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LOGIC AND PROMISE OF INTEGRATED CARE SYSTEMS FOR THE FRAIL ELERLY— International Models and Outcomes

"Integrated Long Term Care: What Can We Learn From Other Countries?"

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Dennis L. Kodner, PhD, Professor of Medicine & Gerontology and Director, Center for Gerontology & Geriatrics, New York College of Osteopathic Medicine, Old Westbury, NY – Email: DKodner@nyit.edu

KEY ISSUE—FRAGMENTATION AND LACK OF CONTINUITY

The fragmentation of long term care (LTC) services, lack of continuity within and between the medical/health and social service sectors, and the high costs of care are key issues globally. There are several factors:

- Services are the responsibility of many jurisdictions, institutions and professionals
- Components of both systems work in parallel, with separate payment schemes and budgets, and often conflicting policies and regulations
- Health and social care distinctly differ in terms of culture, language, professional roles and responsibilities, clinical approaches, and service delivery methods

Source: Kodner (2002)

CARE MANAGEMENT— CRITICAL, BUT NOT SUFFICIENT

International evidence strongly suggests that care management helps LTC clients remain in the community, and also positively affects the efficiency and effectiveness of services provided. Care management is pivotal, but not a panacea. Two main reasons explain the growing sense that the strategy is self-limiting:

1- The breadth and complexity of LTC for the frail elderly demands a more comprehensive and holistic approach

2- Care management is too isolated to be fully integrative—especially for frail elderly clients with complex problems cutting across multiple service systems

Source: Davies (1994); Challis (2003)

INTEGRATED SYSTEMS OF CARE FOR THE FRAIL ELDERLY

Integration—that is, connectivity, alignment and collaboration within and between the care and cure sectors—is at the heart of comprehensive LTC. Integrated Systems of Care entail creating a single structure/entity to organize and manage the medical/health care and social services needed by high-risk clients. Also known internationally as "care networks" and "chains of care", these models—though broad and varied—share several characteristics:

- Focus on, and specialization in, a particular high-risk group (e.g., frail elderly)
- Enrollment or rostering of targeted population in a defined service/catchment area

INTEGRATED SYSTEMS OF CARE FOR THE FRAIL ELDERLY (cont'd)

- Overall responsibility for arranging and/or delivering a comprehensive service package—including outcomes
- Care provided and managed by an organized network of providers—including the active involvement of primary care
- Use of care management, interdisciplinary or multidisciplinary team work, and other techniques to achieve continuity, coordination and tailor-made care

INTEGRATED SYSTEMS OF CARE FOR THE FRAIL ELDERLY (cont'd)

- (Sometimes) devolution of financial responsibility for all care, based on funds pooling from multiple budgets—with or without prepaid capitation

Source: Kodner & Kyriacou (2000); Kodner (2006)

POTENTIAL ADVANTAGES AND DISADVANTAGES

Integrated Systems of Care are designed inherently to remove many of the structural/organizational, professional, clinical, and financial barriers to coordinated, continuous care. There are a number of potential advantages and disadvantages:

Potential Advantages:

-Enhancing feasibility of seamless care
-Maximizing client-centeredness of multiple funding streams
-Improving impact of assessment/care planning
-Facilitating integration of primary/secondary services
-Optimizing rehabilitation
-Preventing inappropriate hospitalization/institutionalization

POTENTIAL ADVANTAGES AND DISADVANTAGES (cont'd)

Potential Disadvantages:

-Acute care can overpower social needs and priorities

-Funds pooling can distort LTC provision, potentially allowing medical care to siphon resources

-Medical cost containment strategies may not "fit" with more socially-oriented LTC services

-It is difficult to develop a fair and balanced financing mechanism covering both medical care and social services

Source: Kodner (2003)

CANADA—SIPA

SIPA—*Système de services intégrés pour personnes âgés en perte d'autonomie*–a *project in Montreal, Quebec between 1999 and 2001—is an integrated service system providing acute and LTC to frail elderly participants. SIPA is responsible for the costs of the care package, but the capitation feature was never implemented.* ***Evidence from randomized control trial (RCT):***

- Organizational:
  -SIPA was grafted onto existing community clinics (CLSCs) to facilitate integration with the medical/health and social service systems

- Integration:
  -Evidence of service/clinical integration noted; the result of care management, interdisciplinary teamwork, protocols, and financial responsibility

