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Integration of service: geriatric

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The quest for the Holy Grail of service integration for the elderly is not new. Although integrated services pilot projects were flourishing during the 80's and 90's (Johri et al. 2003; Williams et al. 2009), the need for the provision of integrated services was already well established in the gerontological literature. According to Tobin (1975), 15% to 25% of people aged 65 and over will eventually require a combination of intensive and comprehensive social and health care services. These findings were to be renewed in the 1990's by Leutz (1994) who highlighted that the elderly will increasingly experience multiple chronic diseases, which should result in the simultaneous need for medical and social services on a short and long-term basis. Both Tobin (1975) and Leutz (1994) agreed on the same analysis of the situation: the multiple services provided to the elderly are ill structured, not available simultaneously and sequentially, lack continuity and integration across settings, while sustaining an inexplicable duplication. The challenge was thus to shift from minimal service delivery to global and flexible services to meet the evolving needs of the population and deliver a continuum of social and health care services bound by a requirement of continuity (Young 1967). These services should be delivered near to where the elderly lives (Gaynes 1993). These recommendations were formulated several years ago, yet they still need to be reminded today (Williams and Sullivan 2010; Hollander and Prince 2002; MacAdams 2009; Ham et al. 2008). Service integration now comes back as the main theme of service planning for frail elders (Leichsenrung et al. 2004). Nevertheless, fragmentation problems remain (Commonwealth of Australia 2010).

Service integration is on every roadmap of the government proposals for the elderly service reform. Marmor (2009) classified the integration movement as one of the fads of the modern management of health care services because, in his opinion, it is impossible to willingly embrace a 'disintegration' policy. Yet, the integration movement is intended to address the fragmentation of services, while privatization of health care financing and delivery and promotion of competition among healthcare providers, impede integration and promote disintegration (Ham 2008a, b).

Combining these contradictory goals, such as integration and competition (Williams and Sullivan 2010), shows the confusion associated with the very concept of integration (Howarth and Haig 2007). This concept is vague and has undefined boundaries, and the practice of integration is a pandemonium (Kodner and Spreeuwenberg 2002). This confusion is manifested through the multiple referents in analysis and comments on service integration (Kodner 2009). For instance, patients, health care providers, executives, and departmental managers have a different view of the concept of integration. There is a plethora of synonyms for integration: coordination, cooperation, managed care, continuity of care, networking. Integration is described (Kodner 2009)

based on its target population (the entire population of a territory, the elderly), its specific type (functional, vocational, clinical (Shortell 2000), its different levels (financial, administrative, clinical), its scope (horizontal and vertical), and its level of integration (patient referrals among health care providers, coordination and full integration).

Under the current state of affairs, there is no real way out of this confusion other than recognizing it on one hand, and choosing the appropriate perspective to minimize it on the other hand. In order to understand the concept of integration, Williams and Sullivan (2009a), as well as Kodner and Spreeuwenberg (2002) suggested favoring the point of view of frail elders, for whom integrated services are necessary. Frailty is the sign, in its advanced stage, of a complex health condition (Fried et al. 2001; Bergman et al. 2007; Rockwood 2005) involving the integration of multiple clinical procedures around the frail person and his/her family and friends. In a fragmented system, each procedure is the sole responsibility of practitioners located in several institutions (Béland 2010). The necessary integration of clinical practices coincides with the decrease of capacity in frail elderly in times when it is most needed. In the frail elderly, diagnosis and treatment are difficult to establish, select and implement in as much as they are adding up to communication problems, late diagnosis of geriatric syndromes, long and laborious processes of clinical data gathering, multiple chronic illnesses with complications of cognitive loss, depression and functional limitations. This entanglement of syndromes, symptoms, as well as of diagnosis and treatment procedures is the center piece of the geriatric approach. The impact of frailty also goes beyond the pure clinical reality. The frail elderly, as well as their family and friends face psychosocial insecurity, and difficulties in adjusting to their social and physical environments. In its most advanced stages, frailty can have drastic consequences on the elderly, their family and friend, and on how they relate to social and health care services. For instance, from the individual's perspective, there is no distinction between health and social services, or between medical treatments and psychosocial support and housekeeping services; one being the result of the other, or consistent with the others. For very frail elders, the distribution of responsibility in care delivery among agencies, organizations, care providers and medical or social specialties is an artefact of the terms and conditions of service organization and funding, as well as of the division of labor between professions. Therefore, service integration is only relevant when it is performed with a focus on the frail elderly.

