KIDS GUIDED PERSONALISED SERVICES (KIDS GPS) CARE COORDINATION

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Kids GPS Care Coordination is a service for children with chronic and complex conditions who frequently utilise hospital services
- The service aims to improve efficiency and patient outcomes by supporting families to navigate services and providers within the hospital and the child's local community, integrating tertiary, secondary and primary health
- Care Coordination intends to reduce avoidable overnight admissions and Emergency Department attendance, improve length of stay, streamline appointments, facilitate discharge and improve the integration of care between community health providers and the hospital
- This document outlines the service in terms of referral, eligibility criteria, model of care and discharge criteria
- Kids GPS Care Coordination can be contacted via email:

  schn-kidsgps@health.nsw.gov.au

CHANGE SUMMARY

- Document due for mandatory review.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st October 2022	**Review Period**: 3 years
Team Leader:	Nurse Manager	**Area/Dept**: Ambulatory Services

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READ ACKNOWLEDGEMENT

- Read Acknowledge Only – All clinical staff, Clinical Directors and Heads of Department should read and acknowledge this document

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1 Introduction

Kids Guided Personalised Services (Kids GPS) Care Coordination is fundamentally based on patient centred principles. It is a goal oriented service of the Sydney Children's Hospitals Network (SCHN) that is responsive to higher risk patients across the paediatric and adolescent lifespan, 0 to 18 years of age, who have a chronic or complex health condition. The service is focusses on children and young people with increased care coordination needs due to a number of factors, including, but not limited to:

- Chronic disease, particularly with associated medical complexity
- Identified as a vulnerable patient or family
- Geography – patients travelling extended distances to access care
- Accessibility and availability of services
- Involvement of multiple health care teams
- Opportunity to improve integration with local services, including primary and secondary health care

It is anticipated that improving the care coordination for this cohort of children and young people will likely reduce overnight admissions and Emergency Department (ED) attendance, reduce length of stay, facilitate earlier discharge and improve the integration of care between community health providers and the hospital.

Kids GPS aligns with the SCHN vision of *Children First and Foremost*, with a mission to help care teams partner with families and local health services so children and young people with chronic and complex conditions spend less time in hospital and more time at home.

2 Objectives of the Service

Kids GPS Care Coordination incorporates the following objectives:

1. To improve the experience and health outcomes of children and young people with chronic and complex conditions by:
    - Improving healthcare utilisation – reduce Emergency Department visits, coordinate outpatient department visits, avoid unnecessary overnight hospital admissions and where appropriate reduce planned and unplanned inpatients length of stay
    - Improving care coordination with a Kids GPS Care Coordinator who partners with the child/young person and their family to coordinate their care, thereby reducing delays, streamlining care and optimising the use of clinical resources
    - Identifying a lead clinician within the child's local community, local health district and SCHN in conjunction with a family lead.
    - Developing a contemporaneous care plan that improves communication, supports decision making for the parent/carers and young people, and facilitates integration of care between SCHN and the child's local community

2. To improve the experience and capacity building of families
    - Enhancing communication and collaboration across health care providers and related service providers to enable the care to be shared and coordinated
3. To optimise appropriate resources across all realms to ensure the efficient provision of care (right time, right place, right care, right team)
4. To enhance existing services and develop evidence-based models for the care of patients within a range of chronic and complex conditions

3 Model of Care

The Kids GPS model of care focuses on the 'Circle of Coordination' which places the child/young person at the centre of the integrated care practice (see Appendix 1.0). The circle is formed by the identification of leads. These being, within SCHN, the local community and the family, who each share the responsibility of ensuring that active communication occurs between all involved in the health care needs of the child/young person.

The model involves:

- Identification of the family, SCHN and community lead
- Assigning of roles and responsibilities to team members
- An individualised and contemporaneous care plan devised for each child

The Family Lead

The child/young person and their family are central in their own care coordination process, including goal-setting and the ability to nominate clinical leads within SCHN and their community whom they see as providing care coordination. The Care Coordinator will assist with establishing goals and the identification of appropriate leads and key people as necessary.

The Community Lead

This lead clinician acts as the family's single point of contact within the community setting and assumes responsibility for ensuring communication occurs between the family and SCHN. The community lead will work in partnership with the Care Coordinator, the family lead and the SCHN lead to develop a care plan, ensuring that this plan is enacted and updated as appropriate. The community lead is usually the child/young person's General Practitioner or Local Paediatrician.

