Overview of Continuing Care and How it Can Contribute to the Sustainability of the Canadian Health Care System

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Time for a Change

• Our work showing the cost-effectiveness of home care and models of integrated care is well documented. However our arguments that integrated systems of care can achieve significant cost avoidance, and contribute to the sustainability of our health care system, have not been taken up by policy makers and analysts.

• This is why we recently published our book entitled Aging in Canada. We believe that there are positive solutions to enhancing the sustainability of our health care system and wish to have these positive messages enter into the public policy debate.

Terminology

• We shall be speaking today about coordinated/integrated models of care for the elderly and persons with disabilities. In order to cover the broader concept of such care models, we shall use the term “continuing care”. This is a term which has often been used in Western and Atlantic Canada.

• Continuing Care was (in the late 1980s and the early to mid 1990s), and would still be today if a system existed, the third largest component of public health expenditures after hospitals and primary care and, as such, deserves a greater policy focus.
So What is Continuing Care?

• Classically, continuing care is a vertically and horizontally integrated system of service delivery with a broad community base for people with functional disabilities and chronic illnesses.

• It includes assessment and case management, home care (including short term hospital replacement home care), home support, palliative and respite care, long term residential care, geriatric units in hospitals, and other related services. New services are being added over time.

• The term refers to care continuing over time, and across types of services (e.g., hospital to home care).
So What is Continuing Care? (Cont’d)

- What is very important, and what is generally recognized by people working in the field, is that it is the integration of medical, health, supportive, community and residential/institutional care into one system that is the essence of the continuing care model and is why it is such a good fit to the actual needs of people with ongoing care needs such as the elderly and people with disabilities. We need to broaden this understanding to decision makers, particularly at the national level.
The Emergence of the Continuing Care System

The Continuation Care Service Delivery System
(The New/Emerging System)

Hospital Based Geriatric Assessment and Treatment Units
Day Hospitals

Chronic Care Hospitals and Units
Long Term Care Facilities

Group Homes
Adult Day Care Centres

Homemaker Services
Meals Programs

Home Nursing Care Services
Community Rehabilitation Services

Acute Hospitals
Government and Charitable Social Welfare Services
Public Health

The Origins of the Continuing Care System
(The Old System)
A Short History of Continuing Care in Canada

- Continuing care started in the mid 1970s in Manitoba and an integrated system of care was developed in BC between 1978 and 1983.
- By the mid-1980s the BC and Saskatchewan Ministries of Health had Executive Directors of Continuing Care.
- In the early 1990s some 7 provinces had, at various points in time, one person responsible for their provincial continuing care service delivery system. There was also a Federal/Provincial/Territorial Sub-Committee on Continuing Care which functioned from the mid-1980s to the early 1990s.
- Continuing care has been in decline since the mid-1990s.
### Previous Canadian System (early/mid 1990s)

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Primary Care</th>
<th>Continuing Care</th>
<th>Drugs</th>
<th>Population and Public Health</th>
<th>Other Services (mental health, Ambulance, etc.)</th>
</tr>
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</table>

### Current System (National Policy Focus)

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Primary Care</th>
<th>Drugs</th>
<th>Population and Public Health</th>
<th>Other Services (long term residential care, home care, palliative care, respite care, etc.)</th>
</tr>
</thead>
</table>

- **Continuing Care** was (in the late 1980s and the early to mid 1990s), and would still be today if a system existed, the third largest component of public health expenditures after hospitals and primary care and, as such, deserves a greater policy focus.

Benefits of Integration

- We are stressing coordinated/integrated care delivery systems for persons with ongoing care needs because they have the following benefits:
  
  - They are good clinically because they allow for well coordinated seamless care for clients across a wide range of services from Meals on Wheels to specialized geriatric assessment and treatment centres in hospitals.
  
  - They are good from a policy perspective because policies can be made at the broader systems level, across all care services in the system, to the benefit of the client.
Benefits of Integration (cont’d)

- They are good economically because such systems allow for trade offs between, for example, less costly home care and more expensive long term facility care or acute care. Such efficiencies can increase value-for-money within the home and community care system, and within the broader health care system.

- They are good because it is possible simultaneously to both reduce costs (or increase efficiencies) and provide better care to clients.
Main Points

• Comments about the dangers of the “grey tsunami”, and the unsustainability of our health care system, have been greatly exaggerated and, in fact, are examples of ageism (“the growth in the elderly population will bankrupt our health care system”).

• The impact of our growing elderly population adds less than one percent to overall health care costs per year – even conservative economists agree on this. Other factors account for most of the increases in health care costs.

