Integrating Care to Older People

A Continuum of Strategies to Promote Health, Wellbeing and Independence

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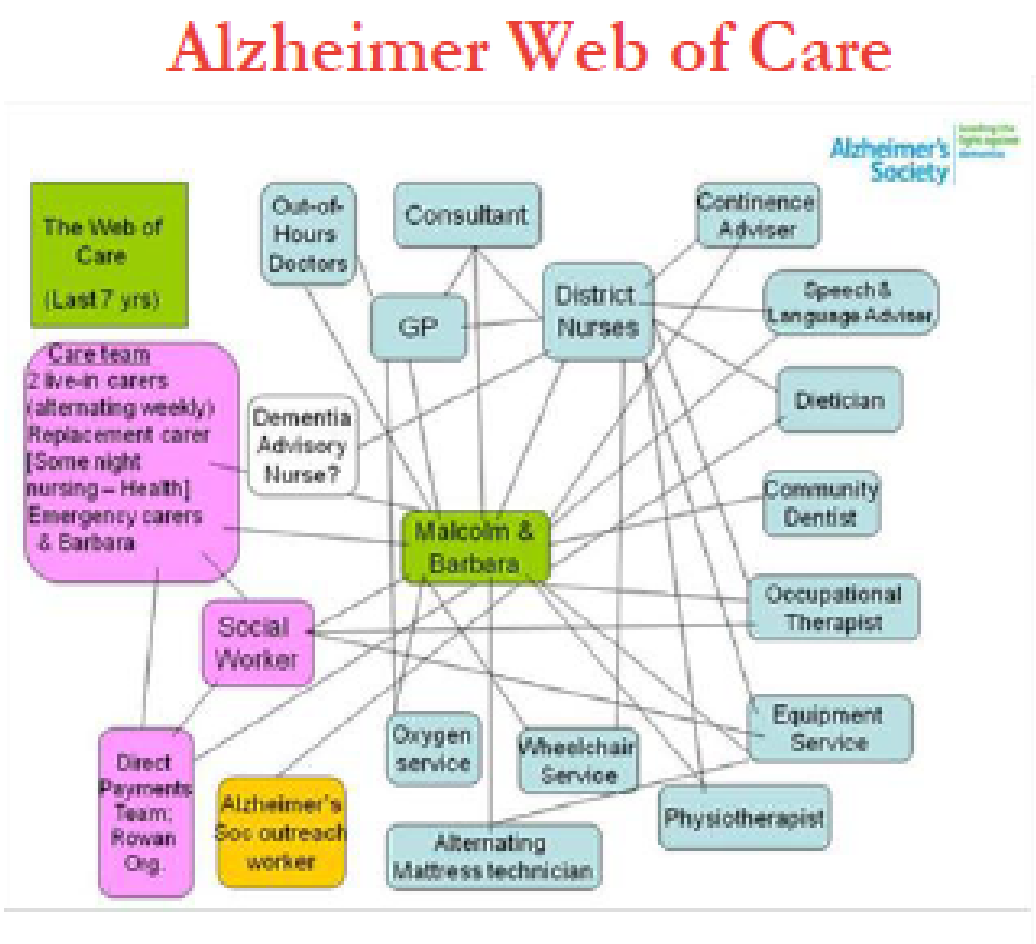
Coordinating Older People's Complex Care Needs: What Works?

A Typical Problem of Complexity

The complexity in the way care systems are designed leads to:

- lack of 'ownership' of the person's problem;
- lack of involvement of users and carers in their own care;
- poor communication between partners in care;
- simultaneous duplication of tasks and gaps in care;
- treating one condition without recognising others;
- poor outcomes to person, carer *and* the system



Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor -

A Range of Needs

- Access, co-ordination and continuity problems in the management of their care;
- Frequent interactions with care providers, including high levels of care transitions within and between systems and settings;
- Older people living with:
  - physical and mental health disabilities including dementia;
  - multiple and/or long-term co-morbidities;
  - frailty that requires ongoing care and support due to limited abilities in going about their daily life;
  - high risk individuals, for example of admission to hospital or residential care facility / nursing home;
  - social isolation and loneliness
- End-of –life care
- Carer burden and stress