The SCHN Lead

This SCHN lead clinician assumes responsibility for ensuring communication occurs between the family and the community. The SCHN lead will work in partnership with the Care Coordinator, the family lead and the community lead to assist in the development a care plan, ensuring that this plan is enacted and updated as appropriate. The SCHN lead will make contact as required with the community lead clinician and local health services ensuring relevant written correspondence is provided.

The role of Kids GPS Care Coordinator

The Care Coordinator's is the single point of contact who partners with the patient, family, community clinicians and SCHN clinicians to facilitate the coordination of the patient's care by:

- Being a consistent point of contact for the patient and family
- Assisting with the identification of the family, community and SCHN lead
- Ensuring a care plan is implemented for each patient enrolled in the service, that they are updated as appropriate and communicated to all involved
- Identifying opportunities for local integration of care and shared care plans, streamlining of appointments and ED avoidance
- For children/young people who have access to local care coordination, Kids GPS will partner with the local care coordinator to ensure an accurate and up to date care plan is maintained.

4 Eligibility Criteria

All referrals to Kids GPS Care Coordination will be assessed against the following eligibility criteria:

- The child/young person is a patient of SCHN or has been referred to SCHN for tertiary level care or advice.
- The patient has a chronic and complex condition, involving multiple health care providers.
- There is not a designated key person coordinating the patient's care within a multidisciplinary team
- There is potential to facilitate a more coordinated approach to the patient's healthcare needs, in particular for patients who frequently utilise hospital services over a twelve month period demonstrating one or more of the following:
    - More than 4 Emergency Department presentations
    - More than 14 days length of stay for hospital admission/s
    - Greater than 10 outpatient appointments
    - **OR** infants identified as being at risk of significant future hospital utilisation

There may be exceptions to the inclusion criteria which may be considered by Kids GPS Care Coordination Service; therefore patients who are identified as potentially benefiting from care coordination who may not fit the above criteria should be referred to the service for an assessment at the weekly intake meeting.

Exclusion criteria

Children and young people who currently receive formal care coordination from their speciality team to avoid duplication of interventions. However, Kids GPS Care Coordination

may be able to assist the specialty teams in the development of a care plan by sharing their knowledge and experience in care plan development. This will empower the specialty team to continue care coordination with the child/young person without the need for Kids GPS enrolment.

5 Referral to Kids GPS

Kids GPS accepts referrals from any SCHN clinician as well as self-referrals from parents/carers. Referrals can be made to the service via:

- Email to the SCHN Care Coordinators – schn-kidsgps@health.nsw.gov.au
- Powerchart electronic referral (at CHW) – see Appendix 2.0 for referral process

The Kids GPS Care Coordinators can be contacted directly via telephone by patients/families and clinicians Monday to Friday 08:00 to 16:00:

- Randwick office: (02) 9382 0529
- Westmead office: (02) 9845 2526
- On receiving a referral the Care Coordinator will endeavour to respond within 72hrs.
- Inpatients being referred to Kids GPS should be referred as early as possible prior to discharge.

6 Implementation of a Kids GPS Care Plan

All patients enrolled in Kids GPS Care Coordination will have a care plan implemented that includes:

- Patient demographics
- Diagnoses, allergies and alerts
- Goals set in conjunction with the family and treating teams (including “what matters to me”)
- Key people involved in the care of the patients, both internal to SCHN and external
- Management plans for specific conditions and devices
- Emergency Department avoidance plans where appropriate
- Management plans for predictable health events
- Endorsement by the three “leads”
- The Kids GPS Care Coordinator ensures care plans are reviewed at 3, 6 and 12 monthly intervals or as clinically appropriate and any changes made to care plans are updated in a timely manner.
- Any updated care plan must be uploaded into EmR by the care coordinators and forwarded to all leads.

The process from enrolment to implementation of a care plan seeks to achieve the following Key Performance Indicators (KPI's):

- Referral to response within 3 days
- Waitlist to enrolment within 14 days
- Enrolment to care plan implementation within 25 days
- 100% of enrolled patients to be linked to a GP

7 Appointment Coordination

Appointment Coordination is a service available to patients with chronic and or complex health needs who are required to attend SCHN facilities for multiple appointments.
The service aims to:

- Streamline appointments in order to minimise the length of time spent away from home, off school and away from employment.
- Coordinate care between clinicians and services to reduce the number of times the patient needs to travel to the tertiary hospital
- Ensure all relevant information is well communicated between SCHN clinicians, local clinicians and the family
- Provide advice to the parents/carers regarding travel and accommodation options

Patients may be referred for Appointment Coordination using the same referral pathways for the Kids GPS Care Coordination Service (see Appendix 2.0).

