Background

In 2009 Inner South Community Health (ISCH) reviewed their care practices for clients presenting with chronic and complex conditions, and found there were inconsistencies in the approach to systems, processes and care across teams and program areas in the organisation.

As a result of this, in 2010 the organisation funded a chronic conditions change management project. The aim of this work was to accelerate the development of a coordinated and comprehensive approach to preventing and managing chronic conditions, in order to improve the overall health and wellbeing of the community.

This case study highlights the work that ISCH has done over the past six years to achieve their aim that:

All ISCH clients have access to integrated, coordinated and appropriate client-centred care, that provides support to meet their goals, and that improves or maintains their health and wellbeing.

What they did

Setting up and resourcing a change team

The project governance structure consisted of the project worker reporting to one of the allied health coordinators (project supervisor) and a working group (governing body).

The working group included representation from all program areas, with all levels of staff, and two consumer representatives.

The project worker also met regularly with a practice reference group that was responsible for testing and providing feedback on aspects of the chronic and complex care strategy that related to day-to-day practice.

This group included representation from most direct care programs.

Set a vision and developed a three-year plan

The vision was to develop, implement and evaluate a coordinated and comprehensive model of care to support all ISCH clients in the prevention and management of chronic and complex conditions.

Over the three-year period, the plan was to define and implement a new model of practice (see Figure 1 for an overview of the practice model).
A defined model of practice was seen as a way of agreeing on an organisational approach and documenting it to ensure:

- the approach is geared to achieving positive outcomes for clients
- clients experience a consistent approach across all services
- clients do not have to retell their story and staff maximise efficiency by coordinating services to avoid duplication
- staff know what the expectations are and the organisation can offer specific staff support to meet these expectations (including offering better-targeted training).

Key strategies implemented over this period were:

- a common assessment preventing clients needing to retell their story. This also includes health-risk screening to assist staff to identify need for additional services. The common assessment is attached centrally into the electronic client management system
- a care plan for all clients. For clients seeing more than one practitioner, all practitioners contribute to the one care plan. Care plans are documented in the organisational template and attached centrally into the electronic client management system
- training for staff in the use of the common assessment, the health-risk screening questions and care planning
- regular communication from management reinforcing commitment to the new model and expectation that all staff use the common assessment and care plans
- regular formal and informal opportunities for staff to provide feedback to the project officer.
The Social Model of Health

Ensures the work we do is guided by social, cultural, spiritual, environmental and economic factors that affect health, as well as biological and medical factors.

Model of practice

The Care Pathway is often not linear:
Elements of the pathway may occur at any point – e.g. intervention may occur prior to a full assessment, review occurs throughout.

Clients engage, disengage and reengage.
Some elements of the pathway may not occur at all, e.g. relationship building may be the only outcome.
Monitoring, reviewing and refining the model

Over the three years 2010–2013, the governance group refined the model through:

- regular consultations with staff about the process and feedback to staff on outcomes
- file audits to monitor use of the common assessment and care plans
- staff feedback questionnaires on training provided
- training-needs survey on client-centred care – this was conducted in 2010 and 2013 to identify training needs and to evaluate the impact of training since the first year
- overall organisational assessment of chronic care using the Organisational Skills Analysis Tool (OSAT)* conducted in 2010 and 2013
- client evaluation of the care plan – this involved asking clients a series of questions about the development of the care plan with their worker, their readiness for change and about the services they had been linked in with as a result of having a care plan
- survey of clients using the Patient Assessment of Care for Chronic Conditions conducted in 2010 and 2013 to look at the client’s perspective of chronic conditions care at ISCH.

* OSAT was developed by Gill and Wilcox to assist agencies recognise the skills they have in chronic disease care and identify opportunities and scope for further system and workforce development.

From 2014 to now

A transition and sustainability plan is being implemented by the governance group with three key focus areas:

- resourcing clients to be active participants in their care – common assessment, health-risk screening and care plan promoted to clients – information written by clients for clients
- resourcing staff to implement the model – staff consultation, continuance of a cross-organisational practice reference group of clinicians, training, intranet resources
- resourcing management to implement the model – sustainability plan with actions at every level of the organisation, including: strategic plan and team plans, all position descriptions, probationary reports, induction, discipline specific models of practice, all coordinators trained to monitor staff uptake of common assessment and care plan, annual record audit.

ISCH plans to focus on further improvements so that practitioners across other program areas in the organisation will be able to access the common assessment and care plans.

The different client management systems across ISCH has meant that program areas such as dental, general practice and post-acute care are not able to use or view the common assessment and care plan.

The common assessment and care plans are included as attachments to the client management system and staff have expressed concerns that this process is time consuming. To address these concerns ISCH is exploring options to have the common assessment and care plan incorporated into the client management system.

ISCH is also working with Southern Melbourne Primary Care Partnership to determine options for secure electronic sharing of assessment and care plan information across Primary Care Partnership agencies (when more than one agency is involved in a client’s care and consent permits).
Outcomes

A clearly documented model of practice embedded in the organisation’s care delivery process supported by protocols.

At the most recent audit in August 2015, there was an 86 per cent completion rate for clients’ care plans, and 59 per cent of these included input from all ISCH workers involved in the client’s care.

Completion of common assessment according to organisational protocol was 76 per cent (down from a high of 83 per cent at 2014 audit).

Staff are very positive about the model (see Figure 2 for a summary of staff views on the model).

**Figure 2: Results of staff survey on the new model of practice**

Staff said they liked these things about the model...

- Consistent approach
- Flexible
- Holistic
- Considers transition and closure
- Encourages early intervention and prevention
- Encourages multidisciplinary / interdisciplinary care
- Person centred “views the client as the expert”
- “views the client as the expert”
- Simple – “self explanatory”
- It fits with what we do

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