Integrated Care Models That Work for Frail Older People

The King's Fund
“Integrated Care: Key Factors for Success” Conference
London, 18 September 2012

Dennis L. Kodner, PhD, FGSA, International Visiting Fellow & Co-Director, Aetna Foundation Care Co-ordination Study, The King's Fund - Email: DLKodner@aol.com
A Complex Population: Frail Older People

About 15-20% of people aged 65+ will eventually need a mix of health care and social care over time. These frail older people present a complex set of needs and challenges:

- Health impaired; sometimes cognitively and/or mentally
- Multiple, ongoing co-morbidities
- Dependent in functioning and self-care (i.e., ADL/IADL)
- High risk of hospitalisation and institutionalisation
A Complex Population: Frail Older People (cont’d)

- Frequent interactions with providers, and transitions within and between systems and settings
- Access, co-ordination and continuity problems
- Difficult to manage and relatively costly
- Carer burden and stress.
Many Weaknesses in Care of Frail Older People

Despite cross-national differences, we frequently encounter a host of weaknesses operating on the macro, meso and micro levels of the health and social care enterprise that work against effectively meeting the complex, long-term needs of frail older people in an integrated way:

- Over-emphasis on acute, single illness-oriented treatment rather than ‘whole person’ care
- Misaligned policy-making, planning, regulation and financing
- Inadequate long term care (LTC) protection
- Imbalance between institutional, in-home and community-based services
Many Weaknesses in Care of Frail Older People (cont’d)

- Poor collaboration at the organisational and provider levels within and between health care, social care and other sectors.

- Lack of a single provider team and/or entity with responsibility for all care and outcomes.
Why Such a Poor ‘Fit’ Between Needs and Care?

There is a very poor ‘fit’ between the needs of frail older people and the existing infrastructure of health care and social care. Access, continuity and co-ordination problems are the most serious barriers to integrating health care. This is the result of a “silo mentality” reflecting:

- Many jurisdictions, system boundaries, institutions, and professionals
- Conflicting policies and regulations, commissioning/financing schemes, and budgets
- Differing professional identities and roles, culture and language, clinical philosophies, service delivery methods, and power relationships.

(Kodner, 2008)
Integrated Care is the Solution

Integrated care is a holistic, person-centred approach to addressing the complex needs of frail older people. There are four (4) main goals:

1- Improve patient journey, experience and satisfaction

2- Enhance service co-ordination and care continuity

3- Strengthen system links between primary/secondary, health/social, and behavioural/physical care

4- Foster overall improvements in service quality, personal health status, efficiency and cost-effectiveness.
Matching Integrated Care Models with Client Needs (Leutz, 2002)

<table>
<thead>
<tr>
<th>CLIENT NEEDS</th>
<th>LINKAGE</th>
<th>COORDINATION</th>
<th>FULL INTEGRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEVERITY</td>
<td>Mild to moderate</td>
<td>Moderate to severe</td>
<td>Moderate to severe</td>
</tr>
<tr>
<td>STABILITY</td>
<td>Stable</td>
<td>Stable to unstable</td>
<td>Unstable</td>
</tr>
<tr>
<td>DURATION</td>
<td>Short to long-term</td>
<td>Short to long-term</td>
<td>Long-term to terminal</td>
</tr>
<tr>
<td>URGENCY</td>
<td>Routine/non-urgent</td>
<td>Mostly routine/sometimes urgent</td>
<td>Frequently urgent</td>
</tr>
<tr>
<td>SCOPE OF NEED</td>
<td>Narrow to moderate</td>
<td>Moderate to broad</td>
<td>Very broad</td>
</tr>
<tr>
<td>SELF-DIRECTION</td>
<td>Self-directed</td>
<td>Moderately self-directed</td>
<td>Weakly self-directed</td>
</tr>
</tbody>
</table>
United States—PACE (Full Integration)

The Program of All-inclusive Care for the Elderly (PACE) is a capitated, community-based, team-managed program that provides comprehensive acute and LTC services which are coordinated by and mainly organised around an adult day health centre (ADHC). Operated as a demonstration between 1987 and 1997; thereafter continued as permanent program. Funding comes from Medicare and Medicaid. Enrollees must be “dually-eligible,” age 55 and over, and State certified for nursing home admission. Goal: Maintain frail elderly in community for as long as possible by avoiding/postponing institutionalisation. Evidence from the quasi-experimental, non-randomised evaluation:

- Decreased hospital inpatient and nursing home use
- Increased utilization of outpatient medical care, therapies, and home- and community-based services
United States—PACE (cont’d)

- Positive impact on Medicare costs vis-à-vis non-enrolee comparison group
- Favourable health status outcomes
- Overall satisfaction with care arrangements
- Positive, but inconsistent impact on physical functioning
- Differences in quality of life (not statistically significant).

