Planning for Health Services for Older Adults Living with Frailty: Asset Mapping of Specialized Geriatric Services (SGS) in Ontario

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Reading this Report

All data, program examples and patient stories included in this report are drawn directly from submissions made by program staff and specialized geriatric services (SGS) leaders who uploaded or emailed content to the project lead (author). In some cases, text submissions have been summarized and edited for brevity, however, every effort has been made to remain consistent to the intent of the submission. Where relevant, additional references and citations have been included if material submitted by contributors has also been published elsewhere and if this is known**.**

Programs and services data has been organized as follows:

Definition: the original working definition of the program category has been included.

Additional comments, summarized from relevant text included in the comments fields of submissions is included to provide more description of each category, in the words of contributors.

Program Example

Where available, an abridged example of a program in the category has been included.

Table 1: Data Tables (sample)

Relevant Data has been consolidated into a table.

Patient Story

A narrative, adapted from a "Success Story" submission from programs, or in some cases, patient or caregiver letters submitted by programs has been included in each section, where available.

Abbreviations and Terms Used in this Report

Abbreviation/Term	Meaning
CP	Psychologist
NP	Nurse Practitioner
RN	Registered Nurse
RPN	Registered Practical Nurse
Rph	Pharmacist
MSW	Social Worker
PSW	Personal Support Worker
RD	Dietitian
OT	Occupational Therapist
PT	Physiotherapist
SLP	Speech Language Pathologist
TR	Therapeutic Recreationist
SGS	Specialized Geriatric Services - health services focused on the provision of care to older people with complex physical, physiological, cognitive, mental and social health concerns by expert health professionals
Comprehensive assessment	Includes comprehensive geriatric assessment and comprehensive mental health/psychiatric assessment
FTE	Full time equivalent - approximately 1950 hours of work per year

Introduction

Patient Letter

"As I approach my 90th year several afflictions of old age were catching up with me. So my general practitioner and I decided that a visit to your hospital's Geriatric Assessment Unit might help us diagnose what is disease, what is old age, when is living by myself safe and reasonable and so on. So I had my first visit to the Geriatric Assessment Unit at the Civic Hospital two days ago.

Well, what an experience. I was there for 3 hours and met my in-charge nurse, the resident and the physician. My whole life situation was summed up. I felt like a King. Why was I getting such expert opinions? It turns out that what I got was what everyone gets."

(Provided to program staff following a visit to a geriatric day hospital)

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 this request on the condition that information collected would be vetted, shared and available to any contributors from the field so that future planning could happen in concert with front line clinicians.

This exercise was envisioned as 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.

A general definition for specialized geriatric services (SGS) was adopted. Throughout this work, SGS is defined as comprehensive, coordinated hospital and community-based geriatric medicine, geriatric psychiatry (including mental health and behavioural support services) and specific primary care services (i.e. Primary Care Memory Clinics, Care of the Elderly Primary Care Physicians). It includes health services focused on the provision of care to older people with complex physical, physiological, cognitive, mental and social health concerns by expert health professionals. The human resources working in these services require specialized competence in assessing, diagnosing, treating and supporting older people living with complex health concerns.

The term SGS used in this exercise is independent of organizations or entities that may have historically operated or funded these types of health care services. It is a definition that resonates with a practice field that is highly skilled, clinically focused and that serves the interests of some of Ontario's most vulnerable citizens.

Context

This project is a first step in capacity planning for health services intended to support older people living with frailty. Table 2 provides projections for the older population who may be living with frailty, which provides a backdrop for the data that follows in this report.

Table 2: Estimated Population Living with Frailty (2019 and 2029)

	Population (P=Projection)				Estimated Population Living with Frailty		
Age group	2016[1][2]	2019 (P)[3]	2029 (P)[3]	Prevalence of Frailty (proxy)[4]	2016	2019	2029
65-74	1,266,390	1,445,373	1,951,997	0.16	202,622	231,260	312,320
75-84	684,190	771,215	1,233,634	0.286	195,678	220,567	352,819
85+	301,075	339,376	493,499	0.521	156,860	176,815	257,113
Total	**2,251,655**	**2,555,964**	**3,679,130**		**555,161**	**628,642**	**922,252**

Asset Mapping - Philosophical Approach

Fuller, Guy and Pletsch (2002) describe asset mapping as

> ...a positive and enjoyable approach to learning about your community. It enables you to think positively about the place in which you live and work. It also challenges you to recognize how other people see and experience the same community. (p. 5)[5]

The authors further note that asset mapping allows a community to "make an inventory of all the good things about your community" (p. 5)[6]. Rather than an exercise in performance management, benchmarking or an accounting for health care spending, the working group was motivated by a genuine desire to understand the scope and nature of existing SGS across Ontario. This philosophy underpins this exercise and frames the reporting of findings.

Project Scope

Data was requested for particular programs and services, most usually aligned with specialized clinical services. Table 3 summarizes the in scope and out of scope programs indicated for this project.

[1] https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/as/Table.cfm?Lang=E&T=11
[2] Health Analytics Branch, MOHLTC
[3] https://www.fin.gov.on.ca/en/economy/demographics/projections/table7.html
[4] 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_
[5] Fuller, T., Guy, D., Pletsch, C. (2002). Asset mapping: a handbook. Canadian National Rural Conference. Retrieved from https://ccednet-rcdec.ca/en/toolbox/asset-mapping-handbook
[6] Ibid

Table 3: In Scope and Out of Scope Programs and Services

In Scope	Out of Scope
Behavioural Supports Ontario (BSO) LTC & Community Geriatric Outreach Teams Geriatric Emergency Management (Nurses) Geriatric Outpatient Clinics Geriatric Day Hospitals Inpatient Geriatric Consultation Teams Acute Geriatric Units/Acute Care of the Elderly Units Geriatric Assessment and Treatment Units/Geriatric Rehabilitation Units Geriatric Mental Health Units Geriatric Psychiatry Outreach Teams Geriatric Psychiatry Outpatient Clinics Residential Addictions Treatment Programs (for the over 65) Geriatric Psychiatry Inpatient Units Primary Care Collaborative Memory Clinics Other Primary Care Based Memory Clinics Specialist Based Memory Clinics Care of the Elderly Physicians Sessionally Funded Primary Care Based Geriatric Services (FHT/CHC) NLOTs (geriatrics)	Long Term Care Homes (except BSO programming) Retirement Homes Assisted Living of High Risk Seniors, Supportive Housing Units Transitional Beds Community and Social Services (e.g. Meals on Wheels) Alzheimer Society Programming (e.g. First Link) Transportation Home and Community Care Coordination LHIN Contracted Services (e.g. PSW, nursing and therapy services) Exercise and Falls Prevention Classes Friendly Visiting Volunteer Programs

Methodology

Following agreement by the Provincial SGS Asset Mapping Working Group (see Appendix 1: Provincial SGS Asset Mapping Working Group Participants) on data elements to be collected and 25 service types (see Appendix 2: Service Type Definitions), Health Sciences North was contracted by the PGLO to create a custom database and data entry portal (see https://secure.hsnsudbury.ca/SGSAssetMapping/).

A request for assistance to compile 2017/18 program data was distributed in early December 2018 to all Regional Geriatric Programs (RGP) and formal specialized geriatric services (SGS) entities in Ontario (see Appendix 3: Original Data Request). A data dictionary was provided with the request to help explain desired fields (see Appendix 4: Data Dictionary). RGP & SGS colleagues, in turn, distributed the request for data to known SGS programs and services.

In January 2019, the MOHLTC followed-up the earlier request by distributing a similar request through the Local Health Integration Networks (LHINs) for the purposes of enlisting LHIN support to engage local HSPs in responding.

The request for data was accompanied by a video link to demonstrate the data entry process to potential contributors (see https://youtu.be/uC9A3H6WY1Y). In addition, a data entry walk through webinar was held in December to provide user assistance with data entry. Potential data contributors, who registered to gain access to the data entry portal, were approved by the database administrator (author) and were permitted to directly enter their own organizational data. Contributors had the ability to enter their data in stages and correct their data independently.

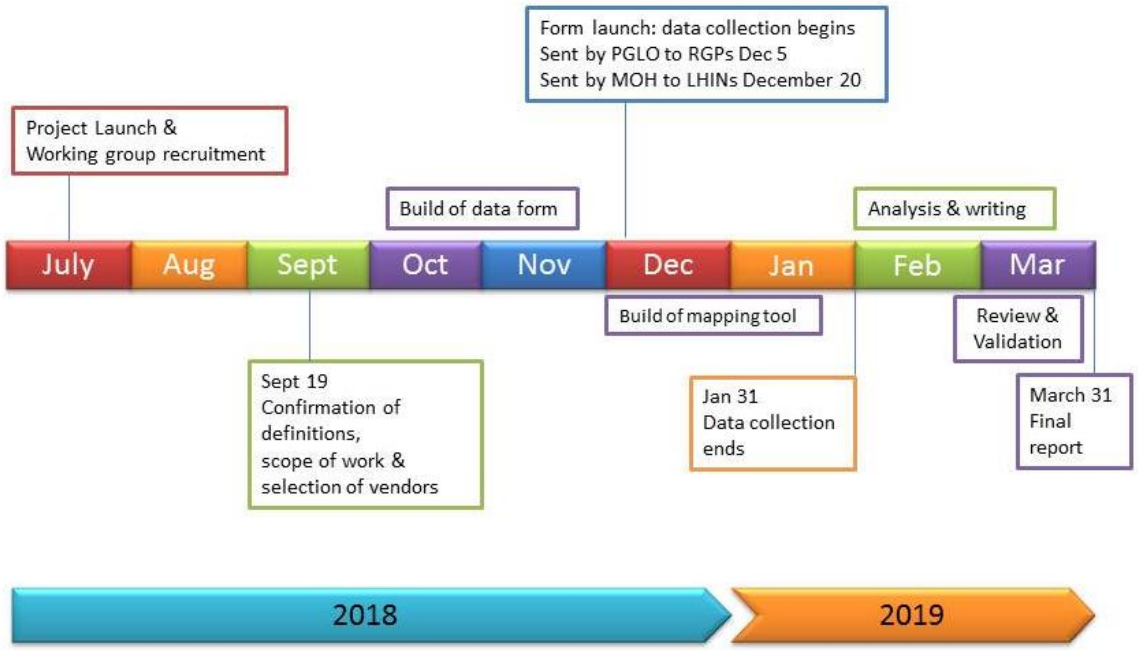
Periodic data extractions were conducted to review incoming data for completeness. If the number of possible program sites was known, follow-up requests for data were sent to groups where large data gaps were noted (e.g. Primary Care Memory Clinics). In February, an additional review of the websites of 91 hospital corporations who did not respond to the original request was conducted. Twenty-four organizations that appeared to be operating seniors' related programs and services were sent a follow-up invitation to submit data.

The development of mapping displays began in January but was temporarily suspended during a major, unprecedented IT outage at Health Sciences North. This outage also impacted portal users, and, during the outage, contributors were instructed to provide their data via email to the author using a downtime template. Emailed submissions from 112 contributors were received and later hand-entered by the author into the portal on behalf of contributors. The IT outage resolved January 28, 2019 and the portal reopened to direct data entry by contributors. Map build-out re-commenced by the end of January and map displays were available for viewing beginning February 26, 2019.

Beginning in early March, all project leads (Dr. M. Borrie, Dr. D. Seitz and author) conducted a series of five webinars, open to all 144 users (including contributors and those who registered to view only). The purpose of these webinars was to validate preliminary results, and discuss data limitations, possible uses of and improvements to the data. Approximately 115 users participated in these sessions and offered comments to inform the context and limitations of this data collection exercise. Several provided follow-up corrections or additions to data and feedback on maps, assisting to identify display problems. Map displays were iteratively improved, and mapping issues (e.g. addresses not mapping) were corrected throughout the month of March. Near-final display formats and maps were published by April 1, 2019, although the opportunity for further revisions will continue into April 2019.

Figure 1 depicts the project milestones and timelines.

Figure 1: SGS Asset Mapping Project Milestones



Contributors

A total of 444 program entries were made by 144 portal users, whom we have called contributors. Contributors included program managers, directors, clerical staff, physicians or other health professionals and LHIN staff.

Programs and services were identified across all sectors of the health care systems, including hospitals (acute care), community and long term care. Contributors provide data from 212 different facilities with some individual contributors providing data for several programs. Table 4 summarizes the data contributed by facilities in each sector.

Table 4: Facilities Contributing Data by Sector

Sector	Respondents
Acute/Tertiary/Rehab Care	95
Community	96
Long Term Care/CCC	21
Total Facilities	**212**

Total Programs/Services	444

Table 5 provides additional detail about the types of facilities that responded to our request for data.

Table 5: Types of Facilities Responding

Type	Number of Respondents	Total Facility Type (ON)
Community and Social Service Agencies	5	
Community Health Centres	7	87
Family Health Team	29	183
Hospital - Corporation	50	151
Hospital - Sites	20	80
Hospital - Floors*	6	
LHINs/LHIN Subregions	43	
Long Term Care Homes	21	
Mental Health Centres	13	
Primary Care Centres (non-FHT/CHC)	5	
Rehabilitation Centres	6	
SGS Service Sites	6	
Other	1	
Total Facilities	**212**	

* Floor category created to enable data collection for multiple programs from same site

SGS Workforce

Across the 444 programs, a wide diversity of health professional disciplines was identified. In many cases, teams were comprised of several professionals of different disciplines, reflecting the interprofessional nature of geriatric care. There was a range of team sizes, with some teams identifying only fractions of FTEs providing SGS (e.g. Primary Care Memory Clinics) and others reporting many team members involved in the program or service (e.g. Geriatric Inpatient Unit).

Overall, in 2017/18, according to the 444 responding programs, approximately 437,250 visits were provided to approximately 116,440 unique individuals[7]. Together, SGS programs and services, and the more than 2500 individuals (excluding Geriatricians, Geriatric Psychiatrists and Care of the Elderly Physicians[8]) employed in these programs, provided more than 11,500 hours of service per week.

Table 6: FTEs by Discipline - All Programs and Services (Excluding Geriatricians, Geriatric Psychiatrists & COE)

Discipline	FTE
Dietitians	11.96
Nurse Practitioners	81.01
Occupational Therapists	124.95
Personal Support Workers (SGS)/UCPs	349.31
Pharmacists	26.77
Physiotherapists	62.5

[7] For reasons identified in later sections, BSO visit and unique individual counts are excluded from this tally.
[8] Physician human resources are addressed in the companion report "Specialized Geriatric Services in Ontario Human Resources Mapping Geriatricians, Care of the Elderly Physicians and Geriatric Psychiatrists".

Discipline	FTE
Psychologists	13.3
Recreation Therapists	52.09
Registered Nurses	686.37
Registered Practical Nurses	637.22
Social workers	149.16
Speech Language Pathologists	10.7
Other	385.32
Total	2590.66

The "Other" category was used by respondents to report positions that were either employed in the program or that worked in collaboration with (or embedded in) the program. Such positions included:

- Alzheimer Society Staff
- Behavioural Therapists/Specialist
- Case Managers/Care Coordinator
- Chaplain
- Clerical/Secretarial Staff
- Counsellors
- Family Physicians (non-COE)
- Home and Community Care Staff
- Information and Referral Specialist
- Kinesiologist
- Managers/Administrators
- Mental Health Workers
- Neuropsychologist
- Nurse Clinicians, APNs
- Orderlies
- Psychogeriatric Resource Consultants
- Psychometrist
- Rehabilitation and Therapy Assistants
- Students
- System Navigators

Specialized Geriatric Services by Service Type

At the outset of this project, the working group identified 24 service types and their respective definitions. These service types were thought to describe the array of program and service designs in specialized geriatrics. A 25th service type was added by the working group before broad data collection commenced. Contributors later added an additional 40 service types, however most were re-categorized to fit within existing definitions. Only one user added service type was ultimately identified and retained. Table 7 summarizes the number of records received by pre-defined and user added service type.

Table 7: Pre-defined and User Added Service Types

Predefined Service Types (n=25)	# of Records Contributed
Acute Geriatric psychiatry units	5
Acute Geriatric Units/Acute Care of the Elderly Units	8
BSO Community	43
BSO LTC	48
Care of the Elderly Physicians	*
Geriatric Assessment and Treatment Units	4
Geriatric Day Hospitals	15
Geriatric Emergency Management (Nurses)	42
Geriatric Outpatient Clinics	59
Geriatric Outreach Teams	34
Geriatric Psychiatrists	*
Geriatric Psychiatry Outpatient Clinics	28
Geriatric Psychiatry Outreach Teams	36
Geriatric Rehabilitation Units	14
Geriatricians	*
Inpatient Geriatric Consultation Teams	23
Nurse Led-Outreach Teams (NLOTS)	7
Primary Care Collaborative Memory Clinics	39
Psychogeriatric Resource Consultants	12
Residential Addictions Treatment Programs (for the over 65)	0
Sessionally Funded Primary Care Based Geriatric Services (FHT/CHC)	0
Shared care geriatric mental health program	3
Specialist Based Memory Clinic Models	5
Tertiary Dementia Specialty Units	11
Tertiary Non-Dementia Geriatric Psychiatry Units	4
25	440
User Added Service Types (n=1)	**# of Records**
Inpatient Geriatric Psychiatry Consultation Team	4
1	4

Total Service Types	26
Total Included Records	444

* Physician human resources are addressed in the companion report “Specialized Geriatric Services in Ontario Human Resources Mapping Geriatricians, Care of the Elderly Physicians and Geriatric Psychiatrists”.

Contributions from Pre-defined Service Types

This section provides a breakdown of definitions and data by service type and includes examples of model descriptions and patient stories where provided.

Acute Geriatric Psychiatry Units

Definition: 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.

Additionally, contributors described these units as:

- Interprofessional or multidisciplinary
- Focused on older people experiencing disturbances in cognition with responsive behaviours related to their mental health, addictions and/or dementia diagnoses
- Generally funded through Acute Mental Health funding, rather than specialized geriatric resources

Program Example[9]

Halton Healthcare's Acute Care Dementia Centre (ACDC) is a highly specialized two (2) bed unit providing psychiatric consultation, close monitoring, timely titration of medication with evidence based behavioral interventions and multidisciplinary assessment. The Unit's approach is aligned with Health Quality Ontario's Behavioural Symptoms of Dementia Quality Standard[10]. The development of the ACDC was an outcome of Halton Healthcare's participation in the Acute Care of the Elderly (ACE) Collaborative, a 12-month quality improvement collaborative aimed at supporting elder-friendly models of care and practices, led by the Canadian Institute for Healthcare Improvement, the Canadian Frailty Network and Sinai Health System-Mount Sinai Hospital[11].

