

St Vincent's Hospital Psychogeriatric
Mental Health and Dementia Service
and
Psychogeriatric SOS

Partnerships and Integration

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St Vincent's Hospital Psychogeriatric Mental Health and Dementia Service



Presentation Overview

‘A team management model of mental health care’

A/Prof David Burke

Director of Psychogeriatrics, SVH



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‘A team management model of mental health care’

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‘A new and unique model of rural outreach’

Dr Jacqueline Huber

Training Fellow, NSW Institute of Psychiatry and SVH



St Vincent's Hospital Psychogeriatric Mental Health and Dementia Service



Team Management Model of Mental Health Care Overview

- Development of SVH Psychogeriatric service
- The operational model of care
- The qualitative outcomes
- The key factors in our model of integrated care



Development of the Service Setting and Context

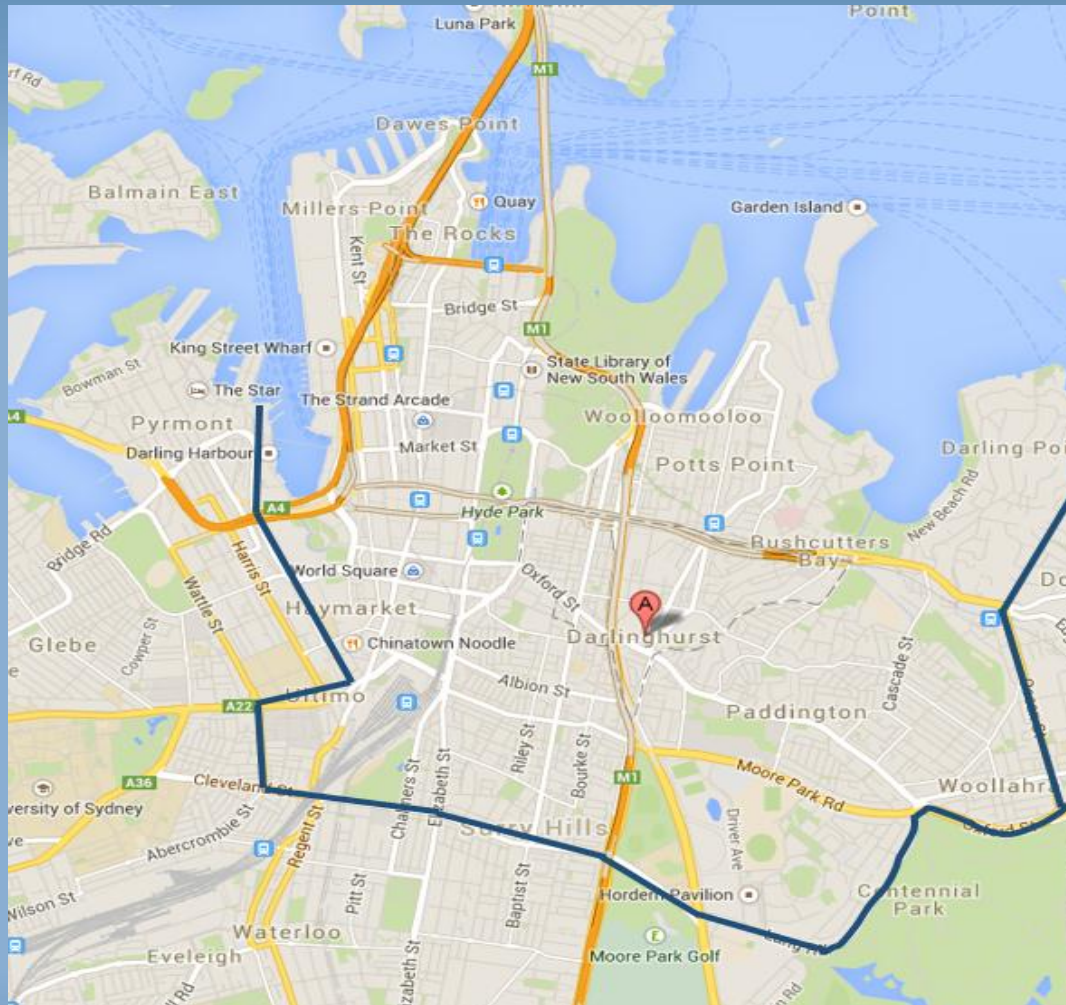
- Inner-city Sydney



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St Vincent's Hospital Mental Health Service Catchment Area



