

Evidence *in* Context

Issue: Community-Based Service Models for Seniors
Released: December 2013

Health research – synthesized and contextualized for use in Newfoundland & Labrador

Community-Based Service Models for Seniors in Newfoundland & Labrador

In consultation with the provincial Regional Health Authorities, the Office of Aging and Seniors at the NL Department of Health and Community Services (DHCS) sought evidence on the effectiveness, feasibility, and acceptability of different service models to support seniors living at home. Our study focused primarily on models of integrated care.

As recommended by the Health Council of Canada, integrated care involves coordinated primary medical and community care that includes both health and social services. The key objective of the project was to find evidence-based strategies and approaches that can enable and empower seniors to stay in their communities for as long as possible, with an acceptable quality of life.

In January 2012, the CHRSP Project Team met to finalize the research question and to establish the scope of the study. Three types of outcomes were identified as priorities: **Residency Status** of the patient/client: *does the intervention increase the time that the person remains at home and, if so, by how much?*



Quality of Life: *does the intervention maintain or improve quality of life measures for the patient/client and caregiver?*

Healthcare Utilization: *does the intervention change the type, frequency, and intensity of the patient/client's utilization of healthcare services and, if so, in what ways and to what extent?*

In addition to models of integrated care for older adults living in the community, the project also studied the following types of

community-based interventions for seniors: supports for caregivers of seniors with dementia and caregiver supports in the form of respite care, end-of-life care, fall prevention programs, home visits, and transitional care. These services have been developed in Canada and other countries independently of models of integrated care. They have also been implemented within this province's Regional Health Authorities (RHAs) to varying

degrees. Their inclusion in the project allowed us to assess the evidence for these existing services for seniors; to compare the evidence for each to the evidence for models of integrated care; and to consider the impacts of local contextual factors on each of these services. Details are available in the full 'Evidence in Context' report and in the Online Companion Document:

<http://www.nlcahr.mun.ca/CHRSP/CSMS.php>

The Research Question: "What does the scientific literature tell us about the characteristics of models of integrated primary medical care and community services for supporting community-dwelling older persons in Newfoundland and Labrador with ADL/IADL* disabilities and mild to complex chronic health conditions (including dementia) and their caregivers and about the effectiveness of these models in terms of health and economic outcomes for clients, caregivers, and the health system?"

*ADL= Activities of Daily Living | IADL= Instrumental Activities of Daily Living

Disclaimer: This document is an executive summary of a larger report that contains fully referenced material. We have omitted references from this summary for the sake of brevity; readers who wish to inspect these references can refer to the full report at <http://www.nlcahr.mun.ca/CHRSP/CSMS.php> together with a companion document that details our project methodology.

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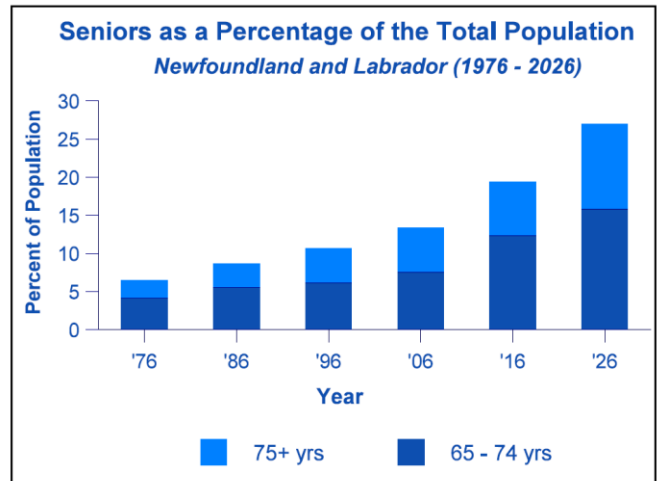
Background: Community-Based Service Models for Seniors

Current demographic trends in Newfoundland and Labrador created the impetus for this study:

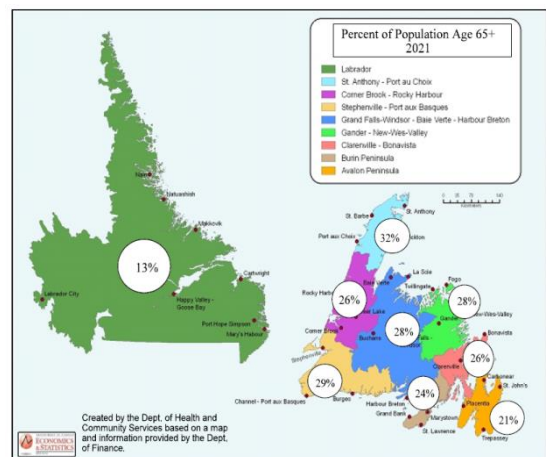
- Seniors in the province are living longer than before and with more chronic disease and frailty;
- The proportion of seniors in the overall population is increasing;
- Out-migration from rural and remote parts of the province is eroding traditional family sources of unpaid, informal care;
- Seniors in Newfoundland and Labrador have high rates of home ownership and a desire to remain in their homes and communities for as long as possible.

The province’s health system is challenged to help seniors age in place and to support their caregivers.

Currently, the RHAs provide support services for seniors living at home through the province’s *Home Support Program*; they also provide medical equipment and supplies through the *Special Assistance Program*. In December 2009, changes to the financial assessment eligibility guidelines for these programs resulted in a significant increase in the number of seniors who are financially eligible for subsidies.