Medical inpatients exhibiting behavioural and psychological symptoms of dementia (BPSD) are first provided with a basic workup to rule out delirium and acute medical instability and then identified to the inpatient psychiatry consultation liaison team. Psychiatry provides consultation and the patient's situation is reviewed in multidisciplinary team rounds. If indicated, patients meeting the program's criteria (e.g. ambulatory, experiencing psychosis related to dementia, ongoing violent/aggressive behaviours, and family willingness to trial psychotropic medications) may be provided with a short admission to the ACDC unit. The goals of admission to ACDC include short term crisis intervention, risk assessment, symptom reduction, rapid stabilization and active treatment, with repatriation to the sending medical unit. On admission to ACDC, patients are assessed by an RN and psychiatrist, medications are reviewed by a pharmacist within 24 hours, OT provides an assessment within 72 hours and geriatric medicine is consulted as needed. Family is involved in the development of a comfort plan. Patients admitted to ACDC may receive behavior planning (ongoing), therapeutic programming (ongoing), integrated care pathway/psychotropic trial and their care is coordinated through weekly interdisciplinary meetings with community partners.

[9] Abridged version of contributor submission.
[10] https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-dementia-clinical-guide-1609-en.pdf
[11] https://www.cfhi-fcass.ca/WhatWeDo/ace

Table 8 lists the five (5) facilities reporting operation of an acute geriatric psychiatry unit and the staff complements identified by contributors. Another name for these units, included in this category, was "Geriatric Psychiatry Treatment Unit".

Table 8: Acute Geriatric Psychiatry Units in Ontario 2017/18

Facility Name	Unique Patients Served	Beds	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	Other	Total FTE	FTE/Bed
Centre for Addiction and Mental Health - Queen Street Site	242	48	36.5	2.1	14.2	0.7	1.0	0.5		1.0	2.3	5.0	63.3	1.32
Grey Bruce Health Services - Owen Sound	n/a	16	8.0	9.3		0.6				0.6	0.8		19.3	1.21
Halton Healthcare Services - Oakville	5	2	0.2	0.1			0.0		0.1	0.1			0.47	0.24
Peterborough Regional Health Centre	n/a	12											n/a	n/a
Royal Ottawa Mental Health Centre	235	45	21	13	14	3		0	1	2	1	4	59.8	1.33

Most contributors in this category reflected an array of interprofessional team members and wide variation in total staffing complements. Full time equivalent (FTE) to bed ratios varied from 0.24 to 1.33.

Acute Geriatric Units/Acute Care of the Elderly Units

Definition: Inpatient hospital units in an acute care setting for persons who require short-term diagnostic investigation and treatment. These units may receive patients directly from the emergency department.

Additionally, contributors described these units as

- Floors or units that are entirely focused on older patients
- In-patient care locations that combine medical management and interprofessional team care
- Focused on assisting patients to maintain or regain their pre-admission baseline level of function
- Emphasizing early mobilization to prevent functional decline

According to the Canadian Foundation for Healthcare Improvement, between March 2016 and March 2017, twelve (12) Ontario facilities participated in the Acute Care for Elders (ACE) Collaborative[12], including:

1. Geraldton District Hospital
2. Halton Healthcare
3. Hamilton Health Sciences
4. London Health Sciences Centre

[12] https://www.cfhi-fcass.ca/WhatWeDo/ace

5. Montfort Hospital
6. Orillia Soldiers' Memorial Hospital
7. Queensway Carleton Hospital
8. Quinte Health Care
9. Scarborough Hospital
10. Thunder Bay Regional Health Sciences Centre
11. University Health Network
12. William Osler Health System

The results of this collaborative, which provided funding, coaching, educational materials and tools, included culture and care process change, changes in data collection and measurement practices and reported "greater compassion for the needs of elderly patients with dementia"[13]. These changes were reported to improve patient outcomes and staff knowledge; however facilities may not have developed stand-alone units referred to specifically as ACE units. The experience of Halton Healthcare's Acute Care Dementia Centre described above is a case-in-point.

Table 9 lists the 8 facilities reporting operation of an acute geriatric unit/acute care of the elderly unit and the staff complements identified by contributors. Other names for these units included "Seniors Care Unit" or "Department of Medicine".

Table 9: Acute Geriatric Units/Acute Care of the Elderly Units in Ontario 2017/18

Facility Name	Unique Patient Served	Beds	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	SLP	Other	Total FTE	FTE/Beds
Humber River Hospital (Wilson)	257	10		6.5	3.6		1.0		0.5	1.0	1.0	0.3	0.5	14.4	1.44
London Health Sciences Centre (Victoria)	940	24		8.0	3.0	2.0	1.0		1.0	1.0	1.0		1.0	18.0	0.75
North York General Hospital (General Site)	n/a	12	*FTEs provided were not broken down by category of discipline										11.7	11.7	0.98
Orillia Soldiers' Memorial Hospital	n/a	10	*FTE details not provided											n/a	n/a
Queensway-Carlton Hospital	1264	34		22.7	13.5	1.6	1.5	1.0		1.5	1.5	0.3	5.8	49.5	1.45
Royal Victoria Regional Health Centre	n/a	34	*FTE details not provided											n/a	n/a
Sinai Health System (Mount Sinai)	n/a	28	*FTE details not provided											n/a	n/a
St. Michael's Hospital	n/a	8	1							1	0.6		22.1	24.7	3.09

Two facilities submitted data in this category for the Hospital Elder Life Program (HELP), a volunteer program that is out of scope for this phase. This data was excluded.

Most contributors in this category reflect an array of interprofessional team members and wide variation in total staffing complements. Full time equivalent (FTE) to bed ratios varied from 0.75 to 3.09.

[13] https://www.cfhi-fcass.ca/OurImpact/ImpactStories/ImpactStory/2018/07/25/overview-cfhi-helps-hospitals-ace-elderly-friendly-care

There is variation in the models of service delivered by each facility. The patient story below describes the impact of one clinical approach and was summarized from information uploaded by the contributor.

Patient Story

Adapted from a "Success Story" Submission from

London Health Sciences Centre – Acute Care of the Elderly Unit

Mr. A was admitted to hospital with a diagnosis of pneumonia, confusion, and shortness of breath. His medical history is complex as he lives with Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), chronic renal failure, hypertension, atrial fibrillation, type 2 diabetes, osteoarthritis, osteoporosis and has a history of falls. He also has a history of dementia. He lives in a basement apartment with a roommate, and has a family member living upstairs, and another who visits daily. He receives once daily home care.

Mr. A's acute pneumonia also resulted in an acute delirium, and his condition deteriorated. Despite walking independently at home, he now could not mobilize without the help of two people and he could not recognize his family. He was admitted to the ACE Unit, where he received treatment for the pneumonia and care from an interprofessional team (physiotherapist, occupational therapist, social worker, care coordinator, geriatrician, patient care facilitator, nurse coordinator). The team worked with him daily to improve his mobility, restore his ability to perform self-care and developed a plan (including meals on wheels, day program, respite, public and private pay supports) to enable Mr. A to return home. His family was involved in planning, committing to organizing a schedule of frequent checks, obtaining needed adaptive equipment and recognizing that Mr. A would incur some risk (e.g. falling) despite everyone's best efforts.

Together, the ACE Unit team, patient and family achieved a realistic care plan to help Mr. A return home and to plan for the future. His son remarked tearfully "I thought this meeting was to tell me I had to put my Dad in a nursing home and he could never go home. That is my worst fear".

Behavioural Supports Ontario (BSO) - Community

Definition: 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.

To align with the BSO program's well established metrics, program leads were provided with a personalized webinar and advised to tally data by subregion (instead of reporting each site's data) and enter existing program data into particular fields as follows:

BSO Metric	SGS Portal Field
Total Number of Accepted Referrals for each service type (i.e. BSO Community and BSO LTC)	# of visits delivered/year
# of unique patients supported for the year (by subregion) for each service type	# unique patients served
# of caregivers served for the year (by subregion) for each service type	# of caregivers supported

Some contributors noted challenges with providing data in the manner it was requested due to differences in data collection approaches and indicator definitions that are unique to the Provincial BSO Program.

Additionally, contributors provided descriptive comments, which highlight the variety of approaches across this category. Contributors described:

- Regionalized program design, in some cases under the leadership of local LHINs
- Inclusion of (in some cases) a mobile outreach team to support individuals and caregivers in the community when in crisis or at risk of a crisis.
- Important relationships (e.g. hosting of staff) with local Alzheimer Societies
- Collaborative relationships and partnerships with multiple health and community agencies (e.g. community mental health and addictions services)
- Support through one centralized number to access multiple resources and services (in some regions)
- After hours support and access to a response team 7 days/week (in one case) (i.e. Huron Perth Seniors Mental Health and Addictions Response Team, Huron Perth Helpline and Crisis Response Team)
- Integrated response across community, acute care and LTC sectors (i.e. North Bay Regional Health Centre's Community Integrated Response Teams)
- Collaboration with various physician supports (e.g. Care of the Elderly, Geriatric Psychiatrists, Geriatricians)
- Use of telemedicine-facilitated or in-person follow-up approaches

Most contributors in this category reflect an array of interprofessional team members, typically Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Workers (MSWs), and Occupational

Therapists (OTs) and, to a lesser extent, Therapeutic Recreationists, Personal Support Workers (PSWs), Nurse Practitioners and Psychologists.

A number of unique unregulated program staff roles were identified by contributors, including:

- Behavioural Support Facilitator
- Counsellors
- FirstLink Care Navigator
- Behavioural Therapist
- Community support workers
- Information and Referral Specialist (e.g. BSO connect)
- Psychometrist
- Responsive Behaviour Specialist
- Social Rehabilitation Specialist
- Social Service Worker
- Transition Worker
- Undergraduate gerontology
- Unregulated Psychogeriatric Resource Consultants (with preparation as MA Gerontology & Health Studies, Therapeutic Recreation, BA in psychology & gerontology)

There is variation in the models of service delivered by each facility. The example below illustrates one clinical approach and was summarized from information uploaded by the contributor.

Program Example[14]

The Huron Perth Seniors Mental Health (SMH) and Addiction Response Team (the name for BSO Community in Huron Perth) provides service 7 days /week from 0830-2030. After hours support is provided by the Huron Perth Helpline and Crisis Response Team. The program has committed to and been able to provide a 2 hour response time for all new referrals. There is currently no wait for the program.

The program provides assessment, treatment, case management, education, individual and group therapy. The interprofessional team assists with medication administration and the majority of the care is provided in the patient's home. Clinical support is provided to the team by local and regional Psychiatrists, Geriatric Psychiatrists and Geriatricians.

The team works very closely with each patient's primary care provider and engages with hospital staff if the patient is admitted to hospital for either psychiatric or medical concerns. Coordinated care planning is completed as patients transition from hospital to home. The team works very closely with community partners in Huron Perth and across the SWLHIN including embedded BSO team members in Long Term Care, St. Joseph's Healthcare, SWLHIN , Alzheimer Society, Adult Day Program, Long Term Care, Community Hospitals and Schedule I facilities.

The Enhanced Psychogeriatric Resource Nurse, along with other members of the SMH team and trained staff from the community partners provide education to enhance local capacity for those caring for individuals with or at risk of responsive behaviour. The team cares for older adults with serious mental illness, dementia and neurological challenges. Individuals under the

[14] Abridged version of contributor submission.

age of 65 are admitted if they have an age related illness. A work plan has been developed for the Huron Perth Geriatric System of care through the Huron Perth Geriatric Cooperative. BSO Pillars of System Coordination and Management, Integrated Service Delivery and Knowledgeable Care Team and Capacity Building are the basis of the work completed by the team.

This program is a regionally integrated service. In addition to the FTEs reported, there are 5.0 FTE transition workers employed by Wendat Community Psychiatric Support Programs that are part of the program.

Table 10 lists the 43 records received indicating operation of a Behavioural Supports Ontario (BSO) Community program or service. These records suggest a total referral volume of 37929, 91% of the total volume indicated by the BSO Provincial Coordinating Office (PCO) in their 2017/18 Annual Report[15]. Contributors cautioned that the program collects a quarterly average of case load rather than unique patients served and that there is a danger of over-reporting patients served in this field. We verified the quarterly average caseload number with the BSO PCO 2017/18 Annual Report and in 2017/18 the quarterly average caseload was 8,586 individuals for All Community BSO Programs. Our data for this number is 3.5 times higher and is suspected to be inaccurate. For this reason, the field "unique patients served" has been excluded for all BSO data. Contributors reported that 13,866 caregivers were supported, which represents 83% of the total reported by the BSO PCO in 2017/18[16].

Table 10: Behavioural Supports Ontario - Community Programs 2017/18

Program Name	Facility Name	Visits Delivered (Total Number of Accepted Referrals)	Caregivers Served	CP	NP	RN	RPN	PSW	MSW	OT	TR	Other	Total FTEs
BSO Responsive Behaviour Specialist - Burlington	Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	n/a	40									0.5	0.5
BSO Responsive Behaviour Specialist - Hamilton	Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	n/a	65									0.5	0.5
Behavioural Supports Ontario, Peel	Alzheimer Society Peel	5850	1806									10.5	11
St. Joseph Health Centre Guelph Community Responsive Behaviour Team	Canadian Mental Health Association - Waterloo Wellington	4873	553	0	2	1	0	0	5	4	2	2	16
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Durham North East Subregion	154	49				2						2
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Durham West Subregion	14	2				1						1
Behavioural Supports Ontario Community	Central East LHIN - Haliburton and City of	82	14				2						2

[15] http://brainxchange.ca/Public/Files/BSO2/BSO-Annual-Report-2017-18.aspx p. 11&12

[16] Ibid

Program Name	Facility Name	Visits Delivered (Total Number of Accepted Referrals)	Caregivers Served	CP	NP	RN	RPN	PSW	MSW	OT	TR	Other	Total FTEs
(GAIN)	Kawartha Lakes Subregion												
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Northumberland County Subregion	98	25				2.4						2.4
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Peterborough City and County Subregion	39	19				1						1
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Scarborough North Subregion	65	25				2						2
Behavioural Supports Ontario Community (GAIN)	Central East LHIN - Scarborough South Subregion	149	30				2						2
BSO Community	Central West LHIN	502	701										0
BSO Community Outreach Team	HNHB LHIN - Brant Subregion	238	87									2	2
BSO Transitional Lead Team	HNHB LHIN - Brant Subregion	26	34									2	2
BSO Community Outreach Team	HNHB LHIN - Burlington Subregion	187	38									2	2
BSO Transitional Lead Team	HNHB LHIN - Burlington Subregion	36	48									1.5	1.5
BSO Community Outreach Team	HNHB LHIN - Haldimand Norfolk Subregion	86	29									1	1
BSO Connect	HNHB LHIN - Hamilton Subregion	574	268									1	1
BSO Community Outreach Team	HNHB LHIN - Hamilton Subregion	503	229									3	3
BSO Transitional Lead Team	HNHB LHIN - Hamilton Subregion	70	55									3.5	3.5
BSO Connect	HNHB LHIN - Niagara Northwest Subregion	653	353									3	3
BSO Community Outreach Team	HNHB LHIN - Niagara Northwest Subregion	450	84									3	3
BSO Clinical Leaders	HNHB LHIN - Niagara Northwest Subregion	294	401									1.75	1.8
BSO Transitional Lead Team	HNHB LHIN - Niagara Northwest Subregion	72	71									3	3
BSO Clinical Leader	HNHB LHIN - Niagara Subregion	155	288									1	1
Behavior Support consultation team	Hopital Montfort	94	151									0.8	0.8
BSO Community - Algoma Integrated Response Team	North East LHIN - Algoma Subregion	n/a	222			2	1					1	4
BSO Community - Cochrane Integrated Response Team	North East LHIN - Cochrane Subregion	n/a	537			0.5	1					2	3.5
BSO Community - Nipissing Temiskaming - Integrated Response Team	North East LHIN - Nipissing/Temiskaming Subregion	n/a	915		1	1			1		2	1	6
BSO Community - Sudbury, Manitoulin, Parry Sound - Integrated Response Team	North East LHIN - Sudbury/Manitoulin/Parry Sound Subregion	n/a	665			1					1	5	7

Program Name	Facility Name	Visits Delivered (Total Number of Accepted Referrals)	Caregivers Served	CP	NP	RN	RPN	PSW	MSW	OT	TR	Other	Total FTEs
South West BSO - Elgin Community	South West LHIN - Elgin Subregion	251	403			1			1			1.5	3.5
South West BSO - Grey Bruce Community Services	South West LHIN - Grey Bruce Subregion	351	1332			3.5	1.5		1.5			0.5	7
South West BSO - Huron Perth Counties Community Services	South West LHIN - Huron Perth Subregion	301	1382			4	1		2			1	8
South West BSO - Middlesex Community	South West LHIN - London-Middlesex Subregion	335	818	1		2			3	2	2		10
South West BSO - Oxford Community	South West LHIN - Oxford Subregion	298	276			1.8	1		1.5			0.8	5.1
St. Joseph's Health Centre Community Responsive Behaviour Team (CRBT), Clinical Intake.	St. Joseph's Health Centre Guelph	4873	553			1			5	4	2	2	14
Huron Perth Seniors Mental Health and Addiction Response Team	Stratford General Hospital	3985	157			4	1					2.5	7.5
North Simcoe Muskoka Behaviour Support System	Waypoint Centre for Mental Health Care - Main Location	n/a	476			1		3	2	1		3.45	10

Patient Story

Adapted from a "Success Story" Submission from

Geriatric Assessment and Intervention Network (GAIN) – BSO Community

81 year old John* lives at home with his spouse. They have 2 adult children who live in Europe and John has two step-daughters living at a distance and visiting infrequently. They have no close friends. Over the past several months John had stopped his daily outdoor walking exercise and stopped drinking coffee.

John has multiple comorbidities and is on many medications. Regular cognitive testing results show a steady decline in cognitive function over the past 4 years. Over the past month John was experiencing delusional episodes of not recognizing his home or his wife and asking to go home; wandering around and outside of the home at night; he was fixated on looking for his vehicle. John demonstrated visual hallucinations, resisted personal care and was verbally argumentative. He was not able to remember his children's names, unable to locate certain rooms in his house and believed himself to be a 25 year old single person. He spokes gibberish most of the time mixing English and European languages. His wife was feeling exhausted as she could not leave him alone for any length of time and John was dependent on his spouse to complete all personal care.

Upon visiting the GAIN team, and following a comprehensive clinical assessment, which included a behavioural assessment by the BSO Clinician (Nurse), the team initiated of needed supports with:

- Alzheimer's Society - support meetings monthly for spouse
- Housekeeper & Respite – weekly, private
- Follow up Geriatrician consult
- Referral to Home and Community Care
- Community Resources list
- Referral to Adult Day Program
- Behavioural strategies (teaching of spouse)

The BSO Clinician involved directly with John's transition to an Adult Day Program (ADP), attending the program with him to assess and intervene with exhibited behaviours and to teach ADP staff appropriate interventions. As a result, John was able to remain at home to await placement in LTC home. John's responsive behaviours were reduced, resulting in the reduction of his caregiver's.

"I didn't know it could work. Now, I believe you. I feel relaxed nowadays. I can stay at home and relax and not worry about his safety when he is at the ADP. I can be his wife now. I don't feel exhausted. I've never slept so good, until now".

