Children's Health Queensland Hospital and Health Service

Integrated Care Strategy

Queensland Government

Integrated Care Strategy v2.0

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Introduction

In paediatrics, as in adult healthcare, increasing specialisation over past decades has led to fragmentation of health service delivery. This is particularly true for children with co-morbid and/or complex conditions, who may navigate multiple service providers and organisations to have their health needs met. Queensland's geographically dispersed population compounds the challenge of integrating care for these children, with many families needing to travel large distances to access subspecialist paediatric care.

It is well understood however that the health and wellbeing of children and young people depends on more than timely, safe and effective medical care. Non-medical services such as education, housing and social support, as well as good family functioning are fundamentally important, underscoring the need for community-wide effort and collaboration if we are to improve child health outcomes in vulnerable communities.

Children's Health Queensland Hospital and Health Service (CHQ) is committed to addressing these challenges and to implementing contemporary health service delivery models to optimise health outcomes for children and their families. The CHQ Strategic Plan 2020-2024 (updated August 2022) articulates our vision of leading life-changing care for children and young people – for a healthier tomorrow. The four strategic objectives of Value all people, Perform at our best every time, Generate knowledge and innovate, and Collaborate in care are all cornerstones of integrated care.

This Integrated Care Strategy (the Strategy) has been developed for use at an organisational and service level. It defines integrated care from a child and youth perspective and outlines the benefits expected if an integrated approach to healthcare delivery is adopted. It articulates the foundations of integrated care and describes system enablers which will allow CHQ to lead integrated care for children and young people in Queensland. The document further breaks down these system enablers into a highly practical 'toolkit' which will allow CHQ services to meet the strategic objectives of the organisation.

It is anticipated this document will be used to:

- build upon the existing strong foundations of integrated care initiatives within CHQ;
- inform quality improvement activity within CHQ, such that services become more collaborative and focused on partnerships in the future;
- raise the profile of the role of the primary care sector, non-health government departments, and other agencies in the care of children and young people; and
- assist other jurisdictions to understand how integrated care can be applied in a paediatric context.

Integrated care: a definition

There is no single, agreed definition of integrated care, and understanding of the concept can vary. It is therefore imperative for organisations to define the term as they understand it.

CHQ defines Integrated Care as follows:

Integrated care is the provision of care in the broadest sense - physical, psychological and social - which is oriented around the needs of children, young people and families, and designed and delivered in partnership with them.

In an integrated system, these needs are met through the coordinated and collaborative working of all providers, irrespective of sectorial, organisational or geographic boundaries.

Benefits of integrated care

The benefits expected from CHQ adopting integrated care across the organisation align closely with the Quadruple Aim:

- improved quality of care for children and young people, by ensuring services are well coordinated around their needs
- improving the experience of care for children and families by reducing fragmentation and duplication in care
- improved cost-effectiveness of care for children and young people through better use of resources and reduced duplication
- improving the working life of care providers, through elimination of barriers to good communication, clarification of roles and support to work to the top of their scope of practice

