Providing Integrated Care and Support for Persons with Ongoing Care Needs: Policy, Evidence, and Models of Care

Ideas to Action
Integrating Community Support Services within Regionalized Models: Innovations and Best Practices from Across Canada

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October 23, 2006

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Introduction

Introduction

- Focus of the day
  - Examine broader policy picture on home and residential long term care.
  - Look at evidence about the cost-effectiveness of home and community based care and support services.
  - Consider leading national and international models of integrated care delivery systems for persons with ongoing care needs, and the role of supportive care in these models.
  - Provide input to the development of care services to Ontario and its Local Health Integration Networks (LHINs).

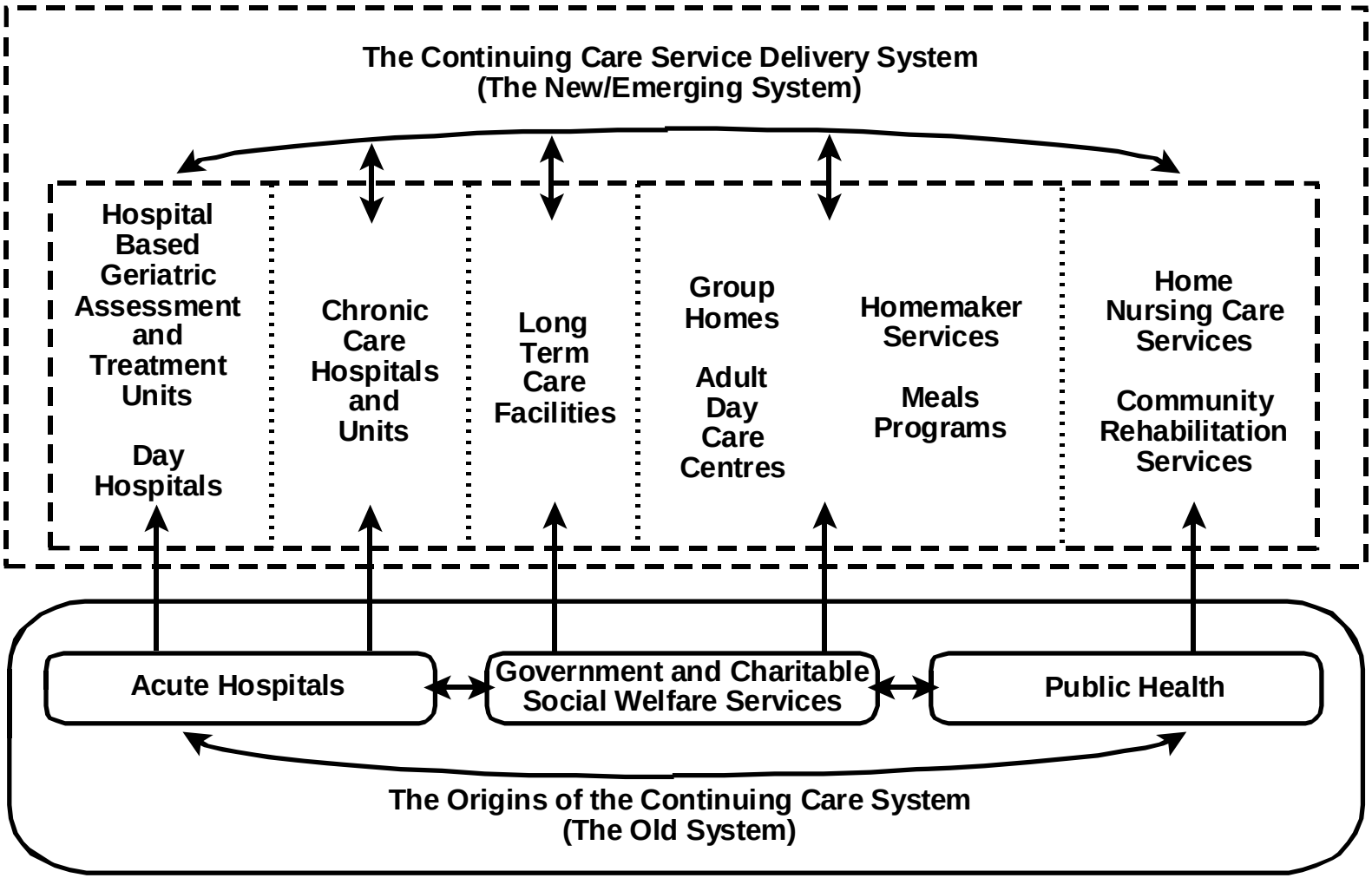
Terminology

I shall be speaking today about coordinated/integrated models of care for persons with ongoing care needs such as the elderly and persons with disabilities. There are many terms which are used to describe such models. In order to cover the broader concept of such care models I shall use the term “continuing care”. This is a term which has often been used in Western and Atlantic Canada to describe integrated models of care delivery for the elderly and persons with disabilities.

So What is Continuing Care?

- Continuing Care is a vertically and horizontally integrated system of service delivery with a broad community base for people with functional disabilities and chronic illnesses. It includes assessment and case management, home care (including short term hospital replacement home care), home support, palliative and respite care, long term residential care, geriatric units in hospitals, and other related services. New services are being added over time. The term refers to care continuing over time, and across types of services (e.g., hospital to home care).

The Emergence of the Continuing Care System



Setting the Context

- Coordinated/integrated care delivery systems for persons with ongoing care needs are a good thing.

  - They are good clinically because they allow for well coordinated seamless care for clients across a wide range of services from Meals on Wheels to specialized geriatric assessment and treatment centres in hospitals.

  - They are good from a policy perspective because policies can be made at the broader systems level, across all care services in the system, to the benefit of the client.

