

health

The Plan Do Study Act (PDSA) Model for Improvement Project

Workbook

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Workbook

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Sourced and adapted from:

1. *The Plan, Do, Study, Act (PDSA) workforce service improvement project workbook*, developed by General Practice Victoria, October 2009
2. *Community Health and General Practice Engagement PDSA project information kit*, Department of Health 2009
3. The Australian Primary Care Collaboratives Program; www.apcc.org.au
4. The Institute for Healthcare Improvement; www.ihl.org/ihl

This workbook and other resources to support this project are also available on the project website at www.health.vic.gov.au/communityhealth/gps/pdsa.

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1 The project

Introduction

Purpose of the project

The Plan, Do, Study, Act (PDSA) Model for Improvement Project is a 12-month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice. It involves participants undertaking small, rapid cycles of quality improvement using the PDSA Model for Improvement.

This project is based on the collaborative methodology, which differs from other approaches to quality improvement, and has been proven to demonstrate improvements in health care settings including Australian general practice. There are three important characteristics to the methodology:

- collaboration
- the improvement model
- data collection.

Strengthening the relationship between general practice and state-funded primary health services is recognised as a critical step in improving health outcomes for Victorians. Of particular importance is improved communication between health professionals and shared planning of care for clients between state-funded primary health services and their general practitioners. The chosen areas for focus of the project support this premise.

The Integrated Chronic Disease Management (ICDM) model and the *Primary health workforce capacity-building strategy* have identified and prioritised areas of need within agencies to support the management of chronic and complex clients. This includes the support for agencies to use the Model for Improvement to achieve sustained practice change, through improved leadership, change management and improved teamwork.

Purpose of the workbook

The purpose of this resource is to provide information to participants of the Plan, Do, Study, Act (PDSA) Model for Improvement Project.

This workbook provides an overview of the project and is designed to provide an easily updated reference source to support you and your team. The ring-binder format was chosen to enable you to update the resource over time by adding additional resources and reference materials over the course of the project.

Although the ideas included in the workbook are what we currently know have the greatest impact on achieving improvements in the management of chronic disease, we acknowledge that you may have individual practical approaches and examples that can improve on these ideas. As the project progresses we look forward to being able to work together to share, learn and ultimately improve best practice to deliver better client care.

Background and overview of the project

The PDSA Model for Improvement Project will sponsor state-funded primary health services to increase their capacity to care for clients with complex needs using the PDSA Model for Improvement. The Model for Improvement framework is a tool used to plan and manage change by breaking it down into manageable components that can then be tested to ensure services are improving.

There are two optional streams of quality improvement focus offered to participants:

- improving communication (including feedback) with general practice
- improving care planning practice (particularly with general practice as part of a team care arrangement).

Project objective

To promote and support a culture of quality improvement in Victorian primary health care services and enhance skills in the improvement model to drive continuous quality-improvement activities, particularly related to chronic disease management.

Project broad objective

1. To improve the health outcomes of clients of state-funded primary health services
2. To increase participants':
 - understanding and application of the collaborative methodology to quality improvement
 - understanding of the importance of data measurement, comparison and collection when testing change
 - understanding of each service provider's role in the coordinated care of shared clients between general practice and state-funded primary health services.

Participants in the project

- Program managers, project managers and clinicians in state-funded primary health services
- Primary Care Partnership (PCP) staff linked with each agency
- Local divisions of general practice within each region

Project methodology

The project has three components:

1. Approximately 50 agencies will undertake quality improvement activities using the collaborative methodology.
2. Staff from 19 PCPs will be asked to assist agencies through the process and are invited to three days of facilitation training in organisational change and support (one day provided prior to each of the first three workshops).
3. Local divisions of general practice will assist through their linkages to general practice, and draw on their experiences of the collaborative methodology used in the Australian Primary Care Collaboratives (APCC) project undertaken in general practice.

The collaborative methodology differs from other approaches to quality improvement and has demonstrated improvements in health care settings including Australian general practice.

There are three important characteristics to the methodology: collaboration; the improvement model; and data collection.

A framework of workshops interspersed with action periods guides the project.

- **Collaboration** is encouraged at workshops. The workshops create a culture of mutual support as participants share ideas and strategies for change.
- During action periods, agencies and their improvement teams test change ideas using the **improvement model**. Change ideas are tested with small, **rapid** cycles of quality improvement (using PDSA) within their own environments. Agencies use a number of specific tools and techniques to promote and experience the benefits of improvement in short timeframes.
- Regular **data collection** is used to provide evidence that a change has resulted in an improvement over time.

Project workshops

The project will provide:

- three full-day facilitation workshops to PCP staff (prior to workshops 1, 2 and 3)
- five workshops to agencies and their partners (divisions and PCPs) to enable participants to undertake service improvements using PDSA cycles under the streams of focus (in November 2010, February, April, June and August 2011).

The second workshop will involve *all* participants coming together for a full-day workshop in Melbourne. All other workshops will be conducted regionally (five in country regions and one held within central metropolitan Melbourne).

Project support

- The Department of Health central office has engaged General Practice Victoria (GPV) to assist with the November 2010 workshop.
- Subsequent workshops are to be provided by a service consultant who will be joining the project team at the Department of Health from the end of 2010.
- Coaching and support will be provided to PCP staff to support the agencies throughout action periods.
- Telephone-based and electronic support will also be available to agencies as a supplement to PCP staff support.
- A training resource will be provided to all participants.
- Up-to-date resources and other project information will be available on the project website at www.health.vic.gov.au/communityhealth/gps/pdsa.

