MacHSR Future Leaders Fellowship program
Final reporting (Cohort 1)

Name: Catherine Grant

Project title: **ACTIVATE**: **A C**o-design projec**T** for care **I**ntegration: **V**iable **AcTi**ons for **E**nhancing connected care between hospital and primary care settings for patients with chronic and complex conditions.

Report:

Overview of problem and project plan

The prevalence of multi-morbidity among the Australian population is growing, so too is the burden these conditions place on individuals, communities, and the healthcare system (Australian Bureau of Statistics [ABS], 2022; Australian Institute Health and Wellbeing [AIHW]a 2022; World Health Organisation [WHO], 2007). Multi-morbidity is used to describe people who have two or more health conditions (van den Akker et al. 1998) People with multi-morbidity often have long-term, communicable health conditions that can lead to ill health, disability or premature death (AIHW, 2022). It is estimated that 47% of Australian's are living with multi-morbidity, accounting for almost half of the total disease expenditure nationally (ABS, 2022; AIHWa 2022; Swerissen, Duckett & Wright, 2016).

Due to the complexity of their conditions, people living with multi-morbidity are high users of health services, often requiring treatment and intervention from many healthcare providers across primary, secondary, and tertiary services (Department of Health [DH], 2016). However, when discharged from hospital, people living with multi-morbidity face poorly coordinated services and lack of integrated care, often leading to poor health and social outcomes (Curry & Ham, 2010; DH, 2016).

Integrated care has been defined as 'the provision of well connected, effective, and efficient care that takes account and is organised around a person's health and social needs' and is particularly important in improving outcomes and experiences for people living with multi-morbidity (DH, 2021). Providing comprehensive, patient centred, coordinated care, along with policy and health system change leads to better health outcomes, including reduction in avoidable hospital presentations, better access and overall improved population health (Cathcart 2007; De Maeseneer et al., 2007; Higginson et al., 2014; Starfield, 2019).

As identified by the Department of Health, the integration of care between hospitals and primary care for people living with multi-morbidity is currently one of the greatest challenges facing the health system (DH, 2016). This study aims to better understand and

develop strategies to address this challenge and improve the interface between hospital and primary care for this patient cohort.

Despite the documented challenges, there remains little evidence as to the best practice approach for hospital and primary health service care integration for people living with multi-morbidity. The COVID-19 global pandemic has changed the global healthcare landscape, with acceleration and adoption of new technology and a focus on innovative delivery of care models. There are significant challenges which include an ageing population, increasing burden of disease and costs of healthcare, a global shortage of healthcare workers as well as the impact of climate change on health. However, there are also opportunities with advancements in technology and artificial intelligence which can support further transformation in healthcare. Development of new co-designed models of care are needed to comprehensively explore the nature of inter-sectoral relationships from the perspectives of key users including patients, carers, hospital medical staff, care coordinators, and GPs.

This study will utilise an experience-based co-design (EBCD) methodology to understand and investigate the hospital and general practice care interface in order to develop a successful and sustainable end-user focused solution (Hjelmfors et al., 2018). Key participant's experiences of the hospital and primary health service care interface will be captured and leveraged to advance our understanding of intersectional collaboration, establish priorities for improving the care transition, and bring key participants perspective to address this complex challenge facing the health system.

Therefore, the objectives of this study are to:

1. Describe and understand the challenges and facilitators to provision of integrated care for patients with multi-morbidity being discharged from hospital care to care in the community.

2. To develop a new approach for hospital and primary health service care integration for people living with multi-morbidity.

Project Design: Experience Based Co-design

Participant Group	Workshop 1: Journey map review and identification of key critical factors	Workshop 2: Focus on solutions, develop prototype	Workshop 3: Consensus workshop – present protypes and form consensus on new discharge service model
Patients/Carers with multi-morbidity	8-10 participants	8-10 participants	2 mixed workshops of 16-20
GP practice representatives	8-10 participants	8-10 participants	
Hospital Doctors	8-10 participants	8-10 participants	
Hospital Care Coordinator	8-10 participants	8-10 participants	

Project Refinements

There have been a number of modifications made to the project plan including:

- Key participants modified to include practice managers, practice nurses and GPs
- Modification to co-design workshops – increased from 2 to 3 and zoom option included
- Modification to identification of patients with multi-morbidity

Activities, achievements and impacts

Oral presentation **Integration of care between hospital and primary care settings for patients with multimorbidity.** Asia Pacific Integrated Care Conference, Sydney, November 2023.

Committee member of **Western Melbourne Integrated Care Community of Practice** Steering committee – this has facilitated collaboration with NWPHN and GP integration unit to support project.

Barriers

The MACH Fellowship program has been an extremely beneficial and valuable experience. This project has been challenging due to the following barriers:

- Difficulty in quarantining one day per week in a busy Operational Management role with no backfill
- Challenge of coordinating meeting times with busy supervisor
- Personal and family health challenges
- Organisational capacity to provide resource to support research for project.

Future plans

This project remains a priority for completion in the next 12 months. Options for resource are currently being explored with high likelihood of this being available by or before mid-2024.

A number of key stakeholders both within Western Health (WH) and external to WH have been engaged and are interested in being involved in the project.

References

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