Designing an Integrated Care Initiative for Vulnerable Families

Operationalization of realist causal and programme theory, Sydney, Australia

John Eastwood
Community Paediatrics
Community Health Services
Sydney Local Health District
Background
Sydney - A City Divided
Population Outcome Indicators for Sydney and South Western Sydney
Realist Multilevel Mixed Method

Maternal Depression

The Political Context of Inequalities

NEIGHBORHOOD ADVERSITY, ETHNIC DIVERSITY, AND WEAK SOCIAL COHESION AND SOCIAL NETWORKS PREDICT HIGH RATES OF MATERNAL DEPRESSIVE SYMPTOMS: A CRITICAL REALIST ECOLOGICAL STUDY IN SOUTH WESTERN SYDNEY, AUSTRALIA

John Graeme Eastwood, Lynn Ann Kemp, Bin Badrudin Jalaludin, and Hai Ngoc Phung

Brain and Behavior

Social exclusion, infant behavior, social isolation, and maternal expectations independently predict maternal depressive symptoms

John Eastwood, Bin Jalaludin, Lynn Kemp, Hai Phung, Bryanne Barnett, and Jacinta Tobin

Integrating Care for Children, Young People, and Their Families

Healthy families, children

Healthy Homes and neighbourhoods
Realist Multilevel Mixed Method

Maternal Depression

Explaining ecological clusters of maternal depression in South Western Sydney
John Eastwood ED, Lynn Kemp and Bin Jalaludin

A Critique of Social Epidemiology

REALIST IDENTIFICATION OF GROUP-LEVEL LATENT VARIABLES FOR PERINATAL SOCIAL EPIDEMIOLOGY THEORY BUILDING
John Graeme Eastwood, Bin Badrudin Jalaludin, Lynn Ann Kemp, and Hai Ngoc Phung
Realist Theory Construction

Global-Economic Level Mechanisms (examples)
“Necessary” Mechanism (M)
Stress
Maternal Outcomes (O)
Depression
Anxiety
Smoking
Alcohol & Drugs

Social Level Stressors
Class
Social economic position
Racism
Income inequality
Marginalisation
Segregation
Neighbourhood decay
Neighbourhood crime

Social Level Buffers
Social Support
Social Networks
Bridging Networks
Bonding Networks
Linking Networks
Social Inclusion
Trust, Safety
Information
Services
Emotions support
Practical support

Psychological Level Buffers
Mastery
Agency
Empowerment
Control
Emotional Resilience
Mattering
Confidence

Cultural Level Mechanisms
Expectations of motherhood, wife, daughter
Expectations of father, husband, son
Australian Dream
Acculturation
Cultural practices

Psychological Level Stressors
Chronic
Colourism
Discrimination
Lifetime trauma
Event
Pregnancy, birth
Perinatal death
Abuse

Context (C)
Corporate Business
Employment
Mega-Malls
Urban Development
McDonaldism

Media & Advertising
Motherhood
Lifestyle
“glam”
Sports Franchises
“Cities” of Malls

Migration
War displacement
Economic
Family groups
Settlement Policy

Integration Care for Children
Young People and Their Families

Research
Realist theory construction for a mixed method multilevel study of neighbourhood context and postnatal depression
John G. Eastwood1,2,4,5,6,7, Lynn A. Kemp3,7, and Bin B. Jalaludin3,7

Trigger Mechanism
Mismatched Expectations

Conditions (other mechanisms)
• Loneliness/isolation
• Lack of emotional support
• Lack of practical help
• Limited support network
• Limited support services
• Financial stress
• Poor health

Outcome
Depression

Stress
Necessary Mechanism
Maternal Outcomes (D)
Depression
Anxiety
Smoking
Alcohol & Drugs
Design and Methods
Previously developed realist causal theory and Realist Syntheses (Tyler et al 2015) were used to inform programme theory and the collaborative design of initiatives for vulnerable families.
Causal Mechanisms Analysed

- expectations
- loss
- being alone
- lifetime trauma
- discrimination
- mastery
- sense of control
- mattering