Project team deliverables

- Five workshops for agencies and their partners (PCP staff and local divisions of general practice), to be held in:
 - November 2010
 - February 2011
 - April 2011
 - June 2011
 - August 2011

The February workshop will be held in Melbourne, the four other workshops will be held regionally.

- Delivery of three PCP facilitation workshops for PCP staff, to be held in Melbourne

- Three data reports of project progression: baseline, end-of-project and post-project
- Three survey reports aligned with collection points: baseline, end-of-project and post-project
- Final project report, including case studies

Roles and responsibilities of agencies

- Attend five full-day learning workshops in:
 - November 2010
 - February 2011
 - April 2011
 - June 2011
 - August 2011.
- Participate in three five-minute surveys (baseline, end-of-project and post-project) in:
 - November 2010
 - September 2011
 - March 2012.
- Collect and submit a dataset at regular intervals between February and September, with a final dataset collection six months post project:
 - Prior to the February workshop a panel of sector experts (the steering committee working group) will confirm:
 - the exact dataset to be collected (indicators will be evidence-based and determined by the area of focus an agency has chosen)
 - the number of data collection points between February and September.
- Develop improvement activities based on the areas of project focus and the clinical indicators provided.
- Submit at least one PDSA report to the project team on the last Wednesday of each month from February 2010 until September 2010 (eight reports in total) using the template provided (this should be about one A4 page in length).
- Provide a final project report using a template provided by the department.

Agency management responsibility

- To support:
 - participant attendance at the learning workshops
 - protected time for work on quality-improvement activities
 - the required structural and system changes required as part of the quality-improvement activities.

Roles and responsibilities of Primary Care Partnership staff

The project requires leadership and coaching of agencies through rapid cycles of quality-improvement activities (during action periods) as well as attendance and support at workshops. PCP staff are best placed to provide this, given their existing relationship with agencies and experience in organisational improvement activities. Specifically this involves:

- attending three PCP and five project workshops
- facilitating one to two workshop activities
- informally reporting on PCP catchment activities and issues in relation to the project
- fulfilling an action period facilitation role comprising:
 - leadership, coaching and motivating
 - problem solving
 - sharing of change ideas across agencies involved
 - supporting agencies to apply the methodology and associated tools

- acting as an information channel:
 - communicating with agencies on behalf of the department
 - communicating with the department on behalf of agencies
 - disseminating information to and from agencies (this would include project and email updates)
- identifying and reporting on themes and issues you have encountered to inform the future direction of the project
- informing the departmental project team of current activities in agencies that may impact on the project.

Roles and responsibilities for local divisions of general practice

Roles and responsibilities for local divisions of general practice will vary according to local arrangements but could include:

- participating in the five learning workshops
- supporting agencies in their understanding of the collaborative methodology by sharing previous experiences in projects such as the APCC program and the Australian Better Health Initiative (ABHI)
 - Primary Care Integration Project
- using the project as an opportunity to increase agencies' understanding of and relationship with general practice
- assisting with problem solving by providing expert knowledge about general practice and input into project design based on experience with the collaborative methodology and drivers for GP engagement
- providing agencies with data/information about general practice to assist in project planning.

Project governance

The PDSA Model for Improvement Project sits under two larger projects: the Chronic Disease Incentive and Innovation Projects and the *Primary health workforce capacity-building strategy*. The PDSA Model for Improvement Project will use the Primary Health Workforce Capacity Building Strategy Project Board as its project board.

The project board will be assisted in its task by the PDSA Model for Improvement Project Steering Committee, whose members have responsibility for delivering the objectives of the PDSA Model for Improvement Project. Communications between the project board and the project steering committee are via the project manager who will oversee the progress of the project.

The project steering committee is a forum for the exchange of ideas and accountability to the PDSA Model for Improvement Project. Its function is to ensure the project objectives and key deliverables are achieved.

Project stakeholders

- Clients and their carers
- State funded primary health providers and services
- GPV and local divisions of general practice
- Department of Health regional advisors
- PCP staff and member agencies
- Department of Health central office

Governance structure



Project timeline for workshops and data collection

Due dates	2010		2011											2012			
	Nov	Dec	Jan	Feb	Mar	Apr	Jun	Jul	Aug	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
PCP workshops																	
Workshops – all participants				18th													
Data collection				Base							End						Post
Participant survey	Pre										End						Post
PDSA submission				23rd	30th	27th	29th	27th	31st	31st	28th						

