



# **Local Ontario context: Older adults with complex conditions**

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**Leveraging the Culture of Performance Excellence in Ontario's Health System**

*HSPRN is an inter-organization Network funded by the Ontario Ministry of Health and Long Term Care* 1

# Older adults with complex conditions

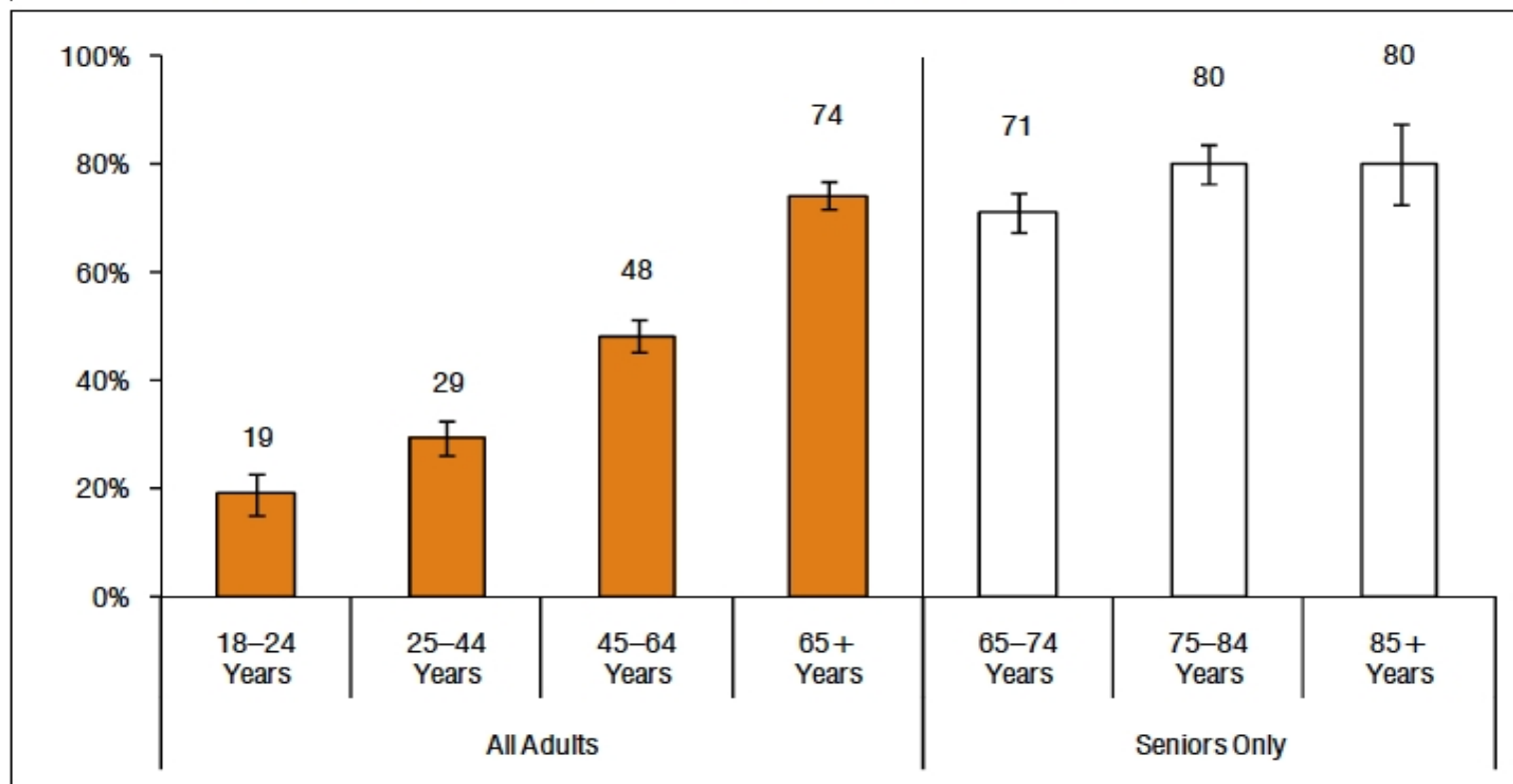
Today is about opportunities...

My three messages:

1. Epidemiological and economic burden
2. Identifying target populations for intervention – predicting risk
3. What is integrated care, who needs it and what do they care about?

