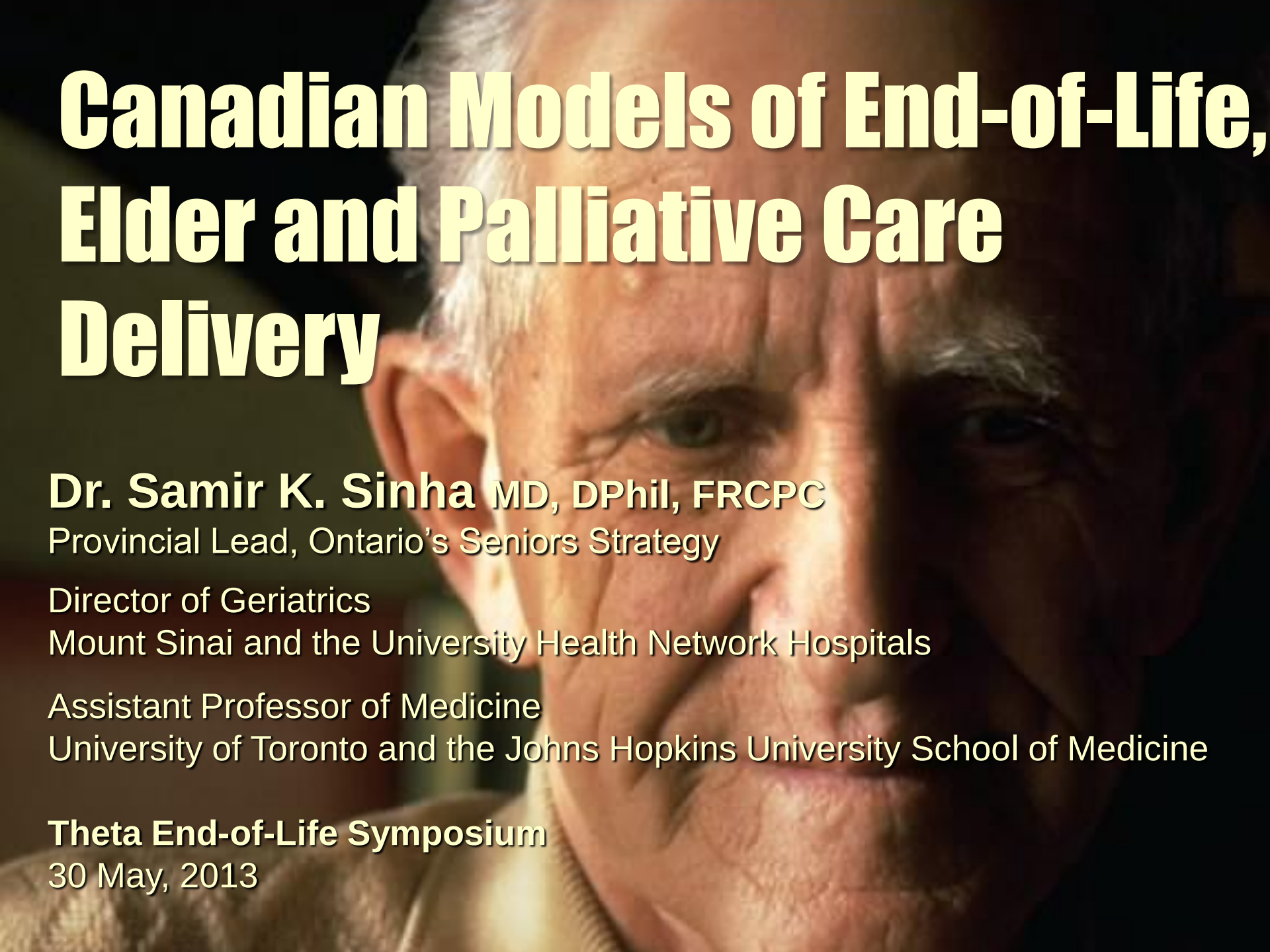


Canadian Models of End-of-Life, Elder and Palliative Care Delivery

Dr. Samir K. Sinha MD, DPhil, FRCPC
Provincial Lead, Ontario's Seniors Strategy

Director of Geriatrics
Mount Sinai and the University Health Network Hospitals

Assistant Professor of Medicine
University of Toronto and the Johns Hopkins University School of Medicine

Theta End-of-Life Symposium
30 May, 2013

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,* Healthcare*Papers 2011).*
- Canada's ageing population represents both a challenge and an opportunity.

