One Patient:
CARP's Care Continuum

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CARP is calling for an integrated continuum of care to address the chronic care needs of an aging population. The current post-acute healthcare system is fragmented and patients have to navigate, on their own, the individual components, such as acute care, ongoing treatment and care, home care, and long term care.

CARP's care continuum calls on the health care system to transform into a single seamless continuum of care that gives patients clear and direct access to care from first diagnosis or acute episode, through acute care, home and community based long term care, through to end of life needs.

CARP's care continuum envisions an integrated system of care that addresses the full spectrum of health needs - emotional, mental, social, and physical – when and where they are needed. That will require a fundamental shift in attitude. The various components of the health system must be coordinated in communication and approach in order to improve patient access to timely and seamless quality healthcare.

Putting People First: An Integrated Continuum of Care

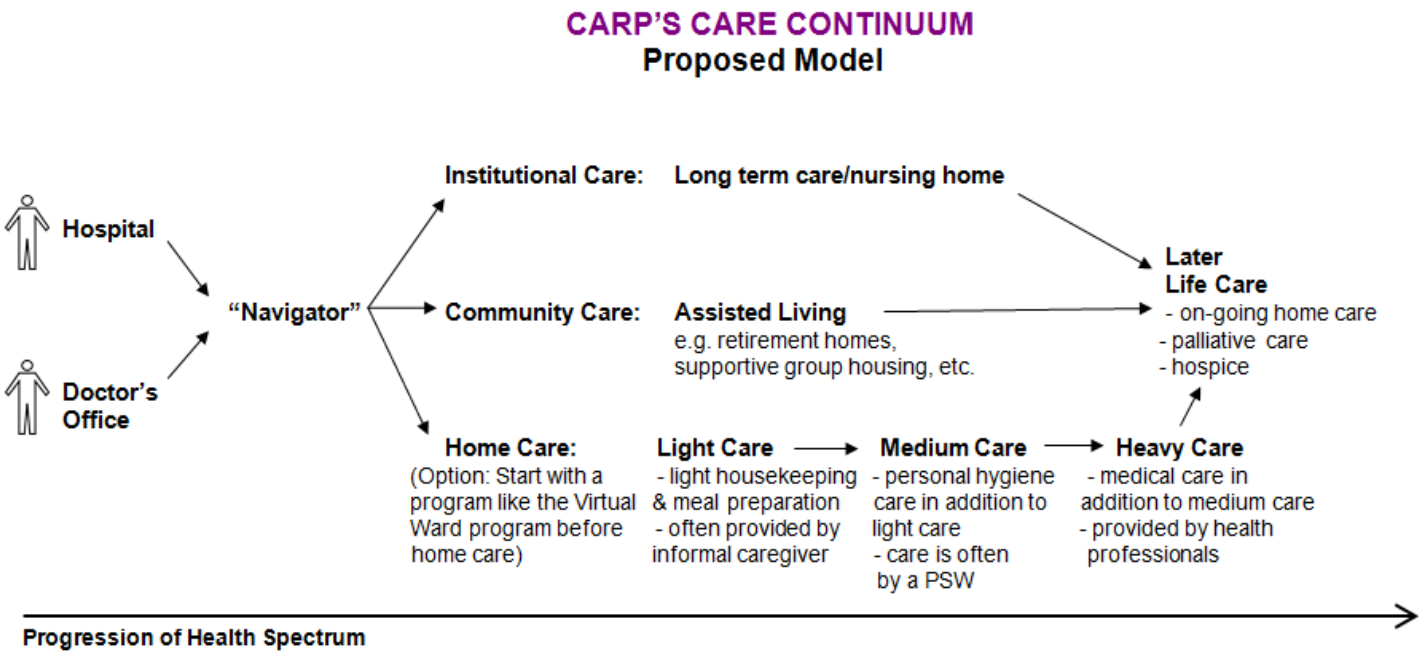
Each individual component of the health care system needs to be better coordinated as a part of a single system. Ideally, each individual component would fulfil their valuable role, supported by stable funding and mandatory standards to better deliver care across the spectrum of health needs:

- **Acute Care** – establish a continuum of care as the first point of entry and contact with the system. Its role is important in ensuring that care follows the patient through the spectrum of health needs.
- **Assisted Living** – enable independent living but within a community setting with some assistance with daily activities.
- **Home Care** – allow people to live at home while receiving a level of care suited to their needs such as light housekeeping, personal hygiene care, up to and including professional medical care.
- **Caregiving** – allow people to receive the care they need, especially at home. Family caregivers, especially those who provide heavy care, should have proper financial support, guidance, and respite resources to relieve their financial and emotional burden.
- **Institutional Long-Term Care (LTC)** –provide individuals who have very heavy care needs and few informal supports with a safe and healthy place to age. LTC homes should also provide short term stays to "restore and release"
- **Palliative/End of Life Care** – provide care with dignity and minimal pain and discomfort in the last stages of people's lives.

Although the system is far from this ideal, there are clear opportunities to make change, and it can start by connecting the dots between the constituent components of the health system.

Connecting the Dots: Integration and Continuing Care

Patient needs are diverse and often change with age or as conditions progress. To meet those needs both effectively and sustainably, the system must be flexible enough to provide care where and when it is need. People should be able to move seamlessly from one component to the next and sometimes back again. The key to CARP's care continuum is clear system navigation and effective communication between the many and various health care providers charged with providing patient care.



Navigation is Key to the Care Continuum

An integrated continuum of care depends on ease of access for individuals and 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 proposes a pathway from one component in the health system to another in a seamless and predictable way. The pathway allows the system to follow patients through the spectrum of health care needs.

CARP care continuum also proposes that a "Navigator" role should be created that can help patients understand and navigate the system as they move through different stages of care. Ideally, 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*[i], should aim to bridge gaps in service quality and provision. While it is necessary to address gaps in health coverage currently in the health system, such as the need for sustained home care funding and better palliative care, the next big step should be transforming health care delivery to facilitate simple and effective navigation of the health system.

Cost Savings through Efficiency and Innovation

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. Easily navigable and properly resourced alternatives to acute and institutional care can help minimize hospital readmissions and their associated high costs. There are many opportunities to save costs and be effective and innovative with our resources.

More Home Care over Hospital Care

Most Canadian seniors (93%) want to live at home and stay in their communities for as long as possible.[ii] Home care services allow seniors to do this but often the services are underfunded, inaccessible, and have long wait lists due to a lack of coordination, resources, good management, and funding. It is time that the value of home care is realized and proper investments are made.

Table 1. Comparative Cost Analysis in BC-1996/97 Cohort in 1996/97 Dollars Average Cost[iii]

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

Not only does home and community care allow seniors to age at home and stay connected with their communities, it also costs must less than institutional care:

- Cost of home and community care is 40%-75% of the costs of LTC depending on the level of care, according to a study in BC [iv] (See Table 1).
- Approx. 5,200 hospital beds in Canada are occupied by those who could manage with home care – most (85%) are seniors.[v]
- Hospital readmissions are costly - An average readmission in Canada costs approximately $10,000.[vi] In 2010, over 180,000 Canadians were readmitted to acute care, costing the system $1.8 billion.[vii]

There are many opportunities to reduce costs without compromising quality of care. The *Virtual Ward Program* provides hospital-like transitional medical support 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, allowing patients to stabilize in their own homes and regain their health and independence sooner.[viii]

Another example is *Mount Sinai Hospital's Acute Care for Elders* unit that has a house call program to keep seniors at home longer. Even if seniors eventually go into LTC, the decision can be made in an orderly fashion rather than on a crisis basis.

