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Setting the Balance of Care for Older Persons in Ontario: Emerging Policy Directions

A. Paul Williams, PhD.
Professor & CRNCC Co-Director, University of Toronto

Alzheimer Knowledge Exchange
Virtual Series on Dementia
February 7, 2012

The CRNCC is funded by the SSHRC and Ryerson University

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Policy Context

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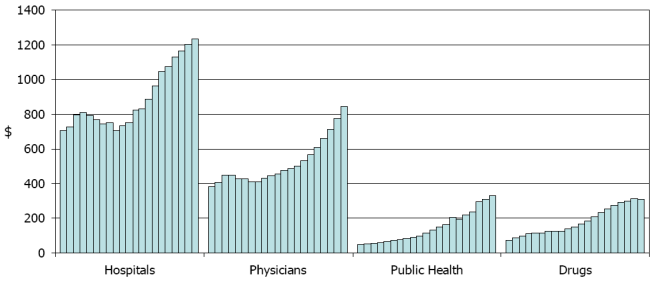
The Health Care Sky Is Falling

Annual increases in health spending at ~8% over the last decade

Ontario Provincial Government Health Expenditures Per Capita: 1989-2009.



Percentage Change:	Hospitals	Physicians	Public Health	Drugs
1989 to 1999:	6 %	19%	156 %	99 %
1999 to 2009:	64 %	86%	182 %	109 %

Source: CIHI 2009 from OACCAC, OFCMHAP & OHA, 2010

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The Prognosis Looks Grim

Rising costs threaten sustainability

- New and more expensive medical technologies and treatments
- Rising professional incomes
- Rising health services use across all age groups
- More people with multiple chronic needs

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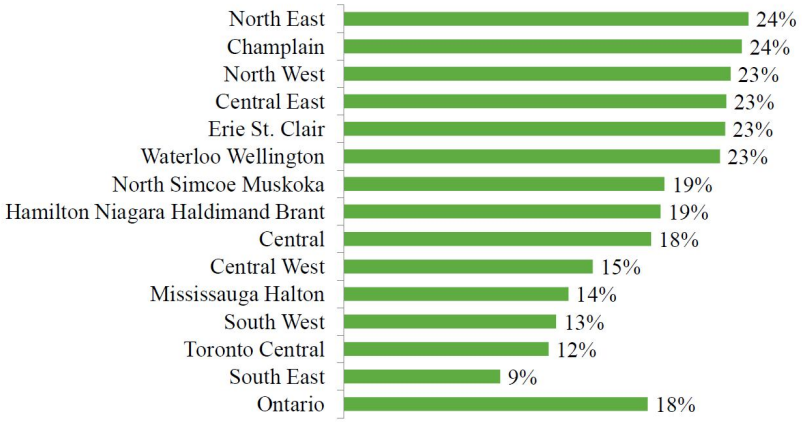
System Problems Persist: Hospital ALC Beds

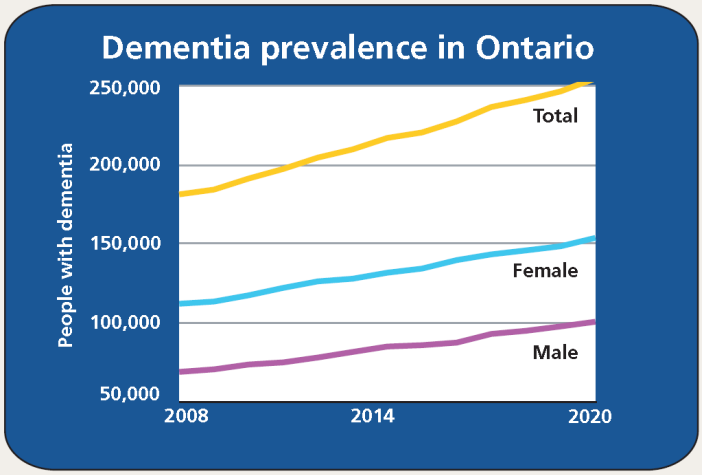


Percent of Acute Care Beds Occupied by ALC Patients = Total number of patients in acute care beds waiting for an ALC / Total acute care beds

ONTARIO HOSPITAL ASSOCIATION

Source: OHA ALC Survey Results – January 2011

Worse to Come: Rising Tide



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Drummond: Therapy or Surgery?

The Doomsday Scenario

- If *status quo* is maintained, healthcare costs are projected to grow 6.5% annually so that healthcare will comprise 80% of Ontario's public expenditure by 2030
- **Doom, at least, for publicly funded health care and everyone who depends on it**

Therapy or Surgery? A Prescription for Canada's Health System, November, 2011

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Drummond Reprised

Ontario's Drummond Commission expected to make 400 recommendations to address slow economic growth, rising public costs

- Including cuts of up to 30% in some ministries

As largest provincial expenditure, health care a big target

- Limit spending increases to 2%
- Shift people out of institutions quicker, deliver more services in the community

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Policy Response

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First Response: Wait Times/ER/ALC Strategies

Improve hospital "flow-through" by targeting specific acute care problems

- Wait times: "big five" (cancer, heart, diagnostic imaging, joint replacements, sight restoration)
- ER: avoidable hospital admissions
- ALC: hospital beds occupied by individuals who no longer need hospital care

Raising the question:

- Flow-through to where?