Shifting Mortality Patterns

Causes of Death	Rank in 1900	Rank in 2005				
	All Ages	All Ages	65+	65-75	75-85	85+
Heart Disease	4	1	1	2	1	1
Cancer	8	2	2	1	2	2
Stroke	5	3	3	4	4	3
Chronic Lung Diseases	9	4	4	3	3	5
Alzheimer's Dementia	10	7	5	10	5	4
Diabetes	-	6	7	5	6	7
Influenza/Pneumonia	1	8	6	8	7	6
Nephritis	6	9	8	7	8	8
Accidents	7	5	9	6	9	9
Septicaemia	2	10	10	9	10	10
Diarrhea and Enteritis	3	-	-	-	-	-

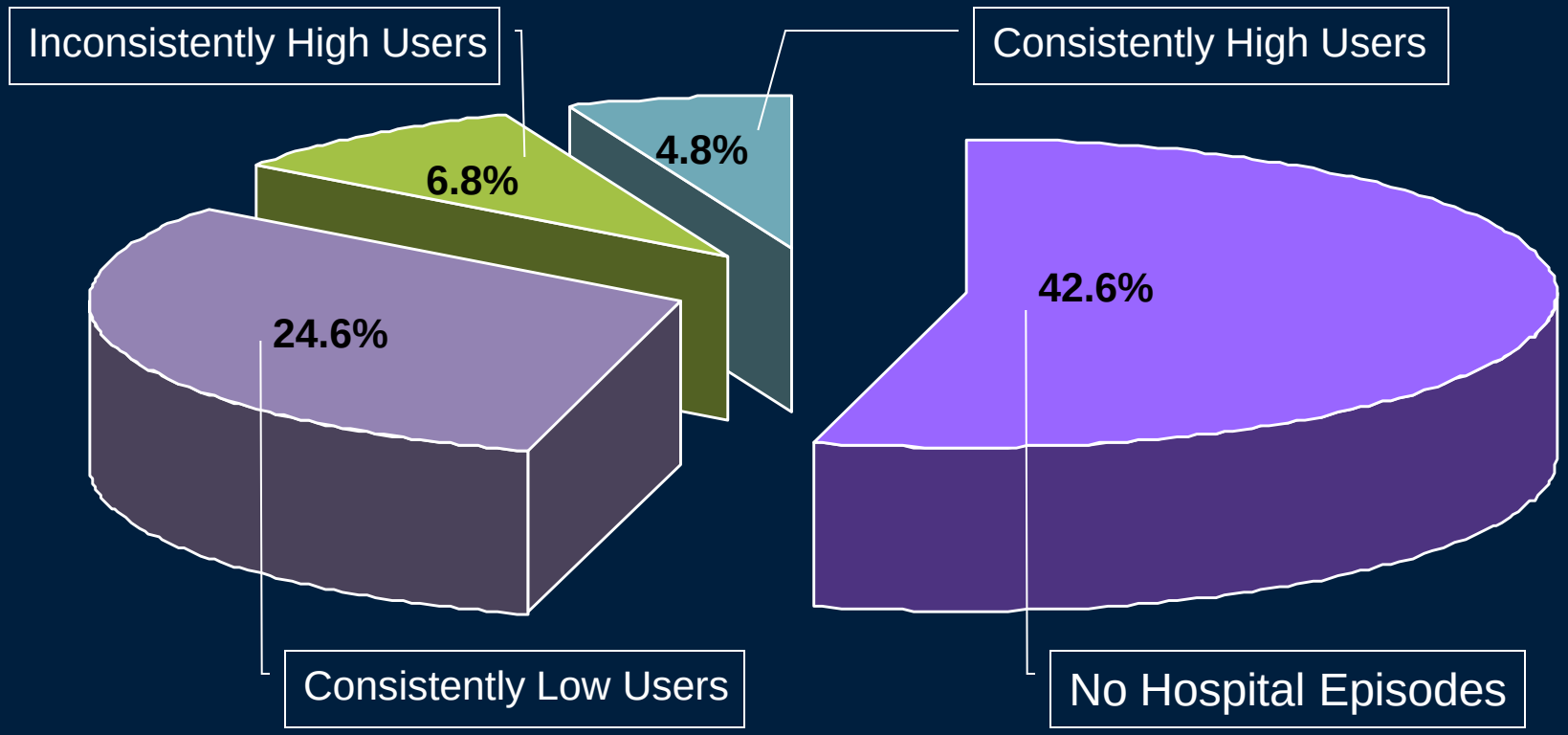
Data for 1900 from Lindor and Grove, 1947; Data for 2005 from National Vital Statistics Report, Vol 56, No. 10, April 24, 2008.