Focusing on Quality of Life

BMJ

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

OPEN ACCESS

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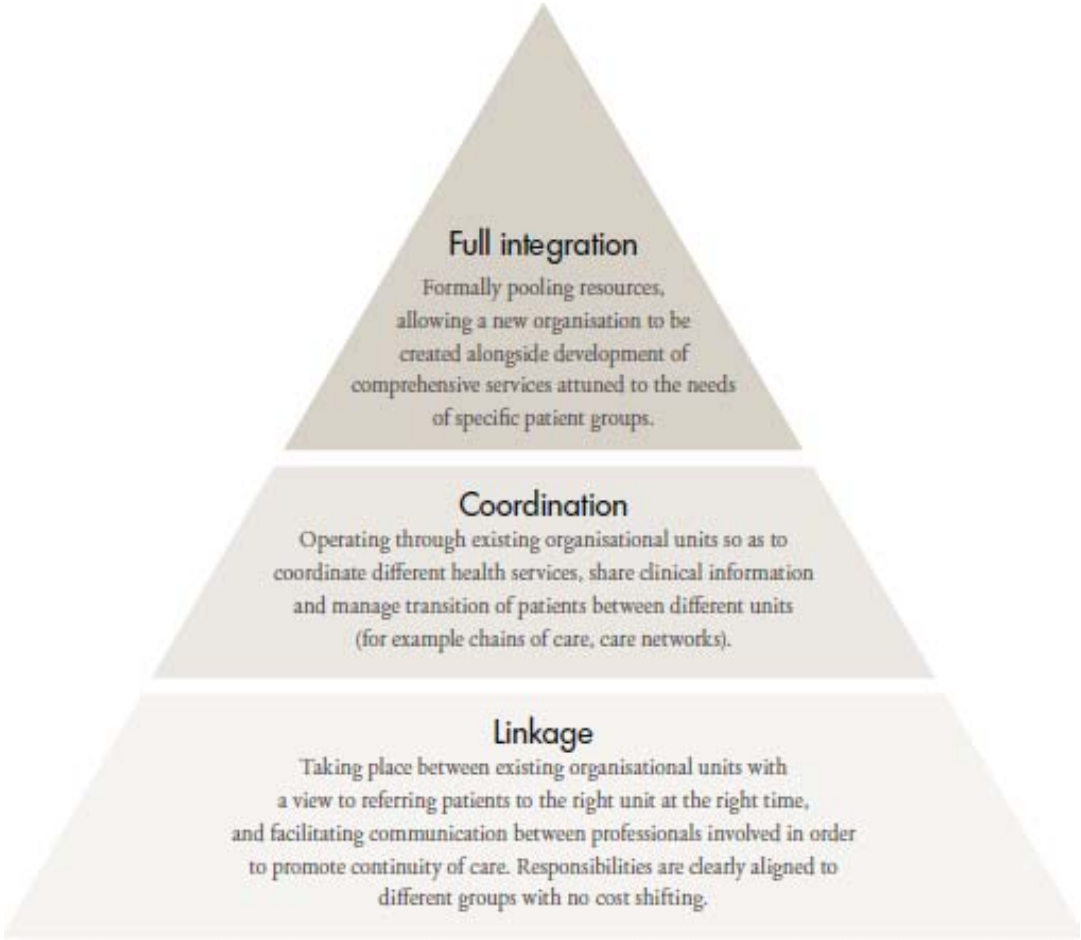
- **More effective approaches:**
  - Population management
  - Holistic, not disease-based
  - Organisational interventions targeted at the management of specific risk factors
  - Interventions focused on people with functional disabilities
  - Management of medicines
- **Less effective approaches:**
  - Poorly targeted or broader programmes of community based care, for example case management
  - Patient education and support programmes not focused on managing risk factors

A Greater Intensity of Integration is Needed



Leutz, 1999, cited in Shaw et al, 2012

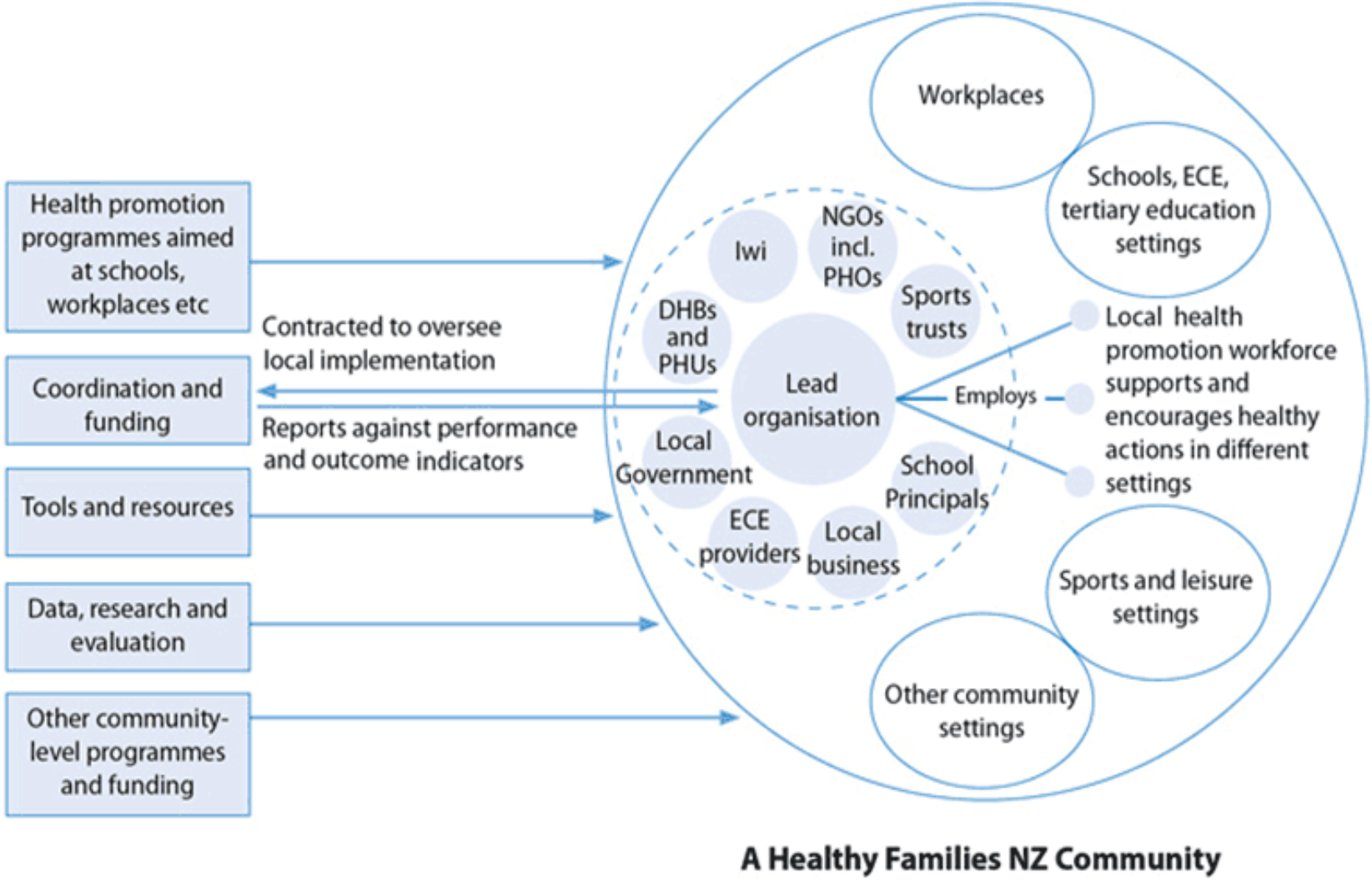
Approaches to Implementing Integrated Care to Older People with Complex Needs in the Home Environment

