Older Adults in Ontario: An Emerging Data Story

Presented by:
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v.2026-02-22

OBJECTIVE

To recognize and respond to the needs of older adults living with complex health conditions (e.g., dementia, frailty, seniors' mental health conditions) by:

- Generating important questions
- Identifying existing data and gathering new data to fill data gaps
- Analyzing and sense making

*Sharing work in progress to spark generative conversation!

RECOGNIZING and RESPONDING: To the need of older adults

Questions

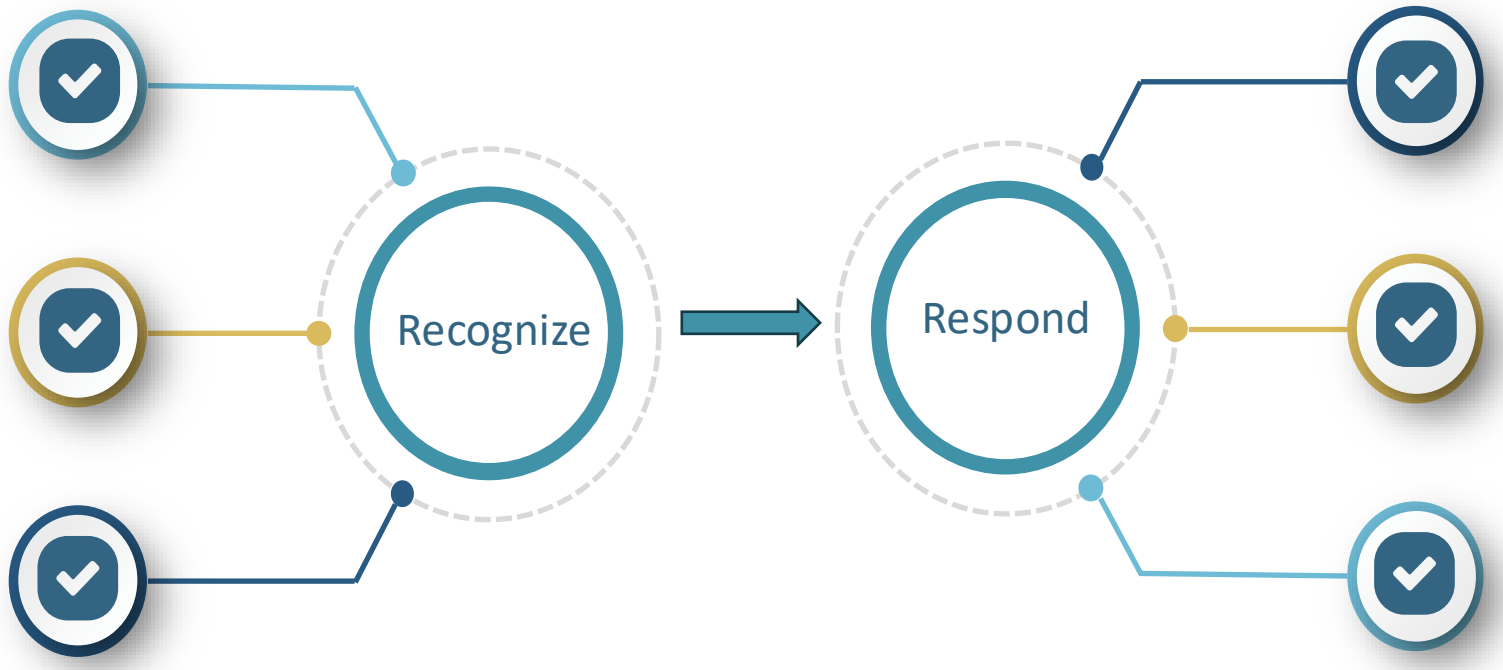
Asking important questions about the needs and experiences of the older adult population

Data

Gathering existing and new data

Analysis

Sense making with data to enable response



Programs & Services

Based on integrated designs reflecting the needs of older adults living with frailty, dementia and seniors' mental health conditions

Education

About the care of older adults, for health professionals and care partners

Advocacy

For quality standards, new partnerships and right-sized resources to address demand

RECOGNIZING

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Clinical conditions of interest (scope)

- Conditions that are impactful to individuals and health systems (e.g., frailty, dementia, seniors' mental health conditions)

Demand and supply information (capacity planning)

- How many older adults are living with frailty in Ontario?
- How many people live with dementia in Ontario?
- How many older people are living with mental health conditions in Ontario?
- What programs and services exist to address the unique needs of these individuals?
- What is the access to existing programs? Are there problem areas?
- What is the anticipated future demand?
- What are new options to address demand?

RECOGNIZING

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Data Sources Examined

- Ontario Health Team reports (Ontario Health)
- Dementia reports (Alzheimer Society of Ontario)
- Dementia Capacity Planning Tool (MOH Health Data Science Branch)
- Hospital Frailty Risk Measure (HFRM) (CIHI)

Data Sources Leveraged

- Applied Health Research Question (ICES)
- Health Analytics Branch Data Requests (MOH Health Analytics Branch)

Data Sources Created

- PGLO Specialized and Focused Geriatric Services Asset Inventory
- PGLO Frailty Estimates

REPORTED DATA CHALLENGES

"Its very difficult to find. I have to beg and knock on doors and phone-a-friend approach"

"Challenging, we try to mine it from our hospital organization EMR via PowerBI but lack of robust databases limit our ability to pull helpful data"

"Some reports are available however very minimal. Tend to recycle same data over and over"

"Lotsa acronyms"