"I am very grateful for all your help and support. Thank you from the bottom of my heart". (Caregiver)

Behavioural Supports Ontario (BSO) - Long Term Care

Definition: There are two models of BSO support for the Long Term Care (LTC) sector.

Embedded Teams: BSO staff or teams that are located within Long Term Care Homes (LTCHs) (e.g., PSWs, RPNs, RNs, Recreational Therapists) and 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.

Mobile Teams: behavioural support teams that are led by a lead organization that delivers outreach support to LTCHs throughout a region

Additionally, contributors noted these programs access geriatric psychiatry consultations and psychogeriatric resource consultants and staff may include additional roles such recreation assistants.

Program Example

LTC embedded BSO teams support older adults residing within their respective LTC homes who are presenting with or at risk of developing responsive behaviours associated with complex mental health, substance use, dementia, or other neurological conditions. The mandate also includes support for the informal care partners of the residents receiving BSO services which can include, but is not limited to education, coaching and emotional support with the goal of lessening compassion fatigue. There is also a strong emphasis on enhancing clinical capacity among all staff throughout the home through direct clinical coaching, education and support with the theme of shared accountability and a team approach in the management of residents expressing responsive behaviours.

LTC Mobile Teams provide episodic and transitional support for residents in or transitioning to LTC. Note that these FTEs may be hosted by the BSO LTC host employer but serve a LHIN or LHIN subregion.

Figure 2 is an infographic provided by HNHB LHIN, highlighting all components of their BSO program.

Figure 2: HNHB LHIN BSO Visual Model Infographic

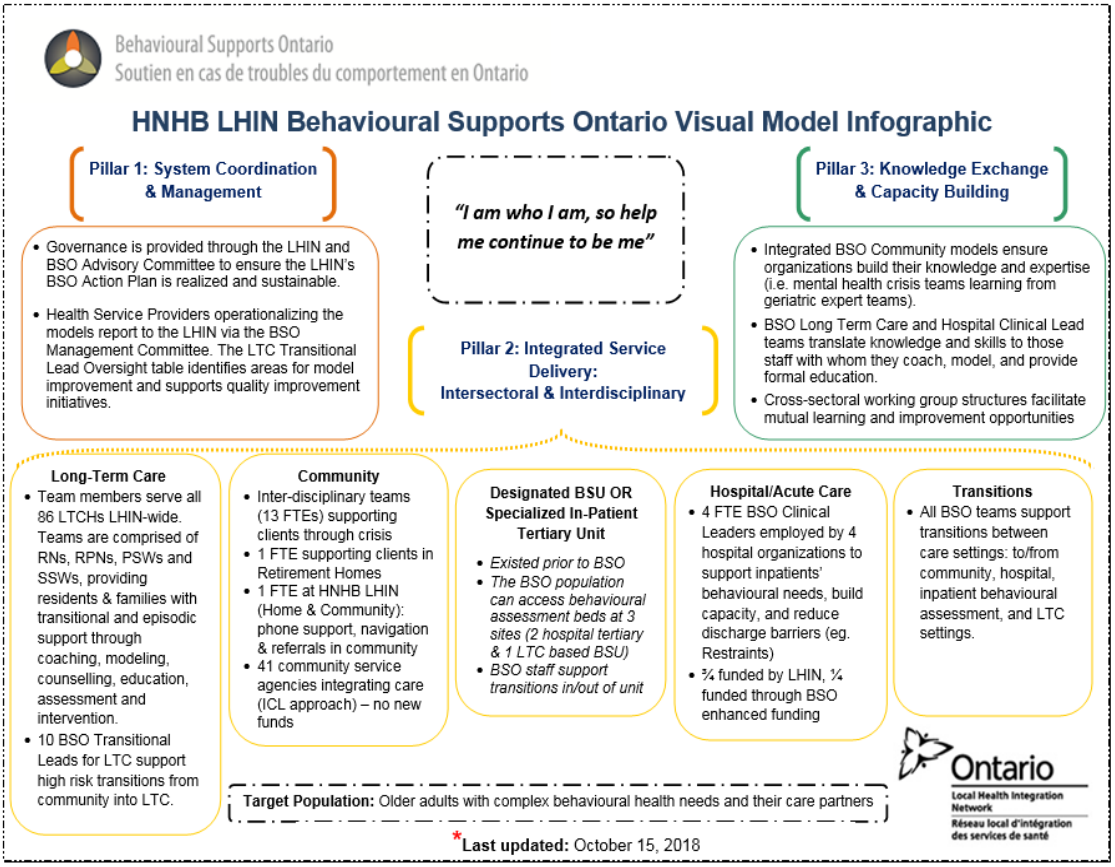


Table 11 lists the 48 records reflecting Behavioural Supports Ontario (BSO) LTC programs or services. With the exception of caregivers served, all visit and patient data significantly exceeds that reported by the BSO PCO for 2017/18. For example, the BSO PCO reports the average LTC quarterly caseload for 2017/18 as 20,685 and the number of referrals for support from LTC as 29,433, for the same period[17]. Our contributor data for similar measures is nearly 2 to 3 times higher, which supports the concerns expressed by contributors about data collection for this program through this process. Therefore, only FTE data has been reported for BSO LTC programs.

Table 11: Behavioural Supports Ontario - LTC Programs 2017/18

Facility Name	RN	RPN	PSW	MSW	TR	Other	Total FTEs
Algonquin Nursing Home		1	2				3
Blind River District Health Centre - LTC Unit		1	1.5				2.5
Canadian Mental Health Association - Fort Frances Branch			5			2	7
Cassellholme		2	3				5

[17] http://brainxchange.ca/Public/Files/BSO2/BSO-Annual-Report-2017-18.aspx p. 11&12

Facility Name	RN	RPN	PSW	MSW	TR	Other	Total FTEs
Central East LHIN - Durham North East Subregion		7.5	4.5				12
Central East LHIN - Durham West Subregion		4.5	2.5				7
Central East LHIN - Haliburton and City of Kawartha Lakes Subregion	1.5	7.5	3				12
Central East LHIN - Northumberland County Subregion		4.25					4.25
Central East LHIN - Peterborough City and County Subregion		7	7				14
Central East LHIN - Scarborough North Subregion	1.5	3.5	5				10
Central East LHIN - Scarborough South Subregion		17	6.7				23.7
Central West LHIN							0
Champlain LHIN						28.23	28.2
Cummer Lodge	1.53	1.53	5.95			1	10
Extendicare Falconbridge		1.75	2				3.75
Extendicare Kapuskasing		1	1.4				2.4
Extendicare Maple View Of Sault Ste. Marie		2	3				5
Extendicare Timmins		1	2.4				3.4
Extendicare Van Daele	0.5	1	1.5				3
Extendicare York		2	3				5
Extendicare York	0.5	1	1.5				3
F. J. Davey Home		2	4				6
HNHB LHIN - Brant Subregion	0.5	2	4			2	8.5
HNHB LHIN - Burlington Subregion	1	4	1			1	7
HNHB LHIN - Haldimand Norfolk Subregion	0.5	2	2			1	5.5
HNHB LHIN - Hamilton Subregion	1	4	10			2	17
HNHB LHIN - Niagara Northwest Subregion	1	5	9			2	17
Lakeland Long Term Care		1.5	2				3.5
MacKenzie Health - Finch Ave		17.5	19			0.2	36.7
Mauno Kaihla Koti		1	1.5				2.5
North West LHIN			3			2.8	5.8
Pioneer Manor		3	4				7
South East LHIN	7.4	9	25.35			0.5	42.3
South West LHIN - Elgin Subregion			2.6			2.2	4.8
South West LHIN - Grey Bruce Subregion			5			4	9
South West LHIN - Huron Perth Subregion			5.5			4.7	10.2
South West LHIN - London-Middlesex Subregion			11			11	22
South West LHIN - Oxford Subregion			3			2.2	5.2
South West LHIN - Oxford Subregion			3			2.2	5.2
St Joseph's Manor		1	2				3
St. Joseph's Care Group			8		0.6	6.4	15
St. Joseph's Care Group	1.4	3.5	8.56		1.7		15.2
Waterloo Wellington LHIN - Cambridge-North Dumfries Subregion	0.2	8.82	5.01		1.86		15.9
Waterloo Wellington LHIN - Guelph-Puslinch Subregion	0.1	2.53	4.31		1.3		8.24
Waterloo Wellington LHIN - Kitchener-Waterloo-Wilmot-Wellesley-Woolwich (KW4) Subregion	2.54	6.66	15.66	0.18	3.2		28.2
Waterloo Wellington LHIN - Wellington Subregion		2.72	3.98	0.18			6.88
Waypoint Centre for Mental Health Care - Main Location	5.5	9	19.6			2.65	36.8
Wilkes Terrace						1	1

Patient Story

Adapted from a "Success Story" Submission from

Regional Municipality of York – BSO LTC

An 85 year old male resident, diagnosed with unspecified dementia Alzheimer's type, was exhibiting verbal and physical responsive behaviours towards staff. He had already had one critical incident involving a co-resident. He presented a risk for staff and residents, a risk of injury to self and was at high risk for falls. The Home took action to keep everyone safe, and implemented 1:1 staffing utilizing High Intensity Need funding. The BSO Lead consulted with the Psychogeriatric Resource Consultant (PRC) and a plan was developed that included redirection interventions and care approaches developed with care team, using information regarding resident's history, likes and dislikes. P.I.E.C.E.S strategies were initiated and external support was obtained through the BSO-Mobile Support Team (MST). He was also referred to Ontario Shores for psychiatric assessment

The resident is presently followed in monthly rounds and collaboration continues with the BSO Lead, staff (all departments), BSO-MST, and Ontario Shores. Education has been provided to staff (Validation, Gentle Persuasive Approach Stop and Go, Behavioural Escalation Prevention). Supportive care strategies were developed and implemented

Outcomes:

As of December 2018, 1:1 Staffing has been reduced 50% and this resident's behaviour has stabilized. A behavioural escalation prevention plan is in place. Staff are confidently managing his care and the resident is adjusting to life in the Long Term Care Home. PRC continues to monitor and support staff.

Geriatric Assessment and Treatment Units

Definition: 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).

Contributors also noted patients on these units have complex health care issues, multiple diagnoses, and ongoing medical needs that require care in a hospital environment with specialized nursing staff. Teams focus on assisting clients to reach their optimum level of functioning and, when possible, transition them through the unit into a non-acute residence or their home.

Contributor descriptions highlight that these units may serve a variety of patients including

- Complex continuing care patients
- Transitional care patients
- Patients receiving palliative care
- Patient receiving rehabilitative services

Table 12 lists the 4 facilities reporting operation of geriatric assessment and treatment unit and the staff complements identified by contributors. Other names for these units included in this category "Geriatric Assessment & Rehabilitative Care", "Geriatric Medicine Unit" or "Seniors Rehabilitative". It should be noted that these some of these names were also used for units not categorized as geriatric assessment and treatment units.

Table 12: Geriatric Assessment and Treatment Units in Ontario 2017/18

Facility Name	Unique Patients Served	Beds	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	SLP	Other	Total FTE	FTE/Bed
Peterborough Regional Health Centre	150	28		0.8	7.4	20.7									2.0	30.9	1.10
St. Joseph's Care Group	547	58			9.7	27.5		1.8		0.5	3.5	3.5		0.3	4.8	51.6	0.89
The Ottawa Hospital - Civic Campus	503	24			16.0	4.5		1.5	1.0	0.5	1.2	1.5		0.5	5.0	31.7	1.32
Providence Care Hospital - Kingston	n/a	30	2.0		9.7	15.1	3.2				2.7	2.3	1.0	0.2	6.5	42.8	1.43

Geriatric Day Hospitals

Definition: 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.

Contributors provided additional comments describing the Geriatric Day Hospital (GDH) model. Baycrest describes their Geriatric Day Hospital (GDH) purpose is to:

> Provide comprehensive geriatric assessment (CGA) and rehabilitative care in an out-patient setting to frail older adults following discharge from hospital or who are at risk of a hospital

admission because of complexity. Care provided in a GDH is tailored to the older adult's goals and aims to promote functional recovery, reduce the burden of illness or disability, improve quality of life, and prolong independent living. GDHs facilitate linkages and referrals to appropriate community services following discharge from the GHD. (Contributor Summary from Baycrest)

Day hospitals include:

- Interprofessional teams from a variety of disciplines
- A rehabilitation program focused on the patient's goal(s)
- An anchor in Geriatric Psychiatry or Geriatric Medicine (or both)
- A focus on supporting transition between a hospital stay and full return to independent living post hospital stay

Other names for the services included in this category were:

- Seniors and Rehabilitation Day Hospital Program
- Seniors Day Rehabilitation
- Day Treatment Centre
- Short Term Assessment and Treatment Program (STAT)
- Mobile Geriatric Day Hospital
- Seniors' Outpatient Assessment & Rehabilitation/Day Hospital - Day Hospital Program
- Geriatric Psychiatry Day Program
- Geriatric Medicine Ambulatory Services and Day Hospital (Day Hospital Portion)
- Geriatric Day Hospital Service

It should be noted that similar names were also used for units not categorized as geriatric day hospitals.

Program Example[18]

The Cornwall Community Hospital – Geriatric Day Hospital (GDH) reports that clients have voiced in surveys that they are happy with the [GDH] program. "We are treated like adults" (Client statement). Clients have discussed the importance of information being presented in formats that are easily understood taking into account age-related issues (i.e. hearing, vision, mobility, etc.). Although the caregiver information session is not a formal component of the GDH, there have positive comments made as this has assisted families with health promotion and maintenance strategies (e.g. coping, etc.).

As the GDH is only open 3 days per week, there are wait times and accessibility is a factor. In 2017/18, the GDH functioned as a "group" only service offering 4 groups per year. Each group participated 2 days per week for 10 weeks with a maximum of 13 participants per group.

An improvement strategy was implemented in 2018 to increase accessibility by offering more group sessions - five groups per year (2 days per week) for a shorted time period 7-8 weeks.

Individual assessments by practitioners also offered (including urgent referrals from GEM nurses, which occur occasionally). A Care of Elderly physician is aligned with the program and

[18] Abridged version of contributor submission.

visits approximately 6 times/year to offer NP support in cognition clinics. Geriatrician availability has been an issue.

Table 13 lists the 16 facilities reporting operation of a geriatric day hospital (GDH) and the staff complements identified by contributors.

Table 13: Geriatric Day Hospitals in Ontario 2017/18

Facility Name	Visits Delivered	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	SLP	Other	Total FTEs
Baycrest Ctr/Jewish HFA	3101	290			1.4			0.6			0.8	0.8		0.2	1.3	5.1
Bruyere Continuing Care	5596	507	0.5		1.8	0.5	0.8	1.4	0.4		2.3	1.4			0.4	9.5
Cornwall Community Hospital	1069	133		0.6			0.2				0.2	0.6			1.6	3.2
Health Sciences North (Ramsay Lake Health Centre)	3209	758		1	0.5	0.5		0.4	0.4		1	1		1	0.8	6.6
North York General Hospital (General Site)	1977	266			0.8			0.6	0.5	0.3	0.5	0.5	0.5		0.6	4.3
Pembroke Regional & Renfrew Victoria Hospitals	1400	100			1			0.4			1	1			0.9	4.3
Providence Care Hospital – Kingston	3277	596			2			0.7			1	1		0.2	3.1	8
Queensway-Carlton Hospital	2916	403			2.4			1			1	1			1.75	7.15
Royal Ottawa Mental Health Centre	12915	250	1		3			2		0.3	0.5	1.3	1		0.5	9.55
St. Joseph's Care Group	6867	185	0.2		1			0.5			1	1	1		1	5.7
St. Joseph's Health Care London (Parkwood)	394	16										1	0.3			1.3
St. Joseph's Health Care London (St. Joseph's Hospital)	5039	589	0	0	1.9	0	0	1	0	0.5	2.4	1	0.8	0.2	3.5	11.3
Sunnybrook Health Sciences Centre (Bayview Campus)	3851	324			2			1			1	1.3	1	0.5	1.1	7.9
The Ottawa Hospital (Civic Campus)	1838	620	0.1	0	1.6	0	0	0.7	0.2	0.2	0.5	1.5	0	0.1	1	5.9
Trillium Health Partners (Credit Valley)	814	561	0	0	0.6	0	0	0	0	0	0.6	0.6	0.5	0.4		2.7
University Health Network (Toronto Rehabilitation Institute)	3572	256			1			0.6			1.1	1	0.5	0.6	2.1	6.9

Altogether, in 2017/18 these 16 GDHs provided 57,835 visits to 5,854 complex older patients. The staff to visit ratios varied from 303 visits per FTE to 1,352 visits per FTE.

Patient Story

Adapted from a "Success Story" Submission from

Day Hospital - St. Joseph's Healthcare London

Mr. S is a typical Geriatric Day Hospital patient; he lives in the London/Middlesex area and is 65 years in age. He has multiple health issues with co-morbidities that influence his functional state. He was referred to the Geriatric Day Hospital from his community Primary Care Provider who has been caring for Mr. S over several years and through this care has identified changes/deterioration in Mr. S's ability to live independently. Mr. S. is referred related to changes associated with aging and health events. The request is for an interdisciplinary geriatric assessment including assessment of past medical, polypharmacy implications, function/mobility, cognition assessment, social changes impacting independence and nutrition status. The team in the Day Hospital work with Mr. S to identify current levels of function and to understand his assessment of his function matched with his goals for improvement. Together, the Mr. S and the interdisciplinary team establish a rehabilitation plan. Mr. S works with the team in identifying his goals to support his ongoing rehabilitation. As Mr. S's rehabilitation programming in the Day Hospital comes to completion, he works with the Day Hospital team to establish transition plans from Ambulatory Rehabilitation programming to continued support in the community.

Other avenues for Patients to be referred to the Day Hospital include referrals from an Inpatient admission, with the ambulatory rehabilitation program being the support model at discharge. The Day Hospital also support patients < 65years old as part of the Ambulatory rehab programming for patients post Hip and Knee surgery requiring ongoing but defined rehabilitation to meet functional goals in recovery.

Geriatric Emergency Management (Nurses)

Definition: Consultation by a specialized geriatric health professional in the emergency department (ED) providing assessment, identification of "at risk" older persons, initiation of appropriate treatment, and linkages with community and primary care.

