

Reflections on Integrating Medical and Social Care: Five Laws Revisited

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ABSTRACT

This paper reviews, rethinks, expands and applies the author's 'laws' of integration, which were first published six years ago. This approach both introduces the laws to readers who don't know them, and tests their utility for those who do. In retrospect, real-world integration efforts mix and match the original components of linkage, co-ordination and full integration. But the message remains to work at all levels, keep it simple, make finances supportive and empower social care.

KEY WORDS: INTEGRATION; INTEGRATING; LONG-TERM CARE; SOCIAL CARE; MEDICAL CARE; ELDER CARE; CO-ORDINATION; CASE MANAGEMENT; CARE MANAGEMENT; INTEGRATED SYSTEMS

Introduction

It's an honour to be asked by the editor to reflect on my paper, 'Five laws for integrating medical and social care' (Leutz, 1999). The request reflects continuing world-wide interest in integration, an interest that remains strong for reasons now familiar to researchers, providers and policy-makers in medical care, social care and other supportive services. Industrial countries have ageing populations whose needs are getting clearer, and the costs of their care are going up. And interest in integration is not limited to elders, but also relevant to other populations that use services simultaneously from multiple care systems, such as individuals with physical and intellectual disabilities or mental illness.

Concerns also remain about declines in informal support potential - fewer multi-generational households, more women working, more divorce and changing preferences. Interest in models of care for chronic illness has increased, along with a realisation (among many at least) that a disease-specific, acute care model is inappropriate for people with multiple chronic illnesses, who need more continuity and broader co-ordination of services. A model for the management of such long-term conditions is currently being promoted by the UK Department of Health (DoH, 2005).

One counter-trend is the consumer-centred care model, which questions the kinds of professional management and co-ordination that accompany integration. But I remain convinced that the availability of an accessible range of co-ordinated services is consistent with focus on consumer preferences.

Since my original thinking is now eight years old, and the integration efforts I reviewed are now generally a decade old or more, I know of more new developments than I could possibly review here, and there is certainly more happening than I know about. So rather than try to be comprehensive, I will use the 'laws' to assess a few of the current integration initiatives that I know best. I hope that this approach will both introduce the laws to readers who don't know them, and test their utility for those who do. I will also toy with a few new laws.

Why think that these laws are still (or ever were) relevant?

For one thing, they are fairly simple notions in a very complex field. There are other thoughtful and more comprehensive frameworks for co-ordinating across service systems, large studies have been conducted (for example in Europe, PROCARE, and in the USA, PACE and MMIP; see links, after References) and this is not the only journal devoted to integration. I also had the audacity to call them 'laws'; I knew that it was presumptuous and far-fetched, but it did get attention.

The original five laws are shown in Box 1, below. But rather than simply re-hash the laws in detail, to frame the discussion, I will introduce them in a new order to help answer three sets of questions.

* Why is integration so difficult?

* Can we make it any easier?

* What other guides for integration exist?

Why is integration so difficult? (4th law)

The fourth law of integration states that You can't integrate a square peg into a round hole, and it frames some important answers to this question. The square-round notion is that medical care and social care contain a series of Inherent differences in financing, administration, providers, clinical orientation, access and benefits which make it difficult to integrate these systems (Table 1, opposite). The people involved simply see and do things differently, and they are supported by different kinds of funding and benefit systems. The financing differences are the most problematic. On the medical side, most people in the US, and everyone in the UK, has a relatively uniform medical care entitlement, but on the social care side, eligibility for services is often means-tested, that is, you can't count on most people's having access to them.

Compounding the challenges to integration is the widespread belief that the only truly effective way to overcome these square-round differences is an all-or-nothing approach. That is, when people talk about 'integration' they mean something multi-dimensional - pooling finances, joint purchasing of services, shared information systems, common assessments and care co-ordination by teams. The view is that, unless you go all the way, the full benefits in terms of clinical outcomes and system efficiency won't be achieved. So how have such full integration initiatives fared in recent years?

