Data Insights About Older Adult Specialized Clinical Services in Ontario:

Highlights from the Provincial Specialized and Focused Geriatric Services Asset Inventory and Other Sources

Supporting the planning and design of clinical services for dementia, frailty and seniors' mental health care in Ontario since 2018.

Summary Report including 2023-2024 Data Submissions

v.2026-02-26

BACKGROUND

Purpose: The **Provincial** Specialized and Focused Geriatric Services **Asset Inventory** (PAI) collects program data from all specialized geriatric services (SGS), seniors' mental health programs (SMH) and focused practice (older adult)/care of the elderly (FP-COE) primary care programs to inform a current state view of the supply and utilization of health services designed for older people living with complex health conditions (e.g. dementia, frailty, seniors' mental health conditions, etc.).

Quick Facts About the Provincial Asset Inventory:

- Data collection in the PAI began in 2018, at the request of the Ministry of Health.
- Designed and led by Provincial Geriatrics Leadership Ontario (PGLO).
- Receives data directly from programs and services via a secure customized web portal.
- The only data initiative focused solely on geriatric and seniors' mental health clinical services in the province
- A detailed PAI report can be downloaded from https://geriatricsontario.ca/initiatives/specialized-geriatric-services-asset-mapping-project/

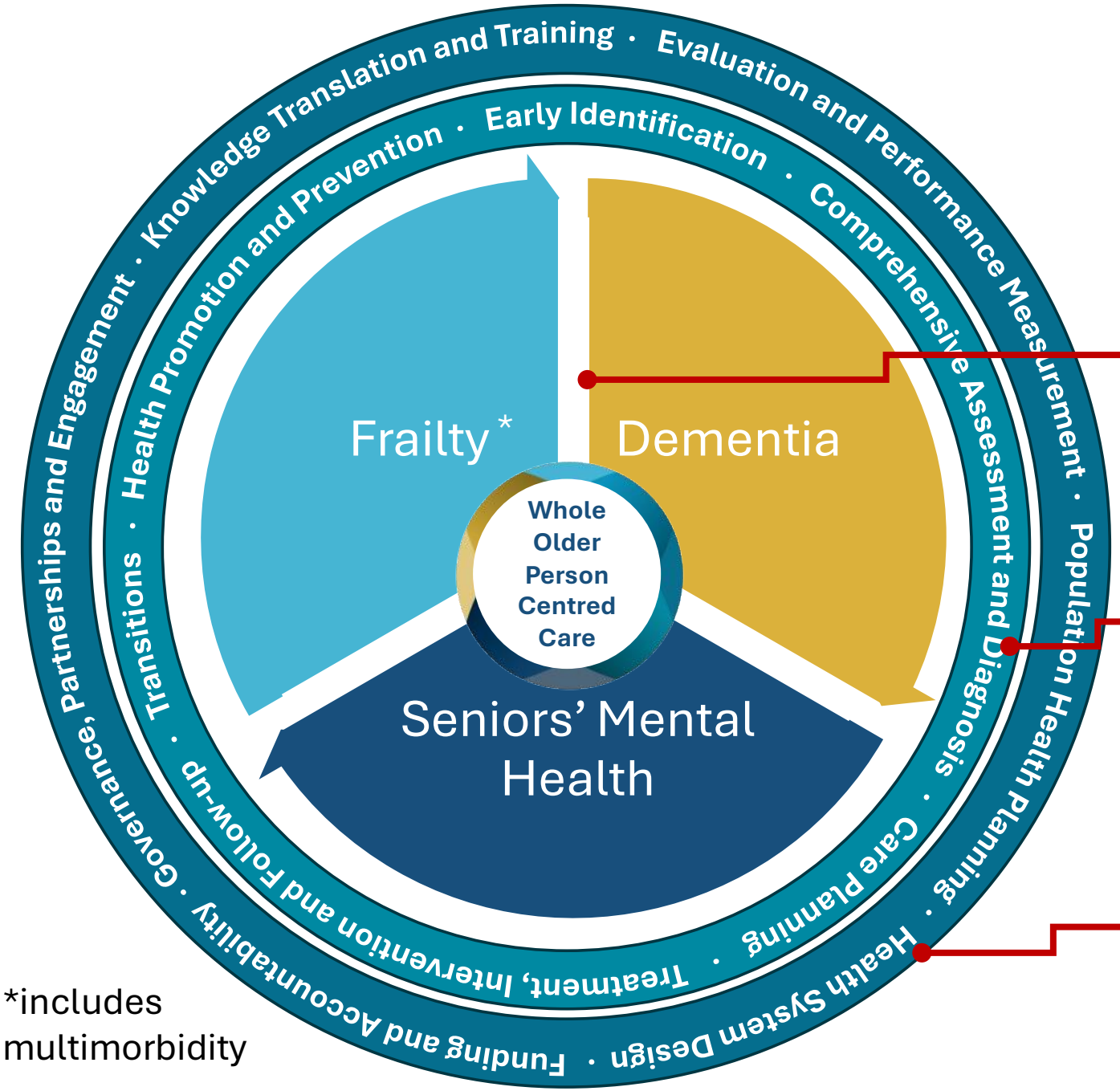
QUESTIONS ANSWERED

The PAI is designed to address important questions about the needs and experiences of the older adult population. The core clinical areas of focus are those conditions that are impactful to individuals and health systems (e.g., frailty, dementia, seniors' mental health conditions) and relevant to SGS and SMH.

Types of demand and supply (capacity planning) questions answered

- 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?

Core Clinical Areas of Focus in Specialized Geriatric Services and Seniors Mental Health



*includes multimorbidity

Defined clinical areas: key areas of clinical focus (dementia, frailty*, seniors' mental health) and mechanisms to recognize and respond to their co-occurrence in individuals (e.g., integrated approaches)

Core work: defined clinical activities that are provided to older adults living with complex conditions, carried out by SGS, SMH and FP-COE services in collaboration with primary care, home and community care and others.

Required system infrastructure: needed supports to enable clinical excellence, carried out by dedicated regional programs (e.g., Regional Geriatric Programs)

DATA SOURCES

This report includes data from several sources, compiled to illustrate the supply of and demand for older adult focused specialized clinical services (i.e., clinical services providing care to individuals living with frailty, dementia and seniors' mental health conditions). The list of data sources includes:

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 Provincial Specialized and Focused Geriatric Services Asset Inventory (PAI)
- PGLO Frailty Estimates

PROGRAM DATA SOURCES (SGS, SMH, FP-COE)

d. Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024

Primary Care Programs

MINT Memory Clinics
Other Primary Care Memory Clinics
Primary Care Geriatric Assessors
Sessionally-funded Primary Care SGS

