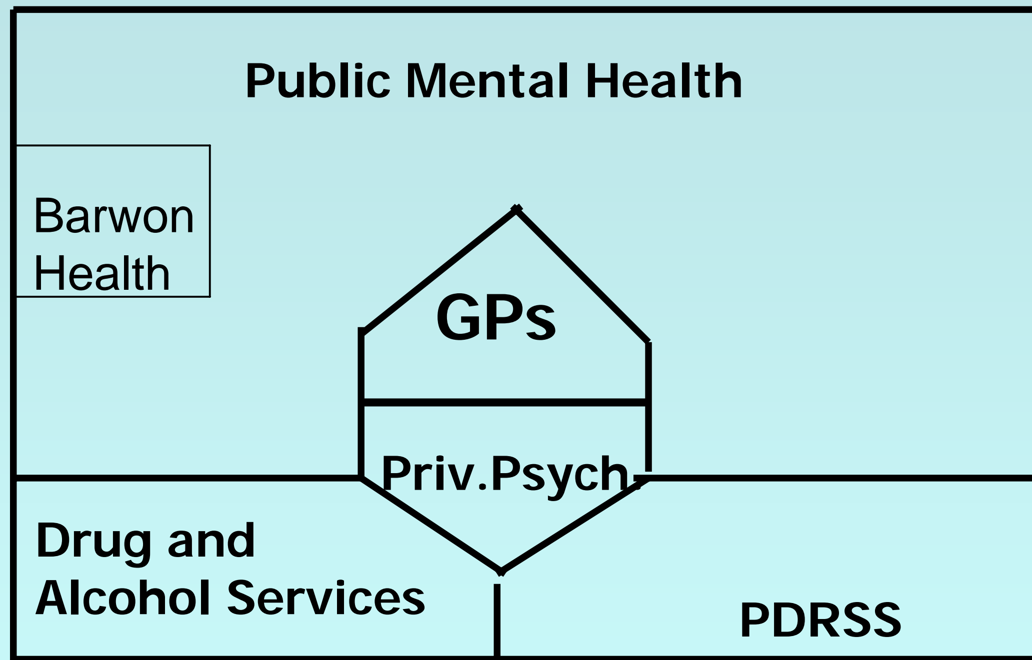
JOINED UP SERVICES ON LINE: SHARED FILE, SHARED CARE.

Barwon sub-region - Victoria – June 2007

Barwon Health
(Acute and Community Mental Health)
and
Pathways Rehabilitation and Support Services Inc. (PDRSS)
and
General Practitioners Assn Geelong

Mental Health services have at least 5 boundaries to manage with each other



All have different systems of record keeping, reporting requirements to Government, thresholds for ‘taking on’ and ‘case closing’.

Current system design blocks continuity of care, encourage ‘boundary protection’ (and energy). Unrealistic expectation of staff with current tools.

Other more recent key drivers

1. COAG National Action Plan on Mental Health.

   Provides: a strategic framework that **emphasises coordination and collaboration** between government, private and non-government providers

2. Victorian future directions for mental health e.g The Boston Consulting Group (BCG) promoting

   - Access, connectedness etc.

Evolution of The Care Manager (TCM)

1996 – Mental health in Barwon - Assessment and Care Evaluation (**ACE**) system - -paper modules tracked the case management continuum (similar to SCTT)

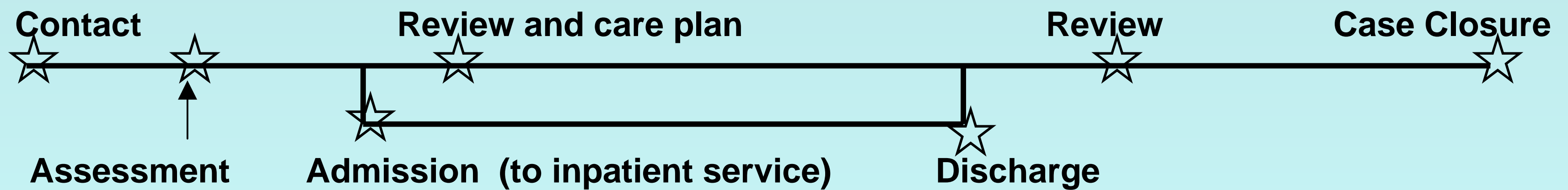
1997 - Obvious that ACE could be computerised – Development of **MH-PIMS – computerised patient tracking system** – not clinical notes but crisis plans

2005 – decision to further develop MH-PIMS (despite introduction of State-wide MH system (CMI-RAPID - which was not connectable locally) → TCM