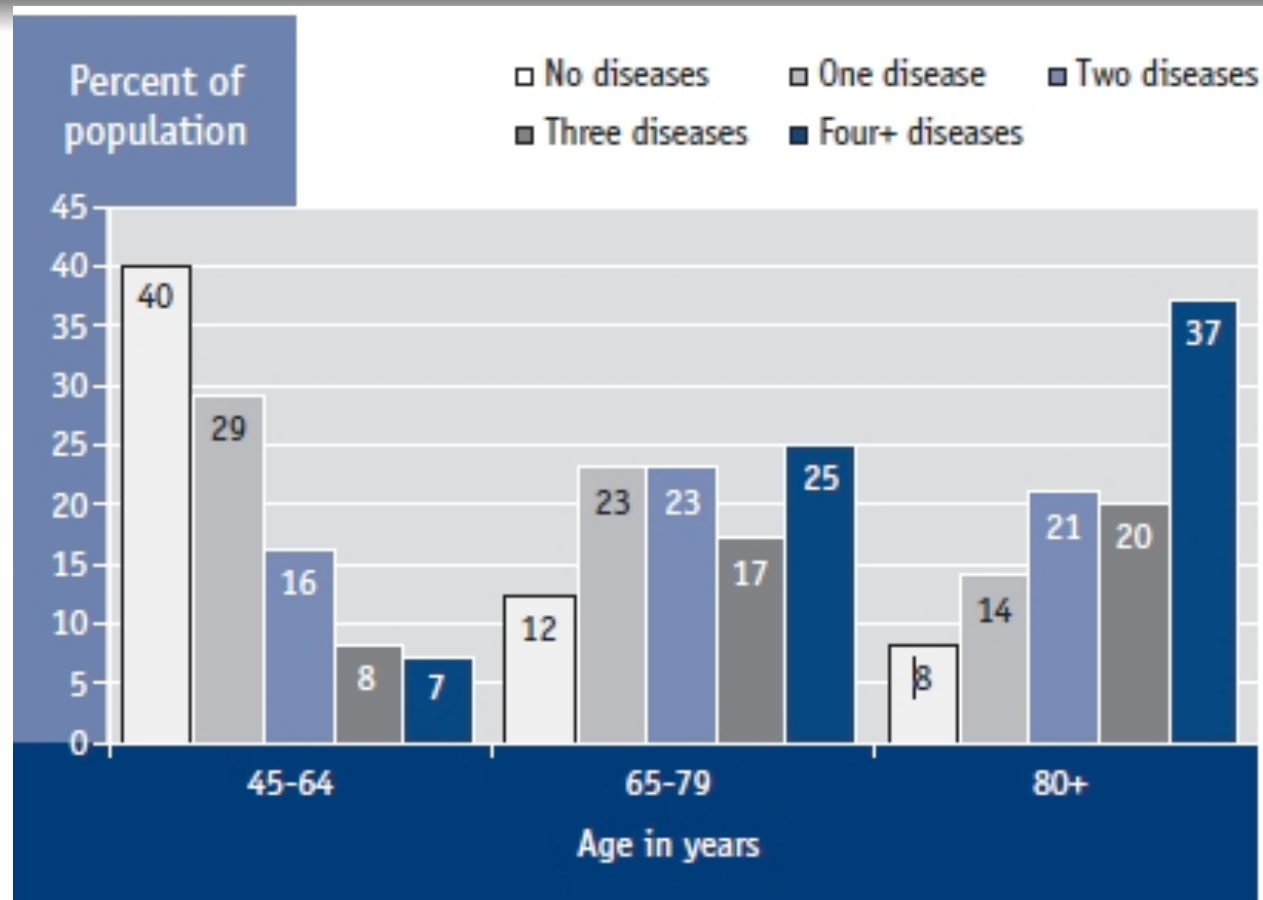
# Chronic Disease is Normal

Figure 3: Percentage of Adults Who Reported Having at Least 1 of 11 Chronic Conditions, by Age Group, Canada (Crude Estimates)



- Source: Canadian Institute for Health Information: *Seniors and the Health Care System: What Is the Impact of Multiple Chronic Conditions?* July 2001