Long Term Care Programs

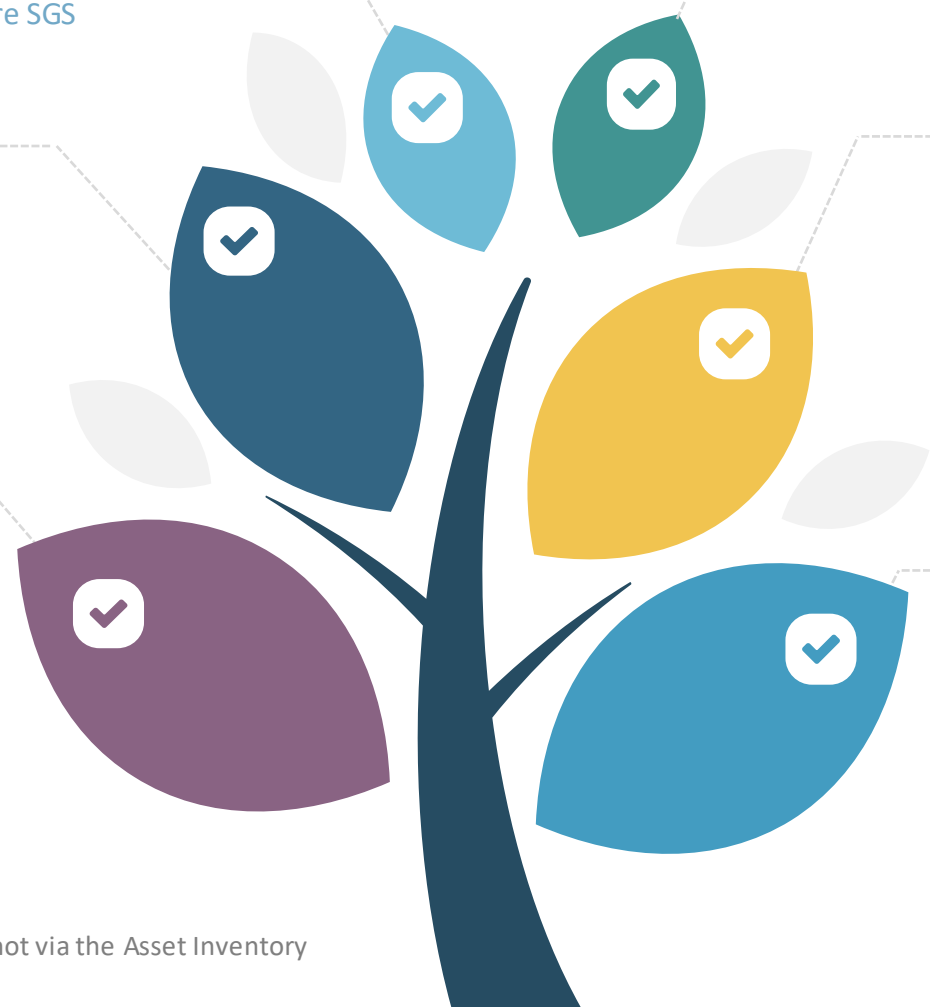
Behavioural Supports Ontario (BSO)*
Nurse Led Outreach Teams (NLOTs)
Psychogeriatric Resource Consultants

Rehabilitation & Post Acute Care Programs

Behavioural Support Transitional Units
E-Geriatric Consult/Telehealth Services
Geriatric Behavioural Units
Geriatric Medicine Rehabilitation Units
Specialist Based Memory Clinic Models
Tertiary Seniors Specialty Units
Tertiary Dementia Specialty Units
Tertiary Non-Dementia Geriatric Psychiatry Units

Emergency/Urgent Care Programs

Geriatric Emergency Management (GEM)
Urgent Care Geriatrics Clinics



Acute Care Programs

Acute Geriatric Psychiatry
Acute Care of the Elderly/Geriatric Units
Behavioural Supports Ontario*
Geriatric Assessment and Treatment Units
Hospital Elder Life Program
Inpatient Geriatric Co-Management Services
Inpatient Geriatric Medicine/Psychiatry Consults

Community Geriatrics Programs

Behavioural Supports Ontario (BSO)*
Community Paramedicine (Linked to SGS)
Fall Prevention Clinics
Geriatric Medicine/Psychiatry Day Hospitals
Geriatric Medicine/Psychiatry Outpatient Clinics
Geriatric Medicine/Psychiatry Outreach Teams
Population Health Focused Programs (Older Adults)
- Delivered by primary care, Ontario Health Teams and others

