"Case management models will not deliver better care for patients and produce cost savings unless they are well designed, involve appropriately and professionally trained case managers and teams, and be embedded in a wider system of care that supports and values integrated and coordinated care." Nick Goodwin Kings Fund and colleagues (2013)

CARE CO-ORDINATION WEBINAR

Sue Barrett RN
Dr David Cochrane
Professor David Colin-Thome
Jayne Molyneux RN

INTEGRAL HEALTH SOLUTIONS

Webinar programme

- Key components of effective practice
- The importance of locality
- Jean's story
- Operational characteristics
- Benefits
- What needs to be in place
- Skills and competencies
- The role of primary care
- The importance of reflective practice
- Tele-health and risk stratification
- House of care
- Questions and discussion

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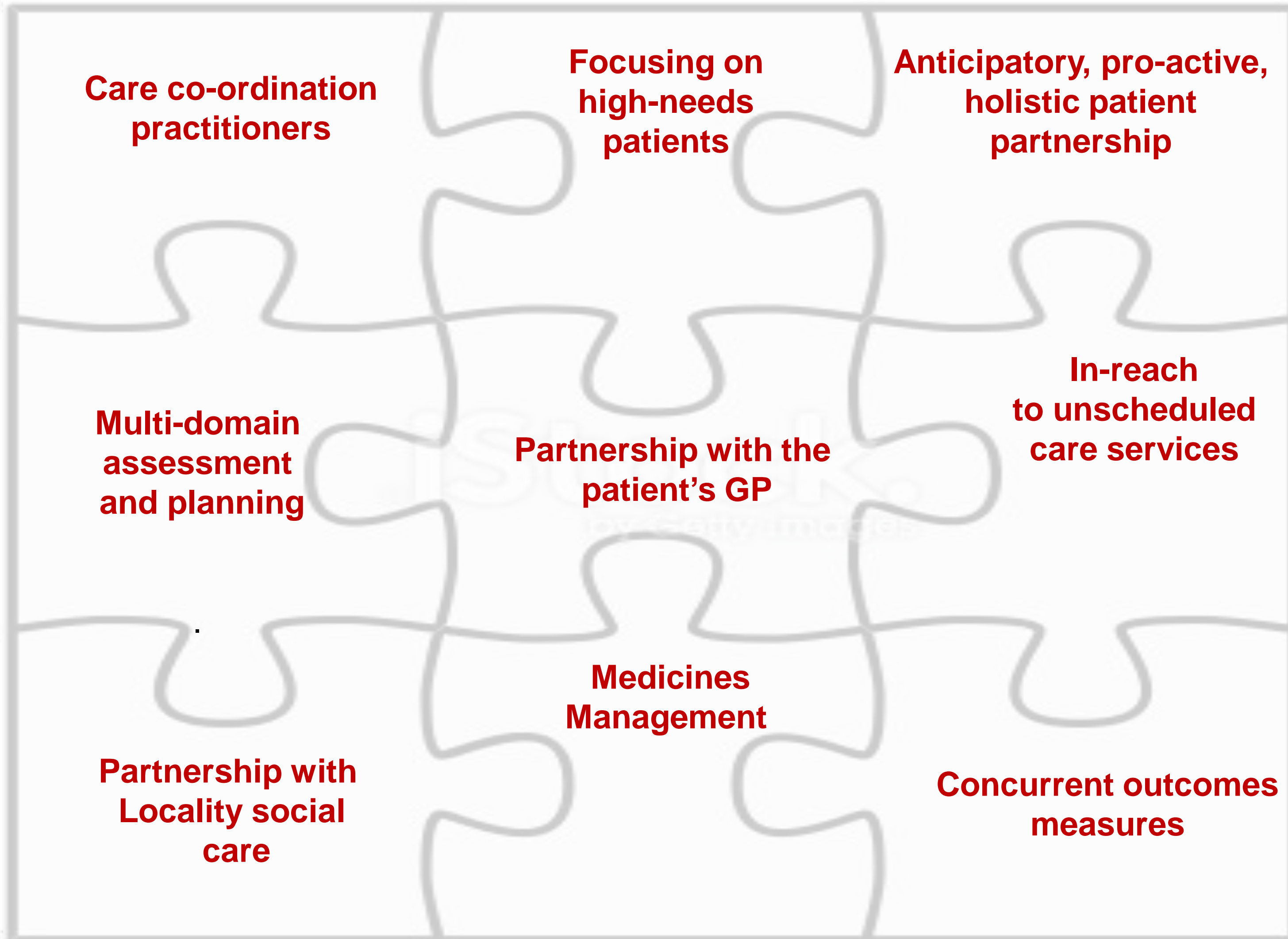
INTEGRAL HEALTH SOLUTIONS

