



One Patient: CARP's Care Continuum

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CARP is calling for an integrated continuum of post-acute healthcare that follows patients from first diagnosis or acute episode, through initial treatment, ongoing care, and through end of life needs. The current health system is fragmented and falls short of effectively and sustainably meeting health care needs. Individual components of the health care system, such as acute care, home care, and long-term care are largely effective in treating isolated health issues, but are often dislocated from one another, failing to follow patients through the full spectrum of health needs.

Health care providers must recognize that there is only one patient or health care consumer and go beyond the individual components towards an integrated continuum of care that connects the full range of health services to patient needs. CARP's Care Continuum is both person centred and aims to achieve greater health efficiency and spending sustainability by integrating disconnected health silos.

Putting people first: An integrated continuum of care

CARP's Care Continuum is person-centric and takes into consideration the full spectrum of health needs - emotional, mental, social, and physical – from first diagnosis, through acute and long term care, to end of life. That means stable funding and mandatory standards of home care, income support for caregivers, especially those providing heavy care, geriatric care, assisted living services at home and in affordable housing, equitable access to decent nursing homes and quality end of life care.

Each individual component plays a valuable role:

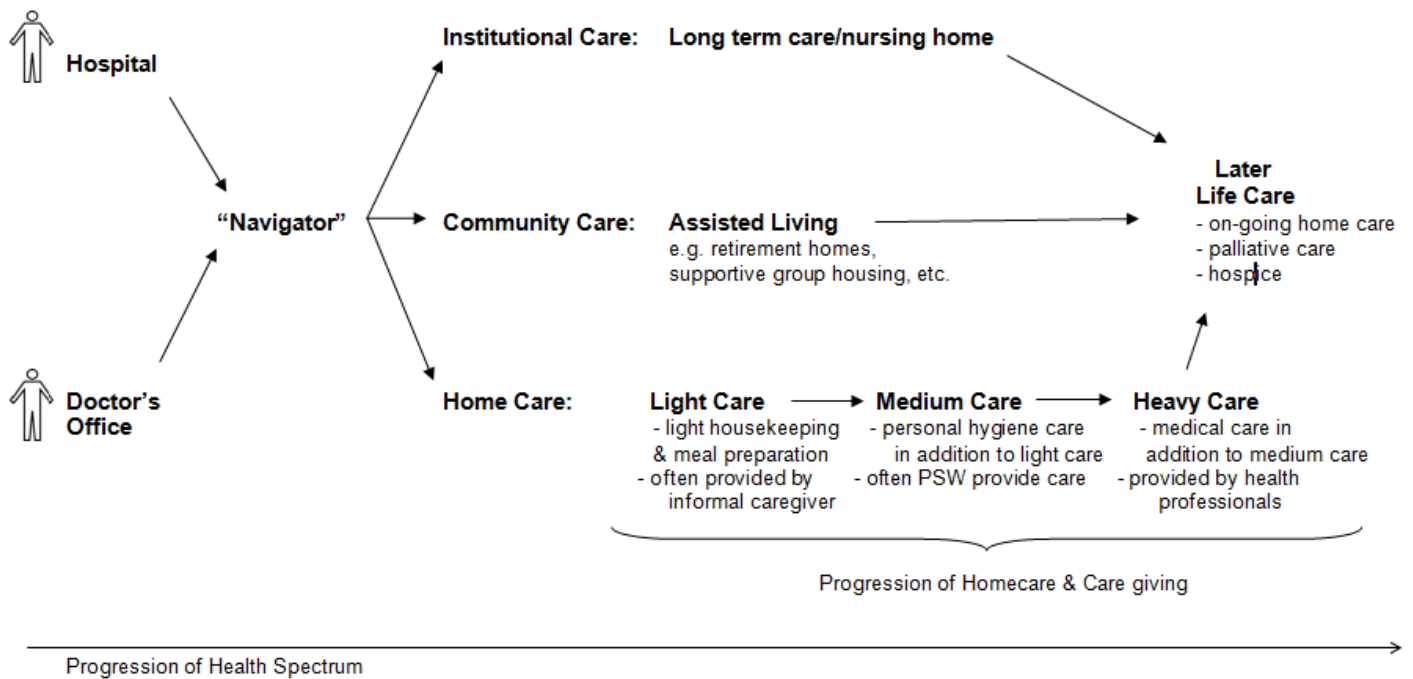
- **Assisted Living** – provides options to allow people to live independently but within community settings while receiving some assistance with daily activities.
- **Home Care** – provides individuals the ability to live within their own homes while receiving a level of care suited to their care needs such as light house keeping, personal hygiene care, up to and including professional medical care.
- **Caregiving** – is integral to home care. It provides options to ensure that caregivers have adequate resources so that they can continue to provide care without taking on large financial and emotional burdens.
- **Institutional Long-Term Care (LTC)** – more emphasis is needed on homecare provision, but LTC provides individuals, who have very heavy needs and few informal supports, a safe and healthy place to age.
- **Palliative/End of Life Care** – provides care that enables people to live their last stages of life with dignity and with minimal pain and discomfort.

Connecting the dots: Integration and continuing care

The fractured health system must integrate the various components and offer people a full continuum of care. Individual components of the health system, no matter how effective, can only treat patients in a piecemeal manner. CARP's Care Continuum challenges health officials to connect the dots between the separate functions of the health system to allow better care for all patients, from first diagnosis.

People's needs are diverse and constantly changing as they age. To meet those needs both effectively and sustainably, the system must be flexible enough to respond to those needs, allowing people to move seamlessly from one component to the next. The key to CARP's Care Continuum is system navigation and formal communication between the many and various health professionals charged with providing patient care.

