Developing Models of Care for Eating Disorders

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Important elements of a MoC

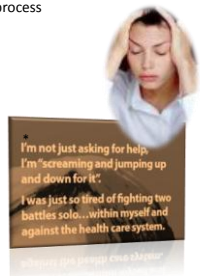
1. Leadership by executives
2. Engaging clinical leaders
3. Multi-disciplinary team solutions
4. Patients & carer collaboration
5. Baseline data collection & monitoring change
6. Targets & timeframes

Other features of a MoC – the Service

1. Solutions that lie within current resources should be implemented
2. To standardise processes & care delivery
3. To maximise resources, & avoid duplication
1. Staff benefit by avoiding frustrating clinical processes

Other features of a MoC – The Patient

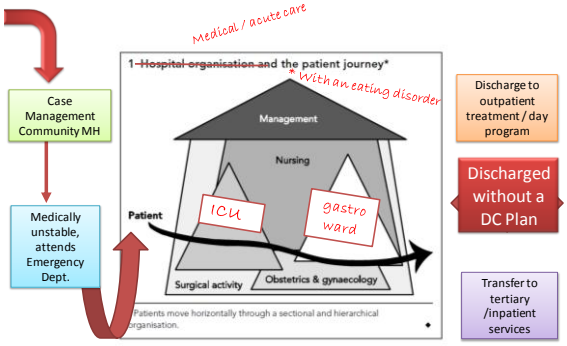
- Coordination of care aims to achieve a seamless patient journey
- By achieving a more simple and coordinated process
  - Patients are not lost to the system
  - Increased patient safety
  - More timely access
  - More effective care
  - Improved patient/ carer satisfaction



* *Taken from "Paying the Price" The Butterfly Foundation 2012*

The Patient Journey

- *"The right care in the right place at the right time"*
- A repeating pattern of key components of every patient journey
  1. Referral/admission
  2. Assessment/service delivery
  3. Discharge/transfer of care



The Patient Journey

Mapping the Patient Journey

- The patient is the only one who sees the whole journey
  - Avoiding disconnection between stages of the patient journey
  - Making essential steps work more efficiently
- The steps make the journey visible to (important) others
  - Real-life problems with real patients engages staff
  - This drives change
- What steps add value and impact on this journey?
- Ask clinicians / managers:
  - *"If this was your **INSERT** {daughter/sister/friend} what would you want to happen?"*

Advantages of a standardised process

Eg *Acute medical admission is required if BMI < 16 and / or HR ≤ 40*

1. A documented set of agreed standards facilitating a consistent care pathway
2. Provide a benchmark when assessing process/pathways etc
3. Improved quality of care
4. Easier for clinicians (*to teach, less decision making, second nature*)
5. Appropriate admissions to care setting
6. Managing patient flow & optimal use of care setting /beds (& supports continuity external to your care setting)

Data & Monitoring

- Do you have a baseline in order to measure benefits?
  - Ideal to collect data prior to implementation
  - The effort to collect data should not outweigh the benefit
- Some examples
  - Waiting times for treatment
  - Length of stay in .....*an acute inpatient bed*
  - Patient & carer satisfaction
  - Time to first appointment from referral
  - % of patients with MDT care plan within 1 week of admission
  - Delays of transfers between care settings due to provider factors *i.e. waiting for an inpatient bed, enrolling in a day program*

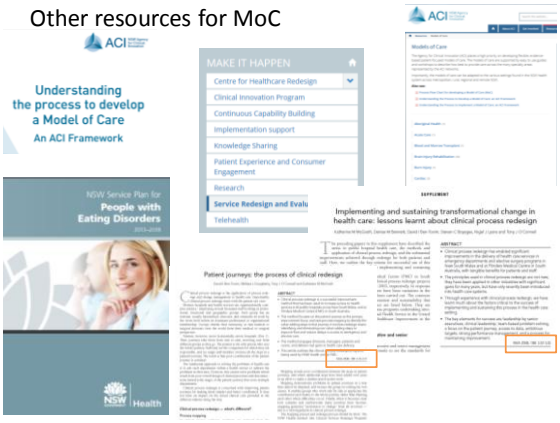
Care plans and discharge planning

- Core elements of good practice
- A consistent planning process from admission to transfer of care / discharge
  - Good communication
  - Clear management plan
  - Realistic goals
  - How does the multi-disciplinary team share information? **i.e. current weight**
  - Plan for follow-up & by who?
  - Inclusion of patients & carers in decision-making