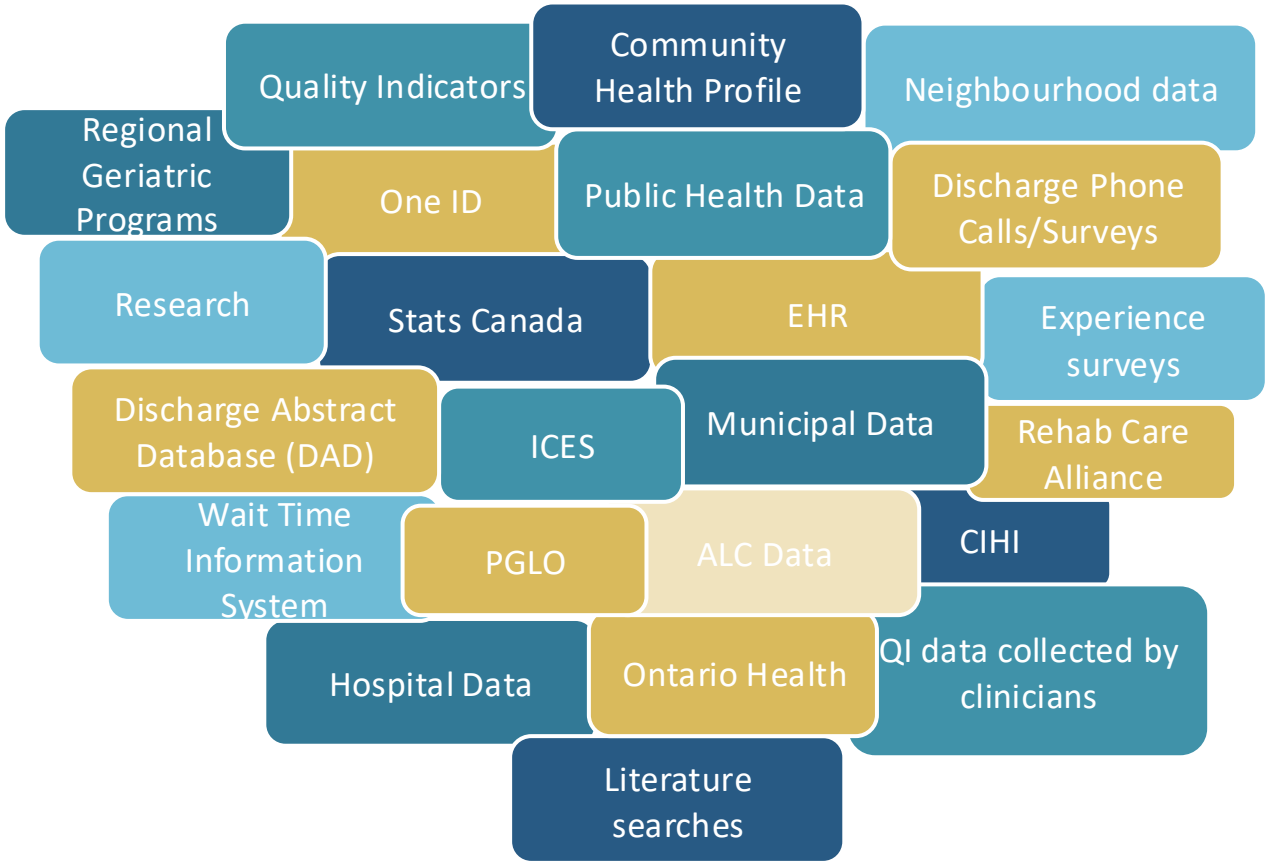


Figure 1: Current Data Sources Accessed by Health Leaders in Geriatric Services

RECOGNIZING

Questions

Asking important questions about the needs and experiences of the older adult population

Data

Gathering existing and new data

Analysis

Sense making with data to enable response

- Calculations
- Visualizations
- Interpretations
- Validations
- Limitations
- Forecasting
- Predictive modelling
- Machine learning

ONTARIO

2023-2024

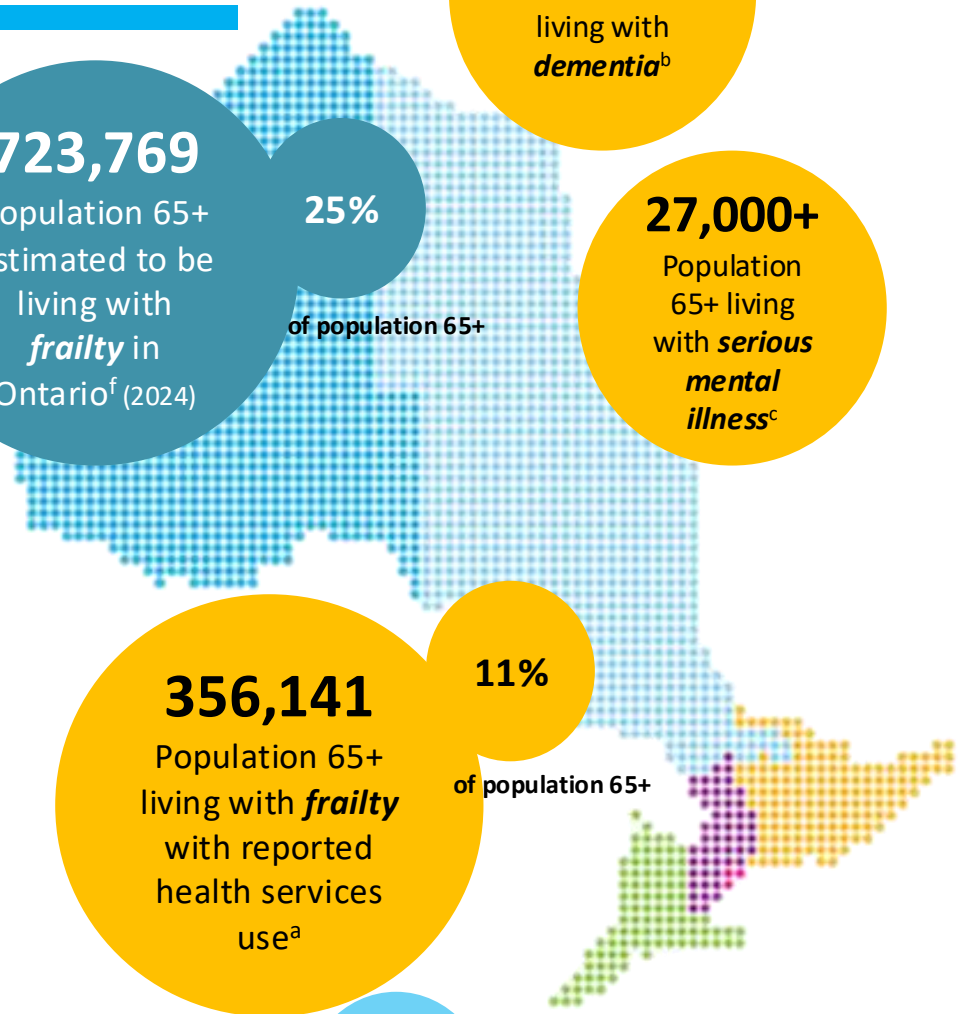
↑↓ Favourable change from prior year
↑↓ Unfavourable change from prior year

