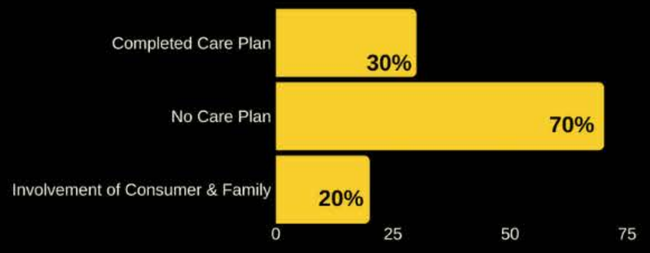
A CASE FOR CHANGE

CARE PLANS



ONE IN EIGHT

= 23 per month
= $4.4 million in 2018

RE-ADMISSION RATES PER WEEK

AND WHAT IF WE DON'T?

THE CONSEQUENCES

TRANSITION TO RECOVERY

GOALS & OBJECTIVES

COLLABORATIVE CARE PLANNING FROM ACUTE TO COMMUNITY	PATIENT INVOLVEMENT IN CARE PLANNING	CONTINUITY OF CARE DURING TRANSITION	REDUCE RE-ADMISSION RATES

COLLABORATIVE CARE PLANNING RESULTS

DAY 1
Collateral and file review of previous admissions, response to treatment including previous community treatment orders. Collateral information from patient, carers and support services. Bio psycho social needs assessment. Draft Short Term Individual Recovery Plan.

DAY 2
First review by treating team. Collaborative clinical review. Review and further development of Individual Recovery Plan with patient and stakeholders. Ongoing review of treatment needs and supports in place. Allocation of duties within plan including referral to services, Community Managed Organisations or Community Mental Health team if appropriate.

DAY 3
If Psychosocial needs are greater than supports available and client is willing to engage referral to Community Managed Organisation to support with clinical responsibility to be transferred to GP on discharge. If Biological needs are greater than can be managed by GP and psychosocial supports are also greater than those available, referral for care coordination with Community Mental Health Service. If risk of relapse is high and client is unwilling to engage a Community Treatment Order with a plan that that is able to be enacted in the Community may be required. If referral to Community Team is identified early at this stage a member of staff will be allocated the role of referrer at this stage

DAY 4 & 5
48 Hour Urgency of Response on all internal referrals to the Community Mental Health Team. Referral is reviewed by Community Mental Health Team and Care Coordinator is allocated within the community team.

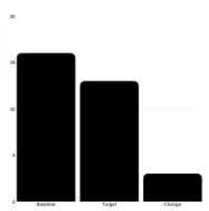
DAY 6
Allocated Case Manager attends the unit to meet with the patient to participate in collaborative care planning and collaborative clinical review. Acute Care Team (ACT) referral may be required with or without the need for Care Coordination to support early safe discharge from hospital.

OUTCOMES

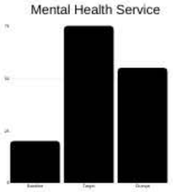
Early referral for community care coordination

collaborative care plan

Collaborative clinical review



Reduce 28-day readmission rate for Mater Mental Health Service



Increase % of care plans completed with consumer over a 12 month period

> I've been talking about this for years.
>
> Well dad...this might be the time.

DAVID & JULIA RUSSELL, FAMILY CARER AND CONSUMER

DIAGNOSTICS

SOLUTION GENERATION TECHNIQUES

BLITZING	18 FRONTLINE STAFF PSYCHIATRISTS NEWCASTLE MENTAL HEALTH SENIOR LEADERS
CLASSIC BRAINSTORMING	CONSUMER PARTICIPATION UNIT 6 CARERS 12 CONSUMERS
LITERATURE REVIEW	5 PEER REVIEWED JOURNAL ARTICLES 5 PUBLISHED ARTICLES
PRIORITISATION	VOTING SYSTEMS AND TECHNIQUES
PEER OBSERVATION	CARE COORDINATION PROCESS OBSERVATION FROM ASSESSMENT TO REVIEW

SUSTAINING CHANGE

- ✓ Continue with regular steering committee meetings through the implementation period
- ✓ Develop Working Parties and local implementation groups
- ✓ TRec Project Team to mentor working group leads
- ✓ Review identified KPIs at monthly local and executive Clinical Quality and Patient Care Committee meetings

CONCLUSION

Individual Recovery Plans allows the consumer, carers and families to participate in the individual's recovery journey. All stakeholders are informed about the consumer's recovery goals which allows a team approach to support consumers in a timely and appropriate way

TRec
TRANSITION TO RECOVERY

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