Aging and life's expansion: New necessities, New designs of health services

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The Shifting Face of Health Care

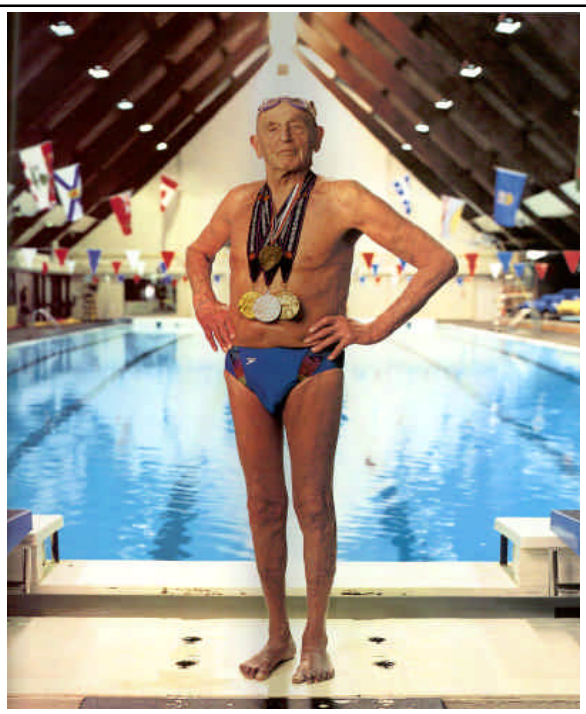
- Health care systems poorly adapted to the management of chronic disease, frailty and dependency; complexity of treating chronic diseases and frail older persons
- Shift from institutions to networks of care
- Many health care professionals: family practitioners, specialists, nurses, physical therapists, nutritionists, social workers, psychologists, etc.
- Many sites of care: home, physician's office, community clinics, ambulatory care centers, community hospitals, academic health centers, rehabilitation facilities, nursing homes, palliative care centers
- Expectations/knowledge/Involvement of patients and family

The Shifting Face of Health Care

- Growth in Diagnostic and Therapeutic Technologies
  - New scientific and clinical knowledge
  - New drugs, new implants, new devices, new equipment
  - Down the road : genomics and proteomics (?)
- Emerging or Re-emerging Infectious Diseases
  - SARS, C-Difficile, MRSA, ERV, Avian Flu (?), etc.
  - ? Antibiotic resistance

The Shifting Face of Health Care

- ? Complexity
- ? Interdependency
- ? Uncertainty
- Continuous Change



Older persons: Insights into health and utilisation characteristics

- Apparent increase in disability free life expectancy
- Increase in old, in particular old/old
  - Healthy; older persons with disabilities
- Importance of chronic disease-impact on quality of life and progression to disability
- Potential for promotion/prevention/chronic disease management in promoting healthy aging and in at least delaying onset of frailty and disability
  - life course approach

Older persons: Insights into health and utilisation characteristics

- Shift from reliance on hospital/nursing home to community as well as assisted living/supportive housing
- Potential to improve quality, change configuration of utilisation of care and control costs
- Integrated systems of care for small group of older persons responsible for a disproportionate proportion of costs

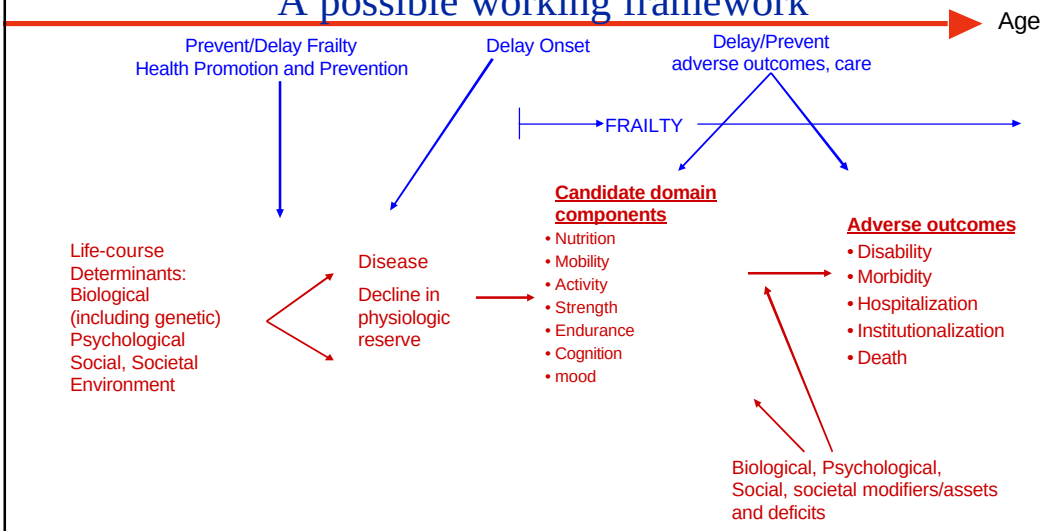
Older persons: Insights into health and utilisation characteristics

Heterogeneity of Older Persons

- Healthy/independent
- Independent/chronic disease
- Frail/vulnerable
- Dependant/disabilities in ADL/IADL with acute and chronic medical problems

Frailty: a Complex Syndrome of Increased Vulnerability

A possible working framework



www.frail-fragile.ca

Focus on very frail older persons with disabilities

- Generally over 75
- Disabilities in ADL/IADL
- Acute and chronic medical problems
- Importance of social network
- Frequent transitions, high utilisation and costs: community, hospital, rehab, NH
- Need for a complex combination of medical and social services