334,500
Individuals living with ***dementia***[b]

723,769
Population 65+ estimated to be living with ***frailty*** in Ontario[f] (2024)

25%
of population 65+

27,000+
Population 65+ living with ***serious mental illness***[c]



356,141
Population 65+ living with ***frailty*** with reported health services use[a]

11%
of population 65+

Key Takeaway

- Administrative data captures 48–64% of the population living with frailty, indicating there may be **unmet or unreported demand** for services.

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)[e]	**2 Respite Beds per 10,000**[e]	Older adults with frailty with 2 or more ED visits/per year[a]	Older adults with frailty readmitted to hospital within 30 days[a]
53.5% ↑	**140** ↓		**19,986 (6%)** ↑	**9,986 (3%)** ↑

a. Ontario Health Team Reports 2026 b. Alzheimer's Society of Ontario 2024. c. ICES 2023 d. Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024 e. HAB Respite by Region 2018-2024. f. PGLO Frailty Estimates, 2026

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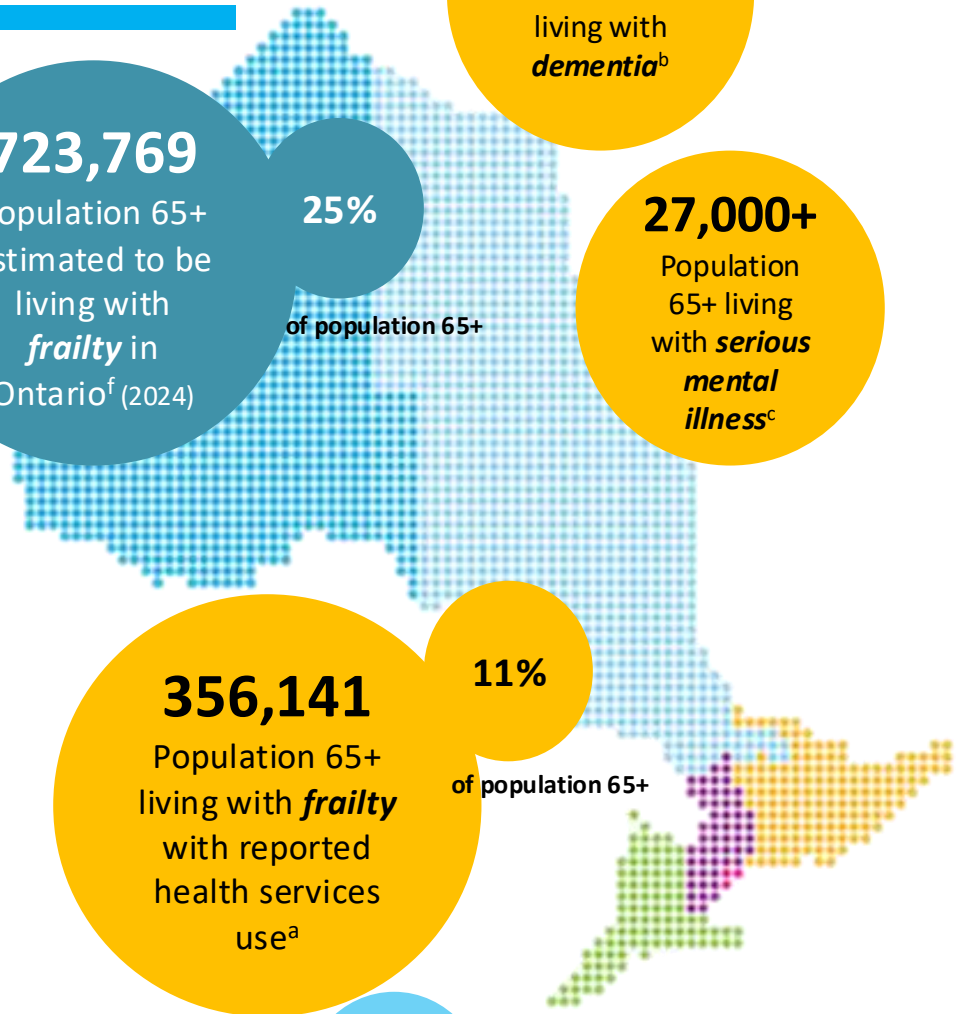

