GP and Mental Health Collaborative Care

Working together for better health in people living with mental illness

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A partnership between the Sydney Local Health District Mental Health Service and the Inner West Sydney Medicare Local

Case for change

People living with severe mental illness die 15-25 years earlier than the general population.

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Most early death in mental health consumers is due to cardiovascular disease.

Mental health consumers access primary care more often than the general public, but receive less screening/ treatment for cardiovascular and metabolic disease.

Goal

To improve physical health care for SLHD mental health consumers with serious mental illness by enhancing collaboration between GPs and mental health services.

Objectives

- Increase consumer linkage to a nominated GP from baseline (62%) to 90% by July 2015 in the project sample.
- Increase consumers receiving an annual physical health GP review with summary in the mental health file from 23% to 50% by July 2015.
- Revise and disseminate the model of care to the broader SLHD Mental Health Service to all care coordination teams and their clients from February 2016

Method

Clinical Redesign methodology was used, including these activities:

- File audit (329): GP linkage, recent physical summary, metabolic monitoring on file.
- Mental Health Staff focus groups (4 groups; 61 participants) and brief staff survey using PETs (96)
- Detailed consumer interviews (17 participants) and brief consumer surveys via Patient Experience Trackers (PETs; 108)
- Detailed carer interviews (11)
- GP online surveys (36) Practice Nurse (12) and Practice Administration Surveys (12).
- Process Mapping: revealed poorly articulated and ad hoc processes.
- GP CPD event / GP Working Party

Diagnostics

Consultation revealed ad hoc processes prevail for Mental Health and General Practice when working together, underpinned by communication difficulties.

Consumer engagement in health varied, but most wanted the mental health service to help manage their physical health in collaboration with GPs.

Table 1: Mental Health file audit data

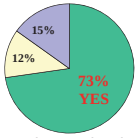
FILE AUDIT DATA	Clients in project sample (n)	Clients with current GP	With accurate GP on Cerner	With physical <12m	With GP/MHS liaison <12m	GP/MHS shared care
TOTAL	329	64%	51%	22%	32%	4%
TOTAL (ex boarding house)	309	62%	48%	20%	28%	2%

~40% of consumers have no regular GP. Details often not correct on file

Few consumers have annual physical health checks; and/or these are not on file

Consumer Survey:

Should the mental health service help look after my physical health with my GP?



GPs need better referral pathways and access to psychiatrist advice to support complex medical management.

Consumers are often not getting the primary care they need, despite GP expertise in primary care

GPs (86%) and Mental Health staff reported communication difficulties

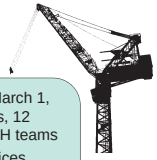
Carers and NGOs often help consumers access health services

Solutions

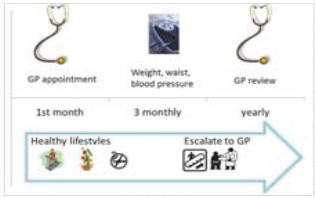
A defined model of collaborative care has been developed, and is underpinned by a suite of solutions, all working to promote sustainability and integration of the new model of care, including:

- Team based training for mental health staff
- Consumer-controlled health record & app
- Collaborative Care HealthPathway
- Specialised Peer Support Health Workers
- GP Templates
- GP access to psychiatrists
- GP CPD events and support
- Secure communications system
- Promote list of GPs and booking tips
- Supported by six new collaborative care coordinators

Implementation:



- ✓ New model of care implemented from March 1, 2015 across ~300 consumers, their GPs, 12 project champions and staff from four MH teams
- ✓ Communication to staff included in-services delivered by SLHD Sponsor and team members
- ✓ IWSML support to work with involved GPs
- ✓ Check measures: monthly audits and feedback

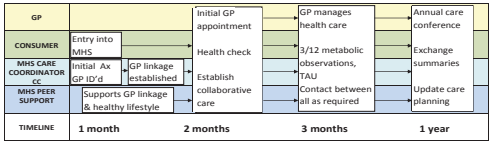


New consumer journey being implemented

Results

Project still undergoing implementation; indicators to include:

- Uptake of new model of collaborative care in project teams.
- Consumer, GP and mental health staff satisfaction with process
- Final audit and evaluation July 2015; usage of HealthPathways and GP access line



New model of care: annual reviews with ongoing care, communication and escalation of health problems

Benefits of adjunct solutions

Enhanced consumer engagement in own health, through:

- Increased specialised peer support workforce
- Physical health app for smartphones & tablets
- Consumer controlled health record

Heightened GP capacity and engagement in collaborative process via increased care coordinator and psychiatrist contact, health summary template provision and support.

Sustaining change

- Part of the overall SLHD Living Well, Living Longer program, comprising multiple
- Health professional education and training
- Prioritising project solutions for funding applications: Integrated Care Planning & Innovation Funding awarded, including pilot for new peer support workers; applied for local funds for an app via SLHD's 'The Pitch'
- Ongoing protection of human resources to guide the project: GP Liaison, Project Officer and project team.
- Executive support, SLHD & IWSML
- Ongoing rollout of collaborative care process planned for entire SLHD community mental health service by February 2016.

Conclusion

This project is addressing a complex problem, which requires system level change. Long term investment will be required for sustainable change in practice.

The model's flexible design accommodates transferability in a variety of settings. A range of adjunct solutions are also working to embed this model into routine practice.

This project has required a broad level of stakeholder engagement; sponsor support has been crucial.

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