Eastern Mental Health Service Coordination Alliance

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

EMHSCA

Shared Care Protocol

Implementation Strategy

Eastern Mental Health Service Coordination Alliance

Developed by the Eastern Mental Health Service Coordination Alliance (EMHSCA)

State Government Victoria Department of Health & Human Services

Background

The Eastern Mental Health Service Coordination Alliance (EMHSCA) Collaborative Pathways Subcommittee was formed in December 2012.

The purpose of the Subcommittee is to explore how member agencies can work together to improve the holistic health outcome for people with mental health and co-occurring concerns by supporting the development and implementation of shared protocols and documentation within and between member agencies.

Vision

“All participating agencies offer opportunities for people to participate in a person centered, integrated, shared care plan with a recovery focus.”

The Collaborative Pathways Subcommittee (CP SC) has reviewed the previous Shared Care Protocol and Individual Recovery Plan in collaboration with EMHSCA and the Dual Diagnosis Consumer and Carer Advisory Council (DD CCAC).

The members of EMHSCA agreed in principle to the revisions that are now provided in the Shared Care protocol (SCP) at their February 2016 meeting.

The CP SC was supported by EMHSCA to develop this implementation strategy for consideration of its member organisations.

Objective

To raise awareness, amongst EMHSCA member services and others, of the existence and content of the SCP Protocol
To support agencies as they align their practice with the SCP.
To support agencies in the introduction of appropriate shared care documents.

Suggested strategies for implementation

1. ☐ Embed the SCP as part of your current model of service provision

Ensure the key elements of the SCP are highlighted and addressed as part of your service's response to implementing models of service provision such as the new Mental Health Act, Recovery framework etc…

2. ☐ Add the SCP to Orientation for new staff

Ensure all new staff are aware of the SCP document as they enter your workforce. This may be done by registering them to attend the next Collaborative care planning workshop and/or by providing the document for them to read at Orientation.

Organizations may also want to consider inviting new staff from other organisations within the sector to specific teams in the region to learn about what services the other provides, similar to that of a reciprocal rotation. This networking would support staff to develop relationships with other workers and increase their knowledge of the service system which will better aid them in supporting client needs.

3. ☐ Work together with the Workforce Development Committee to build capacity of organisations by

a. Ensuring your organisation has an EMHSCA Workforce Development Committee (WDC) member
b. Send staff to EMHSCA WDC events
c. Provide feedback to EMHSCA WDC following events

4. ☐ Embed elements of example policy into existing service policy frameworks (see appendix A)

Examine current policy in relation to Service Coordination elements

5. ☐ Embed key elements described in protocol into job descriptions (see Appendix B)

Examine current job description statements and consider appropriate Service Coordination criteria be added if found to be absent.

6. ☐ Examine current care planning tools to ensure SCP Protocol recommendations are taken into account

Each agency will examine its current care planning tools and practice to ensure that:

- ☐ Written consent is gained from the consumer before any shared care planning
- ☐ The core components of the shared care plan as per page 4 of the SCP are included in your services' Care planning procedures i.e. Individual recovery plan, wellness plan and safety assessment and management plan
- ☐ Reviews occur at least 3 monthly, involving all parties concerned

7. ☐ Incorporate Shared Care planning and collaboration as standard item at team meetings –

Team meetings to incorporate promotion of collaborative practice including awareness/education of other service providers, presentations from other services, promoting clear and regular communication between providers, and promoting shared care planning/problem solving.

8. ☐ Include shared care conversations in clinical reviews, appraisals and supervision or similar forum. –

Individual supervision, direct line, practitioner focused, opportunity to examine practice in relation to complex cases. The usual focus of discussion is around risk and the collaborative work involving external services involved in the shared care of the client.

Group Supervision provides opportunity for collective feedback around appropriate referral pathways between agencies, and building capacity to provide holistic and coordinated responses.

Complex Case Panel, a multidisciplinary panel, who provide recommendations to ensure an integrated approach for relevant internal and external services for the most high risk cases identified by the organization.

Internal Case Allocation Meetings identify the potential for both internal and external services to offer a wrap around treatment plan for individuals and families within six weeks.

9. ☐ Participate in EMHSCA Shared care auditing in conjunction with the CP SC

An annual audit of Shared Care Practices in the EMR will be conducted by the EMHSCA, first conducted February 2014, with the aim of monitoring improvement in shared care practices in this region.

File audit questions regarding shared care practice could be included in an organisational file audit process. An example of a set of shared care file audit question criteria has been included in **Appendix H.** These questions are linked to the shared care practice performance indicators documented in Appendix B, these being:

- Shared care practice occurs when the consumer is identified as requiring a coordinated response from multiple services.
- Shared care planning occurs within and across organisations for consumers needing shared care support.
- A shared care plan document is used to facilitate communication with the health team, consumers, families and carers.

- The consumer, carer and advocate are supported to actively participate in the shared care planning process.

10. ☐ Appoint Service Coordination Champions to lead staff change (see appendix C)

Identify staff leaders that have a particular interest in collaboration with other agencies, consumers and carers. Provide their details to the EMHSCA project officer for allocation to an EMHSCA sub-committee. Support them to attend monthly sub-committee meetings as scheduled. Encourage them to provide service coordination information to their teams.