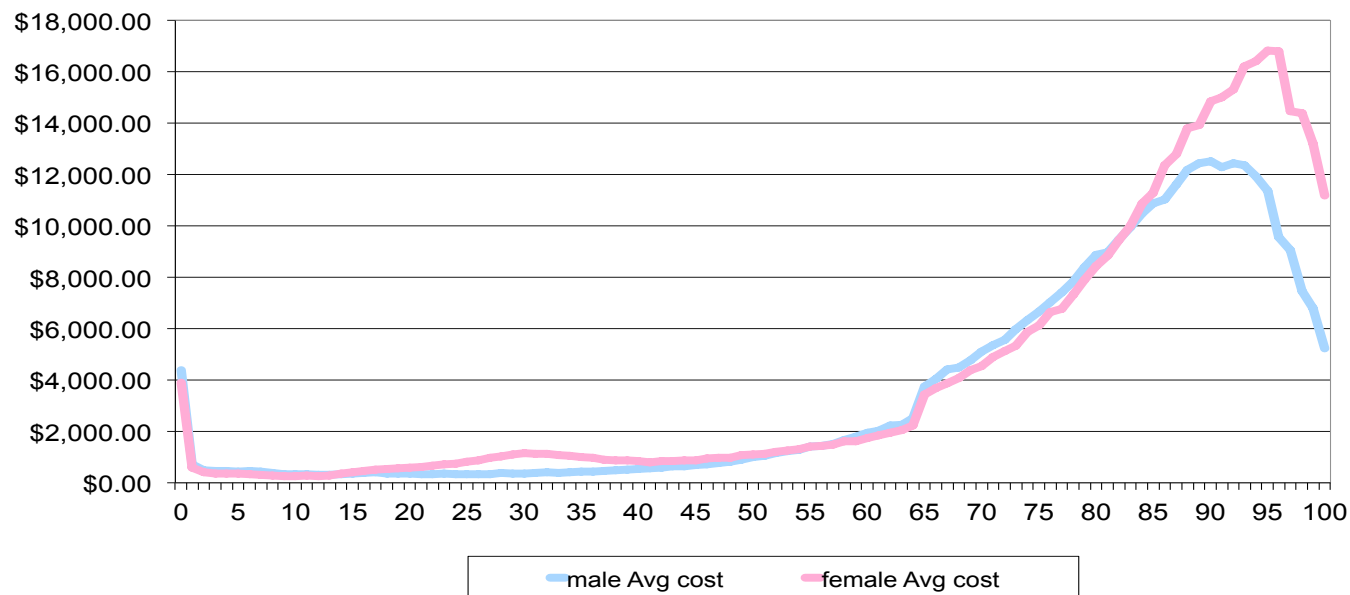
# Multi-morbidity is Normal for Older Adults



- Source: The Chief Public Health Officer's Report on the State of Public Health in Canada. 2010 : *Growing Older – Adding Life to Years*

# Older Adults Are Costly

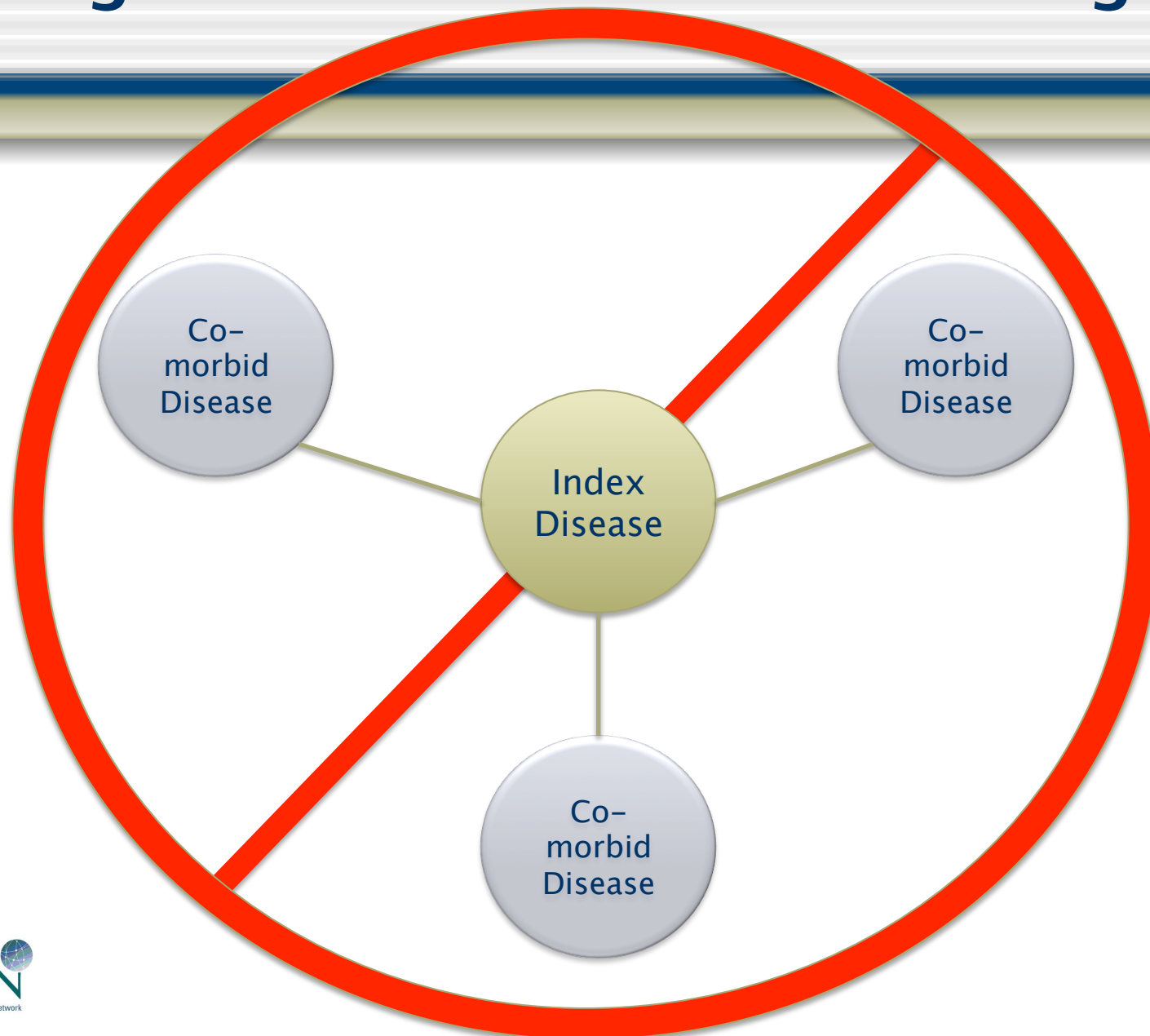
**Figure 2. Average Annual Total Health System Cost by Age and Sex.  
Ontario 2007**



