Integrated Care for Older People

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Key Messages

- To face the increasing demands of healthcare by the growing number of older adults, segmented care system has to be replaced by person-centred and integrated care.
- This includes a comprehensive assessment able to identify health and social care needs of older people.
- The responses to these increased demands include supportive policies, plans and regulatory frameworks.
- Indeed I-technology communication will help increasing training of healthcare workers to provide personalized care to allow older persons to do what matter for them until the latest part of life.
- Actions towards delivery of integrated care for the older people can take place at all levels of healthcare.

19.1 The Policy Context

19.1.1 Rapid Demographic Changes

At a time of unpredictable public health challenges, one thing is certain: the world's population is rapidly ageing. From 2015 to 2050, the proportion of the world's population aged 60 years or older will nearly double (from 12 to 22%) [1]. The consequences for healthcare systems are profound.

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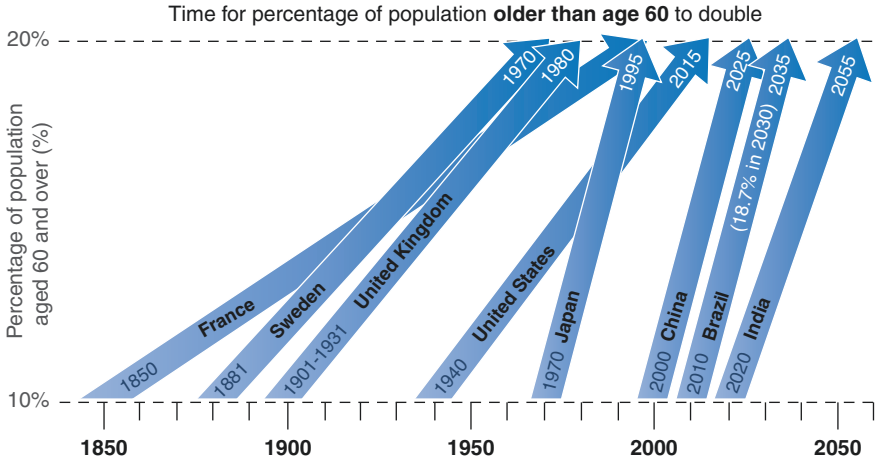

Fig. 19.1 Pace of demographic transition. Source: WHO World Report on Ageing and Health, 2015

As depicted in the Fig. 19.1 below, the rate at which the proportion of the population aged ≥60 years is increasing much more quickly than in the past [1]. For example, the proportion of the French population that was older than 60 years rose from 10 to 20% over a period of almost 150 years, whereas countries such as China and India will have only slightly more than 20 years to adjust to similar changes in the age structure of their populations. A child born in Brazil or Myanmar in 2015 can expect to live 20 years longer than one born just 50 years ago [1].

19.1.2 Diverse Healthcare Needs

As people age, their *intrinsic capacity*—the sum of their physical and mental capacities—tends to decline while their health issues become more chronic and complex. Multimorbidity—the presence of multiple chronic conditions at the same time—is increasingly prevalent with age. Older people can develop geriatric syndromes such as frailty, urinary incontinence, and falls, which do not fall into discrete disease categories.

19.1.3 Challenges and Complexities in Providing Healthcare to Older Populations

Health systems around the world are struggling to respond to the wide diversity of physical and mental capacities of older people and to promote positive trajectories of healthy ageing from early life onwards. An older person's capacities can change rapidly—over the course of hours in some cases. Care systems struggle to be nimble enough to respond quickly to alterations in a person's needs.

Numerous healthcare workers may be involved with one person's care, especially in countries with extensive availability of medical specialists.

The social care sector is often involved when older people experience significant declines in their capacities and need help with activities of daily living. Health and social care services for older people are typically provided in a range of diverse settings, and with greater frequency, than for younger populations. In addition, families and other unpaid carers often play substantial caregiving roles [2].

19.1.4 Healthcare Mismatch

Many healthcare systems around the world were designed for a relatively young population and for a different set of health needs than those we face today. In the past, services were often structured to diagnose and cure acute health issues, using a biomedical 'find it and fix it' approach, which worked well when communicable diseases were the most prevalent healthcare issue. Even though population demographics have shifted, the clinical focus often remains on the detection and treatment of acute conditions, while attention to problems that matter to older people—such as chronic pain, and management of ongoing difficulties with hearing, seeing, walking or performing daily activities—tends to be overlooked. Protocols are often lacking for preventing and managing geriatric issues such as frailty and urinary incontinence. Early markers of declines in intrinsic capacity, such as decreases in gait speed or muscle strength, are often not identified, treated or monitored, which is crucial if they are to be reversed or delayed.

Older people's health issues also are often managed in disconnected and fragmented ways, and there is little coordination between care providers, different settings and over time. Yet, the involvement of numerous health professionals and the use of multiple clinical interventions necessitate a high degree of coordination, both between health professionals, and within treatment levels and settings.

