THE CONTINUUM OF CARE TODAY
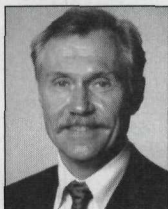
After 20 Years, What Is the Status of Integration of Services?

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The conceptual framework for a fully integrated continuum of services was first posed more than 20 years ago. (It has been described in *Health Progress* articles in 1989 and 2000.[1]) "Seamless" integration of the health care service delivery system is beneficial to the client who has complex, chronic needs; essential to the provider who seeks to achieve effective use of resources; and imperative for the payer who hopes to contain costs. Over the past 20 years, Catholic institutions throughout the nation have embarked upon major initiatives to create integrated health care delivery systems that offer a continuum of care to their patients and clients.

Where does integration stand now? Do services flow seamlessly for clients? Do providers get paid for an integrated package of services? Do payers pay for a comprehensive service package?

In this article, we will examine the status of health care services integration vis-à-vis the continuum of care framework. We will review the rationale for service integration, examine events and trends that have aided or impeded integration, comment on integration's current status, and predict what is likely to happen in the immediate future to a systems approach to health care service delivery for people with complex, chronic conditions.

THE CONTINUUM OF CARE FRAMEWORK

"Integration" is a term used in health care in a variety of ways. The lack of consensus concerning the term's meaning makes it difficult to measure and track integration's impact over time. In this article, we will consider integration defined as a "continuum of care." The concept was first articulated in 1984 as a "client-oriented system of care composed of both services and integrating mechanisms that guides and tracks clients over time through a comprehensive array of health, mental health, and social services spanning all levels of intensity of care."[2] This is the definition we will work with here.

Providing comprehensive care coordinated over time and across services is central to the Catholic mission of offering client-focused, high-quality care. The church's healing ministry is built on a holistic model that recognizes the integration of soul and body. From the client's perspective, the continuum's goal is to provide people with complex conditions access to the services they need at the time they need them, with the clinical goal of maximizing independence of functioning. From the health care organization's perspective, the continuum's goals are to optimize the use of scarce resources (i.e., avoid duplicating or omitting services); enhance quality by matching client need with level of care; and provide care based on need, not financial program eligibility criteria.

As shown in **Figure 1,** p. 47, the continuum comprises a broad array of services, which for convenience are condensed into seven categories: extended care, acute care, ambulatory care, home care, outreach care, wellness, and housing. Service providers do not necessarily cooperate with each other, even if they are part of the same multifaceted and purportedly integrated health care system. Hence, to create integration (sometimes described as "seamless" client flow), one must have formally structured integrating mechanisms. Such mechanisms cannot be assumed to exist, even in formal organizational structures. The four basic categories of integrating mechanisms are *inter-entity management and structure, care coordination, integrated information systems,* and *integrated financing.* This framework incor-

porates both "horizontal" integration, a term used to refer to cooperation across services, and "vertical" integration, which refers to structural integration of services and financing.

The continuum of care framework focuses on integrating the services provided to the *client,* rather than on the integration of service organizations. The focus should be on identifying boundary-spanning mechanisms that ensure that consumer service coordination occurs within and between formal organizational service providers.[3]

The continuum of care framework is consistent with the systems integration model articulated by CHA in its 1995 *Workbook on Long Term Care in Integrated Delivery,* as well as with the model used by the National Chronic Care Consortium.[4] The elements are also compatible with those identified by experts who have studied physician-hospital integration and medical group management.[5] The framework thus seems useful as a tool by which to evaluate the current status of integration.

WHY INTEGRATION?
The rationale for integrating health care services is to provide the highest quality and most cost-effective care for people who have complex and chronic conditions. Integration of services implies that multiple services are delivered, either simultane-

ously or sequentially; that they are appropriate and coordinated; and that they are neither duplicated nor omitted. Integrated delivery systems are especially appropriate for people with complex and chronic illnesses. The integrated-service approach contrasts with the current U.S. health care delivery system, which historically has been organized to provide acute, episodic care.