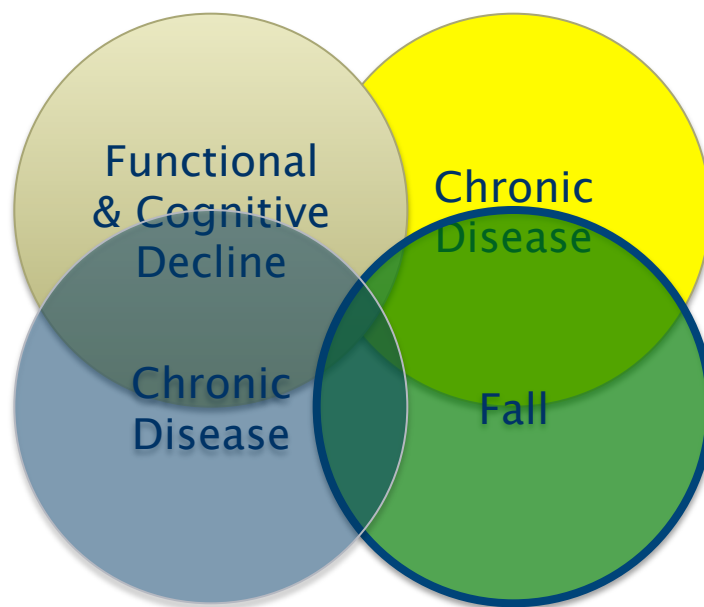
Most people are healthy throughout their lives and incur their highest costs later in life.  
This is borne out in higher average costs for just about every sequential age.