According to the RGPs of Ontario, in 2017 there were 125 GEM nurses across the province[19]. Contributors noted that, provincially, GEM models have remained largely unchanged since 2006 and include the following four core components:

1. Routine risk screening for all seniors 75 years and older presenting to the ED. This may be provided in up to two phases of screening including:
    a) Upfront screening/case finding by ED triage staff (sometimes facilitated electronically) to identify GEM-appropriate patients using pre-established criteria such as
        - aged 75 years and over
        - have had two or more ED visits in the previous six months

[19] https://www.rgptoronto.ca/wp-content/uploads/2017/12/GEM_Frequently_Asked_Questions.pdf

- present with a Canadian Triage and Acuity Scale or CTAS (http://caep.ca/resources/ctas) score of greater than 24

b) Additional screening by ED staff, or in some cases GEM nurses, using one of two standardized tools
   - Triage Risk Screening Tool (TRST), or
   - Identifying Seniors at Risk (ISAR) tool (at discharge)

2. Targeted geriatric nursing assessment in the ED to identify acute symptoms, underlying health conditions, physical, functional, emotional and cognitive status, home environment issues and home supports needed for high risk seniors identified in the emergency department.
3. Initiation of referral and follow-up process upon discharge from the ED (i.e. discharge home, admitted or returned to LTC) including recommendations for older adults with frailty assistance with implementation of recommendations, within the emergency department in collaboration with other hospital services, specialized geriatric services, and with community based service providers.
4. Multi-dimensional capacity building with GEM stakeholders

The recommended model for GEM includes nursing, social work and care coordination[20]. Additionally, contributors noted:

- Challenges related to the increasing volume (and acuity) of those patients 70+ presenting to ED every day, and trying to be a touch point to each one of them.
- Use of strategies to identify patients most appropriate for GEM intervention (e.g. Assessment Urgency Algorithm)
- Linkages with Nurse Led Outreach Teams (NLOTs)
- One specific example, the GEM Plus model in the Champlain region, of a novel funding approach to ensure access to community support services that help to avoid hospital admissions and ED repeat visits. In the GEM Plus model, 25% of program funding is used for the GEM nurses and 75% is directed to service partners to purchase program services for referred patients, which enables the patients to have priority appointments for required services.

Program Example[21]

The Ottawa Hospital's (TOH) two Emergency Departments (ED) (General and Civic) see an average of 170,000 patient visits per year. The unique ED environment, its demands and the constant pressures to manage wait times in the ED can present challenges to the care of older people living with frailty. This may lead to incomplete and inaccurate assessments of high-risk seniors resulting in deterioration and return to hospital.

The TOH Geriatric Emergency Management Plus program (GEM Plus) is the largest GEM Plus program in the Champlain LHIN. In place since 2008, the GEM Plus program has served over 10,000 patients. GEM nurses at TOH support the two EDs seven days a week. Unique to TOH, the role of the Advanced Practice Nurse (APN) for the GEM Plus program develops, implements & evaluates the program to improve clinical outcomes and provides a consultation to the other GEM nurses in the Champlain LHIN.

[20] https://www.rgptoronto.ca/wp-content/uploads/2017/12/Collaborative_Model_of_Emergency_Departments_Services.pdf

[21] Abridged version of contributor submission. Also available from https://healthstandards.org/leading-practice/geriatric-emergency-management-plus-gem-plus/

GEM Plus is an evidence-informed program that targets high risk seniors who visit the ED and will be discharged home. Criteria for GEM referral include an administrative screen or direct referral from staff. The administrative screen is initiated for patients who present to the ED, are ≥ 75 years of age, resident in Champlain LHIN, not currently in Long Term Care, have had a previous ED visit within the last 6 months and are categorized as Canadian Triage and Acuity Scale (CTAS) 3, 4 or 5. Additionally, staff can refer patients who are ≥ 65 years of age, residents in Champlain LHIN, not currently in Long Term Care, and are categorized as Canadian Triage and Acuity Scale (CTAS) 2, 3, 4 or 5. Regardless of the referral method, patient referral reason must address a geriatric concern (cognition, mobility and falls, pain, nutrition, functional assessment, continence, mood, behavior and safety in the home).

GEM nurses are specially trained nurses' who work in collaboration with ED staff; they perform a structured, abbreviated geriatric assessment focused on geriatric giants (cognition, mobility and falls, pain, nutrition, functional assessment (ADL's & IADL's), continence, mood and behavior).

The GEM nurse will provide patient education and recommendations to the patient's primary healthcare provider and coordinates referrals to Specialized Geriatric Services (SGS) and Community Support Services (CSS). Access to SGS and CSS are critical to patients successfully being safely discharged home. Therefore, prompt and timely access to these service providers is essential to optimizing the patient health outcomes and quality of life.

The PLUS component of the GEM program is a critical factor that brings multiple organizations and service sectors together in a coordinated effort to support GEM clients. Urgent capacity response and accountability agreements with CSS and SGS provide an advantage for the GEM nurses to access services on a priority basis, thus preventing unnecessary hospital admissions.

Wilding et al. (2015) reported the realization of savings of 1310 bed days and more than $1.9M in health expenditures in 2012/13 resulting from the GEM Plus program at TOH[22].

Table 14 lists 41 of the facilities that operate a GEM program and the staff complements identified by contributors. Contributors provided data on 101 of the 125 provincially funded GEM positions with the majority of positions being RNs (66.43 FTEs). Collectively, contributors reported that in 2017/18 the GEM program provided approximately 42,600 visits to more than 21,000 unique patients, who are typically aged 75+ with complex health concerns, experiencing emergent conditions.

Table 14: GEM Programs in Ontario 2017/18

Facility Name	Visits Delivered	Unique Patients Served	NP	RN	MSW	Rph	RD	PT	Other	Total FTE
Bluewater Health - Sarnia	572	572	1							1.0
Canadian Mental Health Association (Waterloo Wellington)	6012	6012	1	9						10.0

[22] Wilding L, DiMillo AM, Gilsenan R, Dalziel B, Milne K. Promising Best Practice: The Champlain Geriatric Emergency Management Plus (GEM Plus) Program. CGS J CME 2015; Vol 5(1):6–8.

Facility Name	Visits Delivered	Unique Patients Served	NP	RN	MSW	Rph	RD	PT	Other	Total FTE
Chatham-Kent Health Alliance (Chatham Site)	1102			1.97						2.0
Cornwall Community Hospital	361			0.8						0.8
Halton Healthcare Services (Oakville)	1651	1340		2.31						2.3
Health Sciences North - Ramsay Lake Health Centre	2456			1.5					0.2	1.7
Hôpital Montfort	39			2					0.1	2.1
Humber River Hospital – Wilson*	610			1						1.0
Humber River Hospital - Wilson	1846	1582		2	2	2		1		7.0
Lakeridge Health - Ajax and Pickering	551	379		1						1.0
Lakeridge Health - Oshawa	189	132		1						1.0
London Health Sciences Centre (University)	n/a			1						1.0
London Health Sciences Centre (Victoria)	n/a			1						1.0
MacKenzie Health - Richmond Hill *	333			1						1.0
MacKenzie Health - Richmond Hill	888			2						2.0
Markham Stouffville Hospital	1099	1099	2.5							2.5
Michael Garron Hospital	855			1.4						1.4
North York General Hospital (General Site)	1676									n/a
Northumberland Hills Hospital	495	480		1						1.0
Pembroke Regional Hospital	630	467		1						1.0
Peterborough Regional Health Centre	892	712		1.01						1.0
Queensway-Carlton Hospital	876	700		2.1						2.1
Renfrew Victoria Hospital	n/a	578		0.5						0.5
Ross Memorial Hospital	652	604		1						1.0
Royal Victoria Regional Health Centre	n/a									n/a
Scarborough Health Network (Birchmount)	352	343		1						1.0
Scarborough Health Network (Centenary)	847	832		1						1.0
Scarborough Health Network (General Campus)	440	409		1						1.0
Sinai Health System (Mount Sinai)	802			1.4						1.4
Southlake Regional Health Centre	1223									n/a
St Joseph's Health Centre	1560			2						2.0
St. Joseph's Health Centre Guelph	n/a		0.5	1.2						1.7
St. Michael's Hospital	444			1						1.0
Sunnybrook Health Sciences Centre (Bayview Campus)	1090									n/a
The Ottawa Hospital (Civic Campus)	n/a	4642		12						12.0
Thunder Bay Regional Health Sciences Centre	1890			1						1.0
Trillium Health Partners (Credit Valley)	751			1						1.0

Facility Name	Visits Delivered	Unique Patients Served	NP	RN	MSW	Rph	RD	PT	Other	Total FTE
University Health Network (Toronto Western)	1248			1.4						1.4

* These organizations both self-fund GEM positions and receive funding for a GEM position through the RGPT. The results are not duplicative.

Hôpital Monfort also contributed additional information about a Francophone GEM-like program. This is a clinic-based service called the Geriatric Emergency Management (GEM) monitoring clinic. The clinic team performs regular and more detailed geriatric assessments for patients seen in the emergency department the previous week due to acute problems. The clinic is staffed by physicians who develop treatment plans that include in-hospital monitoring, together with family physicians and/or other specialized geriatric services.

Patient Story

Adapted from a "Success Story" Submission from

Geriatric Emergency Coordination – St. Joseph's Care Group and NW LHIN

A patient presented to emergency with weakness. This patient, a retirement home resident, had several prior presentations to the department. The patient expressed the desire to remain living in the retirement home, but was requiring increased support.

The patient was identified early in their visit and seen by the GEM Coordinator (an RN) who conducted a targeted geriatric assessment and engaged the other members of the ED team. The team assisted the patient to avoid admission and the patient was discharged home with supports in place. A post discharge phone call was made by the GEM Coordinator and the patient was referred to home care for Rapid Response Nursing (RRN). The RRN visited the patient the evening after discharge, noted concerns, and contacted the GEM Coordinator. The GEM Coordinator contacted the patient and family to identify needs, and additional supports were put in place, including a planned visit to the outpatient geriatric clinic for follow-up in less than one week.

Not long after the patient's visit to the outpatient geriatric clinic, the RRN again visited the patient at home and noted further ongoing problems. The RRN was then able to facilitate admission to the inpatient Geriatric Assessment and Rehabilitative Care Unit (GARC). The patient made good progress in the GARC unit and subsequently returned home.

"The referral was very beneficial – there was lots going on in the home when I got there and I was able to help. The process worked great being able to facilitate admission to GARC from home without having to send the patient back to the emergency department." (RRN)

"Thank you for the follow up, I had lots of questions and you clarified them all. Very beneficial to be able to access the geriatrician in such a timely manner." (Family Member)

"Very grateful for the help from the ED staff and coordinator when she was there." (Patient)

"Love the charting it contains a lot of information, beneficial when you see the patient prior to me. What a great option to admission." (Emergency room physician)

"I knew getting [GEM Coordinator] help involved would benefit the patient even once they were gone from the department." (Emergency room nurse – non-GEM)

Geriatric Outpatient Clinics

Definition: Assessment, diagnosis, treatment, monitoring, and follow-up of older persons in a clinic setting (includes general geriatric clinics, geriatric heart function clinics, geriatric osteoporosis, Parkinson's clinics etc.).

Additionally, contributors described these services as:

- Generally operating Monday to Friday, during regular business hours
- Interprofessional
- Usually providing cohorted care to patients in an outpatient clinical setting. Some programs may integrate home visiting, but do not track these visits separately
- Providing visits in a hospital outpatient/ambulatory setting or a family practice setting, such as a visiting specialist clinic hosted at a family health team
- Inclusive of caregiver support although a count of "Caregivers supported" is typically not tracked, but can be very large. Some contributors reported this may be as high as five caregivers per patient
- Inclusive of a triage function to identify patients requiring an urgent visit

Program Example[23]

Elderly Community Health Services (ECHS) is a highly-regarded geriatric program in Toronto. ECHS provides outpatient assessment, health promotion and illness prevention for the elderly, with the aim of assisting patients and families to manage the challenges associated with aging. The team supports patients 65 years and older to remain at home. ECHS provides initial and follow-up assessments, health education, consultation, diagnosis of dementia including Alzheimer's Disease, treatment and assistance in planning for the future. The interprofessional team includes geriatricians, social workers, a geriatric psychiatrist, a nurse, a physiotherapist, a speech/language pathologist, and an occupational therapist. The team's multicultural staff speaks several languages and on-site interpretation is available as required. ECHS offers comprehensive medical, cognitive and functional examination and health screening on a regular basis. Specialized treatment programs are streamlined to the needs of the elderly. The team provides and uses up-to-date information and resources on management of elderly people living at home. Expert consultation and support is provided to families and caregivers who require assistance with caring for frail elderly people living at home. Personalized information is provided to the patients and their families requiring assistance with planning and selecting appropriate accommodation in the community. Referrals to other services are provided as needed. Clients are seen on a medical referral basis only and the team can also arrange referrals to community resources such as home supports and residential options.

Table 15 lists 51 general geriatric outpatient clinics and eight (8) focused practice outpatient clinics and associated patient volumes. Altogether, these contributors indicate they provided more than 67,000 visits to approximately 23,000 patients in 2017/18. Note - several facilities operate more than one outpatient clinic. Program names have been included to illustrate the range of outpatient clinics.

[23] Abridged version of contributor submission.

Table 15: General Geriatric and Focus Geriatric Outpatient Clinics in Ontario 2017/18

Program Name	Facility Name	Appointments Made Available	Visits	Unique Patients Served	Program Name	Facility Name	Appointments Made Available	Visits	Unique Patients Served
OTMH OSTEOPOROSIS CLINIC (OT.OSTEO)	Halton Healthcare Services - Oakville	288	126	88	Health Living Clinic	Humber River Hospital - Wilson		2067	n/a
Geriatric Outpatient Clinic - Movement Disorders Clinic	Hamilton Health Sciences - St. Peter's Hospital	57	57	36	Seniors Wellness Clinic - Continuing Care Program Mackenzie Health	MacKenzie Health - Richmond Hill	1950	1969	1969
Ortho Clinic	Hôpital Montfort		275	275	Seniors Health Clinic	Markham Stouffville Hospital	1035	707	n/a
Clinique de continence	Hôpital Montfort	205	175	n/a	Geriatric Clinic	North York General Hospital - General Site		5093	n/a
Parkinson's Rehabilitation Program	Hotel Dieu Shaver Health and Rehabilitation Centre	768	701	72	Geriatric Assessment and Intervention Network (GAIN) Clinic	Peterborough Regional Health Centre		1126	773
Specialized Neurocognitive Disorders Clinic	Ontario Shores Centre for Mental Health Sciences	940	809	n/a	Geriatric Clinic	Providence Healthcare		1016	n/a
SG-General + General Clinic +Incontinence	Providence Care Hospital - Kingston		337	514	Geriatrician Outpatient Clinic	Queensway-Carlton Hospital	200	116	116
Regional Continence Program	Trillium Health Partners - Mississauga	690	1431	743	Geriatric Outpatient	Royal Ottawa Mental Health Centre		4632	758
Geriatric Outpatient Clinic	Baycrest Ctr/Jewish H F A		1398	n/a	Geriatric Outpatient Clinic	Royal Victoria Regional Health Centre			n/a
Bruyere Memory Program	Bruyere Continuing Care	4266	3562	2234	Algoma Geriatric Clinic	Sault Area Hospital - General Site	1879	3604	784
Cambridge Memorial Hospital Geriatric Medicine Outpatient Clinic	Cambridge Memorial Hospital	1395	921	494	Seniors Wellness Centre	Sinai Health System - Mount Sinai	3922	3922	405
Geriatric Outpatient Clinic	Cottage Country FHT			n/a	Primary Care (Geriatric Medicine Clinic)	Smithville Family Medical Centre	17	17	17
Dr Sidhu's Clinic	Georgian Bay FHT		22	17	Elderly Community Health Services (ECHS) - Outpatient Clinic	St Joseph's Health Centre	4200	3249	1930
Geriatric Medicine Clinic	Grandview Lodge/Dunnville	35	35	24	Seniors' Outpatient Services (Clinic)	St. Joseph's Care Group	1747	1429	892
MDG Geriatric Clinic (MD.GERI)	Halton Healthcare Services - Milton	168	85	76	Health for Older Adults Program	St. Joseph's Health Care Hamilton - Charlton Campus		943	n/a
Urgent Care Clinic Geriatric (OT.UC GERI)	Halton Healthcare Services - Oakville	700	673	474	IMRAC	St. Joseph's Health Care Hamilton - Charlton Campus	48	15	15
OTMH Geriatric Clinic (OT.GERI)	Halton Healthcare Services - Oakville	1600	1140	714	Geriatric Medicine Clinics	St. Joseph's Health Care Hamilton - Charlton Campus		356	190
Sessionally Funded Primary Care Based Geriatric Services	Hamilton Health Sciences - McMaster	43	43	39	Geriatric Medicine Clinics	St. Joseph's Health Care Hamilton - Charlton Campus	450	450	420
Sessionally Funded Primary Care Based Geriatric Services	Hamilton Health Sciences - McMaster	25	25	25	St. Joseph's Health Centre Guelph Ambulatory Care Clinic	St. Joseph's Health Centre Guelph		1647	1267

Program Name	Facility Name	Appointments Made Available	Visits	Unique Patients Served	Program Name	Facility Name	Appointments Made Available	Visits	Unique Patients Served
Geriatric Outpatient Clinic	Hamilton Health Sciences - St. Peter's Hospital	2706	2706	1362	St. Joseph Health Centre Guelph Geriatric Medicine Clinic	St. Joseph's Health Centre Guelph			n/a
Geriatric Outpatient Clinic	Hamilton Health Sciences - West Lincoln	86	86	61	St. Mary's General Hospital Geriatric Medicine Outpatient Clinic	St. Mary's General Hospital - Kitchener	2000	2000	900
Regional Outpatient Geriatric Medicine Service - James Bay Coast	Health Sciences North - Ramsay Lake Health Centre		18	16	Geriatric Clinic	St. Michael's Hospital		1098	n/a
Clinique de gériatrie	Hôpital Montfort	313	259	n/a	Geriatric Outpatient Clinics	Sunnybrook Health Sciences Centre - Bayview Campus		829	n/a
Geriatric Assessment Program	Hotel-Dieu Grace Healthcare		2149	710	Geriatric Medicine Ambulatory Service and Day Hospital	The Ottawa Hospital - Civic Campus	2080	1241	1241
Regional Outpatient Geriatric Medicine Service - Cochrane	HSN-NESGC Cochrane	770	713	173	Geriatric assessment clinics	Trillium Health Partners - Credit Valley	1100	1599	420
Regional Outpatient Geriatric Medicine Service - Elliot Lake	HSN-NESGC Elliot Lake	164	379	122	Geriatric Assessment Clinic	Trillium Health Partners - Queensway	936	1906	1200
Regional Outpatient Geriatric Medicine Service - Nipissing	HSN-NESGC Nipissing	89	128	51	Geriatric Outpatient Clinic	University Health Network - Toronto Rehabilitation Institute		506	n/a
Regional Outpatient Geriatric Medicine Service - Parry Sound	HSN-NESGC Parry Sound	121	304	90	Geriatric Clinic	University Health Network - Toronto Western		1582	n/a
Regional Outpatient Geriatric Medicine Service - Sudbury	HSN-NESGC Sudbury		4637	1137	Dr. Sidhu's Clinic	Waypoint Centre for Mental Health Care - Main Location		36	17
Regional Outpatient Geriatric Medicine Service - Timiskaming District	HSN-NESGC Timiskaming	412	775	150	**Denotes Focused Practice Clinics**				

Table 16 provides the breakdown of full time equivalents by discipline for each clinic.

