**Provincial Geriatrics Leadership Office**
***On Behalf of***
**Clinical Specialists & Leaders In Geriatrics**
***Medicine, Psychiatry, Care of the Elderly and Interprofessional Teams***

February 28, 2019

Dr. Rueben Devlin, Chair
Premier's Council on Improving Healthcare and Ending Hallway Medicine

Via email: hallwayhealthcare@ontario.ca

Dear Dr. Devlin

Re: Response from clinicians practicing in specialized geriatric services

We are writing this response to the first report on ending hallway medicine as a provincial network of front-line clinicians specializing in geriatrics from various specialities including geriatric medicine, geriatric psychiatry, care of the elderly physicians and nursing and allied health services. Our daily work involves caring for older adults in the community and in hospitals. We are trained to understand their unique medical and social needs in a comprehensive manner and provide specialized medical and mental health services that include preventative, acute medical and restorative care. The issues highlighted in the first interim report of the Premier's Council to End Hallway Medicine are very familiar to us and resonate with our clinical experience.

In our day-to-day work, we serve older adults living with or at risk for frailty. In 10 years, there will be nearly 1 million older Ontarians living with frailty. Frailty is a state of functional and cognitive decline that includes dementia and complex chronic conditions. According to the Canadian Frailty Network, Canadian seniors account for 40% of acute care services use and occupy 85% of acute care beds, many of these are designated Alternate Level of Care (ALC). Frail older individuals make up a significant cohort within the 5% of Ontarians that spend over 60% of the health budget. As of February 2019, there were 78,762 Long Term Care Beds in the province, with a long stay utilization rate of 98.7%[i].

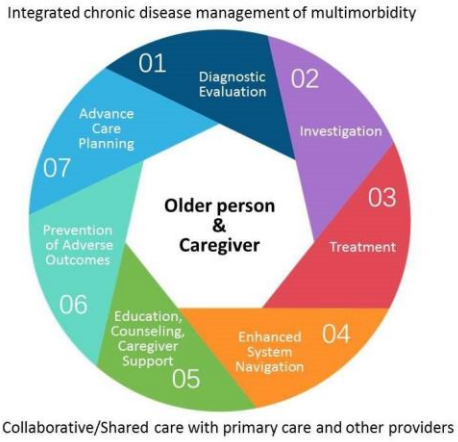
**Table 1: Estimated Population Living with Frailty (2019 and 2029)**

| | **Population (P=Projection)** | | | | **Estimated Population Living with Frailty** | | |
|---|---|---|---|---|---|---|---|
| **Age group** | **2016[iiiii]** | **2019 (P)[iv]** | **2029 (P)[5]** | **Prevalence of Frailty (proxy)[v]** | **2016** | **2019** | **2029** |
| 65-74 | 1,266,390 | 1,445,373 | 1,951,997 | 0.16 | 202,622 | 231,260 | 312,319.52 |
| 75-84 | 684,190 | 771,215 | 1,233,634 | 0.286 | 195,678 | 220,567 | 352,819.32 |
| 85+ | 301,075 | 339,376 | 493,499 | 0.521 | 156,860 | 176,815 | 257,112.98 |
| **Total** | **2,251,655** | **2,555,964** | **3,679,130** | | **555,161** | **628,642** | **922,251.82** |

The reality is that the vast majority of older adults with frailty will have to remain living at home. To help them avoid turning to hospitals as they become more frail and unwell, we must plan appropriately for the health services these unique people need. Providing this cohort with the right care will have

significant health system impacts including: measurable savings to the health budget; fewer hospital beds being used for ALC, and reduced hallway healthcare. Health care services for frail seniors are best led and delivered by clinicians most equipped to work with older people living with complex health concerns – specialized geriatric services (SGS). Please refer to Appendix 1 for details about SGS.

