Grand River Community Health Centre

Société Alzheimer Society
BRANT, HALDIMAND NORFOLK, HAMILTON HALTON

RGPCentral
REGIONAL GERIATRIC PROGRAM

# Seniors Assessment Service Brantford

Presentation for PGLO Webinar: Models and Examples of Integrated Community Geriatric Teams (Part 2)

June 10, 2025

Dr. Cailin Campbell and Dr. Mihaela Nicula

# Brant and Haldimand-Norfolk Counties

| | | Population (P=Projection) | | | | Estimated Population Living with Frailty | | |
|---|---|---|---|---|---|---|---|---|
| Census Division | Age group | 2024 | 2030 | 2040 | Prevalence of Frailty (proxy) | 2024 | 2030 | 2040 |
| **Haldimand-Norfolk** | Subtotal 65-74 (all) | 18,242 | 20,359 | 17,769 | 0.16 | 2,919 | 3,257 | 2,843 |
| | Subtotal 75-84 (all) | 10,194 | 13,277 | 17,205 | 0.286 | 2,915 | 3,797 | 4,921 |
| | Sub total 85+ (all) | 3,199 | 4,384 | 7,748 | 0.521 | 1,667 | 2,284 | 4,037 |
| | County Total | 31,635 | 38,020 | 42,722 | | 7,501 | 9,339 | 11,800 |
| **Brant** | Subtotal 65-74 (all) | 18,160 | 21,253 | 20,389 | 0.16 | 2,906 | 3,400 | 3,262 |
| | Subtotal 75-84 (all) | 9,939 | 12,908 | 17,793 | 0.286 | 2,843 | 3,692 | 5,089 |
| | Sub total 85+ (all) | 3,703 | 4,403 | 7,476 | 0.521 | 1,929 | 2,294 | 3,895 |
| | County Total | 31,802 | 37,801 | 45,658 | | 7,677 | 9,386 | 12,246 |
| **Total 2 Counties** | Regional Total | 63,437 | 75,821 | 88,380 | | 15,178 | 18,725 | 24,046 |

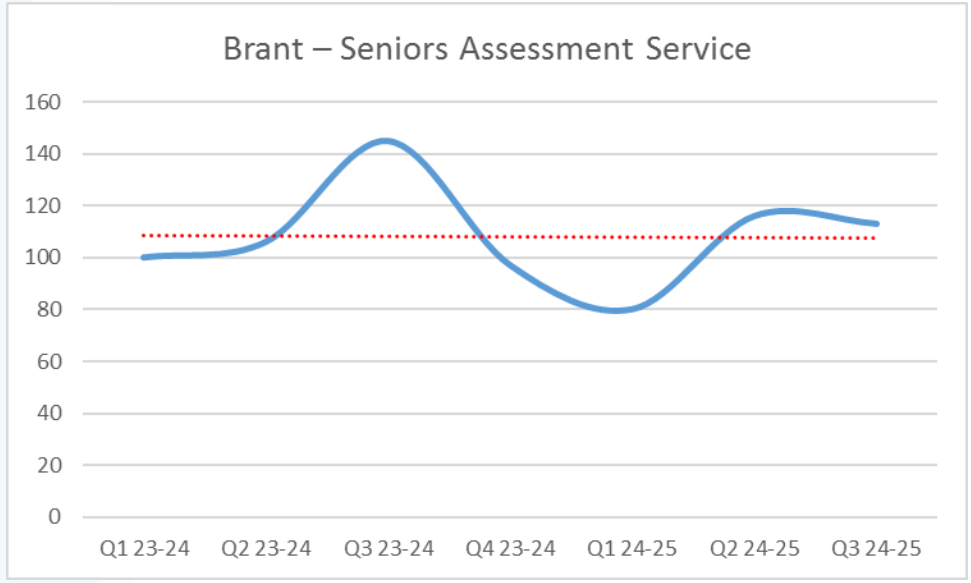
Sources: Statistics Canada for 2023 and Ontario Ministry of Finance projections (Fall 2024).
This analysis made use of work by Hoover, M., Rotermann, M., & Sanmartin, C.. (2013). Validation of an index to estimate the prevale frailty among community-dwelling seniors. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2013009/article/11864 eng.pdf?st=OvvKzg6_