\*note increase at age 65 in spending attributable to ODB coverage at age 65

# Not Singular Chronic Disease Management



# Focus on Disease And Function



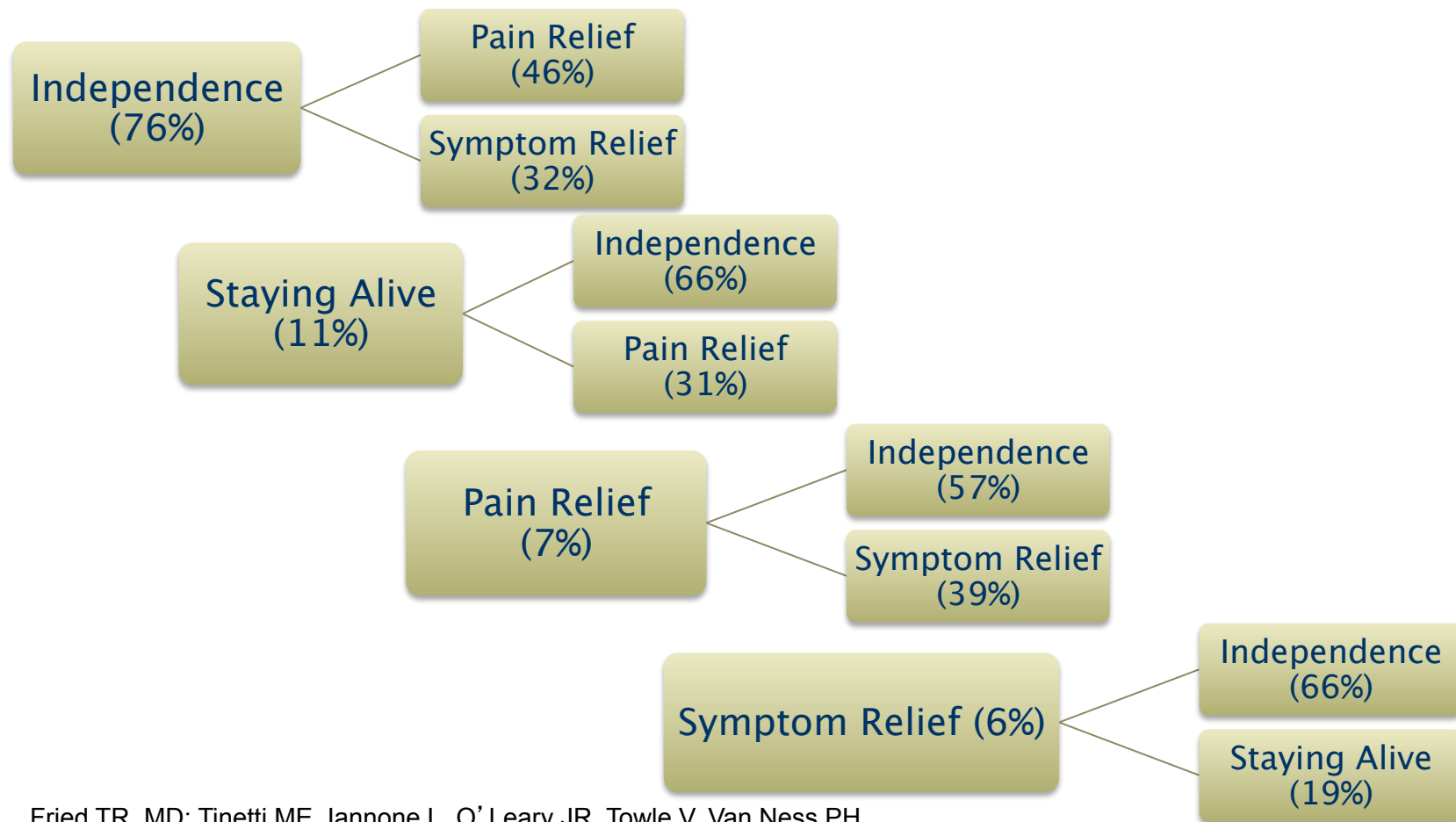
# Why focus on chronic multi-morbidity ?

- Primarily community-based care
- High acute readmission rate
- High LTC admission rate
- High system burden (cost)

# Burden is High, Care is Sub-Optimal

- Seniors with three or more reported chronic conditions account for 40% of reported health care use among seniors
- **Gaps exist in preventive and collaborative care for seniors**
- Though most seniors have access to PHC:
  - ◆ fewer than half (48%) reported talking at least some of the time to a health professional about their treatment goals.

