PALLIATIVE CARE DELIVERY ACROSS HEALTH SECTORS: A POPULATION-LEVEL OBSERVATIONAL STUDY (PUBLICATION)

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CONTEXT

Palliative care aims to provide relief of physical symptoms and supportive care for patients and their caregivers during the dying process. It is delivered by multiple providers, including physicians, nurses, and other healthcare practitioners, in various care settings, including acute care and other hospital settings, long-term care facilities (i.e. nursing homes), hospices, and in people’s homes. Existing evidence shows that home palliative services for adults with advanced illness are associated with positive outcomes, particularly decreased symptom burden and increased odds of a home death. Palliative care has been described as a patchwork of uncoordinated services, delivered unsystematically and varying depending on the services available at the region, care facility, and provider levels. Little population-level information exists about the delivery of palliative care across multiple health sectors, important in providing a complete picture of current care and gaps in care.

OBJECTIVES

The objective of this paper is to illuminate patterns of care delivery and potential gaps in care in the population.

METHODS

An observational retrospective population-level cohort study was used, describing palliative care in the last year of life using linked health administrative databases. All decedents in Ontario, Canada, from 1 April 2010 to 31 March 2012 were captured. Using encrypted health card numbers, records of healthcare use were linked across various administrative databases held at the Institute for Clinical and Evaluative Sciences. For all decedents, the total number of palliative care days delivered (i.e. intensity) in each of the 12 months in the last year prior to death, and the first day of palliative care in the last year of life (i.e. initiation) were observed.

FINDINGS

Across all health sectors, about half (51.9%) of all decedents received at least one record of palliative care in the last year of life. Being female, middle-aged, living in wealthier and urban neighbourhoods, and less multi-morbidity was all associated with higher odds of palliative care receipt. Those with cancer were more likely to receive palliative care than those on the organ failure (eg. congestive heart failure) and frailty (eg. dementia) trajectories. Among 92,276 decedents receiving palliative care, 84.9% received care in acute care hospitals. Among recipients, 35 mean days of palliative care were delivered. About half (49.1%) of all palliative care days were delivered in the last 2 months of life, and half (50.1%) had palliative care initiated in this period. Only about one-fifth of all decedents (19.3%) received end-of-life care through publicly funded home care. Less than 10% of decedents had a record of a palliative care home visit from a physician. There was a large difference in the intensity of palliative care delivered among palliative care decedents in the highest and lowest intensity quintiles (1.8 mean days and 112.8 days, respectively).

CONCLUSIONS

We describe methods to capture palliative care using administrative data. Health care at the end of life in many populations, including in Canada, predominantly occurs in acute care institutions. Augmenting palliative home care programs and increasing palliative care delivered by physicians in both outpatient and home settings require addressing a complex web of barriers. Ontario and other jurisdictions can continue its efforts to support aging and dying in appropriate places of care by improving the reach of palliative care to the dying.

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