Connection is Core Business

The right care at the right time through care coordination

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Case for change

Evidence suggests children and families with complex developmental and psychosocial needs benefit most from early intervention services

These clients may:

- Have multiple or ambiguous needs
- Feel uncertain or overwhelmed
- Be ineligible for many services or experience difficulties navigating and accessing care

WSLHD Child and Family Health (CFH) has no single consistent process for the identification of complex needs and provision of care coordination.

There is variation in the provision of care coordination within CFH. Determinations about which children and families receive additional supports largely depends on individual clinicians or the skills and confidence of parents.

Care coordination can assist these families to navigate and engage with the right services at the right time providing equitable care for all that need it.

Goal

Improve the way CFH identifies and supports families with complex psychosocial and developmental needs through care coordination, with a focus on clients of Auburn and Merrylands Community Health Centres, by December 2025

Objectives

1) 70% of new patients with identified complex needs participate in development of a care coordination plan by December 2025
2) Increase staff confidence and understanding of referral pathways from 50% to 70% by December 2025
3) Improve interdisciplinary communication from 23% to 40% by December 2025
4) Increase client satisfaction of the level of support provided from 58% to 70% by December 2025

Method

Diagnostic activities:

- Staff focus groups (*N=38, response rate = 83%*), process mapping, brainstorming and thematic analysis
- Staff survey (*N=27, response rate = 59%*)
- Client interviews (*N=10*), semi structured interviews and thematic analysis
- Client survey (*N=58, response rate = 6.1%)*, all clients receiving a service at the identified centres in Sept 2024
- EMR data analysis
- Prioritisation activities with clients (interview), staff (dotmocracy) and managers (consultation)

Solution generation activities:

- Staff workshops (*N=37*), (including Blitz; power of 3; dotmocracy and thematic analysis)
- Client interviews (*N=9*), (including magic wand and thematic analysis)
- Prioritisation activities with staff (dotmocracy) and managers (online survey and discussion)
- Benchmarking with Children's Hospital Network
- Prototyping storyboards for staff and managers

Key issues

Low client confidence and capacity to navigate services

62% of clients would like a higher degree of help to access services

Cumulative wait times
Lack of proactive screening means that referrals to other services often occur during intervention phase after service wait times.

46% of clients waited between 3 and 24 months for a referral to a second service

Inadequate collaboration and communication

88% of clinicians rated interprofessional communication as very important"to good care coordination

But the number of clinicians that reported that they always do this was: **23%**

Role scope and staff knowledge varies between clinicians

- Staff surveys identified low clinician confidence in knowing the scope of care coordination within their role
- Care coordination frequently involves indirect client activities, which do not receive Activity-based funding

81% of staff have received no formal training in care coordination, learning on-the-job

55% of staff reported experiencing burn out and carer fatigue as a barrier to the provision of care coordination

Solutions

1) Proactive developmental & psychosocial screening of children for Allied Health referrals

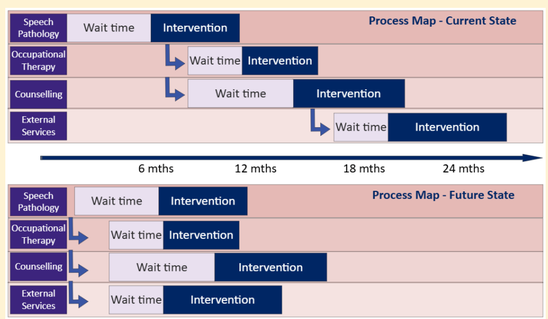
Screening of CFH Allied Health referrals at the point of intake, to identify children and families who require other services. This may include referrals to other CFH services (e.g. Speech, OT, Counselling, and/or Nursing) and external services

2) CFH care coordination practice guidelines and training

- Practice Guidelines will define the roles of CFH clinicians in providing care coordination
- Training in care coordination will ensure all staff have the necessary skills to provide effective care coordination
- Collaborative practice will be supported by reviewing multidisciplinary consultation and improved informal relationships within CFH

Expected outcomes:

1) Early identification and referral



Families that require care coordination will be identified early.

Referrals to internal and external services will be facilitated through screening at the point of intake.

2) Increased capacity of the service

CFH staff will have clear expectations and the necessary skills to provide effective care coordination. Staff will have access to collaborative structures and tools to guide care coordination.

Sustaining change

Modelling, reinforcement and staff involvement have all been identified as areas to support sustainable implementation.

Diagnostic data and designed solutions are relevant to other community-based health services working with vulnerable families or those with developmental and psychosocial complexity.

The current implementation has not yet been tested sufficiently to warrant application to other settings at this stage.

Conclusion

Implementation of Solution 1 is underway. It has been embedded within CFH Allied Health and plans to scale to other CFH locations continue.

Solution 2 is currently on hold, awaiting further risk mitigation and resource allocation from the Steering Committee.

Evaluation of project results has yet to occur.

Lessons learnt:

Stakeholder commitment is key to driving sustainable change.

Well managed risks and issues can enable change to occur despite barriers presenting.

It takes courage and dedication to drive change. Trust the process!

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Acknowledgements

- WSLHD Child and Family Health team
- Families of WSLHD
- Hayley Manyu, Redesign Lead
- CCB Steering Committee
- ACI Centre for HealthCare Redesign

NSW GOVERNMENT

Western Sydney Local Health District