# Seniors Assessment Service

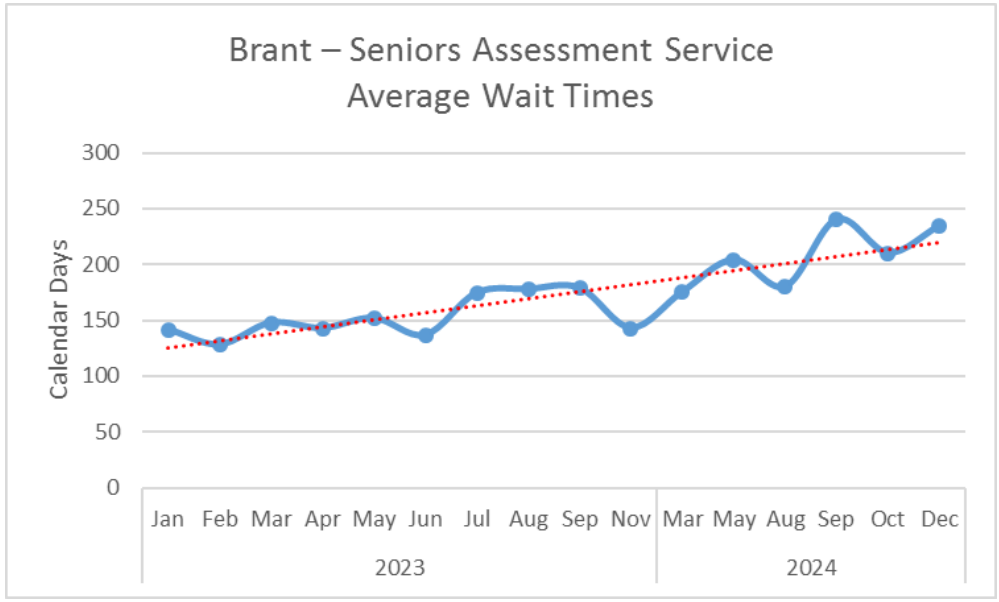
Grand River Community Health Centre

- Specialized Geriatric Services serving Brantford and Brant County
- Interprofessional Team: RNs, Psychogeriatric consultants, OT, COEs, Geriatrician
  - Memory Clinic- MINT Clinic Model, COE Dr. A. George, 1 day/week
  - Geriatric Clinic- CGA model, Geriatrician Dr. M. Nicula, COE Dr. C. Campbell, 1 day/week
- Staff competencies: interprofessional CGA, MINT Clinics training
- Operations supported by GRCHC (space, admin support, staff)
- Partners:
  - RGP Central Clinical Intake (coordination of referrals, summary of information available from primary care provider and Clinical Connect, information regarding the circle of care)
  - Alzheimer Society of BHNHH (dementia resource consultants)
- Referrals initiated by Primary Care Practitioners, hospital, etc.

# Growing Demand for Specialized Geriatric Services




Referrals from CCI




Waiting Times

RGPCentral
REGIONAL GERIATRIC PROGRAM

# Seniors Assessment Service

Grand River Community Health Centre

| | 2013-2022 | FY 22 - 23 | FY 23-24 | FY24-25 |
|---|---|---|---|---|
| Physicians | 0.2 FTE COE | 0.2 FTE COE<br>0.2 FTE Geriatrician | 0.2 FTE COE x2<br>0.2 FTE Geriatrician | 0.2 FTE COE x2<br>0.2 FTE Geriatrician |
| RN | 0.4 FTE | 0.6 FTE | 0.8 FTE | 0.8 FTE |
| Alzheimer Society Staff Support | 0.4 FTE | 0.6 FTE | 0.6 FTE | 0.6 FTE |
| OT | N/A | N/A | N/A | 0.1 FTE |
| Admin Support | N/A | 0.4 FTE | 0.4 FTE | 0.4 FTE |