A Nuanced Response: Walker

Current models rely too heavily on acute care hospitals and "permanent" placement for seniors

- ED becomes the default, leading to hospital admission, ALC

A "fundamental system redesign" is needed that will shift resources out of institutional settings and into the community

Caring for Our Aging Population and Addressing Alternative Level of Care, June, 2011

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Adding Fuel: Baker

Reduce avoidable hospital readmissions to improve quality, safety and use of resources

Improve care transitions through partnerships across the health care system

An emphasis on home and community care is needed to improve transitions

Report of the Avoidable Hospitalization Advisory Panel, November, 2011

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Ontario's Action Plan for Health Care (2012)

"The health care system is facing unprecedented challenges. Most prominent among them are the demographic and fiscal challenges."

- "The most significant part of our plan focuses on ensuring patients are at home instead of in the hospital or long-term care. It means structuring the system to meet the needs of today's population, with more focus on seniors and chronic disease management."

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Balance of Care Research Findings

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Ontario Balance of Care Research

What determines whether older persons can age at home?

- Demand side
  - Needs and characteristics of older persons and caregivers
- Supply side
  - System -- access to safe, appropriate cost-effective home and community care (H&CC)

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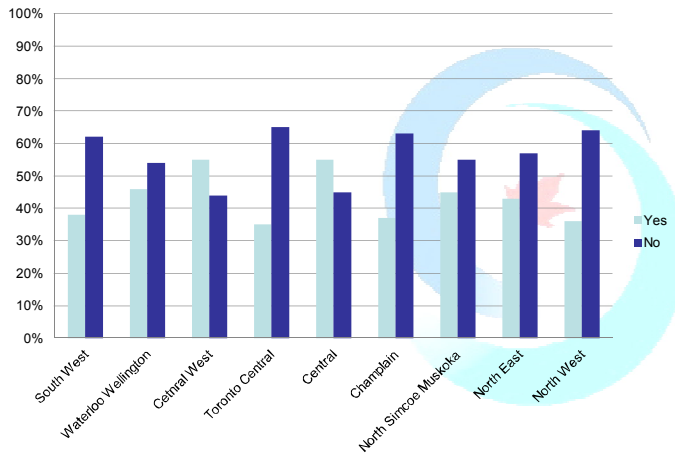
Caregiver in Home?



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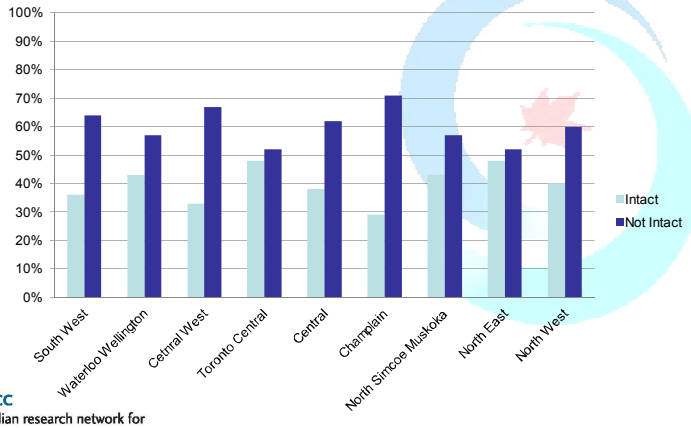
Cognition

Cognitive Performance Scale
Short term memory, cognitive skills for decision-making, expressive communication, eating self-performance



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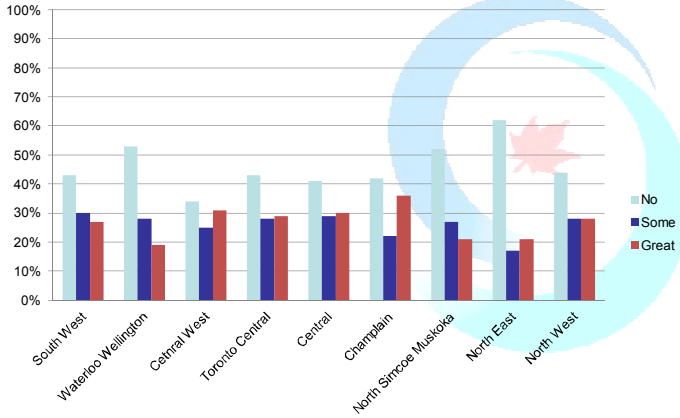
Activities of Daily Living *(ADLs)*

