

Position Statement

The Need for Expert Clinical Care for Older People Living with Complex Health Conditions¹ Required Services in Every Ontario Health Team

By 2029, there will be almost one million older adults in Ontario living with frailty². This conservative estimate acknowledges that many older people living with complex health conditions such as mental health and addictions concerns, dementia and multiple, interacting medical conditions may not be fully identified in health system data. Older people living with frailty are at the highest risk of hospitalization³. Further, people living with dementia are at risk for emergency room use, hospital admission, longer hospital stays⁴ and account for approximately a third of all Alternate Level of Care (ALC) designations in Canada⁵. Service gaps, fragmentation and a health care system that is not specifically designed for this population contributes significantly to hallway medicine, and to avoidable health care costs.

Across the province, Specialized Geriatrics Services provide direct clinical care, programmatic support, education and knowledge transfer (via a range approaches designed for health care providers, patients and caregivers), to ensure optimal care for the most vulnerable Ontarians. We work in collaboration with general primary care, hospitals, home care, community service agencies and the long term care sector. We share a focus on ending hallway medicine, and work directly to decrease repeat emergency department visits, hospital readmissions and prolonged or permanent institutionalization among older people. We do this by providing age and frailty appropriate care and targeted supports to keep seniors safely at home. Our efforts reduce health system costs by providing care specific to the complexity of the population served.

If we are to end hallway medicine, **all Ontario Health Teams must demonstrate the necessary policy, clinical and funding focus on older people living with complex and multiple interacting health conditions (including dementia)**. Each Ontario Health Team must include specific services that focus on this population (see Table 1) and engage the appropriate clinical leadership necessary to carry out this work.

Specialized Geriatric Services (SGS) teams consist of interprofessional staff from Care of the Elderly Primary Care, Geriatric Medicine, and Geriatric Psychiatry and many other health disciplines who are uniquely knowledgeable about how to design and deliver health services for older people living with multiple, interacting medical, mental health problems and/or lack of social supports. This work includes support for people living with dementia, chronic diseases, frailty or mental health and addictions concerns or, often, a combination of several complex conditions. SGS promote wise and efficient use of services and resources to enable older adults to receive the right care, in the right place, at the right time. SGS teams prevent unnecessary treatment, minimize medication use and help to avoid acute episodes for many older adults. Our services assist to match the needs of individuals with the right frequency and intensity of services needed to prevent deleterious outcomes, and ultimately, end hallway medicine.

Older people and their caregivers expect their health concerns to be managed in a comprehensive, family and person centred way. They expect that their issues will be taken seriously and their care to be provided by knowledgeable experts who understand their unique and multifaceted needs. Older people and their caregivers deserve and expect this.

To achieve success in Ontario Health Teams, it is imperative to protect, augment, and prevent fragmentation of these highly specialized clinical services. Integration of health care services alone will not achieve the goal of ending hallway

¹ Includes frailty, co-morbid conditions, dementia, and complexity arising from medical and/or mental health conditions

² PGLO, 2019

³ <https://www.ncbi.nlm.nih.gov/pubmed/29874399>

⁴ <https://www.cihi.ca/en/dementia-in-canada/dementia-across-the-health-system/dementia-in-hospitals>

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4164681/>

medicine unless there is a policy and funding focus aimed at optimizing the health and function of older adults with complex medical and mental health issues.

Care for older adults living with complex health concerns, across all Ontario Health Teams, requires a province-wide focus on leadership, clinical planning and service coordination that is knowledgeable about and specific to this population. Ontario Health Teams will require strong partnerships with the regional and provincial programs in our network to deliver optimal care for this population. These partnerships are currently supported, on behalf of all Regional Geriatric Programs and Specialized Geriatric Services, by the **Provincial Geriatrics Leadership Office (PGLO)**, a focused clinical leadership entity that advances clinical care, quality and operational excellence across Ontario’s more than 400 specialized geriatric services. The work of the PGLO must continue and inform decision-making and funding reform to ensure evidence-informed, high quality specialized geriatric services are available to improve outcomes relevant to health system utilization by older people and to avoid unnecessary use of resources (e.g. avoidable admissions to hospital). **The clinical resources of SGS must be part of all Ontario Health Teams to ensure adequate support for an aging population and the growing numbers of older Ontarians living with complex health concerns.**

The care needs of older people living with complex health conditions are multifaceted and require an exceptional degree of clinical skill and care. Older people and their caregivers expect their care to be provided by knowledgeable experts who understand their unique needs. Ontario Health Teams, working in concert with clinical experts from across the field of geriatrics, can answer this challenge for all Ontarians. Together, we can improve care with reduced costs, and provide positive patient and caregiver experiences.

Table 1: Core Minimum Services Required for Ontario Health Teams to Ensure Adequate Care for Older Adults*

<p>Clinical diagnostic and treatment capability</p> <ul style="list-style-type: none"> Geriatric medicine and geriatric psychiatry focused assessment specific to seniors living with frailty and their caregivers, to address multiple co-morbidities and dementia (geriatric medicine, geriatric psychiatry, neurology, care of elderly primary care, etc.) Interprofessional assessment and intervention teams with expertise in geriatrics, geriatric psychiatry/mental health and dementia care <p>Evidence based clinical service models:</p> <ul style="list-style-type: none"> Community based geriatric assessment and intervention teams, inclusive of geriatric psychiatry and geriatric medicine Acute care older adult specific services (e.g. consultation services for in-patient units, emergency departments, and rehabilitative care) Primary care memory services Behavioural support services Mental health and addictions services for older people Rapid response availability through direct clinical service and/or consultative support for community and long term care Geriatric informed 24/7 telehealth 	<p>Comprehensive community and social supports</p> <ul style="list-style-type: none"> Nursing and therapy services In home personal support worker services Home support (e.g. meals, shopping, homemaking, meal preparation, maintenance etc.) Adult day programming Caregiver education and supports Respite care Affordable, safe, supportive housing options (including Long Term Care Homes) Social and therapeutic recreational supports Transportation services Palliative and End of Life Care <p>Navigation, advocacy, and case management services focused on the specific needs of older adults</p> <ul style="list-style-type: none"> Service navigation and Safety (e.g. risk identification and prevention) Elder abuse response Care coordination and access <p>Performance measurement (with common process & outcome indicators)</p> <p>Digital solutions:</p> <ul style="list-style-type: none"> GeriMedRisk E-consults and OTN supported clinical services Project ECHO – Care of the Elderly Providing CHRIS (Client Health and Related Information System) access for all Ontario Health Teams
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* Requirements for specific individuals will vary and are optimally determined following a comprehensive geriatric clinical assessment.