Evaluation of the Care Collective – Caboolture and Redcliffe – Interim Report for Brisbane North PHN and Metro North Health

28 March 2024

phn BRISBANE NORTH
An Australian Government Initiative

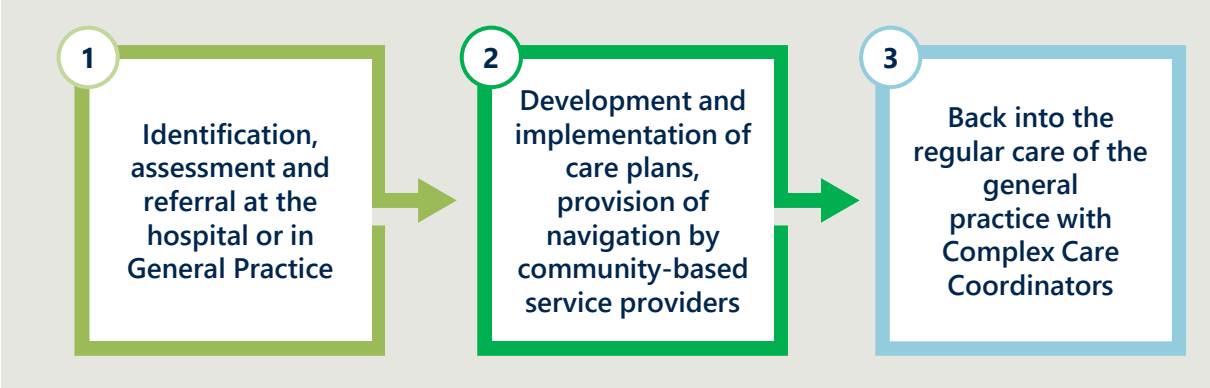
Queensland Government
Metro North Health

Executive Summary

The Caboolture and Redcliffe regions in Queensland have a relatively high proportion of people with complex health and psychosocial needs, placing additional pressure on the health system. Issues have previously been identified with coordinating care across the system for people with chronic conditions.

The Care Collective, a joint initiative of Brisbane North PHN and Metro North Health, was designed in response to challenges with coordination and integration in the health system. The Care Collective integrates and enhances existing pathways. New funding from 1 July 2023 has enabled the continuation of the Care Collective in Caboolture and expansion of the program to the Redcliffe region.

The model is targeted at people living with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and conditions that lead to presentations for debility (e.g. dementia, falls). This cohort were identified as driving a large number of frequent hospital presentations in the region. **The model (illustrated below) consists of Complex Care Coordination services in General Practice, as well as community-based care coordination services, and navigation services to support better health outcomes and reduce unnecessary health service use.**



This is the first report in the ongoing 2023-2025 evaluation, which seeks to understand the reach, effectiveness, adoption, implementation and maintenance of the program operational in the Caboolture and Redcliffe regions. This report presents insights from the evaluation to date from June 2022 until March 2024. This evaluation is informed by engagement with program stakeholders from the Health Alliance, Brisbane North PHN and Metro Health, a review of key program documentation and quantitative data relating to clients and their hospital service use. Referrals for Redcliffe have commenced, however data for inclusion in this report is not available.

The Care Collective has been successfully implemented in Redcliffe, building on learnings from the Caboolture implementation. There has been strong uptake of the program by general practices in both catchments (eight in Caboolture and nine in Redcliffe) with the addition of Complex Care Coordinators (CCCs) in Redcliffe general practices earlier this year. This rate of uptake (of those approached) indicates that healthcare providers recognise the value and potential benefits of the program.

The CCCs in general practice have achieved a diverse range of impactful health and social outcomes for clients. There remain some challenges with the identification and referral of clients in hospital settings, in which discharge planners and nurse navigators play an important role.