St Vincent's Hospital Psychogeriatric Mental Health and Dementia Service



Development of the Service Setting and Context

- Inner-city Sydney
- 15,000 people over age 65
- Unique and diverse population
- 6% with mental health issues
- 6% with cognitive impairment
- 156 GPs
- 565 residential aged care beds



Development of the Service

Scoping, staffing and beds

- Commenced Nov 2003 with 0.2 FTE staff specialist
- Consultation with key clinicians, consumers and managers
- 10 years later, 10.9 FTEs (15 clinicians)
- Nominally 2 inpatient beds (benchmark 6-10)



St Vincent's Hospital, Sydney, Australia



Operational Model of Care

Aims of the service

- Comprehensive, accessible, responsive, individualised, and accountable service (WHO, 1997)
- Appropriate, flexible, high-quality, timely, coordinated, evidence-based, cost-effective care (RCPsych, 2006)
- Multidisciplinary assessment and management, in a collaborative and shared-care model (Burke, 2013)



Operational Model of Care

Team management

- Bio-psycho-social model of mental health care requires a multidisciplinary team (MDT) management
- Intake, triage, assessment, case review meeting
- Appropriately prompt response to all referrals
- Every patient seen by Psychogeriatrician
- Team management needs to include the MDT and the patient, family, other carers, and the GP
- GP's involvement is central



Operational Model of Care

MDT characteristics

- Strong leadership and clear vision
- Professional culture and agreed goals
- Interdisciplinary respect
 - core competencies plus professional expertise
 - working in pairs
 - shared 'ownership'
- Professional development
- Good outcomes



Operational Model of Care

One team – flexible mode

- Health promotion
- Early intervention
- Crisis response
- Acute care
- Short- and medium-term care
- Rehabilitation
- Relapse prevention



Operational Model of Care

Appropriately tailored response

- Delivered in a timely fashion
- In the least restrictive environment
- Using the best available expertise
- With the right amount of support
- To ensure the patient pathway is seamless
- And to achieve the best possible outcomes



Sample Patient Journey

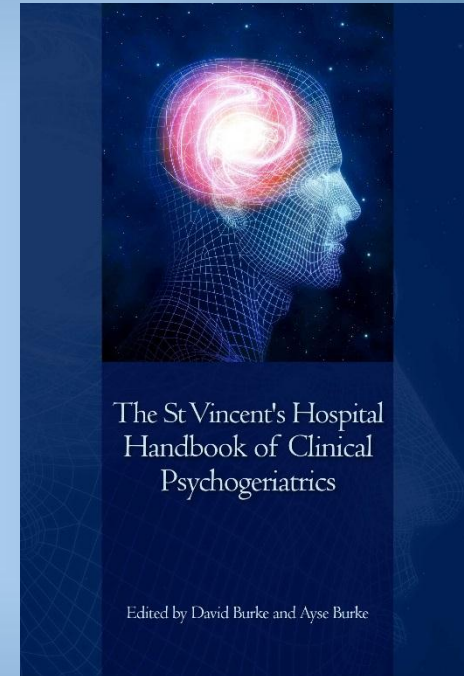
- 76 year old widow. GP: diagnosis?
- Home visit: registrar and neuropsychologist
- Depression and Dementia
- Re-referred 12 months later
- GP: not coping at home
- Home visit: neuropsychologist and social worker
- After discussion, home visit by occupational therapist
- Guardianship and re-located to hostel
- Re-referred 4 weeks later with behavioural problems
- Assessed by registrar and clinical psychologist...



Operational Model of Care

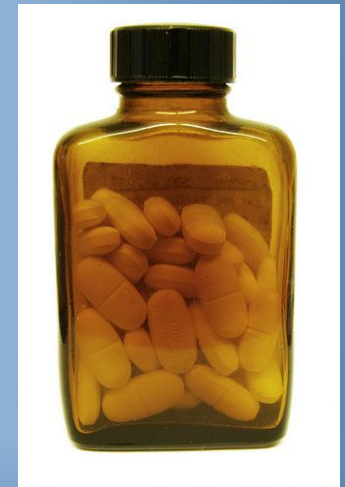
Emphasis on education

- Direct
 - Patient/family/carer education
- Direct and indirect
 - GP education
 - Department of Geriatric Medicine
 - RACFs
- Handbook
- Public forums
- Publications



