INTEGRATING LONG TERM CARE SERVICES AND SUPPORTS—Implications for ‘Aging at Home’ and Ontario

“What Happened to Aging at Home: Shifting Policy Sands in Ontario and Beyond”
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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
“Long Term Care” Defined

“Long term care” (LTC) is part health care and part social service. It encompasses a broad array of primarily low-tech services provided by paid professionals and paraprofessionals—as well as unpaid family members and other ‘informal’ helpers—in home, community and institutional settings to individuals with chronic, disabling conditions who need help on a prolonged basis with activities of daily living (ADL) and instrumental activities of daily living (IADL). These services and supports include:

- Personal care (e.g., bathing and grooming)
- Household chores (e.g., meal preparation and cleaning)
- Life management (e.g., shopping, medication management and transportation)
- Related help with health, mental health and housing needs.
Frail Older People: A Profile

15-25% of people aged 65 and over will eventually need a range of LTC services and supports over time. These frail older people present a complex set of challenges:

- Functionally dependent
- Health impaired
- Multiple, ongoing LTC and acute care needs
- High risk of institutionalization
- Frequent interactions with providers, and transitions within and between systems and settings
Frail Older People: A Profile (cont’d)

- Access, continuity and coordination problems
- Caregiver burden and stress
- Relatively high costs of care.
Many Weaknesses in the Long Term Care System

Despite cross-national differences, we frequently encounter a host of weaknesses in the health and care sectors that work against effectively meeting the LTC needs of frail older people:

- Greater emphasis on ‘cure’ vs. ‘care’
- Fragmented, misaligned policy-making, financing and regulation, with inadequate LTC coverage
- Imbalances between institutional vs. home and community-based resources
Many Weaknesses in the Long Term Care System (cont’d)

- Poor collaboration at the organizational and provider levels within and between the health and care sectors
- Lack of a single provider team or entity with responsibility for all care and outcomes.
The Problem: Bad ‘Fit’ Between Needs and Resources

Generally speaking, there is a very poor ‘fit’ between the needs that frail older people have for LTC and the existing infrastructure of health care, social services and related supports. The lack of continuity and coordination within and between the various sectors produces care silos which are largely responsible for resource imbalances, access problems, inefficient service delivery, suboptimum quality, poor clinical outcomes and high costs of care. There are three (3) main culprits:

- Responsibilities for services are shared: Many jurisdictions/boundaries, institutions, and professionals

- Systems work in parallel: Separate payment schemes and budgets, and conflicting policies and regulations
The Problem: Bad ‘Fit’ Between Needs and Resources (cont’d)

- **Professional domains are different**: Health care, social services and other types of care differ in terms of professional identities and roles, culture and language, clinical philosophies, service delivery methods, and power relationships.

*Source: Kodner, 2008*
Halfway Solution: ‘Rebalancing’ the Long Term Care System

Ontario’s Aging at Home programme—like similar efforts in other countries which emphasize home and community support options in LTC—is an important step in reforming LTC. Rebalancing strategies like Aging at Home can 1) increase the supply and quality of in-home and community-based services; 2) relieve pressure on hospitals and LTC homes; and, 3) enable frail older people to live where they prefer with dignity. But focusing on home and community supports is only a halfway solution. The strategy...

- Can end up being hijacked thru ‘goal displacement’;
- Can distort overall problems and anticipated outcomes; and,
- Fails to systematically/holistically address the range of inter-connected LTC issues/challenges on the macro, meso and micro levels.
The Only Solution: Integration and Integrated Care

‘Integration’ and ‘integrated care’ describe a dynamic set of methods and models on the funding, administrative, organizational, service delivery, and clinical levels to produce connectivity, alignment, collaboration and coordination within and between the cure and care sectors for complex, multi-problem patients/clients whose needs cut across multiple services, providers and settings in order to achieve the following outcomes:

- Improved patient/client experience and satisfaction
- Enhanced quality of care, quality of life, and health-related outcomes
The Only Solution: Integration and Integrated Care (cont’d)

- Greater system/service efficiency, effectiveness and value.