The population of the United States includes vast numbers of people with chronic and disabling conditions, and, as is shown in **Figure 2** (see p. 48), these numbers are expected to increase markedly in coming years. An estimated 133 million Americans had one or more chronic conditions in 2005. By 2030, the number is projected to increase to 171 million.[6] Thus, to the extent that integrated systems are more cost-effective for people with complex, chronic illnesses, the argument for developing integrated systems is undeniable.

Although chronic conditions strike people of all ages, they are particularly common among the aged, many of whom suffer from multiple chronic conditions acquired over time. CHA first addressed the needs of the aged for a "coherent set of long-term care services" in 1988, with the publication of *A Time to be Old, A Time to Flourish: The Special Needs of the Elderly-At-Risk.*[7] As the baby boomer generation ages, 70

FIGURE 1
Services and Integrating Mechanisms of the Continuum of Care
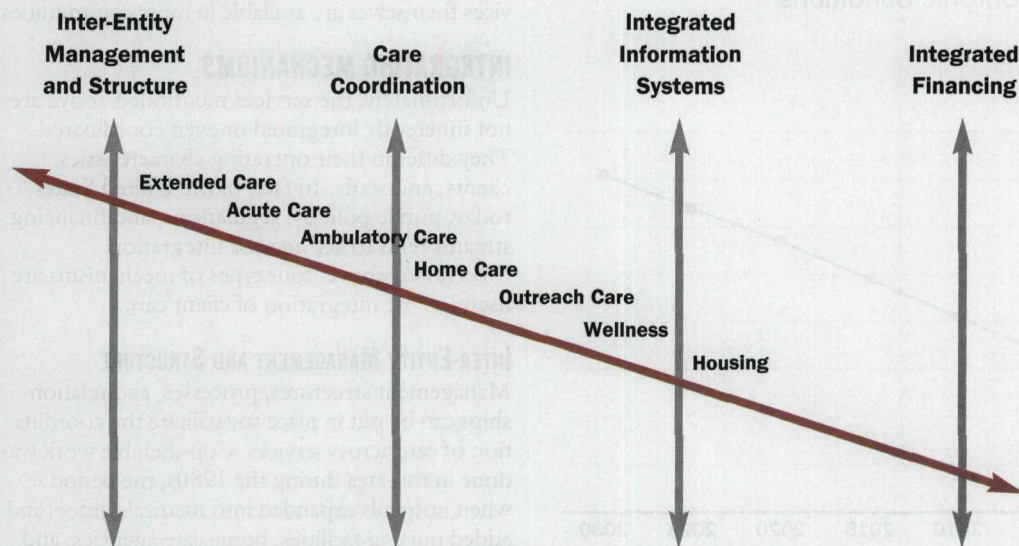
Source: C. Evashwick, *Managing the Continuum of Care,* Aspen Publishers, Gaithersburg, MD, 1987; and C. Evashwick, *The Continuum of Long-Term Care,* Delmar Publishers, Albany, NY, 2005.

million Americans will fall into the category of senior citizens.

SERVICE EXPANSION

Services cannot be integrated if they do not exist. People who have complex, chronic conditions (and accompanying needs that are likely to change over time) will require an array of services, including various long-term care services as well as acute care services. The continuum of care framework was based on a list of 60 services that were derived from a study by the Hospital Research and Educational Trust and then distilled into the seven operating categories noted above.[8]
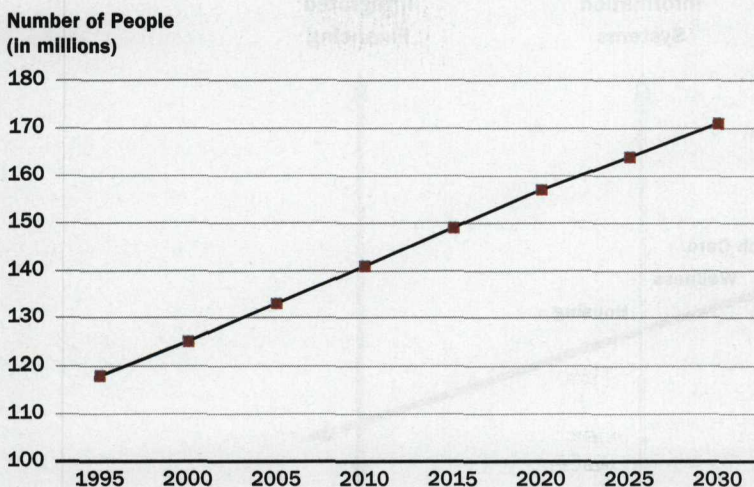
Over the last several decades, the makeup of the health care system has changed. In the late 1970s and early 1980s, the nation gave considerable attention to the need to develop community-based services. Since 1980, acute care hospitals have declined in number, nursing homes have stayed relatively stable in number, and virtually all other services have increased in number. Table 1 (p. 49) shows the growth nationally in select services over the past 25 years. Catholic entities reflect similar expansion. CHA-member institutions today include not only health systems and hospitals but also long-term care facilities, assisted living complexes, Program of All-inclusive