A Continuum of Care Delivery Strategies –1

Supporting older individuals, carers and families to live well and independently

- To individuals and families - health literacy, shared decision making, self-care, care assessments and care planning,
- To communities with older people – participation, awareness, user groups, volunteers, addressing factors that marginalise at risk communities including social isolation and elder abuse
- To policy and decision makers – taking a life-course approach that focuses on promoting active and healthy ageing through tailored public health interventions

Case Example:
Healthy Families, New Zealand



A Continuum of Care Delivery Strategies –2

Care in the home environment

- Strategies, such as respite care, that support carers and families to cope with the ability to manage dependent older people
- Providing home care services through specialist carers or trained nurses
- Supporting assisted living through the use of telehealth and telecare technologies and other approaches that promote independent living
- Tackling social isolation, promoting dignity and respect, building active participation in the fabric of local communities including befriending
- Investing in extra care housing and/or ageing in place initiatives that promote age-friendly homes and naturally occurring retirement communities
- Promoting elder-friendly cities

Case Example:
South Karelia, Finland

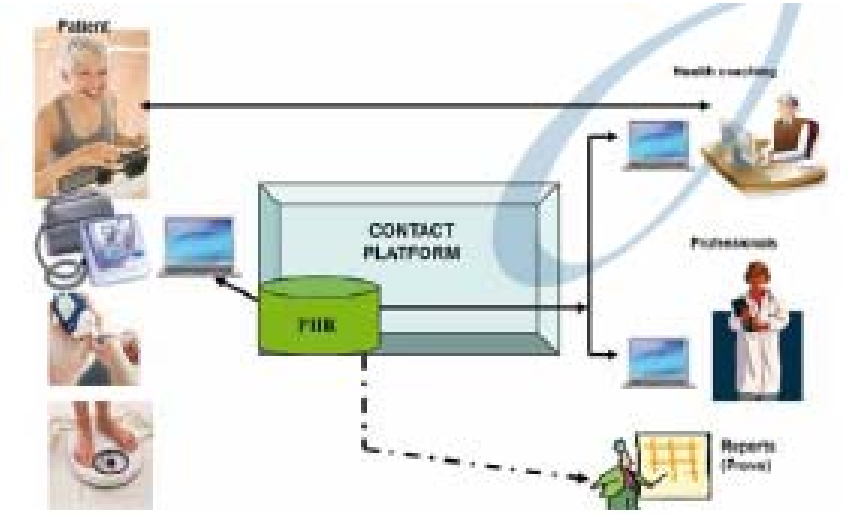
SOUTH KARELIA
DISTRICT OF SOCIAL AND

Eksote provides all health, family and social welfare and senior services for 133,000 citizens some 200km apart

Village associations have a key part to play to promote health and wellbeing and prevent social and medical problems – e.g. themed events for the hard of hearing and with various sports federations

Case Example: South Karelia, Finland

SOUTH KARELIA
DISTRICT OF SOCIAL AND HEALTH SERVICES



HEALTH COACHES MOTIVATE PATIENTS TOWARDS SELF-CARE

The research patients involved in the project are provided with measuring devices for home use to support management of their self-care, along with support from their personal health coach. The patients are able to record the values that they have measured at home (e.g. weight, blood pressure), in a data base by using a mobile phone. They can also see their measurement results in the data base. Their health coach is able to utilize the results in health coaching.

- Established integrated organisation in 2010 combining primary/secondary care with elderly/social care
- Goal was equal access across a rural municipality
- Focus on prevention and citizen responsibility in own care
- Remote monitoring and health coaching
- Mobile health units – use of webcams, broadband and video phones
- Pilot phase had 185 patients
- Care team was a GP, 2 WTE nurses, part-time home care workers, IT engineers and data analysts
- Patients felt less isolated and more secure
- Medication use reduced
- Remote consultations reduced costs by 50% compared to usual care
- Reduced travelling to appointments

RENEWING HEALTH
REgions of Europe WorkING toGether for HEALTH

Case Example: South Karelia, Finland

SOUTH KARELIA
DISTRICT OF SOCIAL AND HEALTH SERVICES

Mallu – Mobile Health Clinic
Launched November 2010

- Acts as a nurse-led mobile clinic to rural villages throughout Eksote
- Works in cooperation with village associations
- Electronic patient record
- Includes:
  - Nurse consultation
  - Health counselling
  - Regular health checks
  - Treating wounds
  - Capillary blood work analysis (e.g. glucose)
  - Vaccinations and medicines
  - Dental care (since 2013)
  - Physiotherapy

RENEWING HEALTH
REgions of Europe Working toGether for HEALTH

Introducing the SUSTAIN Project

SUSTAIN
Sustainable tailored integrated care for older people in Europe

Key Aims: www.sustain-eu.org

1. To improve established integrated care initiatives for older people living at home with multiple health & social care needs;