Setting the Context (cont'd)

- They are good economically because such systems allow for trade offs between, for example, less costly home care and more expensive residential care or acute care. Such efficiencies can increase value-for-money within the continuing care system, and within the broader health care system.

- They are good because, if done well, it is possible simultaneously to both reduce costs (or increase efficiencies) and to provide better care to clients.

Setting the Context (cont'd)

- Home support services are an integral part of such systems and, in fact, it is home support which provides many of the efficiencies which can be achieved in such systems.

- While there are many benefits to continuing care we appear, unfortunately, to have moved away from this approach since the mid-1990s. In my view this is regrettable, given the potential benefits of such an approach.

Setting the Context (cont'd)

- Given my experience as a senior continuing care administrator, and as a researcher, it remains my view that the most effective approach is to recognize continuing care (care for persons with ongoing care needs) as a major component of the health care system along with acute care, primary care, public/preventive/population health, and drugs.

Setting the Context (cont'd)

- It is also my view that we need much greater dialogue and study about the relative strengths and weaknesses of different approaches to organizing our overall health care system, and what approaches are most likely to best meet the needs of persons with ongoing care needs.

- Given the importance of this topic we have brought together today a range of speakers who will talk about leading edge integrated models of care delivery, their relative benefits, and the role played by home support services in these models.

Today's Presentations

- The province of Québec has recently also adopted regional care networks as a way to organize their health services. Today we shall present two models from Québec which are based in a broader province-wide primary health care system using regional networks. As such, these models may be of particular relevance to Ontario's LHIN's.

Today's Presentations (cont'd)

- The PRISMA model provides an example of a care delivery system based on the voluntary coordination of its component organizations, and has a shared clinical record across all its component organizations.

- The SIPA model is one which provides more intensive, multidisciplinary geriatric care at the same cost as regular home care, providing a much bigger care delivery bang for the same buck.

Today's Presentations (cont'd)

- We shall present a model of a national continuing care system operated by Veterans Affairs Canada which focuses on one of Canada' s national home care programs (yes, we already have two national home care programs, one for veterans and one for First Nations and Inuit).

- We shall also hear about new developments in Nova Scotia which has a provincial care model, and one of the leading examples of a care delivery model operating at the Regional Health Authority level in Vancouver, BC.

Today's Presentations (cont'd)

- The Vancouver model is particularly relevant because senior management has made a "leap of faith" that enhanced home care and home support will increase overall value-for-money in the health authority, and it appears that significant efficiencies have been achieved. This example is of particular relevance to senior decision makers who may believe that home care can be a good investment but have not yet been willing to make the same leap of faith to invest in home care.

Today's Presentations (cont'd)

- In terms of the international context we shall cover models from Denmark, Germany and Great Britain. The German model is particularly interesting as they have a system in which individuals can receive funds directly to purchase their own services. This appears to have resulted in significant savings.

- We shall also discuss a conceptual, best practices model for organizing integrated systems of care delivery which builds on the traditions in Western Canada.

Overview of this Presentation

- The major components of my presentation today are as follows:
  - Setting the Policy Context
  - Overview of Key Policy Choices
  - The Cost-Effectiveness of Continuing Care Services
  - Issues Regarding the Structure and Function of Complex Care Delivery Systems
  - A Best Practices Model for Organizing Services for Persons with Ongoing Care Needs
  - Concluding Comments and Key Messages

Setting the Policy Context

A Short History of Continuing Care in Canada

The Early Years

- Before the mid-1970s: Services were splintered across ministries of health and social services.

- Mid-1970s to Mid-1980s: Emergence of the Continuing Care Model and Province-Wide Continuing Care Systems.

A Short History of Continuing Care in Canada (cont'd)

- Mid-1980s to mid-1990s: Consolidation of the model. In the early 1990s some 7 of our 10 provinces had, at various points in time, one person responsible for a provincial service delivery system. There was also a Federal/Provincial/Territorial Sub-Committee on Continuing Care which functioned from the mid-1980s to the early 1990s.

A Short History of Continuing Care in Canada (cont'd)

The Current Situation

- Continuing care does not seem to be recognized as a major pillar of the Canadian Health Care System by policy makers.

- There now seems to be a policy focus on professional health care services in regard to home care, and a shift to re-define supportive non-professional services out of the health care system.

A Short History of Continuing Care in Canada (cont'd)

- There seems to be little, national policy focus on broader systems of integrated care delivery which focus on the actual needs of people for the longer term.

- It also does not appear to be understood is that if continuing care, in fact, were to constitute a major component of our health care system, it would represent the third largest cost, in terms of public expenditures, after hospitals and physician services.

