Improving perinatal health care: multi-disciplinary teams in a rural setting

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Introduction

Greater Southern Area Health Service in NSW has successfully implemented and evaluated a service change process which has integrated health care in the perinatal period, with a specific focus on psychosocial screening and multi-disciplinary team case review. The initial implementation of this program, known as “Families First/Integrated Perinatal Care” (FF/IPC) was presented at the previous Rural Health Conference.1

The New South Wales’ government Families First initiative is a “prevention and early intervention strategy to help parents give their children a good start in life”.2 This involves five government departments—Health; Community Services; Education and Training; Housing and Ageing; and Disability and Home Care—working together with non-government organisations at many levels to support families in the earliest part of life. This initiative was based on the increasing evidence a holistic and integrated approach to family well being, and increased support in the early years of a child’s life can lead to a “lasting effect on children’s development and later education, health and economic outcomes.”3

Universal Home Visiting is one of the strategies under the Families First initiative.3,4 Families who have a new baby are offered a visit in the home by a Child and Family Health Nurse, providing a convenient point of access and engagement with local child health services that will support the family through the first years of a child’s life.4

Integrated Perinatal and Infant Care (IPC) is a program initially funded by the Centre for Mental Health to “ensure the provision of holistic and comprehensive care at a critical stage in the life of a family”5, the perinatal period. This period is defined as the time from conception through the baby’s first year of life.1 During this time, all families accessing health services are offered a psychosocial assessment at regular intervals to identify risk factors that may impact on parenting, and provide early intervention to limit the development of a wide variety of later social and psychological issues.5

The former Southern Area Health Service was able to join these initiatives together to create the FF/IPC program.1 Families First staff within GSAHS worked together with staff from Maternity, Mental Health, Alcohol and Drug Services, Women’s Health and Aboriginal Health to create a program that was piloted by staff in one site and then rolled out to the rest of the area.1,6 The development of multi-disciplinary team processes was an important part the FF/IPC program. Staff and managers from Child and Family Health, Maternity, Allied Health, Mental Health, Alcohol and Drug and Aboriginal Health meet regularly at different levels of the organisation. Managers collaborate and plan for implementation of the program and ongoing issues, and staff meet for case review and planning of clients who are identified during psychosocial screening as ‘at risk’.6

In NSW, Primary Health care reforms have led to a change in the way health services are delivered. There is now more of an emphasis on the social determinants of health, and a multi-disciplinary approach to health care.7 In recognition of the importance of collaboration between professionals within the health care system, significant research is now under way examining how to best educate health professionals, including doctors, during their initial training to work together with other health professionals.8,9

In the Integrated Perinatal and Infant Care program, the need for a multi-disciplinary team is identified with representation from health services working with pregnant women and families with babies. This is to “ensure that the women and their families are linked to the most appropriate service and a case manager is identified.”5 In a rural or regional setting, specialist staff and services are not always easy to
access, and service size is small. The creation of the FF/IPC Specialist teams allowed local health services to “pool the local expertise … and provide them with extra training and support to help ensure long term sustainability of the program”.¹

During the implementation of the program notable additional benefits emerged as a result of the team based approach. Many health professionals prefer to work in a team to access the support of others, and teams can process large amounts of information about a client, therefore reducing cognitive load on already busy individuals.¹⁰ Additionally co-ordinated services also reduce service duplication for clients, providing greater value for money for the health service.⁶,¹⁰

Some research has emerged regarding the factors which support multi-disciplinary team work, and what barriers exist which hinder teams from being effective. Personal commitment from team members, a common goal for the team, clarity of roles and communication and institutional support have been identified as helpful in the development of multi-disciplinary team working.¹¹ Any plan for developing a team would need to take account of these factors and attempt to address them when establishing new processes.

Difficulties can also arise during the team development process. Logistical difficulties such as time, distance, and ability to find an appropriate space for a meeting can make it harder for teams.⁶ Lack of understanding between professions, including not having a common language to discuss issues, and the attitudes of team members towards each others services and their own participation, also need to be addressed.⁶,⁷

It is imperative that attention is paid to internal group processes and functions when developing new multi-disciplinary teams. A new way of working needs to be developed between different professions and services. The specific skills of each worker are crucial, however, a sense of shared work where the clients needs are the most important priority, and roles and responsibilities are explicit and shared also need to be developed. Attitudinal research has shown that shared team training and development, along with dedicated time for team meetings, can result in team member’s expressing values consistent with high functioning teams.¹²

**Method**

Within the FF/IPC program, teams were created at each site utilising a staged approach. Appropriate staff from Maternity, Child and Family Nursing, Counselling, Mental Health, Drug and Alcohol and Aboriginal Health were identified by the Managers group. These staff were considered to be those who were carrying out the most appropriate roles related to IPC within their service, had the most expertise in the area, or would be carrying out assessments during the perinatal period.

