Health Quality & Safety Commission New Zealand

Connecting Care national collaborative

Waitemata District Health Board: Specialist Mental Health and Addictions Services (SMH&AS)

Aim

Improve consumer experience of the quality and safety of their transition from community specialist secondary services to primary care and achieve easier, better processes for clinicians. This will be evidenced by incorporating co-design themes to achieve outcomes, including improving the quality and quantity of transition plans from 17% and 54% respectively (all teams, June 2018) to 80% by June 2019 and the overall target of 95% success.

***Source: Audit, June 2018**

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NZ Triple Aim:
population (health & equity), individual (quality, safety and experience of care), system (value, team, resource) = better outcome for consumers and easier for team

IHI model https://www.hqsc.govt.nz/news-and-events/news/126

- Appreciative Inquiry"
  - Discover: what works?
  - Dream: what's ideal?
  - Design
  - Deliver

Project team

Project teams and steering group											
Project team members	CY&F	Whikiki Maurea		Adult MH			CADS		Asian MH	Takanga a Fohe	Forensics
	MMH	Moko	Te Atea Marino	N	W		Regional	Regional	N/W	Isa Lei	FCT
Steering group	CY&F	Whikiki Maurea		Adult MH			CADS		Asian MH	Takanga a Fohe	Forensics

Engage: key stakeholders – elevator pitch

e.g. Forensics Community Team: Hi (name). You were discharged from our service (time ago). We would like to know how you experienced moving from one service to another. This will help us to improve on the process in future. Would you be willing to share your experience with our consumer liaison person? You can bring a support person

e.g. Adult MH (North): We have talked about how you are in the process of being discharged to GP care. We are looking at how this process can be done best. Could we ask someone to contact you, to get your views on what has worked well so far and what could be improved? You can choose to speak with them or me or both of us, at a time and place that suits you.

e.g. CADS: I am gathering feedback and opinions about how clients feel about the transition from specialist or secondary care to primary care (at this point I define secondary care and primary care using 'CADS and your GP' as examples of the two). We are hoping to find out what works well and what could be improved and would really appreciate it if I could have a chat with you and also ask some questions.

e.g. Takanga a Fohe: You have been discharged from our team to the care of your GP for some time now. We are very keen to understand what has worked well and what could be improved for that discharge process. Would you be able to help us by sharing what it was like for you, what was good or not so good and any ideas that you have?

e.g. Adult MH (West) Hi (person's name). We have talked about how you will soon be leaving our Service and transferred to GP care. We are looking at how this process can be done best. Would it be okay if someone contacts you in a couple of weeks' time, to get your views? They will arrange to meet with you at a time that suits you.

As you are soon moving to GP care, could you tell us what you think is helpful to people when planning their move?

Yes/No/Maybe			**If not already mentioned above, could you tell us whether the following items matter to you:**
Y	N	M	Talking about my goals for discharge together with my treatment team, early in my treatment
Y	N	M	Having a clear plan on what I will keep on doing after my discharge
Y	N	M	Being clear about any early warning signs I and/others should watch for, after I move
Y	N	M	Being clear about what I will do if I need extra support after I move
Y	N	M	Having a summary of my discharge plan for my own use
Y	N	M	Having a summary of my discharge for my GP to use, if the GP is involved with prescribing my medications
Y	N	M	Having my family, whānau, friends or other support people I agree to being involved in my treatment and discharge plan
Y	N	M	Being clear on who will prescribe what medications for me

Anything else?

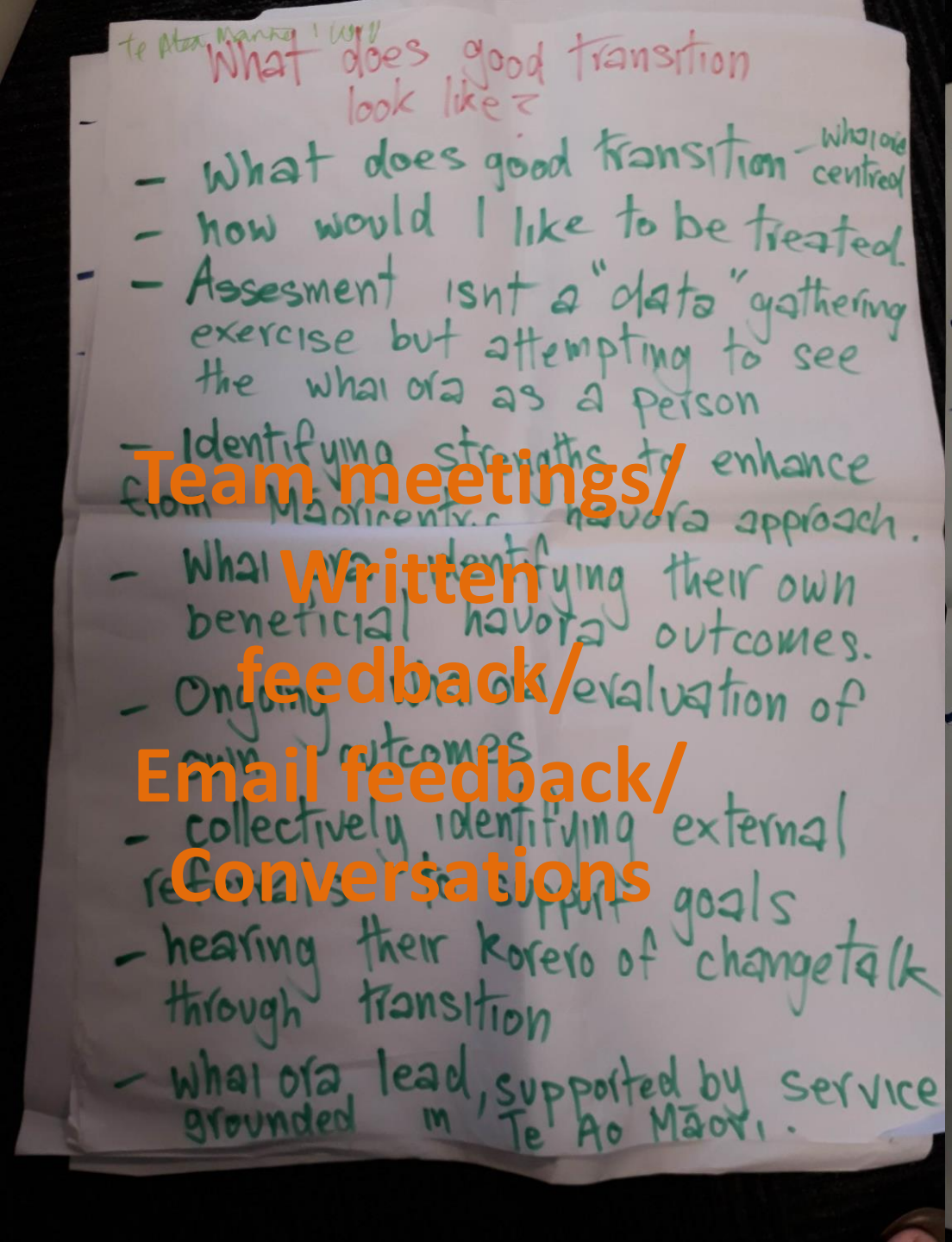
My feelings about moving to GP care:

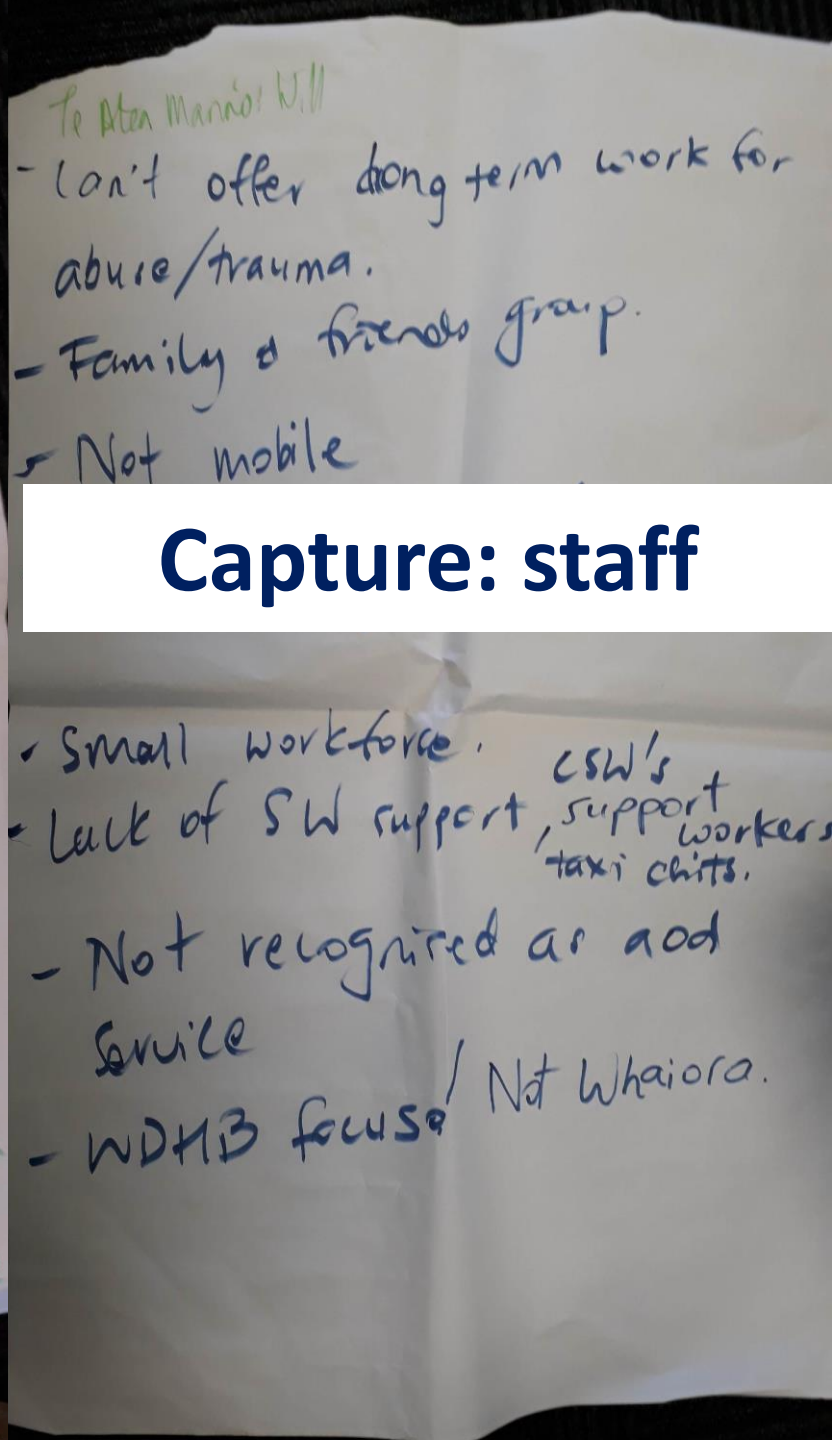




Could you tell us more about that?