Source: Kodner, 2009: Kodner & Spreeuwenberg, 2002
Integrative Processes: Macro, Meso and Micro

There are five (5) integrative processes that help to shape and connect various integrated care methods, strategies and tools at the macro, meso and micro levels:

- **Systemic**
  - Alignment of policy and regulatory levers, and financing/payment incentives

- **Normative**
  - Development of shared mission, vision and values

- **Organizational**
  - Coordination of structures, governance, and relationships across provider organizations and systems
Integrative Processes: Macro, Meso and Micro (cont’d)

- **Administrative**
  - Coordination of back-office functions, budget/finance and information systems, and accountability mechanisms

- **Clinical/service delivery**
  - Coordination of inter-professional teamwork, clinical decision support, and service delivery in a single process across time, place and discipline
  - Facilitation of patient/client and family involvement

*Source: Rosen, 2010; Kodner, 2009; Ramsey & Fulop, 2009*
Integrative Strategies: Some Examples

A continuum of strategies—from the macro to the micro—are available to foster the process of integration and the ultimate achievement of integrated LTC. The following are some examples:

- **Funding**
  - Single funding envelope/funds pooling
  - Integrated budgets for defined care package
  - Global capitation

- **Administrative**
  - Consolidation of responsibilities/functions
  - Integrated information systems
Integrative Strategies: Some Examples (cont’d)

- **Organizational**
  - Co-location of services
  - Partnerships
  - Networks
  - Consolidation, ownership or merger

- **Service delivery**
  - Single or coordinated entry, intake and referral
  - Case/care management
  - Inter-professional teamwork
Integrative Strategies: Some Examples (cont’d)

- Clinical
  - Single, system-level patient/client classification system
  - Uniform, comprehensive assessment
  - Shared clinical records
  - Common decision support tools, i.e., guidelines and protocols
  - Patient/client and family education, counseling and support

Source: Hollander, 2008; Kodner & Spreeuwenberg, 2002; Kodner & Kay Kyriacou, 2000
Integration: Breadth and Degree

Efforts to guide the integration of systems and services in LTC can also be characterized in the following ways:

- **Breadth**
  - Horizontal integration, i.e., similar organizations/units at the same level join together
  - Vertical integration, i.e., combination of different organizations/units at different levels

- **Degree**
  - Linkage
  - Coordination
  - Full integration

Source: Kodner, 2009; Aghren & Axelsson, 2005; Leutz, 1999
Leutz’s Integration Typology (1999)

Professor Walter Leutz of the Heller Graduate School at Brandeis University clarified thinking about the way integrated care arrangements work and for whom. He makes it clear that there is no single model that works for everyone. And there is overlap between models.

<table>
<thead>
<tr>
<th>CLIENT’S NEEDS</th>
<th>LINKAGE</th>
<th>COORDINATION</th>
<th>FULL INTEGRATION</th>
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<td>Moderate-to-severe</td>
<td>Moderate-to-severe</td>
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<td>STABILITY</td>
<td>Stable</td>
<td>Moderately stable</td>
<td>Unstable</td>
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<tr>
<td>DURATION</td>
<td>Short-to-long term</td>
<td>Short-to-long term</td>
<td>Long term-to-terminal</td>
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<td>Mostly routine</td>
<td>Frequent, urgent</td>
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<td>SCOPE OF SERVICES</td>
<td>Narrow-to-moderate</td>
<td>Moderate-to-broad</td>
<td>Broad</td>
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<td>SELF-DIRECTION</td>
<td>Self-directed/strong Informal</td>
<td>Self-directed/varied levels</td>
<td>Weak self-directed/informal</td>
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</tbody>
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The Architecture of Integrated Long Term Care: Important Factors

The architecture of integrated LTC depends on several factors:

- Identified issues and problems
- Common vision
- Objectives of initiative
- Stakeholders involved
- Local health and care arrangements
- Available resources.
The Architecture of Integrated Long Term Care: Other Points

Based on the recent work of Sara Shaw and colleagues (2010) at The Nuffield Trust, we also know that several other important points bear mentioning:

- Integrative processes/strategies are not equal; some end up being more important than others

- Synergies between integrative processes/strategies can improve overall value in integrated care

- Integrative processes/strategies can produce unintended or even adverse consequences.
Is Integrating Long Term Care Worth It?

Mixed evidence drawn from initiatives, programmes and projects in North America, UK, Europe and Australia specifically targeted to, and designed and organized around, the needs of frail older people suggests that integrated care is capable of achieving positive outcomes in LTC, although it is not always clear which combination of integrative strategies—and under what circumstances—produce the following results:

- Expanded access to services
- Enhanced coordination and continuity
- Improved health and functional status
- Reduced hospitalisation and nursing home placement
Is Integrating Long Term Care Worth It? (cont’d)

- Improved patient/client experience, quality of life (QOL), and consumer satisfaction
- Reduced caregiver burden
- Controlled/reduced costs.