The US continues to use private, managed-care provider models fully to square these round holes. The stand-out programmes are the Program for All-Inclusive Care for the Elderly - PACE - and the Medicare/Medicaid Integration Program - MMIP - both of which pool capitated payments from Medicare and Medicaid to create systems delivering all medical and long-term care services. Congress made PACE a stand-alone Medicare programme in 1997. While PACE has received high marks for comprehensive services, quality of care, programme savings and reducing institutional use (Irvin et al, 1997; Gruenberg & Kaganova, 1997; Chatterji et al, 1998; Pacala et al, 2000; ABT Associates, 1997), its national impact is limited by its focus on very frail elders who are also eligible for both Medicare and Medicaid, and by its reliance on states' willingness to participate. In January 2005, PACE was in only 18 of the 50 states, and its 36 provider sponsors served only 10,523 of the more than six million dual eligibles (DataPACE).

The MMIP model was conceived to serve any dual eligible (not just the frail, as in PACE), but the concept has been hard to replicate beyond seven providers in the two pilot states (Minnesota and Wisconsin). After nine years and \$8 million in foundation funding, only one of twelve replication grantees implemented the full model: Massachusetts, with three provider sponsors in 2004 (GAO, 2000). The slow growth of both PACE and MMIP reflects how difficult it is fully to integrate policy, financing and service delivery in the US.

In contrast to the provider-driven and state-driven efforts in the US, the UK has used strong national direction in its health and social care systems to push integration from the top, by giving more planning responsibilities to large primary care groups (DoH, 1997; Drummond et al, 2001; Audit Commission, 2002; Willcocks & Conway, 2002), by improvements in community care management (Hardy et al, 1999; Ware et al, 2001) and through directives to encourage 'joined-up' working between health and social service sectors, including joint policy-making, budgeting and commissioning of services (DoH, 1998, 2001, 2004). The ultimate model became the care trust an NHS organisation incorporating local authority social services functions, and with integrated governance. Legislation was put in place to allow this integrated organisation to emerge at local discretion.

Studies of UK efforts to integrate show some successes, but also tremendous organisational challenges (Charlesworth, 2001), the need for training in public health and interest in planning (Freudenstein & Yates, 2001) and structures, but little content, to health improvement programming (Elston & Fulop, 2002). Analyses sponsored by the Government's Integrated Care Network detail the challenges in getting medical providers, users and carers, and politicians involved (Hudson, 2003), as well as barriers posed by different cultures 'among front-line staff, management and bureaucracy...' (Hudson, 2004). Participants in a 2004 conference wondered whether the costs of 'wholesale structural integration' were worth the benefits, which accrue primarily to small groups at risk of hospitalisation (Glasby, 2004). Only a handful of care trusts have been put in place; progress on large-scale integration in the UK has therefore been as slow and patchy as in the USA.

Can we make integration easier? (1st law)

Many of these challenges with multi-dimensional integration efforts, as well as the fact that they seemed relevant only to small sub-populations, were apparent ten years ago. This led to the conception of the first law. You can integrate some of the services for all the people, all the services for some of the people, but you can't integrate all the services for all the people.

It occurred to me that all the attention was being focused on what to do for relatively small subsets of the most disabled and poorest sectors of the population, which led me to ask what we should be doing for the large majority of chronically ill and disabled people who were perhaps not quite as sick, disabled or poor. Second, the approach that was being taken - to pool financing, create integrated delivery systems and get professionals into interdisciplinary teams - posed tremendous challenges. I started to ask whether there were simpler approaches than trying to integrate everything.

Linkage, co-ordination and full integration

The answer to both these questions was to describe three levels of integration: the 'full integration' of PACE, MMIP and the UK ideal, as well as two 'lesser' levels called co-ordination and linkage. The paper laid out prototypical profiles of the needs of service users - in terms of severity, stability, duration, urgency, scope of services and capacity for self-direction - that could be addressed at these three levels. Needs that could be addressed through linkage were hypothesised to be generally on the lesser end of these dimensions, but they were important because they involved the most people. Co-ordination was in the middle in terms of severity and number of people, and full integration was appropriate for the relatively small number with greatest needs. (This categorisation of need is reflected in the recent UK approach to long-term conditions, which itself is based on a pyramid structure developed by the US provider, Kaiser Permanente.) Concurrently, the model laid out how the three levels of integration connect medical and social care systems in terms of financing, organisation, screening for need, clinical practice, case management, information systems and transition management.