Making the frail elderly the focus of service integration allows to organize ideas around five kingpins: (1) the condition of frail elderly is better understood as multiple, interlinked paths involving the action of many biological, psychological, and social systems; (2) service integration is not the mere wish of health care providers or policy makers, but rather a necessity for the elderly; (3) integration is not initially implemented around service organizations, but around the elderly and their family members and friends; (4) integration is accomplished through management and consistent clinical practices; (5) funding, organization, and management of services are instruments for service integration.

The best definitions of integration refer to these five points. Leutz's definition (1999) is incomplete, as it focuses on the relationships between the different social and health care

services; Nies and Berman (2004) adds to Leutz's definition the combination of services that it is necessary to meet the needs of individuals with multiple health conditions. Kodner and Spreeuwenberg (2002) stress the need to link all the sectors of social and health care services by aligning financial, administrative, and clinical incentives and modalities. The ultimate definition of service integration should refer to each of these items. Thus:

> Service integration is the process of combining social and health care services in order to meet the needs of the frail elderly, through alignment of financial, administrative, and clinical management incentives and modalities with the clinical practices of the multidisciplinary team in charge of their health and social care.

In practice, integration varies according to the effective implementation of the basic components included in its definition. For instance, the objective of meeting the needs of the frail elderly is operationalized through eligibility criteria selecting elders with frailty profiles and through provision of a range of relevant services. The role of the case manager depends upon his or her capacity to mobilize the resources and support of an entire multidisciplinary team. Mobilizing resources around the need of the frail person and his or her family members and friends is linked to how the financial incentives and administrative system are aligned with the requirements of the case manager and multidisciplinary team's clinical practices. The quality and accuracy of their decision also rely upon the quality of the information gathered on the needs of the frail elders and their history in the health care system. Each local program of service integration selects a way to proceed among many options to rise to the multidimensional challenges of service integration for the frail elderly. The outcome of these choices is a wide range of integration practices. Such being the case, these practices are ultimately responsible for the success of failure of the integrated services.

In recent published literature reviews, systematic or not, pertaining to the assessment of integrated services pilot projects, the broad variety of implementation of the components of service integration were highlighted, as well as their impact on the health of the participants, and on the use and cost of services (Johri et al. 2003; Williams et al. 2009; Hollander and Béland, Eklund and Wilhelmson 2009; Armitage 2009). Despite the variety of structures and practices, only some of them are associated with success of integrated services projects. They,are worthy of mention. They will be illustrated through selected case examples.

Integration through Practice

Local integrated services programs adjust to and modify the environment in which they are implemented and the features of the population they serve. They define specific objectives, operate according to available funds, and are aligned with the social and health care systems in which they are operated (Wiliams et al. 2010). In fact, integrated services programs focus on a subset of components of integration and embrace a diversity of procedures, tools, and savoir-faire. If some integrated services programs can be

considered as examplars or paradigms of integration, some others put the emphasis on clinical coordination without seeking to change financial and organizational modalities and incentives. Other programs select the high end of users of expensive health and social services among the frail elderly. Finally, government authorities can modify the organizational and financial configuration of social and health care services in order to facilitate integrated management and clinical practices.

Examples of local integrated programs

On Lok (Bodenheimer, 1999; Yee, 1981) is one of the very first program of integrated care for frail elderly persons. It is consider as an exemplars of integrated service models encompassing all the features associated with a successful implementation of such models. The core of *On Lok* is a daycare center accommodating elderly persons eligible for nursing home placement in the Chinese district of the San Francisco Bay area. Each person is assigned to a case manager who is responsible for implementing and monitoring the clinical intervention plan. At the day care center, a multidisciplinary team manages the intervention plan. Admitted frail ederly persons must choose their family physician among the physicians of *On Lok*. *On Lok* is funded through capitation and all the social and health care services that the person needs are covered. Therefore, *On Lok*'s responsibility is both clinical and financial. *On Lok* is the single-entry point for access to all social and health care services for registered elderly persons. *On Lok*'s program assessment showed that the participants receive more community-based services, are less likely to be admitted to nursing homess, and have lower costs of services than non-participants frail elderly persons (Yordi et Waldman 1985).

On Lok is at the root the PACE program – Program for All-Inclusive Care for the Elderly – (Eng et al., 1997; Kodner and Kyriacou 2000; Mui, 2001; Li et al. 2009; Hirth et al 2009), which ran, from 1986 to 1997, as a demonstration project. In 1997, PACE became an as-of-right program in the United States. The assessment of PACE showed that the participants' expenses related to social and health care services were from 5% to 15% lower than those of the control group, which was formed by individuals who refused to participate in PACE despite their eligibility (Chatterji et al., 1998; Shannon and Van Reenen, 1998; Wieland et al., 2000, Wieland and Boland, 2001; Williamson, 2000). Disability levels were lower in participants compared to the control group in the most performing PACE teams (Mukamel et al., 2007). PACE outcomes in terms of costs were not replicated in a recent study (Kane et al., 2006).

