Integration of Care for Older Persons: The Challenge of Implementation in a Coherent System

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Flies without wings

An evolutionary biologist presented work on long-lived drosophila flies. A demographer asked what the very old flies looked like. “Oh, their wings fall off.”

Policies and therapies that increase humans’ length of life but entail profound disability (analogous to wings falling off) would be unacceptable in human society

Verbrugge, 2005
The Shifting Face of Health Care

• From acute to **chronic disease**

• From institutions to **networks of care**; from a single site (hospital, nursing home) to many sites:
  - home, assisted living, supportive housing, physician’s office, community clinics, ambulatory care centers, community hospitals, academic health centers, rehabilitation facilities, nursing homes, palliative care centers
The Shifting Face of Health Care

• From a single professional, generally a physician to **many health care professionals**:
  • family doctors, specialists, nurses, physical therapists, nutritionists, social workers, psychologists, etc.

• Expectations/knowledge/involvement of patients and family
Why Integration?

- Increase in number of older persons
- Frail older persons need a **complex combination** of health and social services
- **Increasing evidence** for treatment and care management in frail older persons
Why Integration?

• Present difficulty in management:
  • Fragmentation
  • Unmet needs
  • Underutilization of effective geriatric and care management interventions
  • Parallel play-medical, community services
  • Problem in quality of care
  • Negative incentives
  • Inappropriate use of resources
  • Absence of “comprehensive” responsibility and accountability
Embracing the Heterogeneity & Complexity

- Healthy older persons
  - Primary medical care, health assessment/promotion/prevention
- Early frail/low risk/chronic disease
  - Primary medical care, chronic disease management, detection of vulnerability
Embracing the Heterogeneity & Complexity

- Medium risk/mild-moderate disability
  - Primary medical care and home care, chronic disease management, specialized geriatric care
- ↑ Disability and “complex” systems of integrated care
- End of life care
Embracing the Heterogeneity & Complexity

- Comorbidities
- ADL dependency
- Frailty

Monitoring
Medical Intervention

Monitoring Prevention

Complex care
Monitoring Multidisciplinary care
Health promotion/prevention, screening, acute care
Objectives of Integrated Care

Integrated Care seeks to improve:

- Patient/client access
- Clinical outcomes
- Health system efficiency
- Cost-effectiveness
Key Elements of Integration

• Integration based upon a person-centred approach focused on health/functional status of older persons with multiple chronic diseases/disabilities/difficult social context/end of life

• Grounded in primary care with timely user-friendly support from specialty care
Key Elements of Integration

• Geriatric evaluation/intervention based on health, social, environmental needs as well as allocation of services
  • Management of chronic diseases and geriatric syndromes
  • Secondary prevention/early intervention: mobility, falls, etc.

• Governance with an umbrella organization, appropriate budget, incentives based on partnership, joint planning which support clinical objectives

• Community engagement/patient-centred
Based upon and leading to...

- Better coordination between primary healthcare and social services
  - And between primary and specialized care
- Enhanced communication and collaboration
- Less fragmentation
Key Message: Partially Integrated Care

• CHRSP Definition: Services that are **formally linked and coordinated**, but that are provided by **distinct** organizations

• Models of Partially Integrated Care have been shown to help older adults stay in their homes and reduce hospital admissions
Key Message: Partially Integrated Care

• Probably best suited for Newfoundland and Labrador: does not require a major re-organization of the current health system

• Some aspects of partially integrated care are already occurring organically in certain RHA sub-regions of the province
Key Message: Geriatric Assessment

Geriatric Assessment, as an activity of integrated care or as a stand-alone intervention, is consistently and significantly effective for maximizing the time older adults live at home and for reducing hospitalizations among frail older adults.
Key Message: Geriatric Assessment

• A tool for assessing medical, psychosocial and functional capabilities
• It differs from other assessments:
  • Focuses on older adults with complex needs,
  • Considers functionality and quality of life
  • Designed to be used by a multidisciplinary care team
Key Message: Geriatric Assessment

- Reduced nursing home admissions, hospital admissions, and risk of ‘not living at home’
- NL is already moving to the InterRAI-HC
- Do not expect health equity issues
Key Message: Case Management

Case management, when implemented with appropriate patients/clients, is significantly and consistently effective for older adults living in the community, in terms of staying in the community, improving service use, and prolonging autonomy.
Key Message: Case Management

• Reduced hospital and nursing home admissions
• Increased time seniors spent living at home in the community.
• Needs to target appropriate patients/clients
• Workload issues
• Information-sharing challenges
Some Organizational Features of Integrated Care

1. Umbrella organizational features
   - Resources from individual health and social services are combined; new organization has full accountability

2. Financial incentives
   - Promote integration and cooperation from healthcare providers
Some Organizational Features of Integrated Care

3. **Multidisciplinary case management**
   - Strong involvement of primary care providers is key – particularly family physicians and community nurses

4. **Organized provider networks**
   - Common ownership of assessment, care-planning and decision tools between providers; shared access to client records; facilitates access to health and social services; efficiency increases
Potential Impact of Integrated Care

• Improved quality of life
• Reduced hospital admissions
• Reduced long-term care admissions
• Potential cost-containment
A few of the Challenges to Integrated Care in NL

• Communication
• Scheduling
• Remuneration
• Information-sharing
• Human Resources
“I skate where the puck will be” - Wayne Gretzky
A Clear Consensus:

**Primary Care as THE integrating foundation of a sustainable health care system (the Medical Home: Family Health Teams; Family Medicine Groups)**

- Group practice, team based, interdisciplinary and inter-specialty practice
- Patient-centred, patient-active, patient/community engaged
- Pro active care, continuity of care
A Clear Consensus:

**Primary Care as THE integrating foundation of a sustainable health care system (the Medical Home: Family Health Teams; Family Medicine Groups)**

- Population and community responsibility through rostered population
- Integrating public health: health promotion and prevention
- Evolving remuneration
- Electronic Medical Records
Implications for Decision Makers

• **Do NOT import** existing models of integrated care from elsewhere: **adapt, not adopt**
  
  • Use the findings of this review to assess current delivery
  
  • Understand key features which then need to be adapted to provincial circumstances
  
  • Build upon emerging solutions in your province
Implications for Decision Makers

• Based on emerging solutions in the province and based on this review
  • Set targets for more effective care
  • Design and launch pilot projects in **diverse settings**
  • **Evaluate** and **scale up** to rest of the province.