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Population 65+ living with ***frailty*** with reported health services use[a]

11%
of population 65+

138	392↑	2,449.6	142,697	585,166
Organizations providing data	Programs Reported	Full time equivalents (FTEs) of specialized interprofessional team members	Unique Patients Served	Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
60	78	30	184	12	28

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)[e]	2 Respite Beds per 10,000[e]	Older adults with frailty with 2 or more ED visits/per year[a]	Older adults with frailty readmitted to hospital within 30 days[a]
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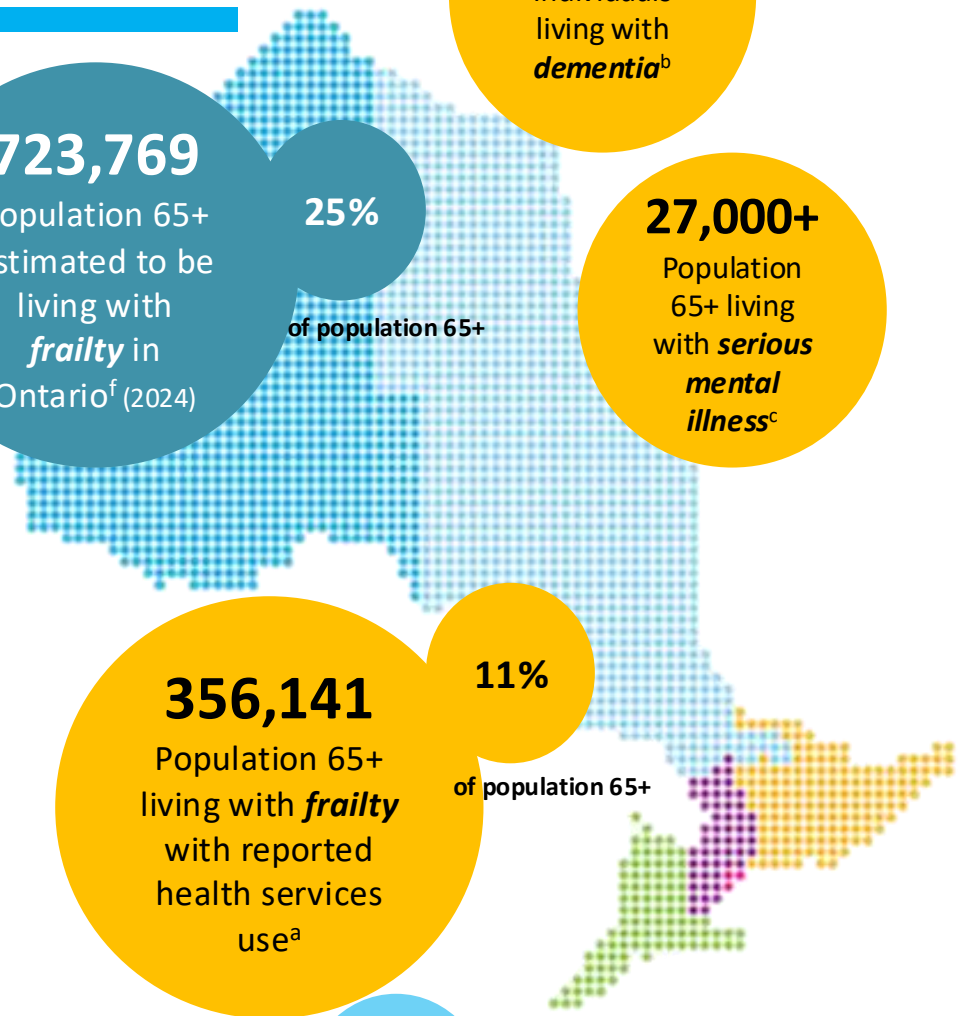

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142,697
Unique Patients Served

585,166
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)[e]	2 Respite Beds per 10,000[e]	Older adults with frailty with 2 or more ED visits/per year[a]	Older adults with frailty readmitted to hospital within 30 days[a]
53.5% ↑	140 ↓		19,986 (6%) ↑	9,986 (3%) ↑

Key Takeaway

- SGS and SMH services currently reach 8–53% of adults 65+ living with frailty, suggesting **significant gaps in clinical service coverage**.

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CENTRAL

2023-2024

↑↓ Favourable change from prior year
↑↓ Unfavourable change from prior year
Rates negatively exceed provincial rate

176,209+
Population 65+ estimated to be living with ***frailty*** in Central[f] (2024)

73,236
Population 65+ living with ***frailty*** with reported health services use[a]

10%
of population 65+

2.5%↑
Older adults with frailty - repeat ED visits due to falls[a]

6.5%↑
Older adults with frailty - hospitalized due to falls[a]

29
Organizations providing data

82↑
Programs Reported

398.2
Full time equivalents (FTEs) of specialized interprofessional team members

38,444
Unique Patients Served

164,239
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
11	21	4	34	4	8

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)[e]	Older adults with frailty with 2 or more ED visits/per year[a]	Older adults with frailty readmitted to hospital within 30 days[a]
60.8%↑	22↓	3,792 (5%)↑	1,981 (3%)↑

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WEST

2023-2024

↑↓ Favourable change from prior year
↑↓ Unfavourable change from prior year
Rates negatively exceed provincial rate

207,768+
Population 65+ estimated to be living with ***frailty*** in West[f] (2024)

101,437
Population 65+ living with ***frailty*** with reported health services use[a]

12%
of population 65+

2.8%↑
Older adults with frailty - repeat ED visits due to falls[a]

7.0%↑
Older adults with frailty - hospitalized due to falls[a]