Ontario Inpatient Hospitalizations

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

Canadian Institutes for Health Information (CIHI)

Ageing and Hospital Utilization in the 70+



- 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+…

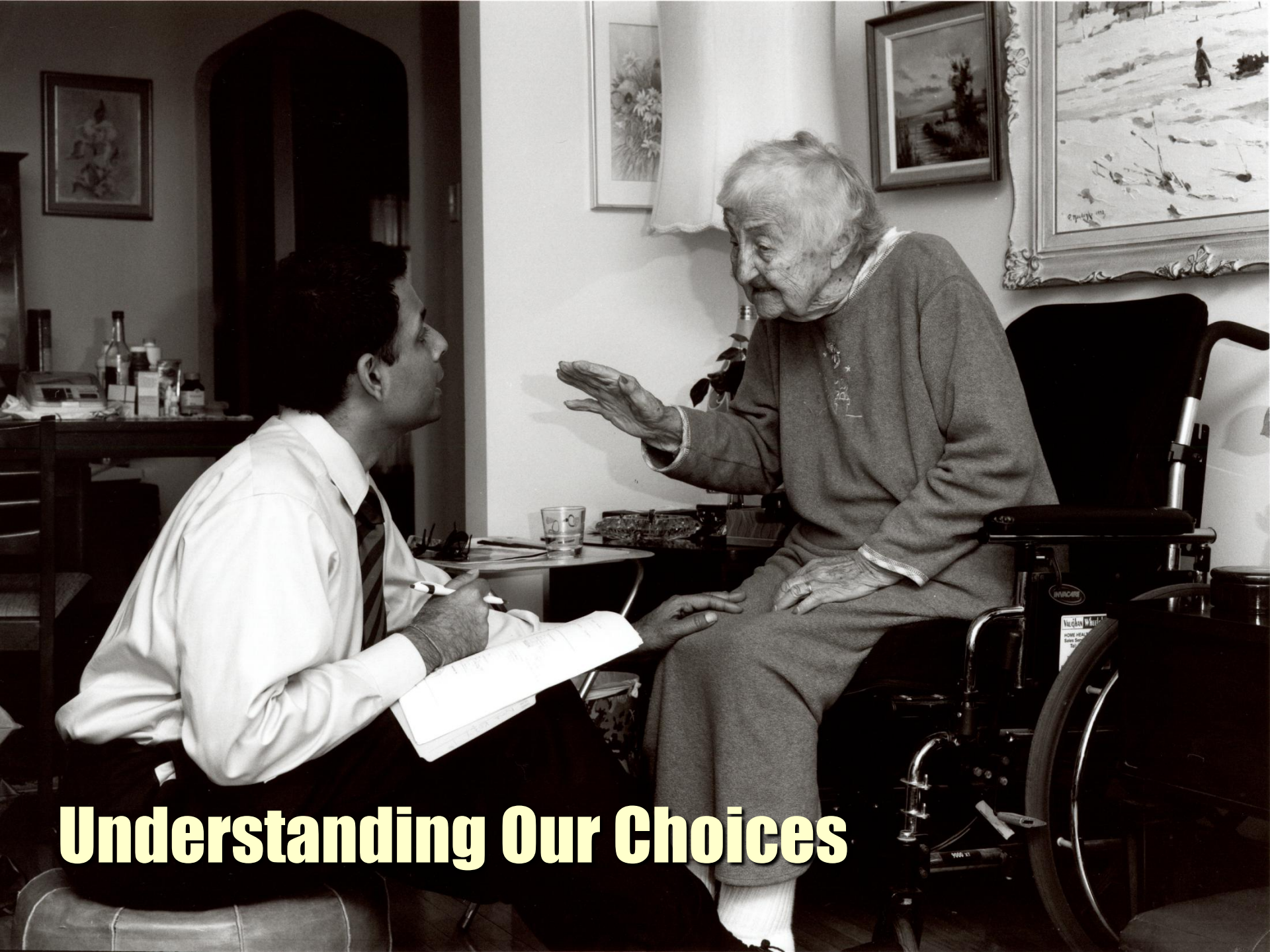
- **The Most Complex 10% of Older Adults Account for 60% of our Collective Health Care Spending.**
- **The Least Complex 50% of Older Adults Account for 6% of our Collective Health Care Spending.**

(ICES, 2012)