This is how I experience how my move has been planned:					
1	**2**	**3**	**4**	**5**	**6**
Really bad	Bad	Less good	Quite good	Great	Excellent





Team meetings/
Written feedback/
Email feedback/
Conversations

Capture: staff

What does a failed transition in primary care look like

- They don't want to go to other services ... ie C.P. N.A. ACC. MH
- Needs not met from our service whanau, cultural ..... accommodation
- They don't want to return to their whānau support systems ....
- We have limited resources
- Whakawātea / Pōhiri
- Short term interventions
- We don't offer a cultural process resources ...
- Whanau focussed
- Weekends / after hours

Stakeholders

lifewise (housing first) - Maslows heracky of needs

Whānau, hapu, Iwi

- G.P, - partnership
- Probation - community workers.
- Social workers. - community
- peer support support workers.
- Enhanced perspective of whai ora

Capture:
Takanga a Fohe: clinical and cultural teams

- Planned: set in place at first appointment. Introduce to NGO early; start discussing discharge three months in advance
- Service information is current: HONOS, client details in HCC (address & GP details)
- Person is stable in treatment, understands diagnosis, good medication management; knows what service can and cannot do
- Family involved: support/understands transition process; improve % to %; start putting plan in place when MH improvements seen
- Social situation stable, reduce social barriers to discharge; plan re WINZ entitlements, adequate accommodation
- Practical support for GP appointments: phone call to GP, good handover to GP and CSW for ongoing support
- Use outcome measures (HONOS) better
- Post-discharge follow up after 90 days
- Written: collaborative written recovery plan with early warning signs/SNAP assessment; good written discharge summary, involving service doctor; GP knows crisis contact details
- Process is used: service knows and works with clients with different needs (moderate-severe versus episodic care/brief service; 10-5-2-1yr-6 months-(different stages of life); consistent approach to deciding on discharge approach; reduced risk of continued dependence/keeping client unnecessarily. Involve MDT and other treatment team members (cultural advisor – language/spiritual culture); consider events e.g. suicidal thoughts, hospitalisation, good risk assessment, static and dynamic factors
- Measures : admission versus discharge (12 months)

Capture: Adult MH (N) team feedback

- Starting to have the conversation at the start of their admission to service and not wait until nearer the end.
- Episodic care: have the conversation about expected length of stay in service on arrival.
- Good information, not scant. Information for GPs to be succinct and informative plus have information about what services could be contacted as an alternative or alongside. Reminding GPs primary of what else is available.
- Give clients other information ie helpline and other phone numbers. Perhaps this could be populated automatically somehow.
- Reciprocal guidelines for GPs to refer back to specialist services
- Personal details complete and correct
- Automatic generated health lines numbers acute etc.
- Team know what standards are involved
- **Gps want:** What happened? What to do if it happens again and medications and what they are used for.
- Clear recommendations to GP, know purpose of referral, or what they would like us to do
- Relapse prevention plan / Symptom check list for clients and be specific about what they can do when symptoms present. List of the tools they have developed.

AND…we know what we want to do and need to do, but process set up to fail (e.g. discharge/handover/no MDT or KW input)

Capture:
Moko team

- Tikanga process: Whakawatea = clearing a road forward
- Hui with whanau & tangata whaiora to discuss their Involvement and service from MOKO
- Review of treatment planning , cultural clinical all objectives, tasks
- Discharge is realistic, planned (not rushed or delayed); providers can provide the care needed/costs/distance other needs
- Discuss discharge summary; what do Whanau Tangata Whaiora want to see in summary
- Concise plan, clear, all stakeholders follow plan
- Cultural input are informed by ' Piki te ora Piki te Maramatanga; cultural tool identifying learning, achievements
- Aware of who does what, know what to do if needing more help and support, can return to specialist care if needed
- Communication and relationships: better understanding , participation, informed whānau consent, participation, involvement, responses, reduced reactions if not treated with respect and understanding
- Treatment team: clinical and cultural work together; involve whanau haup iwi living in area
- Whakawatea : farewell
- Clinical documents current: risk, history, cultural
- Planned handover: transport to handover if possible, knows WINZ certificate due date, appointment date
- Whom else to speak with? Tangata whai ora, NGO's, whanau, GP, friends, peers, taurawhiri, OT, social workers, oranga tamariki , anyone part of the individual's care plan – give them a survey form

Forensics Community Team: Case study, Mr N

- 40-plus NZ European man. Schizophrenia, substance use disorder, antisocial/narcissistic personality disorder; multiple criminal convictions incl. violence; 30-plus convictions from aged 17 yrs; prison time; index offence (2002), after 8 years custodial sentence
- Mason: several admissions, again 2011-2015. Poor insight into his illness, unable to form feasible plans, persecutory ideation
- Community: 2015-2017; Clozapine changed to Amisulpride, CTO rescinded; stable, engaged. Discharged to GP
- 2017: 2 CMHC contacts for concerns about relapse. Not presenting overtly psychotic; possibly concealing symptoms
- April 2018: Waiatarau admission; referred to Mason (presentation; threats - ex-partner & ICU staff; forensic history). Assessed, presented to admission panel – agreed readmission with proposed rehab pathway back to community . Currently in medium secure unit.