26
Organizations providing data

52↑
Programs Reported

315.7
Full time equivalents (FTEs) of specialized interprofessional team members

15,372
Unique Patients Served

65,814
Clinical Visits Provided

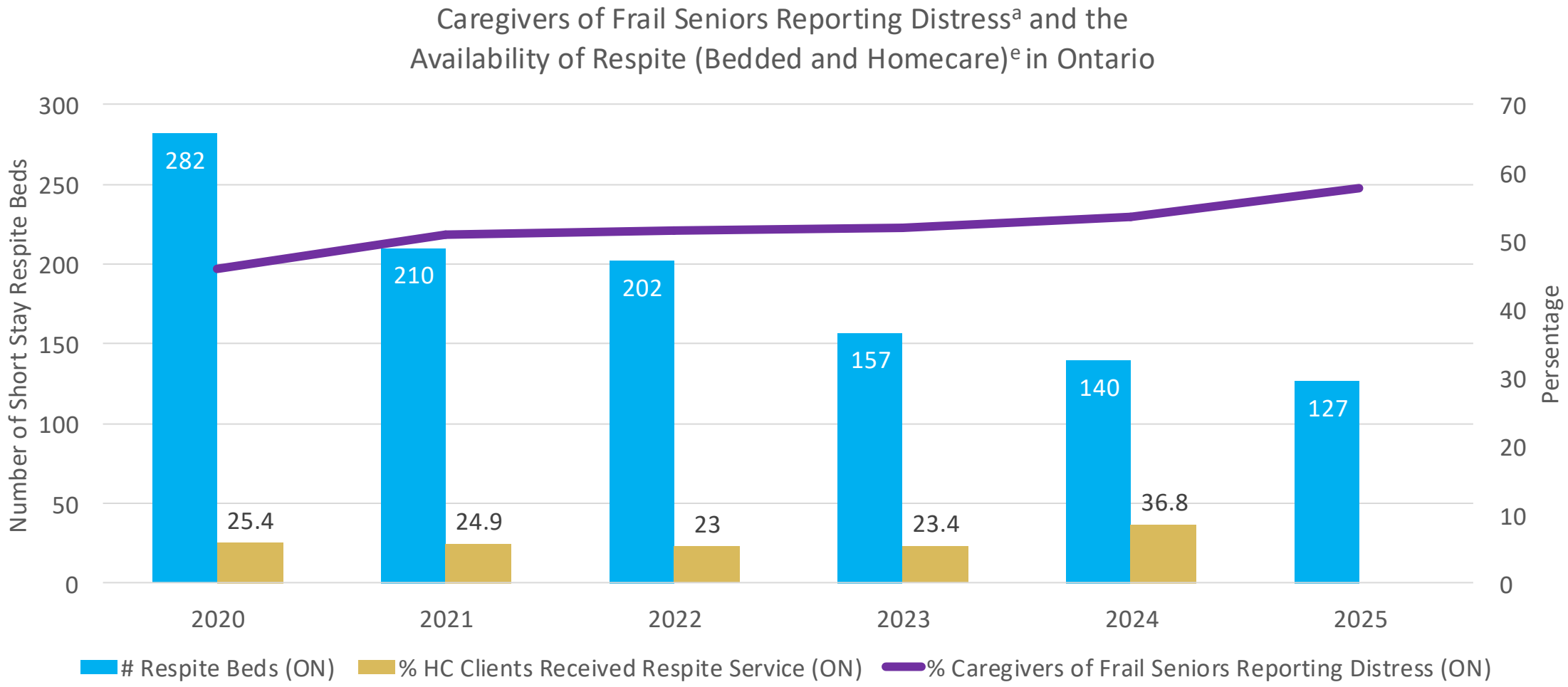
SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
13	10	5	20	1	3

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)	Older adults with frailty with 2 or more ED visits/per year[a]	Older adults with frailty readmitted to hospital within 30 days[a]
55.9%↑	26↓	5,881 (6%)↓	2,782 (3%)↑

a. Ontario Health Team Reports 2026 b. Alzheimer's Society of Ontario 2024. c. ICES 2023 d. Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024 e. HAB Respite by Region 2018-2024. f. PGLO Frailty Estimates, 2026

