SERVICES AND PROGRAM ENTRY

CATEGORY: Therapeutic & Clinical Services

ENTRY TITLE: Clinical Care Coordination at the Peel Health Hub

NAME OF APPLICANT: Paul Loseby, Regional Manager Peel, GP down south

ORGANISATION: GP Down South Ltd (t/a GP down south)

Additional Information about Entry (1 x A4 page).

The vision for the Clinical Care Coordination Team at the Peel Health Hub was that it would be;

… a **transformative model of primary care** *that shifts the epicentre of health care delivery from the clinician to the patient. It is distinguishable from current good general practice by its absolute redesign of infrastructure, health care team roles and modes of delivering care around the preferences and needs of the patient.*

The Peel Health Hub provides a GP supported, comprehensive and coordinated approach to improve the mental, social and physical health of its clients. This is supported through improving access to services and an integrated Model of Care based on Clinical Care Coordination and collaboration.

Key principles of the Model of Care

The key principles of the Model of Care are to:

1. Provide immediate clinical intervention and support to people when they present not knowing what service/s they require.
2. Support people who have complex needs to engage with treatment options across multiple services.
3. Operate a no wrong door policy.
4. Reduce repetition of storytelling.
5. Reduce barriers and enhance access to engagement with services.
6. Provide client centred care.

Clinical Care Coordination is central to the Model of Care embedded in the Peel Health Hub and is a resource available to all co-locators within Hub. Clinically qualified Care Coordinators provide Advanced Access to treatment for individuals who present at the Peel Health Hub and do not know the service/s they require. This will involve assessment on the day of presentation; development of a therapeutic care plan with the client; support and advocacy to navigate the health and welfare system and commencement of treatment as appropriate.
Initial engagement aims to;
a) reduce immediate distress.
b) maintain engagement.
c) prevent deterioration; and
d) improve mental health outcomes.
The Model of Care developed for the Peel Health Hub extends beyond the Health Hub and the Care Coordination Team support and coordinate appropriate treatment options across the wider community to improve health outcomes.

The Peel Health Hub Model of Care improves the health, wellbeing and functioning of clients with mental health and alcohol and other drug issues, with a focus on those who have complex health care needs. These individuals are particularly at risk of 'falling through the cracks' when they are involved with multiple agencies and specialists.

This no-wrong-door practice is central to the Peel Health Hub's Model of Care. This 'Advanced Access' model of Clinical Care Coordination has been independently evaluated, with positive findings of strong inter-agency support and cohesion with the care coordination program, and a strongly positive impact on clients and clinical flow. The model was presented to the joint Mental Health Commission/ South Metropolitan Health Service, Mental Health and AOD Prevention workshop in Peel in March 2021.

Address the following Criteria (max. 10 X A4 pages).

Judges allocate marks to each criterion

1. Evidence of a significant contribution to the field of mental health on a local, state or national level.

Around 20 years ago, the Peel Youth Medical Service (PYMS) was established to service the needs of young people aged 12-25 years in the Peel region. Within a decade, the population in the region had burgeoned and health services were struggling to meet increasing demands. A specialised youth health hub was envisaged, and funding procured to build the Peel Health Hub (Hub). In December 2018 the Hub became a reality. Services available in the Hub include: general practice (GP), mental health, alcohol and other drugs, assault, sexual assault, family violence, vocational training and family support services.

Following the establishment of the PHH, demand for all services increased exponentially, with demand quickly outstripping supply. Consequently, waitlists increased dramatically. One of the guiding principles of the Peel Health Hub's Model of Care (MoC) is that all clients be supported while on waitlists as part their continuity of care. Therefore, a major component of the Clinical Care Coordinator's (CCC's) role within the Hub MoC became the management and support of clients on Pell Health Hub co-locator's waitlists. With demand for Hub services expected to continue to increase, additional staff members were required to meet the growing demand.