Key components of effective care coordination



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The importance of a locality based model

- Access to a multi-disciplinary team
- Knowledge of all local resources
- Working relationships
- Facilitates primary care linkage
- However, care coordination is a specific role:-
    - Requires devoted time
    - Specific set of skills and competences

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INTEGRAL HEALTH SOLUTIONS

A case study – Jean's Story 1.*

90 year- old lady identified by predictive model

Lives alone, isolated

Recent faller, diabetes, CHF and COPD, osteoporosis

Poor use of medication for multiple conditions

Lost confidence 'I have no-one left to love me'

Ex nurse worked in S,A. and present at first ever heart transplant

In the year before coordinated care

5 hospital admits in 9 months (over 10 weeks stay)

18 GP visits in 6 months

Multiple medications

Process

Working with Jean

Gain rapport, confidence

Her priorities to feel less lonely and walk around the garden

Action plan for breathlessness and disease trajectory

Understand medication and support concordance

Multi-disciplinary input of GP, hospital cardiac team, OT, community nurses and falls service

Involve local voluntary services such as village church to visit her and take her out

* Name and pictures are fictional

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INTEGRAL HEALTH SOLUTIONS

A case study – Jean's story 2*

Integration, Coordination and Continuity

Multi-disciplinary team and agencies involved, coordinated by a case manager with Jean in control

GP and MDT working in harmony

Case manager keeps in regular contact

-

What Jean liked

"Working together"

New chair to help with back-ache

Emotional/psychological support of other people

Being dealt with like an adult

Outcome

Clinical Outcomes

No further unscheduled GP home visits

1 rapid response team visit avoided an admission

No further hospital admissions

Can now feed the birds and has returned to the 'Breath Easy' Group

Year 5 after care coordination

Jean seen every quarter by case coordinator

One GP visit in 5 years

Moved into nursing home in the last year of her life facilitate by case manager

* Name and pictures are fictional

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Operational characteristics

'These programmes employ proactive methods (predictive models) to identify and outreach to patients who would benefit from this comprehensive set of preventive services. '

Patients opt into the advanced care management program and receive more individually focused assessment and interventions. Interventions include:-

- 'anticipatory' assessments
- monitoring;
- self-management coaching
- education and counselling
- medication management
- care transition support
- contingency planning
- coordination of additional community health and social services.

- Caseload of circa 50 'active' patients at any one time
- Begin with face-to-face support, moving to telephone contacts (60:40)
- Patient transition to largely self-care
- Once self-managing patients move to the 'monitoring' stage