CAREGIVER DISTRESS - FRAILTY



a. Ontario Health Team Reports 2026 e. HAB Respite by Region 2018-2024

DEMAND - FRAILTY

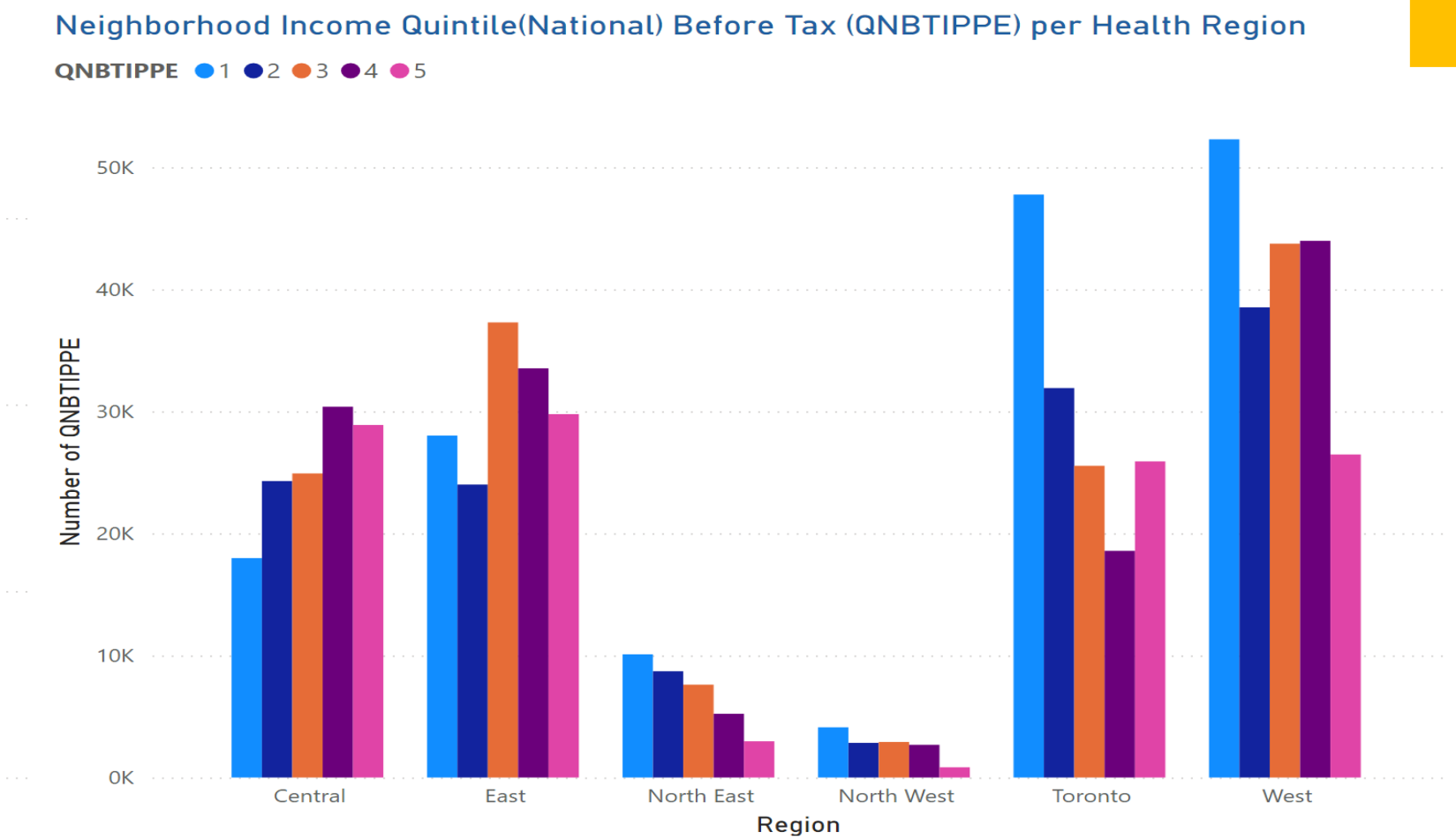
Key Takeaways

- In 2023-2024, approximately 46.2% of hospitalized older adults (age 65+) (164,246 individuals) had 6 or more deficits, placing them in among the highest risk groups for frailty[1].
- This level of frailty suggests the need to prioritize **frailty-focused care in emergency departments and acute care settings**, drawing on **proactive frailty-screening** and response aligned with **proven clinical models**.

[h] CIHI Hospital Frailty Risk Measure (HFRM) (CIHI, 2025)

DEMAND - DEMENTIA

Community Dwelling Persons Living with Dementia by Socio-Economic Variables (2019)[g]



Key Takeaways

- Current data may not adequately reflect the demand for rural and remote services in the North.
- Higher levels of people living with dementia in lower income quintiles (e.g. 1-3) impact **the ability to pay out of pocket for supports** (e.g. Adult Day Programs, additional home care)

g. Dementia Capacity Planning Tool (MOH Health Data Science Branch, 2024)

