Tamas L, 2021 A novel model of integrated care that aims to reduce avoidable hospital presentations for children with medical complexity through partnerships between primary and tertiary care providers. *International Journal of Integrated Care* 22(S1) A1, pp. 1-8, DOI: doi.org/10.5334/ijic.ICIC21031

CONFERENCE ABSTRACT

A novel model of integrated care that aims to reduce avoidable hospital presentations for children with medical complexity through partnerships between primary and tertiary care providers.

21st International Conference on Integrated Care, Virtual Conference – May 2021

Lilian Tamas[1]

1: Children's Health Queensland, Australia

Introduction

Children with medical complexity (CMC) account for considerable paediatric healthcare cost due to uncoordinated care. Whilst CMC often do require acute care, in some cases the condition can be managed through primary care to prevent avoidable hospital presentation. CHQ GPConnect is an evidence-based model of care based on existing hospital avoidance models.

Practice change implementation

CHQ GPConnect model of care has three levels of support for families and GPs.

- Level 1: Phone support

- Level 2: Virtual consultation

- Level 3: In-person clinical support

An implementation science approach was adopted for this project. It is currently in the implementation phase with the 6 month interim evaluation complete.

Aim and theory of change

CHQ GPConnect aims to reduce avoidable hospital presentations and admissions for children with complex care needs by strengthening the linkages with General Practitioners (GPs) and empowering them to effectively manage these patients in the community.

Targeted population and stakeholders

The 12-month pilot targets patients enrolled in the Connected Care Program (CCP) at Children's Health Queensland. CCP provides care coordination for children with chronic and complex health and psychosocial needs.

Stakeholders engaged during model design, implementation and evaluation include:

- Patients and carers
- Executive leadership
- Sub-specialties
- General Practitioner Liaison Officer

- Institute for Urban Indigenous Health
- Senior Indigenous Health Coordinator
- GPs

Timeline

An 8-week implementation roadmap was developed. A rapid-co-design phase with consumers and stakeholders informed the development of the model of care. The pilot will run from August 2020 to June 2021.

Highlights

The key outcomes, impact and innovation of CHQ GPConnect include:

- Reduce avoidable presentations to ED
- Empower GPs to manage children with complex care needs in the community
- Improve communication between GPs and tertiary care centres to foster stream-lined care
- Increased uptake of alternative pathways to the emergency department
- Increased integration of telehealth solutions
- Reduced pressure on hospital resources

Sustainability

- The proposed model leverages existing services at CHQ to support sustained delivery.
- Hospital resources are freed up through avoided ED presentations and reduced bed days.

Transferability

The model of care has extensive applicability in other regions and cohorts. There is significant potential for the model to be replicated in patients with complex care needs who fall outside the inclusion criteria for care coordination services. The telehealth component of the model would have high utility in regional and remote areas.

Conclusions & Lessons learned

- Steady activity growth was observed in the first six months and the intended benefits beginning to be realised.
- The model has provided quality care for children in the right setting and supported integration across care settings while building relationships between providers.
- Individualised engagement with families and GPs is the most effective method of promoting service uptake.
- Nursing and medical champions are pivotal to driving the success of the model.
- This model of care requires significant cultural change within the hospital, GPs, and consumers.