8 Kids GPS 24/7 Hotline

The Kids GPS 24/7 Hotline is a service available to a specific cohort of patients who are deemed as eligible by the Care Coordinators. The hotline is targeted to patients who frequently attend the ED (or are at risk of this) and aims to reduce avoidable ED presentations by providing a support service to enhance the care plan. The service has a mission to empower parents/carers to make confident decisions regarding their child's health care needs.

The Care Coordinators will determine eligibility for the Kids GPS 24/7 Hotline based on the following:

- The child is a frequent presenter to the ED with 4 or more presentations within a twelve month period **OR** is identified as at risk of frequently presenting
- The child has a chronic and complex condition **OR** has a device in situ
- There is potential to reduce ED presentations with senior nurse telephone support and guidance.
- There is a potential to reduce ED presentations by utilizing Ambulatory Pathways such as Acute Review Clinic, HiTH and or Medical Day Units.

- The process for enrolling a patient in the 24/7 Hotline is further outlined in Appendix 5.0.

A patient will be discharged from the Kids GPS 24/7 Hotline when:

- Their device is removed and they do not otherwise meet the criteria for enrolment
- All key leads (Community, Family and SCHN) involved in the patients care are aware and agreeable.
- Potential discharges are discussed at the weekly intake meeting as well as with the family.

A patient may remain enrolled in the Care Coordination Service following discharge from the 24/7 Hotline until they meet the criteria for discharge from the Care Coordination Service.

9 Discharge from Service

A patient will be discharged from Kids GPS for the following reasons:

They have been transitioned to adult services:

- Kids GPS will work in partnership with *Trapeze* and other transition services as needed to assist patients 14 years of age and older in their transition to adult services
- Trapeze/transition services and Kids GPS will remain in regular contact to ensure that the transition needs are met for the patient and to avoid duplication of services
- Kids GPS, Trapeze, the family, and the hospital and community leads will work collaboratively during the period of transition until the patient is successfully transitioned to adult services

They are no longer a patient of SCHN:

- If a patient ceases to access services at SCHN they will no longer be eligible for this service. All effort will be made prior to the patient leaving SCHN to support integration with new services and a streamlined transfer of care

Parent / Family Request

- Parent / family advise that they can navigate the system and feel empowered to move forward and no longer require care or appointment coordination.

Prior to a patients discharge from the service, a verbal conversation needs to occur between the care coordinator and the family lead. All communication must be documented in the EmR.