• There is clearly no crisis nationally. The percentage of GDP spent on health care increased from 10% to 10.5% over a fifteen year period from 1992 to 2007, before the world wide financial crisis. At its worst it rose to 11.9% but as our economy recovers this percentage has been coming down.
Main Points (Cont’d)

• Care delivery for seniors has been in a downward policy drift for over 20 years. The improvements proposed in the early 1990s were not implemented so we now face a similar situation in terms of eldercare as we did more than 20 years ago.

• This constitutes a movement to less, and less coordinated, services achieved by stealth. Major policy changes such as disenfranchising seniors with low level care needs were simply implemented with little or no discussion and were not made clear to the public as election issues.
Main Points (Cont’d)

• This downgrading of services occurred under all political parties and, thus, does not seem to be a party issue. In fact some cross party committees have recently been formed at the federal and provincial levels to try to improve seniors care. These efforts are to be supported and applauded.

• There has been a clear shift away from recognizing that seniors care is a mix of health and social services, resulting in a medicalization of care and, as a consequence, a policy inspired cost escalation spiral.
Main Points (Cont’d)

• The cost escalation spiral works as follows. Hospitals ask for more money. Officials reduce budgets for home support services (as they are “non-professional and not really health services”) to generate money for hospitals. The elderly are cut from service and can not cope on their own without assistance resulting in greater numbers of admissions to hospitals and long term care facilities.

• Hospitals complain about increased workloads due to these new demands by elderly persons and ask for more money and the cycle repeats.

• The consequence of this cycle is that we are, as a matter of public policy, substituting high cost hospital services for low cost home support services and, thus, increasing overall health care costs.
Main Points (Cont’d)

• We are proposing an approach that enhances care delivery while at the same time generating significant cost avoidance to enhance the sustainability of our health care system.

• There are two parts to our argument. More funding improves home care. However it is only through substituting lower cost home care for higher cost hospital and facility care that one can achieve cost avoidance. This substitution can only take place in an integrated system of care.

• Putting more money into home care, or chronic care models which combine primary care and home care, in a splintered system will not reduce requests for additional funding from the hospital and long term care facility sectors. Thus, new funding will constitute an add on cost. However, combined primary care/home care could be a component part of a larger, integrated model of continuing care.
In the fall of 1994, a policy was put into place in British Columbia to cut Personal Care clients (those with the lowest care needs) who only received house cleaning services.

Most cuts were made in the first half of 1995.

They were different patterns of response by Health Units (HUs) to the policy.

Some HUs did not cut services, some cut moderately and some cut severely.
## Comparative Costs

### Per Person Average Costs of Care Before and After Cuts for Health Units With and Without Cuts

<table>
<thead>
<tr>
<th></th>
<th>Year Prior to Cuts ($)</th>
<th>First Year After Cuts ($)</th>
<th>Second Year After Cuts ($)</th>
<th>Third Year After Cuts ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuts</td>
<td>5,052</td>
<td>6,683</td>
<td>9,654</td>
<td>11,903</td>
</tr>
<tr>
<td>No Cuts</td>
<td>4,535</td>
<td>5,963</td>
<td>6,771</td>
<td>7,808</td>
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• A recent study by Markle-Reid also found that modest amounts of home support services may reduce hospital and LTC facility costs.

The Conundrum of Non-Professional Home Support Services

- People with ongoing care needs due to functional deficits clearly have “health” problems and require “medically necessary” care. However, the “medically necessary” care services they require to maximize independence and minimize their rate of deterioration are, in large part, non-professional home support services. This does not seem to be recognized in the current national policy discourse.

- Home support is a low cost alternative to residential care and hospital care for both the preventive and substitution functions of home care.

Comparative Cost Analysis in 2000/2001 Dollars Including Out-of-Pocket Expenses and Caregiver Time Valued at Replacement Wages

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Victoria</th>
<th></th>
<th>Winnipeg</th>
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<tbody>
<tr>
<td></td>
<td>Community ($)</td>
<td>Facility ($)</td>
<td>Community ($)</td>
<td>Facility ($)</td>
</tr>
<tr>
<td>Level A: Somewhat Independent</td>
<td>19,759</td>
<td>39,255</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Level B: Slightly Independent</td>
<td>30,975</td>
<td>45,964</td>
<td>27,313</td>
<td>47,618</td>
</tr>
<tr>
<td>Level C: Slightly Dependent</td>
<td>31,848</td>
<td>53,848</td>
<td>29,094</td>
<td>49,207</td>
</tr>
<tr>
<td>Level D: Somewhat Dependent</td>
<td>58,619</td>
<td>66,310</td>
<td>32,275</td>
<td>45,637</td>
</tr>
<tr>
<td>Level E: Largely Dependent</td>
<td>N/A</td>
<td>N/A</td>
<td>35,114</td>
<td>50,560</td>
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Even If Home Care Is Cost-Effective, Is There Any Evidence That Savings Can Be Obtained In The Real World?