Capture: Forensics Community Team

Ideas

- Building better GP relationships: skills development, building a body of trusted providers in primary care for post-discharge follow-up
  - Goal is to increase awareness of how to attend to early warning signs in primary setting
  - Skilled primary care services for high-risk needs after leaving Forensics Community team

Connecting Care: SMH&AS project, 2018-2019. Transition/discharge from secondary to primary

Clinician feedback, Sept 2018: what does a good transition look like, for people receiving specialist mental health and addictions services

Referral

Client is asked *whom* they will bring to appointment/s

Admission

Discharge planning begins. *(e.g. goals are set articulating what wellness means for client and what supports are needed to achieve the outcome of discharge)*

Episodic care: expected length of stay is discussed

Cultural and other supports: addressed from treatment onset. Tikanga process occurs with Whakawatea *(clearing a road forward)*

Social outcome indicators recorded in client file via demographics form *(housing, employment, work/study)*

Collaborative treatment reviews

Discharge planning is the overall treatment aim *(e.g. client actively engaged in review and able to articulate what wellness means for own needs)*

Specific needs are met *(e.g. long-term treatment outside of clozapine programme)*

MDT consultation occurs. Systematic reviews for special factors *(e.g. treatment longevity; clozapine)*

Clinical treatment needs met *(e.g. needs relating to frequency of mood factors/suicidality/post-hospitalisation care)*. Information is current

Client is well-prepared for transition, in advance of next step *(e.g. articulates own care plan with GP)*

Other stakeholder relationships well established and involved in review and discharge planning *(e.g. CSW, cultural services, other specialist team)*

Collaborative review is meaningful to client *(e.g. client has copy of collaborative plan; SNAP/needs assessed)*. Client able to articulate early warning signs, gives feedback to clinical process. Consensus sought wherever possible and any barriers are managed. Family and whānau contribute *(e.g. whānau and Tangata Whaiora hui, to discuss involvement and clinical treatment)*

Treatment tools provide outcome measures from baseline *(e.g. HONOS/ADOM)*. Sufficient flexibility is in place to meet specific needs within resource availability. Social outcomes are well-documented, resource/supports addressed (*e.g. WINZ relationship for entitlements, pursuing adequate accommodation, support for attending primary care appointments and relationships in place with support via NGO)*. Practical needs are planned *(e.g. access/transport to GP/NGO/group sessions)*

Discharge planning

Client actively involved in discharge planning and has copy of plan

Client is asked whom they prefer involved in discharge plan. Nominated family/whānau involved in planning, confident on role and have a copy

Coordinate medications (*e.g. one pharmacy for all prescribed addiction, mental health and primary-care meds)*

Practical steps are planned *(e.g. next WINZ certificate/GP appointment)*

Discharge summary easily generated from collaborative review. Includes whom and how to contact if client/GP need support (*e.g. acute, after-hours helpline, group, CSW, NGO)*

Transition environment is supportive, engaged, informed and suitable

Phone call to practice (*if discharged to primary care)*

Phone call to pharmacy *(if prescribed)*

Discharge summary finalised in HCC so that it uploads to ASPIRE. GP information is current

Discharge steps and post-discharge care

Handover steps are well-managed and well-planned. Post-discharge services involved well before discharge and are involved in planning discharge together with client, family and whānau

Checklist: review/treatment & discharge

- ✓ Clinical history updated
- ✓ Cultural information & plan evident
- ✓ Risk assessment, static/dynamic factors
- ✓ Early warning signs known, documented
- ✓ Client involved in planning
- ✓ Evidence of client involvement
- ✓ Client has a copy of plan
- ✓ Client address/phone updated
- ✓ GP's details updated in client file
- ✓ Updated social outcome information
- ✓ (housing, employment, work/study)
- ✓ Client and GP know (& in written plan):
- ✓ - steps for support if needed
- ✓ - whom and how to contact supports
- ✓ Other involved services attend planning
- ✓ Family & whānau engaged throughout
- ✓ Mutually respectful, safe, well-supported
- ✓ Meets best practice standards
- ✓ Client and team know what to do
- ✓ Finalise letters in HCC

Connecting Care: Transition from Secondary Mental Health Services to Primary Care

Clinical team views: What does a good transition look like?

PROCESS

- **Admission/recovery treatment steps:**
- Goals: what wellness means for client
- Involve cultural supports early*
- Involve stakeholders at onset of treatment:
  - Family/whānau, friends, employers
  - NGO/CSW/probation officer
  - Supportive transition environment planned and involved early
  - Other specialties or services, internal/external
- Determine estimated length of episode of care/admission
- **Collaborative review/treatment plan:**
- Collaboratively done together with client, support people/family/whanau,, others
- What to continue doing, early warning signs (EWS), relapse prevention plan (RPP) and supports - whom, how, when to contact
- Address practical needs for discharge (e.g. WINZ benefit, GP appointment/accessiblity)
- Copy given to client
- **Measures updated:**
  - Outcome measures (e.g. ADOM/ HONOS)
  - Social outcomes (work/study, housing)

COMMUNICATIONS

- **Clinical information/front page updated:**
  - Client and GP information
  - Client demographics
  - Alerts if needed
  - Mental Health Act status and documentation, if needed
- **Call relevant services**(e.g. pharmacy, GP)
- **Discharge plan and discharge letter:**
  - Collaboratively planned with client and other supports (family/whanau, NGO/CSW)
  - Medication - clarify who prescribes psychiatric/addiction/physical health medication
  - Current main issues, diagnos/es
  - Plan/what to continue
  - Collaborative review/treatment plan information: EWS, RPP and contacts - whom/how/when
  - Finalise letter (to upload to ASPIRE)
  - Copy to client

Capture: consumers (Asian MH)

- Rapport has been built, friendly, safe
- All parties agreed discharge plans
- Confirm client wellbeing before discharge
- Include family and CSW when planning discharge & attend planning session
- Include allocated cultural support
- Hear and respect person's opinions at review meeting
- Client and family's decision respected and well heard
- Be aware of difficulty people have with hierarchical culture, which trusts and respects professional authority