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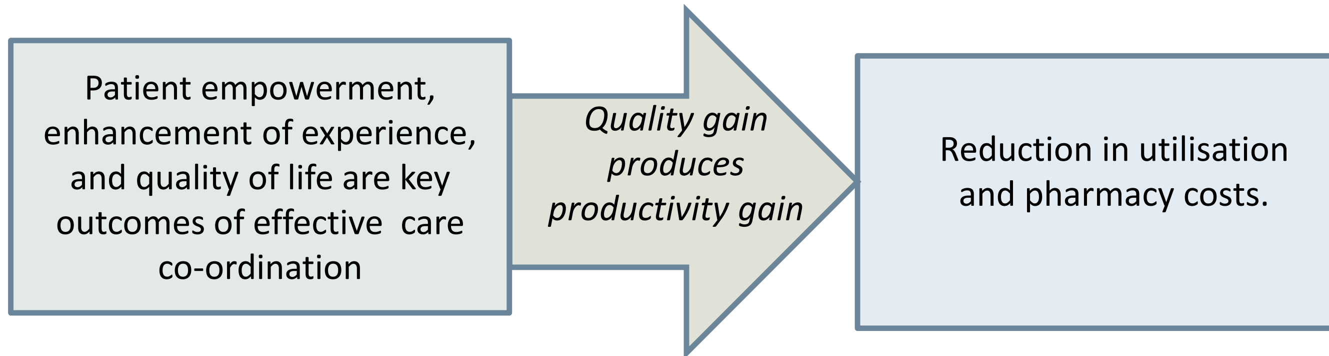
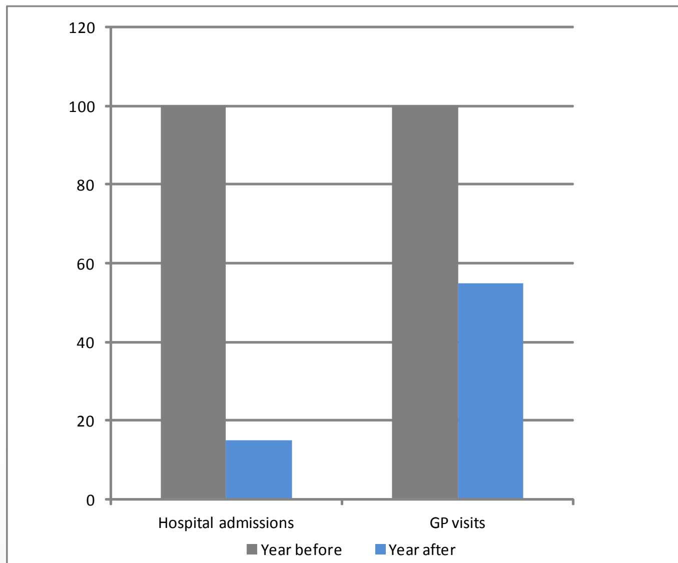
Value for money is a 'by-product' of quality gain





The average high-risk patient:-

- costs 5 times the average per capita spend
- has six times the average hospital admission rate
- Has 3 times the average GP attendance rate
- is prescribed 12 different types of medication

A CCG with a population of 250,000 typically spends £60 million on high-risk patients alone. Hence the opportunity to impact on resource use through effective care coordination is considerable. (excluding community, mental health and social care).

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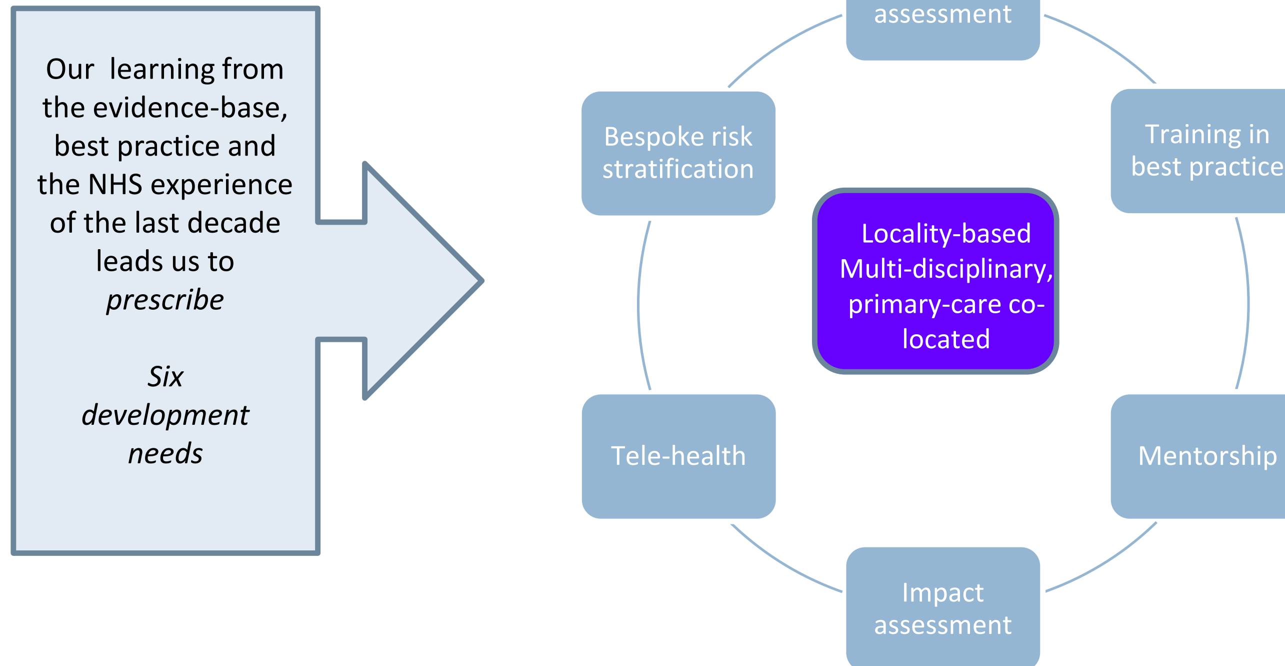
What needs to be in place to make it happen



