

The Case for Implementing a Continuum of Care: A Few Observations

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Backdrop

- Canadian provinces are implementing well developed continuing care systems
- Why?
 - the evidence indicates that community care systems that respond to the needs of clients and caregivers can improve access and quality while improving the cost effectiveness of the health care system



Implementing Best Practice Features of Integrated/Coordinated Care for Seniors

Administrative Features

Six provinces have a single administrative structure for continuing care

Only four report having a single funding envelope

None has implemented an integrated information system but Quebec is very far ahead

None has an incentive system for evidence-based management



Clinical Best Practices

- Seven provinces indicated that they have a single or coordinated entry system
- Nine have province-wide assessment and care authorization instruments
- Seven have system-level classification systems
- Six have ongoing care management
- All have mechanisms for communicating with families



- **Linkages with Hospitals**
 - Eight provinces have case managers co-located in hospitals
- **Linkages with Primary Care**
 - Two reported that there are physicians associated with the home care program who coordinate with primary care physicians
 - Only one province (Ontario) reported that it has case managers co-located in physicians' offices.
 - Five reported that physicians are remunerated appropriately for care of the frail elderly
 - Four reported that physicians are adequately remunerated for home visits



Linkages with Other Social and Human Services

- Only three reported that they have financial arrangements for purchase of transportation services
- Five reported that there is an organized approach to various levels of housing with supportive services
- Six reported that there is a system for high level planning of services for seniors



Conclusions

Our results indicate that all provinces are making progress at the system level in implementing community care systems,

But:

There has been a very slow pace of progress in two key areas:

- 1. Implementing shared information systems
- 2. Implementing effective linkages among hospitals, primary care, and the home and community care system



Back to the Case for Implementing a Continuum of Care

- Are provinces implementing the “right” range of community services?
 - **No**, the data indicate that over the past ten years there has been a reduction in care for seniors who need long-term supportive home care
 - Hollander has shown that access to these services is essential to making cost effective use of hospital and long-term residential care.
 - Especially since implementation of the Health Accord, the case for integrated care has been battling a policy focus on **dis-integrated care** or the powerful forces shaping health policy around the issues affecting hospitals.



- Are provinces targeting services most effectively?
 - **Probably not.** Decision-support tools need to be improved at the clinical and the system level.
 - In particular, the continuing care case management function needs to be valued – caseloads of 120 will never result in excellent results.
 - Inclusion of the needs of caregivers in the assessment and care planning process is another undervalued aspect of effective targeting



One caution:

- Care management teams for seniors with complex needs must include primary care practitioners but must also guard against over-medicalization of the care system.

- **In conclusion:**

- Francois has laid out the case for implementing a continuum of care, Canadian provinces are well on their way to implementing best practice features of continuing care, but there are risks ahead if we do not adopt a broader view of the community care system.