Case management system

Contact Record
Team Intake Record
Decision point
In-patient admission
Psychiatric Assessment and Service Plan
Decision point
Inpatient Discharge Summary and Service Plan
Decision point
Team Review - Case Closure
Decision point
Individual Service Plan (if case managed for 3mths.)
← Annually
NO TEAM FOLLOW UP

TCM based on simple 'backbone'



Virtual integration - TCM

- Mental Health, Drug Treatment Services, Psych. Disability and Rehab. Services (PDRSS) and Community Health (in partic. emergency department admission prevention program) worked on the system together – **all now use the same system – Electronic Record** (since Oct ’05)

- **Master system – PIMS (Barwon Health) – generates single UR No. -** priority given to connectivity with local systems (rather than State-wide system) – CORDis (electronic discharge summaries), acute care, pathology etc.

- Single system to capture clinical information, Commonwealth outcomes data, benchmarking data

- All can access, and contribute to, a ‘Shared Crisis Plan’

- Plan to extend TCM to all of Community health, the basic system to be used by headspace, connectivity with GPs.

Care notes, entries visible

History: Mr Renzo Bortelotto

New Event Episode Print Add-Ins Close!

UR No: 00001/2
Status: A
Registered: 4/04/1999
Accepted: 7/04/1999
Services: 9/04/1999
Completed:
Name: Bortelotto, Mr Renzo
Address 99 Anderson Drive CARRUM DOWNS 3201
Telephone 9577-9999
DoB: 16/02/1924
Sex: Male
Language: Italian
C of Birth: Italy
Indigenous Status: Non-indigenous
Mar. Status: Widowed
Municipality: Frankston
Fund: CACP
GP: Dr Jack Knobel
Care Mgr: Moyle, Des

Episode (All) Show Most Recent
Show Group Events — Summary / Details / List
Show Revoked Events Audit Off
N/A
Program Advance Search
Details Add New Save Current View as Default

May 2006

22/05/2006 15:23 — **HoNOS-65+**
Scores: 232323323234

January 2006

02/01/2006 14:16 — **Program Milestone - Accepted**
Program: SACS Program - Sub-Ambulatory Care (0000013)
Provider: Brotherhood Community Care

December 2004

14/12/2004 — **QDC - Service User**
Summary Info: QDC - Service User
STO Code: 555205
STO:

January 2004

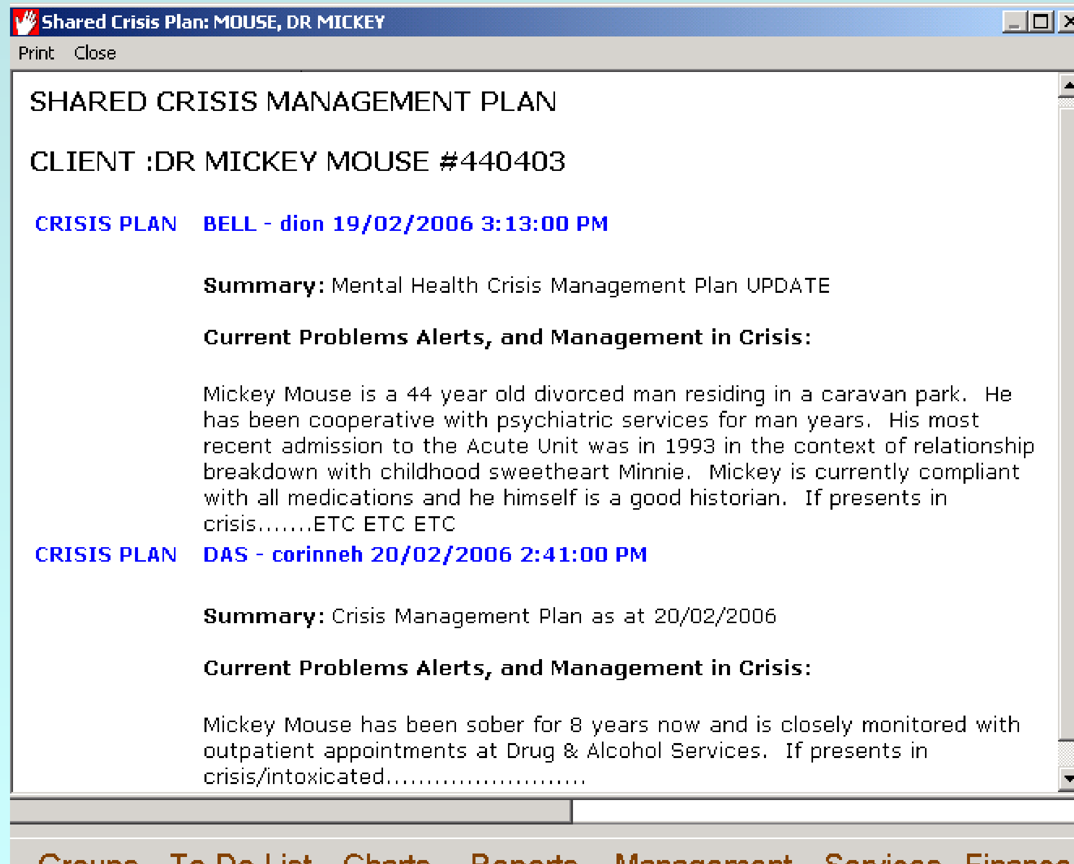
16/01/2004 — **Correspondence**
Title: Weekly Schedule 12 01 2004 to 18 01 2004 for Mr

