How can continuous quality improvement be embedded into the commissioning cycle in a planned and collaborative way?

Presenters:

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PHN Commissioning Showcase 2023

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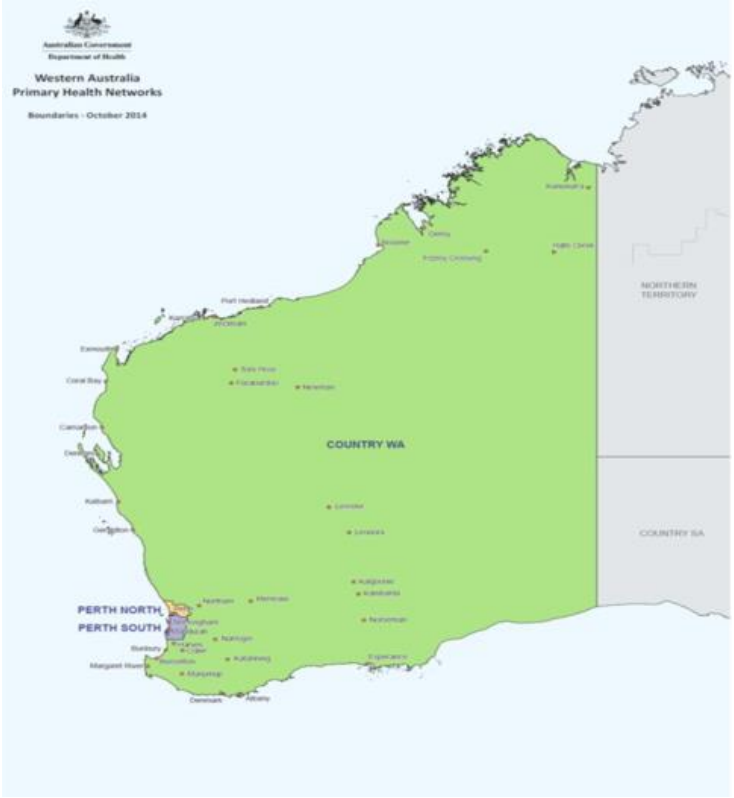
Context

- WA Primary Health Alliance (WAPHA) operates WA's 3 PHNs
  - Perth North
  - Perth South
  - Country WA



- Covers an area of just over 2.5 million square kilometres.
- Approximately 300 contracts delivered by over 100 commissioned service providers.

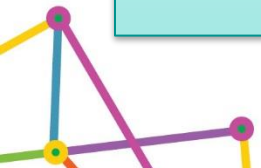
Context

- In 2021 WAPHA made a commitment to the continuous quality improvement (CQI) of its commissioned services by establishing the Program Improvement Team.
- The purpose of the team is to improve outcomes of commissioned services through continuous quality improvement activity.
- The team works across all 3 PHNs.
- Covers all 5 priority areas of Aboriginal Health, Aged Care, AOD, Mental Health and Population Health.
- All Coordinators are subject matter experts for their priority area.
- Is an integral part of the Commissioning Cycle and works closely with the other two portfolio teams, i.e. Contracts and Regional Integration, as well as Data and Analytics.

The Challenge

To develop a system of continuous quality improvement that:

- Is proactive and planned, with flexibility to be reactive or ad-hoc to suit all contracts.
- Is tailored to each priority area.
- Utilises available data to identify, monitor and measure improvement.
- Includes Communities of Practice.
- Engages service providers in the common goal of best practice.



The Need

- Initial focus on programs, i.e. delivering 'like for like' services:
  - **Mental Health** ⟹ Integrated Primary Mental Health Care (IPMHC)
  - **Population Health** ⟹ Integrated Chronic Disease Care (ICDC)
  - **Aboriginal Health** ⟹ Integrated Team Care (ITC)
  - **Aged Care** ⟹ Care Finders
- Ability to broaden the work to cover single service contracts.