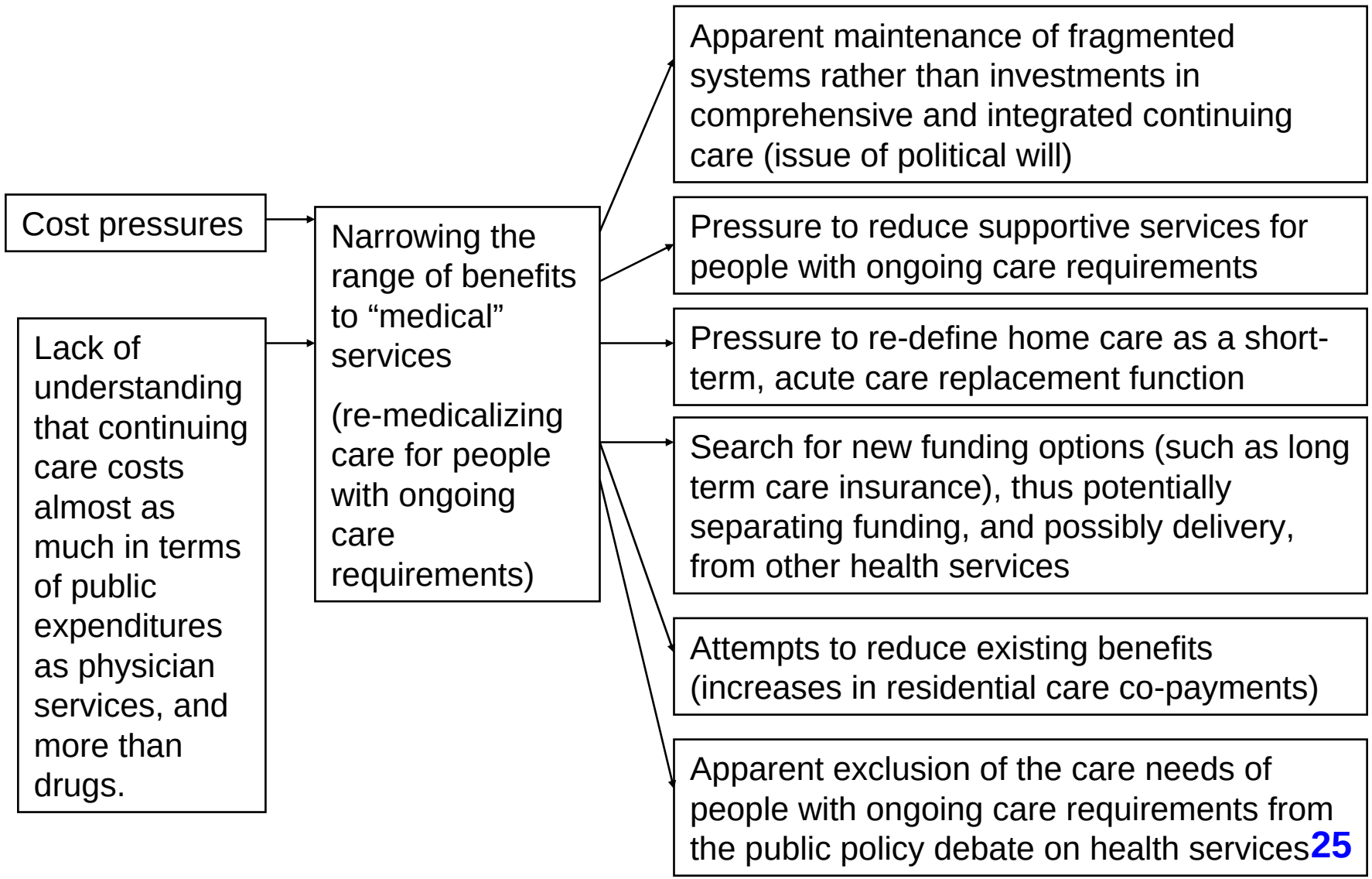
A Short History of Continuing Care in Canada (cont'd)

Emerging Trends

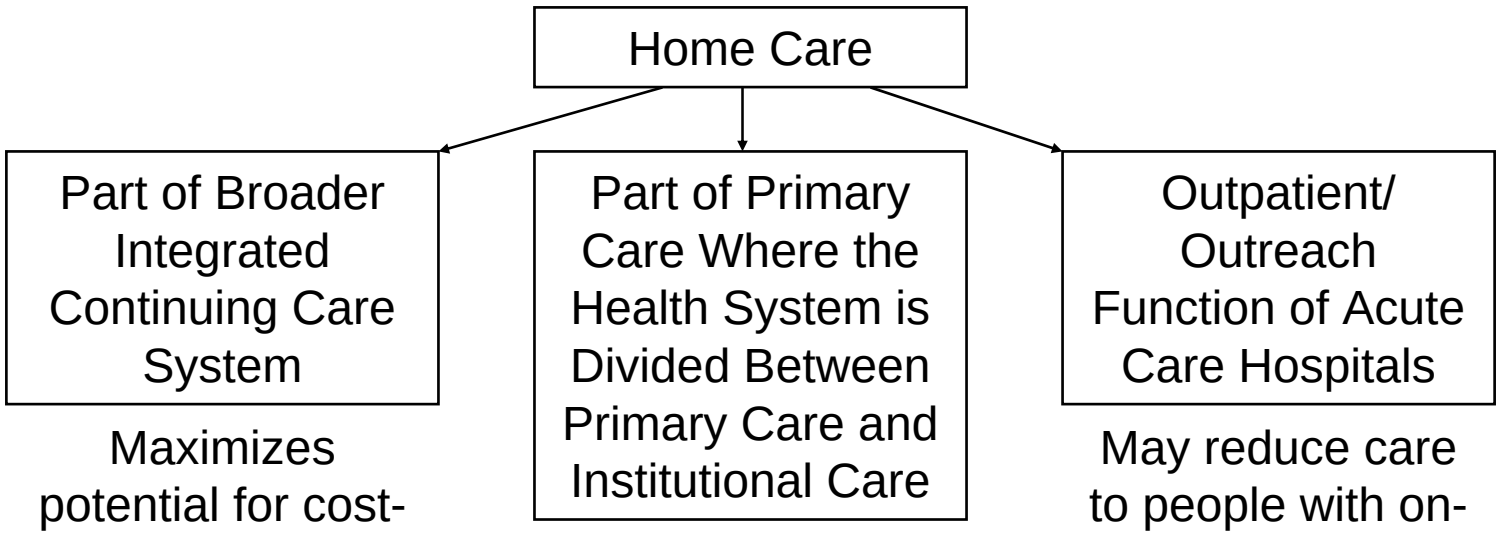
- Many provincial governments are conducting reviews of how to move forward in a positive manner in regard to delivering services over the long term for persons with ongoing care needs.
- The broader continuing care sector, through a variety of efforts including meetings such as this, continues to push for a recognition of the importance of providing long term continuing care services, and the importance of home support services.
- New and innovative models are emerging.