Shared care geriatric mental health program

* BSO Program data is collected by the BSO PCO, and not via the Asset Inventory

ONTARIO

2023-2024

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

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

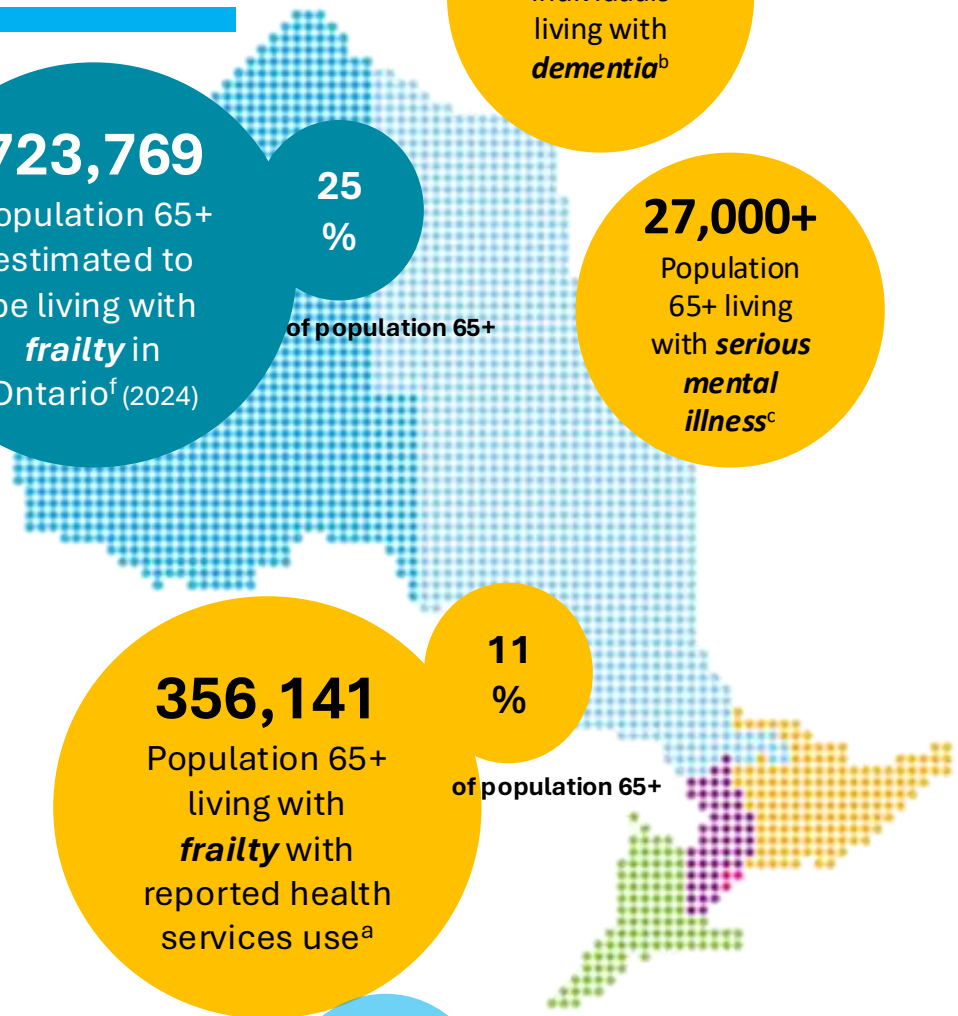
723,769
Population 65+ estimated to be living with ***frailty*** in Ontario[f] (2024)

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+



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	Rehabilitation & Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
60	78	30	18 4	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]
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

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	Rehabilitation & 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%)↑

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

EAST

2023-2024

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

159,983✦
Population 65+ estimated to be living with ***frailty*** in East[f] (2024)

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

12%
of population 65+

3.0%↑
Older adults with frailty - repeat ED visits due to falls[a]

6.7%↑
Older adults with frailty - hospitalized due to falls[a]

33
Organizations providing data

66↓
Programs Reported

643.1
Full time equivalents (FTEs) of specialized interprofessional team members

29,083
Unique Patients Served

117,237
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Rehabilitation & Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
11	5	7	35	5	3

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]
44.2%↓	61↓	4,222 (6%)↓	1,907 (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

NORTH EAST

2023-2024

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

34,498+
Population 65+ estimated to be living with ***frailty*** in North East[f] (2024)

18,282
Population 65+ living with ***frailty*** with reported health services use[a]

13%
of population 65+

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

6.9%↑
Older adults with frailty - hospitalized due to falls[a]

26
Organizations providing data

51↑
Programs Reported

365.5
Full time equivalents (FTEs) of specialized interprofessional team members

12,737
Unique Patients Served

54,863
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Rehabilitation & Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
13	12	3	23	n/a	n/a

Caregivers reporting distress[a]	Short Stay Respite Beds (Total)[e]	Older adults with frailty with 2 or more ED visits/per[a]	Older adults with frailty readmitted to hospital within 30 days[a]
48.7%↓	19↓	918 (5%)↑	330 (2%)↑

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

NORTH WEST

2023-2024

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

12,366+
Population 65+ estimated to be living with ***frailty*** in North West[f] (2024)

7,234
Population 65+ living with ***frailty*** with reported health services use[a]

