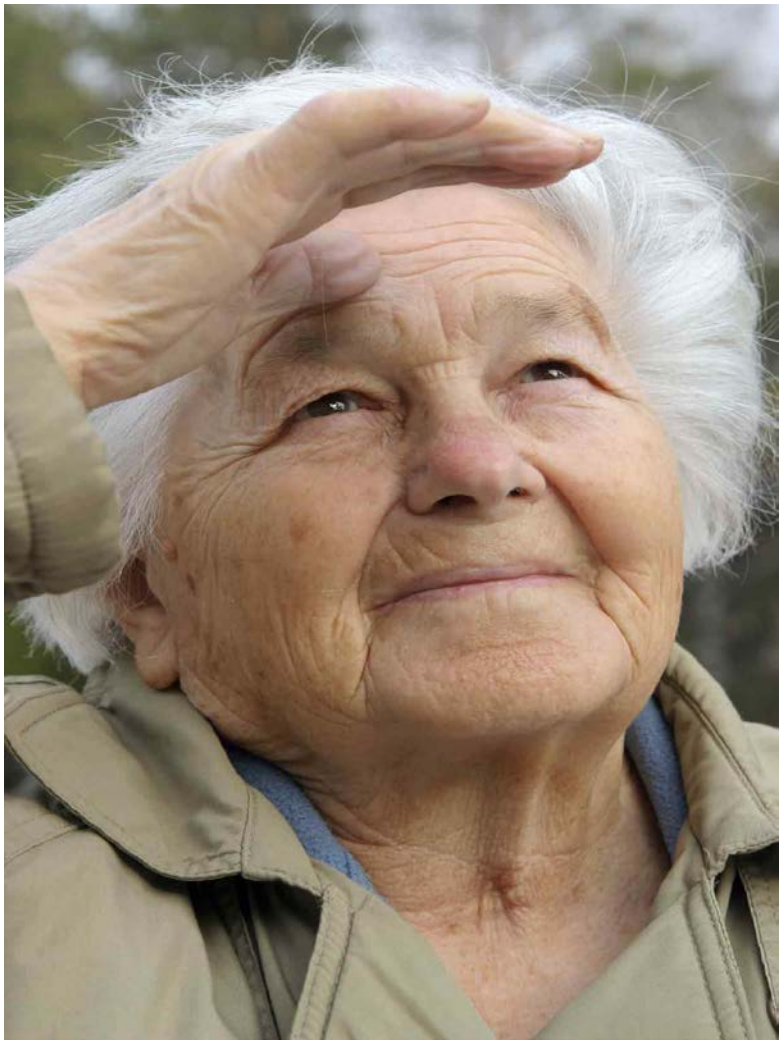
International Foundation for Integrated Care

An introduction to the concept of care co-ordination

Leo Lewis
Senior Fellow, International Foundation for Integrated Care

Introducing Margaret



… a little about Margaret

- 83 years old, a widow and now lives alone in a rural village with elderly neighbours
- Margaret's husband died 5 years ago and she had cared for him for many years
- Margaret's brother lives overseas with his wife and family
- Diabetes Type 2
- Heart disease
- Arthritic joints, especially hands
- Multiple medications
- Memory loss or TIAs?
- Doesn't like technology but thinks she needs to learn about it
- Currently independent and socially active

Margaret's healthcare services and support needs

Margaret has no curable health problems

- General Practitioner: large practice, difficult to see same GP
  - Single disease-orientated and lack of personalised care, general disinterest, repeat prescriptions, referrals to specialists when new symptoms identified
- Orthopaedics: arthritis not bad enough for surgery … yet!
- Cardiologist: medication titration, but little else
- Neurologist: undecided but no dementia screening referral
- Gerontologist: a reassuring arbiter
- Community Healthcare Assistant Nurse: monthly 'just checking' home visit
- Specialist Community Nurse: infrequent diabetes follow-up in community-based clinic
- Pharmacist: friendly and informative

What is the problem?

- No member of Margaret's care team is 'owning', leading, or taking responsibility for co-ordinating her care
- Margaret is not involved as an equal partner in making decisions about her care
- Poor communication between members of care team
- Duplication of tasks and gaps in care
- Treating and addressing each need in isolation
- Sub-optimal outcomes for Margaret, care team members and system
- Health needs likely to escalate without holistic approach

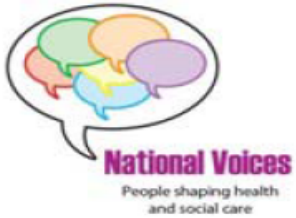
What needs to happen?