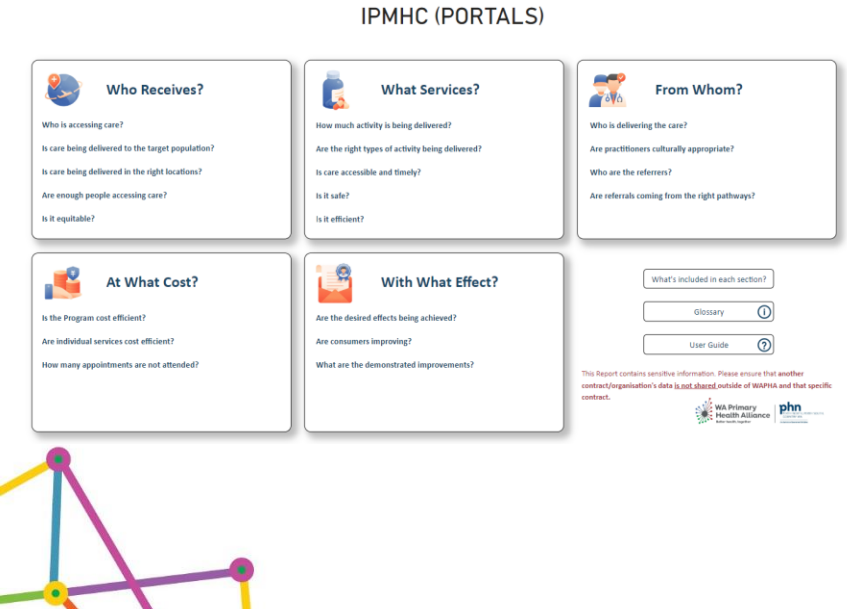
The Approach and Impact:

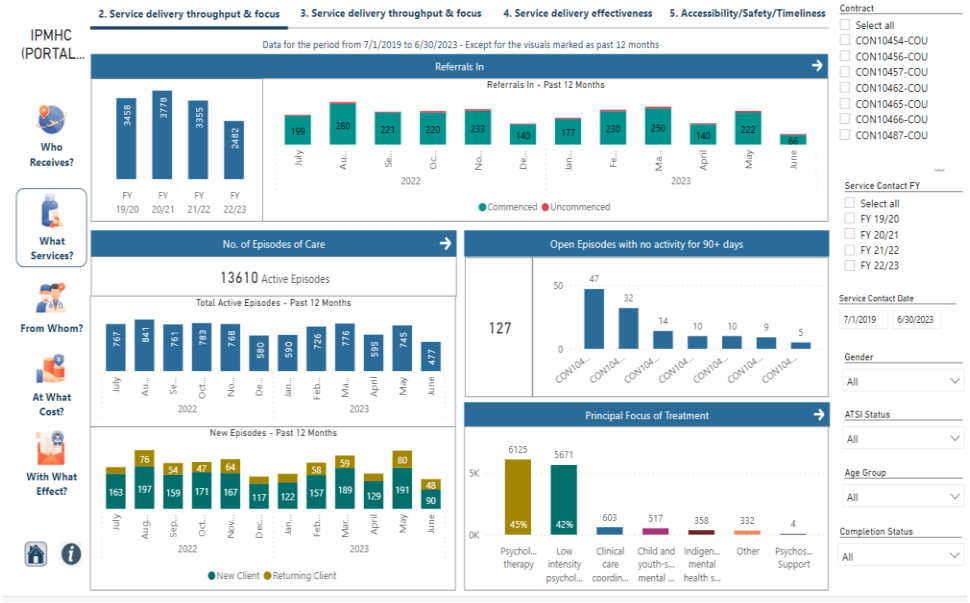
Mental Health

The Approach – Mental Health

- **Information gathering** – what MH contracts are there, what are the programs and other 'single service' contracts.
- **Develop a data tool** using PMHC MDS data that groups services within programs and allows for in-depth analysis and benchmarking - last year's presentation:

  https://rebbeck.com/2022-phn-commissioning-innovation-showcase/



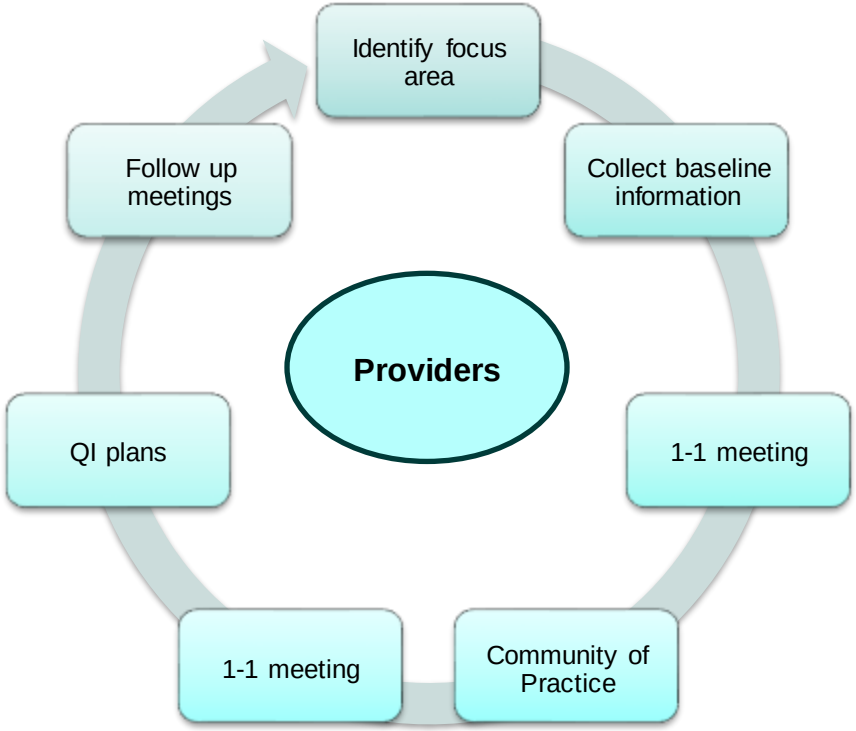


The Approach – Mental Health

Developing the QI Cycle

Collaborative Approach:

- Providers
- Internal stakeholders
  - Contract Managers
  - Regional Integration Managers
  - Data & Analytics



The Approach – Mental Health

The QI Cycle

- Identification of a focus area e.g. via data, providers, KPIs, internal recommendations.
- Collection of baseline information from providers relating to focus area.
- Initial 1-1 discussions, informed by baseline information. Opportunity to explore understanding, practices, processes etc. Early ideas for improvements can be formed.
- 'Community of Practice' (CoP) forum for all providers. Key platform to gain consistency in understanding, problem solve, share knowledge, learnings and best practice. Share de-identified program data.
- Post CoP 1-1 meetings to consolidate information/learnings and discuss possible improvements in more depth.
- Providers are supported to develop a plan for improvement initiatives resulting from the cycle.
- Follow up meetings scheduled to discuss improvement plans and provide data to assist in measurement of change.

The Approach – Mental Health

Provider Engagement

- **First MH program identified:**
  - *six providers deliver services in over 60 locations across Country WA*
  - *same contract*
  - *funded to deliver 3 distinct clinical treatment services (LIPI, Psych T, CCCS)*
  - *engagement with senior staff (good knowledge of service delivery, in a position to make and influence change) via Teams and face to face office visits*

- **Initial steps - relationship building, information gathering**
  - *review services delivered against the Activity Schedule and CW funding intent*
  - *review data entry practices, understanding of PMHC MDS, KPIs, provider data*

The Approach – Mental Health

Review Findings	QI Activity
Inconsistencies in understanding of PMHC MDS and data entry practices: - Made benchmarking difficult - Affecting KPIs and PQF reporting targets - Providers inadvertently advantaged/disadvantaged - Not reflective of service delivery	- Education via 1-1 meetings - Provision of key PMHC MDS information - Guidance documents - Quarterly data forums - 'Open door' approach
Inconsistent interpretation of the contract and clinical service delivery: - Not a standardised State-wide program - Inequities in access (pathways and eligibility) - Confusion for referrers - Inequities in services offered and delivered	Quarterly QI cycles, focussing on: - Low Intensity Psychological Interventions - Clinical Care Coordination Services - Psychological Therapies

The Impact – Mental Health

- Consistent data entry practices across the program allowing for more reliable benchmarking.
- More accurate data for provider and PQF reporting.
- Increased staff confidence in data entry and asking for clarification = fewer errors.
- Increased understanding and standardisation across the state in services offered resulting in:

  - greater clarity for referrers and communities re available services
  - equity in access and referral pathways
  - increased diversity in services offered to regional communities
  - increased support for GPs
  - appropriately skilled workforce, greater quality of services delivered

- Collaboration amongst providers, sharing of ideas, best practice, processes etc.