- trust
- isolation
- access to services
- information literacy
- social capital
- social exclusion.
Theory to Design Analysis

Causal Mechanism: Loneliness

Program Mechanism: Friendship
- Professional Support

Intervention Activity:
- Family or Peer
- Volunteer
- Worker
- Home Visit
- Telephone Call

Design Element:
- Wrap Around
- Family Group Conference
- Wrap Around
- Sustained Home Visit
- Care Coordination

Integrating Care for Children
Young People and Their Families
Collaborative Design

The collaborative design process included:

- identification of outcomes
- identification of contextual factors
- consultation forums
- interagency planning
- integrated care policy framework
- Collaborative tender
Inner West Vulnerable Family Collaborative Design

A Business Case to Invest in Vulnerable Children and their Families
SLHD Community Health June 2013

Vulnerable Families and Communities

Figure 1: Program Design

Component 1: Perinatal Coordination & SHV
Strengthen Sustained Home Visiting
- Maternity Screening System
- Allied Health and Medical Support
- Sustained Home Visiting

Component 2: Research & Analysis
Fidelity, Monitoring, Support
- Community Need Service Mapping Analysis

Component 3: Integrated Service Model Development
Partnerships, Reorienting Services
- Community Participation
- Interagency Collaboration
- Mental Health & Drug Health Medical and Allied Health Health Promotion

Healthy Homes and neighbourhoods
Integrating Care for Children Young People and Their Families
Published Design Papers
Mechanisms to turn activities into outcomes

Willingness to share status and power

provider and client/family

Self-reliance of clients/families

Provider confidence and comfort

Tyler et al 2015
Theory to Design Analysis

Programme Mechanisms

- family-peer trust
- family-provider trust
- willingness to share power
- co-operation
- Information
- building self-help skills

Intervention Activities

- strengthening peer and family support
- client centred workers
- home visiting
- telephone support
- digital media
Healthy Homes and Neighbourhoods
Integrated Care Initiative (HHAN)

Long term care coordination for vulnerable families with complex health and social care needs, who are disconnected from key services and require multi-agency support to have these needs met.

Aims to keep clients and their families safe, and connected to society.
Design Elements

• care coordination
• sustained nurse home visiting
• wrap around services
• family group conferencing
• primary care support
• place-based initiatives

• Family Health Improvement Component
• targeted parenting social media
• workforce development
• outcome monitoring
• realist program evaluation
Design Components

GOVERNANCE STRUCTURES AND PROCESSES
District Partnership Committee
Healthy Homes Steering Committee

Healthy Homes Care Coordination Trial
- Identify families
- Link services
- Sustain review

General Practice Linkage
- Engage
- Support
- Training

City of Sydney - South Trial
- Local hub
- Co-location of services
- Community needs assessment

Canterbury LGA Trial
- Local hub
- Co-location of services
- Community needs assessment

Capability Projects
- HealthTracker
- Patchwork tool
- Care coordination app
- EMR Algorithm

Family Health Improvement
- Key messages
- Website
- Social media

STRENGTHENING SECTOR CAPABILITY
Healthy Homes and Neighbourhoods Network

System Change
- Professional trust and knowledge
- Identification & risk stratification
- Informed consent policies
- Shared intake & communication systems
- Shared standards of collaboration

Capability Building
- Translation research
- Trauma & family partnership skills
- HealthPathways development
- Shared standards of collaboration

Integrating Care for Children
Young People and Their Families
Theory of Change

**Context**
- Disconnected and struggling Families

**Inputs**
- Family focused activities:
  - Service package designed around and negotiated with families
  - Care coordinators broker from existing service system with priority access
  - Key worker walks alongside the family as they engage, disengage and reengage
  - Long contact with family with tapered intensity – from face to face to virtual
- System reforms:
  - Knowledge & Learning Network captures barriers and enablers
  - PatchWork allows coordinated engagement with family

**Outputs**
- Outputs – (stabilisation)
  - Family engaged with Healthy Homes team and services
  - Whole of family plan with specific actions/goals agreed
  - Participation in family focused and individual focused support programs
- All agencies interacting with family through Healthy Homes team & PatchWork
- Family stabilisation/crisis averted

