



# Share Care Clinical Coordination Project – Mental Health and D&A Comorbidity

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# Overview



NSW Health has funded GP NSW to deliver a 12 month pilot program and support up to 10 Divisions to implement and enhance models of shared care for patients experiencing mental illness and drug and alcohol comorbidity.

# Why?



## Patients with mental health and drug and alcohol comorbidities

- frequently move between services without appropriate referral or continuity of care
- are often discharged from acute services into the care of general practice without appropriate care coordination
- who present to general practice often need additional support for their complex needs support their recovery
- these patients can be more effectively managed in primary care settings if services were able to provide coordinated and shared care

# Who?



10 Divisions across NSW

Employ a Shared Care Clinical and Service Coordinator

To deliver clinical services

To facilitate service coordination

# Aims



To improve the **clinical management, treatment and service coordination** for people with mental illness and/or drug and alcohol disorders.

To provide an opportunity to address the **physical health** needs of mental health and drug and alcohol patients by managing their care within the general practice setting.

To increase **drug and alcohol screening** at the general practice level for patients with mental illness

To provide **management options and service integration** for patients experiencing alcohol and drug misuse.

To engage a **Mental Health Nurse** under the Mental Health Nurse incentive Program

# Objectives



To enhance the **physical and mental health outcomes** of people with significant mental health and drug and alcohol issues who are living in the community

To increase the number of people with mental health and drug and alcohol disorders who receive care delivered in a **shared care model of practice**

To increase the **capacity of General Practitioners to support people** with significant mental health and drug and alcohol issues in the community

To improve **communication, collaboration, networks and referral pathways** between general practice, mental health services and drug and alcohol services and other relevant services which aims to provide an integrated system of care.

To provide **early intervention, coordinated care, information and referral services.**

# Expected Outcomes



- **Improved liaison and communication** between general practice, mental health services and drug and alcohol services
- Increased focus, awareness and understanding by mental health and drug and alcohol services on the **role and responsibilities of General Practitioners** in the management of mental health and drug and alcohol patients
- **Improved referral, discharge and admission procedures** between general practice, mental health services and drug and alcohol services

# Expected Outcomes



- **Improved continuity of care and coordination of care** for patients with mental health and drug and alcohol disorders, including improved step up, step down care
- Increased number of patients with mental health and drug and alcohol disorders receiving **physical health** checks.
- Increased number of patients with mental health and chronic disease receiving **drug and alcohol screening**

# Progress



Phase 1: Define project (complete)

**10 Divisions received grants after successful application:**

Central Coast Divisions of General Practice

Central Sydney GP Network

Dubbo Plains Divisions of General Practice

Illawarra Division of General Practice

Mid North Coast Division of General Practice

Northern Sydney General Practice Network

NSW Central West Division of General Practice

Riverina Division of General Practice & Primary Health Ltd

Southern General Practice Network

St George Division of General Practice

# Progress



- Divisions have been contracted by GP NSW to complete the project
- Project Advisory Group identified and engaged

# Progress



## Phase 2: Planning

Project Coordinator employed (CNC)

7/10 SCCC employed

Identification of support, education and training needs for MHN and credentialing with the ACMHN. Network for the SCCC.

## Evaluation Methodology:

Data collection tool and database (referral information and OOS)

Patient feedback form

## Division level:

Reference groups – MOUs, referral systems, referral criteria

SCCC: role development and project development

# Progress



## Phase 3: Implementation

- Provision of clinical service and coordination
- Data collection (Referral information and OOS)
- Monitoring of data
- Reporting
- Implementation of support, education and training needs for MHN and credentialing with the ACMHN. Network for SCCC.

# Progress



## Phase 4: Project completion

- Achievement of outcomes
- Evaluation
- Reporting
- MHN present at conferences

Questions?