

Chapter 3

Investing in a “Rehabilitation Model” to Improve the Decision-Making Process in Long-Term Care

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ABSTRACT

An aging population is a primary factor associated with escalating healthcare costs due to increased drug spending, chronic diseases and co-morbidities, physician visits, and hospital costs (TD Report, 2010). There has already been a marked increase in the number of Long-Term Care (LTC) residents with co-morbidities, and chronic diseases will be more prevalent in future years (Conference Board of Canada, 2011). The chapter explores the use of a rehabilitation model to improve the current decision-making processes that impact the health outcomes of seniors across the Ontario LTC continuum. Improved clinical management of this population through rehabilitation could result in not only enhanced quality of care but also significant cost savings for both the Long-Term Care (LTC) industry and the health system at large. The chapter highlights the need for the LTC sector to identify strategies for harnessing innovation to improve its own activities and outcomes and become a leader in health system transformation.

INTRODUCTION

The sustainability of our healthcare system (due to rising costs and quality challenges) is the most pressing policy issue facing Canada and the provinces in this decade (TD Report, 2010). In 2010,

Canada’s health-care system is forecast to consume 11.9 percent of Gross Domestic Product (GDP) as the costs of health-care continue to rise. By 2025, healthcare is projected to consume 15 percent of GDP (Conference Board of Canada, 2011). The TD Economic Report and the Conference Board of Canada report that “innovation” while reducing the rate of health-care costs and improving health

DOI: 10.4018/978-1-4666-4321-5.ch003

outcomes is the best option for keeping Canada’s health-care system sustainable (Conference Board of Canada, 2011; TD Report, 2010). In Ontario, healthcare costs currently make up 46% of total program spending and is expected to continue to rise in the future due to increasing utilization of services, our aging population, and the prevalence of chronic disease (MOHLTC, 2010).

The number and proportion of seniors in the population is growing and chronic diseases are increasingly prevalent; impairing the ability of many Ontarians to live independently. In this decade, the number of people aged 65 and older is expected to rise to over 1.9 million. By 2035—when boomers are 71 to 89 years old—there will be nearly 238,000 Ontarians in need of long-term care, versus about 98,000 today (StatsCan, 2006; Government of Ontario, 2009). Long term care homes provide care for people who are not able to live independently in their own homes and who require 24-hour nursing or personal care support.

In 2006, Canada’s expenditure on Long-Term Care (LTC) alone was equivalent to about 1.5% of its Gross Domestic Product (GDP). More than 80% of these expenditures were targeted to institutional care (OECD Health Data, 2010). Given the continued rise in our aging population as well as high costs associated with LTC, re-engineering health care delivery through improved decision-making processes in this sector may be an effective strategy in reducing expenditures.

There are currently 625 long-term care homes in Ontario with approximately 76,904 residents who are unable to live independently in the community (Conference Board of Canada, 2011). Hospitalization of LTC residents is highly prevalent and contributes to clogging of emergency rooms and hospital bed shortages (Conference Board of Canada, 2011). The nursing home literature reports estimated rates of hospitalization averaging approximately 35% per year, most of which were classified as Ambulatory Care Sensitive Conditions which are typically considered as unnecessary hospital transfers (Hutt et al., 2002;

Coburn et al., 2002). In Ontario, between 7 and 17 percent of all hospitalizations are Alternate Level of Care (ALC) related—that is, where the healthcare needs of the patient are such that they do not require hospitalization, and could be managed in another setting, provided that other setting is available (Conference Board of Canada, 2011). There are multiple risk factors and predictors of hospitalization for the LTC population including cognitive and functional decline (Hutt et al., 2002; Coburn et al., 2002; Conference Board of Canada, 2011). Numerous studies report that these conditions also contribute to rising costs associated with hospitalization (Cornette, 2005; Intrator et al., 2004; Carter, 2003).

The Canadian healthcare system is effectively designed for reactive, episodic care making it an ideal system for acute disease management but underperforms in the prevention and management of chronic diseases. This system has significant shortcomings for improving and maintaining the health of an aging population with multiple co-morbidities, as found in the LTC population (Conference Board of Canada, 2011; TD Economic Report, 2010). See Table 1 for list of current and estimated future percentages and rates of co-morbidities among LTC residents.

The health-care system is not alone in underperformance on new initiatives. In the Conference Board’s 2010 report, *How Canada Performs: A Report Card on Canada*, Canada received a grade of—D grade on innovation performance, ranking 14th out of 17 peer countries (Conference Board of Canada, 2011). Although lack of innovation is yet to be a priority of the government, the Ontario Ministry of Health and Long-Term Care (MOHLTC) is currently concerned with the impact of population aging on the costs of healthcare. The MOHLTC is focusing on quality to drive value in healthcare: “Excellent Care for All Act, 2010” provides a foundation to reform the health system around the client. This focus promotes innovation while creating incentives for quality, value and evidenced-based care for patients. Both

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