NIRVANA HEALTH GROUP

Connecting Care Project Co-Design Workshop

21 Nov 2018

Transitions in Care –
What does good (and not so good) look like
from a primary care perspective

A Caveat –

Does anyone here lie awake at night, dreaming up ways to provide bad care…??

Why we go into mental health as a career…

What would you do right now if you developed a severe mental illness??

Right now:
You could access world class or truly appalling care, on the same day, in all DHBs in NZ.

Is that OK?

What GPs too often say about transitions into MHS…

GPs never ask for help if they don’t need it…

What GPs I work with said when asked about MH transitions…

Compared to other specialties we seldom get letter updates or advice

If there is any dual diagnosis – A+D issues, ID, Personality etc – we get pushback

They seem to understand risk differently – we can be worried sick about a patient, and they will make a phone call that night and hand back to us the next day.

If you happen to talk to someone you know it always goes better – I have a classmate who is one of the psychiatrists, if I talk to him it usually goes well

Sometimes one of the nurses will call back – when that happens things go better!

MHSOP response to referrals is helpful, timely response

My own experience of how transitions into MH Acute Services feel…

My own experience of how MH transitions too often feel…

BUT we are not talking about rocks or grenades, but people and whanau needing care, connection… and their lives back

What the MH Clinicians I work with said when asked about MH transitions…

Sometimes the response is “well what do you want us to do then?”

NGO support access from primary care has made a huge difference, wish we had this in CMH area

Reluctance to take on referrals from us – fail to appreciate we are a LOWER level of service, provide only brief intervention – manage 500 ref /mth with small team

People with dysregulation, impulsivity – they tend to go by the last assessment, not appreciate dynamic risk factors can change, risk increase if eg depressed

Having MH staff in locality MDTs – case reviews - always get the right outcome, collaboration

When I worked in CMH, the big focus was triage out, send referrals elsewhere

So what would good transitions look like?

The person and family as VIPs –

Isn’t that how we would want to be treated??

So what would good transitions look like?

People experiencing primary, NGO, secondary as 1 team working for and with them

Ensure a warm “hand off” to the next provider

So what would good transitions look like?

A no-referral “warm hand-off” system

So what would good transitions look like?

Talking to each other more - seamless communication –

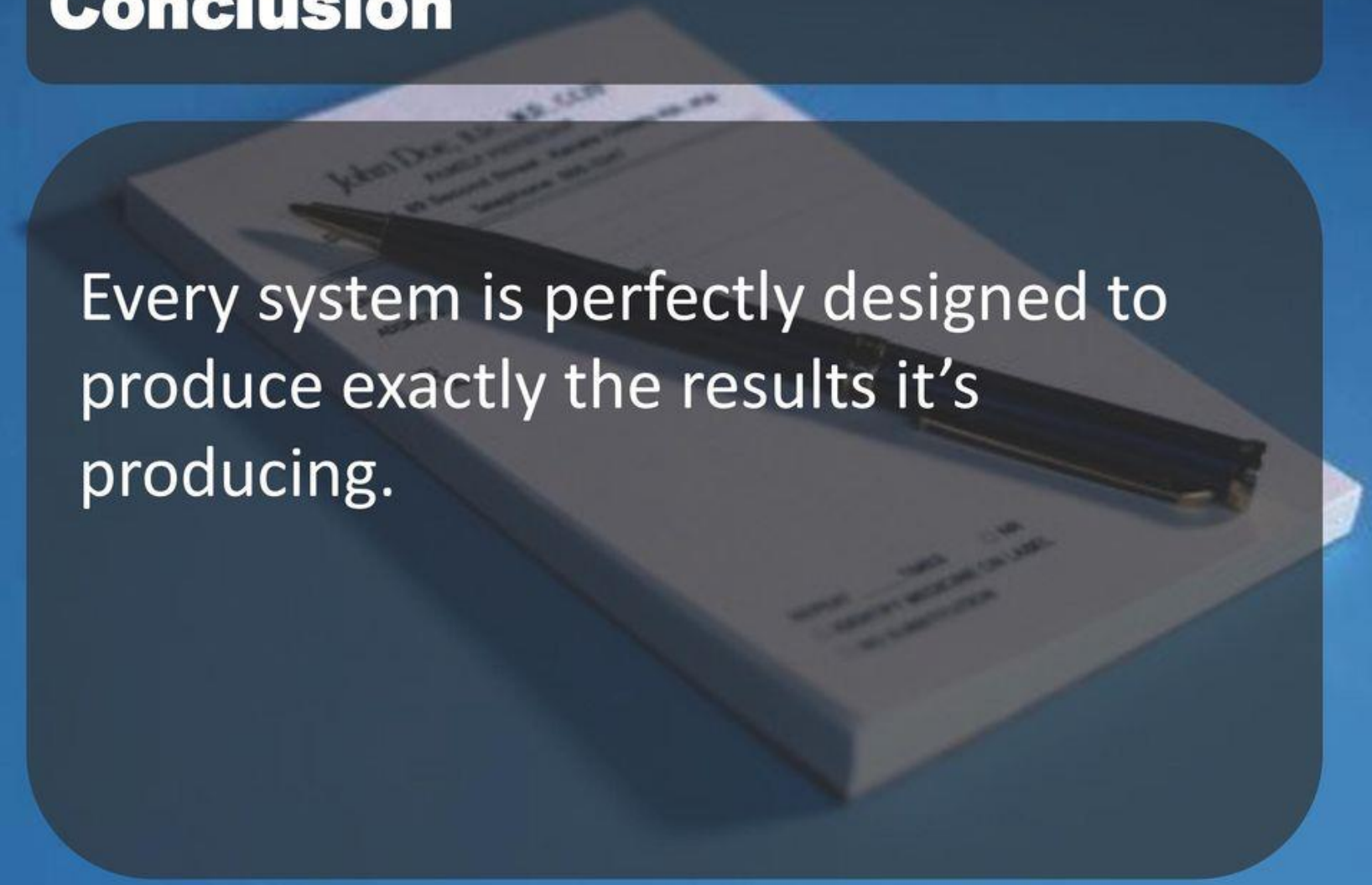
We do live in the 21st century don't we??

So what would good transitions look like?

Response when a GP asks for assistance…

Isn't that how we would want to be treated??

Conclusion



Every system is perfectly designed to produce exactly the results it's producing.

So what would good transitions look like?

When the systems of care we design and work in make doing the above the EASIEST thing to do…