The organisation of psychosocial care in Belgian General Hospitals

‘Clinical Microsystems’ as a management tool to evaluate and facilitate integrated psychosocial care

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Ziekenhuis Oost-Limburg - Schiepse Bos 6 - 3600 Genk - Belgium
Regional university affiliated hospital (Leuven)
814 beds
Flemish part of Belgium
Multicultural region
General hospital with specific specialist functions
Psychosocial care in our hospital: history

• Social work
  • Started in 1978. More administrative function, also from hierarchical/management point of view)
    • Tasks: follow up of payments by patients, registration, health insurance issues,
      ....)
  • 1996: Transferred to nursing department because of wish to work in/to be involved in more patiënt-oriented way

• Liaison psychiatry
  • Initially in addition to the work in the inpatient psychiatric ward
  • From 2001 additional funding for liaison psychiatrist

• Psychologists
  • 2001 hospital itself decided to fund hospital psychologists
  • In later years more public funding for hospital psychologists, numbers increased
Psychosocial care in our hospital: history

• Challenge: how can we make all these disciplines work together in an integrated way?
  • Logical reasons
  • Economic reasons
  • Ethical reasons

• The story continues even further: recently several specialist nurses (diabetes, pain, geriatrics, breast cancer, palliative care, ..... ) were appointed in the hospital.

• Specialised versus generic care: how to find an answer in the organisation?
Current situation: staffing

- **Social work**
  - 15.5 FTE social workers (nurses)
  - Preferentially linked with fixed somatic departments (back up provided)
  - 3.5 FTE intercultural workers

- **Psychology**
  - 10 FTE psychologists
  - ‘couples’: cardiology/pneumology, pain, geriatrics, oncology
  - ‘single’: fertility clinic, diabetes, child psychology
  - ‘Ad hoc’ arrangement for medical services that don’t have their ‘own’ psychologist

- **Liaison psychiatry**
  - 1 FTE for old age liaison psychiatry (linked with geriatric department)
  - 0.6 FTE for adult liaison psychiatry (linked with other somatic departments)
Current situation: integration

- patient level
  - patient briefings systematic
  - ad hoc case discussion and mutual referral
- organisational level
  - briefing
  - meeting with management
  - spatial integration: informal contacts
  - funding
  - secretarial function
  - ict
Pain clinic has standard team:
- Pain psychologist
- Social worker
- Psychiatrist
- Others

Specialised care is formed around patient with chronic pain:

What if?
e.g. geriatric patient with diabetic polyneuropathy, suspected dementia, and husband with malignant cancer and no social support

Specialised Psychosocial care is needed:
Eg. Neuropsychologist (working on Neurology ward) Social worker for the elderly (geriatric ward), gerontopsychiatrist

In most cases: standard care is best care
Tailormade solutions are necessary in some cases
Moving from department centered care to patient centered care:

- Psychology Department
- Social Department
- Psychiatric department

Team Meeting
Psychosocial Care

Patient Clinic

- Neuropsychologist
- Geriatric social worker
- Old age psychiatrist
Een kritische analyse van de organisatie van psychosociale hulpverlening in Belgische algemene ziekenhuizen

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Guido Van Manhe

Promotor: Prof. Dr. K. Dehuytsdare
Co-promotor: Prof. Dr. J. Kips

Werksbeleider:
Masterprof aangesteld tot het verkrijgen van de graad van Master in het management en het beleid van de gezondheidszorg
Overview field study

- Our own hospital
- Literature overview
- Field study
- Conclusions
- Recommendations
- Suggestions
Clinical Microsystems

• “Microsystems are small, organized groups of clinicians and staff working together with a shared clinical purpose to provide care for a defined set of patients.

• The clinical purpose defines the essential parts of the microsystem. A microsystem must be large enough to accomplish its clinical purpose, but small enough to allow knowledge of the individual parts and the interrelationships between the parts.

• Use of information is key to the microsystem’s ability to function; information technology facilitates collecting, assessing, and sharing information.