2 The methodology

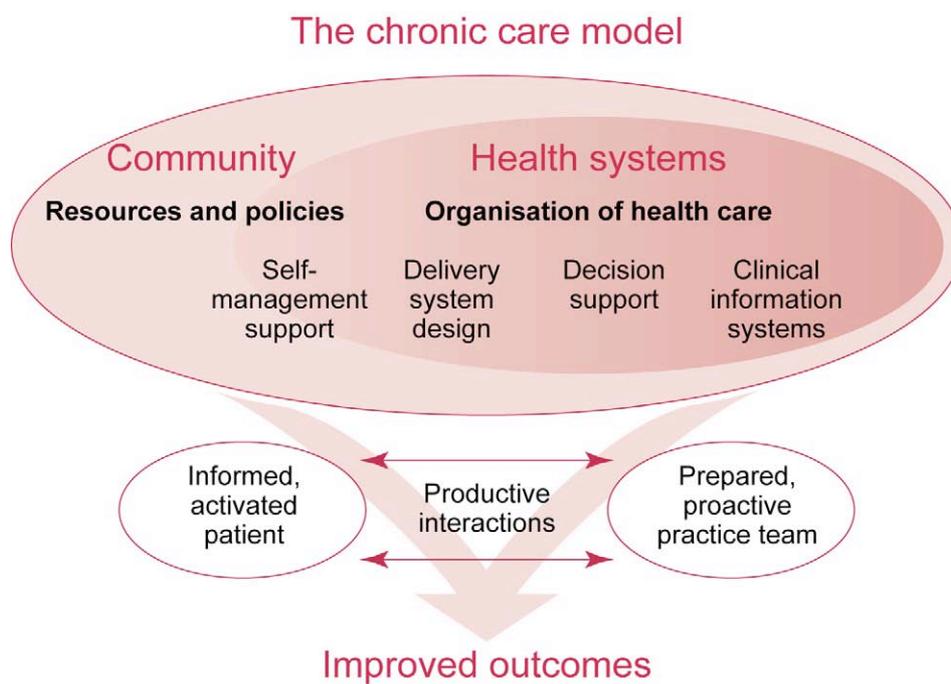
The chronic care model

Health care providers often work in systems that make it difficult for them to provide the care required for clients with complex and chronic conditions. They often feel unprepared and too rushed to meet all the clinical, psychological and educational needs of clients and their carers. Clients can experience care that is uncoordinated, impersonal and unsupportive, which can leave them feeling isolated and incapable of meeting their day-to-day needs. By changing or redesigning systems of care we can close this gap.

Edward Wagner proposes that managing chronic disease requires a transformation of health care from a system that is essentially reactive (responding mainly when a person is sick) to one that is proactive and focused on keeping a person as healthy as possible.

The Department of Health has endorsed the Wagner Model for Improving Chronic Care¹ as the model to guide the service system redesign required to support people with chronic disease. The model has six interdependent elements for improving chronic care that need to be considered to enable individuals to be 'informed and activated' and members of the health care team to be 'prepared and proactive'.

The chronic care model provides a framework that helps to identify the system changes (within and across state-funded primary health services) that are necessary to improve the coordination of care for people with chronic disease.



Developed by The McColl Institute
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¹ Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A 2001, 'Improving chronic illness care: translating evidence into action', *Health Aff (Millwood)*, Vol 20, pp. 64–78.

The Improving Chronic Care model, endorsed by the World Health Organization, was developed by Wagner and his team at The Robert Johnson Foundation based at the MacColl Institute for Healthcare Innovation (Seattle, USA).

The six interdependent elements for improving chronic care are:

1. **community** – resources and activities that provide ongoing support for people with chronic disease/s
2. **health systems** – support prepared and proactive practice teams
3. **self-management support** – empowers and prepares clients to manage their health and health care
4. **delivery system design** – assists care teams to deliver systematic, effective, efficient clinical care and self-management support
5. **decision support** – including design, systems and tools to ensure clinical care is consistent with evidence-based guidelines
6. **clinical information systems** – including data systems that provide information about the client population, reminders for review and recall, and monitor the performance of care teams.

Quality improvement in health care

The terms quality and quality improvement can mean different things to different people in different circumstances. Improving quality in health care makes health care safer, more effective, client centred, timely, efficient and equitable.

Combinations of extrinsic and intrinsic approaches drive quality improvement in health care. Extrinsic approaches include government initiative, economic drivers and professional requirements, while intrinsic approaches incorporate a range of models and methods put in place by individual organisations. By setting their own goals with full staff engagement, organisations can usefully complement extrinsic drivers of quality improvement.

Embedding change is not that easy though. Only around two-thirds of health care improvements go on to result in ongoing, sustainable change.² The most important ingredient to successful and sustained improvement is the way in which the change is introduced and implemented.

Leaders of the quality-improvement approaches within health care

There are a number of leaders in quality-improvement approaches. They include:

- Kaoru Ishikawa, whose many contributions to the field of quality improvement included a range of useful tools and techniques such as his cause-and-effect 'fishbone tool'³
- W Edwards Deming who created the PDSA cycle of continuous improvement⁴
- the US Institute for Healthcare Improvement (IHI)⁵ has influenced quality improvement in the health care sector by using the collaborative methodology. This methodology was originally applied to health care systems by the IHI in the US, and has recently been adopted in a number of countries such as the UK and Australia.⁶

² The Health Foundation (www.health.org.uk)

³ The Institute for Healthcare has a number of useful tools and resources including Ishikawa's cause-and-effect tool. See www.ihl.org/IHI/Topics/Improvement/Improvementmethods/Tools.

⁴ Deming WE 2000, *The new economics for industry, government and education*, The MIT Press, Cambridge, MA.

⁵ IHI (www.ihl.org)

⁶ Australian Primary Care Collaboratives (APCC) program (www.apcc.org.au/about_the_APCC/what_is_a_collaborative)

The collaborative methodology

The collaborative methodology has a specific approach that is user-friendly, simple and promotes rapid change through the Model for Improvement. It allows agencies to experience benefits in short timeframes, promotes 'protected time' for staff to focus on their improvement work and time for participants to spend together solving problems as a team.

The model has three components and relies on the distribution and adaptation of existing knowledge to multiple settings, where participants achieve a common aim. It is not a series of meetings or a passive exercise but is about 'doing and improving'. The process is as follows.

1. Project participants attend a set of workshops where they come together, exchange ideas and experiences, and problem solve around common areas of focus. At workshops, participants also learn practical quality-improvement skills that can be easily implemented using the Model for Improvement.
2. Workshops are interspersed with action periods during which agencies and their improvement teams test change ideas using small, rapid change cycles (using PDSA) within their own environments.
3. Indicators are used to track changes and demonstrate effectiveness of any tested changes.

As mentioned, the collaborative methodology (also known as an improvement methodology) has been proven at demonstrating improvements in health care settings including Australian general practice (through the APCC program). A key component of the methodology's success is the support provided by an expert coach through the activity phase.