Overview of Key Policy Choices

Current Canadian Trends in Policy for Persons With Ongoing Health Needs



Options for the Future of Home Care



The Cost-Effectiveness of Continuing Care Services

Summary of Evidence From Recent Canadian and International Research

- Most of the home care provided as a substitute for residential care is supportive services.
- Home support can be a cost-effective way to maintain people's independence.
- Home support can prevent admission to hospitals and long term care facilities.
- Integrated systems of care delivery appear to make possible cost-effective substitutions of home care for residential care and acute care.

Comparative Cost Analysis - 1996/97 Cohort in 1996/97 Dollars

	Average Cost	
Level of Care	**Community ($)**	**Facility ($)**
IC1	**9,624**	**25,742**
IC2	**16,315**	**31,907**
IC3	**24,560**	**40,324**
Extended Care	**34,859**	**44,233**

Source: Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services.* Victoria, British Columbia: National Evaluation of the Cost-Effectiveness of Home Care.

Comparative Cost Analysis in 2000/2001 Dollars Including Out-of-Pocket Expenses and Caregiver Time Valued at Replacement Wages

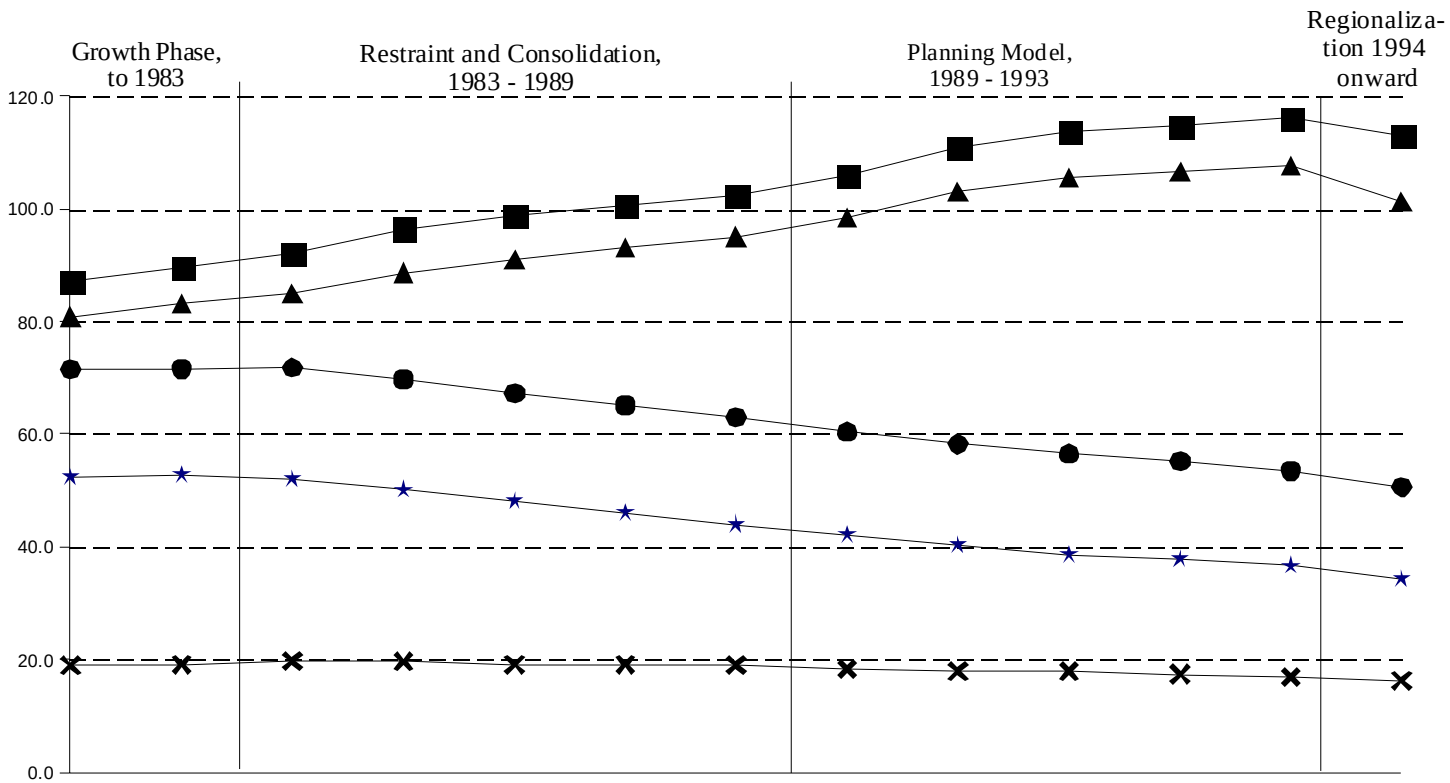
Level of Care	Victoria		Winnipeg	
	Community ($)	Facility ($)	Community ($)	Facility ($)
Level A: Somewhat Independent	19,759	39,255	N/A	N/A
Level B: Slightly Independent	30,975	45,964	27,313	47,618
Level C: Slightly Dependent	31,848	53,848	29,094	49,207
Level D: Somewhat Dependent	58,619	66,310	32,275	45,637
Level E: Largely Dependent	N/A	N/A	35,114	50,560

Source: Hollander, M.J., Chappell, N.L., Havens, B., McWilliam, C., & Miller, J.A. (2002). *Substudy 5: Study of the Costs and Outcomes of Home Care and Residential Long term Care Services*. Victoria, British Columbia: National Evaluation of the Cost-Effectiveness of Home Care.

Even If Home Care Is Cost-Effective, Is There Any Evidence That Savings Can Be Obtained In The Real World?

Yes, this was demonstrated by the BC Planning and Resource Allocation Model developed in 1989. There was a significant shift of clientele from residential care to home care, while the overall utilization rate remained relatively constant.