WAIT TIMES HEAT MAP

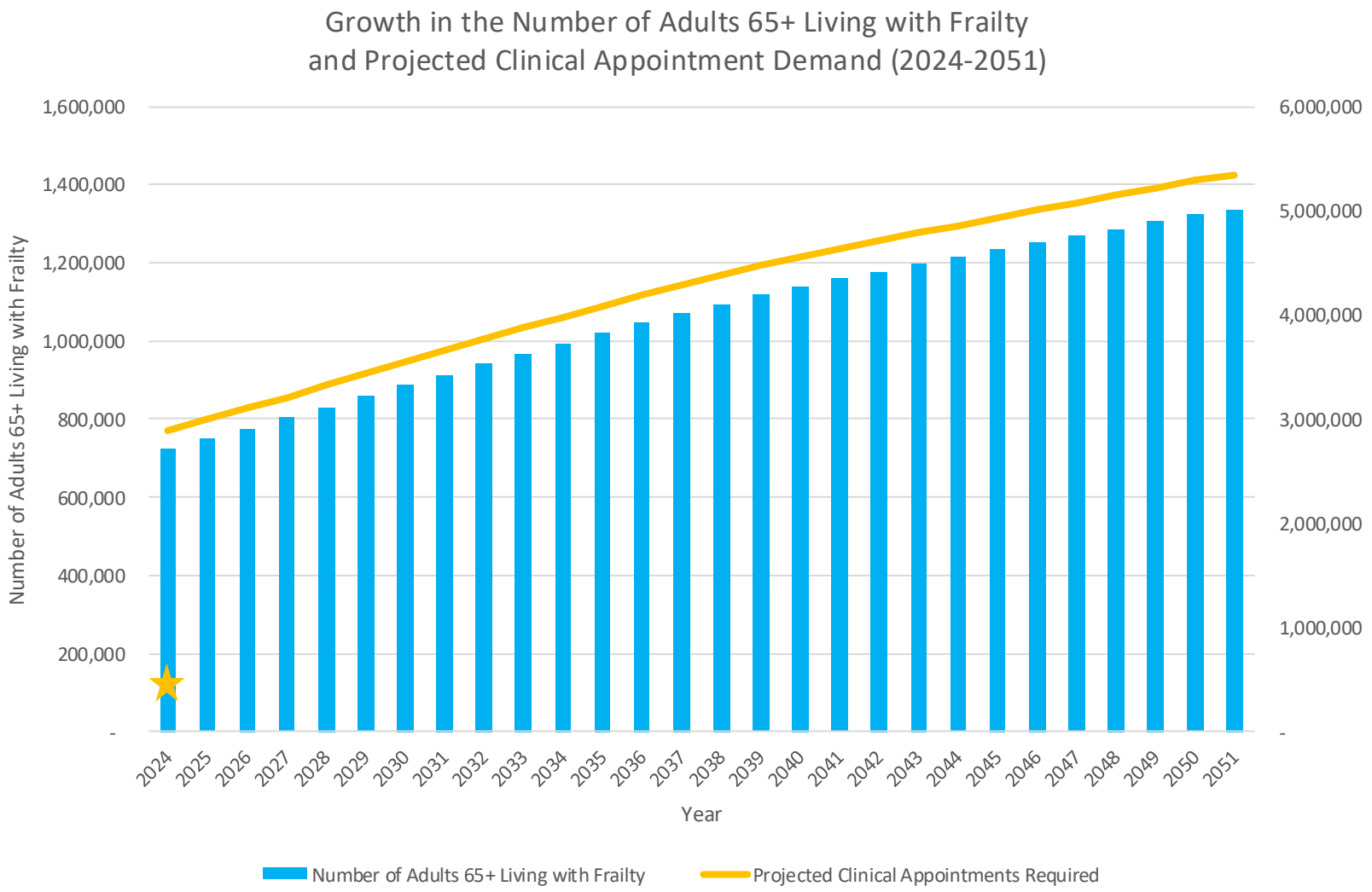
2023-2024

Key Takeaways

- Wait times of 3-7 days in acute care can **add to length of stay.**
- Considerable wait times across **community** geriatric services signal **significant undersupply**, driving older patients to higher levels of care. Access to community programs may also add to **acute care LOS.**
- Wait times of 1-7 days+ in urgent/emergent care can impact **EDLOS and ED diversion** efforts.
- **Year-long wait times for falls prevention programs** are problematic given **rising falls rates** among older adults with frailty.
- Long waits for **SMH supports in LTC** contribute to challenges reported by the sector.
- Existing **primary care geriatric services** are **limited and oversubscribed** and few have **dedicated funding.**

Average Wait Time (Days) By Sector and Service Type	Regions					
	Central	East	North East	North West	Toronto	West
Acute Care						
Inpatient Geriatric Consultation Service/Virtual Ward			1			
Hospital Elder Life Program (HELP)	1		2	2	1	3
In-patient Geriatric Consult Services	2	2			4	2
Inpatient Geriatric Co-management Services			3			
Inpatient enhanced Geriatric Consult Services/Virtual Ward			7			
Geriatric Telemedicine/Telepsychiatry/e-Consult/Virtual Service				25		
Community Geriatrics						
Community Paramedicine (Linked with SGS)		3				
Geriatric Psychiatry/Mental Health Day Hospitals		14				
Geriatric Psychiatry/Seniors' Mental Health Outreach Teams		58		28	18	52
Geriatric Psychiatry Outreach Teams			50			
Geriatric Outreach Teams	80	88			25	7
Geriatric Psychiatry Outpatient Clinics	9	111			123	66
Specialist Based Memory Clinic Models					90	
Geriatric Medicine Day Hospitals	110	134	18	83	66	
Specialty Clinics					120	
Geriatric Outpatient Clinics	207	106	182	116	108	74
Integrated Geriatric Services						210
Exercise/Falls Prevention Clinic/Program	351	35				
Emergency Department						
Geriatric Emergency Management Programs		1				
Geriatric Urgent Care				7	25	
Long -Term Care						
Nurse Led Outreach Teams (NLOTS)	1					
Psychogeriatric Resource Consultants				20		
Post-Acute Care						
Geriatric Medicine Rehabilitation Units		5		2	5	4
Transitional Supports	22					
Tertiary Dementia or Geriatric Psychiatry Units		12			3	150
Behavioural Support Transition Unit	120					
Primary Care						
Population Health Focused Program (Older Adults)	90			7		
Primary Care Collaborative Memory Clinics (includes MINT clinics)	30	168				

DEVELOPING AN APPROACH TO FORECASTING - FRAILTY



Projected Clinical Appointment Demand

- People with frailty or dementia currently visit a physician approximately 12 times per year (ICES, 2023)
- High intensity (>12 contacts per year) does not consistently reduce utilization or costs.
- Moderate structured intensity (3-5 planned contacts per year), within **well-designed proactive integrated models** is associated with
  - Reduced ED visits and unplanned hospitalizations
  - Delayed or reduced transitions to residential care
  - Stabilized or improved frailty or function

★ Current volume of clinical visits reported by SGS and SMH programs[d]

[a.] OHT Reports (Ontario Health, 2025) [d.] Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024 [f.] Frailty Estimates (PGLO, 2026)

RESPONDING

Programs & Services

Based on integrated designs reflecting the needs of older adults living with frailty, dementia and seniors' mental health conditions

Education

About the care of older adults, for health professionals and care partners

Advocacy

For quality standards, new partnerships and right-sized resources to address demand

Provincial Specialized and Focused Geriatric Services Asset Inventory

- Collecting data on clinical programs across the continuum that serve older adults with frailty, dementia and seniors' mental health concerns
- New submissions invited April 1, 2026

Integrated Models

- Defining design elements of integrated care for older adults to inform service design.
- Promoting developing models of Primary Care Integrated Geriatric Teams.