Development of the Strategy

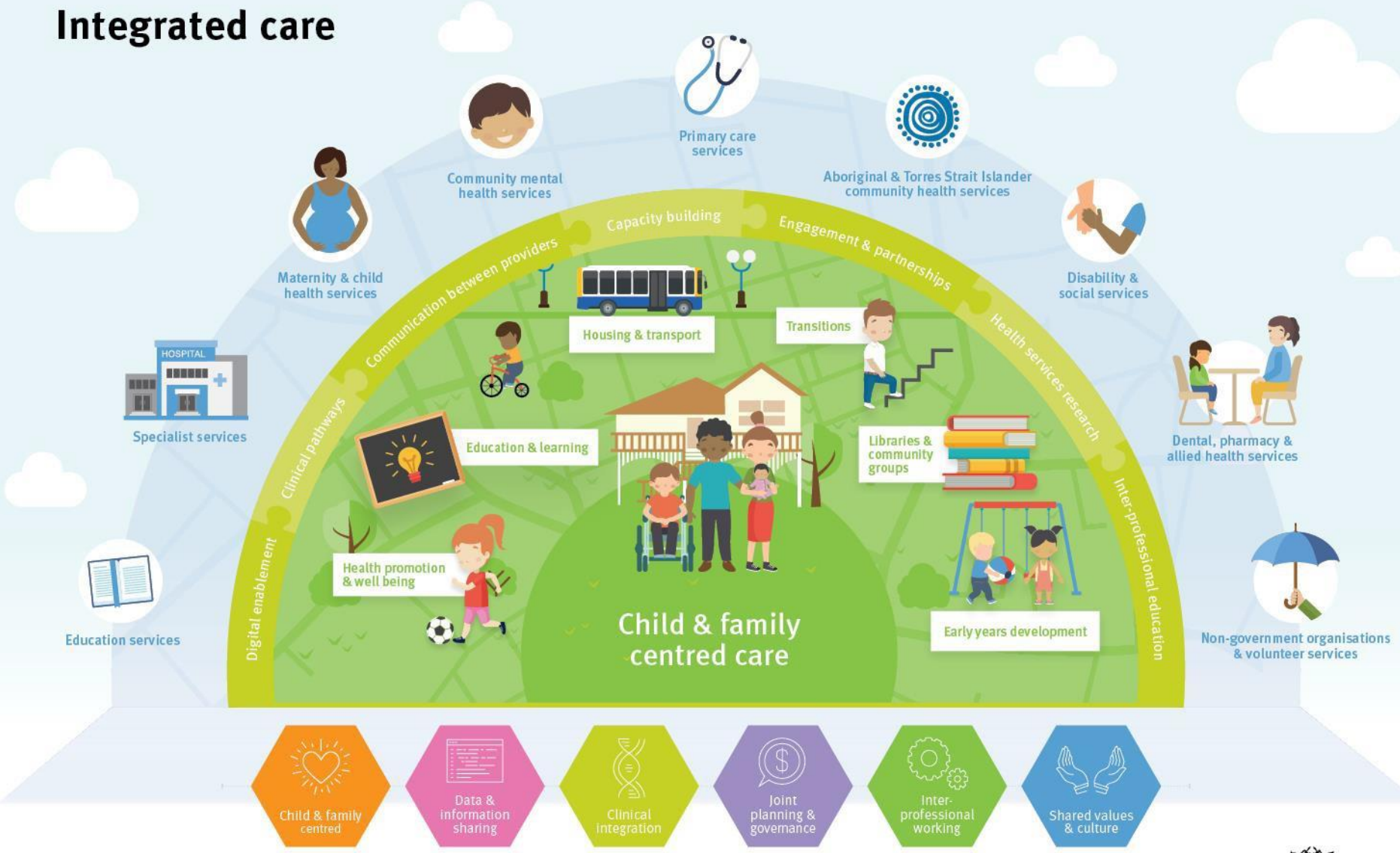
In the development of the Strategy, a number of national and international frameworks and policies were reviewed. The concepts were adapted to suit a child and youth population and further conceptual refinements were made to ensure the Strategy is a highly practical tool and that the concepts within are able to be readily implemented.

Frameworks and policies consulted in development of the Strategy include:

- Calciolari, S., Gonzalez, L., Goodwin, N., & Stein, V. (n.d.). A Conceptual Framework for Integrated Care. Project Integrate
- World Health Organisation. (2015). WHO global strategy on people-centred and integrated health services – interim report. WHO
- Nicholson, C., Jackson, C., & Marley, J. (2013). A governance model for integrated primary/secondary care for the health-reforming first world – results of a systematic review. *BMC Health Services Research; 13*:528.
- Planetree. (2017). Excellence in person-centered care: Planetree Certification Criteria. Planetree
- CHQ Strategic Plan 2016-2020 (reviewed 2018)

Further documents consulted in the development of the Strategy are referenced in Appendix 1.

Integrated care



Foundations of integrated care

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FOUNDATIONS OF INTEGRATED CARE

Child & family centred

We will engage with families in all communities, including the most vulnerable or marginalised, to understand and respond to their needs.

We will strive to orient our services around child and family needs, and provide care as close to home as possible.

We will support parents, caregivers and where possible, young people themselves, to have the knowledge, skills and confidence to make healthy lifestyle decisions and manage their own health care (Patient and family activation).