The physical infrastructure of many healthcare settings is not well matched to older people's needs. This includes a lack of accessible toilets, long waiting lines, physical barriers to access, and communication barriers resulting from a lack of accessible information for people with hearing loss and visual impairment. The shortage of affordable transportation to clinics is another major barrier to accessing healthcare, especially for older people who live in rural areas, because services are often concentrated in large cities far from older people's homes and communities [3].

Finally, healthcare and social care are typically fragmented from one another. Deeply rooted differences in the way that these services are financed, governed, and organized create complications for older people who use both types of services. Separate budgets and competing incentives for the various organizations are not conductive to care coordination. Differences in education and professional culture, and unfamiliarity with other professionals' ways of working, are additional barriers.

19.1.5 Poorly Prepared Healthcare Workers

Like healthcare systems, healthcare workers are often unprepared to effectively manage the healthcare needs of older adults. Most current training approaches were developed in the twentieth century [4], when acute, communicable conditions were the world's most prevalent health problems. As a result, healthcare workers are often trained to respond to pressing health concerns, rather than to proactively anticipate and counteract changes in function; and they are rarely prepared to work with older people to ensure they can increase control over their own health [4–6]. Furthermore, although most patients treated within health systems are older people, training curricula frequently overlook gerontological and geriatric knowledge and training [7, 8] and may lack guidance on the management of common problems such as multimorbidity and frailty.

Meaningful reform will require the concerted and sustained efforts of academic leaders and health professional groups, but, so far, this has not happened to a large degree.

19.2 Responses

19.2.1 Integrated Care for Older People

Evidence suggests that *integrated care for older people* is the best approach for implementing the complex spectrum of interventions that are needed for older people to experience the best possible outcomes [9–12].

Integrated care for older people refers to services that span the care continuum; are integrated within and among the different levels and sites of care within the healthcare and long-term care systems (including within the home); and according to people's needs throughout the life course. Integration does not mean that structures must merge, but rather, that a wide array of service providers must work together in a coordinated way. Experiences to date [13, 14] indicate that most successful programmes have taken a bottom-up approach to change, which has been supported by higher-level policy and mechanisms for shared financing and accountability within teams.

This type of care is person-centred, which means that it is grounded in the perspective that older people are more than vessels of their disorders or health conditions. Instead, they are viewed as individuals with unique experiences, needs, and preferences. They also are seen in the context of their daily lives, as part of a family and a community.

To illustrate the elements of this type of care, WHO proposed in the 2015 WHO World Report on Ageing and Health actions in three levels (below). Key actions at three levels:

1. *Focus on the older person's needs and goals.* All elements of an integrate care approach for older people revolve around each older person's unique needs and goals.

2. *Integrated clinical care*. Integration at the level of clinical care is especially important for older populations. This includes a comprehensive assessment, a common goal, and a care plan that is shared across all providers.
3. *System alignment.* Aligned health and long term care systems can enable the realization of integrated care for older people. Key building blocks of health systems have been identified previously by WHO [15] and include: Service delivery; human resources for health; health infrastructure, products, vaccines and technologies; information and data, leadership and governance, and financing.

19.2.2 What Can Healthcare Providers Do?

Front-line health workers who deliver care to older people can take several steps to provide more integrated care to older people. These include: using case management strategies, including comprehensive assessments, care plans, and proactive follow-up; implementing evidence-based clinical interventions tailored to level of intrinsic capacity; and working collaboratively with other providers.

1. *Undertake case management*. Case management entails assessing individual needs and developing a comprehensive care plan (see below), and then organizing services so they work collectively towards the goal of maintaining intrinsic capacity [16].
   (a) *Conduct comprehensive assessments*. Comprehensive assessments are an essential aspect of case management. They take stock of the intrinsic capacity of the older person and its trajectory; specific conditions, behaviours, and risks that may influence this in the future; and the environmental context. As such, comprehensive assessments provide the information needed to prioritize and tailor interventions.
   - *Set care goals together with the older person*. It is crucial that the older person is involved with decision-making and goal setting from the outset, and that goals are established in accordance with the older person's unique needs and preferences.

   (b) *Develop and use comprehesive care plans*. These are developed based on the outcomes of comprehensive assessments. The care plan is centred around the older person's goals, how they will be addressed, the roles that different sectors of the health and social system will play, and a plan for follow-up and re-assessment. Once the care plan is developed, it serves as a roadmap for unified action and a way of measuring progress against the older person's individual goals and preferences.
   - *Provide systematic self-management support*. This involves providing older people with the information, skills, and tools that they need to manage their health conditions, prevent complications, maximize their intrinsic capacity, and maintain their quality of life [17, 18]. This does not imply that older people will be expected to 'go it alone' or that unreasonable or excessive demands will be placed on them. It does, however, recognize their autonomy

and abilities to direct their own care, in consultation and partnership with healthcare providers, their families and a range of other carers.

