

CONFERENCE ABSTRACT

A model of care coordination for patients with complex health and social care needs - what is best?

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Erin Miller^{1,2}, John Eastwood²

1: NSW Ministry of Health, St Leonards, NSW, Australia;

2: Sydney Local Health District, Camperdown, NSW, Australia

Introduction: Healthy Homes and Neighbourhoods (HHAN) delivers whole of family care coordination to families in communities of disadvantage in Sydney, Australia. The model of care coordination delivered is contextually-bound, and tailored to the unique characteristics of the local community. Services are delivered from place-based hubs.

Evaluation work completed to date indicates that HHAN contributes to better outcomes and experience of care for enrolled patients. However, the outputs and optimal dosage of care that leads to these positive outcomes is poorly understood. Hence the research question to be addressed is: what is the optimal HHAN care coordination model(s) and what contributes to their effectiveness?

Theory/Methods: A mixed methods approach was used. Thirty medical records of patients enrolled in HHAN were reviewed to describe the patient journey, including records from two place-based hubs and one community health centre. Interviews were conducted with core staff involved in the delivery of HHAN. Staff were asked about their role, what and how they deliver services, and what actions lead to positive outcomes for enrolled families.

Results: Patients receiving care from the community health centre received more service events/month than those receiving care from place-based hubs. However, place-based hubs had more face-to-face contact with care coordinators.

Themes were identified from interview data. A similar episode of care with set steps/structures was evident across all sites, implemented by all clinicians, despite there being some variation in delivery across the team. Participants identified "polite persistence" and focus on the development of relationships as crucial to success with patients. Unpredictable, crisis-driven workflow was identified as a barrier to success, as well as differing levels of patient readiness for care.

Discussion: This study provides more detailed information about a model of health and social care coordination that has emerged in Sydney. Whilst the model across sites was perceived to be delivered differently, a set structure with assessment, goal setting, consultation, planning and review was evident. This informs the development of a mechanism for governance and monitoring of patient throughput and caseload planning within this team. It may also inform scaling of the model to other regions.

Conclusion: This study contributes knowledge to the gap in published literature regarding the practicalities of implementing a model of health and social care coordination, and the definition of

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such models. Findings may inform activities that improve the quality of services provided by this team by creating a benchmark or guideline for care coordination services. This may improve access to the service for more families.

Lessons learned: This study contributes to the paucity of literature about models of care coordination for vulnerable families and forms the beginning of a framework of a model of care coordination for this service.

Limitations: Data collected from medical records was existing clinical information, with definitions defined for the purposes of patient activity reporting. Data that was important to the research question may not have been collected.

Suggestions for future research: Further research linking patient experience and outcome data to activity data will enhance the knowledge gained through this study.