APPENDICES

Appendix A Policy Example

Appendix B Job Descriptions

Appendix C Service Coordination Champion Role

Appendix D Shared Care Practices and Collaborative Planning Protocol

Appendix E Individual Recovery Plan example

Appendix F Wellness Tool example

Appendix G Safety Assessment and Management Plan example

Appendix H Audit questions

Appendix A

Policy example

EMHSCA CP SC is committed to facilitating the delivery of quality integrated & coordinated services which will work effectively for better care. We will develop relationships with clients, and as appropriate, their carers, family members, significant others and other professionals that build positive partnerships and support enhanced perspectives. We acknowledge the importance of sharing client information between agencies, with client consent, in order to provide a person-centred response to individual needs and the delivery of a coordinated approach.

Note: This example was developed by examining a number of existing policy statements. It may be used as it is or developed with the key elements in tact.

Appendix B

Job Description statement

Key Selection Criteria

Entry level:

- Ability to liaise, collaborate and negotiate with other services and consumer and carer groups

More experienced staff:

- Demonstrated experience to liaise, collaborate and negotiate with other services and consumer and carer groups

Leadership Level:

- Demonstrated high level ability to liaise, collaborate and negotiate with other services and consumer and carer groups

Major Responsibilities

Organisational /Leadership level:

There are supportive structures in place to enable staff members to:

- collaborate, liaise and negotiate with other services for mutual clients requiring a coordinated service response

- Initiate and develop shared care plans in partnership with consumers, families, carers and other health professionals.

Practice/ Service provider level:

There is demonstrated evidence that:

- Shared care practice occurs when the consumer is identified as requiring a coordinated response from multiple services.
- Shared care planning occurs within and across organisations for consumers needing shared care support.
- A shared care plan document is used to facilitate communication with the health team, consumers, families and carers.
- The consumer, carer and advocate are supported to actively participate in the Shared Care Planning process.

Note: This provides an example only and needs to be translated into local service context.

Appendix C

Service Coordination Champion Description

Service Coordination Champions will be members of the EMHSCA sub committees and will lead their service, its staff and its consumers and families to maximize opportunities for accessing the services required to facilitate the individual's recovery journey. They will do this by:

a) Liaising with management/team leaders around the principals outlined in the Victorian Service Coordination Practice Manual and the Shared Care Protocol.

b) Holding responsibility within their service for disseminating Service Coordination and Shared Care Practice related information to the rest of their team,

c) Supporting the EMHSCA Workforce development events by advertising them to their teams and encouraging staff attendance,

d) Offering support to their fellow staff around Collaborative Care planning issues and/or negotiating contact with a Care Coordinator/Support facilitator when required,

e) Attending professional development opportunities re Service Coordination when able,

f) Obtaining or organising for the purchase (by their service) of relevant resources to enhance understanding of Service Coordination.

g) Attending EMHSCA sub committee **meetings** and reporting back to team members.

h) Facilitating **reciprocal service orientations** (optional) (see description)

Reciprocal Service Orientation (RSO) –
Service Coordination Champions may be called upon by their organisation or by external professionals to facilitate the introduction of professionals to their organisation and / or service areas; with a view to promoting collaborative and purposeful professional relationships aimed to enhance better treatment outcomes for consumers their families and communities

References

AOD Service Coordination Toolkit 2012 http://www.easternhealth.org.au/app_cmslib/media/umlib/mental%20health/emhca/eastern%20metropolitan%20region%20alcohol%20and%20other%20drug%20sector.pdf

Carers recognition Act 2012

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/023A825C23E20790CA2579C7000FB0BB/$FILE/12-010a%20authorised.pdf

EMHSCA Shared Care Protocol 2016

https://www.easternhealth.org.au/images/EMHSCA_Shared_Care_Protcol_2016_FINAL_FV.pdf

Framework for Recovery-Orientated Practice 2011 http://www.health.gov.au/internet/main/publishing.nsf/Content/0ABBFD239D790377CA257BF0001C6CBC/$File/colsev.pdf

Health Records Act 2001 (Vic). www.health.vic.gov.au/hsc/downloads/hppextract.pdf

Mental Health Act 2014, http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/0001F48EE2422A10CA257CB4001D32FB/$FILE/14-026aa%20authorised.pdf

Mental Health Coordinating Council 2012, Service Coordination Workforce Competencies: An investigation into service user and provider perspective, MHCC, Sydney. http://mhcc.org.au/media/3200/service-coordination-workforce-competencies. pdf

Privacy Act 1988 (October 2015 update) https://www.comlaw.gov.au/Details/C2015C00534

Twelve Steps for Agencies developing co-occurring disorder capability https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/integrated_services/12_steps_programs.pdf Evaluation of Stronger Families and Communities Strategy 200-2004 – Improved Integration and Coordination of Services - RMIT 2008

Victorian Service Coordination Manuals https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination

Victorian strategic directions for co-occurring mental health and substance use conditions 2013 http://docs.health.vic.gov.au/docs/doc/Victorian-Dual-Diagnosis-Initiative-(VDDI)-Bulletin--October-2013

Links

Checklist for Sharing Personal Information – Commissioner for Privacy and Data Protection https://www.cpdp.vic.gov.au/images/content/pdf/Checklist%20for%20Sharing%20Personal%20Information.pdf

Family Care Plan http://www.copmi.net.au/documents/product-downloads/32-family-care-plan/file

National Standards for Mental Health Services 2010 Commonwealth of Australia, 2010 https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

Partnership Tools https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/strengthening-partnerships-tools-resources

Victorian Government Mental Health Website https://www2.health.vic.gov.au/mental-health