Your report identified the difficulties individuals and their care-partners face in a complex health care system and recognized a pressing need to integrate care around the patient. This could not be truer in the case of individuals living with dementia. Dementia is a diagnosis that exists in the context of an older adult and caregiver dyad who are coping jointly with multiple medical and, often, mental health comorbidities. At the same time, they also face changes to roles and expectations, concerns about safety, transitions in living arrangements, planning for an uncertain future medically and otherwise and are trying to find a meaningful quality of life amidst all of this.




**The care we provide is specifically designed to support people living with complexity in an integrated way.** Figure 1 depicts the core functions of geriatric clinicians, which are carried out in collaboration with primary care and other providers.

**We have also been working on alternative models of care coordination and navigation that build on our considerable experience identifying and providing supports for frail seniors.** These models include imbedding care coordinating functions within our clinical teams who rally and secure **any** possible support to help a patient and their family, not simply supports drawn from a narrow list of contracted service providers. When we think of care coordination this way, we can ensure that all our team members are actively part of care planning, and we leave no stone unturned in the design of creative solutions to address emerging needs. Such models have the potential to delay placement in long term care and avoid hospitalization and, consequently, end hallway medicine.

> "The care of complex seniors in the community by Primary Care and Home Care alone has failed for decades. It cannot succeed without bringing specialists (e.g. cardiologists, respirologists etc) out of hospital and into the community. We (Geriatric Psychiatry and Geriatric Medicine) do deploy our specialist teams in the community and so represent a leading best practice"
>
> *Dr. Frank Molnar, Geriatrician, Co-Chair, Regional Geriatric Programs of Ontario*

Your report also highlighted complex care needs and capacity pressures. Frail older adults are exemplars of this challenge. While primary care providers have borne the tremendous responsibility of orchestrating care for older adults in a complex system, only 2 out of 5 family physicians feel comfortable with managing community dementia care. While primary care physicians identify that they feel confident with the initial diagnosis of dementia and baseline investigations, they express needing more support as the illness inevitably advances[vi].

When collaborative clinical models are supported, specialist clinicians work with family physicians to provide care right where the patient is. Further, clinicians have already been using digital solutions to address complex problems and provide integrated care with good results; our data demonstrates cost savings to the system.

**We are already planning to meet the needs of older people living with frailty.** In 2018, the Ministry of Health and Long Term Care (MOHLTC) asked the newly developed Provincial Geriatrics Leadership Office (PGLO) to identify and map the various programs, services and human resources that are delivering specialty health care services to older people living with complex health concerns (i.e. frailty) across Ontario. The PGLO, which is a resource serving the broad clinical field of geriatrics, agreed to complete this request on the condition that information collected would be vetted, shared and available to any contributors from the field so that planning happens in concert with front line clinicians.

This is a first step in capacity planning, with a primary goal of informing a current state view of the supply and utilization of health services designed for older people living with frailty (e.g. specialized geriatric services) to contribute to future capacity planning.

In addition to planning, our network is working hard to build the capacity for others to deliver effective health care to older people living with frailty. The clinician experts in our network **are** the geriatric educators who are actively involved in training the future workforce needed to care for today's 228,000 Ontarians currently living with dementia, and the over 430,000 anticipated by 2038.

We are a provincial network of highly trained individuals with extensive experience in, and understanding of, the unique needs of older adults with complex medical and mental health multi-morbidity. As such, we request to be included as active partners in all decision making forums relevant to healthcare system transformations as it pertains to older adults. We have much to contribute with our combined expertise, and our perspectives arising from various clinical backgrounds.

On behalf of the more than 2500 clinicians providing geriatric services in Ontario, we look forward to an opportunity to discuss action towards the common goal of better care for all older adults in Ontario. Please contact Valerie Scarfone vscarfone@rgpo.ca or Kelly Kay kkay@rgpo.ca to arrange a follow-up meeting.