13%
of population 65+

2.7%↑
Older adults with frailty - repeat ED visits due to falls[a]

7.7%↑
Older adults with frailty - hospitalized due to falls[a]

4
Organizations providing data

21↓
Programs Reported

49.8
Full time equivalents (FTEs) of specialized interprofessional team members

5,954
Unique Patients Served

30,708
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Rehabilitation & Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
2	5	2	8	2	2

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]
40.2%↑	1	387 (5%)↑	117 (2%)↓

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

TORONTO

2023-2024

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

132,943+
Population 65+ estimated to be living with ***frailty*** in Toronto[f] (2024)

77,435
Population 65+ living with ***frailty*** with reported health services use[a]

12%
of population 65+

2.4%↑
Older adults with frailty - repeat ED visits due to falls[a]

6.6%↑
Older adults with frailty - hospitalized due to falls[a]

24
Organizations providing data

120↑
Programs Reported

677.3
Full time equivalents (FTEs) of specialized interprofessional team members

41,107
Unique Patients Served

152,305
Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Rehabilitation & Post-Acute Programs	Community Geriatrics Programs	Primary Care Programs	Long-Term Care Programs
10	31	9	64	1	12

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]
54.9%↑	11↓	4,353 (6%)↑	2,661 (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

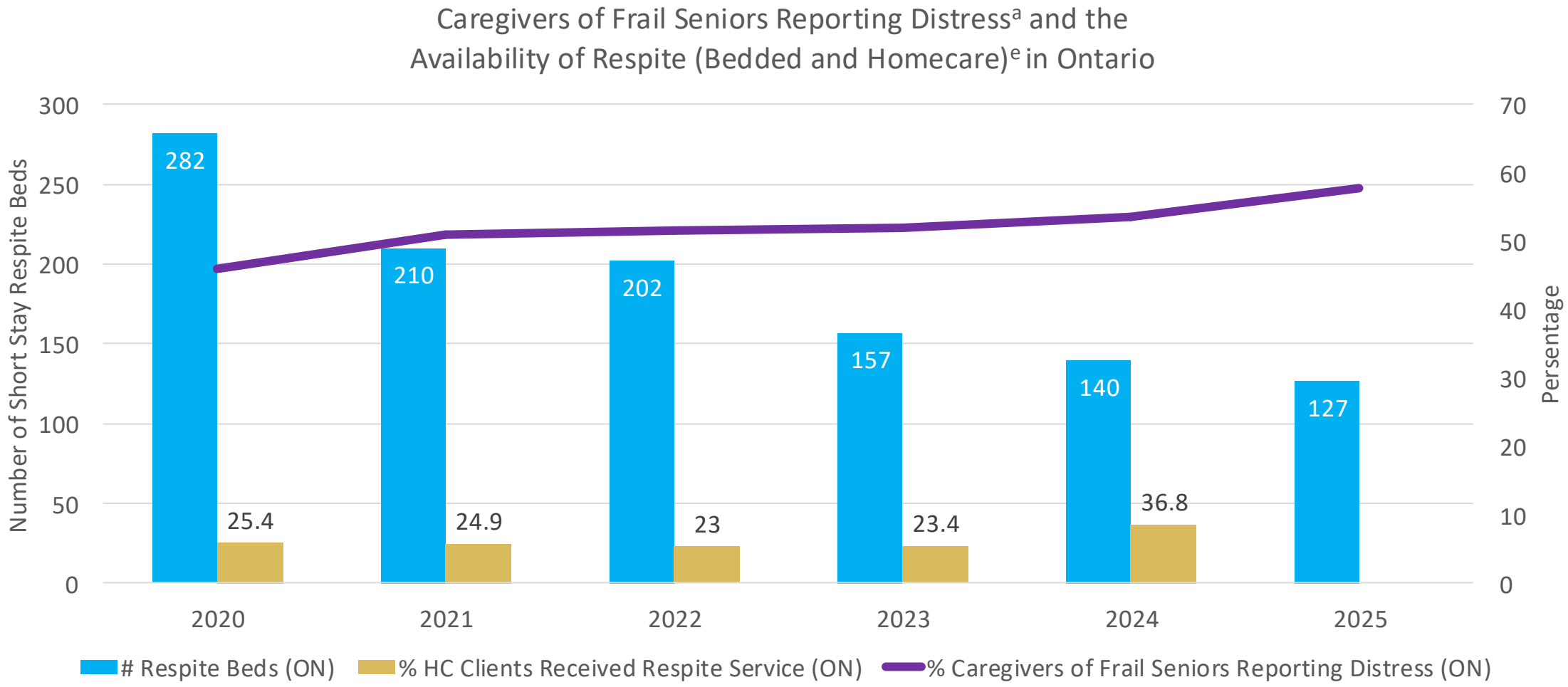
SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES[d]