For example, a primary care system providing linkage with social care might screen the entire population for social care needs, understand who pays for what social care benefits, provide eligible populations with accurate information and make good referrals. A primary care system co-ordinated with social care identifies those with newly emerging need at key points (such as home care after hospital discharge), plans how staff in bordering systems work together to smooth transitions across settings and benefits, decides who pays for what between different benefit systems, using specific guidelines that maximise impact and efficiency, and provides information about individuals' care, routinely, in both directions. In full integration, medical and social care finances are pooled to create a common set of benefits and eligibility guides, teams manage care in all settings and during all transitions, and clinical information is in a common record. Screening for need is not really an issue, since all those served have such severity and/or instability that they must be in frequent touch with team members. A short-hand measure to compare levels of integration is case management: none in linkage, varied in co-ordination and team in full integration.

Since the paper came out, examples of both linkage and co-ordination have been tested. The idea of 'link workers' from social services departments who engage with designated primary health care teams has a long history in the UK, but has so

far not become the mainstream model (Cumella & LeMesurier, 1999), and an interesting, rather different approach, the Care Direct al, 2002). This tested a system of telephone-entry and triage to a range of social welfare services and benefits. The US Community Partnerships for Older Adults initiative is also helping communities to establish linkage capacities (Leutz & Rethmeier, 2004).

An example of co-ordination of medical and social care for frail elders is Quebec's PRISMA demonstration (HÃ©bert et al, 2003; HÃ©bert & Gagnon, 2005). Buy-in to PRISMA was achieved by negotiated agreements with provincial and private medical and social care agencies in test sites. Agencies agreed to use a common assessment administered at a single point of entry, as well as a common clinical chart and care plan. They negotiated budgeting of services, and a single coordinating case manager worked with existing providers in all service sectors. Results of the pilot test were positive in terms of functional decline, use of accident and emergency services, caregiver burden and institutionalisation. A good UK example is hospital discharge, where new collaborative teams emerged when the Government legislated to give hospitals the power to charge local authorities for 'blocked beds' (CSCI, 2004).

Mixed models

While these relatively 'pure' examples of linkage and co-ordination seem to support the first law, on second thought laying out three prototypical models was probably not a true reflection of the reality of what programmes actually have done, which is to integrate different aspects of their programmes to different degrees, depending in part on opportunities. Even the explicitly co-ordinated PRISMA model mixed elements (no financial or team integration, but a common electronic clinical record).

Another example is US Social HMOs, which 'fully' integrate acute care and private financing to create and pay for new benefits, but which use case managers to co-ordinate social and medical care. The degree to which case managers can even coordinate depends on whether corresponding primary care staff operate largely alone or are supported by nurses, social workers and medical care managers who can serve as points of contact (discussed further below) (Abrahams et al, 1992). Similarly, while the MMIP sites fully integrate finances, they also vary in their degree of clinical connection. Case managers in Minnesota operate much like the better co-ordinated Social HMO sites, connecting with medical office staff and physicians (Malone et al, 2004). Even the Wisconsin sites bring physicians into the multi-disciplinary team only by sending the team nurse practitioner to all primary care visits (Wisconsin DHFS, 2000).

Single point of contact

Another piece of making integration easier has become more apparent to me since the laws paper came out This is the creation and use of a 'single point of contact' in an agency to handle either linkage or co-ordination. Using a single point of contact for linkage became clearest to me in my work with a demonstration in the eight-million-member Kaiser Permanente managed care organisation in the US (Leutz et al, 2003). In the demonstration, we asked local clinicians and managers to propose models for connecting Kaiser's acute care to community social care services for its members with disabilities. Again and again in this multi-site demonstration, the same solutions were developed by the successful sites: the designation of an individual (generally a nurse or social worker) whose responsibility was:

- * to develop a referral agreement with one or more types of social care agency
- * to work with clinicians to identify Kaiser members who might need the service
- * to facilitate referrals to the agencies
- * to be available to the agencies to provide information about clinical issues.