Sincerely,

**Dr. Kevin Young, Geriatrician**
Co-Medical Director
Provincial Geriatric Leadership Office

**Dr. Sophiya Benjamin, Geriatric Psychiatrist**
Co-Medical Director
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**Dr. Frank Molnar, Geriatrician**
Chair, RGPs of Ontario
Medical Director of the Regional Geriatric Program of Eastern Ontario

**Dr. Dallas Seitz, Geriatric Psychiatrist**
Division Head, Geriatric Psychiatry
Associate Professor, Department of Psychiatry Queen's University
Providence Care - Mental Health Services
President of the Canadian Academy of Geriatric Psychiatry

**Valerie Scarfone**
Interim Co-Executive Director
Provincial Geriatric Leadership Office

**Kelly Kay**
Interim Co-Executive Director,
Provincial Geriatric Leadership Office

## Appendix 1

## Types of Geriatric Clinical Services

| Service Type | Definition |
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| Acute Geriatric Units/Acute Care of the Elderly Units | Inpatient hospital units in an acute care setting for persons who require short-term diagnostic investigation and treatment, may receive patients directly from the emergency department. |
| BSO Community | Community-based behavioural support teams funded to support patients and family care partners experiencing BPSD residing in the community (including acute services, private dwellings, retirement homes, group homes, assisted living, etc.). Such teams are often linked within existing Seniors' Mental Health, Geriatric Mental Health Outreach or Geriatric Outreach Teams. |
| BSO LTC | Embedded Teams: BSO staff or teams that are located within LTCHs (e.g., PSWs, RPNs, RNs, Recreational Therapists) that are funded to support the delivery of care for residents presenting with responsive behaviours. These staff members are sometimes referred to as "BSO Champions"; responsible for leading, coordinating and spreading effective strategies for residents experiencing responsive behaviours in that LTCH.<br><br>Mobile Teams: behavioural support teams that are led by a lead organization that delivers outreach support to LTCHs throughout a region |
| Care of the Elderly Physicians | Family physicians who have completed a recognized Care of the Elderly Training Program, or grand parented , and hold a certificate of added competence in in Family Medicine in Care of the Elderly . They must be practicing as COE physicians and imbedded in other SGS services. This may include primary care physicians who have received a focused practice designation for Geriatric Medicine. Counting those engaged in SGS (not hospitalists). |
| Geriatric Rehabilitation Units | Inpatient units accepting admissions following an acute hospital stay, serving patients who are frail with multiple co-morbidities and needing rehab before community discharge. The average length of stay may vary from 15-35 days, or up to 90 days for patients receiving slower stream rehabilitation. Patient may require diagnosis clarification, medication change, and short-term multidisciplinary rehab assessment and treatment. Many of these individuals may live in satellite communities where travel is a barrier to coming to clinic or day hospital frequently. |
| Geriatric Assessment and Treatment Units | Inpatient units for frail older persons with complex medical conditions who, following an episode of surgery/illness/injury, require an individualized assessment and treatment. These units do not typically receive patients directly from the ED (e.g. community admissions, internal transfer). |
| Geriatric Day Hospitals | Ambulatory programs that provide diagnostic, rehabilitative, or therapeutic services to persons living in the community who require more care than a Geriatric Clinic can provide. |

