Care Co-ordinator / Navigator

- Common to many integration projects
- Mapped a few in *enhanced roles* document
- Developed learning profiles linked to Qualification Credit Framework
- **Common Core Principles to Support Self Care**
Example of local development of Care Navigator role
Integrated Care

Workforce development – the care navigator role

Michael Moeller
Associate Director of Nursing and Therapies, CHS and Sexual Health & HIV
Who we are?

Are we the same people we were yesterday?

How different are we from others?

What impact has had the change in focus on us as a team?

‘We want the care navigators to recognise themselves in our organisational purpose’

What they feel, what we declare to outsiders and what they see should be aligned
The Journey of the Care Navigators in Tower Hamlets

2003 – start as a 18 month project. Pathway coordinators. Focus has been on complex social care needs of patient staying in hospital (aim – reduction in readmission)

2005 to 2006 - joint funded between health and social care. Case managers. Focusing on patients of 75+, case finding patients in ED, yet integrated with primary care. Team in their own right.

2006 to 2008 - health funded. Case Managers. Combining previous case finding approach with assistive case finding technology. Age limit lowered. 50% of patients identified through ED. Case management focus continued.

2008 to 2012 - health funded. Care coordinators. Case management was primarily done by community matrons. Part of virtual ward offer. Increasingly more referrals from primary care.

2013 to date. Name changed to care navigators. Function fulfilled within the community health teams – extended primary care team. Case finding role made redundant. Case management role with the advent of integrated community health teams
Bridging the gaps between health & social care

...our aims...

To reduce inappropriate service use and hospital admissions by ensuring a person’s care is delivered at the right time in the right place by the right people.

...our objective...

To support adults with complex health and social needs in the community, to try and prevent unnecessary A&E attendances and subsequent admissions. We facilitate complex discharges, by monitoring the care given at home to prevent early breakdown in care.

...our values...

- We are focused on service user health and well-being
- We are enabling and supportive
- We always want to take a collaborative approach to deliver excellence in service user care and to solve the challenges we face
- We aim to only deliver high quality care
- We trust each other and our colleagues
- We are equal partners
- We listen to each other and respect differences of views when they arise but still continue to work together
- We are compassionate
- We are open and honest with each other
- We appreciate each other’s expertise
Learning from experience

• Aims, objectives or expected outcomes
• Management of service/function
• Defining entry and exit criteria
• Team versus function
• Variation in performance
• Identification of patients
• Interface with other support services
• Distinctive skills – setting yourself apart
• Evaluation

Access to role specific training and development
Delivering safe, effective, efficient and equitable services
Avoiding Hospital Admissions

• Selecting people on the basis of their likelihood of hospital admission in order to reduce admissions is not effective.

• There is evidence this DOES NOT work.

• Resources would be better spent on effective, safe and efficient interventions

The Hospital Liaison Case Manager identifies high intensity users or patients with complex health and social needs

Would you be surprised if the service user was readmitted to hospital within the next month

A range of tools to help identify patients at risk of admissions, PARR +, PARR 4+, PAAR 30
Post discharge virtual ward for high-risk patients- RCT

- No significant differences in the primary or secondary outcomes at 30 or 90 days, 6 months, or 1 year.

- 203 of 959 (21.2%) of the virtual ward patients
- 235 of 956 (24.6%) of the usual care patients

- Absolute difference, 3.4%; 95% CI, -0.3% to 7.2%; P = .09.

- JAMA. 2014 Oct 1;312(13):1305-12
Care navigation and readmission

- No reduction in main outcome 30day readmission
- Under age 60 years sig. increase
- Over age 60 yrs sig decrease 4% (95CI -8.0 to -0.2%)
- No change in outpatient follow-up
Local evidence

- Bed day usage decreased from 1142 to 294 bed days
- Average LoS reduced from 60 to 19 days
- Number of hospital admission decreased by 72% (n=49)
Possible outcomes

• 50% reduction in GP attendance
• 64% reduction in emergency community nursing contacts
• 20% reduction in ED attendances
• Increased patients reported experience measures
Outcomes based commissioning

- Case studies are the main source of demonstrating impact
- 97-100% satisfaction rating on FFT

I have a named health or social care professional who coordinates my care and support plan?

All the different people treating and caring for you work well together to give you the best possible care and support?
Mr K
- 2010: 12 A&E attendances; 2011: 12 A&E attendances + 22 Bed days; poor attendance record in clinics
- 48 year gentleman.
- Presenting with Heart Failure, Atrial Fibrillation, taking warfarin had missed many Anti-Coag appointments, pacemaker in situ, blackouts, chest pain, obese and history of alcohol abuse.
- Denies any alcohol intake for 3 years and reported smoking only 3 cigarettes a day.
- He was being seen by Cardiology and had been seen in the Heart failure clinic.

Answer: Case management
- Benefits advice and assistance with housing
- Honest discussion regarding lifestyle and the likelihood it would very likely cut his life short, if action was not taken.
- Home visits to talk about history of alcohol and drug abuse, offering support, accompaniment to court hearings, assistance in cleaning his home, and telephone support

Answer: Patient Activation
- Patient activation
- Motivational interviewing
- Co-production
- Referral to drug and alcohol adviser
- Telehealth
Planning and Delivering Integrated Care

...the role of the care navigator...
…or should it be health coach and facilitator

- Reablement
- Co-creating for health
- Supported Self-Management
- Coordination
- Individuals pathway to recovery
Integrated care is person-centred coordinated care

*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me* (National Voices Narrative for Person Centred Coordinated Care)

- All my needs as a person are assessed
- I am supported to understand my choices and to set and achieve my goals
- The professionals involved in my care talk to each other. We all work as a team.
- I always know who is coordinating my care
- I have one first point of contact. They understand both me and my conditions. I can go to them with questions at any time
- I am as involved in discussions and decisions about my care, support and treatment as I want to be
- When I move between services or settings, there is a plan in place for what happens next
Tower Hamlets
Integrated Provider Partnership (THIPP)

How do we build on a model of Health & Social Care Integration to improve the health and wellbeing of the population?

Health & Social Care Partnership

Voluntary Sector

Community Learning

Voluntary Sector

Red Cross

Patient Participation groups

Nursing

Care Homes

Hospice

IT as an enabler

Access to educate BME & minority communities

Communities

Speak to the community (or listen)

Peer Support

As you can see, the community is a happy

Personal Health Records

Personalised care

Mutual Support

IT as an enabler

Access to educate BME & minority communities

Communities

Speak to the community (or listen)

Peer Support

As you can see, the community is a happy

Personal Health Records

Personalised care

Mutual Support

IT as an enabler

Access to educate BME & minority communities

Communities

Speak to the community (or listen)

Peer Support

As you can see, the community is a happy

Personal Health Records

Personalised care

Mutual Support

IT as an enabler

Access to educate BME & minority communities

Communities

Speak to the community (or listen)

Peer Support

As you can see, the community is a happy

Personal Health Records

Personalised care

Mutual Support

IT as an enabler

Access to educate BME & minority communities

Communities

Speak to the community (or listen)