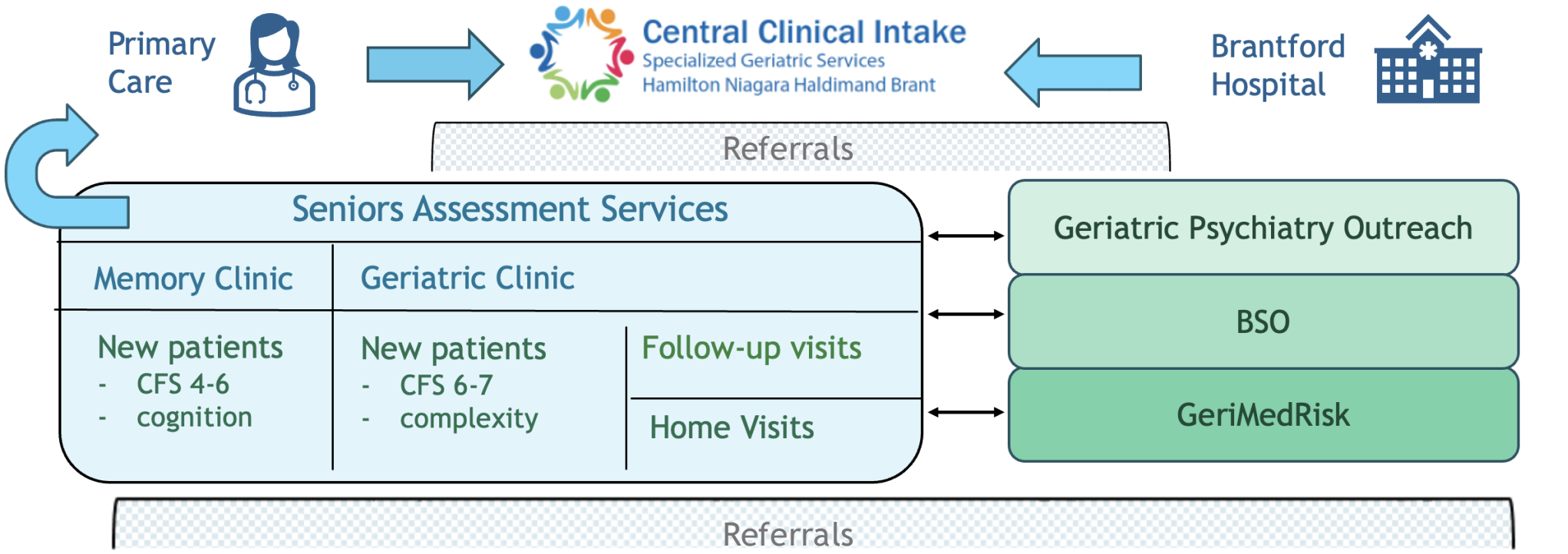
# Our Process

- Triage
  - Based on CCI summary (complexity, urgency, patient ability to come to the clinic)
  - Memory clinic vs. Geriatric clinic (clinic vs. home visit)
  - Completed by clinical coordinator (RN)
  - Some referrals need to be reviewed by other members of the team (Geriatrician, COE)
- Scheduling of clinic visit/home visit
- Pre-visit phone call with patient/care partner (~20-30 min)
  - RNs, AS Staff
- Chart preparation in EMR on template for interprofessional CGA

# Our Process

- Geriatric Clinic visit (90 min)
  - Identify major concerns and obtained a more detailed history
  - BPMH
  - Physical examination, postural VS, gait examination
  - Cognitive testing
  - Debriefing, counselling
  - Book follow-up visit if necessary
- Documentation
  - Summary of recommendations and written information regarding diagnosis and resources provided to patient/care partner
  - Detailed assessment (CGA) sent to PCP/primary source of referral
- Initiate referrals

# Integration of Seniors Assessment Service in Brantford




Alzheimer's Society | Ontario Health atHome | Day Programs

Investigations | Specialty clinics | Other

# Pilot Project Geriatric Clinic Geriatrician/COE Model

Grand River Community Health Centre

Geriatrician: referrals from community for poly-morbidity, polypharmacy, falls, dementia (Parkinson Plus, FTD, NPH), BPSD

COE: referrals from community for MCI, early stages Alzheimer's, BPSD
referrals from BCHS for patients who had a CGA in hospital
follow-up of patients who had CGA in the clinic

| Category | Jan- Jun 2023 | Jan- Jun 2024 | | |
|---|---|---|---|---|
| | Geriatrician | Total | Geriatrician | COE |
| Total new patients | 63 | 100 | 69 | 31 |
| Follow-up visits | 69 | 70 | 12 | 58 |
| Home visits | 0 | 3 | 0 | 3 |

# Seniors Assessment Services Volumes and Waiting Times

Grand River Community Health Centre

| Seniors Assessment Services Statistics FY 2024-2025 | | | | | |
|---|---|---|---|---|---|
| Category | Memory Clinic | Geriatric Clinic | | | SAS |
| | COE | COE | Geri | Total | Total |
| New consults | 157 | 34 | 118 | 152 | 309 |
| Home visits | 0 | 21 | 0 | 21 | 21 |
| F/U in person | 0 | 72 | 30 | 102 | 102 |
| F/U phone | ? | 40 | 21 | 61 | >61 |
| F/U virtual | 0 | 1 | 5 | 6 | 6 |
| Waiting list end FY | 82 | - | - | 77 | 159 |
| Waiting time | 6 months | 4 months | 8 months | 6 months | 6 months |
| Urgent visit waiting | 4 weeks | 4 weeks | 4-6 weeks | 5 weeks | 4-5 weeks |

# SWOT analysis

| | |
|---|---|
| **Strengths**<br>• Patient centered care<br>• Staff retention<br>• Senior leadership support at GRCHC<br>• Collaborations: AS, RGPc<br>• Ongoing education (yearly MINT Clinic Symposium)<br>• Home visits | **Weaknesses**<br>• EMR (PSS) does not input on Clinical Connect<br>• Process for triaging patients<br>• Space<br>• Virtual consults underutilized |
| **Opportunities**<br>• New location (GRCHC leased new building)<br>• Expand collaboration with other stakeholders: OHT, Ontario Health at Home, BCHS/Hospital to Home | **Threats**<br>• Funding for current resources |