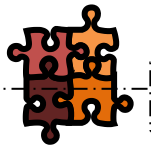
*Dear Students of Social Work,*



## A Continuation on Integrated Care

The subject of integrated care continues to be an active issue for discussion after my earlier letter on this topic. I had reiterated the importance of social and health integration in service delivery for vulnerable adults and in particular older persons who are frail. There are several issues that are common in all countries that are focusing on integrating the health and social care systems or service providers. These often start from who should 'own' the patient and her problems. As there is often no clear ownership, the information gets lost as she navigates the systems. With the pressure of time and urgency in discharging a patient, there is limited involvement of the user or patient and her family in the management and strategy of care. Other issues have to do with the challenge of effectively treating patients for often more than one condition. This often lands the patient in the community without a good handing off to a service provider in the community, if there is to be one. Yet another challenge for providers is to focus attention on how to treat the multiple conditions of users in a coordinated fashion.

A common lament from the formal provider system is the lack of home care and informal support for a patient. This stems from the fact that we do not spend sufficient resources to cultivate the informal care support system, when in fact the system is critical in providing the appropriate combination of social and home care that recognises the interdependence of health and social care outcomes. So what results is the focus on acute care with 'a cliff effect' in managing the patient when she is discharged from the hospital as there is a lag in informal care and home care. Increasing attention should be given to supporting the expansion of the informal care network and integrating this into the care management process and to providing appropriate respite and support for informal carers. This is urgent as we face a larger number of older persons in the community and in need of care.

## Thoughts on what Integrated Care looks like

Integrated care may improve the quality and continuity of care. Yet there is no standard definition of 'integrated care'. Various models in different countries are at an experimental stage and we too must evolve our own principles of integrated care and what integrated care implies in practice.

"[Integrated care] is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion." (Grone & Garcia-Barbero: 2001). So the notion of integrated care has two important components: that of 'care' and that of 'integration'. And we can safely say that integrated care seeks to close the traditional division between health and social care. Ideally, it should begin with the patient's perspective as the organising principle of service delivery and not begin with the typical supply-driven models of care provision. Integrated care should therefore enable health and social care provision that is flexible, personalised, and seamless.

Integrated care is likely to improve the quality and continuity of care when the patient is the focus as she has greater satisfaction from a more seamless care experience. It is that "one experience" that I talked about in my earlier letter on integrated care. I also discussed about focusing on the user so that the patient and her carers are no longer required to coordinate different treatments and navigate across different providers. Hopefully, treatment then is no longer 'stop-start' in nature and the patient and carers have a more satisfying relationship with care professionals.

From a system delivery point of view, the success of health care interventions is often dependent on social care provision. This is so because social care services are able to provide a better insight as to how patients live. For example, social workers can identify if medical problems result from neglect, social isolation, overall status of the home, family situations or patients not taking medication because they forget to, are not sure when to or do not have any support for them to live more independently and go about their activities of daily living.

Current concerns among medical social workers and community based professionals evolve around improving coordination and integration across health and social care in order to be more efficient. An example commonly cited is the duplication of assessments by different professionals, with no coherent approach among different service providers. There are often bottlenecks and gaps in care pathways that arise from poor coordination or an absence of coordination. There is a need too for the system to be more responsive in terms of upstream capacity and resources especially in external organisations such as vacancies for placements.

## Moving Towards Integrated Care

So conceptualising integrated care is a relatively recent field of study in various parts of the world and certainly here too. So what can be helpful for an integrated care agenda even as we gain more experience? For a start, we need to begin to develop coherent care policies that take cognizance of the local configurations of care and that are financially sustainable. In the local context, the role and support by the informal care network, home care and Senior Activity Centres need to be discussed and adequately resourced to avoid hospital readmissions. Investment in training and better still cross-training of all professionals to facilitate coordination and to encourage mutual respect is essential for a shared perspective.

Another common suggestion is the use of information technology to facilitate standardised communication protocols, shared patient information, single assessment procedures and defined care pathways.

Integrated care answers often lie at the community level so we need to shift from the acute care paradigm to one that offers integration of health and social care services challenging though this may be. The shift is urgent given the rapidly increasing number of older persons requiring the management of chronic diseases that often afflict the older population. This is where integrated care is critical in enabling the older persons to maintain autonomy and a high possible level of functional capacity and well being. This is an ideal worth working towards.



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24th June 2014