Care for the Elderly [PACE] projects, and home care agencies. In most communities, diocesan Catholic social service agencies provide an array of social support services for people with chronic illnesses. Indeed, in most metropolitan areas Catholic-sponsored health and social service providers together typically offer a full continuum of care, but the level of coordination varies by community.

Another indicator of the growth of services is the number of dollars spent. In 1970, for example, Medicare nursing home expenditures were $4.2 billion, representing 3.8 percent of the program's total.[9] By 2001, nursing home expenditures comprised 9.4 percent of Medicare's total spending, nearly $193.2 billion. Similarly, annual expenditures for Medicare-certified home care rose from less than 1.9 percent to over 4.1 percent for Part A and 4.2 percent for Part B. Medicaid payments for long-term care also grew markedly. For example, the amount spent per recipient for home health grew from an average of $229 per recipient in 1972 to $3,135 per person in 2000.[10] In 1970, outpatient services of acute care hospitals were quite insignificant. Over the past 30 years, outpatient services representing a wide range of clinical care have grown to become more than half the revenue of many hospitals.

One could analyze the growth of services in greater detail; it's clear, though, that they have expanded in availability. Although some people have trouble gaining access to what is today a variety of acute and long-term care services, the services themselves are available in most communities.

INTEGRATING MECHANISMS

Unfortunately, the services mentioned above are not inherently integrated or even coordinated. They differ in their operating characteristics, clients, and staffs. In fact, in the United States today, public policies, regulations, and financing streams tend to act *against* integration.

As noted above, four types of mechanisms are useful in the integration of client care.

INTER-ENTITY MANAGEMENT AND STRUCTURE

Management structures, processes, and relationships can be put in place to facilitate the coordination of care across services. Considerable work was done in this area during the 1980s, the period when hospitals expanded into medical centers and added nursing facilities, home care agencies, and urgent care centers; purchased physician practices; and bought or started health plans. (CHA offered

FIGURE 2

Number of People with Chronic Conditions

Source: Shin-Yi Wu and Anthony Green, *Projection of Chronic Illness Prevalence and Cost Inflation,* RAND Corporation, Santa Monica, CA, 2000.

TABLE 1

National Service Growth, 1970–2000

	1970	1980	1990	2000
Hospitals[1]	7,123	6,965	6,649	5,810
Nursing Homes[2]	15,700	14,565	15,800	16,886
Medicare Certified Home Health[3]	2,242	2,924	5,730	7,857
Adult Day Services[4]	−10	−300	−2,100	−3,407
Hospice[5]	0	1	825	2,326

Sources: 1, American Hospital Association; 2, National Nursing Home Survey; 3, National Association of Home Care; 4, Cox 2005 Adult Day Services; and 5, National Hospice and Palliative Care Organization.

Note: Data for 1970 range from 1973 to 1975.

guidance on such changes through conferences and a series of publications, including *A Workbook on Long Term Care in Integrated Delivery*.[11])

This expanded vision of health care organizations has not, however, been sustained. Instead, many multilevel health care organizations have closed or divested services as they returned to their "core" business of acute care.[12] The reasons for this trend include the failure of two other types of integration: financing and information systems. (Catholic systems across the nation have consolidated over the past dozen years. In the process, leaders changed, the focus on integration was lost, and financial as well as human resources were committed to other priorities.)

Nonetheless, valuable lessons were learned about integration, and models of multifaceted health care organizations that coordinate care across services have survived. Leaders who tried to integrate too much too fast came to realize that health care is a local business and that reaching out geographically does not necessarily produce the economies of scale or utilization expected. They also found that administrators who were good at one type of health care management could not automatically use those skills in managing other services.