Action periods

While the workshops are about drawing attention to scenarios, ideas and approaches, the activity period is where agencies get the chance to put it all into action. During action periods you have the opportunity to implement the ideas you formulated in the workshop. This is not a passive exercise but a purposeful approach that requires agencies to carry out tests for change and measure their impact.

'It's where the rubber hits the road – we actually get to put ... into practice, test and try at the coal face! In the real world! No RCT, no theoretical promises, no planning, planning and more planning with no doing!' – Melinda, 2004⁷

Action periods are periods of time between workshops where agencies test and implement ideas they have been exposed to and formulated during the workshops they have attended. Agencies test ideas using the PDSA approach of small, rapid cycles of quality improvement.

⁷ Quote from a participant during phase 1 of the CPM Bayside–Monash Collaborative

Change principles and change ideas

Change principles and change ideas are key components of the collaborative methodology. They are the principles and ideas for action that are considered as providing the greatest improvement for each area of focus.

The change principles and change ideas for the project have been developed by a group of experts in each area of project focus. For our project this group comes out of the steering committee (called the steering committee 'working group'). The change principles and changes ideas for the project will be introduced in sequence at workshops 1–5, and will guide participants through their next action period.

Each change principle is selected on the basis that it underpins best practice and signifies a key milestone an agency should aim to achieve. Change ideas are the practical steps the agency will need to take to achieve them. There is a systematic and consistent approach to working through each change principle. They have been developed sequentially and, while it is recommended that the principles be explored and implemented in sequence, the reality is that things don't always follow a linear pathway. The nature of service provision may see teams commencing work on the next principle before they have fully completed the change process on the previous principle.

Change principles underpin best practice in each area of focus. The full set of principles for each area of focus are available in this resource as well as provided to all participants at the first workshop.

Change ideas are practical examples of how agencies can implement and achieve the associated change principle. Each principle has a series of suggested change ideas but these are by no means exhaustive and further practical ideas for change will be introduced to and shared by agencies throughout the course of the project.

The first step with the collaborative approach is concerned with system change improvement. Areas for improvement (changes) are tested sequentially in small cycles so they are rapid and manageable. The results of such changes are measured so that the improvement can be demonstrated and replicated.

There are three broad underpinning elements to the quality-improvement process that provide a foundation for the change principles; each will be explored by the working group and assist in their definition:

1. Build the team
2. The foundation work
 - a. Understanding the business
 - i. Establishing systems
 - b. Changing the business
 - i. Being systematic and proactive in managing care
 - ii. Involving clients in delivering and developing their care
3. Developing effective external links with key partners

Change principles for improving care planning practice within state-funded primary health services

These five change principles are the key milestones for best practice care planning within state-funded primary health services. They have been developed by a group of experts participating on the steering committee 'working group' of the PDSA Model for Improvement Project. Each change principle has a series of change ideas to assist agencies.

Area of focus: 'Improving care planning practice', particularly with general practice as part of a team care arrangement

- | | |
|---------------------|--|
| Change principle 1: | Build the improvement team |
| Change principle 2: | Understand all aspects of care planning within your agency |
| Change principle 3: | Change your business – be systematic and proactive in managing care |
| Change principle 4: | Involve clients in delivering and developing care |
| Change principle 5: | Adapt a multi-skilled, multi-agency approach to ensure effective coordination to caring for people with chronic diseases |

Note that these change principles may not occur sequentially. For example, change principles 3 and 4 will occur simultaneously.

Change principle 1: Build the improvement team

All relevant peers and colleagues should be aware of the project, its aims, what is being tested and what is being attempted. Attempting to implement change without appropriately engaging and assigning roles within the agency is unlikely to lead to successful outcomes.

Change ideas

- Identify and engage key stakeholders involved in care planning within the agency:
 - Hold a team meeting.
 - Inform: outline the benefits of the project to the team.
 - Establish a team purpose.
 - Ensure members commit to agreed team goals.
 - Lead by example, model the behaviour you want, be excited.
- Unpack issues and concerns regarding care planning:
 - Ensure everyone has the opportunity for input and contribution.
 - Use tools and techniques provided at workshops.
 - Prioritise issues and problems to be resolved over the course of the project.
- Assign team roles and responsibilities:
 - Identify all the tasks required to complete the task.
 - Match skills to requirements.
 - Empower with appropriate resources including external (for example, general practice/division) input.
 - Assign tasks to motivated competent members first and consider micro teams.
 - Set realistic targets and time lines.
- Maintain an inclusive communication process to the rest of the organisation throughout the project:
 - Ensure an adequate communication protocol exists.
 - Include management in your communications.
 - Communication should address celebrations and achievements.

Change principle 2: Understand all aspects of care planning within your agency

Agencies need to have systems that enable them to track and identify these clients. Recognising the variability of data management systems across the agencies, this principle may pose some interesting challenges! The key will be to look at what is currently feasible and then work towards improving the system in small, incremental steps.

Change ideas

- Identify and quantify the number of chronic disease clients:
 - Agree on clear definitions and formats for recording chronic disease status.
 - Using a variety of approaches (such as the current client list, manual counts and clinician recognition), create a chronic disease baseline.
- Identify current care planning protocols, policies and systems within the agency:
 - Review current care planning protocols, updating as necessary to meet the *Victorian service coordination manual* requirements.
 - Check how many clients with chronic disease have a current care plan.
 - Identify missing and incomplete plans.
 - Evaluate current process for recording client clinical data and records of visits.
- Audit the client journey:
 - Establish a chronic disease tracking system that meets current capacity.
 - Identify gaps.
- Determine the current understanding and usage of the Medicare Benefits Schedule (MBS) system as it relates to care planning within the agency, including its:
 - payment system
 - communication process.