Data & information sharing

With families

Children, young people and families will have timely access to their health information and be supported to understand it, so they can actively participate in decisions about their care.

With providers

With permission of the family, data and information will be shared with other providers of care, with a view to enhancing the safety and quality of care provided, and to minimise family inconvenience.

With communities

We will promote the capture, analysis and sharing of de-identified data and information at a community level. This will inform and improve the delivery and evaluation of our services, and those of our partners.

Clinical integration

Partners in care will follow defined care pathways to clarify roles and responsibilities of all professionals involved, and to help understand and direct integration of care across boundaries.

This applies equally to hospital/community boundaries within CHQ, as it does to boundaries between CHQ and external providers.

Joint planning & governance

With families

Children, young people and families will participate meaningfully in the planning and governance of our services.

With providers

We will work collaboratively with all providers of care for children and young people.

With communities

Services, projects or bodies of work which are shared with our partners will be jointly planned and governed in a nonhierarchical manner.

Co-commissioning and funding of service delivery will be considered.

Inter-professional working

Our workforce will be our greatest resource in delivering integrated care.

We will build on the skills of our existing workforce to foster:

- respect for, and recognition of, the complementary expertise of our partners;
- open communication and negotiation between all care providers, both internal and external;
- power sharing and team working.

New roles, or redesign of existing roles, may be required to support working across boundaries and a more integrated approach to care.

Shared values & culture

We will foster a culture of collaboration.

We will acknowledge the contexts and pressures that other professionals and organisations face, and focus on what we are collectively trying to achieve:

- better outcomes for children and young people;
- better experience of care for children, young people and their families;
- the most efficient use of resources; and
- improving the work life of care providers.

(Quadruple Aim)

ENABLERS OF INTEGRATED CARE

	Digital enablement	Clinical pathways	Communication between providers	Capacity building	Engagement and partnerships	Research	Inter-professional education
Objectives	Leverage technology to enable: • care closer to home; • family involvement in decision making and care planning; and • continuity and coordination of care across organisational boundaries. Progress work towards a shared electronic health record (eHR) through which patients and families can: • access and contribute to their records in real time; • book appointments; and • find information about their condition and local services. Explore opportunities to deliver services flexibly using technology, including e-diagnostic clinics and e-consultations.	Minimise variation in care across sectors and organisations. Plan for and coordinate transitions across care settings. Identify a 'coordinator of care' for all patients, to work closely with families to ensure needs are met and care plans align with the goals of the child and family. Choice of coordinator will depend on complexity and medical need, as well as the degree of family activation, e.g. • GP • General paediatrician • Nurse navigator • Allied health professional • Other	Communication in all its forms, digital and traditional, is recognised as being fundamental to delivering integrated care, particularly for those with chronic conditions and during transitions of care. This includes shift-to-shift communication, interdepartmental or interdisciplinary communication, as well as communication with external providers within health or other agencies.	Providers of care for children and young people, within and external to our organisation, will be supported to work to the top of the scope of their role. These may include providers: • in LCCH • in community sites of CHQ • in primary care • in other HHSs • others With an 'upskilled' workforce, capacity will be released for specialised services within CHQ to focus on children and young people with the most complex needs.	**Patient and family engagement** Engagement with children, young people and families as our partners, in the process of co-designing and delivering a more integrated system. **Staff engagement** CHQ staff from all parts of the organisation (frontline to executive) involved in improvement activities. **Stakeholder engagement** Collective decision making and accountability between communities, organisations and professions involved in care delivery.	Collect data across the following areas to monitor our progress towards integrated care and continually improve our efforts: • Reach: Are we reaching the population/s we intend to serve? • Implementation: Are we implementing strategy in the way we intended? (fidelity and program adherence) • Outcomes: Are we achieving the outcomes we set out to, for the populations we target?	We will create opportunities for learners from two or more professions to learn about, from and with each other, to: • build inter-professional respect; • enable effective collaboration; and • improve outcomes for children and young people. We will develop inter-organisational learning opportunities.
Toolkit (examples)	**National:** My Health Record **Statewide:** Healthcare Provider Portal (GPTV), HealthPathways, Telehealth **CHQ:** ieMR, Clinical Consolidated Information Systems (CCIS), electronic referrals management	HealthPathways Clinical Prioritisation Criteria (CPC) Care planning tools Case conferencing Red Book	Electronic discharge summaries Phone calls, faxes, outpatient letters Case conferencing Care plans Red Book	Project ECHO® Paediatric Masterclass for General Practice Clinical and biomedical research Simulated Learning in Paediatrics for Allied Health (SLiPAH) Simulation Training on Resuscitation for Kids (SToRK)	Family Advisory Council and other consumer working groups Children's Health Collaborative GP Liaison team Our Children and Communities Matter	Children of Queensland Indicators report 2017 QChild database CCIS databases (Connected Care, Navigate your Health databases)	Project ECHO®