2. To ensure that improvements to these initiatives are applicable & adaptable to other health systems in Europe.

Person-centredness

Prevention-orientation

Efficiency

Safety

SUSTAIN is Funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144

European Commission

A Continuum of Care Delivery Strategies – 3

Promoting access to care in primary and community care settings

- Improving access to GPs and other primary care professionals
- Establishing multi-disciplinary health and care teams to enable pro-active and enhanced coordination of health and social care
- Promoting care management in the community to older people with high levels of functional disability through assessment, care planning, shared decision making, and coordinated shared delivery between providers and through multi-professional teams
- Enabling faster access to specialist support in old age issues, including community-based geriatricians but also to support people with key needs such as mental health issues, neurological disorders, dementia, and palliative care

Case Example:
Virtual Wards, Torbay, UK

Predictive risk modelling and risk stratification

Utilising data from primary and secondary care, combined with the knowledge from local care professionals working in the community the programme can accurately identify and target patients ‘at risk’ of hospitalisation and who may benefit from at-home case management

Locality working through ‘virtual wards’

Multi-disciplinary teams, anchored around the geographies of local GP practices, support health and social care to people at home. The neighbourhood based teams enable a good working relationship for partnership working and tie activities together through shared care accountabilities

Holistic care assessment and personalised care management plan

A single assessment of physical, mental , environmental, social and spiritual needs ensures a detailed understanding of the patient and family members as well as their preferences. A personalised care management plan, goals-based, ensures all members of the MDT understand the care that is required

Dedicated care co-ordination

The case manager has accountability for co-ordinating care and supporting the preferences of patients to be met. The role provides continuity of care and a single point of contact, including for out-of-hours care

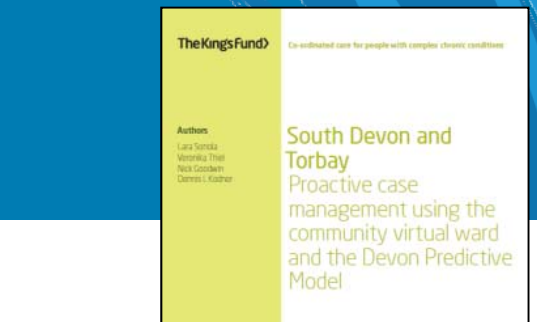


FIGURE 1: The process of care co-ordination

Case Example:
Norrtälje North Stockholm, Sweden

Project INTEGRATE

- Joint governing committee between local authority (social care) and Stockholm County Council (health care) with joint funding (56k)
- Focus on health promotion and prevention
- Development of new health care company with a joint health and social care teams e.g. including intensive home-based case management for older people for better transitions to/from hospital
- Moving to a shared care record
- Professional report improved care co-ordination and patients get faster access to care
- Reduction in nursing home placements
- Lower costs for home care support

Case Example:
Norrtälje North Stockholm, Sweden

- Primary, community and long-term care providers work together within a an integrated health and social care provider that provides comprehensive care to older people
- *TioHundra Forvaltiningen* is the financial arm of the model, established to administer pooled budgets (from Stockholm and Norrtälje municipality) for all care services. It also collects payments and pays providers
- *Tio-Hundra* is jointly owned by the Stockholm county council and the Norrtälje municipality to deliver health and social care services for the citizens in Norrtälje

A Continuum of Care Delivery Strategies – 4

Intermediate care

- Establishing facilities that enable short-term step up and step down care from hospitals to enable respite care, rehabilitation and re-ablement

Care transitions

- Enabling smoother transitions of care between care providers and professionals through the use of named care co-ordinators to support older people and their families navigate their way through complex care systems;
- Developing electronic health records to enable the smooth transfer of data between care providers to support more effective decision-making in real-time;
- Managing the process of care transitions from hospital to the home environment in order to support shorter lengths of stay in hospital and a safe, secure and supported transitional process. This may require specific individuals and teams to support the process

What are Intermediate Care Services?

British Geriatrics Society 2008

- Services targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute care, long-term residential care, or continuing inpatient care.
- Services provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment and opportunity for recovery.
- Services which have a planned outcome of maximising independence and enabling patients/users to resume living at home.
- Services which are time limited.
- Services which involve cross-professional working, with a single assessment framework, single care records and shared protocols.

High Performing Intermediate Care Schemes

- ✓ Clear, agreed scope, **focused on prevention, rehabilitation, re-ablement and recovery**;
- ✓ **Time limited,** linking and **complementing existing services**
- ✓ **Accessible, flexible and responsive** through a single point of access, 7 days a week, and 24 hours a day
- ✓ Based on **holistic assessment** to maximise independence, confidence and personal outcomes sought by the individual
- ✓ **Co-ordinated,** able to draw on **multi-professional and multi-agency skills** and resources as required to meet complex needs
- ✓ **Managed for improvement,** gathering information on the impact of interventions and using this to inform service improvement.
- ✓ **Creating support for self-care** to enable prevention, rehabilitation, re-ablement and recovery and so avoid the need for future hospital admissions
- ✓ **Focusing on those at risk** of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home - **with the potential to regain confidence and independence**

Case Examples of Care Transitions

What do we mean by care transitions?

- Inter-disciplinary communication
- Multi-disciplinary collaboration
- Patient activation
- Enhanced follow-up
- Transitional care staff
- Hand-offs between care providers
- Supporting people between care settings

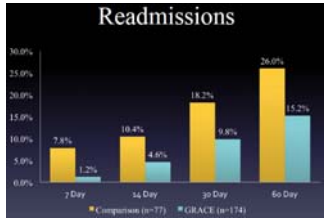
Some evidence-based models

- Care Transitions Programme
- Transitional Care Model
- Bridge Program
- BOOST (Better Outcomes for Older Adults through Safe Transitions)
- GRACE (Geriatric Resources for Assessment and Care of Elders)
- Guided Care ©

Case Example: GRACE

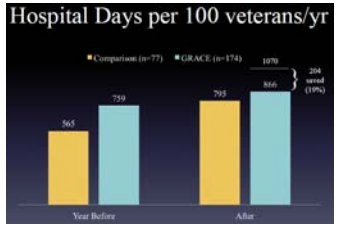
Geriatric Resources for Assessment of Care of Elders