CARP'S CARE CONTINUUM Recommended Model



Navigation is Key to the Care Continuum

An integrated continuum of care depends on ease of access for individual families and requires the health care system to be well-coordinated, easy to navigate, and responsive. It will avoid premature institutionalization of seniors, which burdens the system with unnecessary costs. And it will ensure that no one slips through gaps in care and treatment. Moreover, it will also ensure that patient needs are being met adequately and in a timely manner. CARP's Care Continuum lays out a logical pathway of how one could move from one component in the health system to another in a seamless fashion by integrating disconnected health silos and following patients through the spectrum of health needs.

CARP's Care Continuum emphasizes the importance of integrating the health silos in order to better provide a continuum of care for all people as they age. If the system is fully integrated, a separate function of a "Navigator" should not be necessary. Until then, it is vital.

Health system navigation, electronic health and lab records, and projects, such as the *Virtual Ward*, should aim to bridge gaps in service quality and provision. While it is necessary to address gaps in health coverage currently found in the various components of the health system, including the need for sustained home care funding and better palliative care, the next big step in health care delivery should be a system that facilitates simple and effective navigation of the health system.

Cost Savings and Efficiency

CARP's Care Continuum aims to deliver better patient centred care more sustainably. In a time of tight budgets, reallocating resources to focus on non-institutional care does not require new spending and holds the potential to generate system wide savings.

Hospital readmissions can be costly:

- An average readmission in Canada costs approximate \$10,000.ⁱⁱ
- In 2010, more than 180,000 Canadians were readmitted to acute care, costing the health care system \$1.8 billion.ⁱⁱⁱ

An integrated continuum of care consisting of easily navigable and properly resourced alternatives to acute and institutional care can help minimize the number of hospital readmissions along with their associated high costs. There are many opportunities to save costs and be more effective with our resources:

- Cost of homecare was found to be only 40%-75% of the costs of LTC depending on the level of care, according to a study of BC's cost of homecare^{iv} (See Table 1).
- Hospital bed care would cost \$2.5 million as opposed to only \$125,000 with home care for 424 seniors for a week, according to the North East Local Health Integration Centre^v (See Table 2).
- An average of 5,200 hospital beds in Canada are occupied by those who no longer require acute care but could manage with home care supports – the majority of them (85%) are seniors.^{vi}

Table 1. Comparative Cost Analysis in BC-1996/97 Cohort in 1996/97 Dollars Average Cost^{vii}

Level of Care	Community Care (\$)	Facility Care (\$)
Light Care	9,624	25,742
Moderate Care	16,315	31,907
Heavy Care	24,560	40,324
Extended Care	34,859	44,233

Table 2. Comparative Cost Analysis from North East Local Health Integration Centre, 2011.^{viii}

	Average Cost of Care (for one week for 424 seniors)	Average Per Diem Cost
Hospital Bed	\$2.5 million	\$842/day
Long-Term Care bed	\$372, 000	\$126/day
Care at Home	\$125,000	\$42/day

More opportunities, such as *the Virtual Ward Program* and *Mount Sinai Hospital's Acute Care for Elders* unit, can reduce costs without compromising quality of care. The *Virtual Ward Program* provides hospital-like transitional medical support and attention but without the associated high costs since it is provided within the patient's home. Beyond reducing costs, it has the potential to improve quality of care, allow patients to stabilize in their own homes, and reduce the length of time for people to regain their health and independence.^{ix}

Also reducing unnecessary hospitalizations, *Mount Sinai Hospital's Acute Care for Elders* unit, pioneered by Dr. Samir Sinha, provides a house call program, in which specialists and family physicians can conduct house calls to keep seniors at home longer. Even if seniors are eventually placed in long term care, the decision can be made in an orderly fashion rather than on a crisis basis.

Caregivers enable homecare to be possible, but due to the substantial support that they provide, caregivers are cannot always shoulder the financial and personal strains of caregiving.^x In 2011, Ontario introduced the Family Caregiver Leave Act that will provide up to 8 weeks of unpaid job leave for employees to provide care and support to a sick or injured family member.^{xi} Although the need has been recognized in some provinces, more can be done:

- In 2007, 2.7 million Canadians aged 45 and older reported providing care for seniors, the value of the unpaid labour contributed by informal caregivers is estimated to be \$25 billion per year.^{xii}
- OECD report findings show that caregivers are more likely to leave the labour force entirely instead of reducing their labour force hours, suggesting that caregivers are not balancing both heavy care and employment successfully^{xiii}
- A study compared the cost of a proposed care-giving allowance of \$200/month and services evaluated at \$25/hour with the cost of a bed in a LTC facility at \$130/day. Results showed that the savings from their proposed policy proposal would be 6 times the projected LTC facility expenditures.^{xiv}

Action is Needed Now

Action can no longer be delayed. Increasingly, people are developing chronic conditions and long-term illnesses, where seniors are particularly at risk.^{xv} A comprehensive system of homecare, long-term care facilities, and supports for caregivers along with multi-disciplinary health professional teams can increase both the cost effectiveness and health outcomes of health care spending. However, the current system is complex, fragmented, and inefficient, preventing people from receiving appropriate timely care.

Coordination is one of the most needed factors in making the system work efficiently. A system champion is needed to bring the different components together and develop a system that is easy to navigate, flexible to meet changing needs, and effective in its use of resources.

CARP's recommended Care Continuum calls for a comprehensive system that is easy to navigate and provides smooth transitions between each stage. The system must also be built upon research and evidence with checks and balances in place to ensure transparency and accountability. Overarching this whole reform, there must be a holistic patient-centered approach, in which the perspective and needs of the patient guide and ensure effective delivery.

References

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