Conference Abstract

Care co-ordination and continuity of care for patients with complex needs: emerging lessons from five models in the UK

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Abstract:

Introduction: As populations age, growing numbers of people with chronic and medically complex illnesses require care co-ordination within primary care. The King’s Fund, funded by Aetna and the Aetna Foundation, is exploring five demonstrator sites of integrated care in England and Wales that have developed patient-centred models delivered by a multi-disciplinary team.

Aims: To present interim findings from three of the five case studies and discuss key lessons for delivering successful care co-ordination to people with complex needs.

Results: Emerging findings indicate that the case sites have focused on delivering flexible, reactive patient and carer-centred services with contacts taking place as and when needed rather than on a fixed schedule. Named care coordinators are responsible for organizing care, making appropriate referrals to team members and other care providers. Hierarchies are flat and a subsidiarity system operates allowing team members to make ad hoc care decisions autonomously. Frequent communication ensures the team and other relevant professionals are briefed on patients’ histories and interventions can be carried out by more than one person. Impact measurement is largely underdeveloped but initial data analysis and patient feedback indicates that these models reduce emergency hospital admissions and improve patient experience.

Conclusions: Preliminary conclusions suggest that these models of care co-ordination improve patient experience and help reduce emergency admissions. Important elements are a named care coordinator working within a multi-disciplinary team strongly rooted in the local health system which facilitates effective relationships with patients and other providers of health and social care.

Keywords

integrated care, care co-ordination, continuity of care, primary care, care coordinators, patient experience