Table 16: Geriatric Outpatient Clinics FTEs by Discipline 2017/18

Program Name	Facility Name	CP	NP	RN	RPN	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
OTMH OSTEOPOROSIS CLINIC (OT.OSTEO)	Halton Healthcare Services - Oakville		0.2						0.1				0.3
Geriatric Outpatient Clinic - Movement Disorders Clinic	Hamilton Health Sciences - St. Peter's Hospital												n/a
Ortho Clinic	Hôpital Montfort		0.7									0.3	1

Program Name	Facility Name	CP	NP	RN	RPN	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
Clinique de continence	Hôpital Montfort											0.1	0.1
Parkinson's Rehabilitation Program	Hotel Dieu Shaver Health and Rehabilitation Centre			0.17		0.1		0.1	0.17	0.17	0.17	0.15	1.03
Specialized Neurocognitive Disorders Clinic	Ontario Shores Centre for Mental Health Sciences	0.2								1			1.2
SG-General + General Clinic +Incontinence	Providence Care Hospital - Kingston												n/a
Regional Continence Program	Trillium Health Partners - Mississauga			2.95									2.95
Geriatric Outpatient Clinic	Baycrest Ctr/Jewish H F A												n/a
Bruyere Memory Program	Bruyere Continuing Care	1		1.8								1.8	4.6
Cambridge Memorial Hospital Geriatric Medicine Outpatient Clinic	Cambridge Memorial Hospital		0.5			0.2				0.2			0.9
Geriatric Outpatient Clinic	Cottage Country FHT												n/a
Dr Sidhu's Clinic	Georgian Bay FHT												n/a
Geriatric Medicine Clinic	Grandview Lodge/Dunnville												n/a
MDG Geriatric Clinic (MD.GERI)	Halton Healthcare Services - Milton		0.4										0.4
Urgent Care Clinic Geriatric (OT.UC GERI)	Halton Healthcare Services - Oakville		0.4										0.4
OTMH Geriatric Clinic (OT.GERI)	Halton Healthcare Services - Oakville		0.8										0.8
Sessionally Funded Primary Care Based Geriatric Services	Hamilton Health Sciences - McMaster												n/a
Sessionally Funded Primary Care Based Geriatric Services	Hamilton Health Sciences - McMaster												n/a
Geriatric Outpatient Clinic	Hamilton Health Sciences - St. Peter's Hospital		1	3	1.7					0.8		1.8	8.3
Geriatric Outpatient Clinic	Hamilton Health Sciences - West Lincoln			0.5									0.5
Regional Outpatient Geriatric Medicine Service - James Bay Coast	Health Sciences North - Ramsay Lake Health Centre			0.01									0.01
Clinique de gériatrie	Hôpital Montfort								0.1	0.2		0.6	0.9
Geriatric Assessment Program	Hotel-Dieu Grace Healthcare			4		0.8		0.4	1	1			7.2
Regional Outpatient Geriatric Medicine Service - Cochrane	HSN-NESGC Cochrane			0.4		1.4				1			2.8
Regional Outpatient Geriatric Medicine Service - Elliot Lake	HSN-NESGC Elliot Lake			0.12									0.12
Regional Outpatient Geriatric Medicine Service - Nipissing	HSN-NESGC Nipissing			0.12									0.12
Regional Outpatient Geriatric Medicine Service - Parry Sound	HSN-NESGC Parry Sound			0.12									0.12

Program Name	Facility Name	CP	NP	RN	RPN	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
Regional Outpatient Geriatric Medicine Service - Sudbury	HSN-NESGC Sudbury		1	2.76		0.88			1	1			6.64
Regional Outpatient Geriatric Medicine Service - Timiskaming District	HSN-NESGC Timiskaming			1									1
Health Living Clinic	Humber River Hospital - Wilson			1									1
Seniors Wellness Clinic - Continuing Care Program Mackenzie Health	MacKenzie Health - Richmond Hill				1								1
Seniors Health Clinic	Markham Stouffville Hospital		2				1			1			4
Geriatric Clinic	North York General Hospital - General Site												n/a
Geriatric Assessment and Intervention Network (GAIN) Clinic	Peterborough Regional Health Centre		2.34									1.61	3.95
Geriatric Clinic	Providence Healthcare												n/a
Geriatrician Outpatient Clinic	Queensway-Carlton Hospital												n/a
Geriatric Outpatient	Royal Ottawa Mental Health Centre	0.1		2		1		0.4	0.5	0.5		0.6	5.1
Geriatric Outpatient Clinic	Royal Victoria Regional Health Centre												n/a
Algoma Geriatric Clinic	Sault Area Hospital - General Site		1	1		1				1		1.67	5.67
Seniors Wellness Centre	Sinai Health System - Mount Sinai			1		1						3	5
Primary Care (Geriatric Medicine Clinic)	Smithville Family Medical Centre												n/a
Elderly Community Health Services (ECHS) - Outpatient Clinic	St Joseph's Health Centre			1		1.5		0.2	1	1	0.6		5.3
Seniors' Outpatient Services (Clinic)	St. Joseph's Care Group			1									1
Health for Older Adults Program	St. Joseph's Health Care Hamilton - Charlton Campus											0.8	0.8
IMRAC	St. Joseph's Health Care Hamilton - Charlton Campus												n/a
Geriatric Medicine Clinics	St. Joseph's Health Care Hamilton - Charlton Campus				0.4								0.4
Geriatric Medicine Clinics	St. Joseph's Health Care Hamilton - Charlton Campus												n/a
St. Joseph's Health Centre Guelph Ambulatory Care Clinic	St. Joseph's Health Centre Guelph		0.4	1									1.4
St. Joseph Health Centre Guelph Geriatric Medicine Clinic	St. Joseph's Health Centre Guelph		0.5	0.6									1.1
St. Mary's General Hospital Geriatric Medicine Outpatient Clinic	St. Mary's General Hospital - Kitchener		1										1
Geriatric Clinic	St. Michael's Hospital			1									1

Program Name	Facility Name	CP	NP	RN	RPN	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
Geriatric Outpatient Clinics	Sunnybrook Health Sciences Centre - Bayview Campus												n/a
Geriatric Medicine Ambulatory Service and Day Hospital	The Ottawa Hospital - Civic Campus	0	0	1.6	0				1			1	3.6
Geriatric assessment clinics	Trillium Health Partners - Credit Valley		1									2	3
Geriatric Assessment Clinic	Trillium Health Partners - Queensway		1										1
Geriatric Outpatient Clinic	University Health Network - Toronto Rehabilitation Institute												n/a
Geriatric Clinic	University Health Network - Toronto Western												n/a
Dr. Sidhu's Clinic	Waypoint Centre for Mental Health Care - Main Location												n/a

Geriatric Outreach Teams

Definition: Comprehensive assessments conducted by one or more health care professionals in the older person's place of residence or another setting. These teams collaborate with community and primary care and provide system navigation to keep at-risk seniors at home and out of hospital.

Additionally, contributors described these teams as:

- Interprofessional
- Utilizing a geriatric assessor approach, whereby one or two members of the interprofessional team attend the home visit and gather detailed assessment information for later review and analysis by the entire interprofessional team
- Largely focused on providing in-home Comprehensive Geriatric Assessments (CGA) and interventions, to older adults with complex health concerns who are too frail to attend in-clinic appointments
- Providing initial and follow-up visits, and in some case ongoing case management
- Coordinating referrals to other community services, include home care services

Names for these services include:

- Continuing Care Program Mackenzie Health
- Emergency Department Outreach Service
- Geriatric Assessment and Intervention Network (GAIN)
- Geriatric Assessment Outreach Team
- Geriatric Long Term Care (LTC) Outreach Team
- Geriatric Outreach Team
- Geriatric Outreach Team- Occupational Therapist Assessment Service
- Integrated Community Care Team (ICCT)

- Integrated Psychogeriatric Outreach Program
- Integrated Regional Falls Program: Home Visits
- Regional Geriatric Outreach Program
- Seniors' Outpatient Services (Geriatric Medicine and Geriatric Psychiatry Outreach Team)
- Specialized Geriatric Services (Geriatric Resource Nurses)

Program Example[24]

The Geriatric Assessment and Intervention Network (GAIN) is a network of 12 hospital and community based interprofessional teams, hosted in 11 locations (two teams hosted by one facility). GAIN teams provide comprehensive assessments, according to the Competency Framework for Interprofessional CGA[25] and create practical care plans with patients to optimize function and independence helping older people to remain living at home. Consistent with other geriatric services, GAIN focuses on reduction of distress to the person and the family, improvement and/or maintenance of function, and endeavours to optimize the individual's capacity for autonomous living and independence at the highest level possible. The network has regional coordination and functions as one large team across different sites, with a standardized model of care, systematic performance measurement and rigorous capacity building mechanisms. GAIN teams include Nurse Practitioners, who serve as Most Responsible Providers, in collaboration with Geriatricians, Rehabilitations professionals (OT and, in some cases PT), Social Workers, Clinical Pharmacists, BSO RPNs, Care Coordinators, PSWs and in the Haliburton team, a Community Paramedic.

In 2017/18, GAIN provided ongoing case management and support to 6987 complex older patients who remained out of hospital or a long term care home.

Table 17 lists 34 programs, delivered by approximately 30 facilities (facilities may operate more than one outreach team). Altogether, in 2017/18 these geriatric outreach teams delivered more than 43,000 visits to over 9,500 patients.

Table 17: Geriatric Outreach Teams in Ontario 2017/18

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
Baycrest Ctr/Jewish H F A	n/a	950	n/a												1.2	1
Campbellford Memorial Hospital	2500	2991	955		1		0.5	1		0.4			1			4
Care First Seniors	1550	2992	n/a		1.5				0.9	1			1			4
Carea Community Health Centre	1900	2505	n/a		1			1.85	0.6	0.6	0.25		0.9			5

[24] Abridged version of contributor submission.
[25] https://www.rgps.on.ca/wp-content/uploads/RGPS_CompetenciesFramework_FinalEditOnlineVersion.pdf

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	SLP	Other	Total FTEs
Community Care City of Kawartha Lakes	1550	2521	n/a		0.8	0.8		2	1	0.25			0.8		0.4	6
Couchiching Family Health Team	n/a	1244	n/a			1.8			1				1		1.3	5
Haliburton Highlands Health Services - Minden	2200	1476	n/a		1			1	1		0.4		1		1	5
Hamilton Health Sciences – St. Peter's Hospital	190	190	155			0.2							0.2		0.35	1
Hamilton Health Sciences – St. Peter's Hospital	2519	2519	1110										2.2			2
Health Sciences North – Ramsay Lake Health Centre	n/a	n/a	n/a			4.2									0.2	4
Humber River Hospital - Wilson	119	99	n/a			1			1				1			3
Humber River Hospital - Wilson	n/a	327	273			1			1				0.8		0.6	3
Lakeridge Health - Oshawa	2250	2495	n/a		2.37				1	1		1	1			6
MacKenzie Health – Richmond Hill	n/a	226	226			0.5			0.5			0.5	0.5		1	3
MacKenzie Health – Richmond Hill	n/a	370	357			0.6			0.6			0.6	0.6		1.6	4
New Unionville Home Society	n/a	272	254			1			1				0.4		0.4	3
North York General Hospital - General Site	n/a	417	307			1					0.2	1	0.5		1.5	4
Ontario Shores Centre for Mental Health Sciences	1200	1316	n/a			4										4
Peterborough Regional Health Centre	n/a	1111	354		0.5			2.01	1				1	0.6	1.41	7
Port Hope Community Health Centre	1900	2776	n/a		1			1.9	1	0.7			1			6
Providence Healthcare	n/a	420	263			0.2			0.5	0.4		0.4	1.6		0.5	4
Queensway-Carlton Hospital	585	568	568			1			1			2	1		2	7
Scarborough Health Network - Centenary	2800	2102	n/a		2.26				1	1		1	1			6
Scarborough Health Network - General Campus	4300	2639	n/a		2.22				1	1		1	1			6
Senior Persons Living Connected	2900	3981	n/a		1.6			1	1	1	0.2		1			6
South West LHIN - London-Middlesex Subregion	n/a	n/a	n/a			7										7
Southlake Regional Health Centre	n/a	455	442			0.6			1			0.6	0.8		2.6	6
St. Joseph's Care Group	748	634	989	0.2	1	0.6			0.2							2
St. Joseph's Health Care London - St. Joseph's Hospital	1304	1303	577			2	1	0	0.8			0.8	0.8		1	6
St. Michael's Hospital	n/a	n/a	12													0
Sunnybrook Health Sciences Centre - Bayview Campus	n/a	269	172			1						1				2
The Ottawa Hospital – Civic Campus	2100	1720	1720												11	11
Trillium Health Partners - Mississauga	1049	1459	780		2.4	0.5			1	1			3.7			9
Waypoint Centre for Mental Health Care - Main Location	n/a	1009	n/a			4							0.9		1	8

Patient Story

Adapted from a "Success Story" Submission from

Trillium Health Partners – Seniors' Services Outreach

Mr. S* was an 85 year old male who was referred to Seniors' Services following a car accident and an emergency department visit. There were concerns with cognitive and functional decline, including unexplained weight loss. Mr. S did not have an extensive medical history and was only being managed for high cholesterol and a recent urinary tract infection. He was single and living with his sister who had dementia. His main support and power of attorney was his nephew who lived in Newmarket. Home care supports were only allocated for his sister to help her with bathing in the morning.

The Seniors Services Outreach team Occupational Therapist (OT) went into the home to complete a comprehensive geriatric assessment and identified significant concerns with the patient's cognition, specifically with poor recall, judgement and executive functioning. There were concerns with how the patient was managing his own self-care as he was disheveled and wearing dirty clothes. There were also concerns with his difficulty managing instrumental activities of daily living (e.g. banking, shopping, cooking, medication management etc.) for both himself and his sister and limited supports in place. Specific concerns were raised about how he was managing meals, as he was experiencing unexplained weight loss, and his ability to manage both is own medications and his sister's.

The OT advocated to the patient's home care coordinator to increase supports to enable the patient to be able to safely manage, and both PSW hours and respite hours were given. A Supports for Daily Living referral was submitted, to enable the patient to access Community Supports, but the patient was waitlisted. To increase the patient's ability to manage in the interim, the OT worked on putting visual cues in patient's environment to cue him to take his medications and also to provide his sister's. The patient was able to follow these cues and medication compliance improved. Reminders were also put into place to ensure the patient was eating food brought to him by his nephew, including leaving Ensure out on the kitchen table, which the patient started to consume regularly. Additionally, the OT provided education to the patient's nephew regarding community resources, including meal delivery services, private PSW agencies, emergency response systems, etc. Overall, with the help of Seniors' Service Outreach, Mr. S. improved his medication compliance and nutrition/management of meals , and received increased home care support. He has been able to remain in his home with the necessary supports in place and his nephew is much less stressed.

*name withheld

Geriatric Psychiatry Outpatient Clinics

Definition: 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.).

Additionally, contributors described these clinics as

- Interprofessional, including unique roles such as mental health workers and psychogeriatric resource nurse
- Generally clinic based, however in some cases, mobile – travelling to distal clinical sites, patient homes or long term care homes
- In some cases, inclusive of crisis response (e.g. Crisis Outreach Service for Seniors (COSS) at Sinai Health)

A variety names were used by contributors to describe these programs, including:

- Community Mental Health Services
- Geriatric Memory Clinics
- Geriatric Mental Health Outpatient Clinic
- Geriatric Mental Health Program
- Geriatric Psychiatry Community Services
- Geriatric Psychiatry Outpatient Clinics
- Integrated Psychogeriatric Outreach Program
- Mackenzie Health Richmond Hill Psychogeriatric Clinic
- OTMH GERI PSYCH (OP.GERIPSY)
- Psychiatric Assessment Services for the Elderly
- Seniors' Mental Health Program or Clinic

Table 18 lists 28 programs, whose data was contributed by facilities across the province. Altogether, in 2017/18 geriatric psychiatry outpatient clinics delivered almost 71,000 visits to over 12,200 patients.

Table 18: Geriatric Psychiatry Outpatient Clinics in Ontario 2017/18

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	MSW	Rph	OT	TR	Other
Baycrest Ctr/Jewish H F A	4870	4295	188			1		1		0.8		1.08
Canadian Mental Health Association – Cochrane Timiskaming Branch (Timiskaming site)	126	477	41			1						
Centre for Addiction and Mental Health - Queen Street Site	11231	8918	1595		1.01	2.11		1.57	0.05	0.8		
Collingwood General and Marine Hospital	n/a	3741	552									

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	MSW	Rph	OT	TR	Other
Geriatric Psychiatry Community Services of Ottawa	n/a	6608	1657									19.5
Grand River Hospital - Freeport	n/a	n/a	n/a									
Grey Bruce Health Services - Owen Sound	315	286	n/a			0.1						
Halton Healthcare Services - Oakville	2555	1939	473			1		1				
Hamilton Health Sciences - St. Peter's Hospital	2714	2714	617			0.3				0.3		0.35
Health Sciences North - Ramsay Lake Health Centre	n/a	579	107			1						
Hopital Montfort	170	136	34									0.4
Humber River Hospital - Wilson	n/a	744	267									
London Health Sciences Centre - Victoria	8262	7315	339	1		1		1		2	2	1
MacKenzie Health - Richmond Hill	420	434	112				0.2					0.2
Michael Garron Hospital	2250	2230	n/a			1						
Peterborough Regional Health Centre	4400	4568	848									
Providence Care Hospital - Kingston	n/a	712	319	1.7		1				1		
Providence Healthcare	1768	873	280									
Sinai Health System - Bridgepoint	360	360	120									
Sinai Health System - Mount Sinai	4080	4080	381									
South West LHIN	n/a	2340	300									
St. Joseph's Care Group	2064	1429	892			1						
St. Joseph's Health Care Hamilton	2649	n/a	319			3		1				0.6
St. Joseph's Health Care London - Parkwood	n/a	2340	179			3						1
St. Michael's Hospital	900	889	160			1				0.6		
Trillium Health Partners - Mississauga	6424	10751	1817		1	5.4		2		2		2
University Health Network - Toronto Rehabilitation Institute	850	793	404					0.1				
York Region Newmarket Health Centre	n/a	1363	231			3						0.45

Patient Story

Adapted from a "Success Story" Submission from

Geriatric Mental Health Program - London Health Sciences Centre (Victoria)

A long-term care home contacted our program for a 45-year old woman who was showing a recent rapid change in mood. While she had previously been very social, over a three month period, she became more withdrawn, and was now seen curled in her bed 24/7, declining any interactions of care. She was also expressing delusions about food poisoning, and thus refusing to eat. The home made an urgent call to the team to discuss this lady. A three-person interprofessional team completed a comprehensive assessment and initiated a follow-up referral to a psychiatrist. A team member and psychiatrist visited this lady the following week. The psychiatrist diagnosed psychotic depression and began treatment. At the most recent follow up, she has returned to her near baseline, is enjoying social interactions, and is eating again.

Geriatric Psychiatry Outreach Teams

Definition: 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.