Impact we have/ Benefit to Peel:

- Reduce waitlists across all co-locating PHH services- significant number of referrals are diverted from other services as a result of receiving a clinical intervention through the CCC. The CCC provides clinical interventions and engagement whilst clients wait on other services' lists. This reduces disengagement, risk and often completes care.
- 0 days on a waitlist as clients are seen immediately and engaged by the CCC team
- Reduced admissions to Peel Mental health, ED, and other external services
- Better experience for clients by minimising history-taking sand story-telling, with information shared with consent by the CCC.
- 97% of clients feel that the care received has led to an improved health outcome
- each patient diverted from attending a hospital Emergency Departments saves an average of $645. The cost per patient attendance for forensic sexual assault services at and Emergency Department could be over $2,200.
- each patient diverted from admission into a public hospital for acute general mental health services saves approximately $1,572 per day. The average length of stay is 13.2 days. Therefore the average total cost per admission is $20,750
- each child or adolescent diverted from admission to a public hospital saves $2,906 per day. The average length of stay is 41 days. Therefore the average total cost per admission is $119,146

Who does the CCC team see?

- Clients presenting to the PHH experiencing severe mental health, co-occurring AOD and other drugs, and other biopsychosocial issues.
- Clients who are referred to the CCC program by Peel Community Mental Health, Peel Health Campus (ED) or another external stakeholders.

Benefits of Clinical Care Coordination:

- Build trust and rapport with clients.
- Clients treated with respect and encouraged to take an active role in their care planning and recovery.
- Lack of repetition in telling the story. The initial assessment by the CCC provides information – with consent – for other services who become involved in care.
- Support families and carers with information and advice.

In the last year 2021-22, the CCC team carried out:

- 138 walk-in assessments (clients who presented without prior appointment)
- 3879 Occasions of service (includes face to face appointments, tele appointments and service liaison)
- 240 care coordinated clients, providing therapeutic input, case management on a range of social issues and liaison with other services, including referrals and handovers.

2. Evidence of innovation and/or recognised best practice.

The model of care used is simple and intuitive, but also supported by a large body of independent research. It has been successfully applied overseas, however the Peel Health Hub is the first example of a purpose built 'one stop shop' health service in Australia.

The care coordination workers are highly skilled clinicians who are able to provide triage, screening/assessment, and immediate engagement and therapeutic intervention with the client from the first point of contact. This team operates with a much higher skillset than is typical of a triage, screen/assess/refer function.

The benefit of utilising skilled clinicians at this initial client engagement stage is that clients are supported immediately from the point at which they walk into the PHH. There is no waitlist for service. Clients will be referred to relevant services within the PHH, however whilst they sit on the relevant service waitlist, the CCC team provides continued engagement and begins the therapeutic intervention with the client.

Often, by the time the client has progressed through the waitlist to another service, they no longer require therapeutic support- in other words, the CCC team has provided the appropriate therapeutic intervention for the client at the time that they needed the support. If the client does require further intervention, the CCC team provides a 'warm' handover to the relevant service ensuring that the client does not need to retell their story with a new service, and the new service is able to pick up at the appropriate stage of intervention as opposed to recommencing the intervention from the beginning.

The Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents (ICA) aged 0 – 18 years in Western Australia was released in March 2022 and outlined a framework to transform the mental health system into a contemporary, evidence-informed model of service and models of care that meet the needs of children in WA from the day they are born through to their 18th birthdays.

Prevention, early intervention and primary health care are key priorities outlined in this report and this is exactly what the CCC delivers within the Hub Model of Care.

Key Action 7 of the report proposes: *Enhancing ICA mental health services with contemporary infrastructure, technology and research*. Which supports recommendation 27: *Establish new*

integrated ICA mental health facilities in all regions to support more flexible, responsive and expert care.

The State Government has recognised the innovative approach taken within the Peel Health Hub is best practice in realising substantial health outcomes for consumers as well as providing key systemic efficiencies addressing workforce issues. In fact they detail a vision for "integrated 'Hubs' in the Perth South, Perth North and Perth East metropolitan regions, and across regional WA.

These hubs need to be the 'engine-room' of the future ICA mental health system, delivering comprehensive, child-centred mental health services. The Community ICAMHS Hubs provide an opportunity to bring traditionally separate services together into a single community-based setting as part of a 'one-stop-shop' for all health and mental health supports for children, and their families and carers." (Final report - Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in WA, p97).

3. Evidence of participation of mental health consumers in the planning, implementation and evaluation of mental health service delivery. Evidence of prioritising increased level of engagement and influence of consumers and where higher level participation such as authentic co-design is highly favoured.