• Microsystems may be part of a larger organization and are embedded in a legal, financial, social and regulatory environment”

Mohr, 2000
Clinical Microsystems

✅ System
  ✓ Network of mutual dependent parts that work together to obtain the goal of the microsystem (Deming, 1993)
  ✓ Successfactor: Cooperation between the different components of the system

✅ Smallest replicable unit (Quinn, 1992)
  ✓ Intelligence of the organisation
  ✓ Small unit is easy to replicate in other parts of the larger organisation (Bierly, 2002)

✅ Essential components: Key persons, core activities, micro-measures, process improvement
Clinical Microsystems in psychosocial care

✓ Key persons
  ✓ Social workers, Psychologists, Psychiatrists, Patients, (specialist-) nurses

✓ Core activities
  ✓ Screening, diagnosis, treatment, referral

✓ Micro-measures
  ✓ Patient satisfaction, outcome and quality indicators

✓ Process improvement
Clinical microsystems: 10 critical success factors

- Leadership
- Organisational support
- Staff focus
- Education/training
- Interdisciplinary dependence
- Patient focus
- Market and environment focus
- Performance results
- Process improvement
- Integration of information for patients
- Integration of information for staff
- Information technology
Overview

✓ Literature overview
✓ Field study
✓ Conclusions
✓ Recommendations
✓ Suggestions
Field Study

✓ Method
  ✓ Sample of 10 Belgian Hospitals (9 Flemish, 1 Walloon)
  ✓ Web based questionnaire
  ✓ Hospital visit for semi-structured interview with
    ✓ Hospital management
    ✓ Psychiatrist
    ✓ Psychologist
    ✓ Social worker
  ✓ Use of Clinical Microsystem Assessment Tool (CMAT)
Sample description

<table>
<thead>
<tr>
<th>Table 5: Description of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Type</td>
</tr>
<tr>
<td>Univ</td>
</tr>
<tr>
<td>Non-univ</td>
</tr>
<tr>
<td>Size (beds)</td>
</tr>
<tr>
<td>0-500</td>
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<tr>
<td>501-1000</td>
</tr>
<tr>
<td>1001+</td>
</tr>
<tr>
<td>Presence of Psychiatric Department</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6: Presence of disciplines during visit</th>
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</thead>
<tbody>
<tr>
<td>Social services</td>
</tr>
<tr>
<td>Psychology</td>
</tr>
<tr>
<td>Liaison psychiatry</td>
</tr>
<tr>
<td>Management</td>
</tr>
</tbody>
</table>
Results
Psychology department staffing

**Employed Psychologists**
Mean: 1.57  Range: [0.70-3.00]
Results
Psychology department

✓ 4/10 hospitals have a psychology department
✓ 4/10 hospitals have a functional head of department (always a psychologist)
✓ 3/10 have their own mission statement

<table>
<thead>
<tr>
<th>Higher management</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Director</td>
<td>5</td>
</tr>
<tr>
<td>General Director</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>
Results
Psychology department

 ✓ Funding
   ✓ Different sources
   ✓ Most of resources are governmental
   ✓ 1 hospital has solidarity funding by physicians
   ✓ In 9/10 hospitals patients have to pay
      ✓ Large differences (10-150 €; outpatient vs residential)
   ✓ 1/10 hospital → self-employed psychologists
Results
Social Services staffing

Employed Social Workers
Mean: 1,86  Range: [0,92-3,21]
Results

Social Services

✓ 10/10 hospitals have a Social Service Department
✓ 10/10 hospitals have a functional head of department
  ✓ 5 social
  ✓ 4 nurses (social)
  ✓ 1 psychologist
✓ 7/10 have their own mission statement

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Director</td>
<td>8</td>
</tr>
<tr>
<td>Financial Director</td>
<td>1</td>
</tr>
</tbody>
</table>
Results
Social Services

✓ Funding
  ✓ Different sources
  ✓ Most of resources are governmental
  ✓ 2 hospitals have solidarity funding by physicians
  ✓ In 0/10 hospitals patients have to pay
Results

CLP Department staffing

**Employment CLP**
Mean: 0.0642 Range: [0.009-0.147]
Results
CLP department

✓ Only in 1/10 hospitals, the liaison psychiatrist works exclusively for the general hospital
✓ In 9/10 hospitals, the liaison psychiatrists have other positions out of the general hospital (private practice, psychiatric hospital, community mental health centre, ...)
✓ 3/10 hospitals employ junior doctors in liaison psychiatry work (numbers of junior doctors in psychiatry are dropping dramatically)
Results
CLP department