Self-Performance Hierarchy Scale
Eating, personal hygiene, locomotion, toilet use



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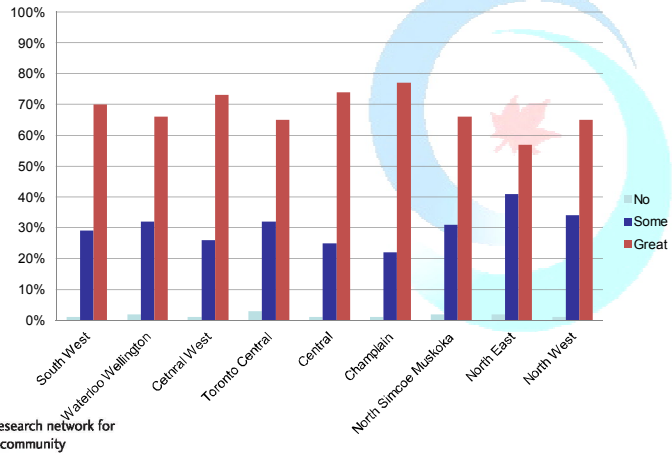
Instrumental Activities of Daily Living (IADLs)

IADL Difficulty Scale
Meal preparation, housekeeping, phone use, medication management



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Aging @ Home: Small Things Matter

4 year, $1.1 billion Aging @ Home initiative introduced in 2007

- …"enable people to continue leading healthy and independent lives in their own homes"
- Included: meals, transportation, shopping, friendly visiting, snow shoveling, adult day programs, caregiver relief/support

- Prevent or delay illness, dependency
- Moderate demand for costly institutional care

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ER/ALC … Big Problems Prevail

By 2011, Aging @ Home overtaken by ER/ALC strategy

- In 2009-2010, 50% of AAH money to be directed to ER/ALC by LHINs
- In 2010-2011, 25% of AAH money "taxed back" for provincial ER/ALC initiatives, and remaining 75% to address ER/ALC problems at LHIN level

From proactive Aging at Home, to reactive "don't age in the hospital"

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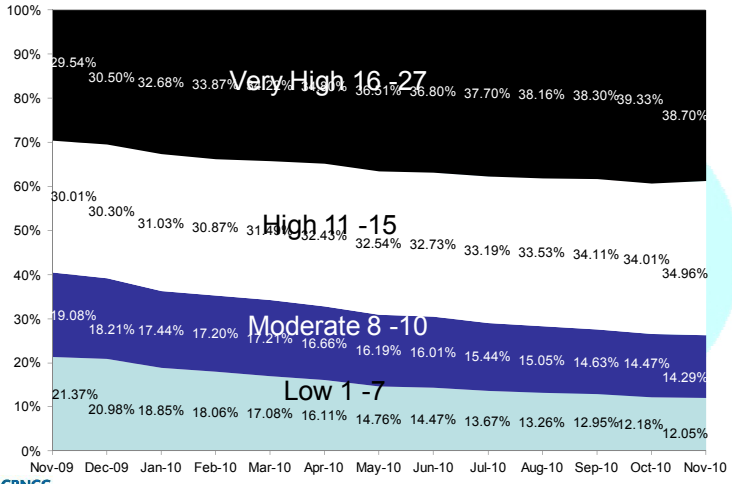
Change in Client Base: Central CCAC PSW Hours by RAI Score



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Source: Central CCAC, January 2011

What About People With Dementia and Caregivers?

The longer you wait, the fewer the options

- Providers told us, risk can be managed, but early
- Supportive housing told us, we can take people with dementia, but early
- Caregivers told us, “holding on” often leads to burnout and crisis

ER becomes the default, fueling a negative, and costly cycle

- Once in hospital, dementia complicated by mental trauma, delirium, hospital born disease, physical decline, restraints …

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Moving Forward

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Out of Crisis, Opportunity?

More of the same, but cheaper, not a viable option for older persons or Medicare

International evidence is clear

- Reactive, curative-focused, "non-systems" of care singularly unable to support people of an age and caregivers with multiple health and social needs in a cost-effective, appropriate way

Emerging policy looks to broader, more integrative, proactive community-based approaches

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Design Essentials

Target

- Document high needs, frequent flyers and their caregivers: on LTC wait lists, in ALC beds, in ER
- But also understand how they got to be there and what could be done to manage better, earlier

Integrate

- Still need Aging @ Home community supports in the toolkit
- Also need primary care

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Design Essentials

Manage

- People with multiple health and social needs (including dementia) least likely to manage on their own
- Someone has to be responsible and accountable for the whole care pathway for vulnerable people

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The Return of Aging at Home

Move from distributive (where everyone gets more) to redistributive politics (where someone gets less) always tough

But shift of resources (not just need) to community now essential

- To ensure people and caregivers have the choice to age at home
- To avoid using hospitalization and institutionalization as costly `substitutes` for more appropriate care

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