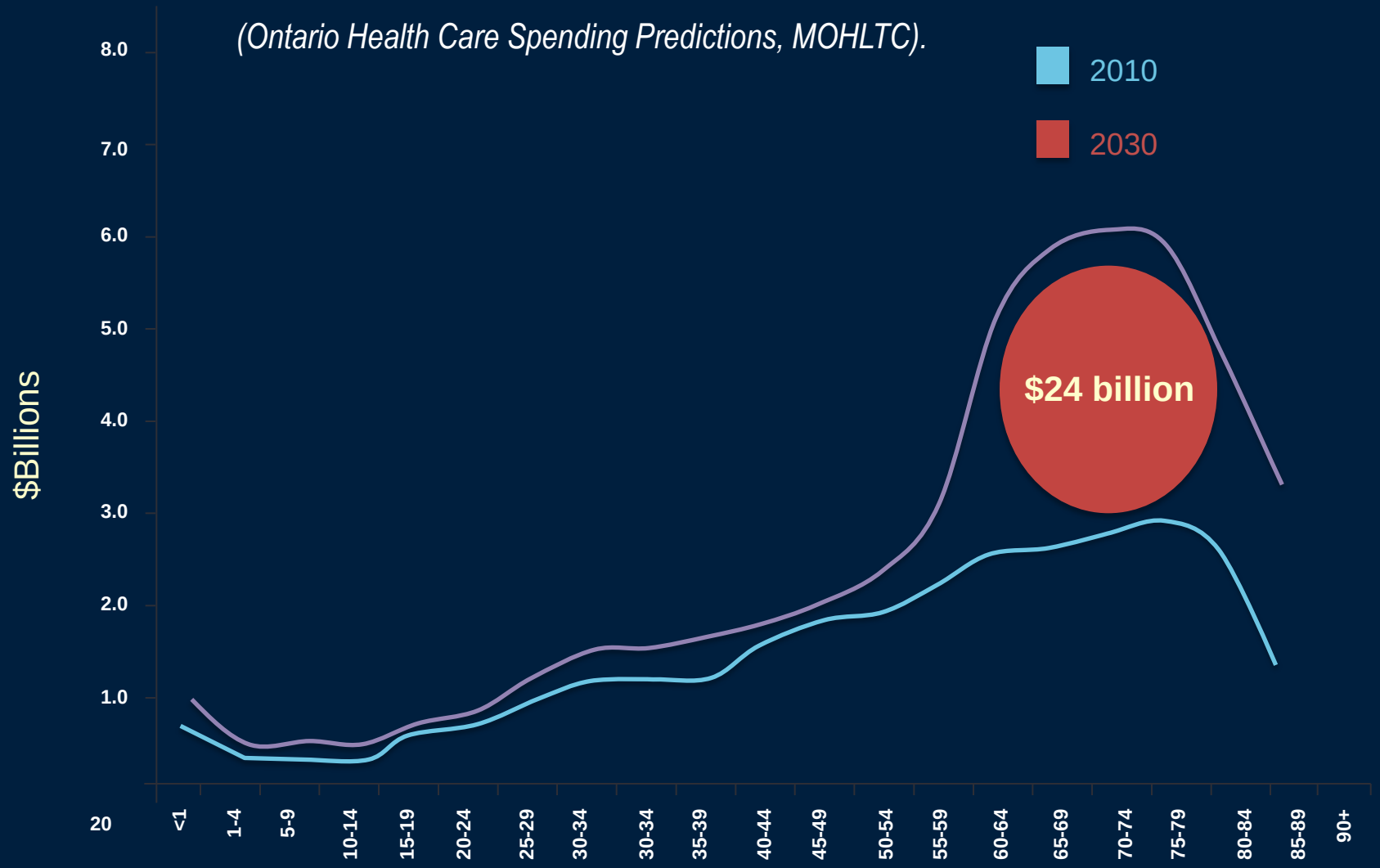
Our Dilemma

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.

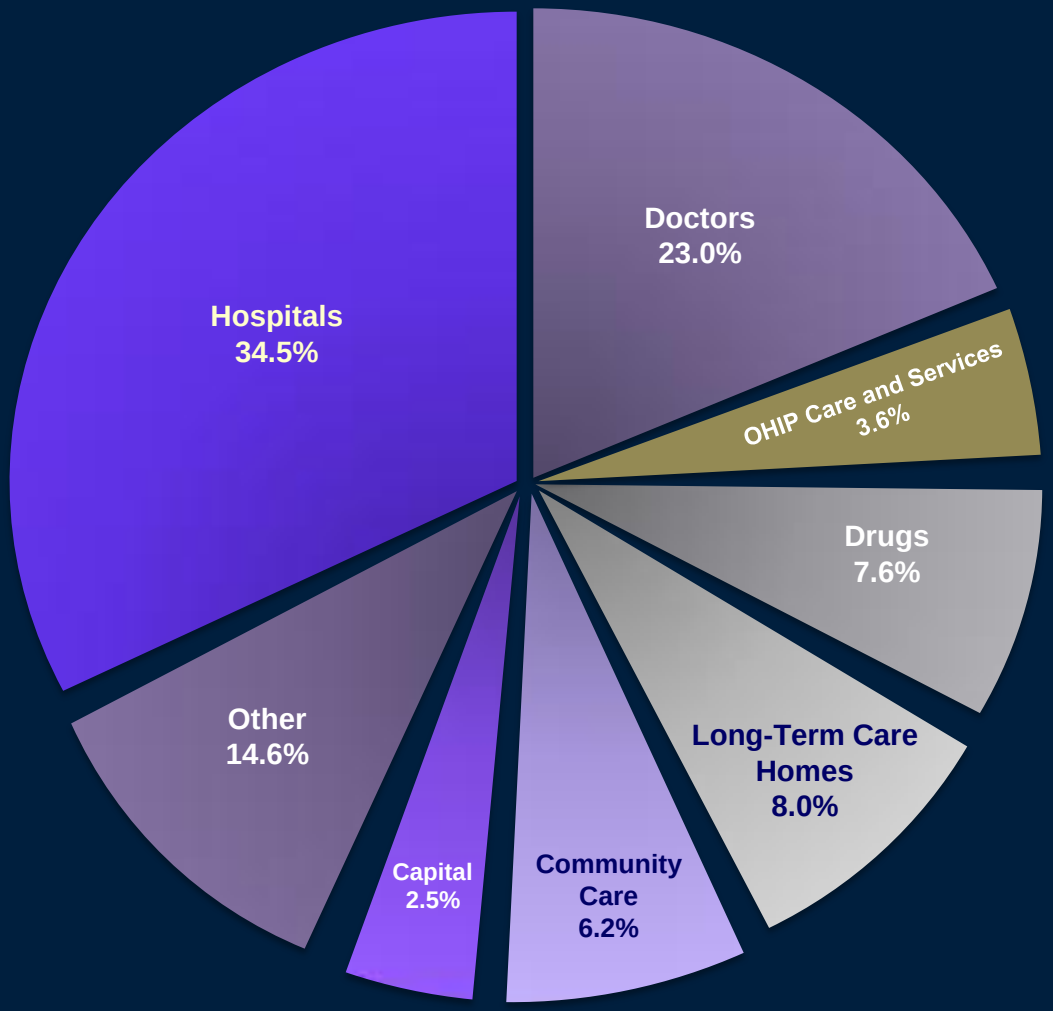
As Ontarians, our Care Needs, Preferences and Values are evolving as a society, with increasing numbers of us wanting to age in place.


