receive a care plan.

## References (optional)

Department of Human Services 2009, Primary Care Partnerships Revised Program Logic July 2009, Department of Human Services, Government of Victoria, Melbourne.

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## List of Acronyms

AHPs	Allied Health Professionals
ASM	Active Service Model
HACC	Home and Community Care
ICDM	Integrated Chronic Disease Management
SCTT	Service Coordination Tool Templates
WPCP	Wellington Primary Care Partnership
YDHS	Yarram & District Health Service