The Peel Health Hub Development Group was formed in September 2016 following a period of consultation with potential co-locators and partners. The Development Group included GP down south, Peel Youth Medical Service (PYMS), PYMS Youth Reference Group, Palmerston Association, Allambee Counselling, Child and Adolescent Mental Health Service, City of Mandurah, Peel Development Commission and Interite Healthcare. The Development Group was actively involved in contributing to the Business Case and Concept Plans for the Peel Health Hub.

The Development Group also developed relationships between stakeholders and partners in the Peel region to co-design the client-centred integrated model of care for the shared facility.

Youth participation is paramount to ensuring the Peel Health Hub Model of Care will deliver the right services at the right time and in the right way. The PYMS Youth Reference Group has been involved in visioning for the Peel Health Hub, providing a sounding board for implementation plans and representing the often unheard voice of youth in the policy and political arena.

As the project moved from development to operational, the principles of co-design have been embedded across the CCC to involve clients and service providers in all aspects of the facility.

The Operational Group evolved into the Operational Group which meets monthly to discuss shared care plans, and other operational matters.

4. Evidence of partnerships and linkages with all key stakeholders (collaboration for continuity between organisations).

GPds have pioneered innovative and successful collaboration between service providers (mental health, alcohol and other drugs, assault, sexual abuse and family violence) through the Peel Health Hub's Clinical Care Coordination Team and its unique Model of Care.

The Peel Health Hub provides a GP supported, comprehensive and coordinated approach to improve the mental, social and physical health of its clients. The unique Model of Care is agreed to and supported by all co-locators so that young people are supported in their journey. The Model of Care takes a 'no wrong door' approach and the role of the Clinical Care Coordination Team (CCC) results in

reduced repetition of storytelling and enables 'warm' handovers of clients who need to be referred to other services.

Current co-locators in the Hub include Palmerston, Youth Focus, JSW, Women's Health Clinic (South Metropolitan Health Service – Dept of Health WA), Allambee Counselling, and Richmond Wellbeing. Additionally, in-reach to the Hub is provided by local agencies including Peel Mental Health, Centrelink, Helping Minds, Jobs and Skills Centre and APM.

The Peel Health Hub model provides essential features for responding to client complexity by creating a single centre for co-locating agencies with a focus or interest in youth health, ensuring the Hub itself is always the right place for a young person to present

GP down south works closely with Peel Health Campus and Peel Mental Health Services to deliver the CCC program from the Peel Health Hub. Most external referrals in to CCC team come from the Peel Health Campus emergency department or Peel Mental Health. Relationships between these organisations and GPds are strong, trusting and well established. This is shown through the recently established joint placement of a psychiatric registrar into the Peel Health Hub a collaboration between Peel Health Campus, Peel Mental Health and GPds. The position is funded by the Royal Australian and New Zealand College of Psychiatrists.

The Peel Health Hub and Clinical Care Coordination Team are involved in a range of direct and multiagency partnerships across the Peel region that facilitate interagency referrals and shared care. Key partnerships include:

- Peel Community Mental Health
- Co-locators within the Peel Health Hub (Palmerston, Youth Focus, Allambee, Jobs Southwest, Child and Adolescent Mental Health (CAMHS))
- Department of Child and Family Services
- Ruah
- Peel and Rockingham Kwinana Mental Health Services (PaRK)
- Wanslea
- Secondary Schools throughout the Peel Region
- Peel Health Campus
- Passages drop in centre
- Billy Dower Youth Centre
- Winjan Aboriginal Corporation
- Ovis
- Peel Youth Services
- Calvary
- City of Mandurah Youth Services
- Clontarf
- Centrelink Community Services
- Jobs and Skills
- St Vincent de Paul
- Helping Minds
- APM (NDIS application assistance)
- Peel Health & Wellbeing Taskforce: Co-ordinated by Peel Development Commission, GPds has 2 nominated representatives on this regional taskforce
- Peel Mental Health Taskforce: GP down south has representation on this group and is an active member of the Stakeholder Reference Group.

5. Verification of effectiveness (quality improvement activity, data collection and its use, including graphs and tables, achievement of performance indicators, e.g. attendance figures, outcome measures, number of document downloads, page views, click through rates etc).