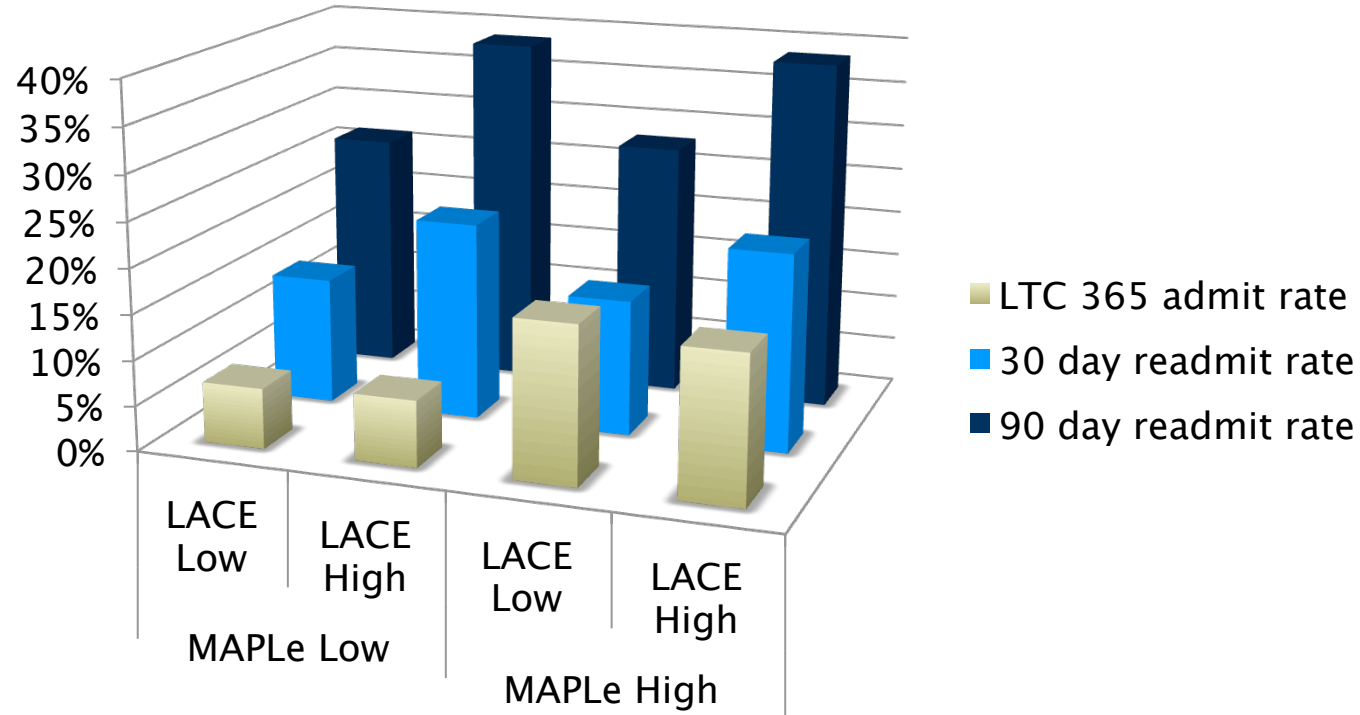
# What Outcome Measures Matter?



Fried TR, MD; Tinetti ME, Iannone L, O'Leary JR, Towle V, Van Ness PH,  
**Health Outcome Prioritization as a Tool for Decision Making Among Older Persons With Multiple Chronic Conditions**  
*Arch Intern Med.* 2011;171(20):1854-1856