Most teams where possible completed training together including a half-day “Psychosocial Assessment Training” which outlined the programs and procedures for working within the model, and the Family Partnership training. Family Partnership Training is based on Hilton Davis Family Partnership model¹³, and has been implemented in NSW as a model for working within Child and Family Health. It advocates working in partnership with the client, their family and with other health professionals to provide an appropriate service that meets the needs of the client. It involves 10 half-day sessions held over 10 weeks, although it can be slightly modified to be held over eight weeks.

During the training clinicians had the opportunity to listen to each other talk about their work, to watch each other work, and to learn about working in partnership with clients and each other. Participants enjoyed hearing about how other parts of the health service worked and were supportive regarding the challenges each group faced. In their training evaluations, when asked what the best aspect of the course was, most clinicians identified the chance to network with, and get to know workers from other professions and parts of the health service.

When training was completed, plans were made for the teams to start meeting. A set of guidelines and terms of reference identifying team structures and roles were provided to the team and reviewed by the team members.¹⁴ A description of the responsibilities of the clinician presenting the case, as well as the
others in attendance for consultation, case planning and referral, was distributed. The teams were able to discuss and review these materials before they began reviewing cases.

Teams meet weekly or fortnightly and have a set agenda. They are chaired by a manager who is also a part of the Manager’s Group. This provides contact between the FF/IPC Specialist Team and the Manager’s Group.

During the implementation phase, teams were given an opportunity to review their project at three months, six months, twelve months and two years. Feedback was received from those who are part of the team, those within the service who do not attend the meeting, but may have cases reviewed there, and managers. These reviews formed part of the evaluation described below. When issues were identified they were discussed within the Manager’s meetings and the Specialist Team meetings, and teams worked together to resolve them.

Evaluation

During the implementation phase, a broad evaluation in the form of a survey was undertaken. Although there was acknowledgment of some difficulties and barriers, the program was widely supported by staff and managers. By far the most valued part of the program for staff and managers was considered the teamwork and collaboration with other staff and managers. Staff valued the support from other clinicians and the enhanced levels of communication that had developed as a result of the program. The benefits of this included feeling more supported and less isolated. Staff felt the potential stress and high workload experienced when working with complex families could now be shared. As well as being of benefit to staff, respondents perceived that co-operation between clinicians from hospital and the community had led to an improvement in the service for clients.

Improvement in communication between services was also highlighted as a benefit of the new multi-disciplinary teams. Regular access to Mental Health Workers in particular was highly valued by staff and managers. Staff felt they understood the work of other services better and were now able to make more appropriate referrals. Work undertaken prenatally by midwives and other health professionals was seen as highly beneficial by staff who completed postnatal assessments. Services were perceived as being “more seamless”, and an improved continuity of care was observed by the clinicians. Client management was seen by managers to have improved, with the teams able to provide better case management plans due to access to better assessment information and team support.

In the survey completed at the end of the implementation phase, 98% of respondents (N=85) stated that there was now a better continuum of care for clients and patients between the different parts of the health service, and 95% (N=85) believed that the program had improved communication and working relationships.

Ongoing team issues were also identified. Some difficulties have now been identified with providing training for new team members when others leave. Management support allowing for team meeting attendance and participation is crucial, and will be a requirement of ongoing success. The process for establishing a team and creating new ways of working can take a long time with a significant commitment necessary from the participants and their managers.

Additionally it was found that the larger the services participating in the model, the more difficulties there were in developing an optimal process for all staff to participate and receive the benefits of working within the multi-disciplinary team. Teams have used multiple strategies to solve this difficulty, including rotating the member of their service that attends the Specialist Team Meetings, and increasing the team work and time spent on case review outside of the Specialist Meetings to enable all the opportunity to participate. No doubt over time more strategies will be developed to suit local needs.
Conclusion

An important part of the FF/IPC Program for those who participated as staff and managers was the opportunity to work effectively with people from other professions and/or other parts of the health service.

Staff and managers reported increased levels of access to these people and services for support and referral of clients. A greater understanding of the work of other professionals developed, which allowed more appropriate referrals between services. Workers were able to collaborate for the good of their clients, and to reduce the duplication of services. For rural or regional health services, it may be appropriate to consider a model of integrating services by the creation of multi-disciplinary teams for case review and planning.

This paper is based on feedback from staff and managers working within a health service. More rigorous qualitative and quantitative research methods could be applied to this information to further study the perceptions and effects of working in multi-disciplinary teams. However, it seems that although it is often challenging and time consuming to create multi-disciplinary teams, within Greater Southern Area Health Service, multi-disciplinary team work is considered highly valued by staff and managers.

References

Presenter

Jo Lawrence is the Co-ordinator of Families First for the Eastern Sector of the Greater Southern Area Health Service, and has had a lead role in the implementation and evaluation of the Integrated Perinatal Care program there. She is a clinical psychologist with a background in child and adolescent mental health.