  -Weak physician collaboration

CANADA—SIPA (cont'd)

- Utilization:
  -Reduced hospital "bed blockers" (50%)

  -No significant differences in ER, hospital and nursing home use

  -Increased home and community care use

  -No differences in medication use

- Client Outcomes:
  -High satisfaction/perceived quality by patients/carers

  -No differences in morbidity, health/functional status, depression and cognition

CANADA—SIPA (cont'd)

- Costs:
  -No difference in total costs between experimentals and controls

Source: Beland et al. (2006)

ITALY—ROVERETO PROJECT

An experimental program of coordinated medical and social care for elderly home care recipients was implemented in northern Italy (Rovereto Region) in the late 1990s. ***Evidence from randomized trial****:*

- Organizational:
  -Community-based geriatric evaluation, care management, multidisciplinary teamwork, involvement of general practitioners, and agreement between municipality/regional authority were part of design

- Integration:
  -Geriatric evaluation unit was effective as gatekeeper/resource allocator and coordinator

  -Close collaboration between care managers and general practitioners

ITALY—ROVERETO PROJECT (cont'd)

- Utilization:
  -Reduced hospital/nursing home admissions and LOS

- Client Outcomes:
  -Less physical and cognitive decline vis-à-vis control group

- Costs:
  -Reduced total health costs vs. controls

Source: Bernabei et al. (1998); Landi et al. (1999)

AUSTRALIA—COORDINATED CARE TRIALS

The Australian Department of Health and Aged Care conducted the first round of the Coordinated Care Trials (1997-1999) to test whether integrated care—incorporating care management, the pooling of Commonwealth and state funds, and general practitioner involvement—could improve client health status and well-being without increasing resource use/costs. Of the nine (9) initial projects, four (4) explicitly targeted the 65 plus population with "complex" needs. ***Evidence:***

- Organizational:
  -Despite different organizational designs, projects were expected to incorporate the three basic elements—care management, funds pooling, and mechanisms to engage general practitioners

- Integration:
  -Care management, funds pooling, and clinical guidelines/protocols improved service coordination and flexibility, but without enhancing efficiency

AUSTRALIA—COORDINATED CARE TRIALS (cont'd)

- Utilization:
  -Community service use increased, but in an inconsistent pattern across trials

  -Service substitution occurred

  -Hospitalization was reduced in some of the trials

- Client Outcomes:
  -Qualitative evidence suggests that participants experienced increased well-being due to their access to care management

AUSTRALIA—COORDINATED CARE TRIALS (cont'd)

- Costs:
  -No across-the-board decline in total costs were found

Source: Commonwealth Department of Health and Aged Care (1999); (2001)

CONCLUSIONS AND LESSONS

Persuasive logic and theory lay behind the idea of Integrated Systems of Care for the frail elderly. While it is difficult to generalize across-the-board about program effectiveness, the experience of these three international models show that such programs are associated with a promising pattern of outcomes in terms of access, clinical coordination and continuity, health/functional status, service utilization, institutional placement, QOL, carer burden, and client satisfaction. Determining what structural factors account for which outcomes presents a challenge. However , four (4) main organizational elements—perhaps acting synergistically—appear to account for the impact of these models:

1- Umbrella organizational structure
   - -Integration on strategic, managerial, service and clinical levels
   - -Teamwork/Joint working
   - -Efficient operations

CONCLUSIONS AND LESSIONS (cont'd)

2- Case managed, multidisciplinary care
- -Single contact or entry point
- -Client targeting
- -Evaluation/planning of client needs
- -Packaging/coordination of services
- -Triaging/allocation of clinical responsibility

3- Organized provider network
- -Access to services
- -Seamless care
- -Service quality

4- Financial incentives
- -Service integration, efficiency, and cost-effectiveness
- -Prevention, rehabilitation, and downward substitution

SOME ADDITIONAL THOUGHTS

The international experience presented in this paper provides some meaningful clues as to how and why Integrated Systems of Care work. But, it is clear that much more work needs to be done to exploit the potentially transformative power of integrated care. We must have :

- Better understanding of the relationships between between structures, teamwork/joint working, services and outcomes
- Greater focus on client- or user-defined outcomes
- Structural, clinical, and other levers to produce better services and results