Closing the Invisible Gap

Haematology Care Coordination as Preventative Infrastructure in a Culturally Diverse Metropolitan District

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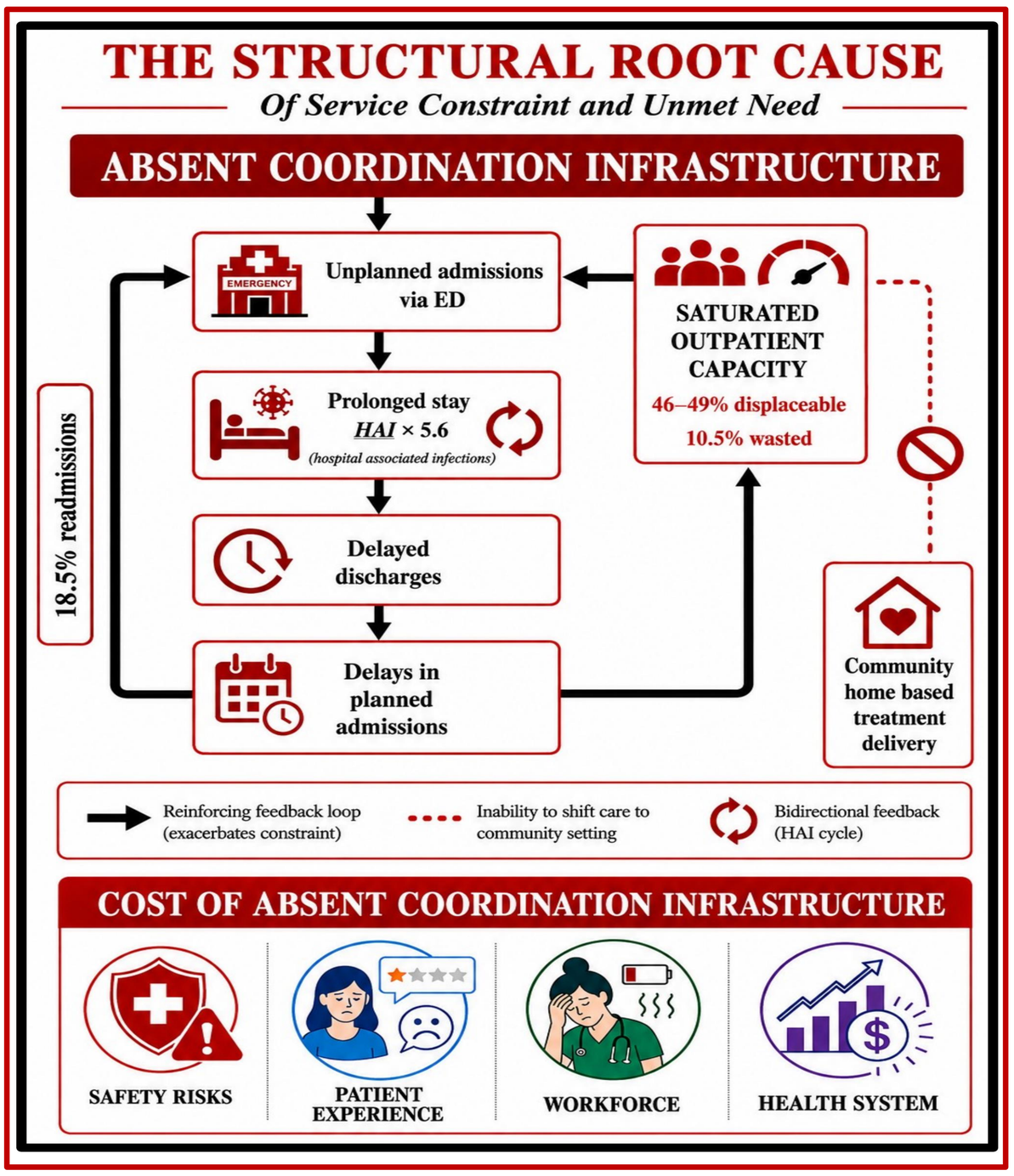

CASE FOR CHANGE

The patients are complex and immunocompromised – malignant and chronic non-malignant conditions.
The pressure: growing demand, treatment complexity, an ageing comorbid population
The Gap: no funded haematology coordination model unlike oncology

KEY FINDINGS

A **whole-of-service assessment** triangulating eight evidence streams identified absent coordination as the principal structural driver of service constraint and unmet need.
ONLY 0.09% of 9,514 patients had documented care coordination in 2024 and none with the non-malignant cohort

KEY MESSAGE

CARE COORDINATION IS THE PREVENTION INFRASTRUCTURE

A multidisciplinary function · proactive care · safe transitions · acute episodes prevented · reduced disease burden and toxicity · better experience of care.

THE MECHANISM

The mechanism: absent coordination drives a self-reinforcing inpatient cycle and outpatient capacity saturated yet under-utilized (10.5% unused, 46-49% unable to shift to community) – the cascade driving the downstream harms mapped in the **Figure (left).**
Implications: service constraints are not independent problems – they are downstream effects of this principal structural driver. Treating them in isolation does not eliminate the burden – addressing the root cause prevents the cascade at its source.

METHOD – WHOLE-OF-SYSTEM DIAGNOSTIC TO REDESIGN

DIAGNOSE
Whole-of-service diagnostic: service data, staff and patient surveys, focus groups
COMPLETE

→

BENCHMARK
14 peer services (national and international models of care)
COMPLETE

→

CO-DESIGN
Executive-sponsored Multidisciplinary Working Party, including consumer voice
ESTABLISHED DEC 2025

→

BUILD
Digital infrastructure, pathways and tools in active development
CURRENT PHASE

→

EVALUATE
RE-AIM evaluation against baseline – routine data and behavioural feedback iteratively refining model
FROM 2027

WE ARE HERE

THE SOLUTION – CO-DESIGNED CARE COORDINATION

The Power of Lived Experiences and Frontline Insights

TARGETING PRIORITY GAPS
where harm is greatest

MEDICATION SAFETY
reconciliation where risk is greatest

SAFE TRANSITIONS
accountable handover between settings

EQUITY & NEEDS-BASED ACCESS
complexity-based, resources effectively utilised

Multidisciplinary Team
16 MEMBERS
Medical · Nursing · Allied health
Pharmacy · IT team
with consumers, GPs and community health

District Working Party with Participatory Research Design

EFFICIENCY & COMMUNICATION
across all care settings

VISIBILITY & ACTIVITY CAPTURE
demand and complexity countable

BEHAVIOURAL CHANGE
built with those who do the work

SUSTAINABILITY
shared care and community models

IN BUILD — THE FIRST DELIVERABLES

Risk stratification tool	MOSAIQ · SDPR digital infrastructure	Medication Safety	Gap Visibility	Community Models	Person-centred Design
VALIDATION IN PROGRESS	PROTOTYPE COMPLETE	IN PROGRESS	ONGOING	DESIGN PHASE	IN PROGRESS

THE IMPACT

Early intervention · Safe transitions · Community care · Better health outcomes

Absent care coordination is not a workforce, capacity or access problem – it is the structural root cause driving these downstream effects.

Haematology care coordination offers scalable prevention infrastructure for complex chronic disease.

An invitation to services, districts and disciplines for integrated collaboration · Prevention for the patients we serve · Contact: Minh.Hua@health.nsw.gov.au

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