Moreover, government regulations have made integration very challenging. A common example is the requirement of the 1996 Health Insurance Portability and Accountability Act (HIPAA) that providers limit sharing of confidential patient information across services—despite the Joint Commission on Accreditation of Healthcare

Organizations's requirement that providers have in place transfer agreements to facilitate such sharing. Although complying with both is ultimately feasible, doing so is both complicated and costly. Similarly, the Balanced Budget Act of 1997 marked the beginning of distinct payment mechanisms for all Medicare long-term care services. This resulted in the closing by hospitals of numerous subacute nursing units and the closing or divestiture of nearly one-quarter of the nation's Medicare-certified home care agencies, thereby erasing years of effort to coordinate acute care and transitional care in a seamless way for patients.

More recently, state governments have sought to streamline health care bureaucracies as a means of reducing their expenditures on health care. In focusing specifically on users of state-supported long-term care, state governments are acting on the realization that care suffers (and its costs increase) if it is parceled out by multiple units of state government in a highly fragmented way. For example, a person with a mental illness may be eligible for provider payment through Medicaid, for mental health services through state and federal mental health funds, for social support services through the U.S. Social Security Administration's Title XX program, for low-income housing through the U.S. Department of Housing and Urban Development (HUD), and so on.

A single intake system can streamline client entry and access to services, meanwhile saving the government staff time and the cost of service duplication. Wisconsin, Minnesota, Florida, and California have all implemented initiatives to

streamline the management structures of state programs for health and related services. The Wisconsin model has been highly successful for a number of years; the California program, on the other hand, had more problems than successes during an initial demonstration period. In 1999, the Robert Wood Johnson Foundation created an initiative, to improve the delivery of chronic care by Medicaid programs, that further elucidated the challenges encountered when providing integrated care under fragmented bureaucracies.

In cases in which the government bureaucracy controlling access to services is fragmented, service delivery to the client or patient is also highly likely to be fragmented. Unfortunately, fragmentation at the government level (whether the government involved be federal, state, or local) is currently more the norm than integration is.

The 1980s and 1990s saw major initiatives to foster integration at the organizational level, integration intended to translate into coordination of care at the patient level. By 2000, however, organizational efforts were focused more often on disintegration than integration. The National Chronic Care Consortium, which included several Catholic systems, closed after a solid 10 years of advocating integration. Many of the major health plan/health provider relationships were broken. Physician groups that had joined medical centers took back, or were given, their independence. A few highly integrated systems remain; and the lessons learned about how to integrate at a management level will, one hopes, be remembered when the pendulum of integration swings back. As of the middle of the first decade of the new millennium, however, structural integration among health care organizations is more the exception than the rule.

CASE MANAGEMENT

When organizational structure and payment systems are fragmented, some way must be found to coordinate clinical care. In the absence of true integration, "case management" has been the most popular means of achieving coordination of clinical care by a designated professional; "disease management" has evolved as a combined form of self-care and professional guidance.

Case management emerged in the 1970s as an activity distinct from public health nursing or social work. It has since proliferated to the point that there are more national organizations for case managers than there are for nurses or social workers. The role has become distinct and also diversified, with case managers having different roles in hospitals, home health agencies, social service programs, PACE and managed care organizations, among others. The authorities vary, with emphasis on direct patient assessment and monitoring ranging from intense to minimal decision making.

Payment for case management is another indicator of progress. In the early 1970s, payers did not recognize case management as a separate and billable activity. This has changed radically, and payment for it is now common. Federal demonstration projects in the 1970s documented the cost-effectiveness of case management under specific conditions. This was followed by payment demonstrations by commercial insurance companies; and when managed care took off, case management was an inherent component. Even HUD, recognizing the need for case managers to help its facilities' clients, finally authorized facilities to pay for such a position. Medicare, which recognized the case management role played by physicians and home health agencies, instituted payment codes for these activities. Case management programs are widespread among Catholic institutions, ranging from acute hospitals to community-based Catholic social service agencies.