Edit Episode... Close

start 4 Mi... TCM ... TestT... Cath... Micro... The ... untitl... 99% 2:36 PM Wednesday

SHARED CRISIS PLANS

All involved programs are viewable, but not editable, to all TCM users



ORGANISATIONAL CONTEXT

Consistent pattern of goodwill between the organisations.

Dialogue and action at the leadership level.

Examples of good, practical working relationships:

Share a part time Neuropsychologist – service contracted to Pathways by Barwon Health

Joined up programs – Homelessness program (HOPS,)with mixed staff.

- Early intervention Services

- Headspace collaboration

- Eating Disorders Service – a 3 way collaboration

Direct partnerships - Aged Care.

Both agencies wanted to look at electronic case files.

CLIENT CONTEXT

"Our" clients are presenting with more complex needs:

Chronic psychotic illness

Substance abuse difficulties

Self care difficulties - disorganised

These clients require a 'support team' approach:

AREA MENTAL HEALTH SERVICE

GENERAL PRACTITIONER

DRUG TREATMENT SERVICES

PSYCHOSOCIAL REHAB SUPPORT

SYSTEMS CONTEXT

At worst:

The client is forced to go from service to service

There are boundary issues for agencies

Different records are kept in each service

Privacy concerns between agencies

The obvious risk that separate Care Plans are created.

At best there is client centred care:

The client is involved in an interagency team - no gates

Agencies collaborate around one Care Plan

Agencies have clear roles

There is relevant, timely information available to team members.

A STEP IN OUR EVOLUTION – EMBRACING emerging State and Federal system reform agendas

A little history:

- In 2003 Barwon Health, Pathways and the GP Association developed a simple paper based ‘Common Care Plan’ because agencies were already doing some form of care plan - without knowing of other partners.
- The ‘Common Care Plan’ resolved issues like common assessment tools, approaches to generating care plans and GP items to support involvement in care plans.
- The Service Co-ordination Template Tools from Department of Human Services - including a Service Co-ordination Plan - were rolled out in 2003/4.
- - funded by DHS
- - evaluated by AIPC – funded by Barwon PCP
- - investment by Barwon PCP still continuing.

THE NEXT LOGICAL STEP IN THIS EVOLUTION

The next goal was to establish a shared electronic file:

- *Already had access to a wide area network*
- *Already had agreed assessment tools*
- *Already had the SCTT system on line*
- *Already had a culture of collaboration.*

The next step involved working with the developers of The Care Manager (TCM) to ‘customise’ their program to our needs.

- *Include assessment and outcomes measures tools*
- *Add in the SCTT and QDC process.*

THE CARE MANAGER IN BARWON

Barwon Health:

All mental health services + alcohol and drug services, HARP , EICD , community health programs

GP Association of Geelong:

Eating Disorders Service

Pathways:

All programs - day programs, outreach, aged, youth, employment , Eating Disorders Service .

THIS MEANS

One server holding all client files

Consent sought / received from clients

Security in place - according to program

An entry onto a file is in ‘real time’ - eg admission,

discharge , critical incident etc

HAS TCM CHANGED THE WORLD?

No...Good communication still involves personal contact between all partners.

- The partners are using the program slightly differently.
- The program is still just a tool.
- Some staff have found the computer skills quite challenging.

HAS THIS PROCESS MOVED US FORWARD?

Yes... There are some important principles here:

- As a group of service providers we have changed to better accommodate the needs of our clients - we no longer force them to go through referral, intake and other paper work hoops.
- Critical information is now available to clinicians, allied health staff, managers, and, in future, to GP's in a timely manner.

  Even small, detailed information is available to all staff working with that person, which helps to personalise the interaction and, therefore, care.
- In the near future, we plan to make TCM , in summary form, available to participating GP's "live ", in order to enhance their participation in shared care.
- We are exploring ways of making the consumers "live"

  e-health record accessible online for their review and participation.