Change principle 3: Change your business – be systematic and proactive in managing care

The multifaceted nature of chronic disease requires a planned and systematic approach to manage care effectively, and systematically implement a care plan process. Agencies will need to identify and prioritise areas for improvement, particularly around the interface between community health and general practice.

Change ideas

- Ensure a chronic disease care planning protocol based on best practice is available:
 - Use guidelines, protocols and computer templates to support care delivery.
 - Update care planning protocols to ensure they meet current *Service coordination tool* recommendations (SCTT tool).
 - Embed the current SCTT tool protocols and templates across the agency.
- Establish clear agency arrangements to:
 - establish small multidisciplinary teams to lead the work
 - ensure effective communication protocols are in place to ensure all members of the team are aware of client care plans
 - using a key worker if feasible
 - establish clear definition of roles and responsibilities within teams
 - consider staff skill and training needs.
- Prioritise and develop action plans to address issues and gaps identified in system review and client service mapping:
 - Pilot the process in a small area then reflect and refine as required.

- Choose a small, easily defined area to test (such as a diabetes clinic).
- Communicate the process and system to all parties.
- The pilot program should be of a short duration.
- Implement successful processes from quality-improvement activities across the agency:
 - Get commitment to implement processes across the department.
 - Communicate the process and system to all parties.
 - Publicise good news stories.
 - Get commitment for a timed/staggered implementation across the agency.
 - Develop a communication/feedback strategy.

Change principle 4: Involve clients in delivering and developing care

Systems should be regularly modified to reflect feedback from clients. Clients have invaluable insight into the standards for information, organisational systems and timing of clinics.

Change ideas

- Maximise self-management by people with chronic disease:
 - Develop a deliberate strategy for self-management.
 - Use goal setting as an opportunity to get client input.
 - Help clients get an understanding of their disease in order for them to make active decisions about their care planning.
- Integrate clients' perspectives constantly in the design of services:
 - Ensure decisions are explained/published before they are implemented.
 - Let clients take the initiative to influence decisions.
 - Seek clients' views before decisions are finalised.
 - Empower clients with authority to take their own (selected) decisions.
- Ensure written communication is appropriate and understood:
 - Ensure all chronic disease clients have written management plans.
 - Ensure care plans are clear and appropriate.
 - Utilise clients in developing patient education material.
 - Use plain language documentation and meet reading age of seven standards.
- Pay special attention to the needs of people from hard-to-reach and disadvantaged groups:
 - Implement a system to identify special needs groups with chronic diseases, including indigenous, CALD, minority ethnic, people with disabilities, and rural and remote.
 - Coopt the services of local community representatives and voluntary organisations as a source for identifying appropriate mechanisms for communicating with these groups.
 - Remember the aged and housebound clients and their communication requirements.

Change principle 5: Adapt a multi-skilled, multi-agency approach to ensure effective coordination to caring for people with chronic diseases

Improving communication and joint planning about the care of shared clients between primary health care services (specifically community health services) and general practice is crucial for improving quality of care and the experience of users of the primary care system. The coordination of other elements between local hospitals, the community and general practice (particularly around agreed care pathways) is in place in Victoria through the auspices of the PCP in every health region.

Change ideas

Support joint working between health professionals and managers in agencies, local health services, general practitioner/practice to enable integrated care for clients.

- Map other local organisations that may influence chronic disease pathways:
 - Investigate possible clinical networks between agencies and other health providers such as Life!, beyond blue and headspace.
 - Ensure these networks have clear roles and responsibilities.
 - Take this as an opportunity to redefine the patient journey.
 - Investigate possible local voluntary-sector contributions.
- Analyse the client journey between service providers and redesign where necessary:
 - Map processes between primary and secondary care from a patient's perspective.
 - Quantify the quality and effectiveness of pathways.
 - Look at alternate options for clients such as one-stop primary care clinics, mobile or at home services and group-based care.

Change principles for improving communication (including feedback) with general practice within state-funded primary health services

These five change principles are the key milestones for best practice GP communication within state-funded primary health services. They have been developed by a group of experts participating on the steering committee 'working group' of the PDSA Model for Improvement Project. Each change principle has a series of change ideas to assist agencies.

Area of focus: Improving communication (including feedback) with general practice

- | | |
|---------------------|--|
| Change principle 1: | Build the improvement team |
| Change principle 2: | Understand how communication is managed within your agency, particularly as it relates to general practice |
| Change principle 3: | Change your business – be systematic and proactive in managing communication |
| Change principle 4: | Involve clients in developing communication feedback pathways with general practice |
| Change principle 5: | Adapt a multi-skilled, multi-agency approach to ensure effective communication, particularly with general practice |

Note that these change principles may not occur sequentially. For example, change principles 3 and 4 will occur simultaneously.

Change principle 1: Build the improvement team

All relevant peers and colleagues should be aware of the project, its aims, what is being tested and what is being attempted. Attempting to implement change without appropriately engaging and assigning roles within the agency is unlikely to lead to successful outcomes.

Change ideas

- Identify and engage key stakeholders involved in communication planning within the agency:
 - Hold a team meeting.
 - Inform: outline the benefits of the project to the team.
 - Establish a team purpose.
 - Ensure members commit to agreed team goals.
 - Lead by example, model the behaviour you want, be excited.
- Unpack issues and concerns regarding communication:
 - Ensure everyone has the opportunity for input and contribution.
 - Prioritise issues and problems to be resolved over the course of the project.
- Assign team roles and responsibilities:
 - Identify all the tasks required to complete the task.
 - Match skills to requirements.
 - Empower with appropriate resources including external (for example, general practice/division) input.
 - Assign tasks to motivated competent members first and consider micro teams.
 - Set realistic targets and time lines.