✓ Funding
  ✓ Consultation fee
  ✓ Solidarity funding by other physicians (2/10)
  ✓ Funding by hospital (3/10)
  ✓ Other medical or surgical departments don’t pay for liaison psychiatry services
Results

General

✓ Presence of Multidisciplinary Liaison Psychiatry teams
  ✓ Stand alone teams (6/10)
    ✓ Psychiatrist (6/10)
    ✓ Psychiatric nurse (2/10)
    ✓ Psychologist (4/10)
  ✓ Integration with psychology department / social work department very poor
  ✓ Tasks: specific psychiatric expertise / attending medical/surgical wards that don’t have a psychologist as member of their medical/surgical team
Results

General

✓ Only 2/10 hospitals have a regular management meeting with different partners in psychosocial care
  ✓ Psychiatry + psychology
  ✓ Psychiatry + psychology + social services + Management
✓ University hospitals have more funding for psychology and social work, but less funding for liaison psychiatry (relative to # beds)
Results
Clinical Microsystem Assessment Tool

Mean scores on CMAT (N=22)
Results
Clinical Microsystem Assessment Tool

✓ Not enough focus on
  ✓ performance results
  ✓ process improvement
  ✓ the environment and market

✓ Enough focus on
  ✓ Staff (training, education, ...)

└── Ziekenhuis Oost-Limburg
Overview

✓ Literature overview
✓ Field study
✓ Conclusions
✓ Recommendations
✓ Suggestions
Conclusions (1)

- There is a great variety in psychosocial care in Belgian Hospitals (staffing levels, organisation, interdisciplinary work,..)
- Belgian hospitals are not fully prepared to develop multidisciplinary psychosocial care
- Psychosocial care in general hospitals lacks quality and outcome indicators
- Hospitals increasingly choose for multidisciplinary psychiatric liaison teams
Conclusions (2)

✓ Identity of Social work is in transition (shifting from broader counseling to discharge planning)
✓ Psychosocial care at a different cost
✓ Relationship between Psychatric Unit in General Hospital and presence of CLP
✓ Continuity of care with primary care needs more attention
Overview

- Literature overview
- Field study
- Conclusions
- Recommendations
- Suggestions
Recommendations

✓ Need for research and ongoing process improvement
  ✓ Wed plenary session M Sharpe: ‘quality assured care’, ‘measurement based care’
  ✓ Thu 2 pm ‘Structural quality in CL services
  ✓ Thu 4 pm ‘Effectiveness and cost effectiveness of different consultation models’
  ✓ Sat 2 pm ‘patient reported outcomes’
  ✓ Sat 4 pm outcome and quality assurance in psychosomatic research)

✓ Need for research on health economics of psychosocial care in general hospitals

✓ Minimal standards (staffing levels of different professions) need to be put in place. What are these standards?

✓ Need for evolution towards organisational standards that allow for (coordination of) good interdisciplinary patient centered care
  ✓ Eg clinical microsystems
Overview

- Literature overview
- Field study
- Conclusions
- Recommendations
- Suggestions
Suggestions

✓ BioPsychoSocial Care >>>> Psychological care + Social care + Psychiatric care

✓ Integrative model of collaboration

✓ Professionalisation of the different groups and adequate organisation within these groups is crucial (eg Psychology department must determine its own needs in training and development, deployment, ...)

✓ Regular management meetings with functional heads of these departments and higher management to coordinated goals and future plans

✓ Individuals can specialise in subdomains but need to be available to colleagues at any time
OK.....

AND HOW CAN WE REACH THAT GOAL?
Why use Clinical Microsystem Theory?

✓ The use of clinical microsystem theory to
  ✓ Evaluate own organisation
  ✓ Evaluate staff satisfaction
  ✓ Inventarise actions to improve quality of care
  ✓ Inventarise strengths / weaknesses in own organisation
Clinical Microsystems as a guide to manage and monitor interventions

✓ Leadership
  ✓ Create professional departments (social work, psychology, ..)
  ✓ Stimulate leadership

✓ Organisational support
  ✓ Create an environment in which people can meet both in formal and informal ways (regular management meetings, location in hospital, ...)