An independent evaluation of the CCC team within the Peel Health Hub was emphatic in recognition of the service being a key service which was needed by the community.

The service averages approximately 300-400 occasions of service per month, with active care coordination of approximately 100 clients at any time. Many of these clients are young and use illicit drugs. Support and recovery is therefore of benefit to the individual, family and the community in terms of reduced illicit drug use and associated disengagement from society.

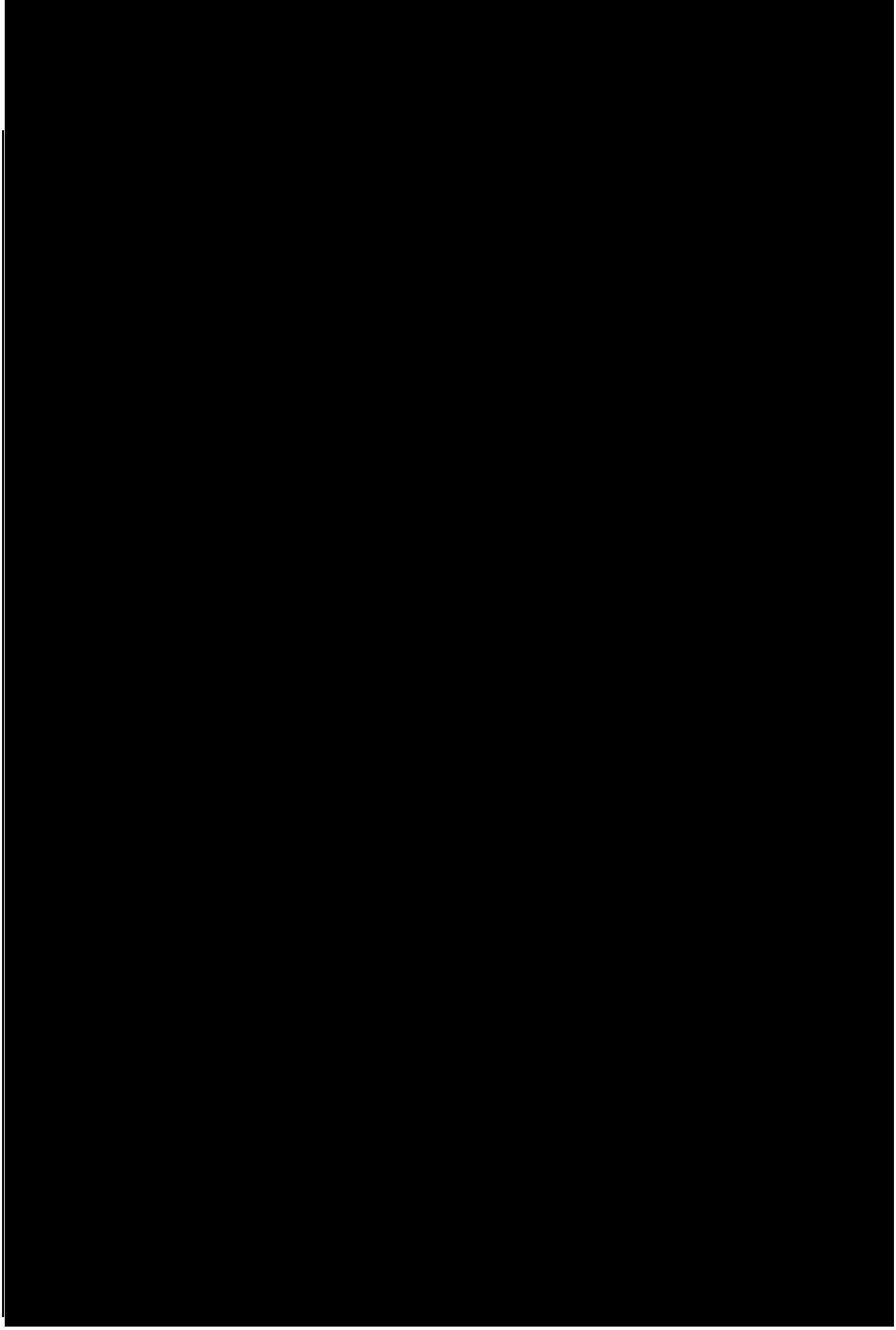
The service also provides advice and direction to callers, mostly parents, seeking help in the care of themselves or family in relation to mental health or drug use. This may be an entry point for service provision.

