"Creating opportunities to work strategically across the region with Multi- Sectoral partners"

EMHSCA Audit Results 2022

Introduction/ Background

System audits are a method of inspection or examination that enables an assessment of procedures or processes. EMHSCA commenced the Shared Care Audit in 2014, seeking to collect baseline data regarding shared care practices for people living with mental illness and co-occurring concerns in the Inner- and Outer-Eastern areas of Melbourne. Following this initial audit, the Shared Care Audit was conducted annually until 2017. Due to significant disruptions in collaborative practice resulting from system reforms, the audit was not conducted between 2018 and 2020.

Overarching Vision

"All EMHSCA member agencies offer opportunities for people to participate in a person centered, integrated, shared care planning process with a recovery focus"

Purpose

The 2021/2022 audit aimed to re-engage member organisations with the annual practice of providing Shared Care data, gain some clarity regarding the current quality and extent of Shared Care practices, and examine trends emerging from system reforms and the pandemic response.

The audit process aims to contribute to EMHSCA member knowledge of service provider shared care practices and behaviours occurring in the region for people living with mental illness and co-occurring concerns. EMHSCA audits are viewed as a systematic mechanism for assessing and identifying areas for learning and continuous improvement.

Audit Execution

Sample

- Consumer target group: N=331

  The consumer group for the audit review was purposively selected; i.e. consumer participants were self-selected so those sampled were relevant to the audit purpose.

- Participating member organisations[1]*: N= 5*
- Service types: N=7

  Alcohol & Other Drug (AOD) counselling and support services; Early Intervention Psychosocial Support Response (EIPSR); Psychosocial Support Services (PSS); Public Mental Health Adult Community rehabilitation services; Public Mental Health Adult Community treatment services; Specialist Homelessness services; Youth Community Mental Health Support services.

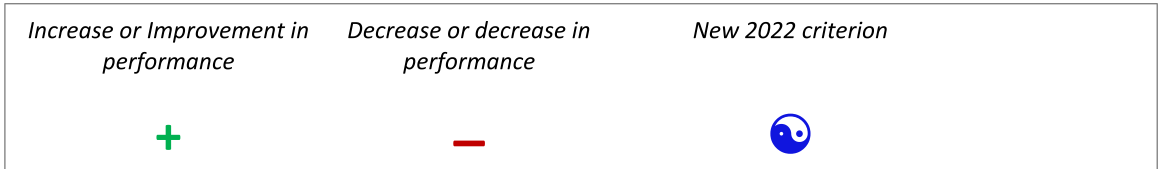
[1] EACH, Eastern Health, MIND Australia, NEAMI National, Wellways.

Audit data collection method and procedure

- The audit method used a common audit guide and Microsoft Excel tool to collect ‘client file audit’ information. An online survey link was provided as the preferred method of entering ‘client file audit’ information, however some providers elected to utilise the alternative excel format. Data was gathered by organisations over any four-week period between the 1st July to the 30th of April 2022.

Analysis and Reporting

- Data criteria were grouped; frequency scores were converted to percentages and interpreted to show general comparisons between previous year’s data.
- This report seeks to provide new baseline data, and also to highlight changes in key audit criteria for 2022 when compared with 2017. Icons below will be used throughout the report to highlight if there has been an increase or improvement or decrease.



- Audit results will be disseminated via the EMHSCA committee meetings and locally via participating organisations.
  - The report will be available via the EMHSCA webpage .
  - Individual data summaries are available to participating member organisations.

Document Descriptors

Safety assessment plan: A safety assessment is an ongoing process of observation and critical thinking to ensure the safety of consumers and those who support them. A risk assessment tool may be used to further identify clear management strategies (e.g. CRAM- Clinical Risk Assessment and Management tool).

Shared Care Plan: A shared care plan is a plan of care in which a group or team of health/ service professionals work together with the client, carers to deliver a holistic, coordinated and individualised service response.