✓ Staff focus
  ✓ Hire the right people for the right job, working hours, human resources management, allow for input from staff, research facilities, stimulate networking with other professionals,...
Clinical Microsystems as a guide to manage and monitor interventions

✔ Education/training
  ✔ Life long learning

✔ Interdisciplinary dependence
  ✔ Stimulate interdisciplinary projects, make sure that different professionals know about each others work

✔ Patient focus
  ✔ Case presentations and discussions, interdisciplinary patient management, continuity of care (avoid unnecessary transfer of care) throughout hospital stay, screening instruments for vulnerable patient groups, patient centered care
Clinical Microsystems as a guide to manage and monitor interventions

- Market and environment focus
  - Continuity of care with primary care, continuous/repetitive marketing of services,
- Performance results
  - Registration (outcome and process parameters), feedback to and from management (balanced score cared), efficiency, costs, ...
- Process improvement
  - Constant focus on improvement of process of care delivery, ‘self-learning organisation’
  - Stimulate staff to take initiatives to improve services
Clinical Microsystems as a guide to manage and monitor interventions

✓ Integration of information for patients
  ✓ Flyers, hospital web site, ...
  ✓ Digital interaction with patient (psycho-education, appointments, ....)
✓ Integration of information for staff
  ✓ Medical files, ...
✓ Information technology
  ✓ Lap tops, PDA, digital patient notes, shared digital environment between different disciplines (confidentiality ?)
# Clinical Microsystem Assessment Tool

Instructions: Each of the “success” characteristics (e.g., leadership) is followed by a series of three descriptions. For each characteristic, please check the description that best describes your current microsystem and the care it delivers OR use a microsystem you are MOST familiar with.

<table>
<thead>
<tr>
<th>Characteristic and Definition</th>
<th>Descriptions</th>
</tr>
</thead>
</table>
| **1. Leadership:** The role of leaders is to balance setting and reaching collective goals, and to empower individual autonomy and accountability, through building knowledge, respectful action, reviewing and reflecting. | - Leaders often tell me how to do my job and leave little room for innovation and autonomy. Overall, they don’t foster a positive culture.  
- Leaders struggle to find the right balance between reaching performance goals and supporting and empowering the staff.  
- Leaders maintain constancy of purpose, establish clear goals and expectations, and foster a respectful positive culture. Leaders take time to build knowledge, review and reflect, and take action about microsystems and the larger organization.  
- Can’t Rate |
| **2. Organizational Support:** The larger organization looks for ways to support the work of the microsystem and coordinate the hand-offs between microsystems. | - The larger organization isn’t supportive in a way that provides recognition, information, and resources to enhance my work.  
- The larger organization is inconsistent and unpredictable in providing the recognition, information and resources needed to enhance my work.  
- The larger organization provides recognition, information, and resources that enhance my work and makes it easier for me to meet the needs of patients.  
- Can’t Rate |
| **3. Staff Focus:** There is selective hiring of the right kind of people. The orientation process is designed to fully integrate new staff into culture and work roles. Expectations of staff are high regarding performance, continuing education, professional growth, and networking | - I am not made to feel like a valued member of the microsystem. My orientation was incomplete. My continuing education and professional growth needs are not being met.  
- I feel like I am a valued member of the microsystem, but I don’t think the microsystem is doing all that it could to support education and training of staff, workload, and professional growth.  
- I am a valued member of the microsystem and what I say matters. This is evident through staffing, education and training, workload, and professional growth.  
- Can’t Rate |
| **4. Education and Training:** All clinical microsystems have responsibility for the ongoing education and training of staff and for aligning daily work roles with training competencies. Academic clinical microsystems have the additional responsibility of training students. | - Training is accomplished in disciplinary silos, e.g., nurses train nurses, physicians train residents, etc. The educational efforts are not aligned with the flow of patient care, so that education becomes an “add-on” to what we do.  
- We recognize that our training could be different to reflect the needs of our microsystem, but we haven’t made many changes yet. Some continuing education is available to everyone.  
- There is a team approach to training, whether we are training staff, nurses or students. Education and patient care are integrated into the flow of work in a way that benefits both from the available resources. Continuing education for all staff is recognized as vital to our continued success.  
- Can’t Rate |
| **5. Interdependence:** The interaction of staff is characterized by trust, collaboration, willingness to help each other, appreciation of complementary roles, respect and recognition that all contribute individually to a shared purpose. | - I work independently and I am responsible for my own part of the work. There is a lack of collaboration and a lack of appreciation for the importance of complementary roles.  
- The care approach is interdisciplinary, but we are not always able to work together as an effective team.  
- Care is provided by an interdisciplinary team characterized by trust, collaboration, appreciation of complementary roles, and a recognition that all contribute individually to a shared purpose.  
- Can’t Rate |
| **6. Patient Focus:** The primary concern is to meet all patient needs — caring, listening, educating, and responding to special requests, innovating to meet patient needs, and smooth service flow. | - Most of us, including our patients, would agree that we do not always provide patient centered care. We are not always clear about what patients want and need.  
- We are actively working to provide patient centered care and we are making progress toward more effectively and consistently learning about and meeting patient needs.  
- We are effective in learning about and meeting patient needs — caring, listening, educating, and responding to special requests, and smooth service flow.  
- Can’t Rate |