Disease management started later, but over the past 15 years has traveled a similar path to clarification and acceptance. Disease management focuses on the process of service coordination and management around distinct types of medical conditions—such as diabetes and coronary heart disease—and emphasizes the role of the individual in self-management, as well as assistance from external care coordination techniques. Overall, mechanisms for coordinating clinical care are widely recognized as essential and, over the past 25 years, have indisputably progressed in sophistication and availability.

INTEGRATED FINANCING

"Form follows financing" is a common quip in the health care field, one that succinctly explains trends toward integration. This article's authors postulate that the fragmented financing that characterizes both U.S. health care services and the regulations that accompany them is the single most significant factor driving service fragmentation and inhibiting integration.

In the 1970s and 1980s, the United States explored several variations of integrated financing that produced both models of integrated care and (with these models) data concerning the impact of integrated financing on health care spending

and quality outcomes. PACE, one such program, has evolved over 30 years from a demonstration project to a formal program authorized by Medicare. In its best form, PACE pools funding from Medicare and Medicaid to provide comprehensive care for frail seniors who qualify for nursing home placement.

PACE is centered on adult day services, but it also includes inpatient placement, home care, and a variety of support services, such as meals and transportation. The original PACE model, On Lok of San Francisco, has clear documentation of quality-of-life outcomes and the program's cost-effectiveness. The original models show that, when adequate funding is provided and allowed to be pooled, a PACE program can offer a wide array of services in a way that enables very frail elderly people to be maintained with some degree of functional independence in their homes and communities, and at a cost no greater than (and sometimes less than) the same services would cost if organized and provided separately. Despite Medicare benefit status, some newer additional PACE sites (including several Catholic-sponsored programs) have struggled to a certain degree, due to the complications involved in getting certification by Medicare and waivers for state Medicaid programs, and due also to varying payment rates set by different states.

In the 1980s and 1990s, managed care proffered hope of establishing an integrated delivery system that would give Americans of all ages and conditions access to integrated health care services. Kaiser Permanente is the most pervasive and lasting private sector model of a health care delivery system that integrates not only a broad array of acute and long-term care services, as well as physician care and financing. Early health plans not only integrated care through payment mechanisms; they were organizationally joined with health care providers, primarily large medical centers and physician groups. The growth of the multilevel health care system was particularly expansive during the 1990s.

Congress also pinned considerable hope on managed care's promise to improve quality and manage expenditures. However, the value of managed care can be realized only to the extent that Medicare beneficiaries enroll in organized health plans. Following the Balanced Budget Act of 1997, managed care enrollments declined as health plans found they had fewer incentives to participate in Medicare. And despite corrections made in the Balanced Budget Refinement Act of

1999, Medicare enrollments continued to decline. From 2001 to 2003, total Medicare enrollment in all managed care options (including PACE and social health maintenance organizations) declined from 6.1 million people to 5.2 million (see **Figure 3,** below).

Since 2003, enrollments have once again been on the rise, reaching 5.4 million by January of 2005.[13] This increase inspires some hope that enrollments will increase as a result of improved incentives to do so, which were built into the Medicare Modernization Act (MMA) of 2003. Nonetheless, at present, only one in eight persons eligible for Medicare is enrolled in any type of managed care.

By the late 1990s, managed care for younger adults had also gone into a minor tailspin from which it has not yet recovered. Consumers (both individuals and employee payers) became dissatisfied with it, in part because the models varied and goals of stakeholders were not aligned. These shortcomings reflected an absence of integrated management, the first of the integrating mechanisms mentioned in this article. When integrated management is not in place—when, that is, integration is on paper rather than in the clinical office—cost savings will not be realized and seamlessness of delivery will not be achieved. Witness the difference between the Kaiser Permanente model of closed-system managed care, which has

