Connecting care: Improving service transitions

Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga

Top tips and examples from provider project teams

The national mental health and addiction (MHA) quality improvement programme is working with Connecting care project teams from New Zealand district health boards (DHBs) to improve transitions between services for MHA consumers[1] and support a change in reporting requirements.[2] Some providers are making great progress but there is more to be done.

To support those engaged in ongoing improvement work in service transitions, the Health Quality & Safety Commission has summarised below some top tips and examples from provider project teams (August 2018 to October 2020).

For more information about the next steps for the Connecting care project, see Appendix 1.

Top tips and examples

TIP: Have a clear aim

TIP: Involve the consumer, family and whānau

Auckland DHB: Family and whānau now have a clearer role in care.

Canterbury DHB: A new transition pathway has been established that promotes consistent process while allowing for flexibility and adaptability based on individual consumer need and circumstances.

Counties Manukau Health: Feedback gathered on the experience for people discharged through improved transition of care pathway, and staff experiences using the pathway.

Northland DHB: Improvement in a transition pathway process must include the consumer and whānau in a co-design approach if the work is hoping to be effective in meeting their needs

West Coast DHB:

- More consumer and whānau feedback captured through Márama Real-Time Feedback survey.
- Independent consumer advisor surveying discharged consumers, focusing on improving the journey.
- Consumer and whānau voice and goals are visible to all and in everything the DHB does.

TIP: Include non-governmental organisations (NGOs) as part of the care team

Auckland DHB: NGOs now part of the care team.

Northland DHB: It is vital to put time into key stakeholder engagement and developing working relationships early on in the project process.

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1 A service transition is the process of managing the ongoing care for a MHA consumer who is transitioning between one health care or social service provider and another, or within a large provider, such as from one DHB service to another. For the Connecting care project, transitions include: (1) from DHB adult inpatient specialist services to DHB adult community services; (2) from DHB community services to primary care; and (3) from DHB youth community services to DHB adult community services.

2 The Ministry of Health expects DHBs to take steps to improve discharge planning and discharges, and has established DHB reporting requirements to monitor them. Since 2017/18, DHBs have been required to report on discharge planning, with targets of 95 percent of people having a transition plan at discharge, and 95 percent of audited plans needing to meet the quality standard. Since October 2020, DHBs have been required to report on community follow-up within the first seven days of mental health inpatient discharge (KPI 19/Improving mental wellbeing MH07 **https://www.mhakpi.health.nz/2020/10/12/new-reporting-requirements-for-7-day-follow-up/**).

Waitemata DHB: NGO members engaged in consumer discharge planning and support in achieving consumers' recovery goals.

Whanganui DHB: Refer to kaupapa Māori services as a first option. This is working well for some consumers and their whānau on discharge from inpatient services who, when offered, have chosen kaupapa services and then do not need to be referred to them via the community mental health and addiction service. From an equity perspective this offers direct choice to the most appropriate service for consumers and whānau.

TIP: Involve staff at every level, including senior clinicians

TIP: Have only one consolidated transition plan

Bay of Plenty DHB:

- Median of 14 percent (March 2019) has shifted to median of 40 percent (August 2020) of people transitioning from the service with a copy of their wellness/transition plan.
- One wellness/transition plan instead of multiple forms being used.

Waitematā DHB:

- Community alcohol and drug service: all teams agreed to use only one discharge letter for client and other health professionals.
- More collaborative transition planning.
- Less paperwork for clinicians.

MidCentral DHB: Standardisation of protocols and practices.

TIP: Automate your processes

Mental Health, Addictions and Intellectual Disability Service (MHAIDS):

- Increased use of telehealth (Zoom) facilities. Draft Zoom guidelines developed.
- Internal transfer of care procedure established; person is digitally tracked and monitored from the initiating to the receiving team.
- Increase in whānau engagement and communication at Hutt South Community Mental Health.
- Automated digital client notes, including service exit plans, are electronically sent to GPs when submitted.
- The GP liaison service and automated digital client notes have improved communication between primary and secondary services.