- *Provide regular and sustained follow-up*. Proactive and planned follow-up is part of most case management approaches. It promotes early detection of complications or changes in functional status, thus preventing unnecessary emergencies and related healthcare waste. It also provides a forum to monitor progress in relation to the care plan and to provide additional support as needed.

(c) *Implement evidence-based clinical interventions tailored to levels of intrinsic capacity*. Within any population of older people, many will experience periods of high and stable capacity, declining capacity, and significant loss of capacity. Each of these three periods requires different responses from healthcare providers.

- *For older people with high and stable levels of capacity, the goal is to build and maintain these levels for as long as possible*. The emphasis should be on disease and risk prevention; promoting capacity-enhancing behaviours; ensuring acute problems are adequately addressed; and detecting and managing chronic, noncommunicable diseases at an early stage.
- *For older people experiencing declining capacity, the goal is to delay, slow, or even partly reverse this trajectory through interventions targeted early in the process* [19, 20]. Healthy behaviours remain crucial, but the focus broadens from risk factor reduction to encompass actions that can directly help maintain and reverse loss in intrinsic capacity. For example, aerobic exercise is important for cardiovascular disease prevention [21], but exercise that can help build muscle mass, strength, and balance becomes increasingly important as people begin to experience declining capacity [22–27]. Nutritional advice also changes as people lose capacity, with the focus shifting to nutrient density, particularly that of protein intake, vitamin D, and other micronutrients, although calorie intake is also an important target [28]. This is a period of increased focus on the chronic care of multiple conditions, in order to mitigate their impact on capacity.
- *For older people experiencing significant loss of capacity, the twin goals are to continue to optimize clinical trajectories and to compensate for these losses through provision of social care services*. Clinical interventions should continue to focus on recovering and maintaining capacity, including ongoing disease management, rehabilitation, palliative interventions, and end of life care. Rehabilitation services can help prevent permanent functional disability and care dependency, and have been shown to reduce avoidable hospital admissions and delayed discharges [29].

2. *Work collaboratively with other providers*. Integrated care for older people requires healthcare providers to collaborate with one another, and with social care providers. This is a different way of working for many providers. Differences in education and professional culture, and unfamiliarity with other professionals' ways of working must be overcome.

19.2.3 How Can Services Be Organized and Delivered?

The starting point for aligning services to support integrated care for older people should be ensuring that better care is provided, rather than adopting a fixed organizational model with a pre-determined design.

Regardless of the organizational structure, active case finding, community- and home-based care—all anchored by a strong and high-performing primary health and long term care system—are important aspects of service delivery for older people. Self-management support provides older people with the information, skills, and tools that they need to manage their health conditions; prevent complications; maximize their intrinsic capacity; and maintain their quality of life. Community engagement leverages existing resources and helps provide support for older people and their families.

1. *Use multidisciplinary teams*. Multidisciplinary teams share responsibility and accountability for clinical processes and care outcomes, for individuals and in defined populations. To succeed, teams meet regularly, share information, explicitly define clinical roles, and perform complementary and coordinated functions for people and populations [30].
2. *Share information across providers, settings, and time*. Rapid advances in information and communication technologies (ICTs) offer much promise for sharing relevant clinical information across providers, settings, and time [31]. Electronic health records can organize information about individuals and entire clinical populations of older people to help identify needs, plan care over time, monitor responses to treatment, and assess health outcomes.
   (a) *Implement active case finding*. Community outreach and active case finding can reach older people who do not self-present to health centres. Moving beyond clinic walls into communities facilitates the identification, monitoring, and support of older people in need of health services.
3. *Prioritize community- and home-based care*. Locating health services close to where people live is especially important for older people. Distances to health centres that might be reasonable for the general population can be insurmountable for older people with significant impairments; accessible and affordable public transportation to healthcare facilities should be available [32]. In cases where specialist health services entail long travel distances, age-friendly and affordable transportation services can be offered.

   Home visits delivered by healthcare providers in the context of community-based programmes have been shown to have positive effects for older people [33, 34].

   For those with significant care needs, hospital-at-home services can provide treatment at home for people who would otherwise be admitted to an acute hospital. These services involve a team of health and long-term care professionals. Evidence has shown higher client and carer satisfaction, reduced deaths, and reduced readmission rates with this model compared to a ‘traditional’ hospital [35]. Most rehabilitation services can be provided outside hospital settings, in communities or at home [28].

(a) *Engage communities*. Community engagement leverages untapped resources and helps to ensure healthy and facilitative environments for older people. The community includes families and households, employers, religious organizations, the physical and social environment, community organizations of different types—including older people's associations, social services, and educational services to name but a few.