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Side A  

Please continue on Side B
<table>
<thead>
<tr>
<th>Characteristic and Definition</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Community and Market Focus:</strong> The microsystem is a resource for the community; the community is a resource to the microsystem; the microsystem establishes excellent and innovative relationships with the community.</td>
<td>We focus on the patients who come to our unit. We haven’t implemented any outreach programs in our community. Patients and their families often make their own connections to the community resources they need. We have tried a few outreach programs and have had some success, but it is not the norm for us to go out into the community or actively connect patients to the community resources that are available to them. We are doing everything we can to understand our community. We actively employ resources to help us work with the community. We add to the community and we draw on resources from the community to meet patient needs. Can’t Rate</td>
</tr>
<tr>
<td><strong>8. Performance Results:</strong> Performance focuses on patient outcomes, avoidable costs, streamlining delivery, using data feedback, promoting positive competition, and frank discussions about performance.</td>
<td>We don’t routinely collect data on the process or outcomes of the care we provide. We often collect data on the outcomes of the care we provide and on some processes of care. Outcomes (clinical, satisfaction, financial, technical, safety) are routinely measured, we feed data back to staff, and we make changes based on data. Can’t Rate</td>
</tr>
<tr>
<td><strong>9. Process Improvement:</strong> An atmosphere for learning and redesign is supported by the continuous monitoring of care, use of benchmarking, frequent tests of change, and a staff that has been empowered to innovate.</td>
<td>The resources required (in the form of training, financial support, and time) are rarely available to support improvement work. Any improvement activities we do are in addition to our daily work. Some resources are available to support improvement work, but we don’t use them as often as we could. Change ideas are implemented without much discipline. There are ample resources to support continual improvement work. Studying, measuring and improving care in a scientific way are essential parts of our daily work. Can’t Rate</td>
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</table>
| **10. Information and Information Technology:** Information is THE connector - staff to patients, patients to staff, needs to actions to meet needs. Technology facilitates effective communication and multiple formal and informal channels are used to keep everyone informed all the time, listen to everyone’s ideas, and ensure that everyone is connected on important topics. | A. Integration of Information with Patients

Patients have access to some standard information that is available to all patients. Patients have access to standard information that is available to all patients. We’ve started to think about how to improve the information they are given to better meet their needs. Patients have a variety of ways to get the information they need and it can be customized to meet their individual learning styles. We routinely ask patients for feedback about how to improve the information we give them. Can’t Rate

B. Integration of Information with Providers and Staff

I am always tracking down the information I need to do my work. Most of the time I have the information I need, but sometimes essential information is missing and I have to track it down. The information I need to do my work is available when I need it. Can’t Rate

C. Integration of Information with Technology

The technology I need to facilitate and enhance my work is either not available to me or it is available but not effective. The technology we currently have does not make my job easier. I have access to technology that will enhance my work, but it is not easy to use and seems to be cumbersome and time consuming. Technology facilitates a smooth linkage between information and patient care by providing timely, effective access to a rich information environment. The information environment has been designed to support the work of the clinical unit. Can’t Rate |