- Discharge when sufficient treated
- Understands treatment process toward discharge
- Understands referral process if need help again
- Informed: knows about plan, aware of timeframes, knows what to do and how to contact team if needed
- Planned – face to face, phone, letter so client is aware
- Follow up a month later to help with confidence and coping skills in real life situations – important to prevent relapse
- Speak to: family, friends, NGO CSWs , pharmacists, community/private counsellors
- How: Online survey, onsite survey, email discharge evaluation, face to face meetings, text, phone call

Capture: GPs
(first response; starting to collect)

- GP wants concise information, e.g.:
  - Medication
  - Situation
  - Plan
  - Contact details

e.g. 4760 CADS clients: 64% have valid GP and 36% do not;

GP involved if there is purpose (e.g. healthcare/medication/ referred by GP)

Capture: NGOs - Procare

- Want to know if person still open to mental health service
- Want to feel we are not the default referral for discharge
- Want information – told to obtain from GP or ask client; often GP hasn't had anything anyway, service may not have written references to referral, unwilling to release info
- Need to be able to call service directly with consistent access
- Want feedback if we refer a person TO service (GP usually informed, but not referrer)
- Want key worker access - more so than medical medication information from service

Capture: NGO's, Takanga a Fohe

NGO themes:
Promote health care visits: need to help clients with at least four free GP visits per year – encourage GP visits when needed
Ensure planning: not walk-in, but pre-planned
Right service needed: e.g. some GP's can't prescribe certain meds
Communicate: sometimes we as support staff are the last to know the client has been discharged to GP; we need first hand information
Collaborate: we can sometimes support clients for up to two years after discharge to GP so we should work collaboratively to come up with good discharge plans for support (not just as 'taxi' service)
Inform: ensure clients know about costs of GP visit; explain benefit and disability allowances

Capture: consumers
Takanga a Fohe

Consumer themes: - starting to collect, two so far – both talked about the value of continued support
Continued support made the difference: - CSW support post-discharge to primary care (continued support up to two years) - Continued clinical support post-discharge (review of consumer's needs with Clozapine).

Ideas generation: Takanga a Fohe team

Involve NGO at an upcoming discharge planning meeting, soon which is something we used to do routinely

Involve family members at an upcoming discharge planning meeting, soon if possible to work through the challenges which prevent this happening e.g. can be difficult to contact, or working fulltime, or not connected with the consumer or difficult for other reasons

Test out doing early planning, for a consumer, soon: if a consumer is going to be discharged in the next two or three months, have an advance review meeting which talks about the future plan toward discharge

Capture: CADS team

A way for the client to know the next steps

The receiving service knows what the plan is for the client

A focus on transitioning, rather than discharging – described as an ‘easy in and easy back’ approach as needed

An appropriate continuation of care

Community Alcohol and Drug Service, Auckland Regional Service

Broadly two types of services:

Medically assisted - detox, opioid substitution

Non medically assisted - counselling

CADS Co-design

How

- Client interviews (telephone and face to face)
- Clinician feedback via meetings and email*

What

1. What would you want communicated with your GP?
2. What would you like your GP to do with that information?

CADS results:

1

- Reason for attending CADS 48%
- Services involved 48%
- Early warning signs 48%
- Medications prescribed 48%
- What their 'treatment' with CADS consisted of (e.g. groups attended or 1-2-1) 22%
- Client's plan for the future 22%
- Risk issues and management plan*
- Information on other supports and services (NGOs, respite, AA etc.)*

2

- just go in their file (most common response)
- one said the GP should discuss it with them if it is relevant
- Use it to review my medications
- Be aware of services I'm involved in
- Address risks, areas of concern*

CADS:

Of note:

- All expect a copy (Nothing about us without us)
- Don’t want CADS communicating with my GP at all 4%
- Less than ¼ were aware that CADS may communicate with their GP
- Makes more sense to communicate with GP when medications are involved rather than for talking therapies
- Clients must engage in primary care prior to transition*

Concerns:

- Implications for us if letters are being sent eg. Health insurance risks
- Where does it go? Who can see it? Will it follow me?
- I wouldn’t come to CADS if communication occurred with my GP

Change ideas:

Service needs to review “sharing of information” discussion that is mostly had only at time of entry to the service

Unplanned discharges – template, less slaving over wordsmithing

Ideas generation

Moko: 3-plus years in treatment (61 of 160), to:
-review with consumer and family/whānau advisor
-plan toward discharge planning meeting together with whānau and key worker of GP practice
-achieve planned transitions