Emergency/ Urgent Care Programs	Acute Care Programs	Rehabilitation & 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**.

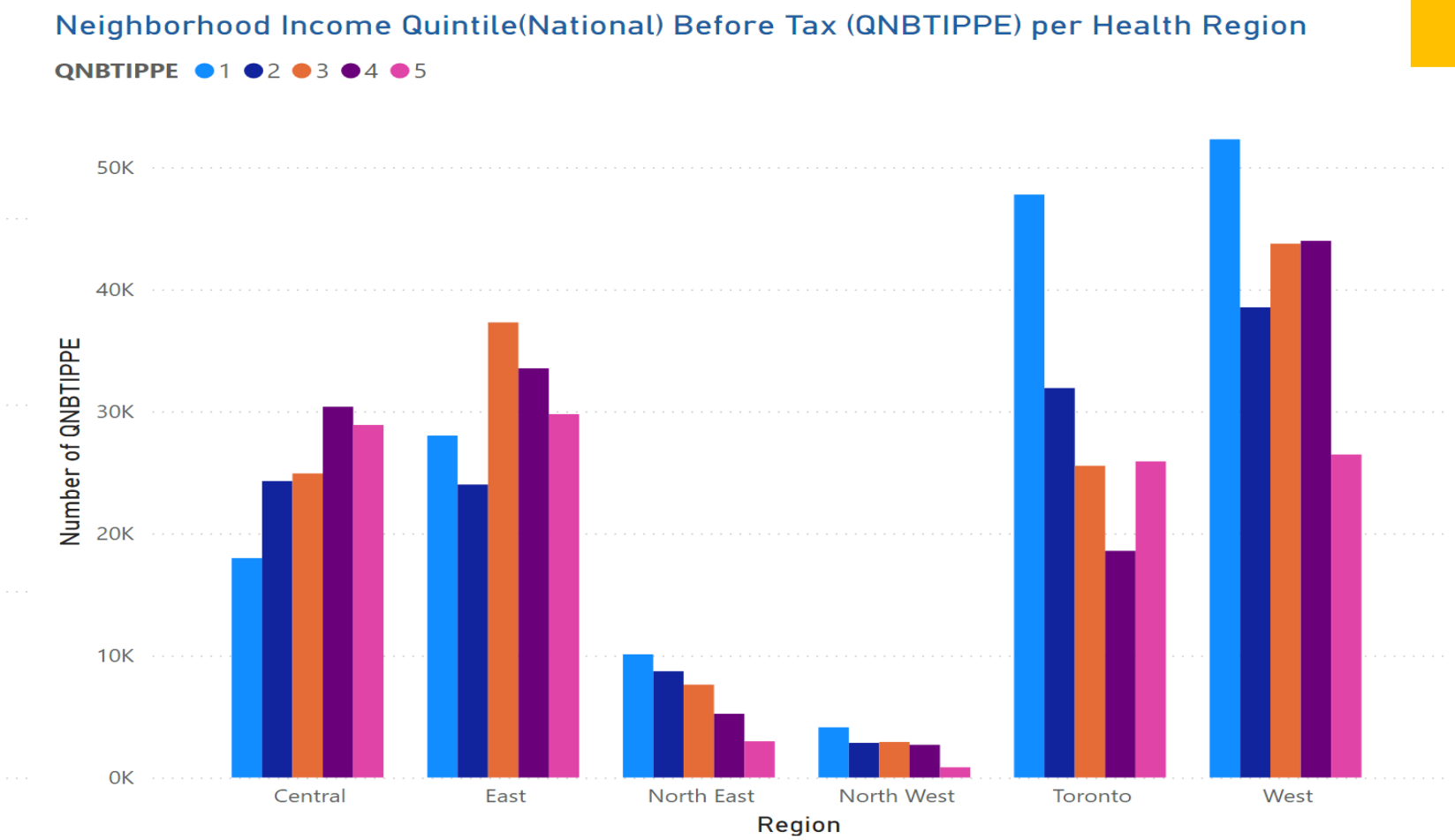
[h] CIHI Hospital Frailty Risk Measure (HFRM) (CIHI, 2025)