(Mukamel et al., 2007)
England—TORBAY MODEL (Almost Full Integration)

Torbay Care Trust was created in 2005 to integrate all adult health and social care (commissioning and provision). The Care Trust CEO is also Director of the Local Authority’s Social Care, and the South Devon Healthcare NHS Foundation Trust is a close partner. Torbay is located in SW England, a popular retirement destination with 23% of the population age 65+. Five (5) community health and social care teams are organized around local GP practices. Health and Social Care Coordinators provide a single point of access. In addition to a shared electronic health record, community teams operate under a pooled budget. **Goal:** Provide coordinated access to health and social services for the most vulnerable patients and make care as simple and quick as possible.

**Evidence from internal studies**

- Improved access to services for users and GPs
- Enhanced coordination of health care and social care
- Reduced hospital admissions/LOS and ED use
England—TORBAY MODEL (cont’d)

- Eliminated delayed transfers of care
- Improved staff morale and job satisfaction
- Generated gap-filling investments in community health and social services.

(Colclough & Mears, 2009)
Canada—PRI SMA (Co-ordination)

The Program of Research to Integrate Services for the Maintenance of Autonomy is a single point of entry, case managed network of health care and social services for moderately/severely impaired persons age 65 and over, which was first pilot tested between 1997 and 1999; it is now being expanded throughout the province. Goal: Integrate service delivery to ensure clients’ “functional autonomy.”

Evidence from the quasi-experimental, non-randomised evaluation:

- Declining trend in institutionalization/client preference for institutionalization
- No deterioration in autonomy/functioning at 12- and 24-months
- Little effect on service utilization
Canada—PRI SMA (cont’d)

- Positive effect on carer burden
- No impact on mortality, i.e., survival
- Cost decreases implied through findings related to reductions in hospital readmissions, institutionalisation, and rate of functional decline.

(Hebert et al., 2010)
Italy—ROVERETO MODEL (Co-ordination)

Introduced in a town in northern Italy in 1995, the project delivered coordinated health and social services for elderly home care clients with multiple geriatric conditions through a community-based, case-managed shared care model involving the case manager, multidisciplinary team of a geriatric unit, and client’s general practitioner (GP). **Goal:** To reduce institutional admissions and functional decline of frail elderly living in community. **Evidence from the randomised evaluation:**

- Admission to hospital/nursing home in intervention group occurred later and was less common than in controls
- Health services were used to the same extent, but controls received more frequent in-home GP visits
- Improved physical functioning (ADL) and reduced decline in cognitive status
Italy—ROVERETO MODEL (cont’d)

- Financial savings in intervention group estimated in 1998 at $1800 (£1125).

(Bernabei et al., 1998)
Does Integrated Care Work?

Evidence from PACE, Torbay, PRISMA and Rovereto—and other programmes and pilots in North America, UK, Europe, and Australia specifically targeted to frail older people—strongly suggests that integrated care is capable of achieving positive outcomes, although it is not always clear which combination of strategies—and under what circumstances—produce the best results:

- Expanded service access, including primary care +++
- Enhanced co-ordination and continuity +++
- Improved health and functional status ++
- Reduced hospitalisation/nursing home admission/LOS ++
Does Integrated Care Work? (cont’d)

- Improved user experience, quality of life (QoL), and satisfaction +++
- Reduced carer burden ++
- Greater efficiency +
- Controlled/reduced costs +
- Perceived improvements in partnership working; also greater focus on governance and guidelines. +++

(Kodner, 2011)
Successful Integrated Care Models: The Main Ingredients

Compelling vision, logic, theory, and evidence lay behind successful integrated care solutions for frail older people. There are ten (10) main ingredients found in successful models:

1- Person-centred focus on frail older people with relatively high care needs, including careful targeting

2- Responsibility for identified population and/or geographic area, including single entry point into system

3- Case managed, inter-professional, evidence-based team care

4- GP involvement, preferably an active role
The Main Ingredients (cont’d)

5- Direct control over broad package of services

6- Heavy emphasis on care co-ordination

7- Organised network of providers

8- Innovative use of population health management tools and integrated information systems

9- Common organisational umbrella or ‘home’ and shared culture

10- Alignment of financial incentives, including funding flexibilities (e.g., funds pooling, single funding envelope or capitation).