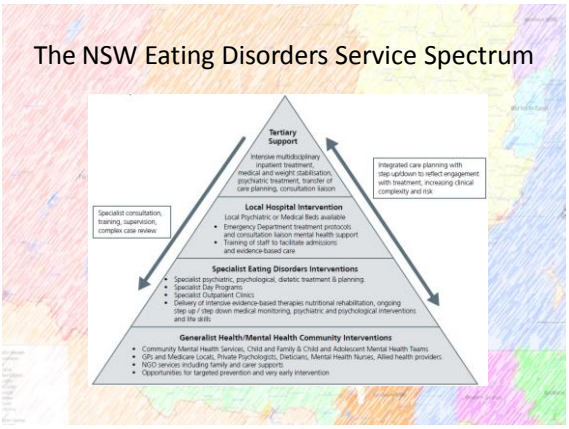
What are your local resources for MoC?

- What are the key relationships required?
  - Which disciplines of staff currently provide services? FTE?
- What processes & tools are in place to support access, referral, admission, assessment, care delivery?

Other resources for MoC



The NSW Eating Disorders Service Spectrum



Key elements of a MoC for eating disorders

- The system / your LHD / service
  - A whole-of-health model of care
  - A responsibility for early identification, assessing and delivering treatment
  - To support self sufficiency in each LHD
  - Developmentally appropriate services (*children, adolescents, adults, older adults, during pregnancy*)
  - Across the care continuum meeting every level of clinical need (*outpatient to inpatients*)
  - Policy, protocols, referral pathways & information
  - Access to specialist/tertiary treatment when required
- Individual
  - All clinicians need to know their treatment responsibilities
  - Patients access treatment where they live
  - Timely access
  - Carer & consumer collaboration

Challenges, barriers & CHANGE

- Traditional view of health
  - Vertical system versus horizontal patient journey
- Groups based on function
  - Orientate work by views endorsed
  - Cherish autonomy
  - Resist change
- Your LHD /service/system?
  - Organisational readiness
  - Breaking down "silo" mentality
- Understanding views (stigma/ bias) against eating disorders
  - System views versus individual views

Stigma/Bias

- System views:
  - Its someone else's problem
  - Assumed to be the domain of experts in some *other* service
  - "They should come under …..{*enter specialty*}"
  - They should be treated by specialists only / at RPA etc
- Individual views:
  - It's a lifestyles choice & they should……..

    "just eat" *"get over it"* *"pull themselves together"*
  - Difficult to communicate with, manipulative, selfish, a liar, don't want to get better
  - Leads to becoming frustrated, judgemental, critical, angry

* *Taken from "Paying the Price" The Butterfly Foundation 2012*

Day Program Pilot model 2008 - 2011

Important aspects of the MoC

- **Location**
  - Terrace house in Glebe relocated to RPA 2014
- **Service to be delivered**
  - 6-8 patients, 4 days/ week, group based CBT, treatment philosophy
- **Staffing requirements** (multi-disciplinary)
  - 3.9 FTE (7 staff)= dietetics, psychology, occupational therapy, RA
- **Key message**
  - Effective clinically, mood, QOL
  - Keeps people out of hospital
  - Consumer / patient satisfaction
  - Accessible
  - Cost effective (when compared to inpatient admission)

5.5 Program structure & content (*see program timetable p55*)

Therapy is provided primarily in a group format, with a weekly individual ca[...] coordination session to set goals, monitor and facilitate progress through th[...]

a. Psychological therapy:
- Motivational Enhancement Therapy;
- Dialectical Behaviour Therapy;
- Acceptance and Commitment Therapy;
- Mindfulness-Based Cognitive Therapy;
- Cognitive Behaviour Therapy;
- Structured weekend planning and debrief;
- Relapse prevention;
- Skills based groups (on distress tolerance; emotional regulation; interpersonal effectiveness; assertiveness & communication skill[...] acceptance and commitment in context of emotional distress);
- Body image.

b. Dietetics:
- Meal planning;
- Food diary and monitoring;
- nutritional education;
- Practical food groups, shopping, cooking, and eating out.

c. Psycho-education & nursing based groups:
- Media Literacy;
- Side effects of eating disorders;
- Health issues, medical management and medication;

d. Occupational Therapy:
- Life skills & integration back to work/uni;
- Exercise /movement groups;
- Creative arts groups;
- Practical meal experiences and social eating.