**Outcomes**
- Intermediate outcomes – at 24 months
  - Chronic health conditions are recognised and managed
  - Parenting capacity has increased
  - Secure connection to GP is established
  - Children and young people are attending school and learning
  - Adults and young people are engaged in meaningful activities
  - The family is connected to their local community
  - Family confidence and competence has increased

**System Outcomes**
- Agencies are signed up Sydney Health Homes Partners
- Barrier and enabler analysis completed and priority actions agreed

**Long-term Impact (5 years)**
- Resilience: Reduced need for intensive, crisis-oriented support and greater use of universal services
- Capability: Increased engagement in learning, earning, community
- Prevention: Reduced intergenerational effects of persistent disadvantage
Family-Centered Care Coordination

- Wrap-around model
- Family Group Conferencing
- Family Partnership
- Shared-care planning
- Clinical review
- Patient reported outcomes
- HealthPathways
Core Partners

- Family & Community Services (Housing, Child Protection, Early Intervention, Disability)
- CESPHN
- SDN Children’s Services – Brighter Futures
- The Infants’ Home Ashfield – Child and Family Services
- Barnardos – Family Referral Service
- The Benevolent Society – Child and Family Services
- Jannawi Family Centre
- SLHD (Community Health, Mental Health, Drug Health)
- Education
- Juvenile Justice and Police
- Local Government
Healthy Homes and Neighbourhoods
Integrated Care Initiative (HHAN)

- SLHD-based with a current focus on two identified “hotspots” of disadvantage
- New funding for expansion to third
Redfern and Waterloo Full Service Hub

- Co-location
- Engaging directly with community and local services
- Identifying community needs
- Providing care coordination
- School Outreach Projects

- Housing for homeless families
- Wrap Around Services
Poet’s Corner Pre-School

- Link to local **General Practice**
- **Paediatric** assessments for learning and behaviour concerns
- **Link** to legal, immigration, parenting groups, toy libraries
- Oral Team offered a **fluoride treatment**
- Allied health outreach
Canterbury Community Project

• Use results of mapping to identify a place-based focus
• Needs assessment with service providers
• Community consultation
• Outreach clinical services

• Identifying a Collocation Hub
Family and Practitioner Knowledge and Skills
Community Literacy
Social Media
Dashboard
This is the dashboard of the application to get access of different features of the application.

Functionality

- **My Profile** moves the user to the primary user’s profile detail.
- **My Family** shows all the family members including the primary profile.
- **What Matters to Me** shows primary user’s preference screen.
- **Topics** leads the user to the family member’s screen from there user specific posts can be viewed.
- **My Care** presents all the care plans of family members.
- **People who help me** shows all the people who helped the primary users and their family members to make them healthy.
- **Appointments** presents all the upcoming and historical appointments of the primary users and his/her family members.
- **My Apps** shows the app directory of the primary user.
The Well Child Health Program
Supporting GPs keeping our families healthy

Your questions answered
eLearning for GPs Login
Videos
Welcome to the Well Child Health program.

Here you’ll find support and online training about the comprehensive use of the child Personal Health Record (ePHR) for health and developmental surveillance for all children under the age of five.
Conclusion
Conclusion

• Critical realism provided the methodological underpinning of this programme of work and has assisted to explicate both the contextual conditions and the underlying causal and programme mechanisms.

• Consequently we have been able to move from our earlier theoretical models toward the design of whole of health and social care system interventions.
Conclusion

• In so doing we have moved from causal and programme mechanisms at the individual level toward mechanistic propositions relating to service systems and providers.