Qualitative Outcomes Patients

- Patient outcomes – very good
- Suicides – one in 10 years ('expected' 10-20)
- Psychotropic medication use – low
- Patient/family/carer satisfaction – very high
- Use of 1:1 nurse, CTOs, Magistrate hearings – very low



Qualitative Outcomes Systems

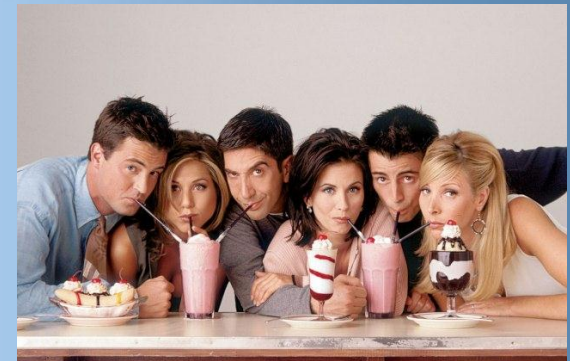
- Inpatient bed utilisation – very low
- Inpatient LOS – moderately high
- Community LOS – low (mostly ‘new patients’)
- Cost-effectiveness – very high (small budget, no complaints)
- Referrals – increasingly complex



Qualitative Outcomes

Colleagues

- Relationship with geriatric medicine – excellent
- Relationships with GPs – very good
- Relationships with RACFs – very good
- Relationships with aged care community teams - good
- Relationship with ED – ‘non-existent’



Key Factors in the Model

Our 'top five'

5. Small catchment population!
4. Central role of the GP!!
3. Community-based flexible response!!!
2. Team management model!!!!
1. Patient focus!!!!!!



The Main Game

To **support, up-skill, and empower** other clinicians to assess and manage the mental health needs of their older patients.

Thank you.



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Partnerships and Integration

Psychogeriatric SOS (services-on-screen)

A new, unique model of rural outreach
- and an international first!

Dr Jacqueline Huber



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A new and unique model of rural outreach

Overview

- The current model of rural outreach
- The beginnings of Psychogeriatric SOS
- How does it work?
- Partnerships and funding
- The key factors in this new model of integrated care





The **current** model of psychogeriatric service in rural and remote Australia

- Strong dependence on nursing and allied health care
- Relying on case management and GP intervention
- Fly in/fly out specialist contingent



The model of e-medicine psychogeriatric service in rural and remote Australia

- Mostly direct doctor-patient consultation
- *Some* tele-case review and tele-supervision
- Overall relatively low uptake

(Access Economics 2010)



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The **potential** model of psychogeriatric service in rural and remote Australia

Providing timely advice, supervision, training, education and support to existing local rural clinicians to empower them to better manage their patients locally.

(Access Economics 2010)



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The Beginnings of Psychogeriatric SOS

- Support from an expert, virtual multidisciplinary team
- To individuals or small groups
- Across NSW
- To up-skill and empower *local clinicians*
- And build capacity within services
- In a cost-effective manner



The Idea Behind Psychogeriatric SOS



Rural clinician

- Clinical guidance
- Professional supervision
- Case conferencing
- Education and training



The Idea Behind Psychogeriatric SOS



Rural clinician

- Community nurse
- Case-managing a 72 year old farmer with depression



The Idea Behind Psychogeriatric SOS

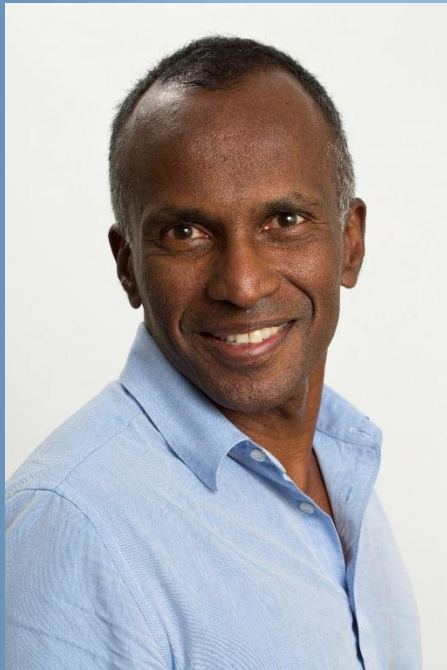


Rural clinician

- A social worker
- Managing an elderly man living in squalor



The Idea Behind Psychogeriatric SOS



Rural clinician

- A GP who had recently relocated to a small town
- Reviewing four elderly people with cognitive impairment