Several programs in the United States or other high-income countries have tried to emulate *On Lok* and PACE. These programs borrowed several clinical, organizational, and financial features from PACE, notably the CHOICE program in Alberta and the SIPA pilot project in Québec, as well as the Illawara model in Australian. CHOICE has not been formally assessed (Pinnell, Beaulne Associated 1998). The Illawara program (Perkins et al. 2001) was meant to be an ambitious experimental project of integrating services for the frail elderly. Funding for all social and health care required by this population was given to an agency. Case management by the family physician and multidisciplinary team were implemented. The Illawara program ran into serious recruitment problems, as only 13% of the eligible individuals had multiple health

conditions. Consequently, the program costs were higher than those of the control group, and differences between both groups' health status were not statistically significant.

The SIPA (Système intégré pour personnes âgées - Integrated System for Frail Elderly Persons) is a version of the PACE adapted for Quebec's Medicare (Béland et al. 2006). The core of SIPA is a multidisciplinary team and a case manager responsible for delivering and funding all social and health care required by the frail elderly population on a given territory. Local SIPAs deliver social and health care services and call upon additional providers or institutions to provide for the other services, such as hospitalization, health centers, medical care and pharmaceutical prescriptions. The SIPA, though run from local health and social care agencies, had its own management team and was financially autonomous. In two territories of the Montreal area, the SIPA experience has successfully helped in reducing long-term admissions in short-term care hospitals, which was a significant problem in the area covered by SIPA at that time. Above all, there was a significant transfer of use and costs of outpatient services and nursing homes to community-based services. This transfer was more important for the very frail elderly than the less-disabled individuals.

Integration through clinical coordination and cooperation between organizations

On Lok, PACE, and SIPA integrate all social and health care services required by the frail elderly on a given territory. Like the SIPA, *On Lok* and PACE are run by organizations with managerial and financial autonomy. Some programs seem to be less ambitious in their quest for service integration. They do not have autonomous administrative units or any control over their funding. They are often associated with institutions or sponsoring agencies and their role is to ensure the cooperation of agencies in patient referral and coordination of providers in the implementing care plans.

Social and Health Maintenance Organizations (S/HMO) may be considered in this perspective (Newcomer et al. 1990; Harrington and Newcomer 1991; Leutz et al. 1991; Manton et al. 1993). S/HMOs add the provision of long-term care services to the usual medical and hospital services they deliver. Thus, they are characterized by the integration of short and long-term services without implementation of a geriatric model in the organization of the provision of care (Kane et al., 1997). However, program evaluation outcomes were generally disappointing (Harrington and Newcomer, 1991), even though some authors have concluded positively on the capacity of S/HMOs to reach their goals (Leutz et al. 2005). In their initial implementation, S/HMOs did not successfully embrace a geriatric perspective, which could explain the disappointing results (Kane et coll. 1997). A second version, S/HMO II, did integrate a geriatric perspective.

Implemented in Québec, PRISMA is a coordination-type integrated service delivery model that does not involve any transfer of financial resources or implementation of a agencies (Hébert et al. 2010). Local PRISMAs are issued from institutions and agencies. PRISMA is organized around case managers that ensure the coordination of services already available in local institutions and agencies. They develop care plans and negotiate their implementation with the institutions and agencies. PRISMA provides a range of

management tools for treatment plans. Assessment of the quasi-experimental design of PRISMA showed that it did not significantly reduce the number of hospital admissions and placement in health centers, but decreased the disability rate.

Some pilot projects meant to integrate services delivered by geriatric outpatient clinics located in hospitals and local services. This approach is more clinical than administrative or financial in nature. The most typical cases are Rovereto (Bernabei et al., 1998) and Vittorio Veneto's experiences (Landi et al., 1999) in Italy. The main goal of both experiences was to promote the geriatric approach by using the geriatric clinical services available in institutional settings. In addition, they provide case management, integrate family physicians to the follow-up process, and ensure proper funding for the additional services required by the frail elderly, along with needs assessment forms and care plans. Interesting outcomes were achieved as the number of placement in nursing homes and hospital admissions decreased, as well as the total cost of health care services. Moreover, the satisfaction rate towards services significantly increased. The Italian experiences are also known to have significantly reduced the risk of functional disability. These successful experiences seem to be based on the close collaboration between case managers, geriatric assessment units, and family physicians. These three components, along with the multidisciplinary team, are also present in the *On Lok* and PACE programs, as well as in integrated services pilot projects for the frail elderly that have been able to demonstrate some positive outcomes.