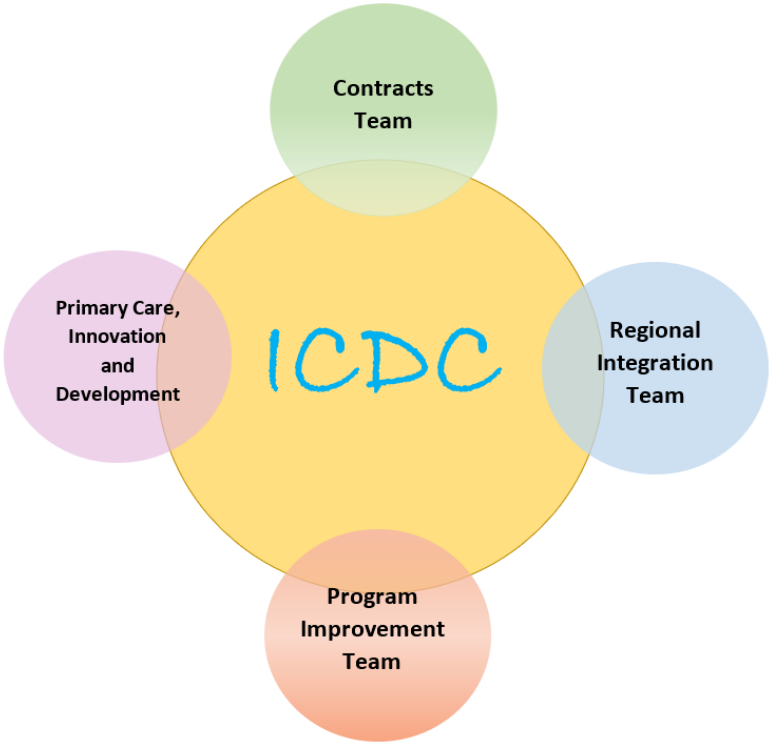
The Approach and Impact:

Population Health

The Approach – Population Health

Internal Stakeholder Consultation and Information Gathering

- Contract details - multiple contracts
- Performance indicators
- Organisation structures & nuances
- Local referral pathways, relationships & networks
- Any engagement from our PCI&D team?
- History of the program, lessons learnt



The Approach – Population Health

Community of Practice Research

- Purpose
- Design
- Establishing
- Cultivating
- Maintaining
- MS Teams
- WAPHA processes

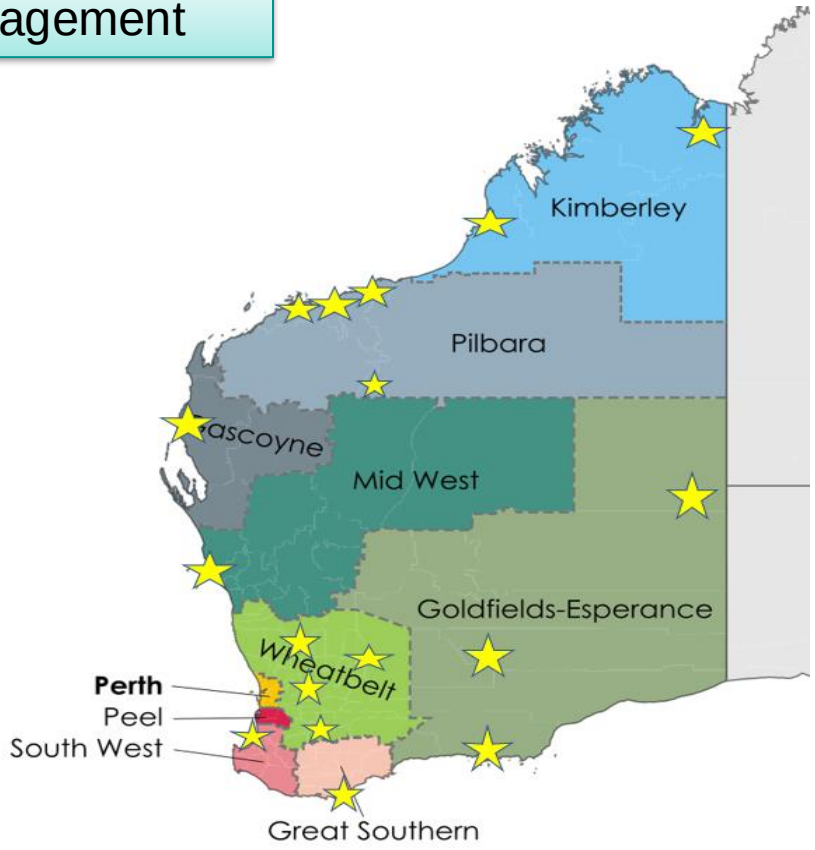
Based on Allan, B. (2008). Knowledge creation within a community of practice