The Idea Behind Psychogeriatric SOS



Rural clinician

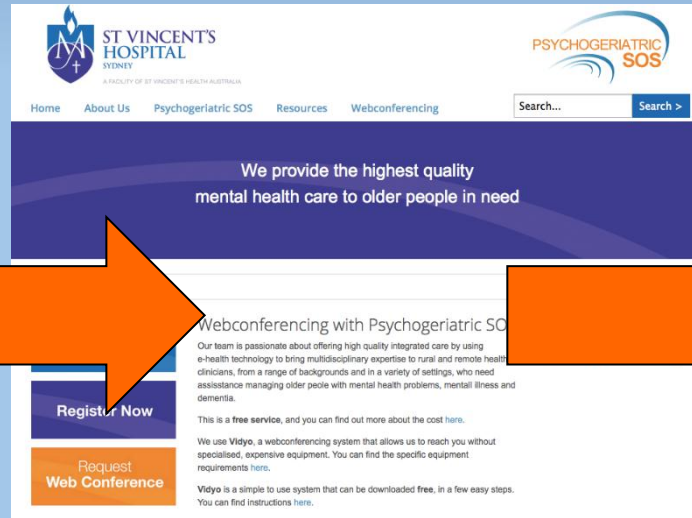
- The DON of a RACF
- Wants her team to be upskilled in behaviour management



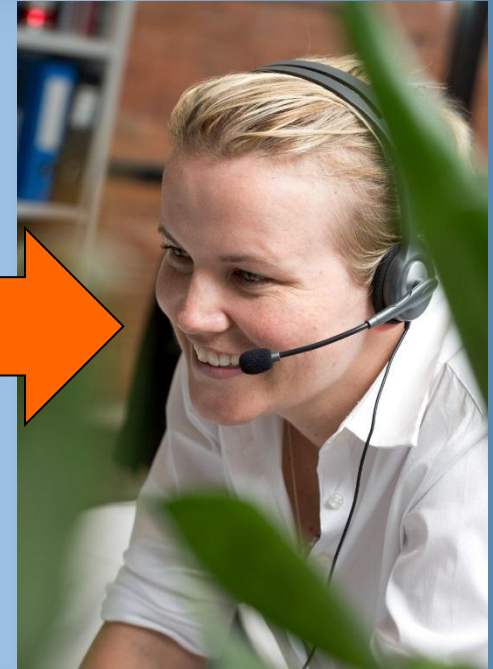
How it works



Rural clinician



The website



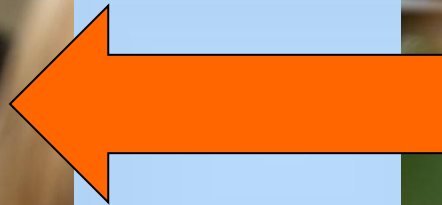
SOS clinician



How it works



Rural clinician



SOS clinician





SOS clinician



SOS clinician



SOS clinician



SOS clinician



Rural clinician



SOS clinician



Rural partnerships

- The most important element before this can work
- Consistent communication with rural LHDs, MLs and NGOs
- Face-to-face meetings
- Clear vision
- Professional culture and agreed goals
- Interdisciplinary respect





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Funding

- NSW Institute of Psychiatry – advanced trainee
- St Vincent's Curran Foundation – project manager
- NSW Ministry of Health – clinicians and education officer
- SVH 'in-kind': hardware/software/admin/38 hrs/wk clinician time
- Longer term: sustainable user-pays model



Challenges

- Technology
- Trust
- Demand
- Local context
 - practicalities
 - politics



Expected Outcomes

- Improved ease of management of psychogeriatric issues
- Increased confidence/empowerment of local clinicians
- Increased job satisfaction for local clinicians
- Referral for increasingly complex issues
- Reduced ED presentations
- Delay in RACF placement



Key factors in the model 'Top Five'

5. Small catchment population
4. Team management model
3. Community-based flexible response
2. Central role of the GP
1. Patient focus



Key factors in the SOS model 'Top Five'

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Key factors in the SOS model 'Top Five'

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Key factors in the SOS model 'Top Five'

5. Small Huge catchment population
4. Team management model
3. Community-based flexible response
2. Central role of the GP
1. Patient Clinician focus



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