

A partnership model for children with complex medical conditions: The Champlain Complex Care Programme in Canada

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Organisation: Children's Hospital of Eastern Ontario (CHEO)

Country: Canada

Level of government: Regional/State government

Sector: Health

Type: Partnerships, Public Service

Launched in: 2012

Overall development time: 1 year(s)

Link to the innovation's website

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Description

According to the Provincial Council for Maternal and Child Health, in 2012 3700 or 0.14% of Ontario children accounted for 50% of overall annual in-patient expenditures for all children. These patients are considered to represent the most technologically and medically complex cases in overall terms.

This case study shows how the Champlain region of eastern Ontario in Canada developed an innovative pilot project that has evolved into a partnership model to reduce the average cost of delivering health services young patients with chronic illnesses, while enhancing their overall quality of life, by providing the right care, at the right time, in the right place, by the right care provider.

Why the innovation was developed

- Clinical and technological advances have allowed patients, including children and young people, to live longer with chronic illnesses.
 - An almost unavoidable consequence is that some infants who would previously not have survived now live with significant physical and neurological disorders.
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Objectives

Develop staff capacity, Improve effectiveness, Improve efficiency, Improve service quality, Improve user satisfaction

- The goals of the Champlain Complex Care Programme are to provide a family-centered approach for technology-dependent, medically complex and fragile children and youth;
 - To facilitate communication and collaboration among care providers;
 - To coordinate needs across the system; and
 - To relieve the burden on families of navigating the system alone, in order to aid in the overall objective of improving health status for those impacted.
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Main beneficiaries

Families, Government staff, Young people

- Young patients with chronic illnesses
- Regional Hospitals

Results

Effectiveness

- Approximately 15% of children/youth who participated in the programme have graduated, and are now equipped with the ability and capacity to navigate the overall health and social care system, using tools and documentation which give them full access to services in the community.
 - The shift to community-based care is supported by a community care coordinator and a primary care physician (or paediatrician), once the patient's condition has stabilised.
 - This model allows for increased throughput and flow through the healthcare system and has the potential to extend the service of a complex care program to a larger population.
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Service quality

Accessibility:

- Overall, results from the pilot show improved access to care, increasing system throughput and providing long awaited coordination of services for families in Ottawa and surrounding areas, allowing them to “normalize” their households, return to work and lead a family life as close as possible to normal.
 - In particular, the programme has demonstrated statistically significant decreases in in-patient services and increases in out-patient services. The programme was also able to improve the response time for consultations, and reduced duplication of services.
 - Similarly, the programme was seen to have beneficial outcomes and impacts on the health of the participating young people, as demonstrated through measurement of scales indicating increases in the strength of children and young people, and decreases in their needs (as demonstrated by Children & Adolescent Needs and Strengths (CANS) assessment).
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User satisfaction

- Survey results have highlighted positive satisfaction from participating families, demonstrating the programme's ability to identify and reach the right population, provide services that impact on health care utilization and health outcomes, and provide an intervention with which children and families are satisfied.
- Specifically families report the following benefits from the programme interventions: No more need to answer the same question from a variety of providers; A noticeable reduction in duplicate procedures/tests and referrals; A single point of contact (care coordinator) whom they can call, eliminating unnecessary contacts with providers and unnecessary emergency department visits; An individualised comprehensive Single Point of Care (SPOC) plan, developed uniquely for each patient/family.

Development

Design

The new model was strongly driven by the Chief Executive Officers of the founding partner organisations as well as the Champlain Local Health Integration Network (LHIN). The LHINs were created by the Ontario government in March 2006 as 14 not-for-profit corporations who work with local health providers and community members to determine the health service priorities of their regions of Ontario. While they do not directly provide services, their mandate is to plan, integrate and fund health care services and they oversee nearly two-thirds of the \$37.9 billion health care budget in Ontario.