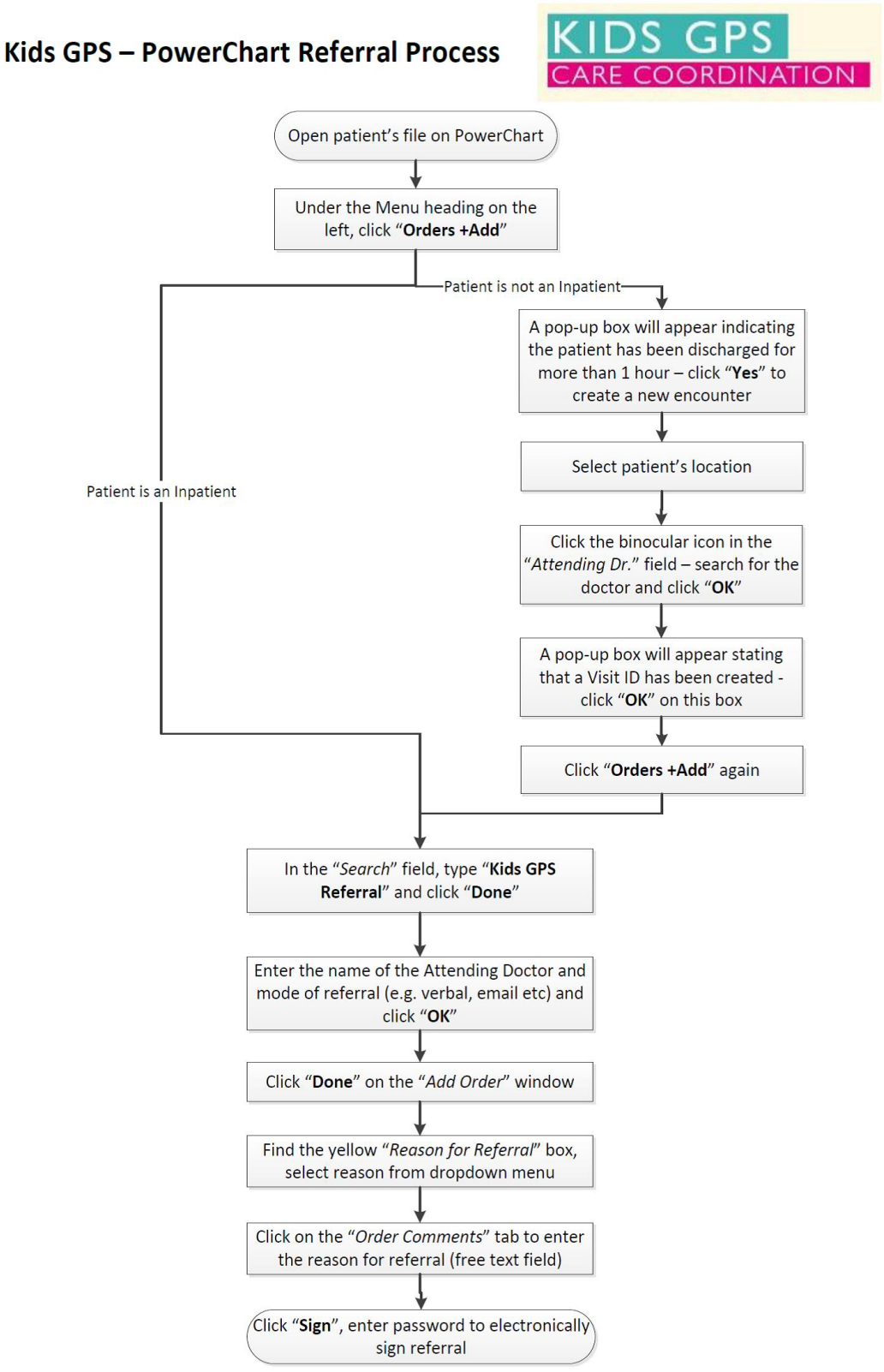
All key leads on the current care plan will be informed in writing of the patients discharge from KidsGPS.

Patients may be re-enrolled in the service at any time at the request of the family, hospital and community leads when there is an escalation of need for care coordination.