The Peel Health Hub is an inclusive centre. The Clinical Care Coordination Team assesses anyone who may present with mental health and AOD issues, though the main demographic is young people in Peel, under 25 years old.

During and at the end of care, clients are assessed for measurement of improved mental health and wellbeing with clients surveyed to obtain feedback on the effectiveness of the service. A summary of this feedback is attached.

Data from a report to funders 1 Jan 2022 – 30 June 2022:

Activities Indicators	This Period			Last Period		
	Numerator	Denominator (Total)	%	Numerator	Denominator (Total)	%
1 Percentage of clients who indicate an improvement in	67	78	85.9%	114	126	90.5%



Door Counters July – December 2022 (all visitors to the PHH)

- • July 4810

- • Aug 6115
- • Sept 5343
- Oct 5984
- • Nov 6100
- • Dec 4363

- **Total 32715**

An analysis of 2015/16 data from the Peel Health Campus reveals that by avoiding just 10% of the 226 adolescent mental health presentations, and therefore the transfer of 52 patients for admission to a psychiatric unit, an average annual cost of $361,727 could also be avoided. The 30-year NPV of the cost avoided would be $9.25 million.

It is difficult to track behaviours that don't occur, however, we have anecdotal evidence that the CCC team through the Peel Health Hub has had a positive impact on the mental health of many young people in the Peel region and as a by-product of the existence of the service, diverted may ED presentations.

Conclusion (1/2 x A4 page).

The Clinical Care Coordination team engages with young people in a way that is client centred, trauma informed, inclusive, safe, culturally secure and accessible for all regardless of background. In our collective experience, the young people who present at the Peel Health Hub experience a range of biopsychosocial comorbidities including co-occurring mental health and AOD issues and significant trauma backgrounds. These young people suffer the worst mental health, employment, housing and financial outcomes of all young people. These young people are also at a key 'turning-point' in life-stages development, in which the opportunities for positive intervention and functional recovery are high and significantly better than in any other stage of life.

For the young clients who seek support and treatment, their goal is to lead a normal life in a meaningful way, part of which is to be engaged in employment or education. However, for many, mental health concerns, drug and alcohol issues and other health issues are fundamental barriers to their participation. Therefore, addressing these barriers is a prerequisite to access and participation in employment and education.

The Clinical Care Coordination team is leading the way in treatment and a new approach by:

- prevention and early intervention treatment of mental health issues to avoid escalation;
- facilitating early discharge from hospitals into the community with adequate support;
- avoiding emergency department (ED) presentations and related costs;
- taking pressure out of child and adolescent care; and
- avoiding the trajectory of joblessness and / or the justice system.

Referees (1/2 x A4 page).
Nominate two referees.

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Appendix of Support Material (max. 8 x A4 pages).

Final report - Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in WA, 2022

Video promoting the Model of Care: https://youtu.be/CC4dx-f_AGQ

GP down south

Local health. Our business.

PEEL HEALTH HUB

CLINICAL CARE COORDINATION TEAM

A unique Model of Care with the Clinical Care Coordination (CCC) team providing Advanced Clinical Access interventions to over 240 clients in the last year. This ensures early comprehensive assessment, initial care-planning and timely care. This model also provides value for money by reducing repetitive assessments and diverts clients from crisis presentations at emergency services.

Employed by GP down south, but working for and with all Peel Health Hub (PHH) co-locators.

- Experienced tertiary qualified clinicians skilled in assessing and working with complex mental health and substance use issues.
- Excellent knowledge of local services to effectively manage people in crisis.
- Central to the Model of Care facilitating shared care between PHH co-locators and with external services.

> *"If the CCC team was reduced there would be less immediate support provided to clients at a time when they need it the most. The risk that this then poses is immense and can disadvantage vulnerable people and can potentially lead to deaths. Without the CCC team a person coming to the Peel Health Hub may be placed on a waitlist for a relevant service, but due to lengthy waitlists will then not have their immediate support needs met. The CCC team provide a safety net."* - Co-locator -

Key principles of the Model of Care:

01 Provide immediate engagement, clinical assessment and support to individuals and carers when they present, often without notice.

