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CONFERENCE ABSTRACT

An exploration of models of care coordination to meet the needs of families requiring health and social care in Sydney, Australia'

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Introduction: The Healthy Homes and Neighbourhoods HHAN team provides care coordination for vulnerable families with complex health and social care needs, who are disconnected from key services and require multi-agency support. HHAN care coordination is delivered across inner western Sydney, with staff based at a community health centre and a c o-located hub in an identified suburb of disadvantage. Care coordination is provided by Senior Social Workers and Clinical Nurse Consultants. At the commencement of the program staff were instructed to deliver care coordination from their respective sites, in response to community need. The study aims to describe the model of care coordination and the variables contributing to its emergence.

Theory/Methods: Semi-structured interviews were conducted with HHAN care coordinators to explore the model of care they were providing and its development over time. Electronic medical records were reviewed to explore case history, activity and outputs delivered by care coordinators. Patient journeys were detailed, analysed and compared.

Results: The review demonstrated that a single model of care exists, with interpretations differing dependent upon clinician skills and expertise, community need, client cohort and service context.

Clinicians based at the community centre have identified assertive outreach to be more time consuming in engaging clients , the failure to attend rates are higher and traditional service models do not take into consideration vulnerable families social needs. Place based initiatives or 'in reach' services have demonstrated that clients presenting take less time to engage due to the immediacy of their needs and are more likely to return due to the locale. Furthermore inter professional collaborative practice is demonstrated more effectively within a co-located hub than centre based care.

Discussions: The model of care is an iterative process of assessing and identifying social and health needs with longitudinal accompaniment, navigation and education to increase families' capacity to manage their complex needs.

HHAN clients are a heterogeneous group with multiple risk factors that threaten the wellbeing of the families. These clients require innovative and creative approaches to meeting their care

needs. The model of care supports this innovation, creativity and integrated care response. This is due to the recruitment of senior staff who exhibit leadership qualities with superior interpersonal skills and a commitment to social justice and demonstrated integrity in practice.

Conclusions: The HHAN model of care provides care coordination for vulnerable families in both a place based initiative and community health centre.

Lessons learned: Care coordination delivered from place based initiatives meet vulnerable clients within their communities and are able to work more efficiently with inter-professional collaboration. Centre based care is a less efficient way of care –coordinating for vulnerable families due to geographic location, traditional service models and longer time required for engagement.

Limitations: The project did not explore the adaptability of the model to other populations.

Suggestions for future research: A comparative study of client outcomes versus place based outcomes.

Keywords: care coordination; colloborative practice; place based initiative; social determinants; leadership