FIGURE 3

Medicare Managed Care Enrollments by Year
(Includes risk-based, cost-based, SHMO, PACE total enrollments)
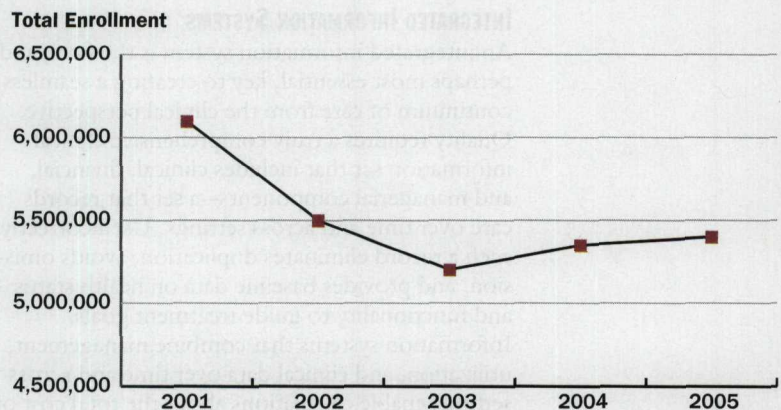
Source: Centers for Medicare & Medicaid Services, *Medicare Managed Care Geographic Service Area Report*

been sustained over time, and the numerous business arrangements in which large health plans buy medical centers (or vice versa) and then disappear, at a high cost to all involved.

The U.S. Veterans Health Administration (VA) is the most fully integrated continuum of care model. It includes a wide array of services and all four of the integrating mechanisms. The VA relies on a single primary source of income (the federal government) and offers, through a single entry point, a broad and virtually unrestricted package of services to those who qualify for full benefits. Regrettably, the VA is open only to those who served in the military; and many of those who qualify do not choose to get their health care through this system. Moreover, the system has not been established with prototypes or transferability in mind, so it is difficult for the private sector or private/public combinations to take advantage of the VA model. Data on costs and outcomes have not been compiled in a way that facilitates comparison with non-VA systems in terms of cost effectiveness or quality of care.

In contrast, the other federal health care payment "gorilla," Medicare, has introduced further disincentives for integration of care through its creation of separate payment mechanisms for each service it funds. As a result of the Balanced Budget Act of 1997, noted above, each service must use a distinct information system and calculate payment based on a formula pertaining to that service alone (see **Table 2,** p. 53) Although Medicare has superficially tried to promote managed care, it has done so in a way that makes its fee-for-service system more attractive to consumers and providers. Thus Medicare has worked against the integration of services by keeping payment streams not only separate but functionally challenging to combine.

INTEGRATED INFORMATION SYSTEMS

An integrated information system is the final, and perhaps most essential, key to creating a seamless continuum of care from the clinical perspective. Quality requires a truly comprehensive clinical information set that includes clinical, financial, and managerial components—a set that records care over time and across settings. Used correctly, such a record eliminates duplication, avoids omission, and provides baseline data on health status and functionality to guide treatment goals. Information systems that combine management, utilization, and clinical data over time and across settings enable calculations about the total cost of complex and/or chronic care, which in turn allow accurate financial projections about the total cost of care over time. Whether this is trans-

lated into capitated payments or long-term care insurance, the information system is the key to full financing.

When the continuum of care concept was first presented in 1984, a fully integrated information system was no more than theoretical.[14] But major technological developments have occurred since then. First, the size of a chip required to hold the magnitude of memory required to store a comprehensive medical record was reduced to micrometers, making large storage of comprehensive records of thousands of individuals possible. Second, the World Wide Web and internet made it feasible to share records across providers instantaneously. More recently, wireless technology has removed even more barriers to instantaneous, cross-site communication. Although none of the existing integrated patient information systems uses the internet as the core data platform, the electronic transmission of information has contributed to the acceptance of a real-time, comprehensive client data set.

Meanwhile, two setbacks countered these advances. First, HIPAA included various provisions to protect consumer confidentiality. Superficially, the provisions concerning the sharing of medical information appeared to inhibit the integration of care. Despite the fact that HIPAA was passed in 1996, a focus on compliance did not really occur until 2002-2003, when the regulations for implementation began to take effect.

Second, as noted above, the Balanced Budget Act of 1997 established distinct payment systems for each long-term care service paid for by Medicare, with each payment system based on a distinct assessment tool and accompanying clinical data set. **Table 2** (p. 53)shows the different payment mechanisms and accompanying assessment tools required by Medicare. A patient who transfers across services is assessed separately and differently for each service received. Thus, rather than fostering integration, the Centers for Medicare & Medicaid Services have created distinct barriers to creating a single, integrated information system that would enable the sharing of clinical and financial data across services and over time. Implementation of long-term care payment systems was phased in over time, but it coincided with HIPAA implementation, thereby causing health systems with long-term care components to have double consternation about the value of operating multiple services.

