
CONFERENCE ABSTRACT

Kids GPS Integrated Care - Leaving the Ivory Tower

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Introduction: Children are increasingly surviving antenatally with complex and chronic conditions. Their families face significant challenges in navigating the health system, and managing transport, cost, and school and work days missed to access care from the network of tertiary children's hospitals in NSW - Sydney Children's Hospitals Network. Transformational change is required from this organisation, frequently seen as an ivory tower that isolates children from primary care and local health services.

Practice change implemented: Partnerships have been formed with local hospitals and general practitioners, to support an integrated model of care that helps families feel safe wherever they are accessing health services. Care Coordinators are responsible for facilitating shared care models, identifying opportunities to localise care and guiding the child and their family in navigating the health system.

The project is using a QI framework, with each of the project streams testing the model of care conducting a series of Plan, Do, Study, Act cycles to refine the model through the experience of each child referred to the program.

Aim and theory of change: The aim is for everyone to understand their role in a child's care plan and feel supported in their work, and for families to feel connected to their local health services. There is emerging evidence that Care Coordination decreases Emergency Department presentations and admissions, and increases parental satisfaction and family functioning.

Targeted population and stake holders: The cohorts amongst this population include babies discharged from the neonatal intensive care unit; children with naso-gastric and gastro-jejunal feeding tubes; school children in rural areas; children who present frequently to ED with asthma; and children with food allergies.

160 care professionals have partnered with the Kids GPS initiative, ranging from sub-specialists, paediatricians and nurses, to GPs and Allied Health practitioners in the community.

Timeline: The project commenced in 2015 and is currently implementing across three regions.

Highlights: Amongst the 190 children enrolled in the Care Coordination service, an estimated 36,500kms in travel and 168 day only admissions have been avoided in the year to June 2016.

The program has facilitated GP engagement for more than thirty families who did not have a relationship with a general practitioner when initially enrolled.

A parent activation measure is being used to establish a measure of parental satisfaction and empowerment in their involvement in their child's care.

Sustainability: The cultural change, cross-boundary clinical networks and system capacity created by the project will continue to support the Care Coordinators – a permanently funded clinical service – after the project's conclusion.

Transferability: The model tested within the initial cohorts will become standard practice for the Care Coordination Team.

Conclusions: Children with even the most complex of conditions can have elements of their care delivered safely in the community provided there is open communication and support available to everyone in the care team, including the family.

Lessons learned: A QI framework allows the project to start small and continue to refine as it scales, and the incremental change does not feel threatening to the participants.

Keywords: integrated care; paediatrics; community; primary; tertiary