- Lack of family carer availability needs consideration
- Health, social care and support input needs aligning and coordinating to ensure Margaret experiences care that is integrated

Integration without care co-ordination cannot lead to integrated care

Overarching summary – service user perspective

Summary



My goals/outcomes

Communication

Emergencies

Person centred co-ordinated care

"My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes."

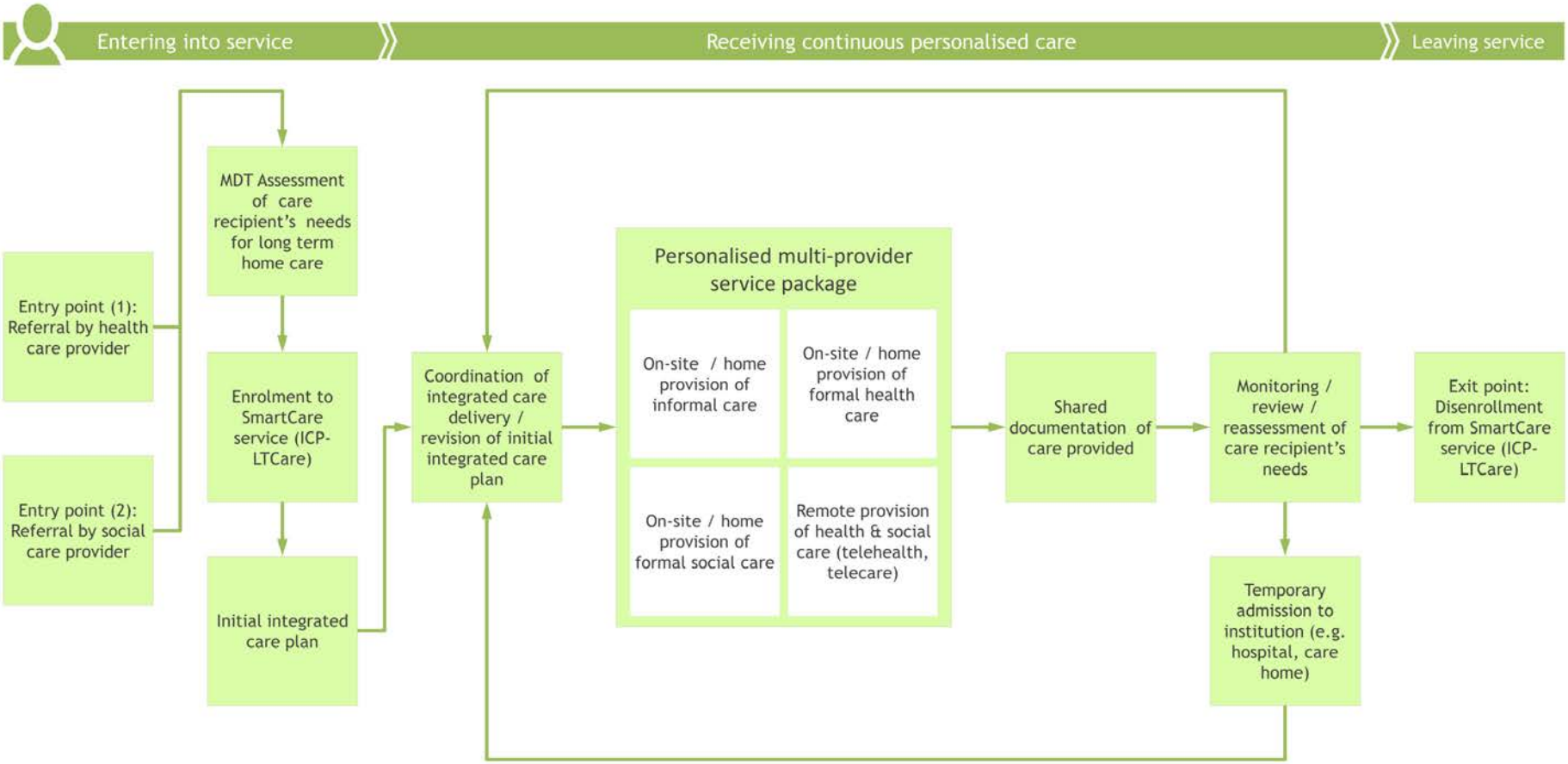
Information

Transitions

Care planning

Decision making

Source: A narrative for person-centred coordinated ('integrated') care, National Voices
http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

Integrated Care Process Pathway example

Integrated Long-Term Home Care Support