The Bush administration offered new hope for renewed resources and attention to a comprehensive patient information system. President Bush emphasized his desire to see progress on the elec-

tronic medical record (EMR). Congress enacted the MMA, which established a Commission of Systemic Interoperability to develop a comprehensive structure for advancement and implementation of standards as the foundation for a universal EMR. Then, in May 2004, President Bush appointed David Brailer, MD, PhD, as the national health information technology coordinator to spearhead the drive for an EMR. Dr. Brailer resigned after 18 months in office.

Regional health information organizations (RHIOs) represent yet another drive to coordinate information. RHIOs are exploring models that will enable health care entities in a community to establish electronic means of sharing patient data.

The MMA offers a new twist. In paying for prescription drug benefits, MMA will encourage the development of pharmacy data systems that keep comprehensive information about medications and the physicians that prescribe them. This may offer a backdoor way of promoting an integrated patient record. But the implementation of the legislation and its long-term effects remain to be seen.

As things stand in 2006, On Lok, the original PACE program; the VA; and, to a certain extent, Kaiser Permanente, have comprehensive, integrated information systems that encompass clinical, management, and financial data. Managed health care organizations, which conceptually should have had such comprehensive information, have instead evolved into preferred-provider organizations and network structures, with less, rather than more, client data. Medicare has perpetuated separate data systems rather than a uni-

form system. In short, the vast majority of Americans are not tracked by such a comprehensive, integrated health care information system. The creation of consensus about an EMR design may inspire more interest in an integrated patient record, but the cost of producing a record that spans time and place remains daunting to organizations already in business.

FOUR TASKS

The continuum of care framework provides a means by which one can assess the current status of integration and identify barriers to integration and consider what might be done to overcome them. Three particular tasks need to be accomplished, all of which apply to Catholic health, social service, and housing organizations seeking to fulfill their missions of providing optimum quality of care for people with complex, chronic illnesses.

■ *Clarify both "integration" and its purpose.* Over the past 20 years, the U.S. health care system has tried a variety of organizational structures, for different purposes, with mixed outcomes. Those who seek integration in the future should be very clear about what is to be done and why. Integration for business reasons is different from integration intended to create a seamless continuum of care for the patient's benefit. The fundamental management tasks of defining goals and operationalizing processes will be an immense help to initiatives referred to as "integration." Those who have tried to help a frail person obtain multiple services, receive timely delivery of care, and sort out myriad bills, know that

TABLE 2

Medicare Prospective Payment System, by Service

LTC Service	Payment System	Assessment
Hospitals	DRGs	DRG
Rehabilitation	CMGs	IRF
Nursing Facilities	RUGS	MDS
Hospice Care	4 levels of care, fixed per level Capped, amount set annnuallly	Prognosis of 6 months or less*
Home Care	HHRGs	OASIS
Long-term Care Hospitals	LTCH-DRGs	DRG
Psychiatric Hospitals	IPF-PPS	MEDPAR

* Assessment tool based on organizational locus of hospice.

Notes: CMG = case mix group; RUGS = resource utilization groups; IRF = functional independence measure; MDS = minimum data set; OASIS = outcomes assessment information system; HHRG = home health related groups; IPF = inpatient psychiatric facilities; DRG = diagnosis-related group; LTCH = long-term care hospital; PPS = prospective payment system; MEDPAR = Medcare provider analysis and review.

Source: C. Evashwick and J. Riedel, *Managing Long-Term Care,* Health Administration Press, Chicago, 2004.

integrated clinical care is badly needed. But other institutional goals are possible and may prevail.

The mission and social-benefit priorities that drive Catholic institutions set them apart from other organizations. It might appear that allocating funds for infrastructure is less important than providing immediate care for the at-risk individual. But devoting resources to structural alignment (such as the maintenance of EMRs) will in the long run improve clinical outcomes for that at-risk individual and for others in the frailest population groups.