- Veteran's Health (VHA)
- GRACE support team
  - Nurse practitioner and social worker
  - 12 session training programme
  - Long-term interventions
- Home visit
- GRACE inter-disciplinary team
- Meetings with primary care physicians
- Individualised care plans
- Home visits and phone call follow-up
- Transitional care team from hospital to home

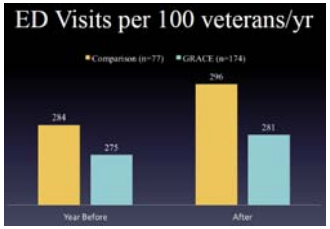


46% reduction in ED readmissions

17% reduction hospitalisations



19% fewer bed days



2% lower ED visits

and a 44% lower mortality rate

Case Example: GUIDED CARE © Kaiser Permanente (and others), USA

- Trained nurses integrated into primary care practice
- Predictive modelling techniques to identify at-risk patients
- Nurse assessment of patient and carer needs
- Co-designed care plan
- Case-loads of 50-60 individuals per nurse
- Multi-disciplinary teams based in primary care
- Self-management support
- Web-based electronic health records support real-time decision-making

GUIDED CARE®

Peer-Reviewed Impact Includes

- High levels of satisfaction with patients and carers
- Improvements in measures related to quality of life
- Reductions in total costs to health care budgets through reduced hospitalisations and lengths of stay (up to 11%)

See: http://www.guidedcare.org/index.asp

A Continuum of Care Delivery Strategies – 5

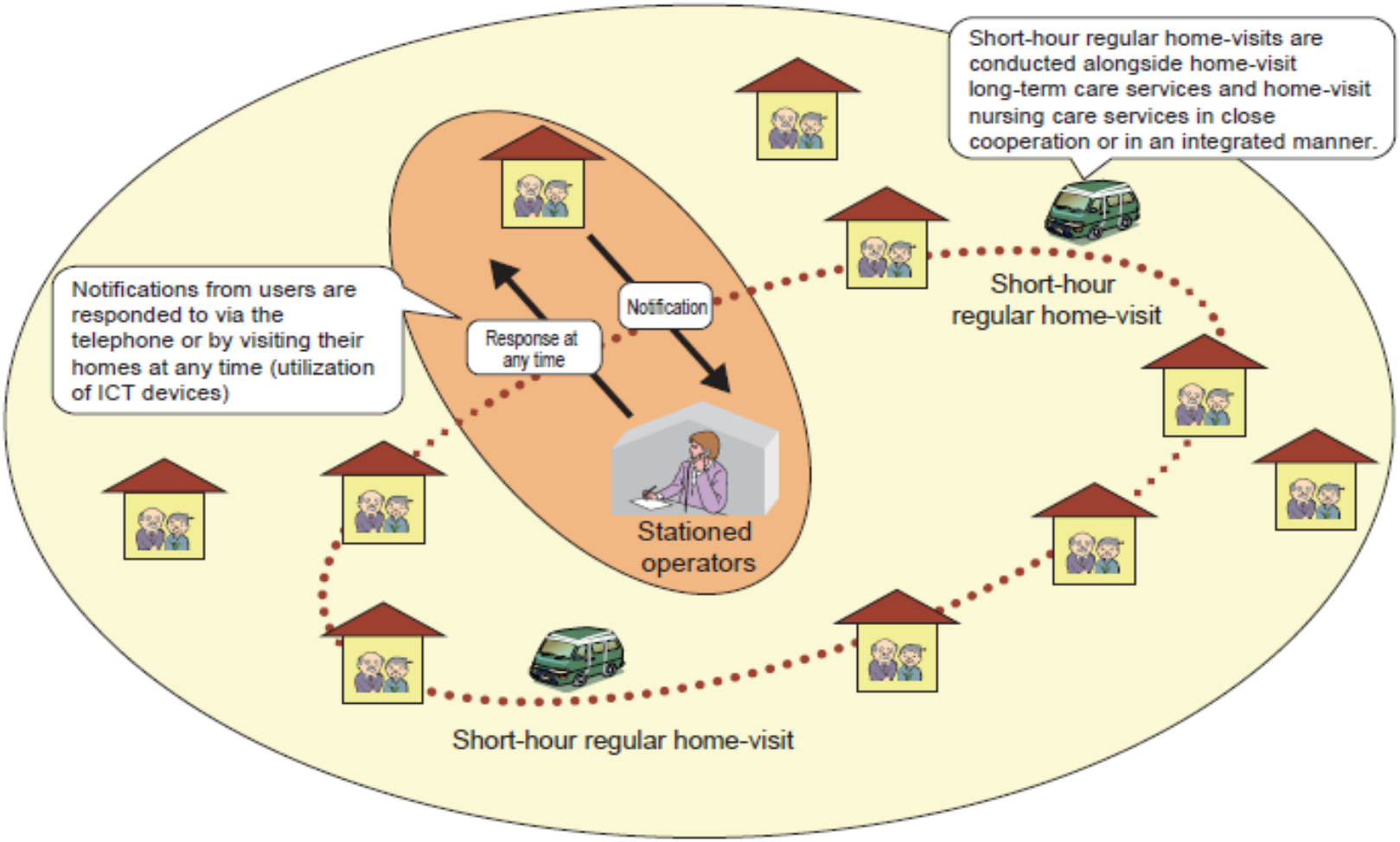
Care in residential and nursing homes

- Ensuring that access to long-term care for people with high needs is available where this is necessary, with the integration of care home support with effective management of older people's medical and nursing needs
- Focusing on quality of long-term care to prevent elder abuse and promote dignity, respect and care