• Yes, this was demonstrated by the BC Planning and Resource Allocation Model developed in 1989. There was a significant shift of clientele from residential care to home care resulting in annual cost avoidance of an estimated $150M by 1995.

• It is believed similar opportunities for cost-effective substitutions still exist.
Major Phases In The Utilization Of Home Care & Residential Care

Utilization rates per 1,000 population aged 65 and over by fiscal year and type of care. Fiscal year 1983 is for the period April 1, 1982 to March 31, 1983.

International Findings

• Stuart and Weinrich in a 2001 study comparing Denmark (which has an integrated model of care and a strong reliance on home and community services) and the United States, found that from 1985 to 1997 per capita expenditures on continuing care for seniors increased by 8% in Denmark and 67% in the United States. Many of the efficiencies were achieved by increasing home care and reducing facility beds.


• Veterans Affairs Canada has also substituted home care for residential care.

Framework for Organizing Care Delivery for Persons with Ongoing Care Requirements (the Enhanced Continuing Care Framework)

- Conducted national studies on service delivery systems for:
  - The Elderly
  - Persons with Disabilities
  - Persons Requiring Mental Health Services
  - Children with Special Needs

- Also conducted survey of leading Canadian experts on the topic of integrated care systems.

- This framework was rated as the best for organizing systems of care delivery for the elderly in an independent, international review of models/frameworks.

The Enhanced Continuing Care Framework for Organizing Integrated Systems of Care for People with Ongoing Care Needs (the Hollander and Prince Framework)

<table>
<thead>
<tr>
<th>Philosophical and Policy Prerequisites</th>
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<tbody>
<tr>
<td>1. Belief in the Benefits of Systems of Care</td>
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<tr>
<td>2. A Commitment to a Full Range of Services and Sustainable Funding</td>
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<tr>
<td>3. A Commitment to the Psycho-Social Model of Care</td>
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<tr>
<td>4. A Commitment to Client-Centred Care</td>
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<td>5. A Commitment to Evidence-Based Decision Making</td>
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<table>
<thead>
<tr>
<th>Best Practices for Organizing a System of Continuing/Community Care</th>
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<tbody>
<tr>
<td><strong>Administrative Best Practices</strong></td>
</tr>
<tr>
<td>1. A Clear Statement of Philosophy, Enshrined in Policy</td>
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<tr>
<td>2. A Single or Highly Coordinated Administrative Structure</td>
</tr>
<tr>
<td>3. A Single Funding Envelope</td>
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<tr>
<td>4. Integrated Information Systems</td>
</tr>
<tr>
<td>5. Incentive Systems for Evidence-Based Management</td>
</tr>
<tr>
<td><strong>Service Delivery Best Practices</strong></td>
</tr>
<tr>
<td>6. A Single/Coordinated Entry System</td>
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<tr>
<td>7. Standardized, System Level Assessment and Care Authorization</td>
</tr>
<tr>
<td>8. A Single, System Level Client Classification System</td>
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<tr>
<td>9. Ongoing, System Level Case Management</td>
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<tr>
<td>10. Communication with Clients and Families</td>
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<thead>
<tr>
<th>Linkage Mechanisms Across the Four Population Groups</th>
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<tbody>
<tr>
<td>1. Administrative Integration</td>
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<tr>
<td>2. Boundary Spanning Linkage Mechanisms</td>
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<tr>
<td>3. Co-Location of Staff</td>
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<table>
<thead>
<tr>
<th>Linkages With Hospitals</th>
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<tbody>
<tr>
<td>1. Purchase of Services for Specialty Care</td>
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<tr>
<td>2. Hospital “In-Reach”</td>
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<tr>
<td>3. Physician Consultants in the Community</td>
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<tr>
<td>4. Greater Medical Integration of Care Services</td>
</tr>
<tr>
<td>5. Boundary Spanning Linkage Mechanisms</td>
</tr>
<tr>
<td>6. A Mandate for Coordination</td>
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<table>
<thead>
<tr>
<th>Linkages with Primary Care/ Primary Health Care</th>
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</thead>
<tbody>
<tr>
<td>1. Boundary Spanning Linkage Mechanism</td>
</tr>
<tr>
<td>2. Co-Location of Staff</td>
</tr>
<tr>
<td>3. Review of Physician Remuneration</td>
</tr>
<tr>
<td>4. Mixed Models of Continuing/Community Care and Primary Care / Primary Health Care</td>
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<table>
<thead>
<tr>
<th>Linkages With Other Social and Human Services</th>
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</thead>
<tbody>
<tr>
<td>1. Purchase of Service for Specialty Services</td>
</tr>
<tr>
<td>2. Boundary Spanning Linkage Mechanisms</td>
</tr>
<tr>
<td>3. High Level Cross-Sectoral Committees</td>
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Application of the Framework to the Elderly

