Meeting the Needs of Disabled Older Persons: Can the Fragments Be Pieced Together?

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ONE of the first things we learn in geriatrics is that, as people get older, their health needs extend beyond the purely medical. Actually, this is the case for other populations (e.g., very young children and all patients with devastating illnesses). The common issue is that these patients are unable to take their illnesses in stride and go on with the rest of their lives. Rather, health becomes the overriding force in their lives, and resources must be mounted to compensate for the deficits incurred by disease and debility. In geriatrics, the onset of functional impairment (particularly in activities of daily living) marks the transition of the role of health from bit player to lead actor.

Certainly, older persons have larger disease burdens, but there is much more contributing to the impact of poor health including the loss of social support, financial limitations, and societal barriers such as the lack of geriatric-friendly housing and communities. When all of these are considered, it becomes obvious that care for the functionally impaired, community-dwelling elderly patient requires more than a physician or a health care system can provide.

In the United States, we are celebrating the 40th anniversary of the Medicare program, a landmark piece of legislation enacted by the Johnson administration. As conceived, this program intended to relieve elderly Americans of the worry of becoming health care paupers once they retired and lost their commercial health insurance. The program has been enormously successful, though costly. Older persons have excellent access to health care and receive plenty of it. Yet, in its design and implementation, there have been inherent flaws in Medicare that fail to recognize the basic principle that medical care alone is insufficient. This oversight is understandable. The fee-for-service Medicare system was largely based on the Blue Cross and Blue Shield insurance plans, which were medically oriented and rewarded the volume of medical services provided, particularly procedures. In addition, life expectancy in the 1960s was substantially shorter (1) than today, and the numbers of older persons, those who were frail, was relatively small.

Now, halfway through the first decade of the millennium, we are anticipating 75 million baby boomers who will begin to reach Medicare eligibility based on age in 2011. Moreover, the most rapidly growing age group in the United States is the 85 years and older population. With advancing age, functional impairment rises. For example, 20% of persons 65–74 years of age have difficulty with activities of daily living, whereas 53% of those 85 years and older have difficulty with these tasks (2). Providing assistance with these tasks largely remains outside the benefits package provided by Medicare.

These demographic data underscore the pressing need to reconsider how health care is conceptualized for older persons. In the United States, several attempts have been initiated to blend medical and social services to meet the comprehensive medical and social needs of frail older persons. Among the most prominent has been the Program for All-Inclusive Care of the Elderly (PACE) and the social health maintenance organizations (SHMO). Both have had some successes (3,4) but they also have limitations (e.g., participants’ inability to retain their own physicians, high premiums for those who are not eligible for Medicaid, modest interest among insurers) and have not become widely available.

In this issue of the Journal, Beland and colleagues report the results of a large, carefully conducted trial of an integrated (blending health and social services) health care delivery system (SIPA; French acronym for System of Integrated Care for Older Persons) launched in Canada (5). Some notable features of the SIPA system include assessment followed by evidence-based interdisciplinary protocols for the conditions that frail older people commonly experience (e.g., falls, heart failure, depression, dementia, medications). SIPA mobilized medical and social services, including case management, to keep patients out of the hospital. Another positive aspect of the program is that the patient’s family physician continues to provide the medical care. Moreover, the program provided financial incentives for physician participation ($400 annually, the equivalent of $33 [Canadian] per member per month) to compensate for time spent communicating with the multidisciplinary team.

Although the results are not as positive as one might have hoped, the authors state that the findings of reducing more expensive care (acute care) while increasing less expensive care (e.g., home health) met the study’s hypotheses. Obviously, the model of care would have been more compelling if total costs were reduced. It is hard to persuade insurers and delivery systems to adopt change in the absence of a bottom line benefit on health or costs. Nevertheless, costs are a fickle outcome because of health care delivery idiosyncrasies and outliers, which can substantially influence...
the results, particularly if the sample is small. Despite the large size ($n = 1230$) of this trial (compared to typical trials using clinical or process of care outcomes), it is small if the focus is on costs. A surprising finding of the study is the lack of differences in hours or costs of home social care between groups. It would seem that one of the benefits (and costs) of the intervention would be the receipt of more social services.

The SIPA study offers some hope for integrated delivery systems but does not provide the convincing evidence that decision-makers will need. Although such integration of medical and services makes so much sense, it has been notoriously difficult to demonstrate benefits, especially economic, of these programs (6). There are so many obstacles to demonstrating success of community-based interventions for disabled older persons in a randomized clinical trial. Selection of appropriate elders for integrated services and utilization of services by appropriate patients remain challenges for both research and clinical implementation. When administered in real-world settings, there is frequently crossover in services received such that intervention group patients may not receive the intervention as intended, and control group patients receive services that are intended only for the intervention group. Such contamination generally leads to dilution of the intervention’s effectiveness in clinical trials. Moreover, some outcomes (e.g., costs, improvement of functional status, reduced mortality) may not be very responsive to the interventions. The burden of morbidity may be so large that the best medical and social efforts may fail. Finally, patient preferences may lead to outcomes that are inconsistent with the intervention’s hypothesized effect. In the end, however, there are little scientific data to support some of the interventions that we, as clinicians, have observed to be beneficial in individual patients.

So where do we go from here? I believe that we need to continue to seek evidence that justifies the integration of medical and social services. In the absence of such evidence, it will be difficult to persuade insurers (primarily the Centers for Medicare and Medicaid Services in the United States) to pay for integrated services or even cover some of the needed social services. We need to improve our ability to provide this evidence by conducting additional studies of new models like SIPA and by studying other relevant outcomes. Small single-site pilot studies need to be conducted to evaluate the most promising of these. These trials need to be powered sufficiently to mitigate the dampening effects of crossovers and infidelity in delivering the intervention. Perhaps most important, we need to think about different outcome measures that are responsive and more relevant to this population. One approach is goal attainment scaling (7), which measures multiple individualized goals and would likely need to be reassessed during the period of the study as patients’ clinical conditions changed. Other approaches could be devised to combine the various perspectives of benefit—the patient, family, health care provider, and insurer into a summary measure of whether integrated care is better. We will need to improve the science of studying health services interventions for disabled older persons before we can prove what our eyes, ears, and hearts tell us is true.

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