- Ensure the rest of the agency is kept informed about the progress of your project:
 - Ensure an adequate communication protocol exists within the agency.
 - Include all stakeholders including management in your communications.
 - Communication should address celebrations and achievements.

Change principle 2: Understand how communication is managed within your agency, particularly as it relates to general practice

Agencies need to have communication systems and protocols in place that maintain consistency and meet best practice standards. Variability of data management systems and communication processes between agencies and general practice may pose some interesting challenges! The key will be to look at what is currently feasible and then work towards improving the system in small, incremental steps.

Change ideas

- Identify current communication protocols, policies and systems within the agency.
- Identify all services offered that involve communication with general practice:
 - Map a communication pathway with each of these services.
 - Profile each service in terms of clients, frequency, professional staff and waiting lists.
- Understand how data is managed within the agency and between stakeholders:
 - Identify how client records are managed (documented, single files, ability to track clients through the agency).
 - Identify the information management systems within the agency (paper-based/ electronic files).
 - Identify the minimum dataset at client intake for each discipline.
- Identify the potential communication gaps and areas for improvement.

Change principle 3: Change your business – be systematic and proactive in managing communication

Effective communication requires a planned and systematic approach. Agencies will need to prioritise and then test their changes using the improvement methodology, particularly around the interface between the agency and general practice.

Change ideas

- Ensure a communication plan protocol based on best practice is available for each service area:
 - Use guidelines, protocols and standard communication tools (refer to *Victorian service coordination practice manual*) to support communication pathways.
 - Embed the protocol across the agency.
- Establish clear agency arrangements to:
 - ensure effective communication protocols are in place relative to referral processes and GP communication
 - use a key worker (where feasible) to communicate and coordinate with general practice.
- Prioritise and develop rapid cycles of quality improvement to address communication issues and gaps:
 - Pilot the process in a small area then reflect and refine as required.
 - Choose small, easily defined area to test such as a diabetes clinic.
 - Communicate the process and system to all parties.
 - The pilot program should be of a short duration.

- Implement successful communication processes from quality-improvement activities across agency:
 - Get commitment to implement processes across the department.
 - Communicate the process and system to all parties.
 - Publicise good news stories.
 - Get commitment for a timed/staggered implementation across the agency.

Change principle 4: Involve clients in developing communication feedback pathways with general practice

Systems should be regularly modified to reflect feedback from clients. Clients and their carers have invaluable insight into the standards for providing and storing information, feedback and other communication with general practice.

Change ideas

- Integrate clients' perspectives constantly in the design of services:
 - Ensure decisions are explained/published before they are implemented.
 - Seek clients' views before decisions are finalised.
- Ensure written communication is appropriate and understood:
 - Ensure all relevant clients have written management plans.
 - Ensure care plans are clear and appropriate.
 - Utilise clients in developing patient education material.
 - Use plain language documentation and meet reading age of seven standards.
- Pay special attention to the communication needs of people from hard-to-reach and disadvantaged groups.

Change principle 5: Adapt a multi-skilled, multi-agency approach to ensure effective communication, particularly with general practice

Improving communication and joint planning about the care of shared clients between primary health care services (specifically community health services) and general practice is crucial for improving quality of care and the experience of users of the primary care system. The coordination of other elements between local hospitals, the community and general practice (particularly around agreed care pathways) is in place in Victoria through the auspices of the PCP in every health region.

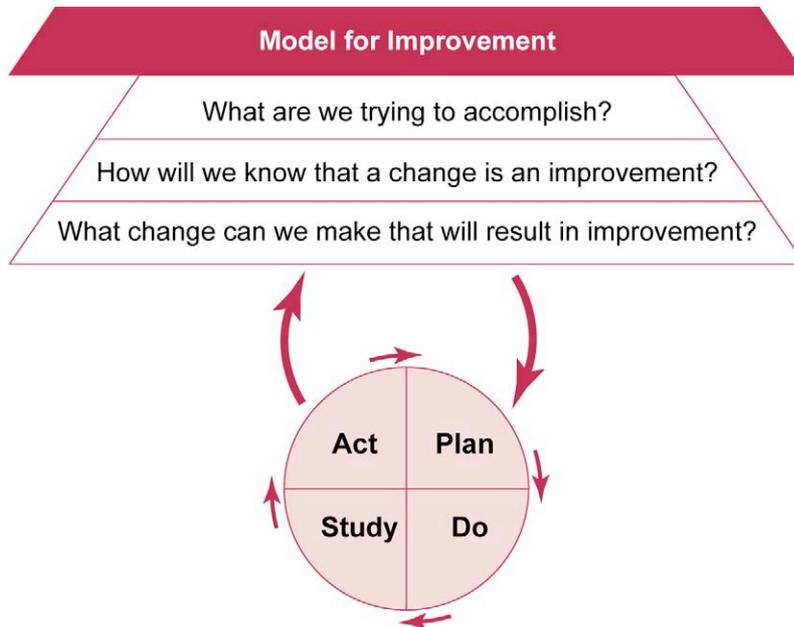
Change ideas

- Support joint working between health professionals and managers in agencies, local health services, general practitioner/practice to enable integrated care for clients:
 - Develop opportunities for shared care between providers.
- Analyse the client journey between service providers and redesign where necessary:
 - Map processes between primary and secondary care from a patient's perspective.
 - Quantify the quality and effectiveness of pathways.
 - Look at alternate options for clients such as one-stop primary care clinics, mobile or at-home services and group-based care.

The Model for Improvement⁸

The Model for Improvement is a simple yet effective tool for implementing changes for improvement. It consists of two parts, a thinking part and a doing part.