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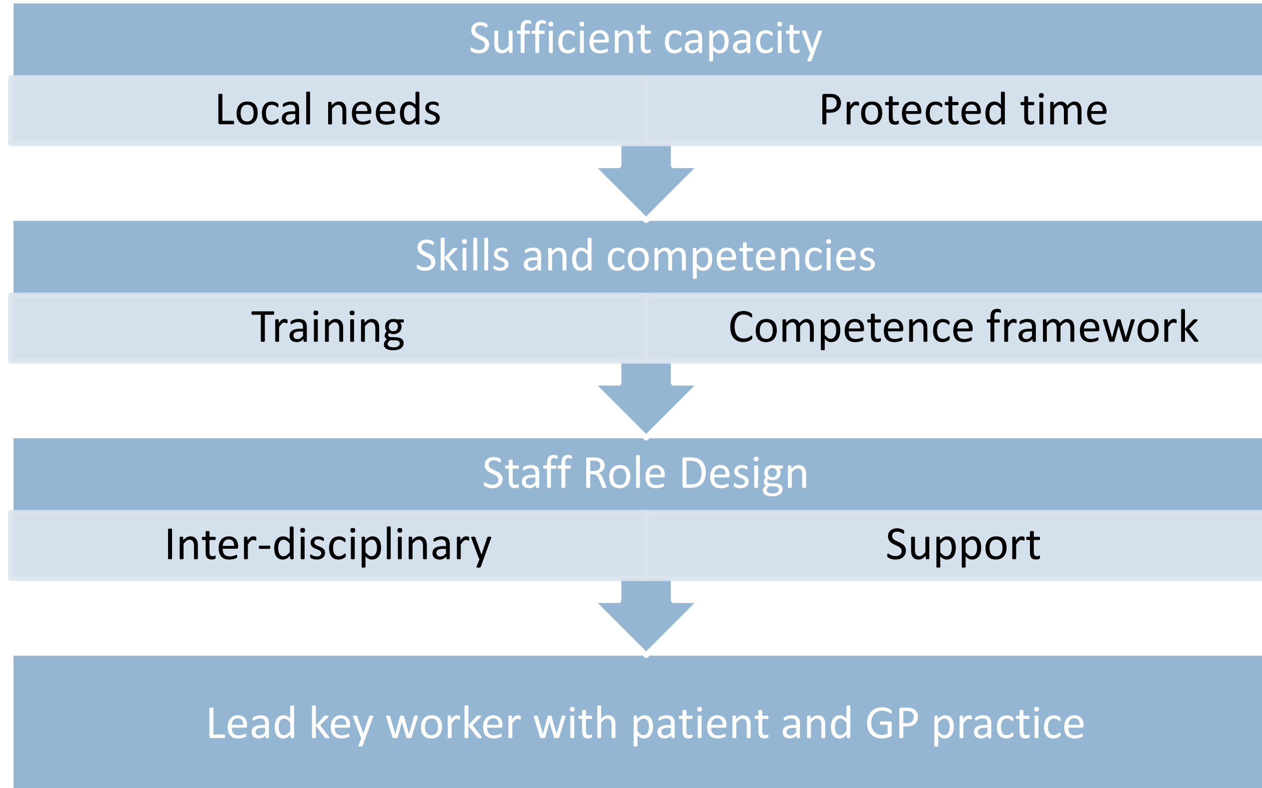
A workforce with the right skills and knowledge

As in all fields of health and social care, workforce development is a critical component.