e. Meal time management and supervision:
- Staff supervise all meals, snacks and rest periods for at least 1 hour after the meals to contain purging and other maladaptive behaviours;
- Access to bathrooms after meals is restricted;
- Staff model normal behaviour by eating with patients and participating in practical food activities such as eating out, shopping and cooking;
- Staff provide feedback to patients about inappropriate eating behaviours and difficulties while eating.

f. Medical/psychiatric monitoring:
- Psychiatrists participate in initial assessment of patients for the program;
- Fortnightly assessment by the patient with their GP;
- Regular liaison with the psychiatrist if there are physical or psychiatric concerns;
- An action plan for management of medical or psychiatric crises during treatment hours;
- Decisions regarding patient admission /discharge are in consultation with the Medical Director;

g. General tasks of program:
- Weekly weigh in;
- Use of treatment contracts;
- Weekly patient feedback session;
- Homework tasks (self monitoring of eating / behaviours / moods & urges);
- Plan and review format, with regular group discussion of successes and failures since leaving the program

6.2 Project timeline from 2008-2011 is outlined in the table below.

Table 6.2: Stages of pilot project implementation

	Project Implementation – Set up	
July '08	NO STAFF	1. Project commencement date
Aug '08		
Sept '08		
Oct '08		
Nov '08	PROJECT PLANNING & SET UP	2. Program Coordinator appointed • *Consultation & research* • *Program format designed* • *Original site designs completed* • *Recruitment commenced – all position descriptions completed*
Dec '08		
Jan '09		
Feb '09		3. Inventory developed and ordering of program supplies • *Kitchen items, cutlery, electrical goods, audiovisual* 4. Alternative site to Missenden Unit needed
Mar '09		
Apr '09		
May '09		
Jun '09	FIRST STAFF MEMBERS EMPLOYED CLINICAL & DISCIPLINE SPECIFIC PROGRAM DEVELOPED	5. RECRUITMENT: a) Food service assistant recruited • *Service agreement with Food Service Dept negotiated* • *Development of Food Safety Program* • *Development of menu & independent food service system* b) Occupational Therapist (OT) recruited • *OT inventory including art supplies* • *Developed OT component of program* c) Research Psychologist recruited • *Psych data & SPSS licence purchased* • *Commenced data base set up* 6. Property at Derwent St found and refurbishment of site started • *Economical interior design to develop a therapeutic ambience, including painting of house, and furniture purchased* • *Stationary* • *Policies & procedures developed and processes established i.e. supplies, payroll, risk management, OHS*
Jul '09		Lease obtained for 2 years
Aug '09		7. Clinical Psychologist recruited *Ongoing set up: furniture, interiors, stationery*
Sept '09		8. Promotion of program & taking referrals for day program 9. Wiring & networking of site completed i.e. phones, computers, secure internet
Oct '09		10. Relocation of Day Program team to Derwent Street 11. Implement OHS procedures including compliance with fire safety & food safety
Nov '08		12. Finalisation of menus and food service agreements • *First food ordered for program on 1/12/09*
Dec '09		13. Pre-treatment program started with waiting list patients
Jan '10	PROGRAM OPERATIONAL 24 hrs/week	13. Program commenced 24 hours per week Research Psychologist re-recruited
Feb '10		14. Food Safety Audit for Licence by Food Authority NSW
Mar '10		15. Data collection commenced
Apr '10		
May '10		CEDD Conference
Jun '10		Admin Assistant recruited
Jul '10	PROGRAM OPERATIONAL 30 hrs/week	16. Program Review and Debrief Program commenced 30 hours per week
Aug '10		ANZAED Conference
Sept '10		EQUIP (Area Mental Health Service)
Oct '10		
Nov '10		Research psychologist re-recruited
Dec '10		Christmas close / staff annual leave Program Review and debrief

Questions for your service/ LHD

- Identify current care
  - Identify 'gaps' of current care
  - How do they enter & exit your service?
  - Where can they fall between the cracks?
  - Can you identify the "patients" in your area?
  - Why is the current model not an option?
  - Find evidence that demonstrates the need for enhanced care
- Identify opportunities appropriate for local context
  - Incorporate core elements of 'good practice'
  - What is the most appropriate model?