International Journal of Integrated Care

Bishop, T et al 2020 Empowering and Engaging Chronic Disease Patients, their Caregivers and Service Providers in the Gold Coast Integrated Care Program. *International Journal of Integrated Care*, 20(S1): A116, pp. 1-8, DOI: doi.org/10.5334/ijic.s4116

CONFERENCE ABSTRACT

Empowering and Engaging Chronic Disease Patients, their Caregivers and Service Providers in the Gold Coast Integrated Care Program

2nd Asia Pacific Conference on Integrated Care, Melbourne, 11-13 November 2019

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Introduction: The Gold Coast Integrated Care (GCIC) program was a patient-centred integrated model of care designed to produce optimal patient outcomes for those with complex and chronic conditions by supporting their GPs in managing their conditions. The program focused on the Gold Coast community to examine whether an integrated care model could improve coordination of care and services between primary and secondary care providers at no additional cost to the health system.

Practice changes and innovation: The program brought together multidisciplinary teams within the Gold Coast Hospital and Health Service (GCHHS), general practitioners (GPs) from 15 network practices affiliated with the program, and community based health services to provide holistic management of high risk patients and enhance communication between their service providers. This was supported by improving data linkage between service providers using innovative information and communications technologies.

Aim and theory of change: The program aimed to demonstrate enhanced proactive and reactive care that would reduce potentially avoidable admissions to hospital and improve clinical management and access to a range of services; patient health outcomes; patient experience and satisfaction with care; and staff experience and satisfaction. The conceptual foundation of the program was aligned with the continuous quality improvement mantra of providing the right care, by the right person at the right time for the right patient.

Targeted population, stakeholders, and timeline: The four year program targeted those with complex and chronic conditions considered high-risk of hospitalisation. Stakeholders included the local HHS, PHN, Queensland Health and GPs. The Commonwealth Department of Health provided financial support for the program evaluation, which was undertaken by the Centre for Applied Health Economics, Griffith University.

Innovation, impact and outcomes: A community coordination centre was established to provide patient holistic assessment and care planning by a multidisciplinary team of medical practitioners, nurses, service navigators, physiotherapists, occupational therapists, social workers, pharmacists and psychologists. This team adopted a generalist approach to linking and supporting clients to extend their health network and improve communication between health providers. The approach included promoting a tailored self-management approach that improved continuity of care, as well as addressing behavioural and psychosocial situations which often led to readmissions, chronic

exacerbations and inability to manage condition at home. Preliminary evaluation data indicate high levels of patient and staff satisfaction with care.

Conclusions, sustainability, transferability: This presentation, from the perspective of clinicians, will focus on shared decision-making, the co-production of health and health services and supported self-care. It will feature the voices of participants and their carers to illustrate both the need for and impact of integrated care programs, which we believe, exemplifies person-centred care.