# Disease and Functional Risks

## Disease Predicts Acute; Function for LTC



MAPLe Measures Function; LACE measures medical complexity

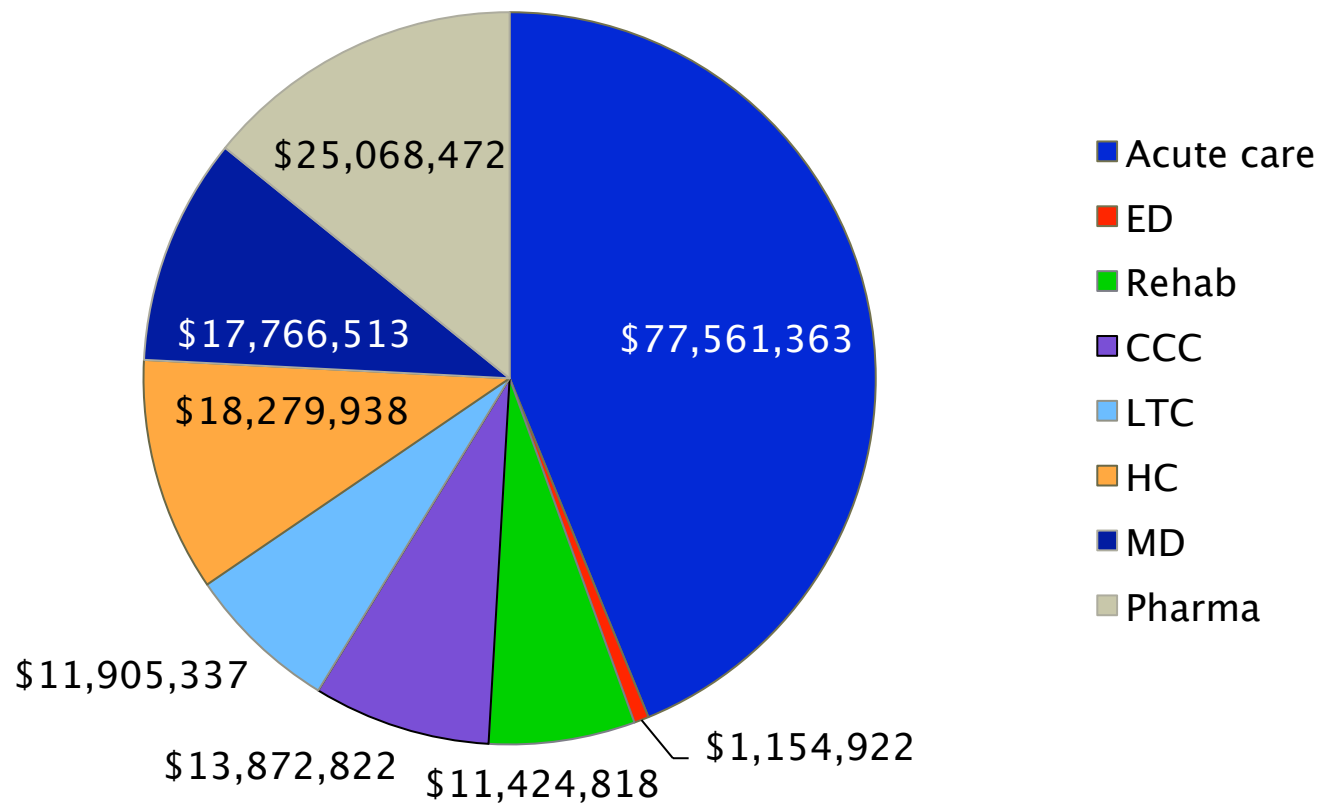
# Multi-morbidity is a complex issue

- Very few Clinical Practice Guidelines address multi-morbidity (many are impractical & may be harmful in some cases of multi-morbidity)
- Trial-based evidence gap: multi-morbid groups are excluded
- Some co-occurring conditions may be managed synergistically (e.g. ace inhibitors in diabetes and hypertension)
- Chances of adverse effects from medications may be related to severity of other diseases (e.g. Cox-2 inhibitors in individuals with severe diabetes or hypertension).

A few key authors: Elizabeth Bayliss, Chad Boult, Cynthia Boyd, Martin Fortier, Alex Jadad, Andres Cabrera, Renee Lyons, etc