Medicines management

- Supporting GPs and other care providers with decision-support tools and methods to review quality of prescribing practices that help to improve quality
- Pharmacist and nurse-led interventions that provide educational information and outreach to reduce prescribing errors amongst high-risk patients
- Supporting older people and their carers with information and support to enable them to manage their medications effectively at home

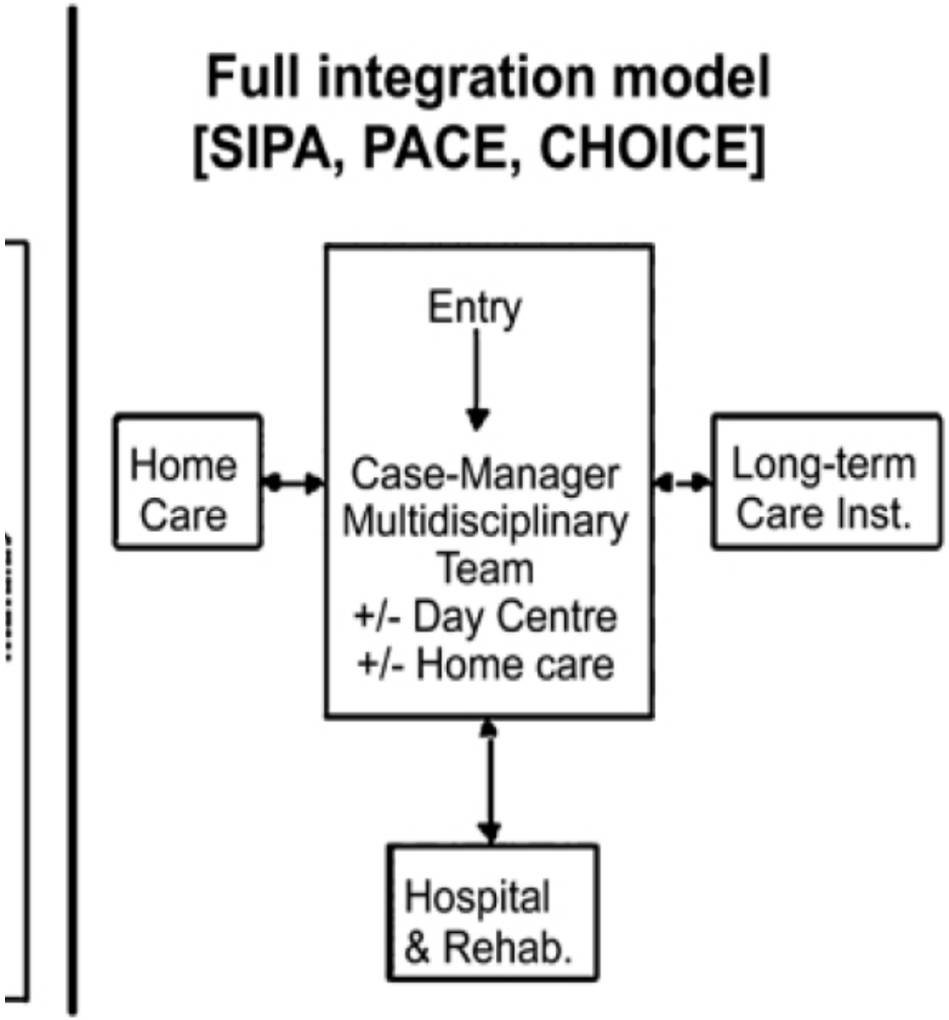
Case Example: Integrated Primary and Long-Term Care in Japan



Case Example: PACE Programme, USA

- Fully integrated system providing acute and long-term care services to older people (>55)
- Grew out of On Lok, an innovative senior centre that developed a day hospital approach to care to frail older people
- Based around an adult care centre that offers:
  - social and respite services
  - primary medical care
  - geriatric outpatients
  - ongoing care and case management
- Designed to maintain frail older people in the community for as long as possible, so avoiding institutionalisation
- Voluntary enrolment, available to those aged >55 eligible for nursing home admissions and covered by both Medicare and Medicaid
- Important role of informal carers and supportive housing often part of care package

Case Example:
PACE Programme, USA



How PACE achieves integrated care:

- **Pooled financing** (Medicare & Medicaid) and authority to control how capitated funding is spent
- **Integrated services** by range of staff employed at adult care centre – outside contracts for medical services, acute hospitalisations & nursing home care
- **Case management** by multidisciplinary teams including comprehensive assessments, service provision and care co-ordination
- **Prevention and rehabilitation** focus

