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Meeting abstract

A generic flow-model as a base for constructing work and monitoring processes in psychiatric care

Anette Larsson, Staffan Rosenius, Annika Stenman and Jan Lindmark*

Address: Hornsgatan 20, Stockholm, 118 82, Sweden

Email: Jan Lindmark* - jan.lindmark@skl.se

* Corresponding author

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Introduction

This abstract describes a structured approach to reorganizing clinical pathways of a psychiatric department, and the adjustment of information systems for planning, monitoring and evaluating. The redesign activities started in 1995. At that point in time, the department was structured in geographic catchment areas. All kinds of patients were treated by the geographical team. Unwanted variations in practice were recorded for the same type of patient between areas, especially for non-pharmacological interventions. In order to cope with this problem, the geographical approach was abolished, and three specialist teams were set up, each working with diagnostically different groups of patients. The department now has three different clinical pathways:

1. Short-term therapy for patients with anxiety, depressions and phobias

2. Long-term therapy for patients with personality disorders

3. Treatment for patients with psychoses

The change led to intense internal discussions. How to direct patient flows to each team? The discussions revealed that education of the staff in the use of the supporting tool, the DSM-III diagnostic system, had recently been carried out.

Another problem identified was that the information system did not help in finding out if a single patient for the prevailing mental health problems had contacts somewhere else in the healthcare system.

The main idea, then, was to build clinical pathways and information flows where the single patient's psychiatric problems would be the drivers of treatment choices. The new concept should use diagnostic procedures, starting with a distinct evaluation phase, followed likewise by a distinct treatment phase and, in the end, result in a choice of where the patient's future contacts with healthcare should be.

In order to achieve stability in the allotment of patients to any of the three teams or pathways, it was decided that all referrals had to pass the head of the department for an evaluation for further distribution to the different teams. The head also decides when a case should be closed. The start of an episode of care at the department, and the ending of it, is strictly regulated by this routine. Now, the system is running continuously. Every care plan is *ex post* evaluated. Evaluation also targets whether goals for changes in the patients' conditions are achieved. This concept is in line with the flow-model, and the information system of the psychiatric department is currently in a development process aimed at supporting the concept of the model.

The organization and management of the processes in the department take the model as a starting point. But they also ensure information necessary for monitoring and analyzing is in line with the model. The flow-model concept applied in these ways has helped the unit to mainstream its processes in order to deliver cost-effective and evidence-based practice to its patients.

Methods

Data are collected from the information system, of which the flow model is one component. Statistical analyses will show what the pathways look like and what the results are for patients.

Results

In the article to come, it will be shown with statistical data what the three different processes look like in real life. How data can be used to draw conclusions, and to what degree the processes match up to demands stemming from evidence-based medicine, will be presented and discussed. Also presented will be how the flow-model data in combination with information from other data sources can help in evaluating the department achievements in relation to the contract with the commissioners.

Conclusion

The model has helped us in defining our processes. At this early stage, we are learning about harvesting data and reporting internally in the unit and to our commissioners. It is necessary to creatively develop visualization techniques and to develop a new "process language" to communicate the results.