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CONFERENCE ABSTRACT

Less time in Hospital; more time at home

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Christie Breen, Joanne Ging, Nadine Shaw, Julie Hollingsworth

The Sydney Children's Hospitals Network, Australia

Introduction: Navigating the maze of the health system can be challenging for families of children with chronic and complex conditions. These children often slip through the gaps, are managed by multiple teams and become disengaged with primary and local services.

The Sydney Children's Hospitals Network (SCHN) Care Coordination Service helps care teams partner with families and local health services so that children with chronic and complex conditions spend less time in hospital and more time at home.

Practice change implemented (methodology): The SCHN Care Coordination program (Kids GPS – Guided Personalised Services) applies a quality improvement framework using 'Plan, Do, Study, Act' (PDSA) cycles to continually implement, evaluate and modify approaches to care coordination. The service consists of nurses and social workers – 'the Care Coordinators' who work in partnership with the hospital, community and family 'lead' to develop a contemporaneous care plan. A strategy of combining ambulatory models of care and a 24/7 telephone service has made this program more robust.

The program was implemented in February 2014. Outcomes are measured on a monthly basis with data comparison driving further PDSA cycles.

Aim / targeted population: To implement a model of care coordination for children with medical complexity that aims to improve efficiency and patient outcomes by supporting families to navigate services/providers within SCHN, Local Health Districts (LHDs) and Primary Health Networks (PHNs).

Care Coordination for this cohort of children intends to reduce avoidable hospital attendance and improve the integration of care between community health providers and the hospital.

Highlights (outcomes): Kids GPS has achieved significant outcomes measured both in terms of hospital encounters saved and patient-focussed outcomes. The program currently has 446 children enrolled. Between July 2015 and June 2017, the service demonstrated:

875 hospital encounters saved, equating to approximately $977,000 in financial savings for SCHN

51,500 KM travel saved for families and 370 school absences prevented

204 ED presentations avoided, with implementation of a 24/7 Hotline in August 2016 increasing the average ED presentations saved per month from 1.6 to 16.7

Analysis of the past six months data (Jan-Jun 2017) demonstrates a 400% increase in encounters saved (448 compared to 111 between Jul-Dec 2016) following service design changes though various PDSA cycles.

Sustainability and transferability: Members of the SCHN Care Coordination team are part of the Children's Healthcare Australasia (CHA) Complex Care Special Interest Group. The networking from this group has resulted in referrals of complex patients moving interstate, enabling care coordination to commence prior to the patient relocating. This has proven an innovative way of inter-state agency collaboration.

It is anticipated that future funding will lead to additional care coordinators with a focus on aboriginal patients/families, and children/youth presenting frequently to the ED for mental health or behavioural disorders.

Conclusion: Effective care coordination can significantly benefit the lives of patients/families with chronic and complex conditions. Key lessons learned:

Combining ambulatory models of care with care coordination makes the integrated model of care more robust

24/7 hotline access providesa further safety net to empower parents/carers

Outcome measurements that are patient focussed helps to create organisational cultural change

Keywords: care coordination; complex; integration; ambulatory

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