POSTER ABSTRACT

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

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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 care coordination 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: An explanatory sequential mixed methods approach was used. Approximately 30 medical records of patients enrolled in HHAN care coordination were reviewed to describe the patient journey, including the nature and frequency of contact with the HHAN care coordinators. This included 10 patient records from two place-based hubs and one community health centre. Interviews were conducted with core staff involved in the delivery of HHAN care coordination, including allied health and nursing staff. Staff were asked about their role, what and how they deliver services, and what actions lead to positive outcomes for enrolled families.

Results: Similarities in the amount of service events/month were noted for patients receiving care coordination via the place-based hubs, while patients receiving care from the community health centre received more service events/month. Patients receiving care from the place-based hubs had more face-to-face contact with care coordinators, despite receiving less service events/month overall.

Themes were identified from interview data across four key areas: the role of the care coordinator; what and how care is delivered; essential components for success; and barriers to success. 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, contributing to the wide variety of definitions that exist in the published literature. Whilst the model across sites and between clinicians is perceived to be
delivered differently, a set structure with assessment, goal setting, consultation, planning and review phases is 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 and model of health and social care coordination, and the definition of 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.

**Keywords**: care coordination; vulnerable families; health and social care; place-based; model of care