DEMAND - DEMENTIA

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)

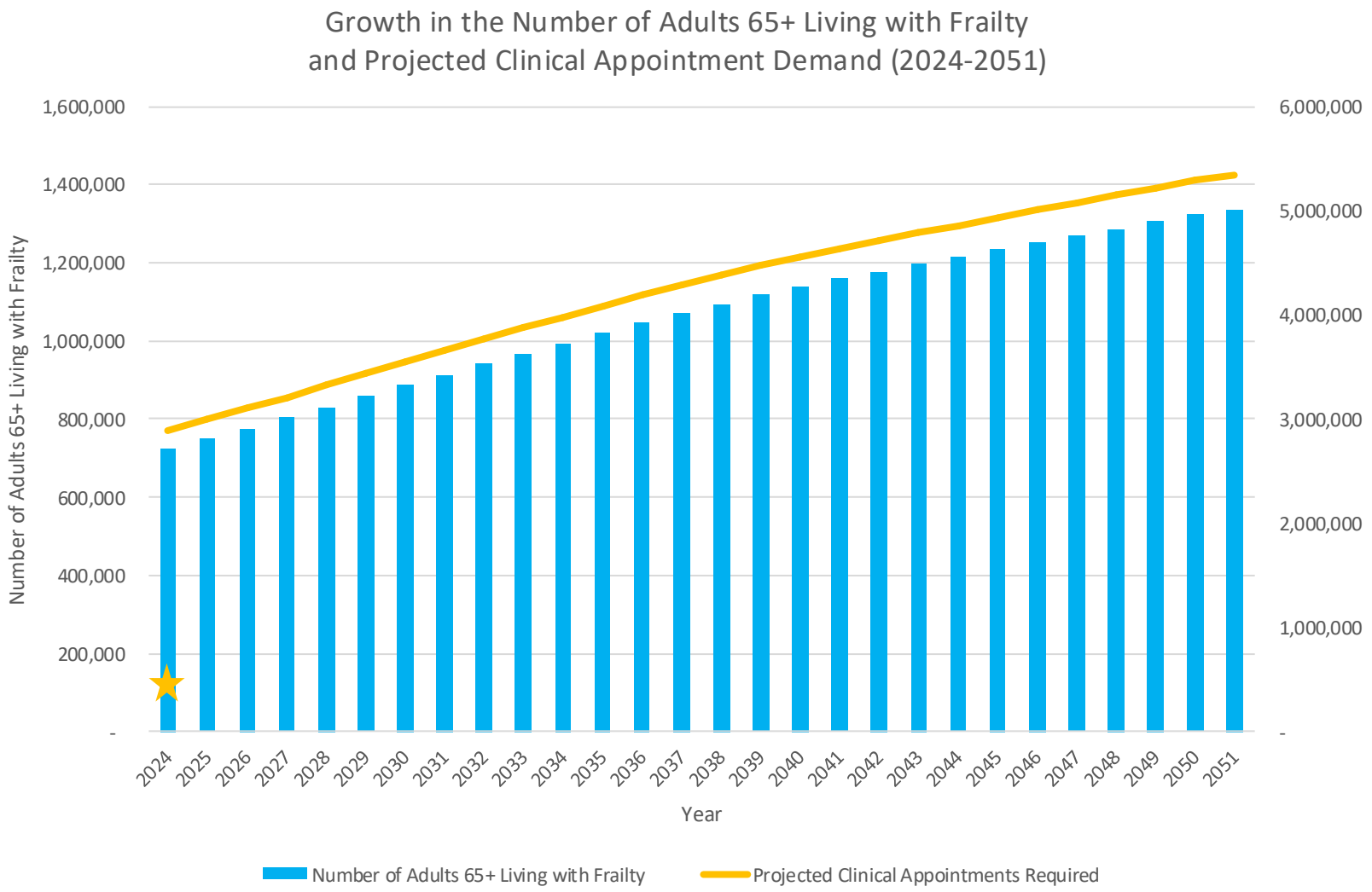
Community Dwelling Persons Living with Dementia by Socio-Economic Variables (2019)[g]