Understanding Our Choices

Our Future Will Cost Us More…



Our Future Requires Choices…

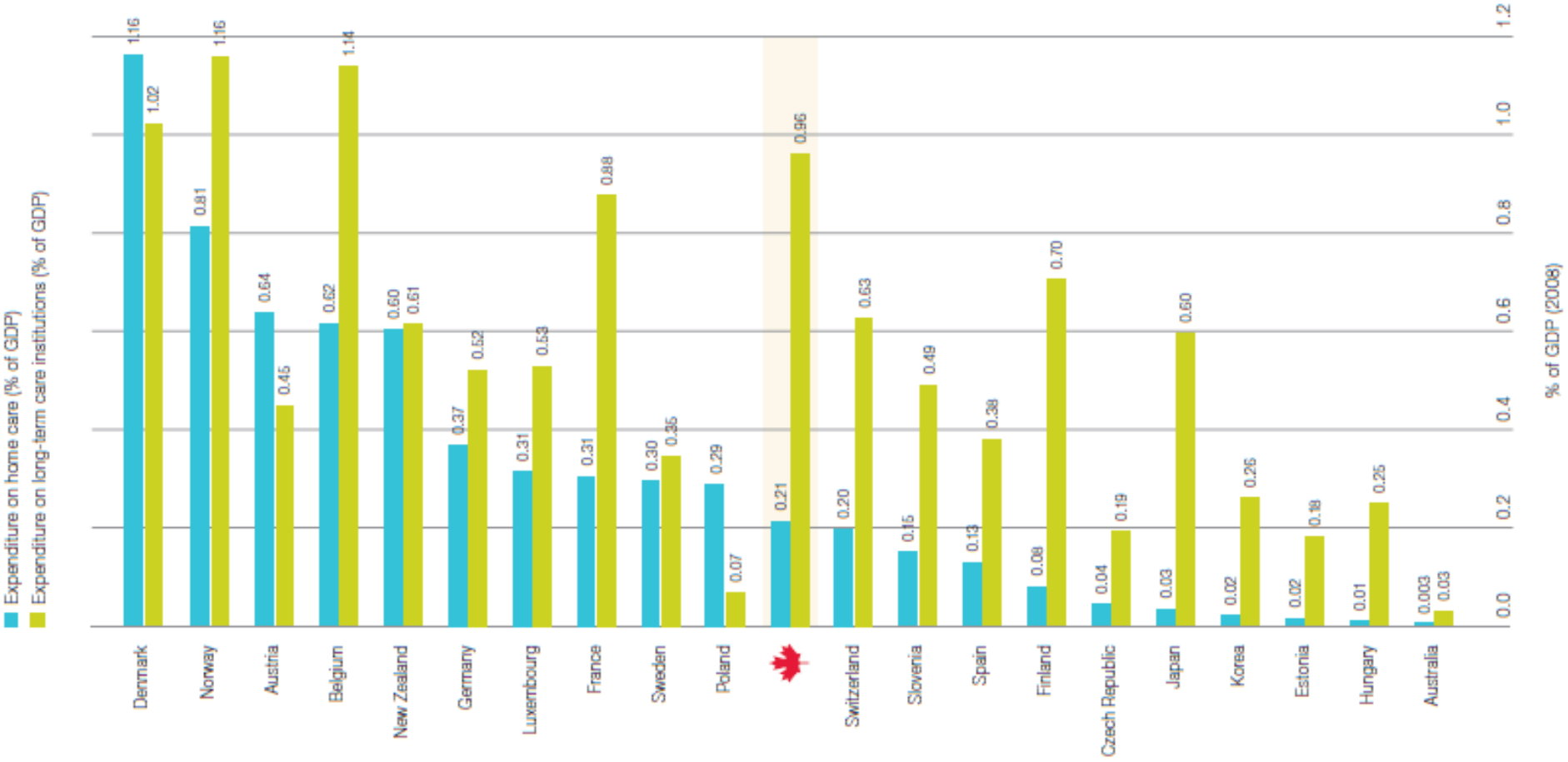


(Ontario Health Care Spending in 2011-12, MOHLTC).

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.



Source: Organisation for Economic Co-operation and Development (OECD) Health Data 2011 (data collected in 2008). http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

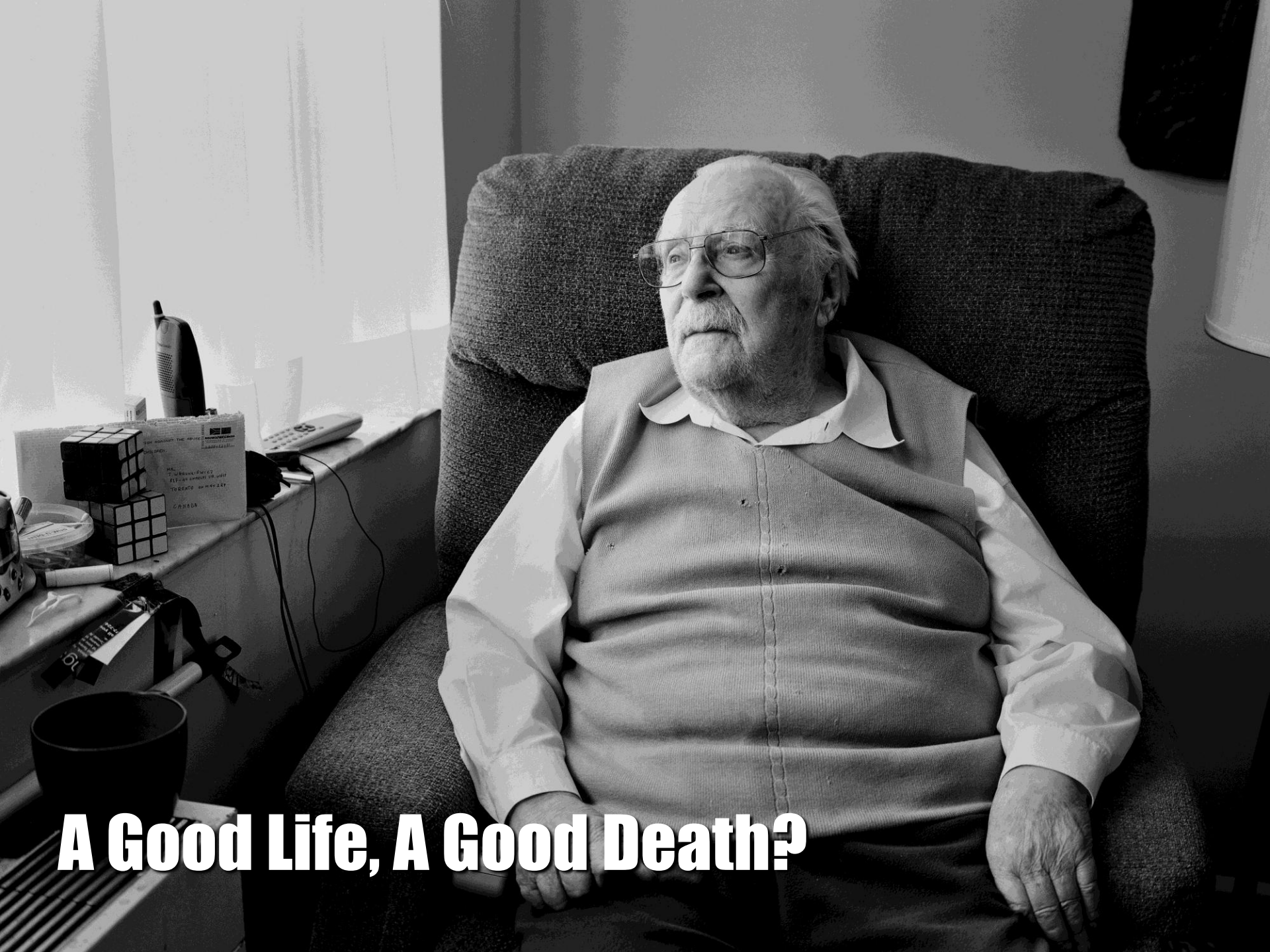
We Have Choices and Options…

- 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 2011through 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

