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CONFERENCE ABSTRACT

Is it person centred multidisciplinary team care?

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Introduction: Australia has a high performing health system. However, care delivery is fragmented and challenging for patients to navigate. In 2016, a Bilateral Agreement on coordinated care was established between the Commonwealth of Australia and New South Wales (NSW) to improve the delivery of care for patients and reduce avoidable demand for health services.

The priority area, Multidisciplinary Team Care in the Community aims to build the capability of healthcare professionals to work together and deliver comprehensive patient-centred care.

Description of policy context and objective: Service provision is split between the Commonwealth and state governments. Coordinating care is challenged when services operate in isolation.

The system fails to effectively meet the needs of people who are vulnerable or have chronic or complex health and social care needs. Service access and care pathways are complicated and disjointed. At a system level, there is variation in care and outcomes with poor coordination between providers.

Integrating health services locally, delivers targeted and coordinated care for vulnerable people and improves patient experiences and outcomes.

Targeted population: People in the community with chronic or complex health and social needs or deemed at risk of rehospitalisation.

Highlights: NSW Health leads a state-wide Multidisciplinary Team Care Working Group. Membership includes representation from Primary Health Networks, Local Health Districts, Ministry of Health and clinicians.

A purpose designed survey to identify existing high-quality models of multidisciplinary team care was developed and distributed broadly across the system. Questions were multiple-choice and free text. Survey topics included: identification of service exemplars; description of models; identification of team members; and challenges, barriers and enablers for high quality coordinated care. A total of 255 responses were received, which identified 1525 examples of multidisciplinary team care. Out of the identified models, 456 will be analysed further.

Comments on transferability: This work builds on learnings from the NSW Integrated Care Strategy and the Commonwealths Health Care Homes program which both support person centred care, collaboration and partnerships.

We aim to develop guidance for multidisciplinary team care in the community that centres on the patient, and engages partners based on the patients clinical need.

Conclusions: Preliminary analysis of the data demonstrates patients are not often included in the multidisciplinary team. General Practitioners, who are usually the first point of contact for patients, are often excluded from many multidisciplinary teams

This could suggest that person-centred care is not truly being delivered across the healthcare system or a lack of awareness of the importance of the role of the patient within the multidisciplinary team or a broader systems issue.

Additional General Practitioner interviews and observational visits at exemplar sites will enhance the survey data and provide more information about models of multidisciplinary team care in the community in NSW.

The learning identified will be written up into system guidance and we will work with the system to implement the key elements and contribute to long term health reforms in Australia.