A quick guide to Establishing a Community of Practice: https://www.aracy.org.au/publications-resources/command/download_file/id/451/filename/A_quick_guide_to_Establishing_a_Community_of_Practice_(ARACY)_2021_-_FINAL.pdf

The Approach – Population Health

Provider Engagement

- Initial virtual Introductions
- Clinician focussed QI
- 15 provider organisations across 17+ locations
- Face to face visits to providers and their outreach locations
- Relationship and trust building a priority
- Contextualisation of data and challenges & strengths



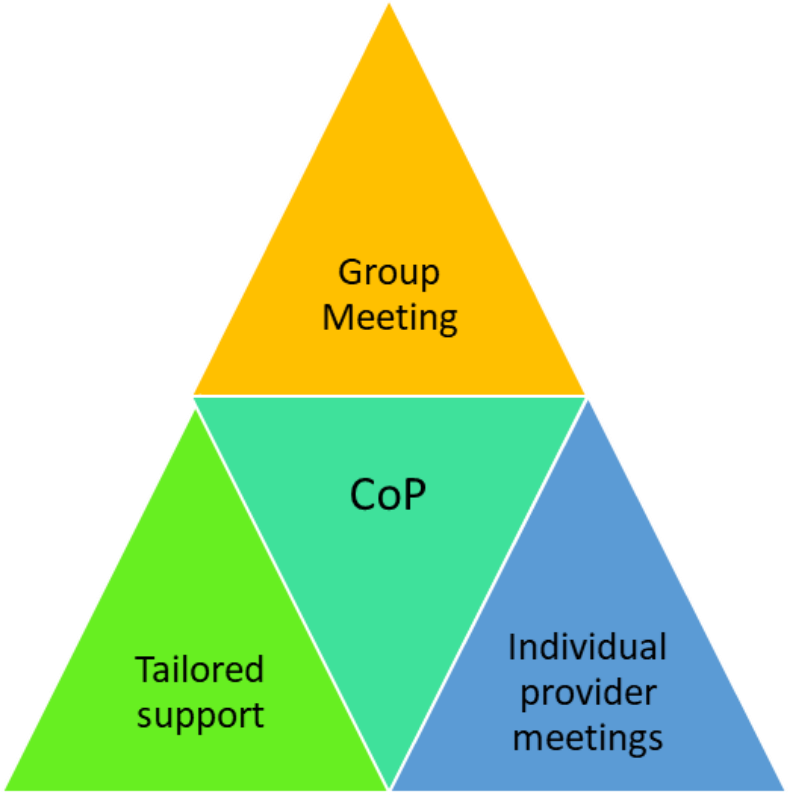
The Approach – Population Health

Face to Face Visits

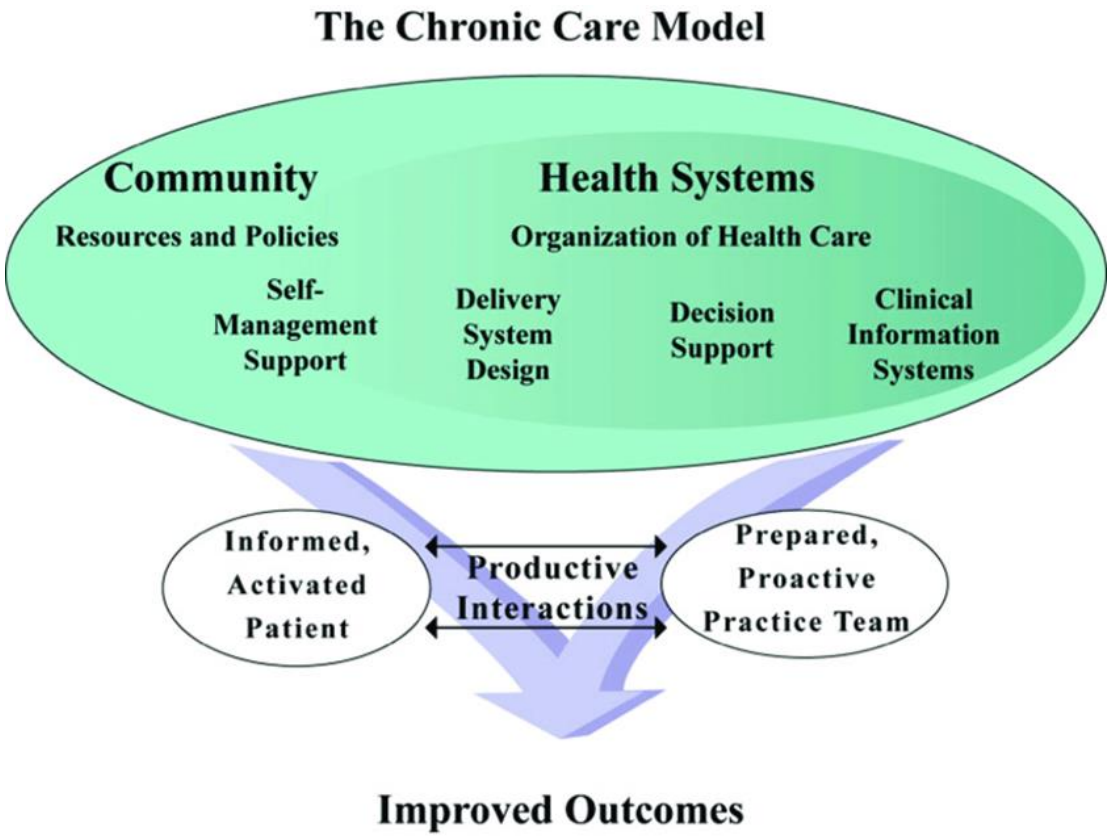
The Approach – Population Health

Review Findings	QI Activity
Care coordination not central	Chronic Conditions Care Planning Workshop and networking CoP
Partners in Health Survey not widely understood and/or valued	Flinders Program training
ICDC taking on increasing numbers and acuity	Collaboration Toolbox CoP resources Linking to relevant organisations
Podiatry access limited and demand increasing	Chronic Conditions of the Foot Road Show

The Impact – Population Health



The Impact – Population Health



Learnings

Learnings for the team

- A structured and planned approach has been well received by providers as it allows for CQI to be factored in to their busy clinical environments.