The thinking part of the Model for Improvement – the three questions



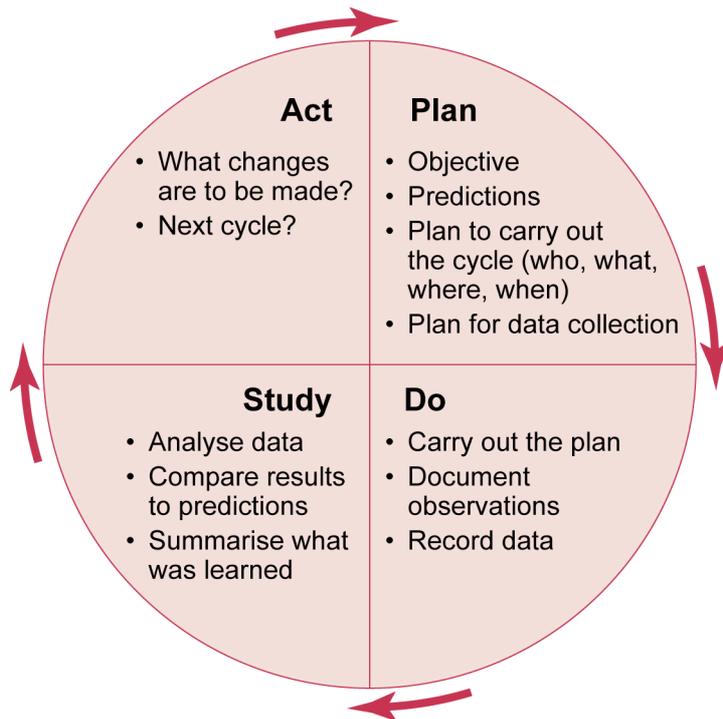
Reference: Langley G, Nolan K, Norman C, Provost L (1996), *The improvement guide: a practical approach to enhancing organisational performance*, Jossey Bass Publishers, San Francisco

The thinking part consists of the three fundamental questions for achieving improvement. People tend to want to jump straight to the 'solution' rather than really work out what the root of the problem is. If you use these three fundamental questions it will help to ensure you are dealing with the issue that really need to be addressed. These questions guide the improvement work and lead to the action part on the improvement cycle, known as PDSA.

1. What are we trying to accomplish? (your goal)
To answer this question you will need to write a clear and concise goal for your improvement. Identify the objective in simple language that is easy to understand.
2. How will we know that a change is an improvement? (measurement)
Measurement is fundamental to answering this question. The objective should be quantitatively measurable if possible. While some improvements may feel intuitively a good thing, it's always best to make sure that you can prove that the change was an improvement. Without measurement how do you know if what we have done has led to an improvement?
3. What changes can we make that can lead to an improvement? (ideas for change)
To answer this question you will need to decide what ideas you will test in order to obtain your goal. Remember, your change should be able to bring about differences that are measurable. This is where you generate ideas that may lead to an improvement.

⁸ The Improvement Model, developed by Langley, Nolan, Nolan, Norman & Provost 1996, *The improvement guide*, Jossey Bass, USA

The doing part of the Model for Improvement – the PDSA cycle



The second part of the model represents the 'doing part'. PDSA is a rapid quality-improvement activity. It was developed in the early 1990s by Langley et al. as a way to approach and break down change into manageable components, testing each small part to make sure services are improving and no effort is wasted. First published in *The improvement guide: A practical approach to enhancing organizational performance* (1996) it is a proven approach to achieving successful change management.

Agencies try out changes on a **small** scale, and use consecutive PDSA cycles to collect information about the effectiveness of these incremental changes. By using small incremental changes in a cyclic process agencies are able to break down change into smaller portions that consistently move projects forward. By working small in terms of scope, the impact of change can be managed. For example, if what is tried does not work as well as planned you can always go back to the way things were done and try something different. When you have built up enough information you will have built up enough confidence to implement the required change.

Use the PDSA template provided in the resource section of the workbook to complete your PDSAs.

The four phases of the doing part of the Model for Improvement

1. Plan phase: the who, what, when, why and how

When developing a plan you should ask yourself the following questions and record your responses:

- **What exactly will you do?**
Clearly define the tasks, activities and so on that will be undertaken to achieve your idea.
- **Who will carry out the plan?**
State the people who will be involved in carrying out the plan. Ownership is important.
- **When will it take place?**
Define the time period. Make this as specific as possible. It should occur over a short period of time.
- **Where?**
State the location where the plan will be implemented and the improvement is to take place.
- **What do you predict will happen?**
State what you think will happen as a result of your planned actions. You will need to compare what actually happened with what you thought would happen to identify 'gaps' in your planning.
- **What data/information will you collect to know whether there is an improvement?**
Think about what data you will need to collect to check the outcome of the change to know whether there is an improvement.

2. Do phase: the execution

It is important to do the activity and not get caught in the planning phase for too long. The doing phase should be as short as possible. It is important to document what really happened after the plan was carried out.

- **Was the plan executed?**
Did it mean deadlines? What unexpected events or problems arose?

3. Study phase: the review

We use this phase to quantify and measure what happened. Study the data collected and think about its impacts. Think about what could have been done differently.

- **Where were we, and where are we now?**
Has it made a difference? Were our expectations met in the real world?
- **What could be done differently?**
What would I change?

4. Act phase: moving forward

In this section you need to think about what will be taken forward. Also think about opportunities that have arisen. Document what you will move to and when.

- **What will be taken forward from THIS cycle?**
Or do we need to run it again, gather more information?

Facts about the Model for Improvement

No PDSA is too small.

You should expect to complete a series of PDSAs to reach your goal.

You can achieve rapid results.

They help you to be systematic and to learn from your work.

They can be used in almost any area.