We need professional practitioners in the lead, supported by competent assistant practitioners.

Relationships are vital for partnership working. So a single key worker works with each patient and GP practice



Care coordination is an inter-disciplinary, practitioner role. Core professions are doctors, nurses, social workers and allied health. Generally though, GPs are busy people and a relatively expensive resource. Care coordination also encompasses support functions which can be delivered by an assistant practitioner.

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The role of the GP and primary care team

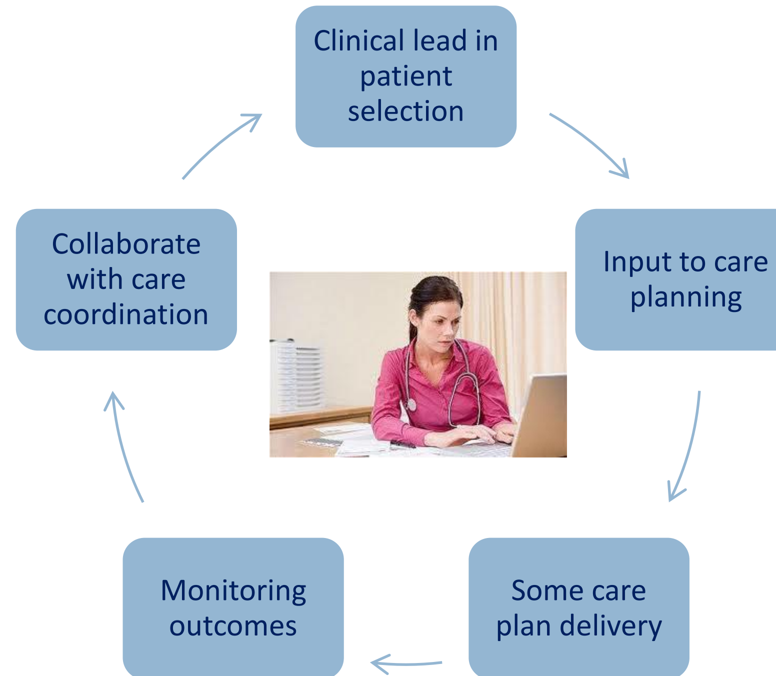
The most successful programmes are primary-care embedded or co-located.

Partnership working with GPs will be facilitated where care coordination:-

(1) improves quality and patient experience

(2) Mitigates the workload and costs to the practices.

GPs are busy people. So care coordinators should manage this risk stratification process day-to-day under GP leadership. Not only can GPs enrich the care planning process, the primary care team may well have a role in the delivery. GPs will need to see outcomes data to confirm the benefits of the programme for their patients.



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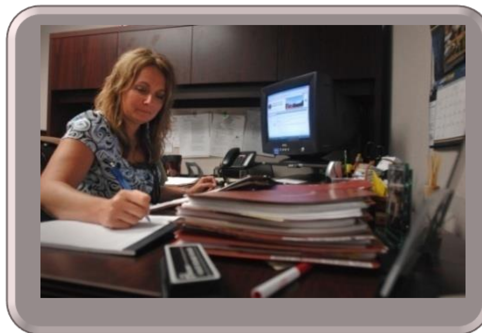
Impact assessment and reflective practice

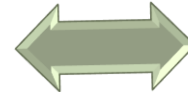
Outcomes data should be captured by intervention over time, by locality, by GP practice etc.

This is also be provided direct to the clinicians managing the patients, which support reflective practice and clinical audit.

Practice

Clinical Audit





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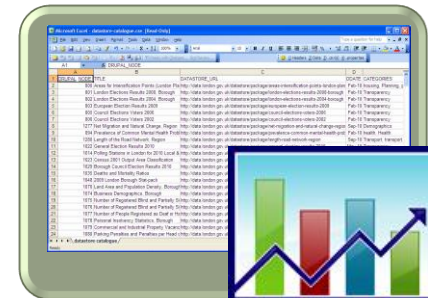

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Intelligence systems

Used as part of evidence-base practice, tele-health can support key stages in care coordination. With well-designed applications , tele-health can support patient partnership and empowerment.