Single points of contact are also a common adjunct to case management in co-ordinated systems. As discussed above, case managers in Social HMOs and MSHO sites rely on particular nurses in medical offices to get information to and from

physicians.

This has resonance in the UK, of course: the Caie Direct pilots, the implementation of the single assessment process (SAP) and the plans for telecare.

Other guides to integration (3rd, 4th & 5th laws and more)

Help not hassle for physicians

In my earlier review of integration initiatives, I looked at the efforts of integration advocates - for elders, the mentally ill and children with disabilities - and I kept feeling sorry for the poor doctors. They took so much grief: for not co-operating, not understanding and not taking the initiative even when they were given the chance to plan integration. Then I saw an evaluation that said doctors were suffering from 'consultation fatigue', and it all came together in the 3rd law: Your integration is my fragmentation.

The physicians were getting pulled in different directions by all these integrators, and physicians experienced it as fragmentation of their jobs. This also seems true for GPs in the UK, but their 'independent contractor' status is also an unfortunate barrier.

Would-be integrators should remember that a way to address this new kind of fragmentation problem is to help solve a problem for doctors and other would-be collaborators, not create new problems. In the Kaiser Permanente demonstration discussed above, the successful sites approached physicians with a solution to a problem in their practice; not with a new demand. Patients with disabilities certainly presented challenges to physicians, so there were opportunities. The integrators also made it simple for physicians, for example, just to refer anyone who seemed to fit the criteria to a single point of contact who functioned as the link between the medical and social care systems. For example, neurologists and primary care physicians were told, we can help you with your patients with dementia - send them to us.

Put the right person/organisation in charge of integration

This is a dearer statement of the fifth law: The one who integrates calls the tune. This law hit me when I saw how different people could look at the same fragmentation problem and come up with different solutions. And, not surprisingly, the solution was usually to address their own problem with lack of co-ordination, rather than the problem experienced by others in the broader system, who of course would each see things from their own points of view.

We exercised this law in reviewing proposals in the Kaiser demonstration. Among the 200 proposals we received, there were many to improve nursing home care for Kaiser members with disabilities, to expand skilled home health care or to add to geriatric speciality care. These proposals were all worthwhile, but they didn't address the problem we were most interested in - the lack of connections with community-based social care. So we decided that we just wouldn't consider the medically based proposals. We would use the money to empower the social care people.

And that's the point of this law. If you have the authority to design an integration programme, you have some power and resources to hand out. Here are some guides to choosing whom to empower.

* Put someone in charge of initiating integration who shares your goals (co-operation, inclusiveness, social care and so on).

* Use planning and administrative roles to empower weaker system actors - social care agencies, adult day care, volunteers and of course service users and family members.

* Watch for professionals' (particularly the most powerful ones) prioritising their own care. The result could be upward substitution, for example social care money going to skilled care.

* Find ways to get clients' views on the table; they may not want to talk in a group with professionals. Organise separate gatherings with resolutions and then send spokespersons to meet the professionals. Attend to transport, time and place, and caregiving.

* Give individual budgets to service users when they prefer, and when they are able to manage the complexity of care being purchased (now being considered as part of future plans for UK social care).

Support integration financially

This is an update to the original statement of the 2nd law: Integration costs before it pays, which was a reaction to the frequent promise of integration initiatives to save money from the start. Based on this kind of thinking, when integration is introduced, somebody's budget gets cut and/or their responsibilities get expanded. Often this comes in the form of the so-called 'downward substitution', where cheaper social care is supposed to do what a skilled service provider was doing. This is seldom a good start to a working relationship. The Five Laws article found that integration efforts worked better when three things happened - each of which can increase costs, at least in the short run:

* provide start-up support

* add staff and support systems

* add new services or funding for existing services.