Integration for high users of health care services

Frail elderly inpatients present a high risk of hospitalization, of readmission to hospital or placement in nursing homes. One of the first integrated services pilot projects was implemented in Darlington, United Kingdom. This project was specifically designed for frail elderly inpatients at discharge (Challis 1991a,b). The pilot project provided the services of a case manager who, supported by a multidisciplinary team controlling its own funding, had the mandate to keep this population at home. Costs of services were generally lower than in the control group, and the institutionalization rate and functional disability decreased.

The high-intensity case management model (Applebaum et al. 2002) uses case management without financial incentives to improve and coordinate service delivery to the frail elderly following hospitalization. Like most of the interventions based on case management, this model reduced neither costs nor disability rates. In Hong Kong (Leung et al. 2004), an experimental design was used to assess an integrated services experiment for elderly persons who were recently hospitalized. Case management was integrated to plans for treatment, follow-up, home visit, and support to family caregivers. As a result, the number of readmissions to hospital decreased and costs were lower than in the control group who received the usual care. Improvements in health status were also observed.

State intervention in structuring projects

The government authorities responsible for social and health care services for frail elderly persons have promoted policies toward integration of care. Governments are rarely involved in the design of policies on the relationship between patients and service

providers in the clinical setting (Ballem 2007). However, they retained two means of reforming services that are under their jurisdiction: (1) structural changes, and (2) modifications of the financial incentives. Thus, the influence of government bodies is usually indirect on service providers' clinical practices, as well as on the management policies (Kodner 2006). They develop the foundations on which integration practices are built, and then implemented or forgotten (Williams et al. 2009). However, service integration for the frail elderly should bring significant changes in management and clinical practices. Two positive governmental interventions went beyond purely structural reforms and are worthy of mention, that is the intervention of British Columbia's government, a Canadian province (Hollander and Pallan 1995), as well as the Arizona Long Term Care System (ALTCS) (Weissert et al. 1997). In both cases, government bodies empowered local or regional organizations, used specific budget allowances and financial incentives to promote service integration. A model of services delivery based on case management and multidisciplinary, the goal of which was to keep the frail elderly at home through delivery of community-based services, was the backbone of the program. Management tools, such as a case classification system based on a scale of needs, allowed to classify cases into homogenous groups, and to provide for a service plan. On one hand, both these interventions detailed the program's organizational and financial structure, eligibility criteria, as well as critical items of the interventions for admitted frail elderly persons. On the other hand, they both would let autonomous community-based organizations care for the daily management of the program. In the end, they were both successful in reducing costs and redirect frail elderly persons towards communtiy-based services, keeping them away from nursing homes.

Which kind of integration?

Successful programs for service integration align financial, organizational and management policies on the requirements for running integrated clinical practices. For example, successful large scale governmental initiatives from British Columbia and Arizona focused on community-based clinical practices, while entertaining structural reforms. They departed from departmental authorities acquaintance with a strict focus on structural reforms.

Hollander and Béland (2007) identified a set of features of integrated service programs for the frail elderly that seems to be associated with their clinical and financial success. These features refer to components of the definition of integration introduced earlier in this paper. First, success is due to the development of eligibility criteria and case classification systems that allow the recruitment of individuals in need of integrated services. The Illawara experience (Perkins et al. 2001) is a convincing counter example. Second, a single-entry point facilitates the access to the entire range of services. Third, case managers and multidisciplinary teams ensure together the integration of family physicians and other health care and social service professionals in the process. Similarly, the clinical responsibility of case managers is extended to hospitals and health centers. Fourth, clinical practices are based on treatment and follow-up plans under the supervision of case managers and multidisciplinary teams. The progression of the frail elderly through different institutions and follow-up of the diagnostic and therapeutic activities are available in real time. In addition, clinical data management systems are

needed to adjust treatment plans to changes observed in the status of the elderly. Finally, a single budget allowance supervised by a community-based organization responsible for the integration of care allows case managers to mobilize resources according to the evolving needs of the elderly. Management terms and conditions should also enable case managers, supported by multidisciplinary teams, to fulfill their role respecting their professional autonomy.

One feature associated with the success of integrated services remained implied in this paper, that is a point of view on the delivery of integrated services shared by members of the multidisciplinary team, and a common understanding of the frailty processes and vulnerability status of elderly persons in need of integrated care and of the ways and means to meet their needs, as well as those of their family and friends.

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