Key Findings

Of the files audited (n=331):

Audit elements	2022	2017
General practitioner		
91% of people who accessed a service had an identified general practitioner N=300	+31 %	-29%
60% of people had written or verbal information communicated by the support service to the G.P. N=194	**New**	☯
The level of involvement of the G.P as part of a shared care arrangement was rated as: **41% A little** (N=136); 28% None at all (N=94); 20% A moderate amount (N=65); 8% A lot (N=28); 2% A great deal (N=8)	**New**	☯
Mental Illness		
84% percent of consumers with a mental illness received assistance from two or more services due to having multiple needs	+51%	-30%
Of those consumers with an identified mental illness and receiving services from two or more services (n=242):	+50%	-24%
87% had a documented safety assessment and management plan	+48%	-47%

Shared Cared		
73% of consumer service activity was translated into receiving shared care from a group or team of service professionals working together to deliver coordinated care (n=242). Of those consumers:	+32%	-32%
Evidence of a documented care plan	**Not asked**	-22%
57% carers and significant others were involved in the care planning process	+21%	+26%

Table 1: Care plan elements and comparable proportions for 2017 & 2022	**n=**	**%**	**2022**	**2017**
(a) Overview of Person’s current situation	326	99	+29%	-12%
(b) Person’s goals	291	88	+15%	-23%
c) Strategies or actions	305	93	+20%	-25%
(d) List of supports involved	296	89	+20%	-23%
(e) Roles and responsibilities of all parties involved	241	73	**No Change**	-23%
(f) Planning Coordinator or Support facilitator identified	243	73	+7%	-24%
(g) Planned Review dates and agreed form of communication	245	75	+15%	-30%
(h) Consumer consent documented	279	85	+14%	-23%

Analysis

The Annual EMHSCA Shared Care Audit has been on hold since 2017, and was reinstated in 2021. It is noted that participation in the audit has reduced in 2022. There were just 5 participating organisations in 2022, compared to 6 in 2017 and 7 in 2015. The number of files audited fell by 80% from 1,589 in 2017 to 331 in 2022.

The introduction of an online platform to capture the data was well received by most participating service providers, although one service provider chose to utilise the excel document to provide data. For the purposes of collating and reporting and given EMHSCA's limited resources, the online platform proved more adequate.

The results of the 2021/2022 audit reveal a significant improvement across almost every domain when compared with the 2017 data. It should however be noted that the 2017 audit had demonstrated a large decline in Shared Care practices, at a time of multi-sector reform. The 2022 audit results have been discussed at the EMHSCA implementation committee meeting in September. It was thought that the improvements in Shared Care may be attributable to better policy and funding models that more adequately support a collaborative approach to care. Increasing complexity in presentations of people needing support in recent years may be necessitating cross-sector connections. It was also thought that maintaining a tighter scope of practice in the face of workforce shortages may have led to staff needing to reach out for support from other services providers in the form of Shared Care.

Significant capacity building has been provided across our region to support an improved understanding of the importance of Shared Care and better navigation of local supports. Long standing networking opportunities that occur via EMHSCA meetings and events, and the Dual Diagnosis Linkages may have led to improved confidence of staff in connecting and collaborating for the benefit of people requiring support.

A limitation of the 2021/2022 version of the EMHSCA Shared Care audit has been the removal of the question regarding a formal Shared Care plan. The Shared Care plan has been an important tool to enable and ensure a Shared Care approach since it was introduced as an attachment to the EMHSCA Shared Care protocol in 2010. Although the data captured regarding Shared Care appears to have improved this year when compared to 2017, it is impossible to conclude an overall improvement in Shared Care without knowing if the work is translating into a simplified care plan that is agreed to by the person needing support and their supporters. For this reason, it is recommended that efforts be made to reinvigorate knowledge of the Shared care plan template amongst EMHSCA member services, and that future audits include identification of such a plan.