More current sources are required that can be stratified by sub-population

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

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]

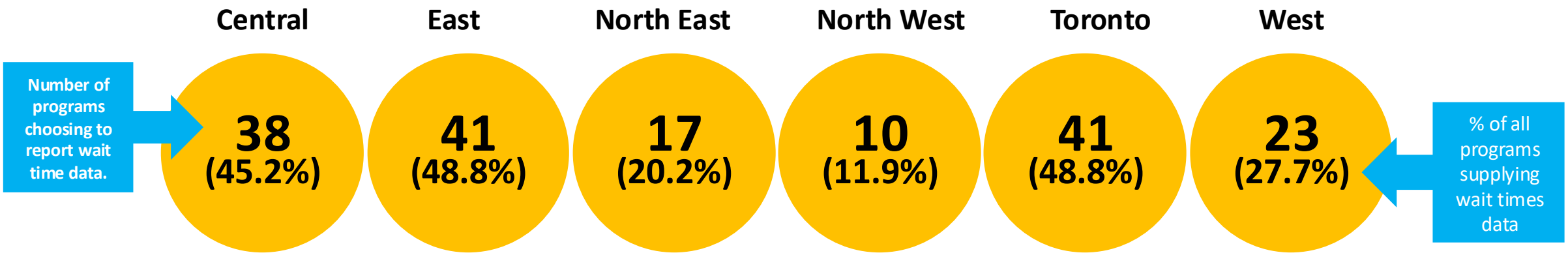
[a.] OHT Reports (Ontario Health, 2025) [d.] Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024 [f.] Frailty Estimates (PGLO, 2026)

PROGRAMS REPORTING WAIT TIMES*

2023-2024

Key Takeaway

- Across all regions, 170 programs have reported wait times.
- Of these, 132 (77.6%) report wait times of ≧ 7 days, **suggesting significant gaps in clinical service capacity**.



*Wait times reporting is not mandatory. This information reflects data from programs that opted to provide wait time data. There may be more programs with wait times than have been reported.

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		
Rehabilitation & 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				

ASSET INVENTORY IMPROVEMENTS FOR NEW CYCLE

Improvements

- Updated and streamlined fields and addition of insitu instructions
- Integration of new outcomes indicator fields
- Migration to Microsoft Forms environment
  - Form sharing to support local data collection
  - Opportunity for enhanced data visualizations (Power BI)
  - Single sign-on through Share Point using MS credentials
- Updated website access and information, updated tutorial
- Continued efforts to improve data completeness

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

RELATED ACTIVITY

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.

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.

Supporting the Uptake of Clinical Guidelines and Quality Standards

- Focus on implementation supports with regional programs; collaborating on forthcoming frailty and falls quality standards with Ontario Health

SUMMARY

- Ontario's 392 Specialized Geriatric Services (SGS), Seniors' Mental Health (SMH) and Focused Practice/Care of the Elderly (FP-COE) programs provide the majority of Ontario's specialized dementia, frailty and seniors' mental health clinical services, and complement the work of primary care in **supporting aging in place**.
- 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** among caregivers of older adults living with frailty and dementia.
- 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.
- **Primary care requires additional trained human resources** 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**.** This can be accomplished through the training of primary care teams through programs such the Provincial Common Orientation to the Care of Older Adults, the development of new models such as Primary Care Integrated Geriatric Teams and strategic investment in community based geriatric services
- 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 and PGLO is interested in working with Ontario Health and the Ministry of Health to enhance completeness.

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.