A Continuum of Care Delivery Strategies – 6

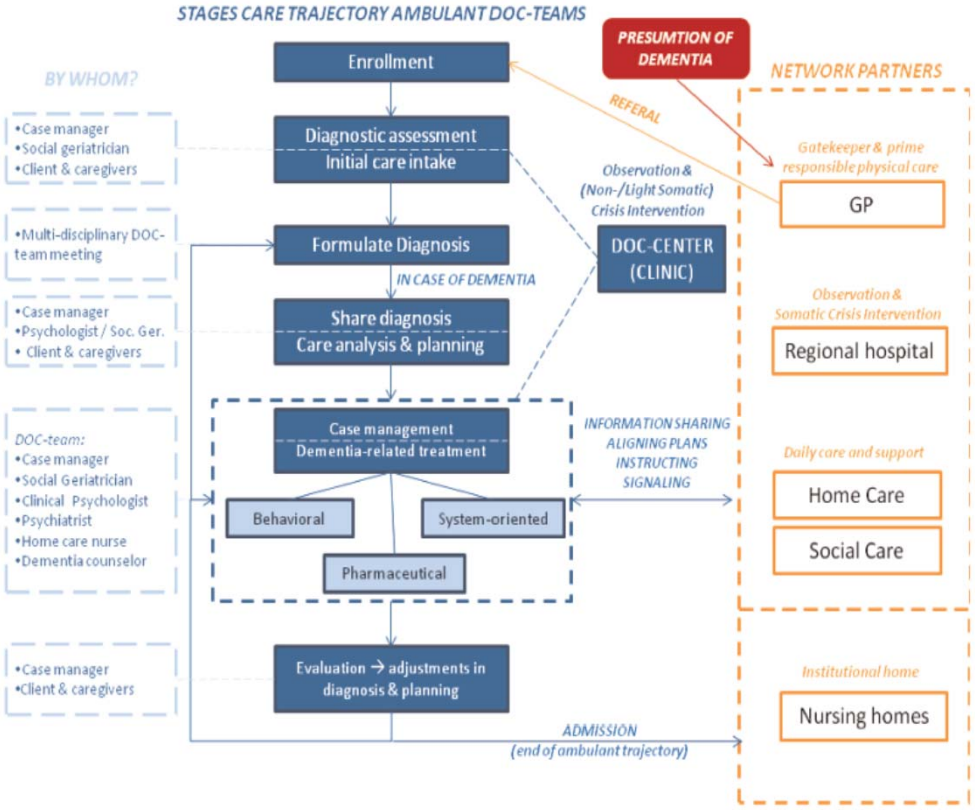
Dementia care

- Ensuring that dementia care services are available to older people living in the community, including access to specialist support and support at home tailored to people with different levels of severity;
- The development of centralised co-ordination of dementia care in the community enabling 24/7 care through rapid response and multi-disciplinary teams

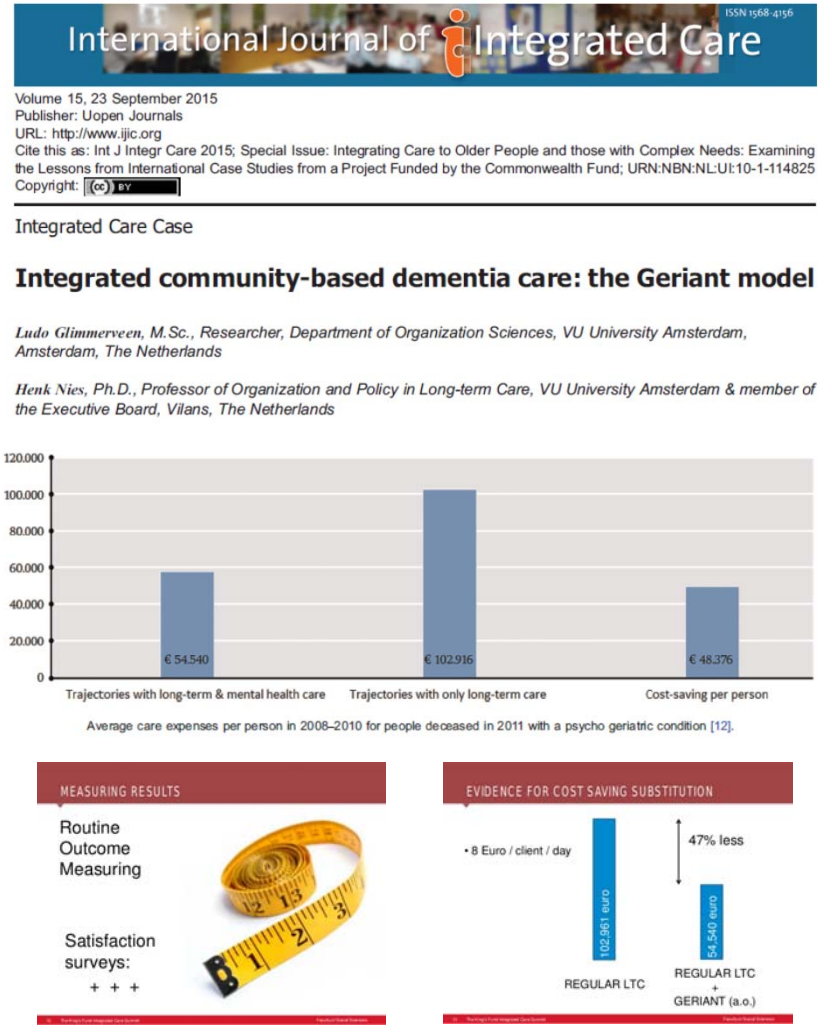
End of life care

- Ensuring that palliative care services are available to older people living in the community to support dignity in dying in places of choice;
- The development of centralised co-ordination of end-of-life care in the community enabling 24/7 care through rapid response and multi-disciplinary teams

Case Example: GERIANT, Dementia Care, Netherlands



Annex I. Client flow chart.



Case Example:
End-of-Life Care, Midhurst, UK

Awareness-raising and relationship-building
GPs, community staff, hospital consultants, volunteers and local people strengthening its ability to 'capture' people nearing the end of life before, or very soon after, a hospital admission.