Major Phases In The Utilization Of Home Care & Residential Care



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
❺ Community	87.2	89.5	92	96.5	98.7	100.7	102.4	105.8	110.8	113.8	114.8	116.2	113
❿ Homemakers	80.9	83.1	84.9	88.7	90.9	93.3	95.1	98.4	103	105.5	106.5	107.6	101.2
❸ Residential	71.5	71.6	71.7	69.7	67.2	65.1	63	60.4	58.2	56.5	55.2	53.5	50.7
♓ LTC Facilities	52.5	52.7	52	50.1	48.1	46.1	44	42.1	40.3	38.6	37.8	36.7	34.4
♦ EC Hospital	18.9	19.1	19.7	19.6	19.1	19.1	19	18.3	17.9	17.9	17.4	16.9	16.3

Utilization rates per 1,000 population aged 65 and over by fiscal year and type of care.
Fiscal year 1983 is for the period April 1, 1982 to March 31, 1983.

Source: Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services.* Victoria, British Columbia: National Evaluation of the Cost-Effectiveness of Home Care.

A Cost Breakdown for 1996/97 Intermediate Care 3 Clients: Home Support Costs in Context

Type of Service	1996/7 Cohort	
	$	%
Physician Services	1,367.00	5.6
Hospital Services	7,936.00	32.3
Professional Home Care	773.00	3.1
Home Support	11,988.00	48.8
Other	2,498.00	10.2
Total	24,560.00	100

Source: Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services.* Victoria, British Columbia: National Evaluation of the Cost-Effectiveness of Home Care.

- Home support has constituted over 90% of the costs of home based care in British Columbia.
- A pilot study from Veterans Affairs Canada also shows that home support can be an effective substitute for residential care.

Cost-Effectiveness of the Maintenance and Preventive Function of Home Care

- In the fall of 1994 a policy was put into place in British Columbia to cut Personal Care clients (those with the lowest care needs) from service, for clients who only received house cleaning.
- Most cuts were made in the first half of 1995.
- Different patterns of response by Health Units (HUs) to the policy.
- Some HUs did not cut services, some cut moderately and some cut severely.

Comparative Costs

Per Person Average Costs of Care Before and After Cuts for Health Regions With and Without Cuts

		Period			
		Year Prior to Cuts	First Year After Cuts	Second Year After Cuts	Third Year After Cuts
All Costs	Cuts	5,051.84	6,682.77	9,654.22	11,903.38
	No Cuts	4,535.02	5,963.10	6,771.45	7,807.96

Source: Hollander, M.J. (2001). *Evaluation of the Maintenance and Preventive Model of Home Care.* Victoria: Hollander Analytical Services Ltd.

International Findings

- Weissert, Lesnick, Musliner, and Foley in a 1997 American paper found that integrated systems with system wide case management, home care, residential care, and capitation funding, were more cost-effective (fewer admissions to long term care facilities) than regular, less integrated approaches.

  [**Source:** Weissert, W. G., Lesnick, T., Musliner, M., & Foley, K. A. (1997). Cost savings from home and community-based services: Arizona's capitated Medicaid long term care program. *Journal of Health Politics, Policy & Law, 22* (6), 1329-1357.]

- Scuvee-Moreau, Kurz, Dresse, and the NADES group in a 2002 Belgian study found that home care costs much less than residential care for dementia patients.

  [**Source:** Scuvee-Moreau, J., Kurz, X., Dresse, A., & National Dementia Economic Study Group. (2002). The economic impact of dementia in Belgium: Results of the National Dementia Economic Study (NADES). *Acta Neurologica Belgica, 102* (3), 104-113.]

International Findings (cont'd)

- Stuart and Weinrich in a 2001 study comparing Denmark (which has an integrated model of care and a strong reliance on home and community services) and the United States, found that from 1985 to 1997 per capita expenditures on continuing care for seniors increased by 8% in Denmark and 67% in the United States. Many of the efficiencies were achieved by increasing home care and reducing facility beds.

  [**Source:** Stuart, M., & Weinrich, M. (2001). Home- and community-based long-term care: Lessons from Denmark. *Gerontologist, 41* (4), 474-480.]

International Findings (cont'd)

- Landi et al, in two Italian studies (1999 and 2001), showed that an integrated home care program reduced the rate of hospitalizations, the number of hospital days, and costs, in a before and after study.

  [**Source:** Landi, F., Gambassi, G., Pola, R., Tabaccanti, S., Cavinato, T., Carbonin, P. U. et al. (1999). Impact of integrated home care services on hospital use. *Journal of the American Geriatrics Society, 47* (12), 1430-1434.; Landi, F., Onder, G., Russo, A., Tabaccanti, S., Rollo, R., Federici, S. et al. (2001). A new model of integrated home care for the elderly: Impact on hospital use. *Journal of Clinical Epidemiology, 54* (9), 968-970.]

- For more in-depth information on the cost-effectiveness of continuing care services see the literature review on this topic prepared for Veterans Affairs Canada at www.hollanderanalytical.com

The Conundrum

- It is not self evident that home support services such as cleaning, meal preparation, basic hands on care and other such services are health services and that they can actually substitute for residential and acute care services.

The Conundrum (cont.)

- People with ongoing care needs due to functional deficits clearly have “health” problems and require “medically necessary” care. However, the “medically necessary” care services they require to maximize independence and minimize their rate of deterioration are, in large part, non-professional home support services. This does not seem to be recognized in the current policy debate.

The Conundrum (cont.)

- It is, in fact, the integration of medical, health, supportive, community and residential/institutional care into one system that is the essence of the continuing care model and is why it is such a good fit to the actual needs of people with ongoing care needs.

Issues Regarding the Structure and Function of Complex Care Delivery Systems

Key Issues

- In order to have an efficient and effective organization one has to have specialization and differentiation of function, lines of authority and accountability, and formal and informal coordination mechanisms within the system, and across other systems. This will apply to the LHINs and to any integrated model of care delivery which may be adopted.