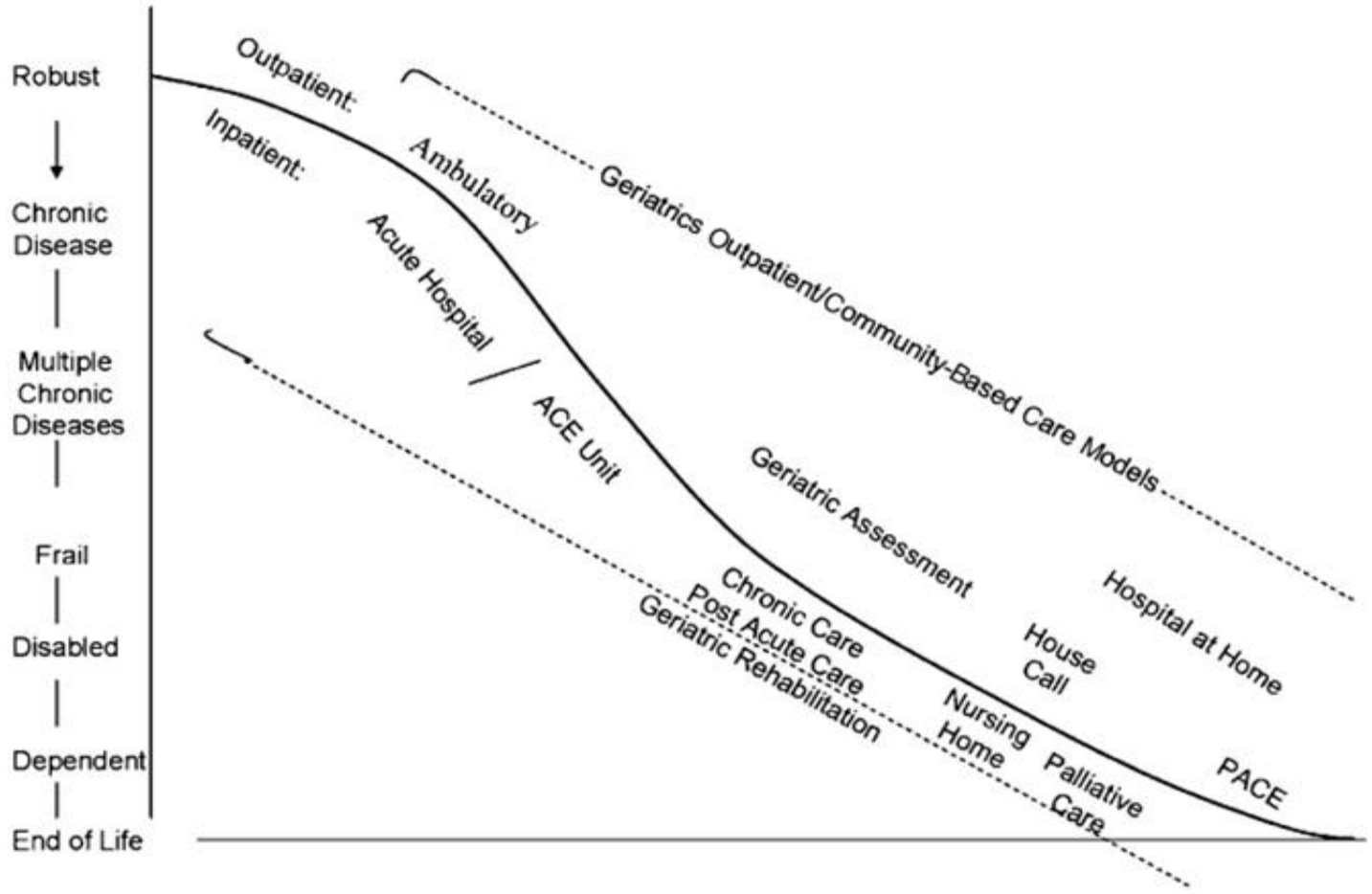
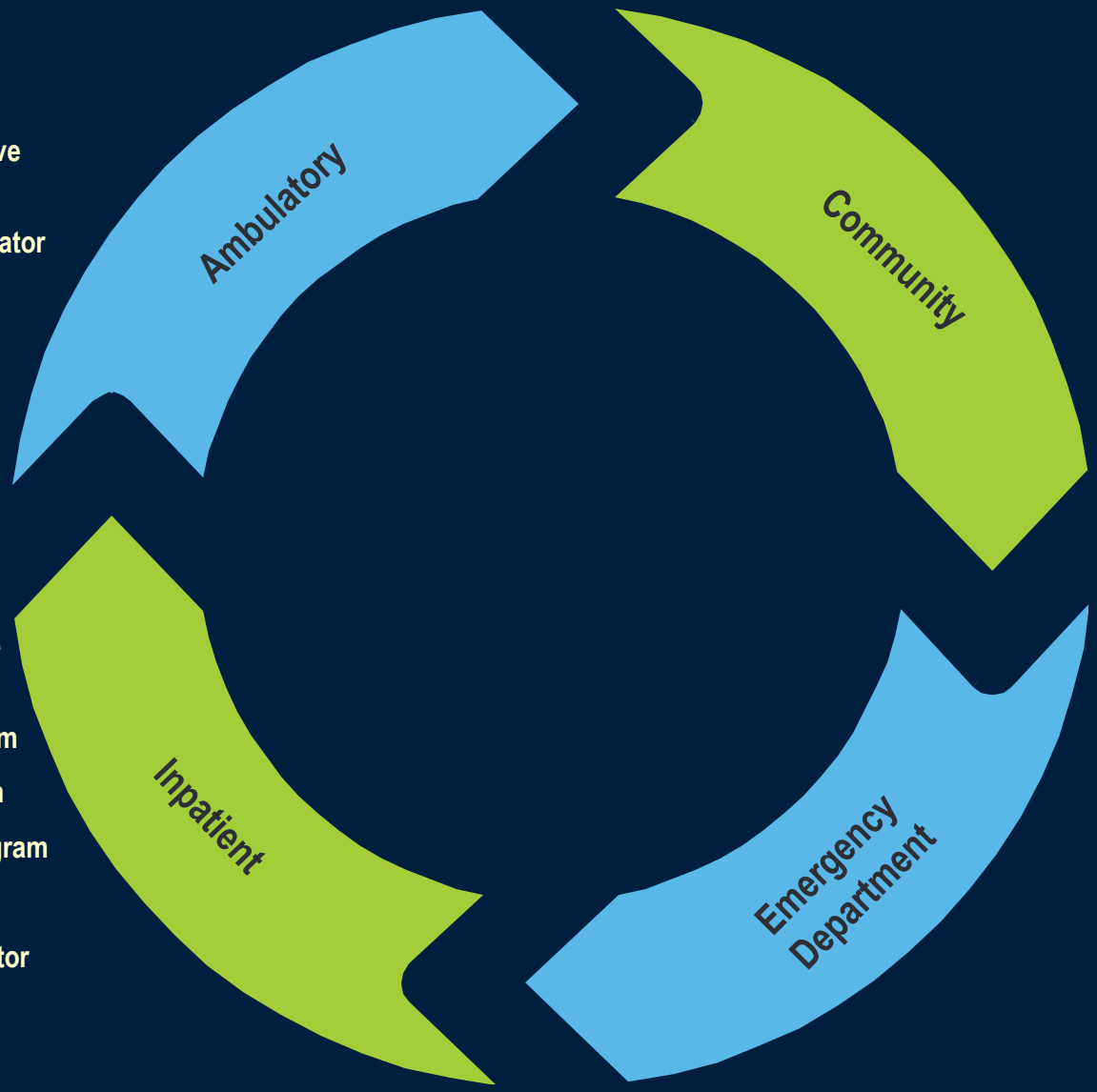