Acute Care Hospital Services
- Day Hospitals
- Hospital-Based Geriatric Units
- Short Stay Assessment and Treatment Centres

Residential Services
- Group Homes
- Assisted Living
- Supportive Housing
- Residential Respite Care
- Residential Palliative Care

Home-and Community-Based Services
- Meal Programs
- Home Nursing Care
- Home Support Services (Homemakers/Care Aides)
- Adult Daycare/Support
- System-Level Case Management
- Community-Based Respite Care
- Community-Based Palliative Care

Hospital Services (stepdown care)
- Chronic/Extended Care Facilities
- Long-Term Care Facilities/Nursing Homes

Tertiary/Quaternary Care Level

Secondary Care Level

Primary Care Level

Vertical and Horizontal Integration Through System Level Case Management
A Schematic of How A Client Goes Through the System of Care

- Client Referral
  - Ineligible and Leaves System
  - Single-Entry Process
    - Eligible for Care and Assessment Is Conducted
      - Development/Review of System-Level Care Plan
        - Client Enters Care System
          - Reassessment
            - Home and Community Care
            - Long Term and Chronic Residential Care
            - Hospital Services Including Specialized Assessments
              - Referral to Health and Human Services Outside the System
                - Consultation with Physicians
                - Ineligible but is Referred to Other Resources
  - Reassessment
    - Client Leaves System
Policy Choices

- We do recognize that many jurisdictions have developed laudable new programs, but it is now time to come together to develop a system-wide solution. Worthy care initiatives can be rolled into this broader, system-wide approach, as appropriate.

- The first step to achieving actual progress will be for governments to again recognize integrated care delivery for persons with ongoing care needs as a major component of our health care system alongside acute care, physician care and population and public health. This recognition existed in the early 1990s but has been lost and now the component parts of an integrated system have been splintered and are seen as separate “Other” health services. This pattern needs to be reversed.
Current Canadian Trends in Policy for Persons With Ongoing Health Needs

Cost pressures

Lack of understanding that continuing care costs almost as much in terms of public expenditures as physician services, and more than drugs.

Narrowing the range of benefits to “medical” services (re-medicalizing care for people with ongoing care requirements)

Apparent maintenance of fragmented systems rather than investments in comprehensive and integrated continuing care (issue of political will)

Pressure to reduce supportive services for people with ongoing care requirements

Pressure to re-define home care as a short-term, acute care replacement function

Search for new funding options (such as long term care insurance), thus potentially separating funding, and possibly delivery, from other health services

Attempts to reduce existing benefits (increases in residential care co-payments)

Apparent exclusion of the care needs of people with ongoing care requirements from the public policy debate on health services
Options for the Future of Home Care

- **Part of Broader Integrated Continuing Care System**
  - Maximizes potential for cost-effective substitution of home care for residential care and acute care.

- **The Chronic Care Model, or Where There is Greater Coordination Between Primary Care and Home Care**
  - Enhances integration of home care with physicians and other community services, but may reduce potential for cost-effective substitutions with institutional care.

- **Outpatient/Outreach Function of Acute Care Hospitals**
  - May reduce care to people with ongoing care needs and may lead to fragmented services.
Key Messages For Decision Makers

- We need to think in terms of integrated and coordinated systems of care. There is essentially no evidence that fragmented systems provide good care or are cost-effective. Thus, it is critical for senior decision makers to re-recognize Continuing Care as a major component of our health care system.

- Home support services are health-related services and are critical to keeping people out of more costly hospital care and long term residential care. Even a small amount of support can go a long way. Choosing to adopt a narrow definition of health care will be counterproductive and may well lead to increasing pressures on more costly, institutional services resulting in a negative cost spiral.
There are now well-developed frameworks for organizing health services for people with ongoing care needs which have the potential to simultaneously improve care and reduce costs. Not having a plan is no longer a viable reason for not dealing with complex problems related to systems of care delivery.

There are real and far-reaching policy choices to be made. Not making a decision is as much a policy choice as making a decision. Choices will be made. It is hoped that the decisions will be wise and informed ones.
Key Messages (Cont’d)

• There is a need to not only support older adults, but also, their caregivers.

• Policy is made by people and can be changed by people. Whether we improve services or regress backwards is in the hands of our policy makers.