19.2.4 How Can Health and Long Term Care Systems Support Integrated Care?

The primary role for policymakers and health system leaders is to support the integration activities of front-line providers at the level of clinical care (see Box below).

National-Level Support for Integrated Care for Older People

1. Adopt an integrated care approach to older people within the country's National Health Policy.
2. Adapt and implement clinical guidelines for providing integrated care for older people.
3. Evaluate the country's capacity to deliver integrated care, identify gaps, develop a plan, and monitor progress.
4. Make needed changes within local health systems (essential medicines, health information system, infrastructure) and long term care systems.
5. Train health and social workers about the integrated care approach and interventions to prevent declines in capacity and functional abilities.
6. Develop support mechanisms within communities for self-management, caregiver support, and transportation of older people to clinics and hospitals when needed.

Organizational and structural integration are not necessary to achieve this aim.

As a first step, senior leaders must recognize the importance of addressing this agenda and make it a health system priority. One entry point is to evaluate the country's capacity to deliver integrated care, identify gaps, elaborate a plan to guide the necessary changes in local health systems, and monitor progress.

Policies, plans, and regulatory frameworks can be updated to support integration at care levels (e.g. primary healthcare, nursing homes, and hospital-based services), and also between health and long term care systems. Joint budgeting, monitoring, and accountability systems can be used to solidify integration. Strong political support from senior leadership can spur this type of action.

Other essential action points are presented below.

1. *Develop the workforce*. Healthcare and social care workers need the right competencies, and to be organized and deployed in ways that make the best

use of their potential contributions. Core competencies for all health professionals include basic gerontological and geriatric skills. Both health and social care workers need general competencies related to integrated care, such as working as part of a multidisciplinary team and proactively supporting older people to optimize their health and capacity. More physicians and nurses with expertise in geriatrics are also needed, to provide support to primary care healthcare workers and to treat complex cases. In addition, new workforce cadres (such as care coordinators or community health workers) can be considered, alongside options for extending the permissible scope of practice for some professions.

Developing the workforce in these ways will require a well-functioning governance infrastructure. Workforce assessment, policy development, planning and monitoring are essential aspects of governance. Strengthening governance capacities and coordination mechanisms to address major workforce challenges associated with population ageing will be important in many settings.

(a) *Invest in information and communication technologies*. Information and communication technologies (ICT) can help transform health systems to deliver integrated care for older people, particularly in middle- and high-income settings. Advances in ICT are being used globally to improve access, quality, and safety of healthcare, and cost-effectiveness of health services delivery [30]. In many ways, ICT has become fundamental to effective multidisciplinary team care. Automated reminders, prompts, and warnings on clinical health records systems can assist providers to deliver evidence-based care. Patient portals and other e-health infrastructure can enable older people to participate more fully in their treatment and care; and link them with their healthcare team, as well as with community and social services.

ICT also can be used to monitor, evaluate, and plan care at the policy level, in order to improve the care of older people. For this to be realized, common indicators must be broadly agreed and consistently used. Indicators for underlying causes and domains of intrinsic capacity—such as undernutrition, mobility impairment, cognitive impairment, and sensory impairments—must be defined, operationalized, and consistently measured.

2. *Implement shared financing and accountability*. Several financing mechanisms can be considered to stimulate integrated care for older people. Within a wide range of financing schemes, pooled budgets and/or bundled payments can be used to enable providers and organizations to work together in a more integrated way. Other financing mechanisms include contractual incentives to encourage new ways of working, or to reward positive outcomes; and stimulus or seed funding to support the development of local initiatives.

Regardless of the financing scheme, providers must be compensated and provided with incentives to undertake key functions associated with integrated care. They must, for example, be remunerated for the time and resources spent conducting comprehensive assessments and developing care plans, as well as for the time spent on consultation and collaboration within the multidisciplinary team. Providers should also be eligible for compensation related to the services that they provide in older people's homes or communities.

Conclusion

Integrated care for older people produces a better return on investment than more familiar ways of working, and enables older people to participate and contribute as productive members of society [1].

Integration at the level of clinical care is especially important for older populations. This generally includes a comprehensive assessment, a common goal, and a care plan that is shared across all providers. Ongoing case management, led by a designated care coordinator, has been shown to ensure that integration continues over time [2]. Key health system levers are: supportive policies, plans, and regulatory frameworks; workforce development; investment in information and communication technologies; and use of pooled budgets, bundled payments, and contractual incentives to support integrated ways of working.

Action towards the delivery of integrated care for older people can take place at all levels of healthcare: from front-line providers through to senior leaders. This action might make a substantial contribution towards the Sustainable Development Goals (SDGs), fostering inclusive economic growth, achieving universal health coverage for current and future populations, and ensuring older people have the opportunity to contribute to—and are not left behind by—development.

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