■ *Remove government-imposed barriers to integration.* The federal government is the single largest payer for health care services, particularly for populations with chronic illnesses. As such, government should recognize the barriers to integration resulting from its own actions—including the costs those actions force the health care system to incur at the very moment the nation is trying to curb rising health care expenses. Federal, state, and local governments should continue efforts to streamline health care system bureaucracies. Catholic organizations, with their public support and structured advocacy avenues, can lead by bringing together diverse government factions and actively advocating policies and programs that foster integration.

■ *Create an EMR.* The evolution and enactment of an EMR will expedite clinical integration and thus lend impetus to financial and management systems integration. An EMR should be encouraged, articulated, and funded by health care institutions as a long-range strategy for high-quality and efficient care. RHIOs should continue to be examined as a mechanism for sharing data on a community-wide basis. Social service and housing agencies, which are not necessarily involved in the current EMR health-focused initiative, should attempt to structure records in a manner that makes them compatible with private sector and government agency record systems.

■ *Gather better data to elucidate these three tasks.* Data are available from individual organizations (as are data on limited aspects of integration), but larger and more encompassing studies would help provide the evidence needed to convince payers, providers, and consumers to advocate and work for an integrated system of care. Federal or private funding for research on integration is miniscule compared to funding for research on clinical topics, payment mechanisms, or other health systems issues. Catholic systems, many of which have continued to provide long-

term care and home care (along with acute care) as a mission commitment, are poised to contribute vital information concerning the cost-effectiveness of integration as it pertains to the care of the frail and chronically ill.

FROM THEORY TO PRACTICE

In the early years of the new millennium, the United States faces a portending tsunami of demand for complex, costly care for chronic conditions. A cost-effective, high-quality system of care calls for integration of services, information, and payment. Initiatives over the past 20 years have largely failed to produce the desired streamlined systems of care.

The continuum of care framework provides a tool with which we can examine what has worked and what has not. Service availability has grown nationwide; only acute care hospital beds have declined in number as they have been replaced by other service options. Case management has evolved into a strong and recognized mechanism for coordinating care across fragmented services and payment streams; disease management offers an increasingly popular format that involves consumers in managing their own chronic conditions. Organizational coordination has, for the most part, retrenched in the light of payment systems, management issues, and industry consolidation. Financing systems have become more fragmented, despite superficial government attention to managed care. Information systems have exploded in potential, but remain costly and undirected as applied to integration.

Managed care has led many patients to believe that they are in a single system of care. In most cases, unfortunately, the only facets of such care that may be coordinated are access to services and payment of those services that happen to be covered. The majority of patients who require care for chronic, complex illnesses must coordinate their care among multiple providers, with multiple payment arrangements.

The ability to manage chronic care, whether on the part of the individual or the professional, will become particularly important as the U.S. population ages and the chronic illnesses of adults become more prevalent than the contagious diseases of childhood. The magnitude of the challenge facing the nation's health care delivery system is unprecedented.

The good news is that, throughout all of the gyrations of the 1980s and 1990s, a few genuine stars have emerged. The VA, Kaiser-Permanente,

and the On Lok program and its PACE replications are all model systems. These organizations, having achieved integration, give their patients access to a wide array of services tailored to individual need. These organizations have some form of the four basic integrating mechanisms in place and have made a commitment to put resources into integration.

Catholic health care systems, long-term care facilities, housing complexes, and social service agencies interface in many communities. In some, they work closely together, creating continuity of care through informal or formal use of the integrating mechanisms. In others, communication and coordination are not accomplished as easily. Over the past 25 years, Catholic institutions—both single organizations and multifaceted delivery systems—have explored various techniques for integration. Although many of these initiatives have concluded, some remain strong, and even those that have disappeared have made lasting contributions. Foundations grounded in the ultimate mission of caring for the frail remain to be built upon. Catholic health care and social services are well-positioned to allow this to occur. Truly integrated organizations demonstrate that the theoretical construct is indeed realistic; and that, once integration has been achieved, it will improve cost-effectiveness and quality of care. ∎

NOTES

1. C. J. Evashwick, "Creating a Continuum of Care," *Health Progress,* vol. 70, no. 5, June 1989, pp. 36-39, 56; and "Integrating Housing and Health Care," *Health Progress,* vol. 81, no. 3, May-June, 2000, pp. 40-43, 51.
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