Seniors as a Percentage of the Total Population of Newfoundland and Labrador. Government of NL- Dept. of Finance/ Economics and Statistics



Percentage of Population Aged 65+ by 2021
Government of NL Dept. of Health and Community Services

Summary of Findings

Our literature search focused on high-level research, including systematic reviews, meta-analyses, health technology assessments, as well as some very recent high-quality primary research studies not included in the review literature.

Activities of Integrated Care

The available review literature covers a broad range of care-related activities used in models of integrated care for seniors living at home. These activities have been studied individually and in combination with other activities.

Evidence from the review literature consistently supports the use of two activities in particular: **Geriatric Assessment** and **Case Management**.

Geriatric Assessment collects information about the medical, psychosocial and functional capabilities of elderly patients using a standardized and validated instrument. Geriatric Assessment results are then used to design needs-based, individualized interventions for the patient/client. The use of Geriatric Assessment has been shown to be more successful at enabling seniors to remain in their homes than any of the other activities of care studied in this report. Geriatric Assessment has also been demonstrated to reduce the rates of hospital admission among the frail elderly more effectively than any other intervention studied in this report. Among the individual activities studied in this project, Geriatric Assessment has the most consistent and substantive impacts on clinical health outcomes for older patient/clients living at home.

Case Management interventions coordinate services for older patient/clients. These interventions also monitor and follow up on health outcomes, functional status, quality of life and well-being. Case Management has been shown to help reduce hospital admissions and nursing home admissions. Research-based evidence has demonstrated that Case Management is an effective intervention for increasing the time older patients/clients remain at home in the community. It should be noted, however, that for Case Management to be effective, it has to be selectively used with appropriate patient/clients, i.e., seniors who are at greater risk for adverse health outcomes.

Organizational Features of Integrated Care

The research on the organizational features of integrated care is observational in nature and so it is limited in its ability to provide strong conclusions. However, this evidence may be used to infer lessons for the development and implementation of effective models of integrated care based on the organizational features of existing models. The evidence indicates that certain features are strongly associated with the success of integrated models of care for seniors: *umbrella organizational structures, organized provider networks, appropriately aligned financial incentives, and multidisciplinary case management* (see Table below). These features are associated with reducing hospital and long-term care admissions for seniors and with the sustainability of the model itself. Collectively, these features may act synergistically to achieve desired results whereas, when employed individually, they may not be as effective.

Features of Successful Integrated Care Models Associated with Improved Health, Quality of Life and Access to Care	
Umbrella Organizational Structure	Resources from individual health and social services are combined; the new organization has full accountability for outcomes
Organized Provider Networks	Common ownership of assessment, care-planning and decision tools among providers; shared access to client records; facilitates access to health and social services
Financial Incentives	Promote and support service integration and cooperation
Multidisciplinary Case Management	Single entry point into the healthcare system; more effective assessment and monitoring of clients

Implications for Decision Makers

This report indicates that effective models of integrated care share certain **essential elements**; decision makers are encouraged to understand these essential elements, to avoid trying to implement a “one-size-fits-all” approach, and to work towards flexible approaches that recognize the differences between urban, rural and remote areas. A sensible first step would be to use the findings of this review to assess the effectiveness of current care delivery (i.e., primary, medical, community and social care) to seniors and their caregivers now living in the community. The second step would be to use the report’s findings to set targets for more effective care. Based on the solutions that would emerge from these exercises, the next step would be to design and launch implementation projects in several diverse areas in order to progressively scale up services to the rest of the province.

Key Messages from the Report

Very High Level of Certainty

- **Geriatric Assessment**, as an activity of integrated care or as a stand-alone intervention, is consistently and significantly effective for maximizing the time older adults live at home and for reducing hospitalizations among frail older adults.
- **Case Management**, when implemented with appropriate patients/clients, is significantly and consistently effective for older adults living in the community, in terms of enabling them to remain in the community, improving appropriate service use, and prolonging autonomy.
- Several well-established **Community-Based Fall Prevention Exercise Programs**, including individual and group exercise programs, have been shown to significantly reduce the occurrence of falls among seniors living at home. Environmental fall prevention programs that focus on home safety and personal mobility are also effective for high-risk older adults.

High Level of Certainty

- The evidence indicates that models of **Partially Integrated Care** have been shown to help older adults stay in their homes and to reduce hospital admissions whereas the evidence concerning Fully Integrated Care is unclear or of low quality.
- Some forms of **Support Group**, including psycho-educational and educational training, are consistently effective at reducing caregiver burden. These support groups, in addition to mutual support groups, can also improve caregiver health and well-being.
- Community-based models of **Respite Care** have been shown to be beneficial for some, but not all, caregivers and for some, but not all, outcomes of interest. Respite care appears to be of limited effectiveness in supporting caregivers and patients/clients with dementia.
- Preventive **Home Visits** that include health promotion reduce the risk of mortality among at-risk older adults.

Moderate Certainty

- **Facilitated access** to health and social services appears to be a critical component of effective integrated care programs.
- The **involvement of primary care health service providers**, including family physicians and community-based nursing, appears to be a critical component of effective integrated care programs.

For the complete *Evidence in Context* report, including details on the evidence reviewed by the project team, and for more information about the CHRSP process, please visit the NLCAHR website: www.nlcahr.mun.ca/chrsp