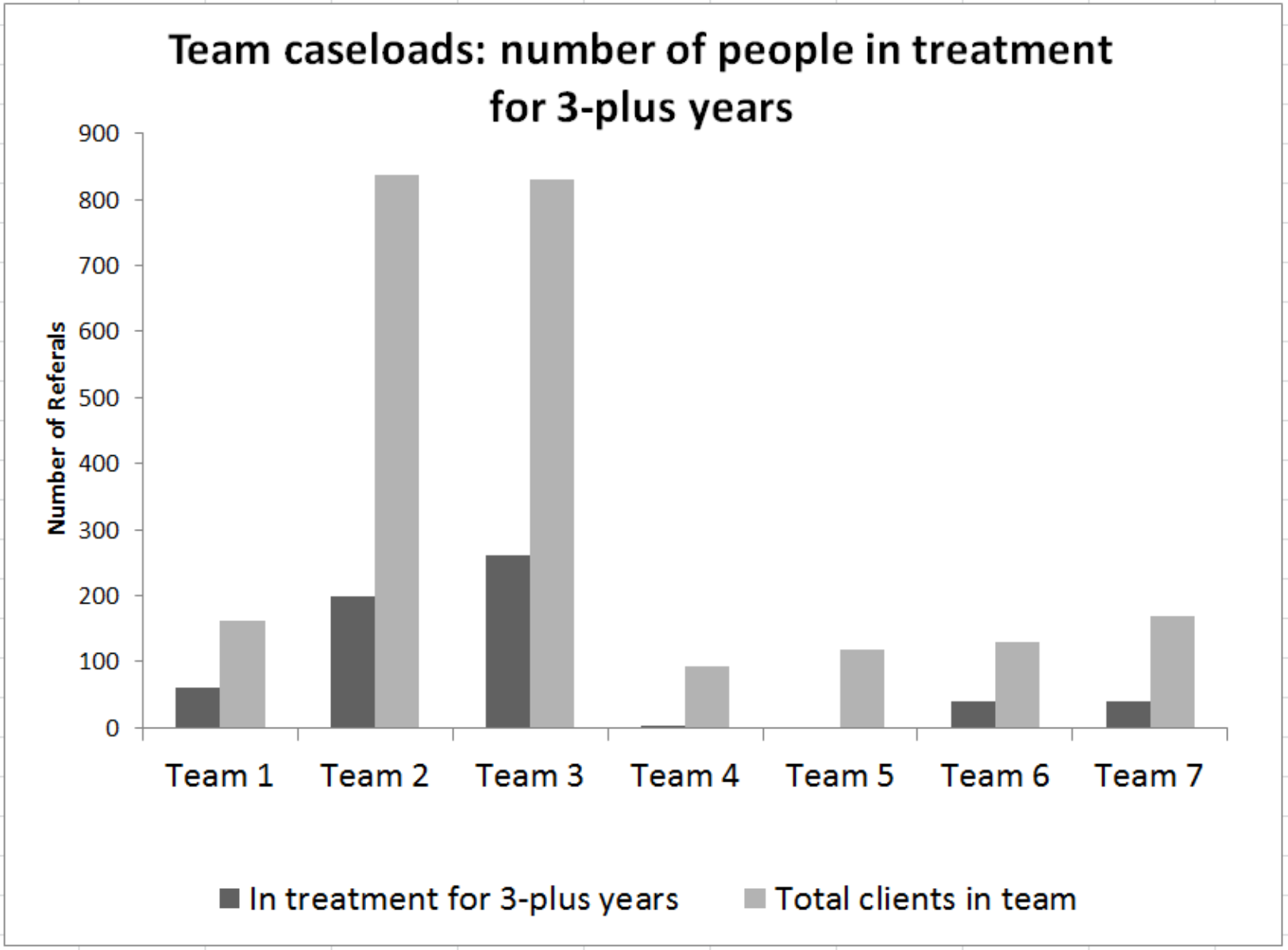
Adult MH North: focus on pre-discharge process

Forensics: GP relationship, build skills (above)

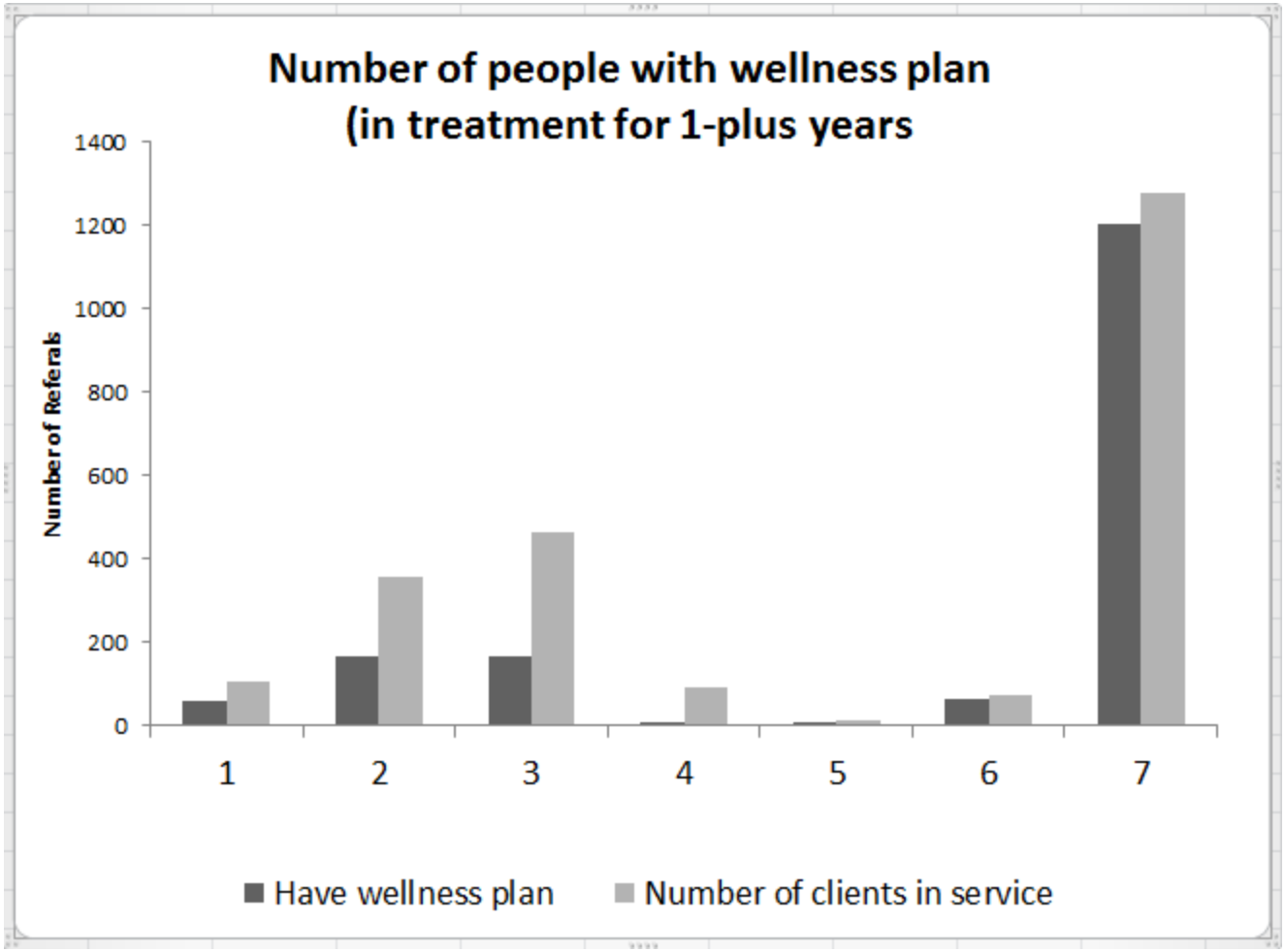
Takanga a Fohe: early planning with family, NGO