02 Operate a no wrong door policy.

03 Reduce repetition of storytelling (warm handovers between agencies).

04 Improve communication between services to reduce barriers and improve access.

05 Support individuals and carers who have complex needs, or are in crisis, to engage with support and care involving multiple services.

06 Provide client centred care, including on-going engagement whilst individuals wait to connect with relevant services. This reduces deterioration and crisis, manages risk, reduces emergency service involvement and improves health outcomes.

> *"The CCC team will never know how positively they have impacted my life"* - Client -

The main components of the CCC service:

- To be the first point of contact for anyone coming into the PHH as a walk in or telephone self-referral.
- To conduct intake assessments, determine risk, plan care with the individual and facilitate access to identified services.
- Develop shared care plans with input from relevant service providers.
- Engage with clients in the on-going development of their care plan and whilst they are on other service waitlists.
- Coordinate service planning to ensure efficiency across the service network.

> *"The Model of Care used is simple and intuitive, but also supported by a large body of independent research. It has been successfully applied overseas, however the Peel Health Hub is the first example of a purpose built 'one stop shop' health service in Australia"* - External Stakeholder -

Why is the CCC service important

Demographics of Peel community:

of the population is made up of 12 – 25 year-olds

MANDURAH (Peel Region) has a relative **LOW** SEFIA score denoting relative socio-economic disadvantage to the population

20% - 30% of clients are on waitlists for other services. Engaging with the CCC team reduces disengagement, deterioration and crisis events. Some clients do not go on to specialist services due to their work with the CCC team.

> *I have been a GP in Mandurah for nearly 30 years with a focus on working with people adversely affected by the social determinants of health who typically struggle to manage the health and welfare system and frequently fall between services. The difference that the CCC make to the lives of everyone they come into contact with is significant on the measurable outcomes such as ED presentation and suicidality but its the immeasurable qualitative benefits to the individual's lives that are most significant. The input from the CCC team also increases the effectiveness of the other agencies by more appropriate referral pathways and supported transitions to those agencies. Personally my working life has been transformed and the CCC team enable more effective primary health care and I feel much less frustrated with the system that fails so many.* - Dr Rupert Backhouse -

Services co-located within The Peel Health Hub

- Peel Youth Medical Service (GP practice)
- Counselling & Psychology
- Women's Health Service
- CAMHS
- Youth Focus
- Palmerston
- Allambee
- Streetnet
- Jobs South West
- Centrelink

External agencies working closely with PHH services:

Peel Health Campus, Peel Community Mental Health, Fiona Stanley (In-patient Mental Health, YCATT, Eating Disorders Clinic), Department of Communities, Department of Justice, schools, Anglicare, Relationships Australia, Jobs & Skills, St Vinnies, Carers WA, APM.

> *We constantly refer. We're ringing parents telling them to take their kids to the PHH. The service has become important to us. It's now our first port of call externally.* - External Stakeholder -

> *It's a great team ... achieving great things ... the value of it is absolutely clear to everyone.* - Co-locator -

> *Finally, someone listened to our concerns. Finally, someone who cares.* - Client -

In the year 2021-22, the CCC team carried out:

138

walk-in assessments (clients who presented without prior appointment)

3879

occasions of service (includes face to face appointments, tele-appointments and service liaison)

240

care coordinated clients, providing therapeutic input, case management on a range of social issues and liaison with other services, including referrals and handovers.

Who does the CCC team see?

- Clients presenting to the PHH experiencing severe mental health, co-occurring AOD and other drugs, and other biopsychosocial issues.
- Clients who are referred to the CCC team by Peel Community Mental Health, Peel Health Campus (ED) or another external stakeholders.

> *I loved the service and what they offer, they saved my life. Staff are amazing and helped me through so much. Love that I found this place. Always feel well looked after and respected :)* - Client -

Benefit to Peel:

- ✓ 0 days on a waitlist as clients are seen immediately and engaged by the CCC team.
- ✓ The CCC is a community based support service improving outcomes for clients and reducing referrals to tertiary health services.
- ✓ Each patient diverted from admission into a public hospital for acute general mental health services saves approximately $1,572 per day. The average length of stay is 13.2 days. Therefore the average total cost per admission is $20,750.

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