The 2003 Medicare Modernization Act in the US is the motivation for updating statement. From 2006, this legislation requires capitated provider organisations like Social HMOs, PACE and the MMIP plans:

* closely to document and report on their costs for providing Medicare benefits

* to give back 25% of the savings if they can deliver those two provisions may make it much more difficult than previously to use savings to pay for additional services and care management. Under current policy, accounting is much less specific and there is no give-back requirement. Additionally, once Medicare asks for more specific financial information about what its money is paying for, Medicaid may also want evidence that its money is paying for Medicaid services. On the surface this sounds rational, but how is a programme to pay for services that overlap the two systems (such as a visit by a home health nurse or aide) or care management to co-ordinate the two systems? The efficiencies of pooled financing and integrated provision of services could easily be lost if the major medical and social payers demand to see services split into 'mine' and 'yours'. Time will tell whether the new law leads to disintegration of long-standing integration efforts.

All integration is local

This was not one of the original laws, but perhaps it should have been. On the one hand is the notion locally in a way that is consistent with the particulars of local systems and personnel. On the other is the idea that larger policies should facilitate rather than dictate the structure and pace of local action. The UK's Section 31 'flexibilities' are a good model for letting locals take the lead and not get forced, and successes have been based on local leadership, development of trust, doing what works, etc, rather than top-down directives (Hudson et al, 2002). Another Department of Health-commissioned paper says that partnership is a means to an end and that the system should avoid structural solutions and focus on local solutions.

What matters is the processes employed to overcome and work round existing boundaries rather than action to eradicate such boundaries altogether. (Glasby, 2004)

The EPICS programme in Buckinghamshire is a wonderful example of starting small and local and building a larger system (Foote & Stanners, 2002).

Keep it simple, stupid

This admonition to Bill Clinton by his campaign advisors was almost one of the original laws. The idea is to look first for a simple solution for a seemingly complex problem. The single point of contact is a good example. It can work on both sides of the border and can take on more as needed and as resources permit. The Japanese long-term care insurance (ITCI) system appeals to use this simple model for co-ordination. In interviews Naoki hospital staff, and elders and families, we found that both case managers and medical system staff rely on the home care nurse as the single point of contact (Leutz & Ikegami, 2004). Working with the nurse is facilitated by the fact that home nursing is part of the ITCI benefit and is therefore ordered by the case manager (CM) (2001 data show 15% of beneficiaries with home nursing in their ITCI care plans). When there is a medical problem at home, the nurse, not the CM, can get through to the medical offices when needed and talk their language. And when the medical side needs support in the home, they look for the nurse - not the CM. The nurse as a link doesn't seem to have been a piece of the clinical design of ITCI but rather a way to sell the programme by saving health insurance money. But the professionals seem to be taking advantage of it. The designers of single points of contact in the Kaiser demonstration also used the 'keep it simple' model; they approached physicians with a solution to a problem in their practice, not with a new demand.

Don't try to integrate everything

Social care is different from medical care and by many measures just as valuable. This is implicit in the first law, but it's worth stating it directly. An ability to focus on better using but not subsuming social care systems maybe the most important benefit of paying attention to linkage and coordination, which can maintain and even strengthen the weaker partner in integration initiatives. While it maybe difficult to show that social care services save or even prolong the lives of people with disabilities, it is possible to show that making them more accessible and better coordinated will increase satisfaction and make their lives easier (Capitman, 2003; Capitman & Leutz, 2002; Leutz et al, 2001).

Integration isn't built in a day

Finally, watching the efforts of some of the full integration initiatives in the US, I have joked with a paraphrase of Winston Churchill: seldom have so many done so much for so few for so long. Integration takes time. You can't rush it. And the timelines maybe another reason to consider the easier linkage and co-ordination approaches if they can get some of the job done.

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Links to major studies

PROCARE (EU): www.euro.centreorg/procare/

MMIP (US): www.hhp.umd.edu/AGING/MMIP/

PACE (US): www.cms.hhs.gov/pace/default.asp

See also *International Journal of Integrated Care*: www.ijic.org/.

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