Re-think, Re-prioritise, Re-design for Child and Family Health
(Triple-R for CAF)

Dr Limin Buchanan, Naome Reid

Child and Family Health Services, Community Health, Sydney Local Health District

Case for change

- Despite having a centralised intake team, client handling process varies across the diverse disciplines in Child and Family Health Services. This has led to working in silos, inefficiency, and negative impacts on client wait times, and potentially their quality of care.
- The rising presentation of clients with complexity i.e. children with multiple developmental concerns and with psychosocial risks and needs, have placed further strain on the workforce, and lengthen client's wait times.
- The change will ensure a more streamline workflow and client access to care.

Goal

To ensure equity and timely access to care for children aged 0 to 8 years by February 2025.

Objectives

- To increase the percentage of clients who have their developmental and psychosocial indicators recorded from 31.7% to 100% by February 2025.
- To increase the percentage of staff satisfaction with clients handling process from 59% to 80% by February 2025.
- To increase the percentage of clients identified at the point of intake as requiring multidisciplinary care from 15% to 100% by February 2025.

Method

Ethics approval received to gather data from diagnostic to solutions implementation evaluation.

A multi-faceted approach during **diagnostic** phase:
- Online surveys (n=266 clients and 52 referrers)
- Interviews (n=13 clients)
- Focus groups, consultation workshops, and interviews (n=42 staff)
- IMS+ system consumer feedback and incident reports

Solutions identification:
- A focus group and three staff consultation workshops (n=34 staff)

Solutions development:
- Stakeholder consultations including baseline survey evaluation
- Co-design workshop on e-Solution (n= 5 clients)

Diagnostics and solutions

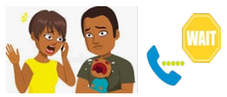
Clients voice

Staff voice

Issues identified in diagnostics	Root-causes
➢ Long wait time on phone with centralised intake and phone tag issues ➢ Long wait time to see clinicians ➢ Need to repeat the 'same story' every time they see a different clinician	➢ No alternative mode of contact that allows clients to access the service outside of phone line operating hours (Mon-Fri 8:30am-4pm) ➢ Existing database does not support cross-disciplinary care delivery
➢ Staff confusion on clients' eligibility and prioritisation ➢ Staff concerns about clients with complex needs not being prioritised appropriately.	➢ Inconsistent and outdated Models of Care across disciplines ➢ Lack of systemic criteria and a centralised platform to record client's psychosocial risks and needs

Targeted Issues

Outdated Models of Care



Clients frustrated with lack of access, long wait time and having to repeat 'same story'

Solutions

Revised or New Models of Care that include:
- ➢ Less confusing eligibility and prioritisation criteria
- ➢ Consistent criteria for priority population, psychosocial risks and needs across all disciplines

Introduce e-Solutions
A REDCap online referral tool that:
- ➢ Clients can access at any time
- ➢ Supports triage, screen and identification at intake
- ➢ Captures client's developmental and psychosocial indicators

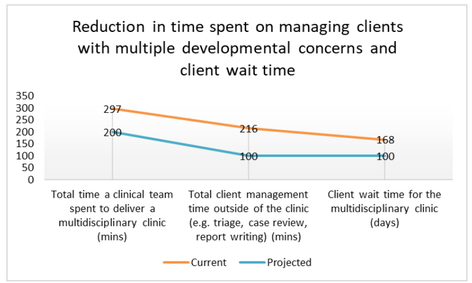
New eMR feature that supports:
- ➢ Cross-discipline service delivery
- ➢ Client prioritisation

An example of potential impact

The proposed solutions will positively impact clients who require multidisciplinary care as well as staff who are involved in the multidisciplinary clinic. Clients will no longer need to repeat their 'story' more than once, and clinicians will spend less time on administrative tasks.

Based on the available data, it is estimated that clinicians involved take a total of 5 hours (including 2 hours face-to-face clinic), and additional of 4 hours outside of the clinic to manage a client who may have waited for 5-6 months.

Proposed changes in the new Model of Care aim to streamline this process. This figure shows the estimated current vs projected data after the implementation.



Sustaining change

Staff have been engaged in establishing the change process, from diagnostics through to solutions development. As a result, key staff members have strong ownership of the proposed changes which will assist in sustaining the implementation of:

- *Solution one:* Team leaders and service managers from various disciplines work collaboratively to revise the Models of Care. While overarching criteria are developed across all disciplines, each discipline still have the 'ownership' of how their team will operate.
- *Solution two:* Manager from the centralised intake team and Health Information Manager are heavily involved in the development of e-Solutions.

Conclusion

- **Feasibility:** It was clear from the commencement of the Triple-R for CAF project that other than the in-kind contributions of the two project leads, there is no additional funding to support this project. The strength of this project is that the Solutions implementation can be sustained using existing resources i.e. Solution 1 is embedded within staff's existing workload and responsibilities while Solution 2 is building on existing databases.
- **Scalability:** The change ideas and solutions are transferable to other services within Community Health Services. The project leads now have the skillsets and experience to support this.
- **Key lessons:** Service models and simplified databases are the foundation of streamlining workflows to support both staff wellbeing and equity of access to services of our clients.

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Contact

Naome Reid, A/Child and Family Allied Health Manager, naome.reid@health.nsw.gov.au

Dr Limin Buchanan, Service Development Manager, limin.Buchanan@health.nsw.gov.au