Key Issues and Questions for Structuring Integrated Systems

- When one is considering different care delivery systems one may wish to consider the following questions:
  - For what group(s) was the care delivery system developed?
  - Is the system an appropriate response to the needs of these groups?
  - What organizational entity is in charge of the system, and is this appropriate?
  - What authority do system leaders have to make policy and program decisions about the system, and its component parts?

Key Issues and Questions for Structuring Integrated Systems (cont.)

- What is the nature of the authority, is it line authority, coordination, authority through the purchase of services, or some other form of authority?
- How are services coordinated, within the system of care, and across other components of the health care system?
- How are services funded and reimbursed, is there a budget model, capitation, etc.?
- What kind of information is collected and is it useful for the overall system, or just for components of the system?
- What are the basic principles which were used to form the system and which underlie its operations?

Key Issues and Questions for Structuring Integrated Systems (cont.)

- If these questions can not be answered clearly, for new or existing systems of care delivery, or if the answers do not seem to be reasonable, then there is an increased probability that the system may not be optimally effective and/or may not be sustainable over the longer term.

A Best Practices Model for Organizing Services for Persons with Ongoing Care Needs

Source: Hollander, M.J. and Prince, M.J. (2002). *Final Report: "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.* Victoria: Hollander Analytical Services Ltd.

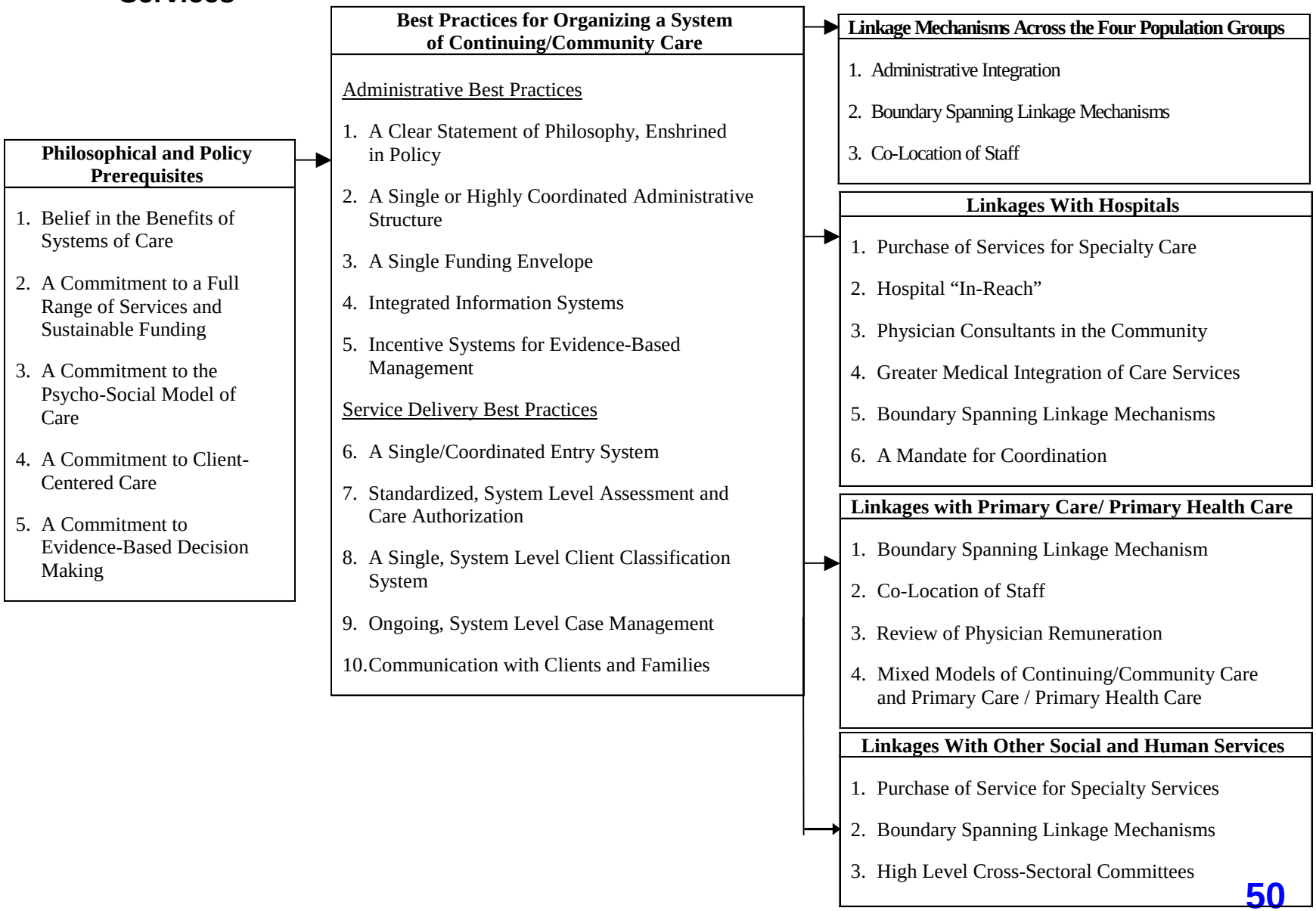
Framework for Organizing Care Delivery for Persons with Ongoing Care Requirements

- Conducted national studies on service delivery systems for:
  - The Elderly
  - Persons with Disabilities
  - Persons Requiring Mental Health Services
  - Children with Special Needs
- Also conducted survey of leading Canadian experts on the topic of integrated care systems.

Findings

- Service delivery systems are still fragmented and have gaps.
- Similar services required by all four population groups.
- Numerous impediments to coordinated care identified.
- Thus, developed a best practices model for organizing service delivery systems for persons with ongoing care requirements.

