CARE CONTINUUM

Continuum of care includes both services and integrating mechanisms.
The services can be broken down into seven basic categories:

- EXTENDED CARE
- ACUTE HOSPITAL CARE
- AMBULATORY CARE
- HOME CARE
- OUTREACH
- WELLNESS
- HOUSING

The four basic integrating mechanisms are:

- PLANNING AND MANAGEMENT
- CARE COORDINATION
- CASE-BASED FINANCING
- INTEGRATED INFORMATION SYSTEMS

The continuum of care will vary for each patient depending on their unique needs.

Source: HIMSS https://iii.hm/2bv

TIPS FOR COLLABORATION

- ✓ a trusted convener, whether an individual or an organisation.
- ✓ the cultivation of trust, through a focus on common goals.
- ✓ a shared understanding of the challenges faced by each participant.
- ✓ starting small and building on early progress.
- ✓ expanding the type and number of participants as needs arise.
- ✓ using both quantitative and qualitative data to identify opportunities for improvement and monitoring progress.
- ✓ focusing on patients' needs and experiences to help spur action.

Source: Commonwealth Fund https://iii.hm/2c1

CARE CONTINUUM INSIGHTS

"A lot of the technology solutions being worked on are really focused on helping our members optimise patient care and succeed in this value-based world. That means tying imaging results to electronic health records and clinical research databases to help evaluate the efficacy and the importance of imaging in the continuum of care."

Mike Tilkin, chief information officer at the American College of Radiology (ACR).

Source: Forbes https://iii.hm/2bw

According to HIMSS Analytics' 2014 Telemedicine Study, the need to fill care-continuum gaps is what drives providers to adopt telemedicine solutions.

Source: Media Post https://iii.hm/2bx

Currently, the total lifetime cost of treating a heart failure patient after diagnosis is over

$100,000

To begin reducing these costs, programmes must first establish an infrastructure conducive to collaboration through initiatives such as multispecialty strategy boards and committees.

Source: The Advisory Board https://iii.hm/2by

An individual person living with HIV may go through several stages and may also return to earlier stages of the continuum throughout his/her life.

Source: U.S. Department of Health and Human Services https://iii.hm/2bz

The homes of patients are becoming a more significant part of the care ecosystem, where patients (and caregivers) must manage, monitor and respond to changes in their health. When patient engagement apps integrate patients and caregivers into the care continuum, the financial and emotional burden of delivering care to chronic disease patients is alleviated. Source: Practice Unite https://iii.hm/2c0

ASSESSING THE CARE CONTINUUM

Beyond the specific challenges posed by the nature and quality of the existing research evidence as it relates to economic outcomes, there is the broader question as to whether the concept of 'integrated care' lends itself to evaluation in a way that would allow for clear-cut or definitive evidence, given its polymorphous nature. While it may not be possible to generate clear-cut evidence as to the effectiveness of diverse and complex programmes such as integrated care, there is potential for transferable lessons to be learned across different studies to identify core elements that will support better outcomes.

Source: World Health Organization Regional Office for Europe https://iii.hm/2c2