INTEGRATED CARE MODELS FOR THE FRAIL OLDER PEOPLE: Some International Case Studies and Lessons

Cambridge Health Network and The King’s Fund
“Caring for growing numbers of the frail elderly: An international perspective”
London, UK, 7 February 2012

Dennis L. Kodner, PhD, FGSA, International Visiting Fellow, The Kings Fund
Email: DLKodner@aol.com
About 15-20% of people aged 65 and over will eventually need a range of long term care services and supports—a mix of health and social care—over time. These frail elderly present a complex set of needs and challenges:

- Functionally dependent (i.e., ADL/IADL)
- Health impaired
- Multiple, ongoing, complex needs
- High risk of hospitalisation and institutionalisation
- Frequent interactions with providers, and transitions within and between systems and settings
FRAIL OLDER PEOPLE: A PROFILE (cont’d)

- Access, continuity and co-ordination problems
- Carer burden and stress
- Relatively difficult to manage and costly.
“LONG TERM CARE” DEFINED

“Long term care” (LTC) is part health care and part social service. It encompasses a broad array of primarily low-tech services, supports and care provided by paid professionals and paraprofessionals—as well as unpaid family members—in home, community, and institutional settings to individuals with chronic and disabling conditions who need help on a prolonged basis with activities of daily living (ADL), instrumental activities of daily living (IADL) and related medical/health needs. LTC services and supports include:

- Personal care (e.g., bathing and grooming)
- Household chores (e.g., meal preparation and cleaning)
- Life management (e.g., shopping, medication management and transportation)
“LONG TERM CARE” DEFINED (cont’d)

- Personalised assistance with medical, psychosocial and housing needs
- Co-ordination of services, supports and care across time, setting and discipline.
MANY WEAKNESSES IN THE LONG TERM CARE SYSTEM

Despite cross-national differences, we frequently encounter a host of weaknesses in health, social care and related sectors that work against effectively meeting the LTC needs of frail older people in an integrated way:

- Greater emphasis on ‘cure’ vs. ‘care’
- Fragmented, misaligned policy-making, planning, regulation and financing
- Inadequate protection for personal LTC risks
- Imbalance between institutional vs. home and community-based resources
MANY WEAKNESSES IN THE LONG TERM CARE SYSTEM (cont’d)

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

- Lack of a single provider team and/or entity with responsibility for all care and outcomes.
NEEDS AND CARE: WHY SUCH A POOR ‘FIT’?

There is a very poor ‘fit’ between the LTC needs of frail older people and the existing infrastructure of health care, social services and related supports. Access, continuity and co-ordination problems are the most serious barriers to integrating LTC, the result of:

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

(Kodner, 2008)
“INTEGRATION” AND “INTEGRATED CARE” DEFINED

“...a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors...[to]...enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex problems cutting across multiple services, providers and settings. The results of such multi-pronged efforts to promote integration...is called integrated care.”

(Kodner & Spreeuwenberg, 2002)
## Matching LTC Clients with Integrated Models (Leutz, 2002)

<table>
<thead>
<tr>
<th>Client Needs</th>
<th>Linkage</th>
<th>Co-ordination</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>
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. Enrolees 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)
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 in Bois-Franc, Quebec between 1997 and 1999; now has been expanded to the Province’s Eastern Townships. Goal: Integrate service delivery to ensure clients’ “functional autonomy.”

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

- Declining trend in institutionalisation/client preference for institutionalisation
- No deterioration in autonomy/functioning at 12- and 24-months
- Little effect on service utilisation
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 co-ordinated 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)
KEY LESSONS

Compelling vision, logic and theory lay behind successful integrated care models for the frail elderly. While it is difficult to generalize across-the-board about effectiveness, the PACE, PRISMA and ROVERETTO cases nonetheless show that they are associated with a promising pattern of outcomes. As in all models, determining what factors account for which outcomes presents a challenge. However, nine (9) main elements—probably acting synergistically—appear to account for overall impact:

1- Person-centred focus on frail elderly 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 team care
KEY LESSONS (cont’d)

4- GP involvement, preferably an active role

5- Direct control over broad package of services

6- Heavy emphasis on service and clinical integration

7- Organised network of providers

8- Common organisational umbrella or “home,” including centralised or cross-agency governance and accountability arrangements

9- Alignment of financial and other incentives, including funding flexibilities (e.g., funds pooling, single funding envelope or capitation).
FINAL THOUGHTS

These international programs provide important clues as to how and why integrated care works for the frail elderly. But, it is clear that much more work needs to be done to unpack the transformative power of system-service-clinical integration. Here are some final thoughts:

- Forget about one-size-fits-all integrated care models
- Start from where you are
- Success demands social entrepreneurship, innovation, and risk-taking, as well as time and resources to achieve
- Specialise; don’t generalise
FINAL THOUGHTS (cont’d)

- Size matters

- Seriously weigh benefits of smaller-scale, community-based models vs. larger-scale, regionalised systems of care

- Focus first on outcomes, not costs

- Support development of integrated health information systems (HIS)

- Step up education and training activities in integrated care at all levels.