Figure 1: A Best Practices Framework for Organizing Systems of Continuing/Community Care Services



Philosophical and Policy Prerequisites

1. Belief in the Benefits of Systems of Care
2. A Commitment to a Full Range of Services and Sustainable Funding
3. A Commitment to the Psycho-Social Model of Care
4. A Commitment to Client-Centered Care
5. A Commitment to Evidence-Based Decision Making

Administrative Best Practices

1. A Clear Statement of Philosophy, Enshrined in Policy
2. A Single or Highly Coordinated Administrative Structure
3. A Single Funding Envelope
4. Integrated Information Systems
5. Incentive Systems for Evidence-Based Management

Service Delivery Best Practices

6. A Single/Coordinated Entry System
7. Standardized, System Level Assessment and Care Authorization
8. A Single, System Level Client Classification System
9. Ongoing, System Level Case Management
10. Communication with Clients and Families

Linkages with Hospitals

1. Purchase of Services for Specialty Care
2. Hospital “In-Reach”
3. Physician Consultants in Home Care
4. Greater Medical Integration of Care Services (e.g., hospital to home, mental and physical health)
5. Boundary Spanning Linkage Mechanisms
6. A Mandate for Coordination

Linkages with Primary Care/ Primary Health Care

1. Boundary Spanning Linkage Mechanism
2. Co-Location of Staff
3. Review of Physician Remuneration
4. Mixed Models of Continuing/Community Care and Primary Care / Primary Health Care

Figure 2: A Schematic of the Structure of the Continuing/Community Care Service Delivery System

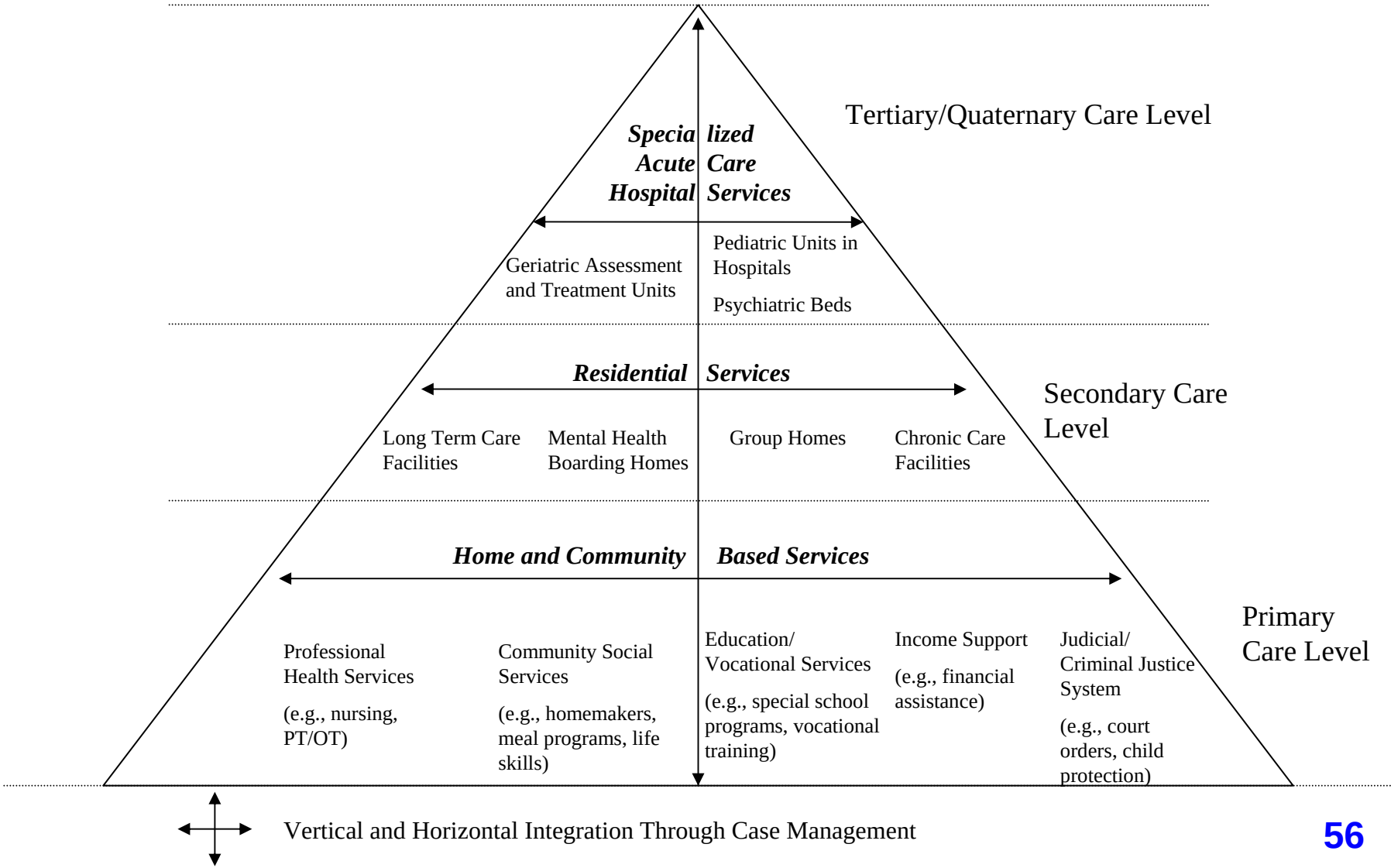
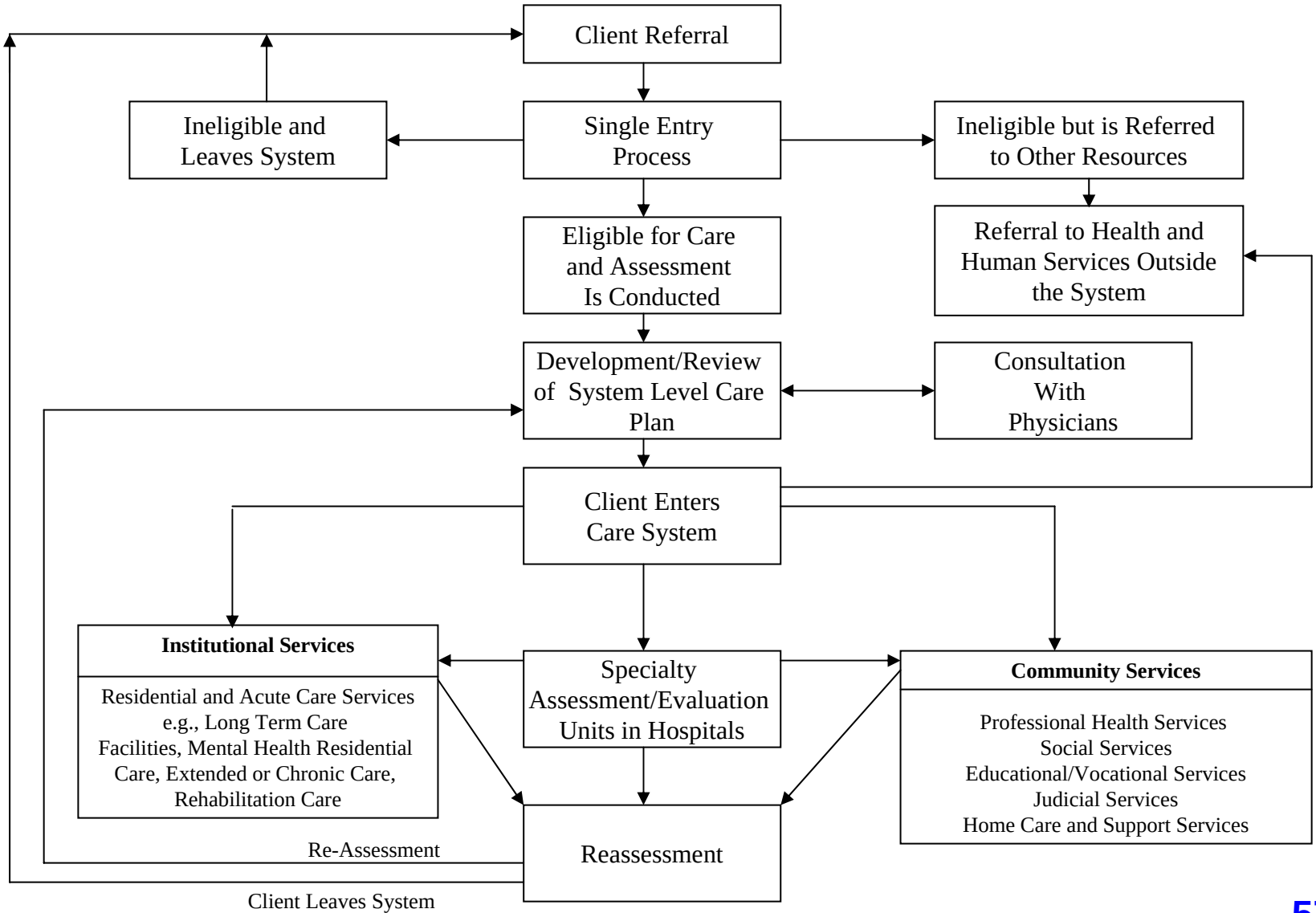