Successful Integrated Care: Ten Key Ingredients

Despite the range and diversity of approaches and formats for health-related system/service integration, there are ten (10) key ingredients— independent of the population served, context or model—found in successful integrated care initiatives:

- **Person-centered focus:**
  - Well-defined target group(s)
  - Holistic, patient/client-centered philosophy
  - Patient/client engagement and participation

- **Population and geographic coverage:**
  - Responsibility for identified population/geographic area
  - Defined entry point(s)
Successful Integrated Care: Ten Key Ingredients (cont’d)

- **Comprehensive basket of services:**
  - Broad range of health and care services
  - Strong links between sectors, organizations, services and providers
  - Linkages with primary care

- **Standardized service delivery**
  - Inter-professional teams
  - Case management/care coordination
  - Evidence-based guidelines and protocols
  - Single standard of care
  - Outcomes orientation
Successful Integrated Care: Ten Key Ingredients (cont’d)

- Physician integration:
  - Active involvement of PCPs/Geriatricians

- Organizational design:
  - Structure which promotes collaboration at all levels
  - Strong, focused, varied governance
  - Shared vision and leadership
  - Cohesive culture
  - Effective communications
Successful Integrated Care: Ten Key Principles (cont’d)

- Financial levers and incentives:
  - Integrated budgets (various models)
  - Aligned incentives

- Infrastructure support:
  - Common clinical decision support tools
  - Integrated information system to collect, track and report activities
  - Continuous quality improvement (CQI)
Successful Integrated Care: Ten Key Principles (cont’d)

- Innovation:
  - New professional/institutional roles, care frameworks, and services
    - Boundary-spanning professionals

- Time and resources:
  - Results over the long-run
  - Sufficient funding for sustainable change
  - Constant fine-tuning

Source: Kodner, 2010; Kodner, 2009; Suter et al, 2009; Williams et al, 2009
Successful Integrated Care: Ten Important Lessons

Developing successful integrated care organizations and systems—in LTC and other fields—is enormously challenging. International evidence from a wide range of projects provides useful practical guidance on the integration of health and care services for the frail older population:

- The objectives of integration should made be explicit
- Approach integration in a broad, holistic and systematic way
- Forget about ‘one size fits all’ solutions
- Integrated care interventions should be carefully targeted—targeting, targeting, targeting
Successful Integrated Care: Ten Important Lessons (cont’d)

- Improvements on the frontline should come before organizational integration—‘bottom-up’; not ‘top-down’

- Build consumer/provider “buy-in” and support as early as possible; don’t stop

- Consider local and cultural challenges

- Structure the right incentives

- Don’t assume economies of scale and scope—at least initially; it costs before it pays

- Be patient; it takes time to achieve positive results.

Source: Kodner, 2010; Fullop et al., 2005
An Integrated Long Term Care System: Core Elements

An integrated LTC system should have the following core elements:

- Aligned financing and incentives
- Consumer-directed philosophy and choice
- One or more strategically located access points with outreach capabilities
- Comprehensive, standardised assessment
- Comprehensive range of home, community and institutional services
An Integrated Long Term Care System: Core Elements (cont’d)

- Organised “continuum of care”
- Focus on home and community support options
- Effective links with primary care
- Transitional care arrangements with hospitals/LTC homes
- Availability of mental health services and supportive housing
- Inter-professional team care
An Integrated Long Term Care System: Core Elements (cont’d)

- Case management/care coordination
- Active caregiver support
- Integrated information system—with access to single electronic record
- Continuing education and training
- Support for innovation, feedback and adaptation
- Applied research and evaluation capacity.

Source: Kodner, 2004
The Many Enemies of Integrated Long Term Care

As if the successful achievement of integrated LTC is not difficult enough, the enterprise also confronts many enemies:

- Inertia
- Addiction to ad hoc, piecemeal ‘fixes’
- Overpowering medical/acute care paradigm
- Provider centricity
- Supply-driven mentality: ‘feed the monkey’
The Many Enemies of Integrated Long Term Care (cont’d)

- Power imbalance
- Inadequate resources—funding, services, and people
- Unwillingness to surrender autonomy: sectoral, organizational, and professional
- Poorly meshed professional cultures
- Misaligned incentives
The Many Enemies of Integrated Long Term Care (cont’d)

- Lack of stakeholder trust
- Weak commitment and leadership
- Poor communication
- Intra-/inter-organizational friction
- Unreasonable time expectations.

Source: Kodner, 2009