PROVIDING INTEGRATED CARE FOR OLDER PEOPLE WITH COMPLEX NEEDS: LESSONS FROM SEVEN INTERNATIONAL CASE STUDIES

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CONTEXT

People are living longer, increasing the incidence of multiple chronic conditions (MCCs). Older people with MCC increasingly live alone and the availability of informal care by spouses or family members is declining. These trends have resulted in a growing demand for health care services to treat MMCs, as well as services to help individuals cope with everyday activities such as dressing, bathing, shopping, or preparing food. Often, these formal social care services are organised and funded separately from health care or medical services, which can result in fragmented care for people who need both services. A common response is to develop integrated health and social care for older people with complex needs.

OBJECTIVES

This report synthesises evidence from seven case study programmes—from Australia, Canada, the Netherlands, New Zealand, Sweden, the United Kingdom, and the United States—that are successfully delivering integrated health and social care for older people with complex needs. The aim is to identify universal lessons for policy-makers and service providers to help them improve how care is designed and co-ordinated.

METHODS

Care projects that met the following criteria were identified: (1) population-focus on older people with complex needs; (2) process-focus on integrating health and social care; (3) community-based models of care; (4) outcome focus on one or more of: user experience, functional ability, quality or cost; and (5) established models of care (not pilots) covering a defined population/geographic area. Case study programmes were invited to participate in the project. The research team developed a template to summarize programs, and local researchers completed the information using document sources as well as key informant interviews with staff from each programme.

FINDINGS

All seven countries have a publicly funded programme for providing health care to people aged 65 and over, covering primary care and specialist physician services as well as acute care hospitals. However, each case study is taking a different approach to supporting older people with complex health and social care needs. One distinguishing feature of all seven case study models is the presence of a named care-coordinator/manager who takes personal and direct responsibility for supporting service users. Overall, these studies suggest that high-touch, personalised care which engages service users and their informal carers/family members is more important than reliance on high-tech care which relies on shared electronic patient records or telehealth devices. While there are clear advantages to having a unified organisation with a common structure, the evidence suggests that a great deal of time/effort is required to merge organisations, and also appear more vulnerable to top-down interference.

CONCLUSIONS

The findings of these case studies suggest that national policy-makers would do well to do: 1) recognize the importance of addressing this agenda of integrating care for frail older people; (2) provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of people; (3) avoid a top-down policy that requires structural or organisational mergers; and (4) remove barriers that make it more difficult for localities to integrate care, such as differences in financing and eligibility. Named care co-ordinators are integral to ensuring continuity of care and, as a matter of necessity, multidisciplinary teams must work flexibly and communicate effectively with each other. What also seems clear is that these processes are more likely to be supported within integrated systems of care delivery, where care providers are working within common governance and incentive rules, facilitated through closer organisational partnership arrangements.

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