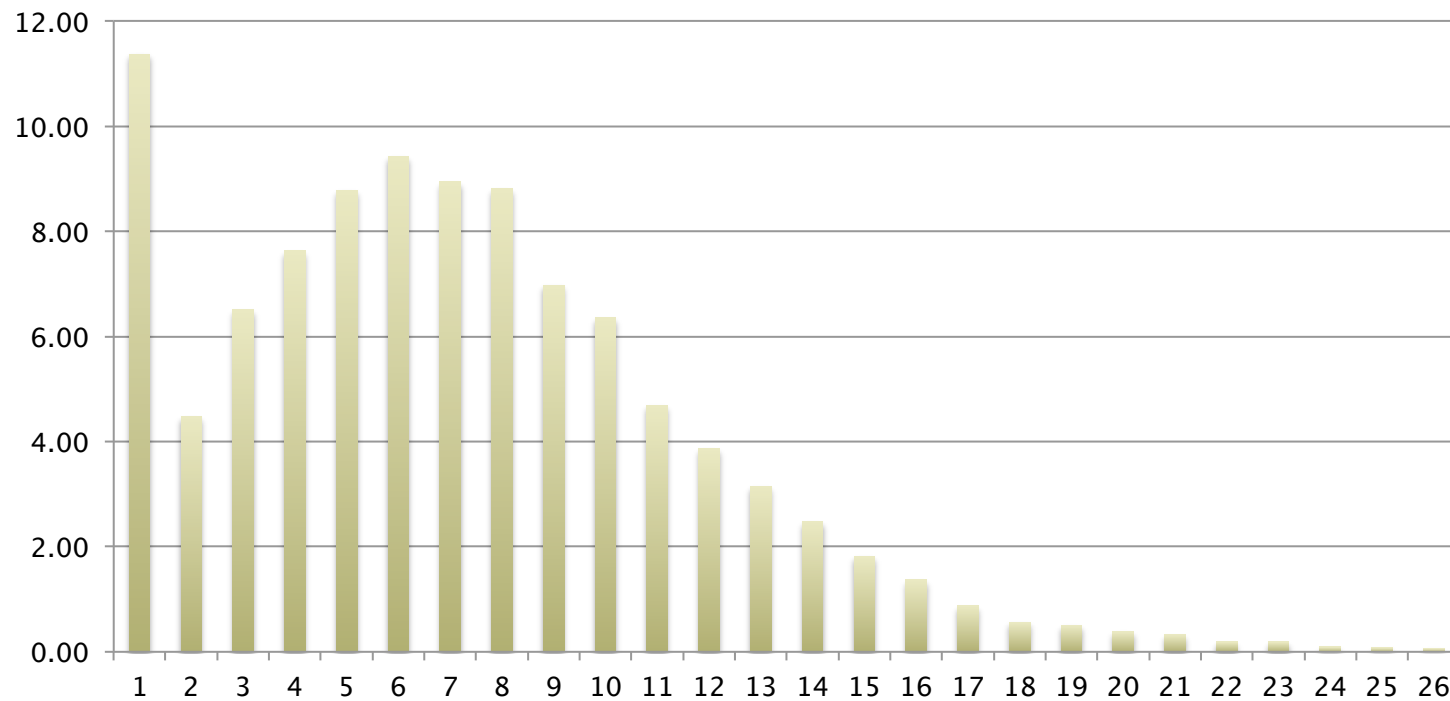
# Ontario Spending in 2009

MULTI-ACSC...\$177+ Million



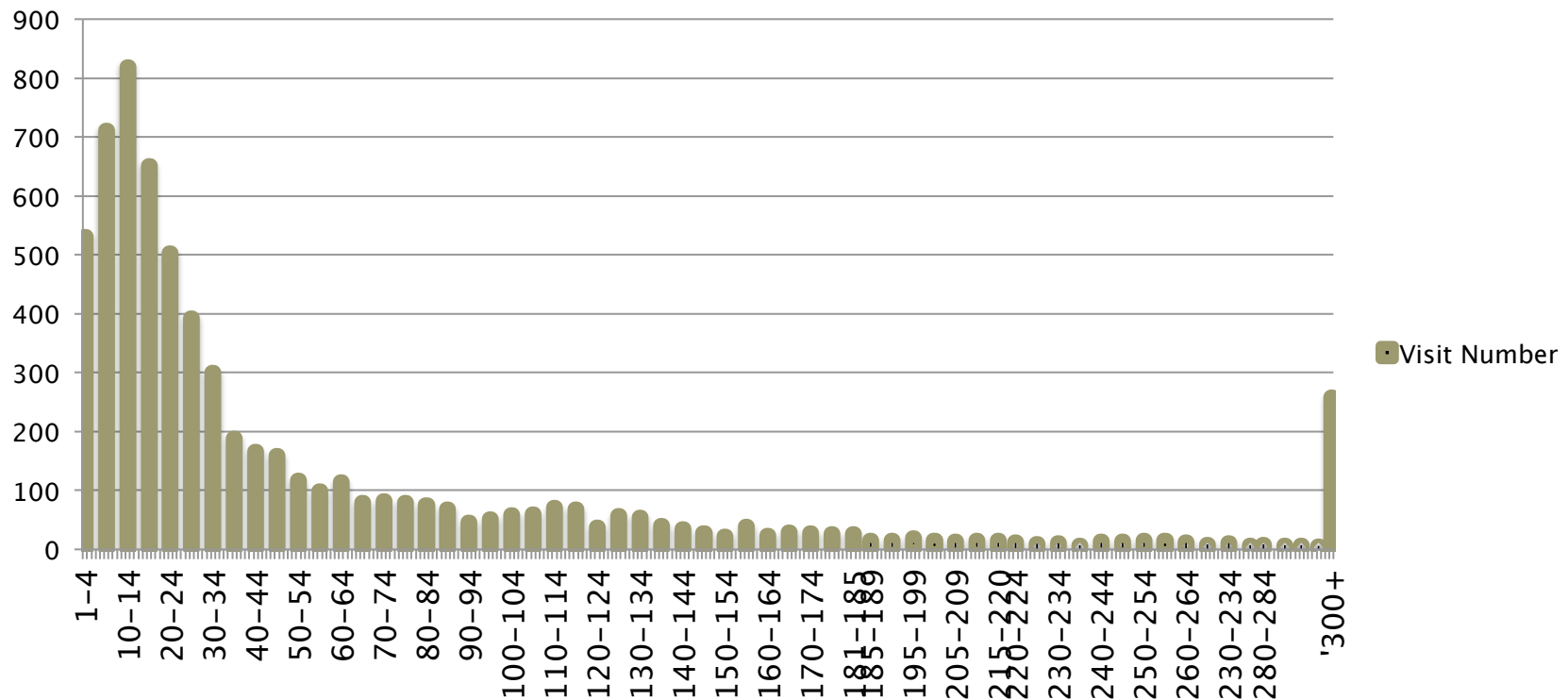
# Patients see different providers

Percent of MACSC by Number of Different Providers



# Some patients have many encounters

Patients with visit counts



# What to do ?

- Many good intervention ideas
- How to identify “service package” for different clients
- Targeting may be key:
  - ◆ Who is at risk for what outcome ?
  - ◆ What is the best intervention to avoid that outcome ?
- For example: risk of acute readmission and LTC placement among home care clients who were admitted to acute...

# Patient/Family-centered strategies



How do I get support to help me and my dad when his dementia acts up.



I would like to :

1. Know who to call when I have a question about my medication
2. Have the same person check on me
3. Take my grandchildren to the park

