Coordinating care to older people in the home environment
What works and how can we improve care delivery?

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Coordinating Complex Care Needs: What Works?
A Typical Problem of Disintegration

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 to support their ability to self-care and who may have limited abilities in going about their daily life;
  – high risk individuals, for example of admission to hospital or long-term care institution such as a residential care facility or nursing home;
• End-of-life care
• Carer burden and stress
Ten Priorities for Action

1. Active support for self-management
2. Primary prevention
3. Secondary prevention
4. Managing ACS conditions
5. Integrating care for people with mental and physical health needs
6. Care co-ordination - integrated health and social care teams
7. Primary care management of end-of-life care
8. Effective medicines management
9. Managing elective admissions – referral quality
10. Managing emergency admissions – urgent care
Focusing on Quality of Life

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

Full integration
Formally pooling resources, allowing a new organisation to be created alongside development of comprehensive services attuned to the needs of specific patient groups.

Coordination
Operating through existing organisational units so as to coordinate different health services, share clinical information and manage transition of patients between different units (for example chains of care, care networks).

Linkage
Taking place between existing organisational units with a view to referring patients to the right unit at the right time, and facilitating communication between professionals involved in order to promote continuity of care. Responsibilities are clearly aligned to different groups with no cost shifting.

The Rainbow Model Framework

We examined context-dependency in two ways:
- similarity/difference between contexts
- the connections between Framework dimensions (e.g. taking person-centred care as the outcome measure)

Positive scores on clinical integration (i.e. how care is co-ordinated around people’s needs) was the key factor associated with higher scores across the Framework when holding for context
  - *This potentially corroborates other research findings that suggest it is integration at the clinical and service-level that matters most*

Positive scores in person-centred care (as the outcome) was correlated most closely with functional dimensions
  - *This potentially corroborates other research findings that suggest that relational continuity – i.e. how information is shared and the way in which it is shared through good clinical integration – supports better system outcomes*

System-level factors seemed to be negatively associated with achieving person-centred care
  - *This potentially corroborates that a focus on system reform and structures is NOT as important in achieving integrated care outcomes when compared to other aspects such as person-centredness, care co-ordination and functional integration*
Approaches to Implementing Care Coordination to People with Complex Needs in the Home Environment
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 planning,
- To communities with older people – participation, awareness, user groups, volunteers, addressing factors that marginalise at risk communities
- To policy and decision makers – taking a life-course approach that focuses on promoting active and healthy ageing through tailored public health interventions
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
Established integrated care organisation in 2010 combining primary/secondary care with elderly/social care.

Goal is equal access to care across a rural municipality with a focus on prevention and citizen responsibility in own care.

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: Eksote, Finland

Home-based rehabilitation services, with significant use of remote monitoring and health coaching including an ER “in your living room” rapid response service

Nurse-led mobile health units across rural villages. Services include:

- Nurse consultation
- Health counselling
- Regular health checks
- Treating wounds
- Capillary blood work analysis (e.g. glucose)
- Vaccinations and medicines
- Dental care
- Physiotherapy

Impact includes an 88% reduction in need for hospital care; 56% reduction in the need for home-based visits; and a 30% cost reduction to the care system
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: Norrtälje, Sweden

How it works

➢ 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
➢ Intensive home-based case management for older people for better transitions to/from hospital
➢ Moving to a shared care record
➢ Improved care co-ordination and faster access to care in the community

Impact
✓ Reduction in nursing home placements
✓ Lower costs for home care support
✓ Reduced utilization of hospital
✓ Balanced commissioners’ budgets
Case: Norrtaelje, 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 Forvaltningen* 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
Initiatives include:
✓ Falls prevention
✓ Elderly care pathways from the emergency room
✓ Medication management
✓ Nutrition and fresh food in community and in long-term care institutions has improved sleeping & reduces anxiety
✓ Community psychiatry and hubs reduces inpatient care needs
✓ New academic health centre

Positive impacts include:
✓ Reduction in nursing home placements
✓ Lower costs for home care support
✓ Reduced utilization of hospital
✓ Faster access to treatments and shorter elective waits
✓ High patient satisfaction
✓ Balanced health and care budgets
✓ Awards for high quality of care
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
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

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: 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 coordination
- **Prevention and rehabilitation** focus
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

Integrated community-based dementia care: the Geriant model

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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.
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.

http://eprints.hud.ac.uk/20267/1/noble_et_al.pdf
Conclusions
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, and focus on an older person’s personal health and wellbeing.
Introducing the SUSTAIN Roadmap

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