Additionally, contributors described these teams as:

- Interprofessional, including unique roles such as mental health workers, outreach workers, psychogeriatric resource nurses and neuropsychologists
- Providing community outreach consultation services to older adults (usually over the age of 65) residing in private homes, retirement homes or long-term care homes
- Responding to consultation requests for in-depth assessments by specialized teams that are generally initiated by family doctors/nurse practitioners
- Providing comprehensive psychogeriatric assessment, diagnosis, psychoeducation, counseling and psychiatric treatment.
- Addressing serious mental health issues including responsive behaviours associated with dementia.
- Provided some, limited follow-up for older adults with late-onset mental illness
- Frequently coordinating with and often interdependent with local Behavioural Supports Ontario (BSO) Teams

In some cases, these programs also endeavor to address arising crises, which can create high staff workloads. One contributor noted:

> "Our program does not have appointments available, because when people contact us for help, it's at a time they need it most. We fit them in. This is why there is no wait list as well. This has caused our worker's caseloads to be at extreme levels, and staff stress levels high as a result."

The programs may be called:

- Community Consultation Service: Geriatric Psychiatry
- Geriatric Mental Health Outreach Program (GMHOP)
- Geriatric Mental Health Outreach Team (GMHOT)
- Geriatric Mental Health Program
- Geriatric Psychiatry Outreach Team
- Psychogeriatric Outreach Program (POP)
- Seniors Mental Health

Program Example[26]

Seniors Mental Health Outreach (SE) provides comprehensive assessment, treatment, planning, advocacy, referral and education for older adults living with complex mental health needs, substance use and associated changes in behaviour. These services are available to people living in their own homes, retirement homes, long-term care homes or hospitals.

Team members include case managers (registered nurses or occupational therapists) and psychiatrists.

In Kingston, Frontenac, Lennox & Addington this service is offered through Providence Care. In Leeds, Lanark & Grenville this service is referred to as Geriatric Mental Health Outreach and is offered through The Royal.

Referrals are accepted through primary health care providers (family physician, nurse practitioner). If family, caregivers or community health care providers have concerns they can contact the primary care provider.

Table 19 lists 36 programs, whose data was contributed by facilities across the province. Altogether, in 2017/18 geriatric psychiatry outreach teams delivered more than 97,500 visits to just over 17,100 patients.

Table 19: Geriatric Psychiatry Outreach Teams in Ontario 2017/18

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	OT	Other	Total FTEs
Barry's Bay Mental Health Services	n/a	n/a	n/a									n/a
Baycrest Ctr/Jewish H F A	5574	5345	727			1.5			1.5	1.5	1.2	5.7
Cambridge Memorial Hospital	1263	1071	215						1.7			1.7

[26] https://www.providencecare.ca/community-services/behavioural-support-services/

Facility Name	Appointments Made Available	Visits	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	OT	Other	Total FTEs
Canadian Mental Health Association – Cochrane Timiskaming Branch (Timiskaming site)	126	477	41			1.0						1.0
Canadian Mental Health Association – Cochrane Timiskaming Branch (Timmins SIte)	655	1864	72			2.0					0.6	2.6
Canadian Mental Health Association - Fort Frances Branch	n/a	19538	731			3.0	1.0		9.7	1.0	1.0	15.7
Canadian Mental Health Association - Waterloo Wellington	5376	5226	392			1.0		4.0	4.0			9.0
Centre for Addiction and Mental Health - Queen Street Site	2212	2169	821			2.0			0.5		1.0	3.5
Chatham-Kent Health Alliance - Chatham Site	n/a	2385	366		1.0	1.9	0.7		1.0	1.0		5.5
Hamilton Health Sciences - St. Peter's Hospital	1343	1343	460			0.7				2.7	1.8	5.2
Health Sciences North - Ramsay Lake Health Centre	n/a	1287	265			1.0			2.0	1.0		4.0
Hotel-Dieu Grace Healthcare	n/a	2203	427			3.8			3.4		1.0	8.2
North Bay Regional Health Centre	n/a	2377	435									n/a
North of Superior Counselling Programs (NOSP)	n/a	n/a	n/a									n/a
Pembroke Regional Hospital	n/a	2242	1041			5.5						5.5
Peterborough Regional Health Centre	n/a	3647	249			2.0			1.8	0.6	1.8	6.2
Providence Care Hospital - Kingston	n/a	285	421							1.0		1.0
Providence Care Hospital - Kingston	n/a	1453	596			4.0						4.0
Providence Care Hospital - Kingston	n/a	2430	1129			7.0						7.0
Providence Care Hospital - Kingston	n/a	1429	799			3.0						3.0
Providence Healthcare	312	82	27									n/a
Renfrew County Geriatric Mental Health Program	n/a	n/a	n/a									n/a
Renfrew Mental Health Services	n/a	n/a	n/a									n/a
Royal Ottawa Mental Health Centre	n/a	9261	4042	0.4		25.3					13.8	39.5
Scarborough Health Network - Centenary	n/a	2010	380									n/a
Scarborough Health Network - General Campus	n/a	2884	190									n/a
South West LHIN	n/a	2788	262			8.0					2.0	10.0
St Joseph'S Health Centre	n/a	1933	316			1.0						1.0
St. Joseph's Care Group	7680	4894	466	0.6		3.0	3.0		3.0	1.0		10.6
St. Joseph's Health Care Hamilton - Brant Seniors MHOP	420	3300	96			1.0						1.0
St. Joseph's Health Care Hamilton - Halton Seniors MHOP	4266	4514	838								9.9	9.9
St. Joseph's Health Care Hamilton - Niagara Seniors MHOP	1932	1717	427			2.0				0.6	3.0	5.6
St. Michael's Hospital	900	888	160			1.0				0.6		1.6
Sunnybrook Health Sciences Centre - Bayview Campus	n/a	6192	503			1.0			2.0	0.5		3.5
University Health Network - Toronto Rehabilitation Institute	400	364	80								0.4	0.4
Waypoint Centre for Mental Health Care - Main Location	1660	n/a	202			3.0					1.0	4.0

Patient Story

Adapted from a "Success Story" Submission from a Caregiver on behalf of

District Mental Health Services for Older Adults – CMHA Fort Frances

Six years ago my mother started to forget simple things… I started to notice that she was not paying her bills, and received disconnection notices for her utilities… I sought out advice from the Older Adults Program and tried to get my mom to see someone there. My mom refused and maintained there was nothing wrong (quite emphatically). I continued to monitor and had medications put into blister packs and made other changes recommended by the Older Adults Program that my mom would accept… [Eventually] not only her memory but her physical health declined significantly. Within one week, the ambulance was called twice, and I was all but living with my mother to ensure her safety. She was not eating, not taking any medications and was confined to bed and needed assistance toileting etc. At the time of the second ambulance call, I was at my wits end. I had not slept in almost 72 hours, and remember sitting on the front steps as the ambulance left the drive crying, wondering if I would ever get my mother back… [At the hospital] the doctor and I sat with my mom and finally my mom consented to a referral to the Older Adults Program. Within 48 hours of that referral my mom had met with a team member from the program and so had me and my siblings.

This was the start of better things to come.

This team member met with my mother several times, as well as the family members to provide support and information on the disease and its progression. She performed many cognitive tests and arranged home support for medication reminders and daily assistance. She helped us make things easier for my mom in her home so that it was easier and less stressful for my mom to function on a daily basis. She liaised with my mother's family physician and was able to get an appointment with a geriatric psychiatrist from the Baycrest Centre for Geriatric Care. My mother was diagnosed with Vascular Dementia/Alzheimer's.

The Older Adult program assisted the family in putting in security measures in my mother's home to ensure my mother's safety during the progression of the disease, and continues to provide ongoing support and information to both my mother, and to the family members on ways to help maintain my mother's dignity and independence and be able to live in her own home.

I do not hesitate to say that the main reason that my mother is currently able to stay in her own home is a direct result of the assistance provided by this wonderful program. . I am now able to have a bit of my life back not having to be with my mother 24/7 to provide care. We know that as my mother declines that things will have to change, however we also know that we will have the assistance and support from the Older Adults Program to get us through the tough times to come.

Geriatric Rehabilitation Units

Definition: 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 rehabilitation, 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.

Contributors also described these units as inpatient units in chronic care/complex continuing care hospitals for persons who require an individualized assessment and rehabilitation program for a period of one to three months. Team members include a wide array of regulated and unregulated health professionals, and include roles such as rehabilitation assistants (e.g. PTA, OTA) and behavioural therapists.

Units may be called:

- Complex Transitional Care Unit
- Geriatric Assessment and Rehabilitative Care Unit (GARC)
- Geriatric Assessment and Treatment Unit (GATU)
- Geriatric Rehabilitation Unit (GRU)
- Geriatric Transitional Unit (GTU)
- Sub-Acute Geriatric Unit (SAGe)

There is some overlap noted with names used to describe these units and the names of other inpatient geriatric units.

Table 20 lists 14 GRUs, reflecting broad distribution of these services across Southern Ontario.

Table 20: Geriatric Rehabilitation Units in Ontario 2017/18

Facility Name	Unique Patients Served	Beds	Avg Length Of Stay	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	SLP	Other	Total FTE
Baycrest Ctr/Jewish H F A	171	30	63	*FTEs provided were not broken down by category of discipline												32.4	32.4
Bruyere Continuing Care	679	50	26.8	0.5		5.0	5.0		2.8	1.7	0.6	4.5	3.4		0.6	9.7	33.8
Halton Healthcare Services - Georgetown	218	30	45.5			7.9	16.0		0.5		0.1	0.5	0.5	0.7	0.3	1.0	27.4
Halton Healthcare Services - Milton	289	20	22.4			6.7	11.8		1.0		0.2	0.5	0.6	0.7	0.2	0.7	22.4
Halton Healthcare Services - Oakville	445	53	52			25.3	27.4		1.0		0.3	1.0	1.0	1.0	0.3		57.3
Hamilton Health Sciences - Juravinski	372	18	17.8			11.5	9.2		1.0	0.5	0.5	2.2	4.4	0.6	0.6	1.7	32.1
Hotel-Dieu Grace Healthcare	n/a	30	20.8														n/a
Ontario Shores Centre for Mental Health Sciences	n/a	20	59			6.5	10.4	10.4	1.0	0.2	0.2		0.5	1.0			30.2
Providence Healthcare	468	35	25	*FTEs provided were not broken down by category of discipline												43.7	43.7

St. Joseph's Care Group	547	58	30			9.7	27.5		1.8	0.0	0.5	3.5	3.5	0.0	0.2	5.8	52.5
St. Joseph's Continuing Care Centre of Sudbury	182	16	45.2			1.6	4.6		0.3		0.3	1.0	1.0	0.3		2.2	11.1
St. Joseph's Health Care London - St. Joseph's Hospital	305	30	37	0.0	1.0	10.0	10.8	1.8	2.0	0.8	0.8	3.0	2.8	0.2	0.4	2.0	35.6
Trillium Health Partners - Credit Valley	300	20	19.9	0.0	0.0	10.0	4.0	0.0	1.0	0.5	0.5	2.0	2.2	0.5	0.5	1.0	22.2
University Health Network - Toronto Rehabilitation Institute	n/a	n/a	30	*FTEs provided were not broken down by category of discipline												49.1	49.1

Average length of stay has been included, as reported by contributors, as this is of particular interest to rehabilitative services.

Inpatient Geriatric Consultation Teams

Definition: Interprofessional teams that provide inpatient consultation, assessment and treatment of patients with complex needs and/or geriatric syndromes.

Contributors also noted:

- A focus on completion of comprehensive geriatric assessment (CGA)
- Some inpatient consultation services include only physician human resources (e.g. no additional interprofessional team members)
- This service is not typically an appointment based service, but rather referrals are triaged according to urgency
- Some services include automatic consultations for older adults (65+) with fragility and fracture who are admitted to Orthopedics or for older adults (65+) with major traumatic injury admitted to Trauma Units.
- A distinction between geriatric medicine and geriatric psychiatry inpatient consultation teams/services. This resulted in the creation of two categories of consultation teams, reflected in the tables below.

Program Example[27]

The Ottawa Hospital Geriatric Psychiatry Behaviour Support Team operates across two campuses. The team offers dementia focused support for responsive behaviours among inpatients, including evaluation, assessment and management. The team supports families who are living with someone with dementia – addressing family/caregiver stress and anxiety, making community referrals and suggestions, and linkages with the Alzheimer Society and Community Geriatric Psychiatry services.

Table 21 lists 23 geriatric medicine inpatient consultation services and their associated interprofessional team members. In 2017/18, in total, more than 10,500 patients received inpatient geriatric medicine consultations across Ontario.

[27] Abridged version of contributor submission.

Table 21: Geriatric Medicine Inpatient Consultation Services in Ontario 2017/18

Facility Name	Visits	Unique Patients Served	CP	NP	RN	Rph	RD	PT	OT	Other	Total FTEs
Guelph General Hospital	1195	595									n/a
Halton Healthcare Services - Milton	289	244		0.6							0.6
Halton Healthcare Services - Oakville	976	737		2		0.3				0.25	2.6
Hamilton Health Sciences - Hamilton General Hospital	359	323			1.02						1.0
Hamilton Health Sciences - Juravinski	372	349			1.02						1.0
Health Sciences North - Ramsay Lake Health Centre	10023	798			1			1.5	0.8	2	5.3
Hôpital Montfort	n/a	n/a								0.4	0.4
Hotel Dieu Shaver Health and Rehabilitation Centre	54	31			0.02						n/a
Joseph Brant Hospital	1300	800			2					1	3.0
North York General Hospital - General Site	n/a	707									n/a
Orillia Soldiers' Memorial Hospital	n/a				0.5						0.5
Providence Healthcare	n/a	180									n/a
Royal Victoria Regional Health Centre	n/a										n/a
St. Joseph's Care Group	1079	1079									n/a
St. Joseph's Health Care Hamilton - Charlton Campus	n/a	680		1					1		2.0
St. Michael's Hospital	n/a	644								1	1.0
Sunnybrook Health Sciences Centre - Bayview Campus	n/a	789									n/a
The Ottawa Hospital - Civic Campus	4242	1749			1			1		4	6.0
The Ottawa Hospital - General Campus	n/a										n/a
Trillium Health Partners - Credit Valley	n/a				1						1.0
Trillium Health Partners - Mississauga	n/a				2						2.0
University Health Network - Toronto Rehabilitation Institute	n/a	289									n/a
University Health Network - Toronto Western	n/a	557									n/a

Four contributors provided information about geriatric psychiatry inpatient consultation services, summarized in Table 22.

Table 22: Geriatric Psychiatry Inpatient Consultation Services 2017/18

Facility Name	Visits Delivered	Unique Patients Served	RN
The Ottawa Hospital - Civic Campus	3578	605	3
The Ottawa Hospital - General Campus	included above		
MacKenzie Health - Richmond Hill	1239		0.55
St. Joseph's Care Group	455	133	1

Nurse Led-Outreach Teams

Definition: Nurse-led outreach teams (NLOTs) 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.

Contributor data reflects that these programs are largely NPs led. NLOT programs are typically regional programs, with associated human resources providing coverage across LHINs or LHIN subregions. One contributor noted some challenges with program uptake by local LTC homes. In one case (Central East), the program includes nine (9) mobile FTEs and two (2) NPs who are embedded, providing support to two LTC homes each.

Six of the seven programs listed below provided visit data. Together, these six programs provided more than 17,500 visits to LTC residents to assist in the management of acute conditions and in an effort to prevent transfer to hospital. Table 23 provides a summary of NLOT program information.

Table 23: Nurse Led Outreach Programs in Ontario 2017/18

Program	Facility Name	Visits	NPs
Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)	Central East LHIN	5154	11
Humber River Hospital Nurse-Led Outreach Team	Humber River Hospital - Wilson	3095	4
Mackenzie Health Nurse-Led Outreach Team	MacKenzie Health - Richmond Hill	1560	1
Markham Stouffville Hospital Nurse-Led Outreach Team	Markham Stouffville Hospital	3167	2
Nurse Lead Outreach Team (NLOT)	South West LHIN	n/a	5
Southlake Regional Health Centre Nurse-Led Outreach Team	Southlake Regional Health Centre	2891	2.4
Nurse Led Outreach Team (NLOTS)	The Ottawa Hospital - Civic Campus	1732	4.5

Primary Care Collaborative Memory Clinics

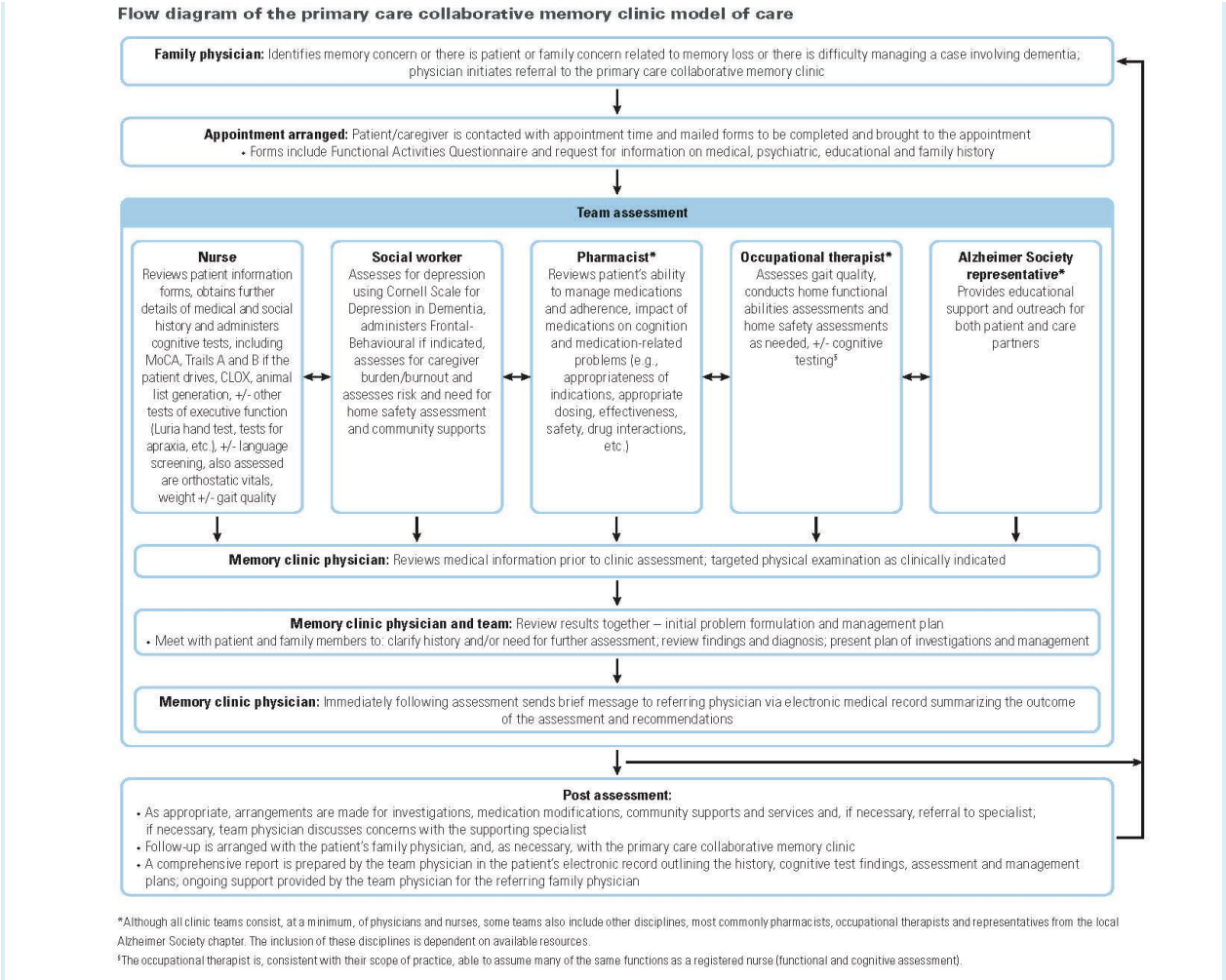
Definition: Diagnosis, treatment and care for people living with dementia provided at the primary care level through a recognized clinical model

Several contributors reported difficulty identifying a specific "facility" as the home for their Primary Care Collaborative Memory Clinics (PCCMC). This was reported as due to collaboration of multiple partners, operating in shared space that no one party owns, thus there is no "leader/owner" of the service, but rather partners.