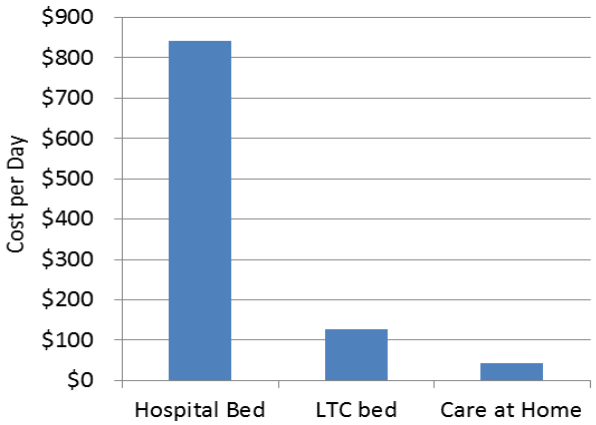


Chart 1. Comparative Cost per Day - source North East Local Health Integration Centre, 2011.[ix]

Caregiving Supports

Family caregivers make homecare possible, but cannot always shoulder the financial and personal strains of caregiving.[x] Although most provinces have recognized the need for more caregiver support, action is needed:

- 3.8 million Canadians aged 45 or older provided informal care to a senior in 2009. The unpaid labour of informal caregivers is valued at an estimated $25 billion/year.[xi]
- Caregivers are more likely to leave the labour force entirely instead of reducing their hours, suggesting that caregivers are not balancing both heavy care and employment successfully[xii]
- 6 times the cost of a LTC bed can be saved with a Care-giving allowance. A study compared a proposed $200/month care-giving allowance with a $25/hour rate for services and $130/day for a LTC facility bed.[xiii]

Long-Term Care Insurance

As the population ages, more people will require long-term care (LTC), which will make the current system too expensive and unsustainable. Change is needed to meet long-term needs without reducing the quality of care. Many countries are facing similar challenges and some are already adapting health systems to plan for increased LTC needs. For example, Germany and the UK are addressing the issue with LTC insurance programs.

Germany adopted a universal public LTC insurance in which participation is mandatory with optional additional private LTC insurance.[xiv] Individuals and employers pay equal contributions, and benefits can be received in cash and /or in-kind (e.g. form of service) when LTC is needed. Family caregivers can get up to 4 weeks of leave during the time the benefits are being used.

The UK adopted an income-based LTC insurance program. People pay "premiums" to a certain threshold based on their wealth (including their property and assets).[xv] The maximum threshold is £72,000 for those in the highest income bracket. The program allows people to borrow money from their local authority to cover residential care fees if they have savings of less than £23,250 and do not wish to sell their home. When their home is eventually sold, people repay the authority.

End-of-Life Care

People facing terminal illnesses can benefit from palliative care services which include social support, advance care planning and effective pain and symptom management. However, many do not have access to these services or even know about their options.

Advanced care planning is needed, in which health care providers engage with patients to discuss their options. Advanced care planning has shown to increase the quality of life for dying patients, improve the experience of family members, and decrease health care costs.[xvi]

CARP is calling for an adult conversation on end of life care. Many avoid having such conversations due to fear, among other reasons. But planning for a good quality of life does not have to exclude the very last stages of life. It is important that people have these conversations.

Action is Needed Now

Action can no longer be delayed. Despite a decade of health reform efforts, governments are failing to meet the chronic health needs of Canadians.[xvii] The current system continues to be complex, fragmented, and inefficient, preventing health improvements. More people are developing chronic conditions, long wait times remain, and drug costs are still too costly.[xviii].

A comprehensive system of homecare, LTC facilities, and supports for caregivers along with multi-disciplinary health professional teams can improve both cost effectiveness and health outcomes. Coordination is central to making this comprehensive system a reality. A system champion is needed to bring the different components together and develop a system that is easy to navigate, flexible enough to meet changing needs, and effective in its use of resources. Everyone is, after all, one patient in need of quality, timely, and effective care. The health care system stands to gain in efficiency and cost –effectiveness but most of all, in a patient-centred world, better health outcomes.

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