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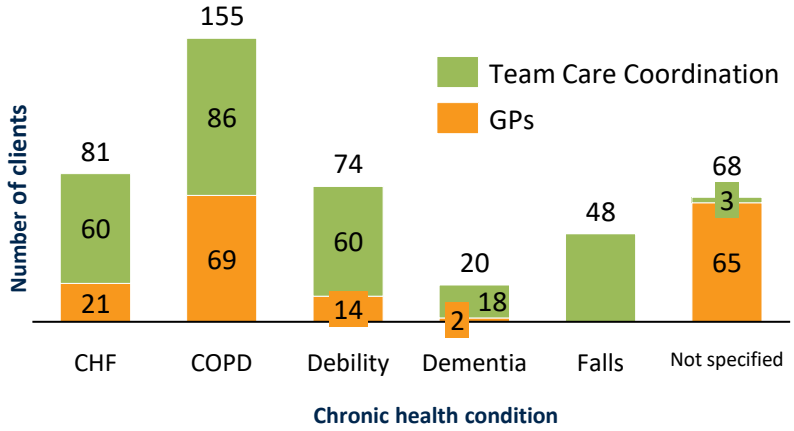
Results

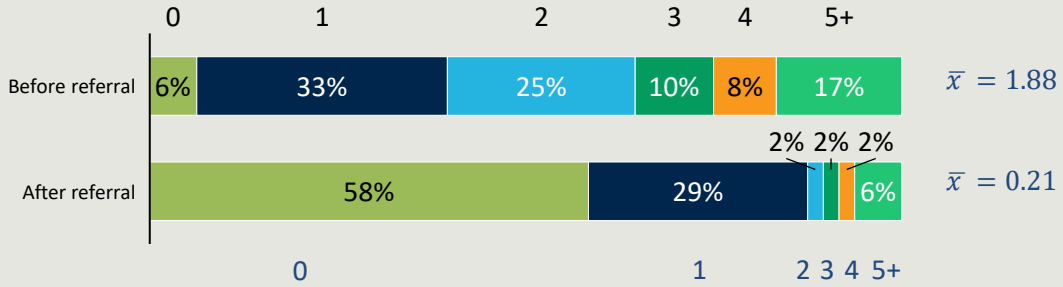
The number of referrals to the Care Collective in the Caboolture region is steadily growing. Referrals have largely come from Caboolture Hospital and CCCs in Caboolture general practices.

Although the shorter period analysed in this report compared to previous evaluations[1] creates limitations in the significance of the analysis, data to date provides an indication that the Care Collective is successfully reducing clients' emergency department (ED) presentations and unplanned inpatient admissions. It also appears to be producing savings of more than quadruple its funding in reduced hospital service use.

Referrals by chronic health condition (primary diagnosis)



EMERGENCY DEPARTMENT PRESENTATIONS (PER MONTH)



The number of emergency department presentations per month has significantly reduced after referral to the Care Collective *(p < .01)*. On average clients had a **63% reduction in ED attendances.[2]**

There has been a **77% decrease in the number of clients with greater than one ED presentation per month.[2]**

INPATIENT SEPARATIONS (PER MONTH)[3]

The number of planned and unplanned admissions to the previous evaluation period is significantly lower, but for the new cohort no statistically significant changes are observed after referral (below).[2]

Notably, this may indicate increased engagement with planned care. Planned admissions are predominantly not related to the in-scope conditions and are on average shorter (excluding episode changes).

RETURN ON INVESTMENT

Based on avoided ED presentations and the resulting avoided admissions, the Care Collective has returned

450% of the funding invested in savings to the health system.

$1,829
Average saving per month per client

$429,822
Estimated average saving per month

1. The estimates provided in this report are interim only and only include data for clients enrolled between June and December 2023. While the results are reasonably consistent with the previous report, the limitations we have identified mean that this is liable to change when final and full data is analysed.
2. Analyses showed a reduction from 1.88 average attendances per month before referral (SD = 1.40) to 0.21 attendances per month after referral to the Care Collective (SD = 0.35). A paired t-test showed a significant reduction at the 0.99 significance level.
3. These analyses were based off clients working through Team Care Coordination only, due to confidentiality issues with data sharing for clients in GP clinics.

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