Building systems to address functional decline and dependence in ageing populations

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Integrated care models for frail older people - Overview and main challenges

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Background paper

Challenges of Western health systems

Western health systems face several challenges over the coming decades that demand strategies to optimize health care delivery:

1. An increasing need for health care [1]. An important explanation for this increase is the ageing of the Western population. In 2020, about 20% of the population will be 65 years or older. This percentage is predicted to rise to almost 30% by 2060 [2, 3]. At least two-thirds of older people have several chronic conditions and/or functional limitations often leading to complex health and social care needs [4-7]. These needs are commonly insufficiently addressed since health systems for older people are often poorly planned and coordinated [7-10]. As a result, older people are disproportionately heavy users of high-intensity, high-cost health care services such as hospital care and other forms of institutional care putting pressure on health budgets [4, 7, 11, 12];
2. A well-recognized need for delivery system reform. Traditionally, health systems have been dominated by a reactive approach and by highly specialized echelons. However, particularly in care for older people, a more proactive approach is assumed beneficial in which health and social care needs are acknowledged and acted upon before they cause significant deterioration [1, 10, 13-15];
3. A move towards providing patient-centered care, including self-management and prioritizing treatment goals in consultation with patients. Patients are increasingly being involved in decisions affecting their health and treatment in response to the traditionally supply-driven provision of health services [1, 14]. This demands new skills and competences of caregivers in order to be able to educate and coach patients in managing their chronic diseases and to ultimately maximize their independence in community settings. It should therefore be acknowledged that in addition to the level to which treatment standards are met, also aspects such as patient engagement, independence, and social participation are important indicators for quality of care. Hence, optimizing health systems and health services interventions has become a priority especially in view of the need to contain growing costs and to prepare for future challenges.

Integrated care to optimize health systems

In response to the challenges that health systems face, in several countries across Europe and the USA integrated care models have increasingly been put in place to optimize delivery of health and social care services to older people. Many different terms are being applied to integrated care including case management, coordinated care, collaborative care, disease management, guided care, managed care, shared care, transmural care, and transitional care [10, 15-17]. Core elements of integrated care models are: 1. a well-coordinated and proactive approach to health care needs; 2. patient-centeredness by involving older people in decision-making and planning their care process, and by taking their

individual needs into account; 3. (simultaneous) delivery of multiple interventions; and 4. Involvement of professionals from multiple disciplines [10, 18-20].

Evidence for effectiveness of integrated care models is inconclusive

The number of integrated care initiatives is increasing across Europe and the USA and there is a mounting number of studies evaluating their effects on health outcomes, quality of care, health care utilization, and health care costs. Nevertheless, evidence remains inconclusive regarding the merits of these models. A recent study on integrated care models for frail older people [21] suggests that integrated care models are most effective in reducing healthcare costs (mainly due to less (re)hospitalizations and ER visits), in improving health behavior of patients and in realizing satisfaction of patients and caregivers. Evidence is, however, inconclusive for the effects of integrated care on medication appropriateness, patient's quality of life, and caregiver burden, whereas almost no evidence is available for the effects of integrated care on cognition, depressive symptoms and functional status. Moreover, information regarding the implementation of integrated care models is hardly available. Insight into the factors that hamper and expedite the implementation of integrated care models is, however, of importance since it cannot be assumed that a model of care developed in one setting can be easily transplanted to another [15].

Several unanswered questions remain

Although the number of integrated care initiatives is increasing and several evaluation studies have been performed, it is still unclear which models are effective for which group of older people, in which context, and at what cost [14, 15, 17, 21-27]. As a consequence, policymakers and decision-makers are not able to make informed decisions regarding implementation and improvement of integrated care models. Important questions that are still unanswered are listed below:

1. *Which models are effective for which group of older people, in which context and at what cost?*
   The diversity of healthcare systems means that there is unlikely to be a universal solution to the challenges posed by health and social care needs of frail older people. What may be possible in one healthcare system may be impossible in another system if the two differ in critical aspects. Each system must find its own solution, although it can also draw on the lessons learned by others [15]. It is therefore necessary to discover what constitutes best practice in integrated care for older people, i.e. what works for whom in which context and at what cost. Future studies should therefore address the several domains relevant to evaluate the impact and implementation of integrated care models including the context (e.g. local relationships between professionals and institutions that deliver care, health payment systems, incentive regimes, cross-cultural differences) in which the models are being practiced. Such insights may be of help to gain insight into which aspects of integrated care are essential to realize the gains from these models and which aspects are context-related [21], and thus provide insight into the transferability of models to different health

systems (e.g. which aspects of integrated care models in high income countries are transferable to low and middle income countries);

2. *Which payment systems and incentive regimes are most appropriate for integrated care and the health system in which they are embedded?*

   There is significant literature outlining the different sorts of payment mechanisms which could be used to fund healthcare systems. Much of this literature has focused on the theoretical aspects of these different systems, and in particular the incentive regimes generated by the different payment systems. There are, however, very few studies focusing on the payment systems and incentive regimes of integrated care models [28]. This makes it difficult to provide policy guidance on which payment system and incentive regimes are likely to be appropriate in integrated care.

3. *How to assess quality of care for frail older people?*

   To achieve optimal care for older people, it is necessary to measure quality of care and to analyze where, when and for which conditions quality deficiencies exist in order to know where improvements are needed. The level of quality of care very much depends on the perspective of the stakeholder. As stated before, the perspective of quality of care is changing from a providers' point of view (i.e. meeting the treatment standards) towards a patients' point of view in which aspects such as functional health, patient engagement, social participation, andquality of care are included. However, most sets of quality indicators for older people mainly focus on specific diseases, rather than on functional health and assess the care delivery process rather than outcomes. Maintaining functioning and participation and quality of life are often of much higher priority to older patients than clinical outcomes. In addition, current indicator sets are developed from a provider perspective while indicators covering the patient perspective are hardy incorporated. Development of such indicators is of importance for evaluating and benchmarking integrated care initiatives.

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