Canadian Models of End-of-Life, Elder and Palliative Care Delivery

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Establishing our Context

- 14.6% of Canadians are 65 and older, yet account for nearly half of all health and social care spending (Census, 2011).

- Canada’s older population is set to double over the next twenty years, while its 85 and older population is set to quadruple (Sinha, HealthcarePapers 2011).

- Canada’s ageing population represents both a challenge and an opportunity.
## Shifting Mortality Patterns

<table>
<thead>
<tr>
<th>Causes of Death</th>
<th>Rank in 1900</th>
<th>Rank in 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Ages</td>
<td>All Ages</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Stroke</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Chronic Lung Diseases</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Alzheimer’s Dementia</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Influenza/Pneumonia</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Nephritis</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Accidents</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Diarrhea and Enteritis</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>

## Ontario Inpatient Hospitalizations

<table>
<thead>
<tr>
<th>Age</th>
<th>Discharges</th>
<th>Total LOS Days</th>
<th>ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Total</td>
<td>945,089</td>
<td>6,075,270</td>
<td>6.4</td>
</tr>
<tr>
<td>Population 65+</td>
<td><strong>370,039 (39%)</strong></td>
<td><strong>3,516,006 (58%)</strong></td>
<td>9.8</td>
</tr>
<tr>
<td>65-69</td>
<td>6.9%</td>
<td>7.9%</td>
<td>7.3</td>
</tr>
<tr>
<td>70-74</td>
<td>7.7%</td>
<td>9.8%</td>
<td>8.2</td>
</tr>
<tr>
<td>75-79</td>
<td>8.5%</td>
<td>12.5%</td>
<td>9.4</td>
</tr>
<tr>
<td>80-84</td>
<td>7.9%</td>
<td>13%</td>
<td>10.5</td>
</tr>
<tr>
<td>85-89</td>
<td>5.3%</td>
<td>9.4%</td>
<td>11.4</td>
</tr>
<tr>
<td>90+</td>
<td>2.8%</td>
<td>5.3%</td>
<td>12.2</td>
</tr>
</tbody>
</table>

*Canadian Institutes for Health Information (CIHI)*
Only a small proportion of older adults are consistently extensive users of hospital services (Wolinsky, 1995)
What Defines our Highest Users?

- Polymorbidity
- Functional Impairments
- Social Frailty
Why Should this Matter?

According to ICES, in Ontario amongst the 65+…

- The Most Complex 10% of Older Adults Account for 60% of our Collective Health Care Spending.

- The Least Complex 50% of Older Adults Account for 6% of our Collective Health Care Spending.

(ICES, 2012)
Our Dilemma

The way in which cities, communities, and our health care systems are currently designed, resourced, organised and delivered, often disadvantages older adults with chronic health issues.

As Ontarians, our Care Needs, Preferences and Values are evolving as a society, with increasing numbers of us wanting to age in place.
Understanding Our Choices
Our Future Will Cost Us More…

(Ontario Health Care Spending Predictions, MOHLTC).

$24 billion
Our Future Requires Choices…

Ontario Health Care Spending in 2011-12, MOHLTC.

- Hospitals: 34.5%
- Doctors: 23.0%
- Long-Term Care Homes: 8.0%
- Community Care: 6.2%
- Capital: 2.5%
- Drugs: 7.6%
- Other: 14.6%
- OHIP Care and Services: 3.6%
What We are Learning in Ontario...

- Current Projections see the need for Long-Term Care (LTC) increasing to 238,000 Ontarians in the next two decades (Conference Board of Canada, 2011).

- Supply of LTC Beds ≠ Demand for LTC Beds across Ontario

- 37% of hospitalized Ontarians designated as ALC-LTC could be maintained at home with community care supports. (The Change Foundation, 2011)
Spending on Home and Long-Term Care Across OECD Nations.

