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CONFERENCE ABSTRACT

"Instead of just assuming what people need, actually ask them what they're after": Patient Reported Measures for families with complex needs

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Introduction: The Sydney Local Health District (SLHD) Healthy Homes and Neighbourhoods Integrated Care Program (HHAN), Australia, seeks to improve the care of families with complex needs and/or inter-generational trauma by providing care coordination and undertaking activities that promote inter- and intra-agency integration. To facilitate integration and a collaborative approach to family assessment and measurement of progress, HHAN has developed a database of Patient Reported Measures (PRMs).

Description of policy context and objective: By collaborating with partners in the completion of PRMs for shared clients, PRMs are drivers of integration of patient-centred health care. HHAN aim to extend this to include non-health agencies such as education and housing. A collection of PRM tools have been identified by HHAN to be used with families to provide service providers with a holistic view of psychosocial parameters and risk stratification. These tools can be used for assessment, screening and goal setting, and can be repeated over time to monitor client progress and outcomes. HHAN is utilising the web-based application Research Electronic Data Capture (REDCaP) to develop a database on which PRMs can be completed and scored electronically for immediate feedback to the family.

Targeted population: Families with children aged 0-17 years, where the parent or carer has complex health or psychosocial care need, are referred for care coordination with HHAN. In Phase 1 of the PRM roll-out, HHAN Care Coordinators will trial the use of a suite of PRM tools with HHAN families. In Phase 2, use of the PRM database will extend to health and non-health partners who share care of HHAN families.

Highlights: This PRM project enables integration of family-centred care across child and adult health and psychosocial care agencies. The PRM tools serve multiple purposes: risk stratification; screening; assessment; developmental surveillance; and measurement of outcomes.

Risk stratification information and responses to the outcome measure tools can be shared with other providers accessing the database. The database enables immediate calculation of the outcome measures so feedback can be provided to families straightaway.

We anticipate the benefits to be two-fold:

Benefit to the family: Reduced burden of repetition. Families are often known to multiple agencies due to multiple care needs. When service providers collect and share PRMs the family only answer questions once and these responses are used to inform all relevant carers working with the family. This allows services providers to plan integrated and collaborative care that is meaningful to the family, increasing the likelihood of improved outcomes.

Benefit to the service provider: A streamlined assessment and review process, and access to family information to support coordinated care.

Comments on transferability: This PRM database can be used on other platforms for use by health, education or social service providers working with families.

Conclusions: We will be reporting on findings related to the implementation of the project within the HHAN Care Coordination team, and the expansion to an interagency collaboration.

Keywords: patient reported measures; family-centred care; outcome measures