• Those situated activity – face to face activity; and intermediate level social and service organisational mechanisms, continue to highlight the important of trust and willingness to share power.
Conclusion

Thus the development and implementation of system change initiatives, such as general practice focused “health homes” and interagency “task groups” will be very reliant on approaches to sharing power and building trust between actors.
Slides of Detail
**Context**

**Component 1**
- Identification

**Component 2**
- Care-Co-ordination

**Component 3**
- Evidence-Informed

**Component 4**
- General Practice

**Component 5**
- Family Health

**Component 6**
- Place-based

**Component 7**
- System Change

**Component 8 & 9**
- Outcomes & Evaluation

**Interventions**

**Clinical Care**
- Strengthen existing identification and referral pathways through review, training and digital tools
- Implement population level high risk family care coordination and cohort tracking
- Integrated service models including wrap-around and family group conference model
- Parenting Programmes

**Provider Capacity**
- Shared design and implementation of evidence-informed interventions including parenting
- Capacity building of service network including eLearning, web-based and mobile technology
- Support for general practice
- Immunisation and Healthy Housing
- Healthy lifestyle initiatives

**System Change**
- “Hub” and “place-based” community building and service coordination
- Project management and leadership
- Sector capacity building projects
- System change projects
- Child and Family public health (research, program, evaluation)

**Mechanisms**

**Program Mechanisms**

**Consumer Level**
- Family – provider trust
- Family – peer trust
- Provider willing to share power with consumer
- Sharing of information
- Building of self-help skills

**Provider Level**
- Service providers share information and power
- Shared policies, standards, protocols
- Shared assessment tools

**Service System Level**
- Shared vision at the agency level
- Shared outcome framework
- Information sharing protocols
- Resources shared
- Training opportunities shared

**Outcomes**

**Causal Mechanisms**

**Consumer Level**
- Increased mastery
- Increased sense of control
- Increased expectations implemented
- Increased knowledge and confidence in ability to provide care to child and self