Program Example (Model)[28]

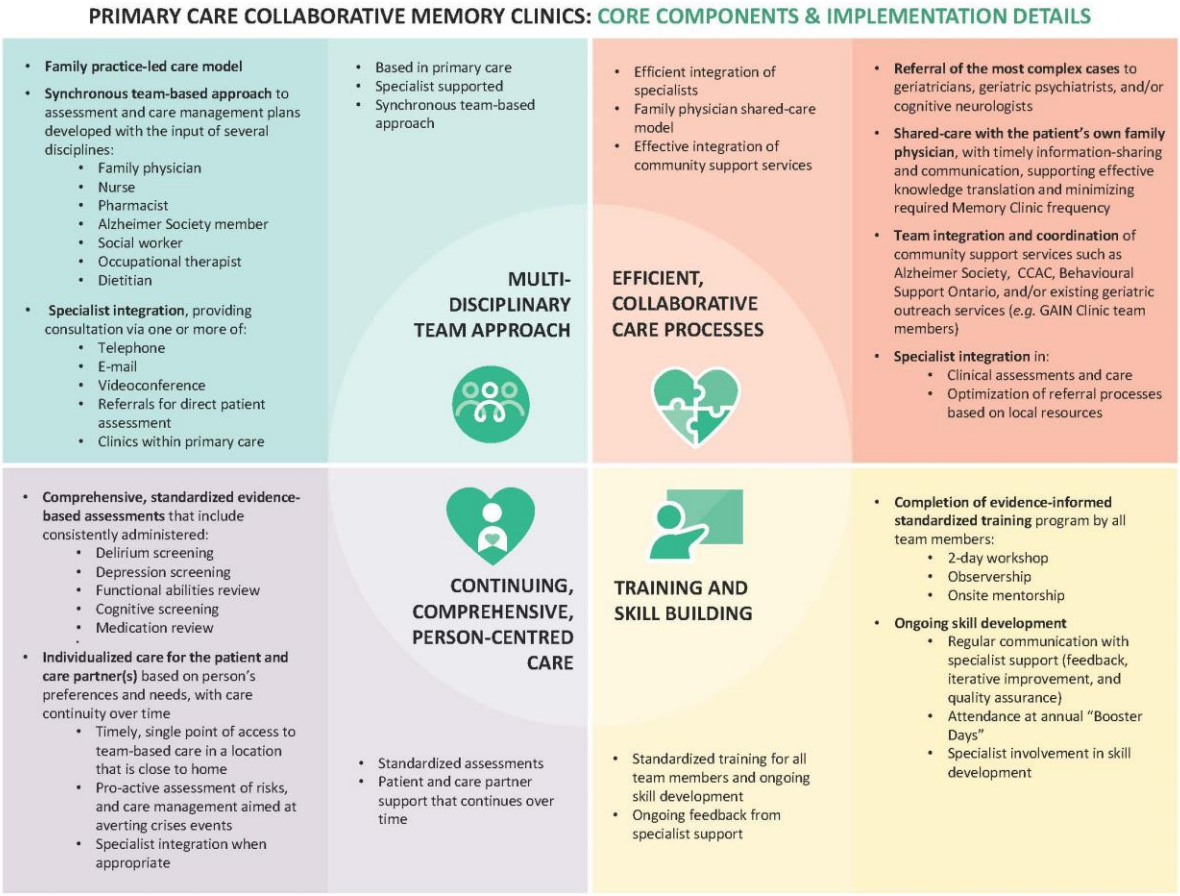
Contributors provided sophisticated descriptions of PCCMC, illustrated in Figure 3 and Figure 4.

Figure 3: Flow Diagram of Primary Care Collaborative Memory Clinic Model



[28] Lee, L., Hillier, L.M., Molnar, F., & Borrie, M. (2017). Primary care collaborative memory clinics: Building capacity for optimized dementia care. *Healthcare Quarterly, 19*(4). Used with permission.

Figure 4: Primary Care Memory Clinics: Core Components and Implementation Details29



Of the approximately 110 known primary care collaborative memory clinic sites, 39 provided program data, which is summarized in Table 24.

Table 24: Primary Care Collaborative Memory Clinic Contributors 2017/18

Facility Name	Appointments Available	Visits Delivered	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	OT	SLP	Other	Total FTEs
Bluewater Area Family Health Team	36	30	0		2		2		1						5
Brockton And Area Family Health Team	44	42	40	0	0	1	0	0	0.5	0.5	0	0	0	0.5	2.5

[29] Used with permission L. Lee

Facility Name	Appointments Available	Visits Delivered	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	OT	SLP	Other	Total FTEs
Byron Family Medical Centre of London Health Science Centre	48	45			0.09				0.09	0.05		0.05		0.05	0.3
Care First Seniors	4	177	108				1		1	0.3		1			3.3
City Of Kawartha Lakes FHT	96	147	90			0.1			0.1	0.1	0.01	0.1			0.4
Clarington Family Health Organization	288	229	109				0.5		0.5			0.5			1.5
Cottage Country FHT		71	33			0.05				0.02				0.1	0.2
Eastern Ontario Community Family Health Team	50	26	18		0.01	0.02			0.03	0.35				0	0.4
Family First FHT	56	48	39			0.04	0.04		0.08	0.04					0.2
Grand River Community Health Centre	188	181	179			0.6			0.4						1
Haliburton Highlands Health Services - Haliburton	57	55	46			0.1			0.1			0.1			0.3
Hamilton Networked Family Health Team	38	18	18			0.04			0.04	0.04	0.04			0.4	0.6
Harrow Health Centre Family Health Team	46	42	33		0.08		0.04		0.04	0.08					0.2
Hotel Dieu Shaver Health and Rehabilitation Centre	96	67	60			0.2			0.2						0.4
Inner City FHT	n/a	75	18	0.04		0.09			0.07					0.11	0.3
Kensington Village	50	30	30		0	1			1	1		1		1	5
Loyalist FHT	40	32	23			0.1			0.49			0.49			1.1
Maitland Valley Family Health Team	76	63	58		0.06		0.05		0.06	0.05				1.5	1.7
Minto-Mapleton Family Health Team	40	30	15						0.15					0.55	0.7
Niagara North FHT - St. Catharines	38	34	31		1	2			2						5
Niagara North FHT - Virgil/Niagara-On-The-Lake	48	50	40		1	2			2	1					6
North Huron FHT	44	43	35		0.05	0.14			0.05	0.05				0.22	0.5
Northumberland FHT	42	37	33				0.05		0.1	0.1		0.1			0.4
Norwest Community Health Centre	110		64		0.09	0.05	0.09		0.05					0.3	0.6
Oshawa Clinic Family Health Organization	378	313	144				0.5		0.5			0.5			1.5
Owen Sound Family Health Team	144	144	102			0.09						0.09			0.2
Petawawa Centennial Family Health Team	48	48	24		1		1		1	1				1	5

Facility Name	Appointments Available	Visits Delivered	Unique Patients Served	CP	NP	RN	RPN	PSW	MSW	Rph	RD	OT	SLP	Other	Total FTEs
Port Hope Community Health Centre	36	40	32		0.05		0.05		0.05	0.1		0.1		0.25	0.6
Portage Medical Group FHT	48	17	17			0.05			0.05	0.05				0.14	0.3
Sunset Country Family Health Team	100	102	72			0.2			0.1	0.1	0.1	0.1		0.1	0.7
Temagami FHT	30	26	24											0.16	0.2
Trent Hills Family Health Team	7	7	7			0.05									0.1
Two Rivers Family Health Team	74	72	72		0.3	0.3			0.1	0.1		0.3			1.1
Upper Canada Family Health Team	192	185	120	0	0	4	0	0	4	0	0	0	0	1	9
Waterloo Wellington LHIN - Kitchener-Waterloo-Wilmot-Wellesley-Woolwich (KW4) Subregion	265	289	197				0.6		0.2	0.2		0.2			1.2
West Champlain FHT - Eganville	30	22	14		0.05	0.05			1.04					0.09	1.2
West Champlain FHT - Pembroke	30	22	17		0.05	0.05			1.04					0.09	1.2
West Lambton Community Health Centre	57	55	31		1	1				0		1		2.6	5.6
Whitewater Bromley Community Health Centre	40	22	22			2			1	1				1	5

"Other" team members participating in PCCMC include participating physicians, clerical staff, Alzheimer Society staff, kinesiologists, and physician assistants. It is of note that FTEs reported may not be FTEs paid by the practice.

One contributor questioned whether PCCMC were "too small to count". It is of note that most PCCMC sites operate one to two days per month with small staff, yet at the same time are widely distributed across the province. Altogether, in 2017/18 the 39 sites contributing data made more than 3000 appointments available, and provided more than 2900 visits to approximately 2000 patients.

Patient Story
Adapted from a "Success Story" Submission from
West Lambton Memory Clinic

Our main impact in the Memory Clinic for this 92 year old patient was the ability to prolong his stay at a retirement home as opposed to earlier admission to long-term care. Outcomes achieved included timely access to care, appropriate referrals to community resources, and caregiver education and support to better manage patient symptoms and self-care. Our interventions provided a clear diagnosis of the patient, which the caregiver used to access proper care through appropriate community resources. The main caregiver expressed her gratitude with the Memory Clinic, as without the initial assessment to confirm her initial suspicions, she fears she would not have been able to access the care her father-in-law required. In late 2018, the patient's health deteriorated to the point where admission to long-term care was required. The main caregiver expressed her thanks to the Memory Clinic via phone call to the primary physician. She noted that without the clinic her father-in-law would have entered long-term care many years earlier as she was at a loss what to do with his decline by herself.

"Without the help of the Memory Clinic at the West Lambton Community Health Centre I know that we would not have known what to do." (Caregiver)

"I am a family physician practicing here in Sarnia. For the last number of years I have referred quite a number of patients to the Memory Clinic. I have found their assessments and recommendations indispensable in terms of my ongoing patient's care with regards to memory and dementia issues."(Physician colleague)

Psychogeriatric Resource Consultants

Definition: 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.

Additionally, contributors noted that PRCs support those who care for seniors with complex physical, cognitive and mental health needs and associated behaviours. PRC roles were created through the 1999-2004 Alzheimer Strategy to support LTC, community service agencies and contracted service providers of the then Community Care Access Centre. Roles include consultation, capacity development and education[30].

[30] Summarized from contributor submission.

Contributors noted that the requested data elements were not a good fit for the nature of the PRC's work. PRCs clients/interactions are formal care providers (e.g. staff), rather than patients. "Unique clients" are in fact, referral sources such LTC, LHIN, Adult Day Programs. PRCs may provide client consultation, but this is generally done in the context of providing advice to staff on care planning, assessment tools, and care approaches. Education is provided through formal and informal education and support.

Staff positions may include regulated (e.g. RN, MSW) and unregulated roles (e.g. educators, resource counsellors).

Program Example

The RGP of Toronto Psychogeriatric Resource Consultation Program (PRCP) is an interprofessional team of 12 Knowledge to Practice (K2P) specialists who help build the skills of caregivers in long-term care, community service agencies, home and community care, and primary care settings. They focus on caring for older adults with responsive behaviours – the behavioural and psychological sequelae of complex neurological diseases and mental illness in late life.

Service innovations have been a key element of the PRCP performance framework. Most recently, the PRCP has focused on two innovations – the development of Behavioural Support Resource Teams (BSRTeams) and the training of BSRTLeads. By the end of 2017–18, all LTCHs in the Toronto Central LHIN and Central LHIN will have these teams and their leads in place. BSRTLeads represent a net new LTCH human resource. Together with the Behavioural Supports Ontario lead agencies (Baycrest Health Sciences – Toronto Central LHIN, and Mackenzie Health – Central LHIN), the PRCs have developed communities of practice that include coaching, peer-to-peer mentoring and a forum to support the sustainability of the BRSTeams.

Evaluation of the BSRTLeads training using objective measures has demonstrated statistically significant knowledge gains, role clarity and understanding, and confidence in the ability to sustain the BSRTLead role. Subjective evaluations of the KTP work have been equally positive.

"I feel confident in my role, I am able to provide education and open communication with staff and management, and create activities for residents. The team works together to share ideas, interventions and care tips, which have decreased responsive behaviours." (BRSTLead)

Of the approximately 50 known PRC positions, data was contributed for 36.9 FTEs, and is summarized in Table 25.

Table 25: Psychogeriatric Resource Consultants in Ontario 2017/18

Facility Name	Visits Delivered	Patients Served	RN	MSW	OT	Other	Total FTEs
Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	515	78				2.8	2.8
Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	229	42				1.5	1.5
Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	70	67				1.5	1.5
Alzheimer Society of Niagara Region	2923					2	2
Centre for Addiction and Mental Health - Queen Street Site	9753	9000	2	5	3	3	13
Ontario Shores Centre for Mental Health Sciences	n/a	n/a	2				2
Peterborough Regional Health Centre	2915	2711				1.46	1.46
Sinai Health System - Mount Sinai	3000	354	1.5			1	2.5
St. Joseph's Care Group	402				1		1
St. Joseph's Health Care Hamilton - Halton Seniors MH Outreach Program	4300	630				1.25	1.25
Waypoint Centre for Mental Health Care - Main Location	n/a					3	3
York Region Newmarket Health Centre	806					4.07	4.07

Program Story
Adapted from a "Success Story" Submission from
Alzheimer Society Niagara Region

The PRC implemented a Knowledge to Practice (K2P) approach, incorporating on- site training at a 65 bed Long Term Care Home. This approach assist staff to recognize responsive behaviours in persons living with dementia as the result of unmet needs and/or protective behaviours, which are sometimes also influenced by comorbid mental health or physical illness.

The K2P approach included:

- Monthly training sessions facilitated by the PRC over the past year.
- Providing staff with knowledge, resources and tools required to interact with residents in a way which would hopefully result in a reduction in responsive behaviours. Some existing resources were utilized, such as Behavioural Charting using the Dementia Observation System, Positive Approaches to Care™, as well as in-services related to more resident specific mental health diagnoses such as Personality Disorders and Compulsive Disorders. Interactive learning approaches were implemented along with Dialogue Education.
- Monthly follow up to ensure knowledge was put into practice, including coaching around what worked, what didn't and what needed adjustment or revisiting.

Both management and front line staff were involved, across disciplines. When necessary, management would cover the floor in order to permit the attendance of front line nursing staff. To facilitate opportunities for training, sessions were done in 30 minute segments each building on the previous. Challenges included times when particular staff were unavailable, but this was addressed by review with the PRC at the next session.

Results

Behaviours are reported to have significantly decreased over a 6 month span. Staff report better understanding of resident responses and improved means of communicating with residents. Incident reports and behaviours charted have decreased. Staff report increased knowledge and skills to better enable communication and work with their residents.

"Staff are engaged and motivated because of the approach to teaching"

"The staff always have positive feedback when you provide us with in-services, always ask when you're coming back; they learn and take the skills and knowledge you deliver"
(Long Term Care Home Administrator)

Specialist Based Memory Clinic Models

Definition: Locally developed approaches to memory/dementia care in which medical direction is provided by specialists.

Additionally, contributors noted these clinics are

- Under the leadership of specialists (e.g. geriatricians, geriatric psychiatrists)
- Integrated with other programs (e.g. geriatric psychiatry clinics)
- Inclusive of other program partners (e.g. Alzheimer Societies)

There were 6 specialist based memory clinics reported by contributors. Collectively, in 2017/18 these clinics served over 2600 patients. Table 26 provides a summary of program submissions.

Table 26: Specialist Based Memory Clinic Models in Ontario 2017/18

Program Name	Facility Name	Appointments Available	Visits Delivered	Unique Patients Served	CP	RN	MSW	OT	SLP	Other	Total FTEs
Baycrest Memory Clinic	Baycrest Ctr/Jewish H F A	3719	2704	1240		2	0.5		0.5	2.64	5.64
Specialist Memory Clinic	Centre for Addiction and Mental Health - Queen Street Site	1798	1715	76	0.7		0.1	0.19		0.38	1.36
SG-Memory	Providence Care Hospital - Kingston	n/a	120	240							n/a
Alzheimer Society Lanark Leeds Grenville	South East LHIN - Lanark, Leeds & Grenville Subregion	384	321	300						1.2	1.2
Memory Disorders Clinic	St. Michael's Hospital	1496	1236	551							n/a
Geriatric Psychiatry Clinic	University Health Network - Toronto Rehabilitation Institute	n/a	n/a	265							n/a

Shared Care Geriatric Mental Health Programs

Definition: A collaborative geriatric psychiatry service that includes indirect support and education, and direct clinical consultation and follow-up care with primary care.

This category of unique programs includes three programs that utilize geriatric psychiatry, interprofessional teams (and at times geriatric medicine) to provide assessment, consultation, short term case management and education to community dwelling seniors over the age of 60 who are experiencing mental health challenges. The focus is on providing comprehensive psychogeriatric assessments of seniors to assist the referring professionals or caregivers better understand, treat and manage the presenting issues.

Program Example[31]

The Centre for Seniors' Medical Psychiatry (Trillium Health Partners) is an outpatient program integrating Geriatric Medicine and Geriatric Psychiatry anchored in primary care, where the primary care practitioner remains the most responsible provider. Under the supervision of geriatric specialists, RN Care Managers or allied health professionals will work with the patient and the primary care provider to manage both the physical and mental health needs with a collaborative care intervention for up to 16 weeks.

Contributors identified three of these programs, summarized in Table 27.

Table 27: Shared Care Geriatric Mental Health Programs in Ontario 2017/18

Program Name	Facility Name	Visit Delivered	Unique Patients Served	RN	MSW	Rph	OT	TR	Other	Total FTEs
Consult Liaison Service	Halton Healthcare Services - Oakville	489	179	0.45						0.45
Centre for Seniors' Medical Psychiatry (Medical Psychiatry Alliance Seniors' Outpatient Program)	Trillium Health Partners - Queensway	489	104	1			1		0.05	2.05
Seniors' Mental Health Program	West Park Health Centre	2320	305		2.4	0.1	1.2			3.7

Tertiary Dementia Specialty Units

Definition: 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.

