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CONFERENCE ABSTRACT

A Mallee population health approach to vulnerable children in OOHC

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Introduction: Mildura is a regional city in the Mallee area, a major horticultural centre in north-west Victoria with one of the highest rates of children in statutory care in Victoria. Aboriginal and Torres Strait Islander children are over-represented. Although it is accepted that children in statutory care are more likely to experience complex and chronic health conditions, lack of area-level data about child healthcare needs has hampered health services planning.

Practice change implemented: Multi-agency project governance and clinical governance groups are steering the development of an integrated, area-based approach to health care delivery for children and young people in statutory care in the Mildura LGA. New health workforce positions have been created to support improved health care coordination, health systems navigation and record keeping. An area-based senior program advisor in the Victorian Department of Health & Human Services (DHHS) plays a key coordinating role.

Aim and theory of change: Our aim is to enhance the accessibility and effectiveness of health care and improve continuity of care, coordination and patient safety. We have identified nine discrete systems where change is needed for care integration including child registration, health records, referrals and clinical assessment. The theories of change stem from chronic care and population health approaches.

Targeted population and stakeholders: Community Health Centre leaders, the Primary Health Care Network, Out-of-Home Care services and DHHS are actively engaged. In the first phase, the child population has been segmented. We need to test new systems designs while at the same time ensuring a direct benefit for the child. The test cases are children aged 4-18 years living in kinship care who are prescribed medications by a health professional. These children are at heightened risk of medication-related adverse events or less than optimal management of symptoms.

Timeline: Integrated care planning began in 2017 with an innovation grant from the Department of Health & Human Services in 2018-2019. A further year of funding is supporting business case development for a 3-5 year innovation program and additional funding enables prospective evaluation.

Highlights: Senior leadership is vital for progress to be made and sustained. We have successfully engaged local executives, clinicians and practitioners. Professional development across the disciplines has begun. Standardised clinical assessment tools have been adopted. Child identification and tracking has begun.

Sustainability: This approach moved quickly from its origins as a small, time-limited project to an area-based approach with a 10-year vision and multi-agency engagement.

Transferability: Our objective is to redesign and integrate the systems of interest to the extent that they are fit for purpose, whether for 5 or 500 children from statutory care.

Lessons learned: Rural areas have an advantage in more rapid uptake of joint working when stakeholders are well known to each other. Appreciation of the complexity of systems change continues to grow along with joint commitment to work for sustainable solutions. Academic input has helped our work have a sharper focus.