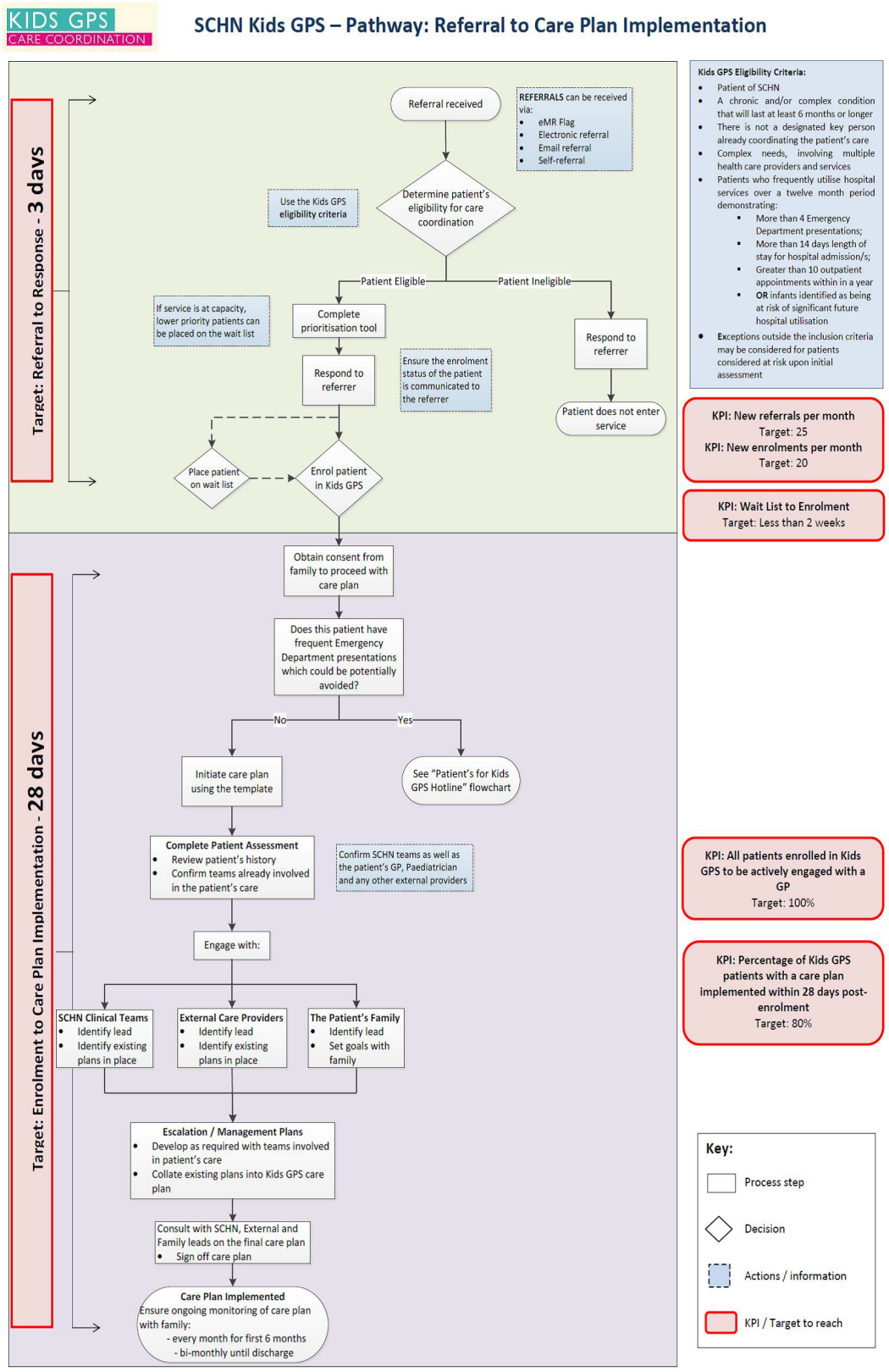
10 Appendix

Appendix 1.0: Kids GPS 'Circle of Coordination'

Appendix 2.0: Process for Powerchart eReferral to Kids GPS



Appendix 3.0: Referral to Care Plan Implementation



Appendix 4.0: Kids GPS Key Performance Indicators (KPIs)

KIDS GPS MONTHLY KPI REPORT		
#	**KPI**	**Target**
1	**KPIs based on Current Month's Activity**	
1.1	Number of new **referrals** per month	**25**
1.2	Number of patients **enrolled** per month	**20**
1.2.1	Tier 1: Integration with Primary Health only	**Report**
1.2.2	Tier 2: Requires integration + shared care plan +/- Primary Health	**Report**
1.2.3	Tier 3: Chronic/complex care coordination between tertiary, LHD and Primary	**Report**
1.3	Number of eligible referrals placed on waitlist per month	**Report**
1.4	Number of patients discharged from Kids GPS	**Report**
1.5	Number of Kids GPS patients with no GP on enrolment (not identified in system; or identified but no active engagement)	**Report**
1.6	Number of patients integrated with a local hospital for ongoing maintenance treatment (e.g. infusions)	**Report**
1.7	Number of patients integrated with a GP for ongoing maintenance treatment (e.g. infusions)	**Report**
2	**KPIs based on all Active Kids GPS Enrolments - Care Plan Implementation**	
2.1	Average time from referral to response*	**3 days**
2.2	Average time from waitlist to enrolment	**14 days**
2.3	Average time from enrolment to care plan implementation	**28 days**
2.4	Average time from ED flag to ED Avoidance Plan implementation**	**5 days**
2.4	Percentage of all Kids GPS patients with a care plan implemented in 28 days post-enrolment	**80%**
2.5	Percentage of Kids GPS patients actively engaged with a GP following care plan implementation	**100%**
3	**KPIs based on all active Kids GPS Patients - Activity**	
3.1	Total number of patients actively enrolled in Kids GPS***	**200**
3.2	Total number of patients actively enrolled in Kids GPS 24/7 Hotline	**200**

** Response = communication to referrer regarding enrolment/waitlist/not eligible/*

*** For patients flagged with 4+ ED presentations who are eligible for the Hotline*

**** Target based on 50 patients per 1.0 FTE CNS2*

Appendix 5.0: Process for enrolment in the Kids GPS 24/7 Hotline