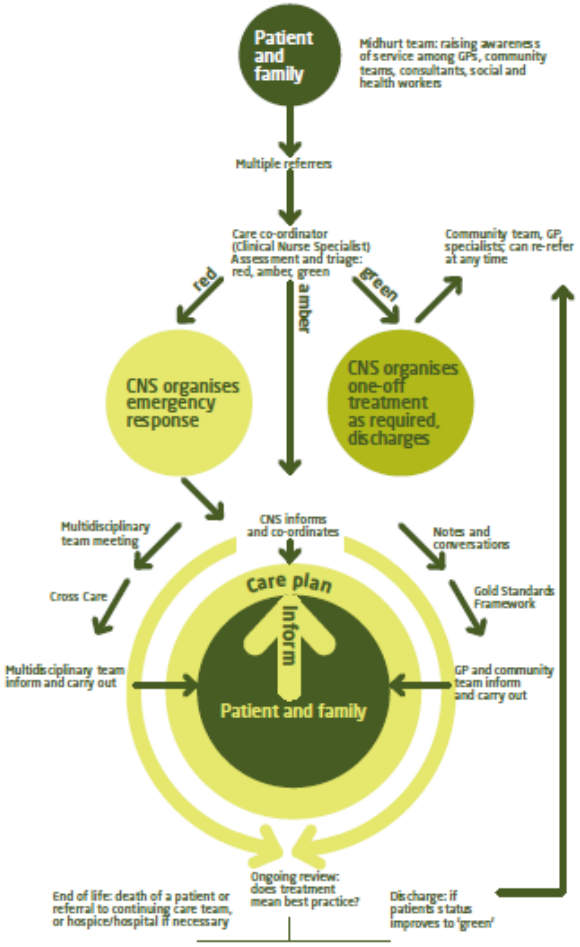
Holistic care assessment & personalised care plan
A single assessment process examines both the health and social care needs of the patient and their family. It also takes into account their personal choices about future care and treatment options.

Multiple referrals to a single-entry point
The service accepts referrals from any health professional and also local people. All referrals come into the service and are assigned to a clinical nurse specialist from a single-entry point.

Dedicated care co-ordination
The care co-ordinator has a number of roles: acting as the principal point of contact with the patient and their family; effectively co-ordinating care from within a multidisciplinary team and liaising with the wider network of care providers.

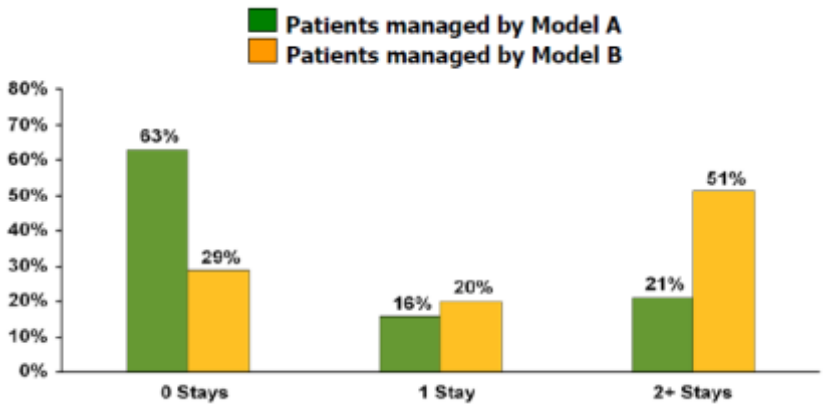
Rapid access to care from a multidisciplinary team
Both professionals and volunteers can be rapidly deployed by the service to provide care or support to meet the needs of people living at home. The service operates 12 hours a day, with access to an on-call clinician out of hours.

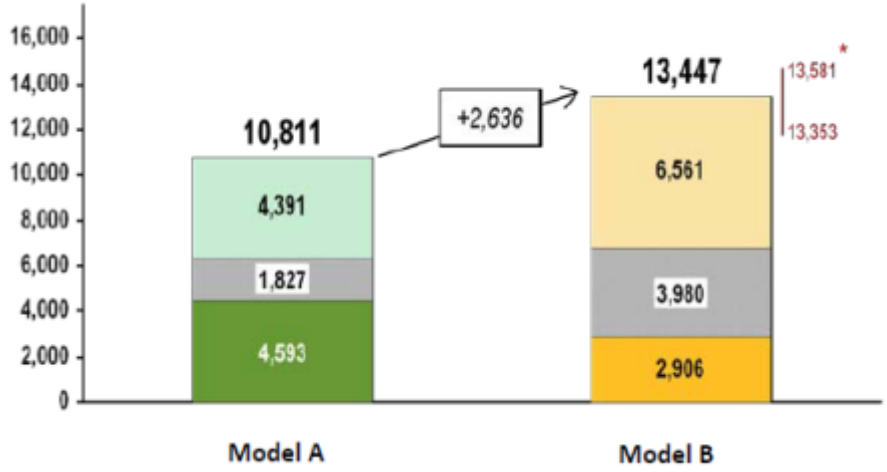
Figure 2: The care process for patients in the Midhurst Macmillan Service



Case Example:
End-of-Life Care, Midhurst, UK

Total assumed cost of 1000 patients in the last year of life under the Midhurst model was 20% less than care in other settings (hospital and hospices). The cost savings were due to fewer stays in hospital in the integrated model of care





Noble, B., King, Nigel, Woolmore, A., Hughes, P., Winslow, M., Melvin, J., Brooks, Joanna, Bravington, A., Ingleton, C. and Bath, P.A. (2014) Can comprehensive specialised end-of-life care be provided at home? Lessons from a study of an innovative consultant-led community service in the UK. European Journal of Cancer Care. ISSN 0961-5423 (In Press)- http://eprints.hud.ac.uk/20267/1/noble_et_al.pdf

Conclusions:
Improving Quality of Life and Services for Older People

A Range of Solutions

- Enhancing service co-ordination and care continuity;
- Strengthening services provided in the home environment, and in primary and community care settings, to improve access to needed health care services;
- Developing integrated approaches in the work of care providers and professionals in order to achieve, for example, team-based working between health and social care, across primary and hospital care, or to integrate physical and mental health care;
- Improving the clinical quality of the patient journey to improve experience and satisfaction, with a specific focus on care transitions from hospital to home; and
- Working with older people, their families and local communities to strengthen social networks, enable independent living
- Focus on an older person's personal health and wellbeing

Contacts

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International Foundation for Integrated Care

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