We Have Choices and Options…

- One Day in Hospital Costs ~ $1000
- One Day in Long-Term Care Costs ~ $130
- One Day of Supportive Housing or Home and Community Care Costs ~ $55
- Denmark avoided building any new LTC beds over two decades, and actually saw the closure of thousands of hospital beds, by strategically investing more in its home and community care services.
- The Ontario government while freezing its hospital budgets has committed to at least an annual 4% increase in the Home and Community Care Budget from 2011 through to 2014.
ALC in Ontario By the Numbers

Over the Last Three Years...

- Home First Initiatives in Ontario have helped to transition back home over 30,000 patients at high risk of needing Long-Term Care.

- The numbers of ALC Patients has dropped 17% while those waiting for LTC in Hospitals have dropped from 3,145 to 2,141 (-32%).

- While there remain 19,000 Ontarians on LTC Waitlists, Supply (-2.7%) of, Demand (-6.9%) for, and Placement Rates (-26%) into LTC Beds have all decreased in Ontarians aged 75 and better.
A Good Life, A Good Death?
Truths and Realities...

- There is no standard for Canadian Models of Care.
- The US is in a better position – with an established hospice and palliative care benefit and where Palliative Care and Geriatrics are seen as partners in care.
- In Canada – integrated geriatrics and palliative care models are rare but are where the future lies. Future Models embrace:
  - Home-Based Care
  - Outpatient Care
  - Institutional Care (PCU and Hospice)
  - There is no required training for health care professionals in Canada in geriatrics, palliative or end-of-life care.
Understanding the Continuum of Care

Heterogeneity increases with age

Figure 2. Continuum of geriatric care models.
ACE = Acute Care for the Elderly; PACE = Program for All-Inclusive Care for the Elderly.

JAGS 56(10):1791-1795, October 2008
The Mount Sinai Geriatrics Continuum

Outpatient Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Clinics
CCAC – Clinic Coordinator

Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Consultation Services
Orthogeriatrics Program
ICU Geriatrics Program
MAUVE Volunteer Program
ACE Unit
CCAC – ACE Coordinator

Home-Based Geriatric Primary/Specialty Care Program: House Calls
Temmy Latner Home-Based Palliative Care Program
CCAC – Integrated Client Care Project (ICCP) Site
Reitman Centre for Alzheimer’s Support and Caregiver Training
Community and Staff Education Programs

ISAR Screening
Geriatric Emergency Management (GEM) Nurses
ED Geriatric Mental Health Program
Evaluating Mount Sinai’s ACE Strategy

LENGTH OF STAY (Age 65+)

\[
FY\ 09/10 = 8.3 \rightarrow 6.9 \quad \text{(Provincial Average = 9.8)}
\]

ALOS/ELOS RATIO (Age 65+)

\[
FY\ 09/10 = 96.1 \rightarrow 78.7
\]

CATHETER UTILIZATION RATIO (Age 65+)

- \[
FY\ 09/10 = 56\% \rightarrow 14.7\%
\]

% RETURN HOME AT DISCHARGE (Age 65+)

- \[
FY\ 09/10 = 71.1\% \rightarrow 77.3\% \quad \text{(Current LHIN Average = 72.4\%)}
\]

READMISSION w/n 30 DAYS (Age 65+)

- \[
FY\ 09/10 = 14.8 \rightarrow 12.8\%
\]

PATIENT SATISFACTION (Age 65+)

- \[
FY\ 09/10 = 95.4 \rightarrow 96.9\% \quad \text{(LHIN Average = 93.5\%)}
\]
An Emerging Model of Care

The Palliative and Therapeutic Harmonization (PATH) Clinic Initiative Principles in Action

- **Encounter 1 – Understand** Health Status
- **Encounter 2 – Communicate** and Provide Detailed Information to Patients and their Families.
- **Encounter 3 – Empower** the Patient/Family to Make Informed Decisions Beyond the Clinic.

In examining the decisions of the first 100 patients seen in this model – **93** made new treatment decisions.

www.pathclinic.ca
This is Our Time to Lead
Thank You

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