Leveraging the culture of performance excellence in health systems.

Understanding Care for Older People with Complex Needs: An International Collaboration
Overview

• Rationale
• Principles
• Outlining a relevant research agenda
Rationale

• Health and social care systems across North America and Europe face the common challenge of providing care for a growing number of older people with complex needs.
Rationale

• The mixture of health problems and functional impairment, both physical and cognitive, requires the development of delivery systems that meet those needs by bringing together a range of professionals and skills from the health and social care sectors.
Background

• Shared recognition of the importance of overcoming fragmentation in the delivery of this care and increasing coordination among providers, institutions and sectors of care.

• Little evidence on the effectiveness of different system-level payment and organization strategies on coordination, costs and patient outcomes.
Background

• Unclear how well different systems perform and what system-level features may be more successful and more sustainable in the long term.
• Need to better understand how to identify complex-needs populations, the pathways they take in different systems and the impact these have on costs and quality of care.
Goals

• Need to develop measures to assess the performance of health and social care systems in these populations
• Need evidence on which system-level interventions are successful for whom and under what circumstances
Goals

- Share ideas about how to better understand, assess and provide health and social care for elderly people with complex needs
- Define a shared research agenda
Principles

• Research with a goal of promoting healthy aging and independent living to reduce the social and economic burden of illness and disability

• Identify, describe, compare and evaluate needs and services for older individuals with or at risk for complex needs
Principles

• Employ a broad system-level performance framework that incorporates safety, effectiveness, patient experience, costs and uses an equity lens

• Evaluate integration in the context of its impact on safety, effectiveness, patient experience and costs
Principles

• Focus on well-defined cohorts of older individuals with multiple conditions/needs as they move through health and social care systems

• Include needs determined by health conditions and functional impairment both physical and cognitive

• Use policy-relevant boundaries such as countries or autonomous regions as the unit of analysis for comparative purposes.
Research Agenda

• Who are these people?

• What are we currently doing for these people?

• What woks?
Who are these people?

- **Quantitative - Conceptual issues (taxonomy)**
  - Age, clinical conditions, physical and cognitive function
  - How do we define complexity, risk-based approach to population identification

- **Qualitative self-perception & caregivers**
  - How well supported are they, what do they need?
What currently happens?

• Starts with the patient perspective
  – Vignette example: 75 year old woman with CHF, a bit of dementia, dyspnea caused by COPD…
• Focus on how such an individual encounters providers in the health system
• Measure and understand transitions
What currently happens?

- Costs
- Impact of lack of integration
  - duplication, gaps and costs
- Outcomes
  - Clinical (acute and long-term care institutional care settings)
  - Patient experience
  - Provider experience
What should happen for them?

- Conceptual
- Policy vision
- Best-practice pathways/trajectories of health