From this audit it would appear staff capacity building should focus on the Shared Care plan elements such as identification of key stakeholders, and their roles and responsibilities. Future EMHSCA capacity building events should address the need to be clear about communication mechanisms, and emphasise the importance of a consumer led Shared care plan.

This is the first audit which has included data regarding G.P involvement with the Shared care team. Results indicate that in 70% of cases G. P's are not significantly involved. This gap should be further explored in future work.

Conclusion

Results from the 2022 EMHSCA Shared Care audit are encouraging, and demonstrate an increasing appetite in this region for Collaborative and Coordinated care. As a key objective of the current Victorian Government led Mental Health and Wellbeing reform, we can conclude that Service Integration is supported by collaborative arrangements such as those provided by EMHSCA. Although many factors are responsible for improved Service Integration, we know from the EMHSCA study conducted in 2019 that local partnerships and networks are important facilitators. The EMHSCA Shared Care audit can be utilised as a means of assessing the effectiveness of efforts to integrate service provision during the Mental Health reform, and ideally would be conducted annually for the foreseeable future.

The EMHSCA Shared care audit remains the most efficient and appropriate means of measuring the progress of EMHSCA in supporting improvements to collaborative and coordinated care. With historical data dating back to 2014, the changes to coordinated care are able to be monitored over time. This enables analysis of system change impacts on integration, and provides useful information about where Shared Care capacity building is required.

It was reported by EMHSCA leaders that a number of organisations have embedded the audit questions into regular auditing practices to some extent. In this way, the EMHSCA Shared Care audit was more readily embraced by these members. Further efforts across newer EMHSCA member organisations may lead to increased participation in future audits. This will require a reinvigoration of the EMHSCA Shared Care protocol implementation strategy in 2023.

Appendix

	EMHSCA Audit Results	Total 2017		Total 2016		Total 2015		Total 2014	
	Sample(N=)	1589		1763		1296		2322	
	Questions	n=	%	n=	%	n=	%	n=	%
1	Person has an identified GP	957	60%	1556	89%	1014	87%	1026	81%
2	Person asked the 6 basic questions as part of a physical health screen	952	60%	1436	82%	731	69%		
3	Physical health needs were identified	533	34%	969	55%	625	56%		
4	Person has a mental illness and is receiving assistance from two (2) or more	516	33%	1104	63%	710	64%	1378	63%
5	Person with a mental illness has a Wellness plan documented	392	42%	730	66%	305	54%	1026	81%
6	Person with a mental illness has a safety assessment and management plan documented	370	39%	944	86%	462	67%	772	52%
7	Person with a mental illness Is receiving shared care from a group or team of health professionals who are working together to deliver coordinated care with the client, carer	382	41%	802	73%	528	78%		
8	Shared care has been formalised into a care plan document	275	42%	509	64%	326	76%	650	55%
9	No. of service providers not included on the care plan	57	16%	156	31%	90		165	
10	Person with a documented care plan has an Advance Statement	32	9%	179	48%	97	65%		
11	Carer/ significant other is involved in the care planning process	116	36%	50	10%				
12	Person's physical health needs were documented on the care plan	162	63%	268	71%	202	80%		
13	Of the documented shared care plans-plan included the following elements (fields).								
a.	Overview of the consumer's current situation	268	74%	440	86%	282	78%	485	81%
b.	Consumer's goals	265	73%	486	96%	313	89%	600	90%
c.	Strategies or actions	265	73%	498	98%	318	91%	612	90%
d.	Roles and responsibilities of all parties involved	264	73%	488	96%	309	89%	477	81%
e.	List of participants involved in the development of the plan	250	69%	468	92%	305	88%	480	80%
f.	Planning Coordinator or Support Facilitator identified	239	66%	459	90%	300	78%	351	71%
g.	Planned Review dates and agreed form of communication	220	60%	459	90%	277	73%	345	54%
h.	Consumer consent documented	258	71%	476	94%	295	86%	480	69%