Contributor input suggests that this category also includes acute care-based behavioural units. Activities include a focus on management of agitation and aggression associated with dementia and other neurodegenerative disorders.

Names for these units include:

- Behavioural Support Transitional Unit (secure in-patient)
- Geriatric Assessment and Behavioural Unit (GABU)
- Geriatric Behavioural Unit
- Geriatric Dementia Unit (GDU)
- Inpatient Geriatric Dementia Unit (Post-Acute)
- Specialized Dementia Unit

[31] https://trilliumhealthpartners.ca/patientservices/seniors/Pages/Centre-for-Seniors%E2%80%99-Medical-Psychiatry.aspx

- Tertiary Dementia Specialty Units
- Tertiary Seniors Specialty Units

Staffing includes a variety of regulated health professionals (see Table 28) and other roles such as rehabilitation assistants, geriatric resource counsellors and administrative staff. There are 11 programs identified in this category.

Table 28: Tertiary Dementia Specialty Units in Ontario 2017/2018

Facility Name	Unique Patients Served	Beds	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	SLP	Other	Total FTEs	FTE/Beds
Baycrest Ctr/Jewish H F A	64	20	1		8	13	8	0.8	0.3	0	0.45	1	0.75	0.5	1.61	35.4	1.77
Hamilton Health Sciences - St. Peter's Hospital	145	63	0.5		9.1	52		1.8	0.4	1	1	1.5	3	0.5	3.2	73.9	1.17
Ontario Shores Centre for Mental Health Sciences	n/a	23		1	11	17	3	1	0.5	0		0.5	1			35.6	1.55
Peterborough Regional Health Centre	n/a	12			5.2	9.4									4.11	18.7	1.56
St. Joseph's Health Care London - Parkwood	18	18			6.2	8.9	6	1				0.5	1		1	24.5	1.36
University Health Network - Toronto Rehabilitation Institute	94	17			13	11		1.5	0.2	0	0.5	1	2	0.2	3	32.9	1.94
London Health Sciences Centre - Victoria	n/a	12		0.8	4.8	7.3	9						1			23.4	1.95
St. Joseph's Health Care Hamilton - West 5th - Harbour East 1	n/a	12		0.2	4	6	2	0.5	1	0	0.1	0.5	1	0.1		15.5	1.29
St. Joseph's Health Care Hamilton - West 5th - Harbour North 1	n/a	24			7	16	3	0.5	1	0	0.1	0.5	1	0.1		29.3	1.22
St. Joseph's Health Care Hamilton - West 5th - Forest 1	n/a	12	0.1	0.2	5	6		1	1	0	0.1	1	0.5			15	1.25
Quinte Healthcare - Belleville	n/a	20			1	8.6	11						1		1.2	22.3	1.12

Full time equivalent (FTE) to bed ratios varied from 1.17 to 1.95, in contrast to the same ratios in Acute Geriatric Psychiatry Units, which were 0.24 to 1.33.

Tertiary Non-Dementia Geriatric Psychiatry Units

Definition: 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.

Contributors confirm that these units represent a variety of different services, including short stay assessment and treatment units for older adults with mental health challenges or longer stay units. The

distinction between units categorized here and Acute Geriatric Psychiatry Units is unclear, but may reflect the nature or severity of mental health concerns treated in GPUs.

Four contributors provided data in this category, which is summarized in Table 29.

Table 29: Tertiary Non-Dementia Geriatric Psychiatry Units in Ontario 2017/18

Facility Name	Unique Patients Served	Beds	CP	NP	RN	RPN	PSW	MSW	Rph	RD	PT	OT	TR	Other	Total FTEs	FTE/Beds
Baycrest Ctr/Jewish H F A	92	20	0.2		8.8	4.8	0.6	0.8	0.3	0.2	0.1	0.8	0.8	1.5	18.8	0.94
Ontario Shores Centre for Mental Health Sciences	n/a	25			13.5	15.4		1	0.2	0.2		0.5	1		31.81	1.27
St. Joseph's Health Care London - Parkwood	n/a	24			8.6	7.4	4.9	1				0.5	1	1	24.35	1.01
Waypoint Centre for Mental Health Care - Main Location	60	28		0.2	16.5	15.9	4.5	2				1	1		41.17	1.47

No Data Received

There was no data received for the following categories

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

Excluded Contributions

The following data was excluded, for the reasons indicated:

Table 30: Data Excluded/Out of Scope

Program/Service	Reason for Exclusion
Caregivers Program (Reitman Centre)	Out of scope
Falls Prevention Programs (various)	Out of scope
Hospital Elder Life Program (HELP) (various)	Volunteer Program – Out of scope
Long Term Care Based Behavioural Support Units (various)	Out of scope
Neuropsychiatry Unit (NPS) (Ontario Shores)	Not specific to geriatric population

Program/Service	Reason for Exclusion
Physician Led Telemedicine/Telepsychiatry (various)	Out of scope – physician HR[32]
Seniors Wellness Centre (Sinai Health)	Out of scope
SGS Telemedicine Nurse (St. Joseph's Care Group)	Resource shared with other services already captured.
Third Age Outreach (St. Joseph's Health Care London)	Recreational programming – Out of scope

Mapping Displays

All data is housed in an IIS hosted .NET framework 4.7 MVC application, storing its data in SQL server and using OpenStreetMaps and Leaflet to provide the GIS interface[33].

All contributors have access to the mapping application to create and view desired maps. Contributors select a service type, or an "asset", that they wish to view and the application generates a map with pinned locations, illustrating all locations of that service type. Multiple service types can be selected to study services in relation to each other. The application includes various filters, which allow viewers to examine particular items of interest (e.g. LHIN boundaries, specific FTEs, census data related to populations over 65+). Pinned locations can be clicked to expand details about the specific asset (e.g. name, street address, FTEs, visits etc.) The application is available to all registered users of the data portal and located at https://secure.hsnsudbury.ca/SGSAssetMapping/.

Discussion

This report depicts a broad array of services focused on supporting older people living with complex medical and/or mental health concerns (or both). Services are characterized by:

- Interprofessional teams inclusive of all health disciplines and an array of unregulated health professional roles
- Flexible delivery models and service designs that both cohort patients and distribute services directly to the homes of older people
- Partnerships among agencies, particularly in rural communities
- Interdependency between SGS programs who may share care for patients as they move along the health care continuum
- Small teams, with lean administrative supports – with some contributors noting small team size and lack of administrative/clerical support as a challenge in the face of high demand
- Patient stories that reflect success measured in quality of life, social inclusion and retained citizenship, as much as it is measured by reducing repeat emergency room visits

Data contributions included submissions related to several out of scope programs serving older people. Although such program data has been excluded from this report, for future planning purposes, it may be

[32] Physician human resources are addressed in the companion report "Specialized Geriatric Services in Ontario Human Resources Mapping Geriatricians, Care of the Elderly Physicians and Geriatric Psychiatrists"

[33] Additional technical detail is available from Grant Duncan, Team Lead, BIID – Business Intelligence, Integration and Development, Health Sciences North, gduncan@hsnsudbury.ca

pertinent to consider SGS programs in context with other seniors' focused programming (e.g. CSS services, caregiver programs), given their important role in helping older people to remain living at home.

The overlap between unit names and functions across categories calls into question the relevance of categorizing programs and services along largely historical division or by cost centres. Newer integrated service delivery models, and the organization of services around functions arising from the needs of complex patients may offer new forms or categories that are more important in future planning.

Supporting Caregivers

Many contributors indicated they do not regularly collect metrics related to caregivers served. Some indicated they had estimated at one-for-one (one patient = one caregiver) in their responses, although this may underestimate the number of caregivers actually involved with complex patients.

Overall, contributors identified supporting more than 68,000 caregivers in 2017/18. However, only 166 of 444 programs or services provided a response in the "caregivers served" data field, 278 records left this field blank. Only BSO programs/services have defined and routinely collect this metric.

Caregiver support is likely a taken-for-granted and under-measured component of geriatric care. Many recommendations and interventions arising from comprehensive assessments in geriatrics are aimed at supporting caregivers to continue their caregiving role and alleviating burden, and the patient stories included in this report provide several such examples.

Wait Times

Wait time information was contributed in several categories of services. Individual programs reported average wait times for service. Table 31 illustrates the median average wait time value reported in the category.

Table 31: Median Average Wait Time Values by Service Category

Category of Service Types	Median Wait Times (days)
Geriatric Psychiatry Outreach Teams	21
Shared Care Geriatric Mental Health Programs	26
Geriatric Outreach Teams	29
Geriatric Day Hospitals	40
Geriatric Psychiatry Outpatient Clinics	43
Primary Care Collaborative Memory Clinics	60
Geriatric Outpatient Clinics	90
Specialist Based Memory Clinic Models	122

There are patients waiting for service. Given that these same categories of service also produce the highest volume of visits, waiting as an indication of demand and need requires further examination.

Limitations

Despite best efforts to be comprehensive, this data picture is incomplete. In some cases, the scale of the incompleteness is known (e.g. only 35% of primary care memory clinics responded). In other cases, we have yet to identify all relevant programs and services for inclusion.

There is a high degree of variation (by site and service type) in both the definition of services and the way data is collected and reported. The data contributed to this effort ranges from systematically defined metrics to, in some cases, a good guess (e.g. caregivers served). There is additional variation in the availability of data, and in model design, that is a product of multiple drivers.

Contributors also reported challenges separating data by service types as many models are fully integrated (e.g. an outpatient clinic team might also do home visits and support primary care), and so discrete categorization may be somewhat artificial. Contributors reported that drivers for the organization of SGS include funding (or lack of), and high need/demand – and that this has resulted in innovative, creative grassroots approaches that do not fit current definitions.

Readers must avoid the temptation to benchmark or draw conclusions from this data and note that the data included in this report is not suitable for statistical analysis or outright planning. The information gathered is useful to raise inquiry questions and to develop preliminary planning assumptions. It also raises awareness of taken-for-granted assumptions in the current state of geriatric care in Ontario.

Conclusions

There is work to be done to further define and categorize the function and scope of programs and services for older people living with frailty. At the same time, there is a need for new definitions and engagement with performance measurement experts (e.g. MIS and OHRS Chapter 10 definitions tables) to develop indicators that are specific to the nature of care for older patients with complex health concerns.

This report provides a partial current state view of specialized geriatric services that can help to identify the foundation needed to support expert care for older people living with frailty in Ontario.
The present work raises a number of important inquiry questions, such as:

- Who ought to travel in the health service relationship (and how far)? Patients or Providers?
- In what ways might the role of geriatric experts in supporting caregivers be better understood? What ways of supporting caregivers do caregivers find most helpful?
- How might our health system build on the readiness, and the existing infrastructure and distribution of specialized geriatric services to prepare for increase demand for health services from an aging population?
- What are the opportunities to better connect services that address care plans developed through SGS to an overall system of integrated frail senior care?
- What data matters most related to measurement in geriatric clinical care?

It is hoped that this information provokes conversation among clinicians and health system planners (e.g. workforce planning, capacity planning, service planning, master planning) as it highlights the need for planners and clinical leaders to continue to work collaboratively to learn from this and other data to inform future capacity plans.

Appendix 1: Provincial SGS Asset Mapping Working Group Participants

South West SGS	Michael	Borrie
South West SGS	Tracey	Cooper
South West SGS	Beth	McCarthy
MOHLTC - Capacity Planning Branch	Justin	Armstrong
	Adam	Morrison
	David	Morris
MOHLTC - Health Data Science Branch	Kerimov	Aidyn
Provincial Geriatrics Leadership Office	Valerie	Scarfone
	Kelly	Kay
Queen's University Policy Analysis & Development	Dallas	Seitz
Health Science North	Grant	Duncan

Appendix 2: Service Type Definitions

Service Type	Definition
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. 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.

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, Parkinson's 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.
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).

Appendix 3: Original Data Request

Request for Program and Service Data
Specialized Geriatric Services in Ontario – Asset Mapping Project

The Regional Geriatric Programs (RGPs) of Ontario, in collaboration with the Ministry of Health and Long Term Care, is undertaking a new initiative to collect comprehensive data related to specialized geriatric programs and services in the province of Ontario.

Specialized Geriatric Services (SGS) are defined as a comprehensive, coordinated system of hospital and community-based health and mental health services that assess, diagnose, and treat frail seniors. These services are provided across the continuum of care by interdisciplinary teams with expertise in care of the elderly. SGS is inclusive of both geriatric medicine and geriatric psychiatry services

This project will inform a current state view of the supply and utilization of health services designed for older people living with frailty (e.g. specialized geriatric services) and will contribute to future capacity planning. Data is requested for the fiscal year of 2017/18.

You have been identified as a Regional Geriatric Program Lead or key program contact who can contribute program and service data about specialized geriatric services in your region. You are requested to enter your program data in our custom designed web-based portal found at https://secure.hsnsudbury.ca/SGSAssetMapping/. Please register as a new user at this site, and pending approval from the site administrator, begin entering your data. Please note that your LHIN has also received this request.

Your data is requested by **January 15, 2019**. If you are not the correct contact or will be forwarding this request on, please let us know who will be responding. All contributors will have the opportunity review their data submissions for accuracy prior to the completion of the final report.

A brief data dictionary is attached to assist you with data entry. This includes a list of the types of data needed and the in-scope specialized geriatric service types. You are also invited to join a data entry walk-through on Zoom on December 11, 2018 at 11:00 am at https://zoom.us/j/182631731. If you have any questions about this request please contact:

For the RGPs of Ontario:
Kelly Kay
Co-Executive Director
Provincial Geriatrics Leadership Office
kkay@rgpo.ca
905-376-3331

For the MOHLTC:
David Morris
Senior Policy Advisor
Partnership and Consultation Unit
david.morris3@ontario.ca
416-212-8165

Appendix 4: Data Dictionary

Thank you for assisting us to compile a complete picture of specialized services serving older people living with frailty, inclusive of primary care-based memory services. This work is part of the development of a current state view of specialized geriatric services. Your data can be entered directly into the data entry portal at the following data entry portal link: https://secure.hsnsudbury.ca/SGSAssetMapping

For a video overview of how to use and enter data in the SGS Asset Mapping Portal, please see the video posted at the following link: https://youtu.be/uC9A3H6WY1Y

Data is requested by **January 18, 2019**. Questions? Please contact Kelly Kay, Interim Co-Executive Director of the Provincial Geriatrics Leadership Office of the Regional Geriatric Programs of Ontario (e. kkay@nhh.ca or c. 905-376-3331).

We are requesting the following data from you (for the year April 1, 2017 to March 31, 2018) be entered into the portal (this should take about 20-30 mins, depending on your records):

Field	Definition
Facility	Enter the corporate name of the organization hosting your specialized geriatric service.
Fiscal	Select 2017/18.
Load Form	Select this button to open a data entry form.
Organization	This is the organization attached to your user account. This is established at registration and is not edited.
Service Type	Select from the provided drop-down list of service types. You may also enter a new service type if your program or service has not been included. (See Service Type Definitions below).
Name of Service	Enter the name your program or service operates under (e.g. Geriatric Assessment and Intervention Network, Geriatric Outreach Assessment Team).
Contact Email	Enter your email so we can contact you to clarify data entered.
# of Appointments made available each year	Enter the yearly total of the number appointments you had available to be booked for 2017/18. Usually applies to outpatient, outreach, community or primary care based services.
# Visits delivered/year	Enter the yearly total of the visits (or attendances) your program or service actually provided to patients in 2017/18.
# Unique patients served/year	Enter the yearly total of unique individuals who received service from your program 2017/18. (Note count once, even if the same individual had multiple appointments).
# Caregivers served/year	Enter the yearly total of caregivers who received service from your program or service in 2017/18.

# Beds in Service/year	Enter the yearly total of beds on your program or service (if this is a bedded service).
Annual Occupancy Rate of Bedded Service	(Average #of beds filled /# of beds in service)x100
Average Length of Stay	Average of number of days of admission per each patient on service.
Hours of Service per week	Total number of hours your service operates each week. Usually applies to outpatient, outreach, community or primary care based services.
Weekdays of Service Mon-Friday	Select if your service operates Mon-Fri. Usually applies to outpatient, outreach, community or primary care based services.
Weekend days of Service	Select Sat/Sun or Both as appropriate. Usually applies to outpatient, outreach, community or primary care based services.
# patients waiting at year end	Total number of unique patients with an accepted referral who were waiting for an initial visit as of the last day of the fiscal year (i.e. March 31, 2018).
Mean/Average Wait Time (days)	For the last ten patients seen in the fiscal year, take an average of the number of days between components (a) Date of referral and (b) Date of first appointment/admission. Calculated as: Days Waiting = (b) – (a) [expressed as a single value in days] (there will be one value for each patient) Average number of days waiting = [(days waiting for patient 1) + (days waiting for patient 2)…+ (days waiting for patient 10)] / 10
Location Address	Include your program's full street address – use a separate form for each location. This will help us to map the location of all services accurately.
Location Postal Code	Include your program's full postal code – use a separate form for each location. This will help us to map the location of all services accurately.
Upload Attachments	Include additional descriptive information if available such as program description/overview, descriptions of integration with specialty services (geri-med & geri-psych, other specialty) and primary care, leadership structure, enablers, key characteristics of success, service barriers etc.
FTEs	Include the FTE count for each health professional discipline working in your program or service. Assume 1950 hours/year = 1.0 FTE. Note on physician FTEs: While physicians may not be funded through your program/service budget, if physicians are providing support or service integral to your program, please indicate the approximate FTE by specialty. For example 2 days per month would be (7.5 x 2 x 12)/1950 = 0.09 FTE

Specify	Use this field to provide a narrative description of any FTE information not captured in the fields above.
Upload Client Success Story	Using the template provided, submit one anonymized success story from the 2017/18 fiscal year. This information will help to round out the qualitative description of the contribution of SGS programs and services to the care of older people living with frailty.
Comments	Use this box to share any additional information that will make interpretation of your program data more accurate (e.g. context, unusual circumstances, and additional details).

Field	**Definition**
Facility	Enter the corporate name of the organization hosting your specialized geriatric service.
Fiscal	Select 2017/18.
Load Form	Select this button to open a data entry form.
Organization	This is the organization attached to your user account. This is established at registration and is not edited.
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Average Length of Stay	Average of number of days of admission per each patient on service.

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Location Address	Include your program's full street address – use a separate form for each location. This will help us to map the location of all services accurately.
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Specify	Use this field to provide a narrative description of any FTE information not captured in the fields above.
Upload Client Success Story	Using the template provided, submit one anonymized success story from the 2017/18 fiscal year. This information will help to round out the qualitative description of the contribution of SGS programs and

	services to the care of older people living with frailty.
Comments	Use this box to share any additional information that will make interpretation of your program data more accurate (e.g. context, unusual circumstances, and additional details).