Transitions of Care Project –

A joint project between Counties Manukau Health Mental Health and Addictions Services and East Tamaki Healthcare PHO

Project Storyboard

KO AWATEA

HEALTH SYSTEM INNOVATION AND IMPROVEMENT

Our Project Sponsors

Project Sponsors		
Name	Role Title	Organisation
Tess Ahern	General Manager, Integrated Mental Health and Addictions	Counties Manukau Health
Pete Watson	Clinical Director, Integrated Mental Health and Addictions	Counties Manukau Health
David Codyre	Clinical Lead Mental Health/Consultant Psychiatrist	East Tamaki Healthcare

Our Project Team

Name	Role Title	Organisation
David Codyre	Clinical Lead Mental Health/Consultant Psychiatrist	East Tamaki Healthcare
Pallavi Mishra	Operations Manager, Wellness Support Team	East Tamaki Healthcare
Fran Voykovich	Clinical Quality and Risk Manager	Mental Health Services, CMH
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Sue Cotton	Family/Whaanau Adviser	Mental Health Services, CMH
Scarlett Teng	Clinical Nurse Specialist	Mental Health Services, CMH
Angeline Hekau	Clinical Lead Pacific	Mental Health Services, CMH
Tavita Asiata	Clinical Quality Coordinator Integrated Care Adult North	Mental Health Services, CMH

Our journey so far

The Project Team has met four times and discussed:

- Geographical area – ETHC Bairds Road, Otara – large high needs clinic
- Focus population – 18-25 yo vs whole adult population
- AIM statement – what we are trying to achieve
- Problem
- Possible measures

Discussion highlighted differing views regarding the issue.

Outcome of these first discussions was that we need to look at the data first.

Cross Matching the Data – open referrals age 18+

- CMH cross-match: 0.8% (116/14,743)
- ETHC cross match: 0.9% (135/14,743)
- (Comparison - For all CMH current open referrals/census est. current pop: 0.9% (3614/397000)

NB: Excludes CADS and NGO-only access

Cross Matching the Data – age and ethnicity

	CMH		ETHC
18-24 yrs	25		21
25-64 yrs	81		101
65+	10		13
Maori	39		41
Pacific	52		74
Asian	18		14
Other	7		6
Total	116		135

Aim Statement

Through improved communication between the person and their whanau, primary care, and secondary care; we will improve quality and experience of transitions for people, as reflected in 25% reduction in unplanned entry to secondary care via Police/ED; and 25% more service users and their whanau having copies of their care plans and relapse prevention plans, and copies of all GP letters regarding their care.

Define the Problem

- Unplanned entry to secondary services
- Lack of shared understanding of risk between primary and secondary care
- Key information from secondary care not in patient's primary care file
- Poor quality of information from primary care
- Patient and whanau don't have copies of relapse plans and/or GP letters
- GPs don't have letters and plans from secondary care
- Patient and whanau not involved in decision making regarding care transitions

Voice of the Customer

- **We will gather qualitative data re the experience of service users, whanau, primary care clinicians and secondary care clinicians**

1. **Consumer co-design forum – 10 people with DHB MHS longer term, 10 people back in primary care after an episode of DHB care:**

- Gathering feedback over the phone and/or through focus groups
- Questions to consider asking:
  - What's worked well in your transition in and out of DHB MH Services?
  - What's not worked well?
  - What would have improved your experience?
  - Was the referral via GP or police or ED?
  - Were you and/or your whanau involved in decision making?
  - Did you get copies of the relapse plan and/or GP discharge notes?
  - Were you involved in and did you understand the plan/letters?

Voice of Primary Mental Health –

GP and Primary MH clinician focus group

PMH to secondary MH Feedback - Well	Not well Discussion	Improve
MHSOP response to ref very helpful, timely response	Letters go to wrong GP (?our vs their problem)	Have referral form with common agreed language re esp risk and how to assess/level of risk – eg Zero Suicide
CMHC nurse calling to clarify things after referral made	Pts under their care – no/seldom letters/updates – compared to other specialties and ADHB/WDHB	Develop r'ships – meet face to face – to develop r'ships
	MedTech/Healthlink issue – psychologists can't use e-referral	Better connection with PCL nurses and WST …and the GPs
Goes better when patient speaks on phone to svc referring to – outcome seems to be better	Pushback when is any dual diagnosis – A+D, ID	"MDT" with PCL nurses and/or other CMH members – did happen in past with PCL Nurse/PPS and was really helpful
Things tend to go well when you know the person on the other end of the phone – have an established r'ship	Differing definitions/understanding of risk and how to respond – we think risk ++, CMH make phone call and hand back	Have greater clarity re what CMHC provide, entry criteria, how to access

Voice of Primary Mental Health

PMH to secondary MH Feedback - Well	Not well Discussion	Improve
Things tend to go better when you ask for a specific response re what you want from them – eg phone f/u – support – rather than asking service to take on care generally	Reluctance to take referrals on if they know person is being seen by us – fail to appreciate we are a LOWER level of care/brief intervention	CMH staff/psychiatrist and/or Suicide Prevention coord, training PC staff in assessing/managing risk
	People with dysregulation, impulsivity – tend to go by last assessment if within recent mths and not appreciate fact risks can be dynamic	Regular letters from MHS just like other medical specialties – incl assessment then discharge - plus re any medication changes
	Issue with people with past CMH contact who need but don't want to be re-referred	Share updated care plan with primary care
	Restricted access to NGO CSW/PSW support from primary care	Trial doing joint consults WST-CMH
	Crisis line response time – urgent referrals have to wait for them to call you back – can be significant length of time – up to 2 hrs plus – even if clinic about to close have to wait.	Better knowledge/understanding in CMH of what WST does/what we offer/who would benefit AND vice versa
		Replicate Awhi Ora – NGO access from primary care – makes a big difference

Diagnosis of the problem

- ETHC will do file reviews to look at communication between primary and secondary services – Letters to GP, and Relapse Plans
- CMH will gather base line data regarding unplanned entry to services via ED/police

Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Through improved communication between the person and their whanau, primary care, and secondary care; we will improve quality and experience of transitions for people, as reflected in 25% reduction in unplanned entry to secondary care via Police/ED; and 25% more service users and their whanau having copies of their care plans and relapse prevention plans, and copies of all GP letters regarding their care.	Secondary Care	•GP letters •Relapse prevention plan copies to patient and whanau •Existing knowledge of person
	Primary Care	•Screening/detection of mental health issues •Quality referral information sent •Know key secondary staff •Understand what MH&A services can provide, know the referral criteria •Knowing the person and whanau
	Patient/Whanau	•Understanding mental health •Stigma – patient and whanau •Access to care and engagement •Understanding the system – primary and secondary services •Whanau actively involved •Past experience of secondary care

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