Figure 3: A Schematic of Client Flow Through the System of Care



Concluding Comments and Key Messages

Worst Case Scenario

- Professional home care becomes a hospital outreach function.

- Home support services are excluded from the concept of “health services” and become income and/or asset tested social welfare services, funded by individuals themselves, new taxes or “insurance” schemes.

- This approach would set us back some 30 years.

Best Case Scenario

- Continuing care is recognized by policy makers as a major component of the health care system and is treated accordingly.

- Broad discussion by policy makers, major health organizations, and associations, regarding how to optimize continuing care services.

- The important role of home support services is fully recognized and respected by policy makers.

Key Message Number 1

We need to think in terms of integrated and coordinated systems of care, not just one or two services at a time such as home care or residential care. There is essentially no evidence that fragmented systems provide good care or are cost-effective.

Key Message Number 2

Home support services are health-related services and are critical to keeping people out of more costly hospital care and long term residential care. Even a small amount of support can go a long way. Choosing to adopt a narrow definition of health care will be counterproductive and may well lead to increasing pressures on more costly, institutional services resulting in a negative cost spiral.

Key Message Number 3

There is now mounting and credible evidence to indicate that home care, including home support services, have the potential to be cost-effective and to increase the efficiency and effectiveness not only of the continuing care system, but also, the overall health care system. It is easier to make cost-effective trade-offs in larger, integrated systems of care.

Key Message Number 4

There are now well-developed frameworks for organizing health services for people with ongoing care needs which have the potential to simultaneously improve care and reduce costs. Thus, not having a plan is no longer a viable reason for not dealing with complex problems related to systems of care delivery.

Key Message Number 5

There are real and far-reaching policy choices which must be made. Not making a decision is as much a policy choice as making a decision. More thinking and analysis is required about the relative effectiveness of different models of care delivery, and how to organize the overall health care system. Choices to do something, or do nothing, will be made. It is hoped that the decisions that are made will be wise and informed decisions.

Key Message Number 6

Policy is made by people and can be changed by people. Whether we improve services (the best case scenario) or regress backwards (the worst case scenario) is in the hands of our policy makers.

For more information visit our Web Sites at:

www.homecarestudy.com
www.hollanderanalytical.com