TIP: Include transition planning as a standard agenda item

TIP: Use a discharge checklist

Northland DHB: A checklist approach for standardising transitions can help staff with both a best practice guide along with providing a sense of quality expectations. But keep it easy to use – clear, simple language, not too many words and a simple format. If the checklist can be developed as a form in an application, then it can also be useful for reporting.

Waitematā DHB: Use of checklist prompts clinicians about what needs to be done to support discharge of tangata whai ora (consumers) from the service.

TIP: Inter-DHB transfer communication envelope

West Coast DHB: Inter-DHB transfer communication envelope developed.

TIP: Practise co-design

Whanganui DHB: Consumer ideas and feedback are shared at a monthly 'Conversation Café',[3] a joint effort by the Mental Health & Addiction Service, Balance, Te Oranganui Trust and Mental Health & Wellbeing Support, to 'hear the voices of the community and people with lived experience of mental health and addiction services (consumers) and their whānau' in line with He Ara Oranga.

TIP: Establish ongoing measurement plans

MidCentral DHB: Gather good baseline data on the number of transitions and alternative destinations.

Northland DHB: Creating a measurement framework beyond project close as the work moves into BAU is important to see the ongoing results of the work and can help to maintain relationships with partners in the transition pathway.

Waikato DHB:

- Huge learning about data, how information is collected, what the organisation records, and how to use Excel, designing audit tools, stakeholder collaboration and communication.
- Updating demographic data is important – the DHB now has a proactive process for keeping this information current, which has had a positive flow-on effect.

Whanganui DHB: For 7-day post-discharge follow-up data, ensure that all activity codes are entered correctly and promptly as, if not, it may appear that some consumers were not being seen when it is documented in the clinical notes that they were.

More information:

- Next steps for the Connecting care programme: see Appendix 1.
- MHA quality improvement programme: **www.hqsc.govt.nz/our-programmes/mental- health-and-addiction-quality-improvement**

3 Read the full news story about the Conversation Café here: **www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4035**.

Appendix 1: Next steps for the Connecting care project

The project was planned to run from August 2018 to December 2019 but was extended to June 2020 at the request of DHB project teams. The timeline was then further extended to October 2020 in response to COVID-19-related constraints.

Now that this extension period has ended, the project is being transitioned to DHBs, with some support from the MHA quality improvement programme team continuing. The team will:

- provide support to project teams, particularly on scale-up, spread and sustainability, on a case-by-case basis as requested or in response to data outcomes
- monitor community follow-up within the first seven days of mental health inpatient discharge data, and provide support to DHB project teams as required
- produce one video illustrating a consumer's lived experience during a service transition, as part of the 'Pono' consumer video series we are developing for the different projects (see Kolini Baker's story).[4]
- develop a transition report with the most important learning from the project
- undertake quarterly interactive networking sessions via Zoom, driven by project teams, to enable project teams to network and share successes and challenges
- continue to profile Connecting care project work and achievements.

Connecting care data

The best nationally available Connecting care data is for the adult inpatient to community transition. In partnership with the MH&A Key Performance Indicator (KPI) Programme, it was proposed this data is monitored through the requirement of DHBs to report to the Ministry of Health on community follow-up within the first seven days of mental health inpatient discharge from October 2020.

Since March 2021, this data has been available to the Health Quality & Safety Commission, to interrogate and report via the KPI Programme dashboard, hosted on the KPI Programme website. Other transition-related indicators will be progressively added to the KPI Programme dashboard, such as 28-day re-admission rate and transition plan in place. (See article, 'Reinforcing our 'why' – the importance of 7-day follow-up for tāngata whai ora'.)[5]

It is not possible to have oversight of DHB community services to primary care and DHB youth community services to DHB adult community services transition data, because this is not collected in PRIMHD[6] and there is no requirement to report this data. Some of this data may be held in primary care but there is no national data set currently available.

4 Health Quality & Safety Commission. 2021. *Connecting care: improving service transitions – Kolini Baker's story. URL:* **www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4305**.

5 KPI Programme. 2021. Reinforcing our 'why' – the importance of 7-day follow up for tāngata whai ora. *The Indicator 3.* URL: **www.mhakpi.health.nz/2021/06/03/reinforcing-our-why**.

6 PRIMHD is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers. www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data.