Integrated Care Program – Logic Model

This program logic model demonstrates the linkages between CHQ activities and the outputs and anticipated outcomes of the Strategy. It represents a high level overview of the program of works, and is unlikely to remain static. As outputs are delivered and outcomes and benefits realised, ongoing evaluation and continual refinement will occur, as integrated care activity within CHQ matures.

Foundations	Inputs	Activities	Output (short term)	Impact (mid term)	Outcomes (long term)
Child & family centred Data & information sharing Clinical integration Joint planning & governance Inter-professional working Shared values & culture	*Children's Health Queensland Hospital and Health Service Strategic Plan 2016-2020 (reviewed 2018)* CHQ workforce Population health data Cross-sector service activity data Information sharing Internal and external partnerships	Raise awareness of integrated care amongst CHQ services, support the understanding, and foster the translation of theory into practice.	Services have the knowledge and skills to refine service delivery and develop new models of care in line with principles of integrated care.	New models of integrated care adopted and evaluated.	Equity of access to care for all children and young people. Improved health and social outcomes for children and young people in targeted communities. Better experience of care for children, young people and their families. Reduced need for crisis/emergency services and greater uptake of primary care and preventative activities. Longitudinal shared eHR in widespread use. More efficient use of available resources.
		Develop HealthPathways, incorporating CPCs, to enable point of care access to best practice management and referral information for GPs.	Evidence based HealthPathways published and in use at CHQ. Pathways made available for localisation to all regions within Queensland.	Variation in care reduced. Transitions across care settings will be planned, coordinated and seamless.	
		Contribute to the development of a shared eHR and other digital integrated care projects.	Co-design of a future shared eHR with families and external providers.	New digital enablers of integrated care meet the needs of families and all care providers.	
		Coordinate, administer and evaluate Project ECHO® series to create inter-professional education and capacity building opportunities.	Providers of care for children and young people, within and external to our organisation, will be supported to work to the top of the scope of their role.	Specialised services withdraw from providing primary or secondary level care. Timelier access to specialist care for the most complex children.	
		Coordinate and deliver annual GP Masterclass.			
		Engage cross-sector stakeholders with a shared interest in working collaboratively to address the needs of priority regions and populations.	Cross-sector partners have a shared understanding of the health, development and wellbeing needs of children and young people in targeted communities, informed by population health data and community need. Framework for cross-sector partnerships available for use in future place-based initiatives.	Collective decision making and accountability between organisations and professions involved in care delivery lead to the development of a more integrated system.	
		Undertake current state analyses of supply and demand for paediatric services focused on defined geographical areas of need.			
		Engage with children and families living in targeted communities to understand the context in which they live including their unmet needs.			
		Develop a framework for building authentic cross-sector partnerships.			
		Develop a means of identifying kids at risk of readmission or avoidable ED presentations.	Risk stratification tool developed and in use. Patient-reported experience measure (PREM) of integrated care developed and in use. Tool to measure the coordination of care across settings developed and in use. Evaluation plan for Integrated Care Program developed.	Risk stratification tool and PREM validated. Reduction in avoidable ED presentations. Reduction in preventable readmissions. Continual evaluation and improvement of integrated care activities.	
		Develop a means to measure families' experiences of, and external providers' experiences of integrated care.			
		Develop a means to measure outcomes and impact of integrated care initiatives.			

Appendix 1 - References

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