Core Services Framework (new)

- Clearly articulating the clinical service requirements for dementia, frailty and seniors' mental health care to enable a planned and coordinated response to and support for health system priorities.
- We welcome collaborators in this work.

PROVINCIAL ASSET INVENTORY

Learn More Link

Data Collection Cycle

- Begins April 1, 2026 and closes July 30, 2026
- Requesting data for 2024-2025 and 2025-2026

Complete an access request here

Help us capture a complete picture of available clinical programs and services!

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Provincial Common Orientation to the Care of Older Adults

- A free workforce training series for health and social care professionals.
- Spring Cohort starts April 10 - registration open until April 1, 2026.

Caregiving Strategies

- Resources (handbook and on-line course) for caregivers of older adults living with frailty to help them with the people they are caring for.

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Supporting the Uptake of Clinical Guidelines and Quality Standards

Provincial Clinical Guidelines & Strategies for Older Adult Care

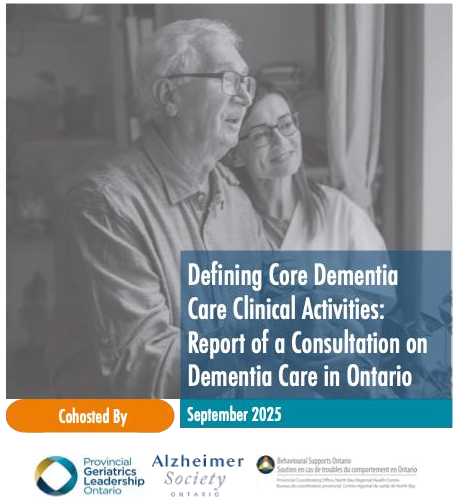
- Senior Friendly Care Framework (2017) and Senior Friendly 7 (2024);
- Assess & Restore Guideline (2014);
- Direct Access Priority Process (updated 2024);
- Competency Framework for Interprofessional Comprehensive Geriatric Assessment (2017);
- Design Elements of Integrated Care for Older Persons (2020);
- Rehabilitative Care Best Practice for Older Adults Living With/At-Risk of Frailty (2021);
- Post Fall Rehabilitative Care Pathways (updated 2024);
- Quality Standards:
  Dementia (updated 2024); Behavioural Symptoms of Dementia (updated 2024); Delirium (2021); Transitions from Hospital to Home (2020); Palliative Care (updated 2024), etc.;
- The Alternate Level of Care (ALC) Leading Practices Guide (Hospital - 2021), (Community – 2022);
- Behavioural Supports Ontario Provincial Practice Standards (2021)
- Behavioural Supports Ontario Core Competencies (2019)
- Frailty Screening & Management Guidance Documents (2024)

The Standard of Care for Older Adults Living with or At-Risk of Frailty: A Framework

Core Elements of Care	• Older Person & Care Partner Engagement • Equitable & Culturally Appropriate Care • Interprofessional Teams • Specialized Geriatric Expertise • Comprehensive Geriatric Assessment (CGA) • Evaluation
Processes of Care	• Early Identification • Comprehensive Assessment • Care Planning (includes Advanced Care Planning) • Intervention • Transitions
Domains of Care	• Cognition • Social Engagement • Mobility & Falls • Skin Integrity • Polypharmacy • Nutrition & Hydration • Delirium • Function • Continence • Pain • Mood & Mental Health • Sleep

Figure 1: Synthesis of Provincial clinical guidelines and strategies to define the Standard of Care for older adults living with/at-risk of frailty. [6,7,8,9,10,11,12,1314,15,16,17,18,19,20,21,22,23,24,25]

NESGC, 2025



- Focus on implementation supports with regional programs
- Forthcoming frailty and falls quality standards with Ontario Health
- Revised competency framework to support interprofessional practice

SUMMARY

- The **demand for frailty and dementia focused care is increasing**. Limited data about older adults living with mental health conditions is available, however clinicians and long-term care homes report increased need among this group.
- **Caregiver distress is increasing**
- There are **equity concerns** about access to clinical and other supports in rural and remote communities.
- A significant number of people living with dementia are in the **lower economic quintiles** and **cannot pay for needed supports** to remain living in place.
- **Additional skilled human resources are needed to support primary care** to respond to the needs of community-dwelling older adults living with dementia, frailty and seniors' mental health conditions, prevent unnecessary hospitalizations and enable aging in place**.**
- The **Asset Inventory is a useful planning tool**, and in conjunction with other data, informs capacity planning for clinical services for older adults in Ontario. It is only as useful as it is complete.
- There are tremendous opportunities to **co-develop integrated models** across traditional service lines (e.g. primary and specialty care) in service of older adults with complex needs.

Provincial Geriatrics Leadership Ontario. Connecting Expertise. Driving System Change.

Five Strategic Priorities 2026-2031

Performance

Fostering a high-performing care system for older adults and care partners

Data

Advancing equity and data driven decision-making

Partnerships

Strengthening partnerships with primary care to expand capacity and coordination

Innovation

Accelerating and spreading innovation across Ontario

Value

Clarifying and promoting the value of Ontario's network of specialized clinical services for older adults.

Four Core Activities 2026-2028

- Develop a plan for a core services framework for older adult specialized clinical care
- Build the PGLO Data and Analytics Program
- Accelerate integrated models with primary care
- Support the uptake of clinical guidelines and quality standards

A Shared Vision for the Future

Older adults in Ontario—regardless of location, background, or complexity of need—have timely access to integrated, compassionate, and evidence-informed care that supports their health, dignity, and quality of life.

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