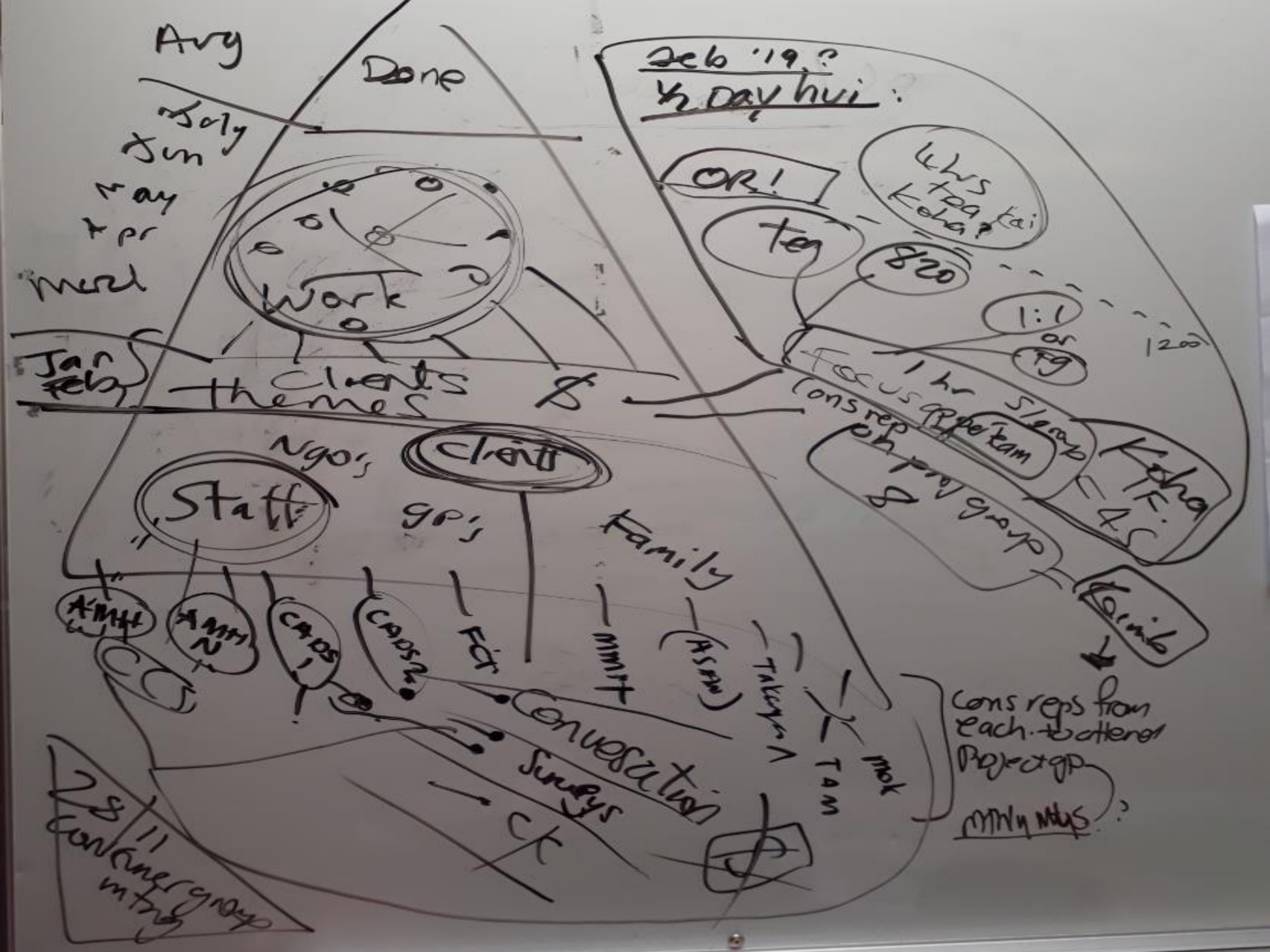
Measures list	
Percentage of clients with plan	
Percentage of plans which meet standards (hand-search/audit)	
No. discharge summaries ‘finalised’ for ASPIRE	
Clinician confidence (PDSA) with use of process – individual feedback/forms	
Consumer feedback about transitions (compliments/complaints)	
No. clinicians with co-design training/collaborative note-taking skills/……?	
BALANCING MEASURES:	
Average length of stay in treatment (MH, excludes CADS, forensics)	
No. consumers returning to treatment within 3/12	
No. consumers under CTO	
No. consumers with frequent episodic care, MH	

Adult community mental health teams 15/11/2018



Community SMH&AS 16/11/2018

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Koha
Ngo's
Clients
Staff
GP's
Family
Conversation
Surveys
Cons reps from each to attend Project gp
28/11
Consumer group mtg

Understand

What did you understand: emotions and ‘touch points’ along the journey of care?