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| Geriatric Emergency Management (Nurses) | Consultation by a specialized geriatric health professional in the emergency room providing: assessment, diagnosis, identification of “at risk” older persons, initiation of appropriate treatment, and linkages with community and primary care. |
| Geriatric Outpatient Clinics | Assessment, diagnose, treatment, monitoring, and follow-up of older persons in a clinic setting (includes general geriatric clinics, geriatric heart function clinics, geriatric osteoporosis, geriatric falls /fracture clinics, Parkinsons clinics etc.). |
| Geriatric Outreach Teams | Comprehensive assessments conducted by one or more health care professionals in the older person’s place of residence are. These teams collaborate with community and primary care and provide system navigation to keep at-risk seniors at home and out of hospital. |
| Geriatric Psychiatrists | Psychiatry specialists who hold a subspecialty in geriatrics and are registered to practice in Ontario (holds FRCPC designation) |
| Geriatric Psychiatry Outpatient Clinics | In clinic assessment, treatment and support for older people who are experiencing symptoms of serious mental illness. May include first occurrence of the illness, or an individual requiring longer term intervention (inclusive of Mood clinics, Psychosis clinics etc.). |
| Geriatric Psychiatry Outreach Teams | Interprofessional mental health teams who provide specialized geriatric psychiatry consultation that includes assessment (in home or community), diagnosis, treatment and behavioural recommendations that will assist the primary care provider with their treatment plan for their patient. (includes Geriatric Mental Health Outreach Team) |
| Acute Geriatric psychiatry units | Acute mental health services that include short term crisis intervention, risk assessment, symptom reduction, rapid stabilization and active treatment for older people who require more support than can be provided in the community |
| Tertiary Non-Dementia Geriatric Psychiatry Units | Tertiary mental health services that include short and longer term crisis intervention, risk assessment, symptom reduction, rapid stabilization and active treatment for older people who require more support than can be provided in the community or in acute care settings. |
| Tertiary Dementia Specialty Units | Tertiary mental health services that include short and longer term crisis intervention, risk assessment, symptom reduction, rapid stabilization and active treatment for older people with a diagnosis of dementia who require more support than can be provided in the community or in general acute care facilities. |
| Geriatricians | Internal medicine specialists who hold a subspecialty in geriatric medicine and are registered to practice in Ontario (includes those who hold RCPSC certification or who has status as a CPSO Recognized Specialist in geriatrics. |
| Inpatient Geriatric Consultation Teams | Interprofessional teams that provide inpatient consultation, assessment and treatment of patients with complex needs and/or geriatric syndromes. |

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|---|---|
| Primary Care Collaborative Memory Clinics | Diagnosis, treatment and care for people living with dementia provided at the primary care level through a recognized clinical model |
| Psychogeriatric Resource Consultants | Geriatric Mental Health professionals who provide education, training, and consultative support to staff at long term care homes and community agencies. PRC's work as advisors, educators, facilitators, and network builders, in partnership with other mental health services. They assist staff in managing complex behaviours, with a specific focus on long term care and transition. |
| Residential Addictions Treatment Programs (for the over 65) | Assessment and integrated mental health and addictions treatment in a residential program, which may include graduated passes home, transitional discharge, family support, and aftercare. |
| Sessionally Funded Primary Care Based Geriatric Services (FHT/CHC) | Family Health Teams, CHCs and other primary care models that have secured and utilized sessional funding for geriatric medicine or geriatric psychiatry in 2017/18 |
| Shared care geriatric mental health program | A collaborative service that includes on site geriatric psychiatry support that includes indirect support and education, and, direct clinical consultation and follow-up care with primary care . |
| Specialist Based Memory Clinic Models | Locally developed approached to memory/dementia care in which medical direction is provided by specialists. |
| Nurse Led-Outreach Teams (NLOTS) | Nurse-led outreach teams travel to long-term care homes to assess the health care needs of residents and provide timely treatment in the home. These teams of health care professionals help to ensure residents in long-term care homes receive the appropriate care in their home to avoid an unnecessary trip to an emergency department (include locations in narrative). |

[i] https://www.oltca.com/OLTCA/Documents/SectorDashboards/ON.pdf
[ii] https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/as/Table.cfm?Lang=E&T=11
[iii] Health Analytics Branch, MOHLTC
[iv] https://www.fin.gov.on.ca/en/economy/demographics/projections/table7.html
[v] Hoover, M., Rotermann, M., Sanmartin, C., and Bernier, J. (2013). Validation of an index to estimate the prevalence of frailty. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2013009/article/11864-eng.pdf?st=OvvKzg6
[vi] "How Canada Compares: Results From The Commonwealth Fund ...." https://www.cihi.ca/sites/default/files/document/commonwealth_fund_2015_pdf_en.pdf. Accessed 24 Jan. 2019