Figure 2. Continuum of geriatric care models.
ACE = Acute Care for the Elderly; PACE = Program for All-Inclusive Care for the Elderly.

JAGS 56(10):1791-1795, October 2008

The Mount Sinai Geriatrics Continuum



Outpatient Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Clinics

CCAC – Clinic Coordinator

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

Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Consultation Services

Orthogeriatrics Program

ICU Geriatrics Program

MAUVE Volunteer Program

ACE Unit

CCAC – ACE Coordinator

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 →** ***6.9*** **(Provincial Average = 9.8)**

ALOS/ELOS RATIO (Age 65+)

FY 09/10 **= 96.1 →** ***78.7***

CATHETER UTILIZATION RATIO (Age 65+)

- ***FY 09/10*** **= 56% →** ***14.7%***

% RETURN HOME AT DISCHARGE (Age 65+)

- ***FY 09/10*** **= 71.1% →** ***77.3%*** **(Current LHIN Average = 72.4%)**

READMISSION w/n 30 DAYS (Age 65+)

- ***FY 09/10*** **= 14.8 →** ***12.8%***

PATIENT SATISFACTION (Age 65+)

- ***FY 09/10*** **= 95.4 →** ***96.9%*** **(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


DOLOMITE
This is Our Time to Lea

Thank You

Samir K. Sinha MD, DPhil, FRCPC
Director of Geriatrics
Mount Sinai and the University Health Network Hospitals

Provincial Lead, Ontario's Seniors Strategy

ssinha@mtsinai.on.ca