Co-design themes so far

Early planning with relevant others
Communication well in advance
Collaboration between services
First address practical needs

Shared learning

Engaging our own team members as stakeholders is significant, time-consuming and necessary.

Encouraging people to make their views more useful by channelling feedback into project ideas (rather than unused water cooler ideas).

Connecting Care national collaborative

Perinatal & Maternal Mental Health Service (PMMHS)
Waitemata District Health Board

Overarching Aim

The overarching aim is to collaboratively support recovery and achieving best outcomes for service users.

Our SMART Goals

- **Specific** – Focus on strengthening the discharge and transition planning in the Perinatal & Maternal Mental Health Service

- **Measureable** – we will utilise a suite of satisfaction surveys for service users, clinicians, and other service stake-holders (GP's & Practice Nurses). We will also review service data to evaluate successful transition between service tiers

- **Attainable** – We will ensure the buy-in of all stakeholders by providing information and opportunities for input and feedback into the improved processes

- **Relevant** - We will utilise a co-design approach incorporating appreciative inquiry, to ensure the revised processes are meaningful to recipients of services and service providers, and give consideration to the child & family inclusive and systemic practice relevant to the target population.

- **Timely** – We will work to a timely project plan which provides sufficient time for appropriate consultation, collating of information and implementation of a test phase and review.

Project team

Perinatal & Maternal Mental Health Service Project Team

The Child, Youth & Family Mental Health Portfolio members are:

- Tania Wilson, Primary Care Strategy Coordinator/Clinical Psychologist (Project Lead)
- Selena Griffith, Innovations & Quality Co-ordinator/Registered Nurse
- Sharon Logan, Nursing Advisor/Registered Nurse
- Synthia Dash, Family/Whanau Advisor
- Gill Graham, Team Manager
- Wayne Forsythe, Clinical Coordinator/Occupational Therapist
- Kelly Konsten, Social Worker/Family Therapist

With support from

- Epenesa Ola-Whaanga – Acting Operations Manager
- Mirsad Begic – Service Clinical Director

Engage

1. *Identify key stakeholders*

We have developed an engagement plan which will remain a ”live” document to ensure key stakeholders are identified throughout the co-design process. Targeted stakeholders will include the following:

- Service users (past & present)
- Mental Health Clinicians
- GP’s
- Nurse Practitioners
- Practice Nurses
- & other key stakeholders

2. *Promote the Connecting Care Project with Promotional Pitch* targeted to stake-holder groups

3. *Meet & engage* – providing information & addressing Q & A

General Pitch

National strategic directions highlight the importance of continuing to develop collaborative and integrated models of connected care which support early intervention, and transition to the right service for the right level of need with services across the care continuum working together to mitigate unmet needs

The Perinatal & Maternal Mental Health Service is keen to capture the experiences and ideas of service users, clinicians, Mental Health clinicians, GP's & Practice Nurses across the care continuum to help us to improve our transition planning processes to:

- *Improve the coordination between primary and secondary services*
- *Enable smooth transitions between services and exits from services*

Our overarching aim is to collaboratively support recovery and achieving best outcomes for service users.

Our Pitch for Service Users

We are working on a project to improve and strengthen your ongoing care once you leave our service and are discharged to your GP. We want to make sure the transfer of information is smooth and timely.

We would like to invite you to share about your discharge experience or how you would prefer for this to happen. We would appreciate your ideas and suggestions to help us do this.

If you are willing to participate in this project and work with us to improve our processes please complete the checklist below and let us know what would best work for you, so one of our project team can get in touch

- Best contact (Please circle) By phone / text / email
- Preferred times (Please circle) Mornings/Afternoons/ Evenings/Anytime

Please let us know how you would prefer to share your experiences with us.

a. Individual meeting
b. Small group with other service users
c. Via a Electronic Question and Answer survey

Capture

- **PMMH Clinicians** – Workshop using Process Mapping taking an Appreciative Inquiry approach.
- **Service Users** – Offer 3 options (small focus group, or individual interview, or electronic survey)
- **GP's & PC clinicians/practitioners** - Offer 3 options (small focus group, or individual interview, or electronic survey)

PMMHS Project Status

- ✓ We have developed Project plan
- ✓ Developed a draft engagement plan
- ✓ Identified service driver team
- ✓ Commenced promoting the project
- ❑ Nov – 2018 Promotion of the project to key stakeholders
- ❑ Nov – Dec 2018 Will begin the co-design capture late Nov-Dec
- ❑ Jan – Feb 2019 Collate data, identify themes & review with existing best practice guidelines
- ❑ Feb- March 2019 will develop new process, information , templates & satisfaction questionnaires. Also establish service data capture protocol
- ❑ 1 April 2019 – Implement new transition planning process with quarterly reviews.

Understand

What did you understand: emotions and ‘touch points’ along the journey of care?

Co-design themes

What themes have emerged from your co-design process so far?

Ideas generation

What change ideas have been generated through your co-design process?

Measures

What is your outcome measure?

Include any baseline data for your chosen outcome measure if available.

Shared learning

What have you learnt that would be useful to share with other teams?