**Provider Level**
- Improved provider engagement with families
- Improved provider collaboration
- Increase shared care

**Service System Level**
- Improved agency collaboration
- Improved trust between agencies

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**Figure 4. ToC Logic Model**
<table>
<thead>
<tr>
<th>Functional Component</th>
<th>Key Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient and carer empowerment</strong></td>
<td>- The implementation of processes and systems that ensure the integrated care plan meets the needs and preferences of patient/caregivers as defined by patients or caregivers themselves (shared decision making).</td>
</tr>
<tr>
<td><strong>Using patient reported measures in care delivery</strong></td>
<td>- The implementation of a system of patient reported measures for enrolled patients that measure both the patient's perceptions of both their care experience and their outcomes, due to the care that they receive. - This includes the timely provision of the information to clinicians/teams delivering care to enable shared care planning/decision making.</td>
</tr>
<tr>
<td><strong>Supporting and promoting self-management</strong></td>
<td>- A set of defined care interventions specific to the targeted patient cohort to support self-management. - This also includes strategies to increase capacity for patients and caregivers to better self-manage their condition.</td>
</tr>
<tr>
<td><strong>Building patient / carer health literacy</strong></td>
<td>- The implementation of processes and systems (such as training and information) that improve the patient's understanding of their health condition(s), how to maximise their ability to manage it themselves, how/when to access health services and what role they play in managing their health condition(s). - This also includes care plan access, and active participation to the extent possible in care planning.</td>
</tr>
<tr>
<td><strong>Defining local health needs</strong></td>
<td>- The set of local health system parameters which broadly identify the types of patients that require the implementation of an integrated care model of care across the continuum of care.</td>
</tr>
<tr>
<td><strong>Identifying target cohorts</strong></td>
<td>- Patient level parameters (such as demographic, e.g. age; clinical, e.g. diagnosis; utilisation, e.g. number of medications; other, e.g. measure of social disadvantage) that define the group of patients that will be targeted/enrolled in the integrated care program.</td>
</tr>
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<td><strong>Developing systematic approaches to risk identification</strong></td>
<td>- The standardised approach to risk identification (such as signs of health deterioration and methodology (such as automated processes in PAS/EMR/EHR)) for identification of the targeted cohort of patients who would benefit from an integrated model of care. - The targeted risks and cohorts can vary locally, and can vary over time within locality as programs mature.</td>
</tr>
<tr>
<td><strong>Establishing new business models</strong></td>
<td>- The identification and implementation of business models across the continuum of care, or to promote care delivery which improves patient care and experience through improved coordination and integration. - The models sit alongside service models (such as operationalised service delivery). - They potentially incorporate financial and/or non-financial elements. - The models may include the selection of alliance partners (such as GPs, NGOs or other government organisations) and investment in new roles, as well as the use of known business models (such as Person Centred Medical Homes or a Commissioning Framework).</td>
</tr>
<tr>
<td><strong>Ensuring appropriate and timely access to specialist care</strong></td>
<td>- Needs for the identified cohort. - The function may be achieved in a number of different ways (for example, quarantining appointments in hospital based clinics or purchasing services from a telehealth provider).</td>
</tr>
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<td><strong>Shared/joint care planning and management with the patient/ carer</strong></td>
<td>- The development of shared or joint care planning and management strategies between the initiator of the care plan, the patient, and other health professionals who are to be involved in the care and service delivery to targeted patients.</td>
</tr>
<tr>
<td><strong>Establishing roles focused on organising patient-centred care</strong></td>
<td>- The establishment of roles (such as care managers, care navigators, care facilitators) to support the implementation of the integrated care model of care across care settings (such as hospital, primary care, specialist care, community care).</td>
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<td><strong>Embedding agreed models of care</strong></td>
<td>- The uptake of models of care for patients with specified conditions that are based on evidence-based medicine and adhered to by those clinicians seeing targeted patients. - This includes the process of designing and agreeing the models with stakeholders to optimise uptake.</td>
</tr>
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<td><strong>Connecting people to their healthcare team</strong></td>
<td>- The assignment of targeted patients to a clinical provider (individual/practice) whose role is to be the lead clinical provider with responsibility for the shared care plan and initiating communication with other care providers (such as specialist, GP, aged care, community care).</td>
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<td><strong>Systematic assessment, review of patients</strong></td>
<td>- The implementation of a system of standardised assessments, regular patient reviews, and uploading of relevant clinical metrics by clinical care providers based on developed integrated care pathway protocols.</td>
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<tr>
<td><strong>Building capacity/capability in primary and community care</strong></td>
<td>- The enhancement of resources (such as care navigators, training programs, care pathways, shared care planning tools) in the primary and community care settings to support integrated care delivery to targeted patients.</td>
</tr>
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<td><strong>Establishing a trackable cohort list</strong></td>
<td>- The establishment of an electronic patient list/register that identifies all patients enrolled in the integrated care initiative and enables the monitoring of the patient journey, as reflected through the patient's use of healthcare services.</td>
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<td><strong>Establishing shared access to patient information</strong></td>
<td>- The extent of electronic patient information on enrolled patients available to clinicians across care settings who are delivering the agreed integrated model of care (such as care plans, e-referral, discharge summaries, medication profiles, test results, service events).</td>
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<td>Design Component</td>
<td>Inner West Sydney Collaborative Design</td>
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<tr>
<td>1 Shared identification and intake</td>
<td>Strengthen existing perinatal screening and coordination system through review, training and monitoring</td>
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<td>High risk infant tracking models</td>
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<td>2 Care Coordination</td>
<td>Strengthen existing perinatal screening and coordination system through review, training and monitoring</td>
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<td>Strengthen Tier 2 support services</td>
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<td>Integrated service models including wrap-around and family group conference model</td>
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<td>3 Evidence informed practice</td>
<td>Strengthen current SHV by training, resourcing, management support</td>
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<td>Targeted parenting programmes</td>
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<td>4 General Practice engagement and support</td>
<td>Connecting people to their healthcare team</td>
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<td>5 Family Health Improvement</td>
<td>Review and strengthen universal services</td>
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<td>Targeted parenting programmes</td>
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<td>Universal family and community capacity building</td>
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<td>6 Place-based initiatives</td>
<td>Implement new Tiered model of SHV in Canterbury and Redfern and Waterloo</td>
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<td>7 System Change</td>
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<td>System change projects</td>
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<td>8 Child and family Outcomes</td>
<td>Child and Family public health (research, program, evaluation)</td>
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