Aim big, test small.

Selecting the correct measure is important – measures demonstrate effectiveness of any tested changes

Just do it (think 'What can be done by next week?' and so on).

Involve people. Teams can achieve a lot more than an individual.

Most of all, keep it simple.

3 Measures

Measures and indicators

There are two types of indicators:

- process indicators
- outcome indicators (which measure the outcome of a process, such as mortality, length of stay and complications).

Significant research shows that if you can improve process indicators you can almost always improve outcome indicators.

If we wish to improve quality then we must measure it. Measurement provides objective and quantitative values to our subjective experiences. Relevant data needs to be measured in small samples over time if we wish to improve. To be able to influence indicators we need to modify our practice and re-measure our performance to see if our actions have altered the indicator. By providing feedback on the data collected to those who affect the indicators we can show whether the changes we made had an effect.

What is the difference between indicators and measures?

A measure is a value that is quantified against a standard at a point in time. For example, if we calculate the number of clients who have had a care plan for January 2011, the measure is the total number of clients for January 2011. A single measure usually has little value without some context. How do we know if 60 clients for that month is good or bad? Suppose we track monthly numbers of care plans over a 13-month period between January 2010 and January 2011. Now we have some context to see whether 60 clients receiving care plans for January 2011 is good or bad. In our example, the total number of care plans each month gives us more context and understanding of the relationship between measures. However, the fact that the number of care plans the agency may be providing clients is trending up may not give us the complete perspective of how the agency is performing. If we measure the number of care plans against a baseline, such as predicted numbers of care plans, then we get a truer indicator of performance. In this instance the total monthly care plan numbers compared with the predicted or estimated number is our indicator. This provides us with actionable information that we can use to drive our business. We can then consider this to be a key performance indicator.

4 Workshops

The workshops have been designed to build learning incrementally over the life of the project. It is therefore important that, if possible, the same two people from each agency attend all five workshops. They offer a unique opportunity to hear from other participating agencies about how they have sought to improve communication (including feedback) and care planning with general practice.

Each workshop will include a break-out session and team time to allow participants to actively share, debate and learn from each other in a safe and supportive environment.

'Team time' is scheduled into the workshop to provide teams with protected time to discuss what you have heard and how you might apply it back in your own environments and to start the process of developing PDSA ideas.

Some of the questions you might regularly ask at these sessions include:

- Where are we now?
- Where do we want to go?
- How do we want to get there?
- How will we implement changes in our own environment?
- How relevant have the sessions been to our agency?
- Who else do we need to involve in the implementation of the idea?
- Which elements of the presentations could be used?
- Is there something we do that is similar or better?
- What will be the challenges?

The project is about developing strong collective knowledge.

Your experiences are valid and important.

Please contribute to this process and be prepared to learn from others. Having access to what others have done successfully and, importantly, less successfully 'short cuts the learning process and speeds up our ability to deliver improved care for our patients'.⁹

⁹ National Primary Care Collaboratives (NPCC) 2006, *Collaborative handbook*, Flinders University, Adelaide.

The first workshop is over – so now what do I do?

Your personal challenge from the project team

Generate enthusiasm and commitment among your peers and colleagues for your proposed activities.

Hold a meeting within a few days of the workshop to inform your colleagues about your project. It will help you to refine, adjust and gain commitment to the plans generated.

It also makes a great first PDSA!

As discussed at the first workshop, it is vital to get all members of your agency (particularly management) engaged in the area of focus for your project.

Attendees at the workshops are the agency representatives and the conduits for the many ideas and discussions generated at the workshop.

The improvement team – tasks to be achieved by February

- Perform a needs analysis around the improvement team requirements.
- Engage the agency improvement team members.
- Hold your first improvement team meeting.
- Clearly articulate and agree goals and objectives with the improvement team.
- Develop terms of reference for the improvement team.
- Assign roles and responsibilities to each improvement team member.
- Define and unpack the issues and problems related to your area of focus using the problem-solving tools introduced at the first workshop.
- Prioritise issues and problems and areas to work on relating to your area of focus.
- Set realistic goals for the improvement team around a project communication strategy within your agency.
- Start to identify local exemplars and enablers to assist in the uptake of changes.
- Formally reflect and review your progress.

Documenting and submitting PDSAs

Each agency should document their PDSA activities for discussion/presentation at each workshop.

We suggest your improvement team maintain a journal or diary to make the process easier.

We only require you to submit only **one PDSA each month** to the Department of Health project management team, which will provide feedback on your progress.

Documentation should detail:

- which clinical indicators were chosen
- how issues were identified and addressed
- who was involved
- how was feedback gathered
- what followed on from the feedback
- if the improvement was successful
- if the results were expected.

Submit one PDSA each month to reita.minogue@health.vic.gov.au.

Gathering knowledge – the PDSA journey

Each time you test a change using the PDSA Model for Improvement, document it on a chart like the one below.

You will be surprised at the amount of knowledge you gain over the 12-month project. You can use this as part of an ongoing journal. Use it for referral at each workshop when providing feedback on your project and include the information in your final project report.

Date	Cycle number/change tested	What we learnt

February – your next workshop

This is the *only* workshop when *all* participants of the project have an opportunity to meet and share ideas in a large forum.

The PCP facilitation workshop will be held on the previous day.

February PCP facilitation workshop 2 Thursday, 17 February 2011 Room 1.10
Department of Health
50 Lonsdale St
Melbourne

February workshop 2 for all participants Friday, 18 February 2011 Room 1.10
Department of Health
50 Lonsdale St
Melbourne

5 Resources

Note: In the printed version of this workbook, the final tab – ‘Resources’ – is provided to allow users to attach handouts from workshops, and other related material.