Focus on integration of care for very frail older persons with disabilities

- Increase in number of older persons and costs of care
- 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
- Increasing evidence of the effectiveness of treatment and care management in frail older persons

SIPA Integrated System of Care for the Frail Elderly: intensive team-based case management

- Community primary care based system responsible for the full range of services
  - Health and social services, acute and long-term care: community, hospital and institutional
- Responsibility (health outcomes, utilisation) for a defined population

Bergman, Béland, Lebel et al CMAJ 1997

SIPA Intervention Assessment and management

- Multidisciplinary team, including case manager, responsible for assessing needs, organizing and delivering most of health and social services in community in collaboration with primary care physician
- Comprehensive Geriatric Assessment on entry
- Early detection and intervention (medical, rehabilitation, social)
- Evidence based interdisciplinary protocols development
  - Nutrition, falls, CHF, dementia, depression, medication, vaccination, etc
- Rapid communication, mobilisation of resources
  - Intensive home care, group homes
- 24 hour nurse on call with MD backup

Béland, Bergman, Lebel, Clarfield et al, J of Gerontol A Biol Sci, Med Sci 2005; In press

SIPA Intervention
Case Management

- Consolidated case management with multidisciplinary team
- Intervention with patients and caregivers
- Liaison with family MD and specialists
- Maintain clinical responsibility
- Actively followed patients throughout trajectory of care including in hospital
  - Assure continuity
  - Ease transitions

Béland, Bergman, Lebel, Clarfield et al, J of Gerontol A Biol Sci, Med Sci 2005; In press

SIPA Intervention
Accountability

- Clinical responsibility and accountability for utilization in community, hospital, etc.
- Monitoring of application of protocols and service utilization
- Agreements, mainly informal, with other providers
- Control over budget and resources allowing for increased intensity and flexible utilization of home services, group homes, additional services based on clinical assessment
- Per capita budget with full financial responsibility not implemented

Béland, Bergman, Lebel, Clarfield et al, J of Gerontol A Biol Sci, Med Sci 2005; In press

Principal SIPA Impact

- Improved satisfaction/perception of quality by caregivers
- ? utilization of hospital and SNH utilization in SIPA group
  - As expressed by the ? combined costs of hospital and SNH
  - Driven by decreased ALC "admission"; ? N.S. differences in utilization in other areas such as ED
- ? hospital utilization for those with increased ADL disability
- ? use of hospital as conduit for SNH placement
- Delaying SNH placement for those with few chronic diseases (lesser risk) and those living alone (higher risk)
- Cost neutral

Béland, Bergman, Lebel, Clarfield et al, J of Gerontol A Biol Sci, Med Sci 2005; In press

Conclusion

The results of this and other trials (Canada, USA, Italy) demonstrate:

- Feasibility/impact of clinical/utilisation responsibility
- the potential to change the configuration of utilization of services with at least no increase in over all costs
- while maintaining or improving quality and satisfaction
- for those older persons with moderate/severe disability of the population which need a complex combination of health and social services

Opportunities and Challenges to Rethink the Paradigm

Limits of integrated systems of care for the very frail older persons

- Effective mainly for ? disability/complexity; does not take into account the heterogeneity of older persons
- Primary Medical Care and Home Care
  - Traditionally separated organizationally, functionally and geographically
  - Difficulty in meeting the complex needs; population approach; chronic disease management
- Geriatric Medicine and other specialty care
  - hospital “restricted”

Themes to explore

- Primary medical care integrated with primary multidisciplinary care supported by specialised programs, in particular specialised geriatric programs
  - Caring for full spectrum of older persons
  - Clinical responsibility/accountability for a defined population for health outcomes and for utilization of services; throughout the entire continuum/trajectory of care

Themes to explore

Clinical protocols and care-management programs supported by information and communication systems adapted to population characteristics and needs and developed through clinician leadership:

- Study population characteristics: health, functional status, social…; utilisation of health and social services

- Health promotion and prevention
- Chronic disease management programs-detection, management, follow-up, patient education, etc- for selected clinical priorities (eg. diabetes, CHF, hypertension, depression, cancer)
- Interdisciplinary protocols for geriatric assessment and the detection and management of geriatric syndromes (falls, dementia, depression, nutrition, etc)
- Intensive team-based case management for complex older persons with disabilities/chronic and acute medical and social problems

Themes to explore

- Integration/coordination of care
  - Balancing care in the home, community and institution
    - Emphasis on home and community based social and supportive care integrated with primary health care
    - Alternatives to institutional based care
  - Integrating acute and continuing care
- Patient and caregiver:
  - involvement/empowerment and education
  - Caring for the carer
- Align governance and sources of financing to support clinical objectives

Themes to explore

- Healthy older persons
  - Primary medical care, Health assessment/promotion/prevention
- Independent/chronic disease
  - Primary medical care, Chronic disease management, Preventive home visits
- Frail/mild disability
  - Primary medical care, home care, Chronic disease management. Specialized Geriatric care,
- ? Disability and complex medical and social profile (the SIPA type population)
  - Intensive team-based case management

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Béland, Bergman, Lebel, Clarfield et al, J of Gerontol A Biol Sci, Med Sci 2005; In press

NHS: Supporting People with Long Term Conditions