- Having subject matter experts in the roles has brought credibility to conversations with providers, a deeper understanding of the challenges they face and ability to contribute towards suggested improvements and problem solving.
- The QI cycle allows for any area of service delivery to be the focus for improvement and can be driven by PHN or provider, e.g. improving clinical outcomes, meeting KPIs, streamlining processes, reducing wait times and DNAs etc. Increases opportunities for a proactive approach to CQI.

Learnings for the team

- Not all providers will be equally invested in participation, e.g. if not a contractual obligation, dependent on funding amount.
- Staff turnover within provider organisations can delay work, increase risk of knowledge loss, may need to repeat some elements.
- Both top-down and bottom-up approaches can work – flexibility is key.
- Recognise that you are only a small part of the provider's competing priorities, e.g. they may be undertaking accreditation, end of FY reporting etc.
- Acknowledge that all improvement calls for change – which takes time.

For more information please contact:

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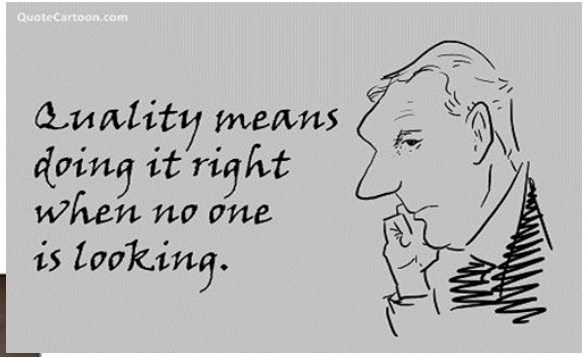

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