Risk Stratification not only identifies patients at risk, it should also inform other key stages in the care coordination pathway

Tele-health

Tele-health can support individualized, holistic care planning, patient self-management, contingency planning and measure patient experience

Our Partner

A nurse-led tele-health project for patients with COPD helped to slash unnecessary hospital admissions at an acute trust in Leicestershire. C.Lomas *Nursing Times* September, 2009

Risk stratification

The IHS ACG Risk Stratification solution supports four key stages in the care coordination patient pathway

Our Partner

The risk stratification tool should be locally bespoke to specific patient needs. A clinician delivers user training

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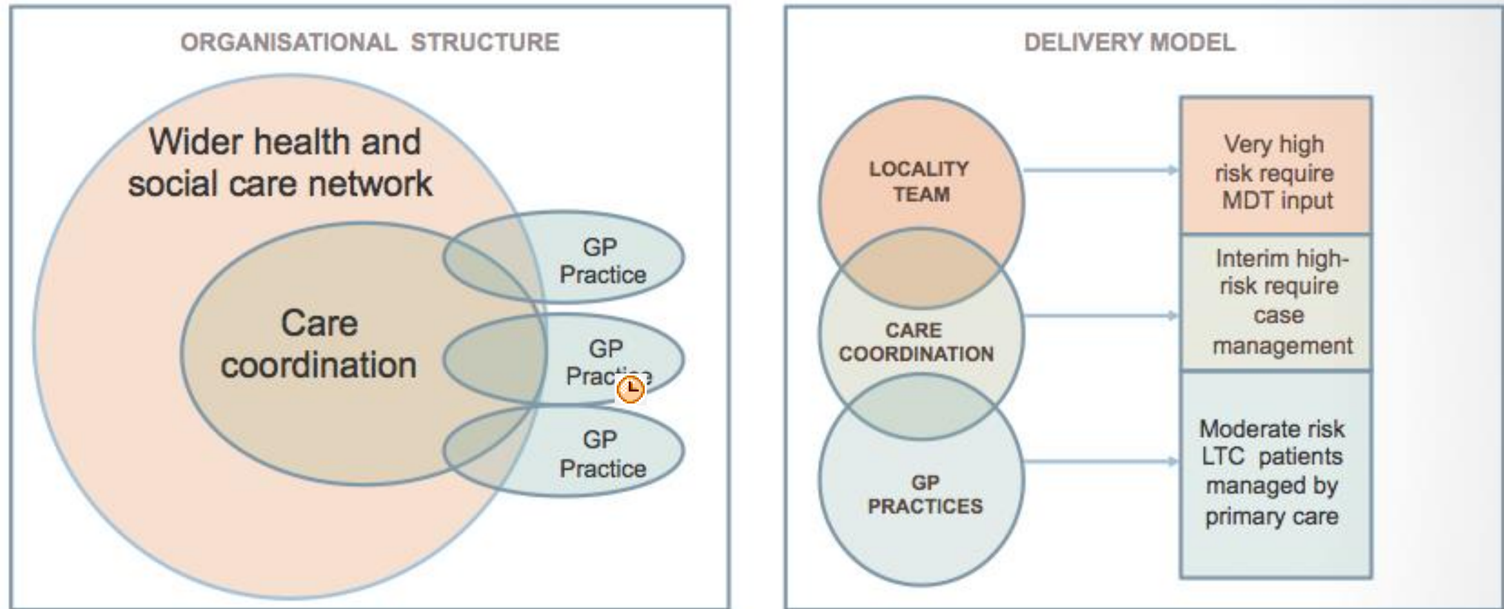
Locality model of care coordination: a 'house of care'

Care coordinators should be based at a locality level and be part of the locality team. They should be co-located in primary care.

To develop genuine partnership working with GPs, each care coordinator should work with a limited number of practices



High-risk patients comprise 5% of a population with average case mix. However this prevalence can vary markedly by locality and practice. Some high-risk patients will require full multi-disciplinary input whilst the care coordinator and the primary care team can meet the needs of others.

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Questions and discussion

Further resources at
www.integralhealthsolutions.co.uk

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