Testing

- The programme partners established a governance structure to ensure evidence-based decision making, including both a Steering Committee consisting of family members and senior executives from each partner organisation and an Advisory Committee consisting of family members and middle management from each partner organization, as well as a Programme Team that is CHEO-based and runs the day-to-day programme.
 - The partners set up an inter-disciplinary programme team consisting of a project manager, several nurse coordinators and a Most Responsible Physician (MRP). The project manager and MRP were CHEO-based, the care coordinators were based in each partner organisation and were assigned to the patient and family based on an assessment of the unique care needs required and which partner organisation or combination of organisations could best meet those needs.
 - 33 patients and families were randomly selected to participate in a pilot after having met the programme's defined 'inclusion criteria'. Family-Focused Meetings were conducted that included patients, families, specialists, multi-disciplinary medical teams and allied health providers to assess the unique needs of each patient and determine if their care team should be hospital or community-based or a combination of both.
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Implementation

Tools used:

- The pilot was evaluated in early 2013 with a view to scaling up the existing programme to serve more patients in the Champlain Region. In order to accomplish this objective the Care Coordination Model was maintained and the programme formalised its structure to include a Service Delivery Model with three levels of coordination to further meet the needs of a complex paediatric population and further integrate community and hospital providers. In this model the best care provider for a particular patient is determined by the patient condition and required interventions. Patients can move back and forth across the model based on their needs.
- Furthermore, the partnership proposed that the pilot project expand beyond the pilot to create the Champlain Complex Care Programme that would support a larger number of patients and extend to further community-based involvement.
- A further enhancement was that Rapid Response Nurses were put in place in November 2013 to reduce re-hospitalization and avoidable emergency department visits by improving the quality of transition from acute care to home care. These nurses will visit the homes of children with complex needs within 24 hours of discharge to ensure that discharge instructions are understood, to contact the primary care provider, to arrange for a follow-up appointment within 7 days and to assure the medication arrangements. Research has demonstrated that these activities decrease the risk of readmission to acute care.

Resources used:

- The pilot project and subsequent Complex Care Programme has been funded by the Champlain Local Health Integration Network (LHIN) and the partner organisations, with in-kind services (administrative expenses, office and clinic space and overhead, allied health) provided by each. The annual budget for the pilot which supports the programme team has averaged CAD 350 000.
- Results from the pilot show that, in addition to making a significant difference to the health of individuals in the programme (as outlined above), the pilot actually made a major contribution to reducing healthcare costs by almost CAD 1 million each year, compared to annual costs of CAD 0.35 million. This has amounted to total savings over three years of approximately CAD 1.65 million.
- Specifically, the cost reductions to the overall health system have included: decreases in number of in-patient days, equating to CAD 900 000 in annual savings; decreases in emergency room visits, resulting in CAD 7000 annual savings; offset by increases in clinical visits in year one resulting in additional CAD 13 000 costs and then a decreased trend in year two, resulting in the equivalent savings.

Lessons Learned

Lessons Learned

- Our programme has made the transition and is an example of the “ideal reformed system” defined in the report of the Commission on the Reform of Ontario's Public Services, chaired by Don Drummond on behalf of the Ontario provincial government.
 - The partnership is governed by a Steering Committee consisting of the CEOs of all its component organisations, as well as family and physician representatives. The partnership is supported by an Advisory Committee and Programme Team.
 - Annual renewal of Partnership Agreements keeps key issues to the forefront and provides an opportunity for each partner to report their proposed financial and in-kind services for the upcoming year. All members of the partnership exhibit a willingness to collaborate in order better and more quickly to coordinate health care services for children and young people with complex conditions.
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Other information

This programme is a model that can be replicated in other communities or settings with the following characteristics: Patient-centric and family-centred care; Driven by co-ordination and navigation of services across providers (hospital, community, education) by inter-professional Patient Focused Teams; Focused on complex chronic care of the small population of children and young people with technology- dependent and medically complex cases, which use the most resources; Data collection, sharing and comparison between all providers; Dedicated to reduced healthcare spending, by demonstrating rigorously the scope for diverting care out of hospital and into the community; Quality assurance and supervision of the impact of the model of care on the system.

It is anticipated that the model may be generalised to other groups of children and young people with high use of health care, including all children with medically complex cases and ultimately all children with complex cases of any kind, who would benefit from similar models and tools (e.g. children and young people with mental health issues).

The partnership additionally has the capability to provide tools and resources and assume a lead role in successful transition of young people to the adult hospital system.