

2026-2031 Strategic Plan



Provincial
**Geriatrics
Leadership**
Ontario

Connecting Expertise. Driving System Change.

Provincial Geriatrics Leadership Ontario (PGLO) developed its 2026-2031 strategic plan through extensive consultation with nearly 200 interest holders including older adults, care partners, clinicians and policy-makers. Over the coming years PGLO will collaborate courageously to address impactful strategic priorities.

We cannot do this work alone, and will continue to connect and support a provincial network that works to improve care for older adults and care partners through collaboration, innovation, and system-wide leadership in specialized geriatric and seniors' mental health services.

By convening partners, facilitating collective impact, influencing policy across dementia and frailty care, seniors' mental health and more, and supporting specialized geriatric and seniors' mental health services, PGLO will elevate provincial health system design - supporting work that enables older adults to receive equitable, high-quality care while enabling partners to deliver and scale impactful solutions. It is our vision that, through collective action, we will realize a future where every older adult in Ontario - regardless of location, background, or complexity of need - has timely access to integrated, compassionate, and evidence-informed care that supports their health, dignity, and quality of life.

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

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.

Four Core Activities

Accelerate integrated models with primary care



Supporting the development of Ontario Health's Geriatric Standardized Referral Form

Defining models of Primary Care Integrated Geriatric Teams

Training Primary Care IP Team Members and others in the care of older adults

Support the uptake of clinical guidelines and quality standards



Providing implementation support for Ontario Health's ALC, Delirium, Dementia, Hip Fracture, Insomnia, and Transitional Care Unit Quality Standards

Co-Developing Ontario Health's Falls and Frailty Quality Standards and related implementation supports

Develop a plan for a core services framework for older adult specialized clinical care



Co-designing a core services framework for dementia, frailty and seniors' mental health clinical services and building capacity for the care of older adults

Co-designing a Geriatrics Provincial Coordinated Access (GPCA) System

Build the PGLO Data and Analytics Program



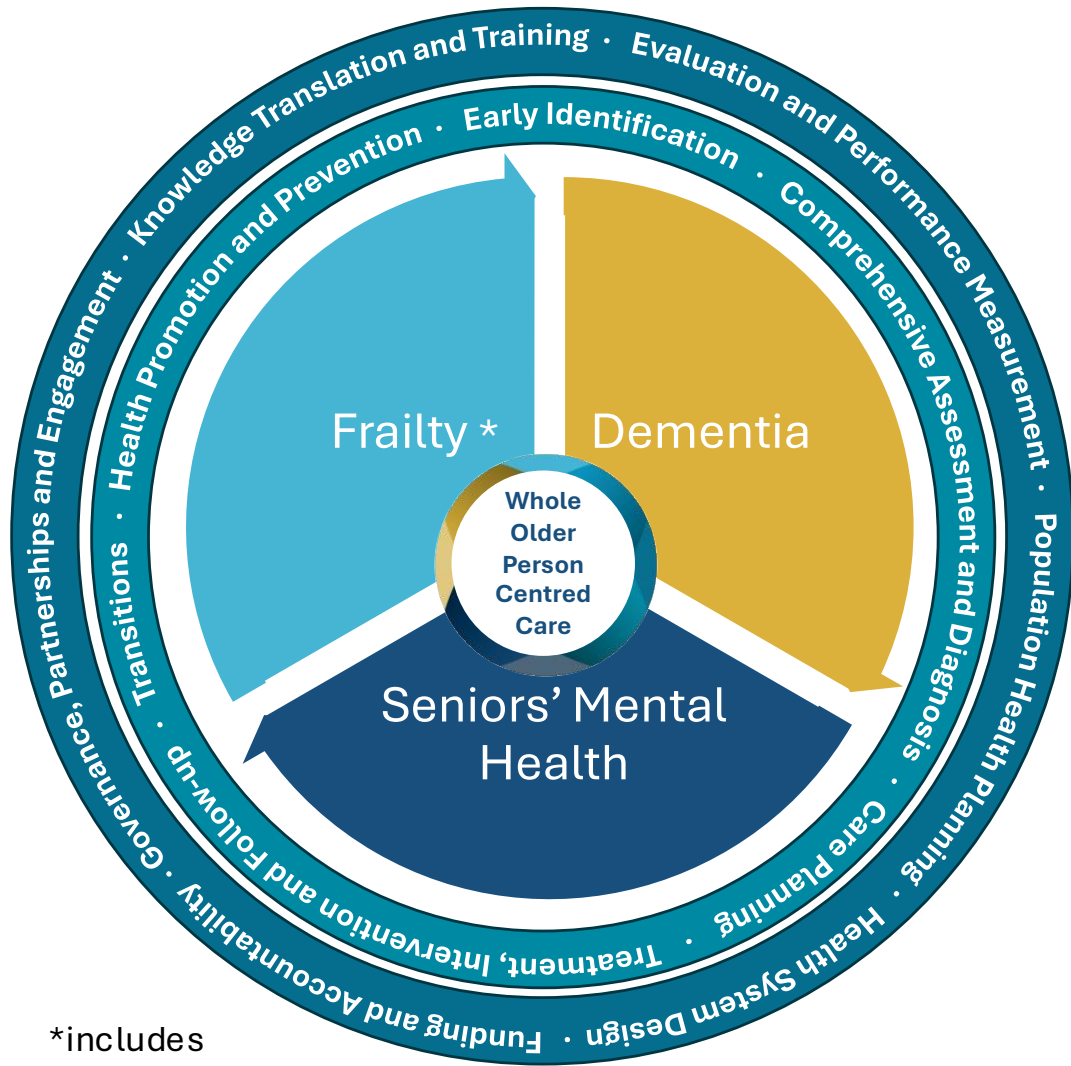
Launching the refreshed Provincial Asset Inventory (PAI) of specialized clinical services for older adults

Supporting the development of data reporting reflecting supply, demand and outcomes of geriatric clinical service

Current Initiatives (2026-2028)

Appendixes

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

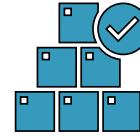


*includes multimorbidity



138

Organizations providing data



392

Programs Reported



2,449.6

Full time equivalents (FTEs) of specialized interprofessional team members



142,697

Unique Patients Served



585,166

Clinical Visits Provided

SPECIALIZED GERIATRIC and SENIORS' MENTAL HEALTH SERVICES^d (2023-2024)

Emergency/
Urgent Care
Programs



60

Acute Care
Programs



78

Rehabilitation
& Post-Acute
Programs



30

Community
Geriatrics
Programs



184

Primary Care
Programs



12

Long-Term
Care Programs



28

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

CLINICAL SERVICES DEMAND: ONTARIO

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

723,769

Population 65+ estimated to be living with **frailty** in Ontario^f (2024)

25%

of population 65+

334,500

Individuals living with **dementia**^b

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+

Caregivers reporting distress^a

53.5% ↑

Short Stay Respite Beds (Total)^e

140 ↓

2 Respite Beds per 10,000^e

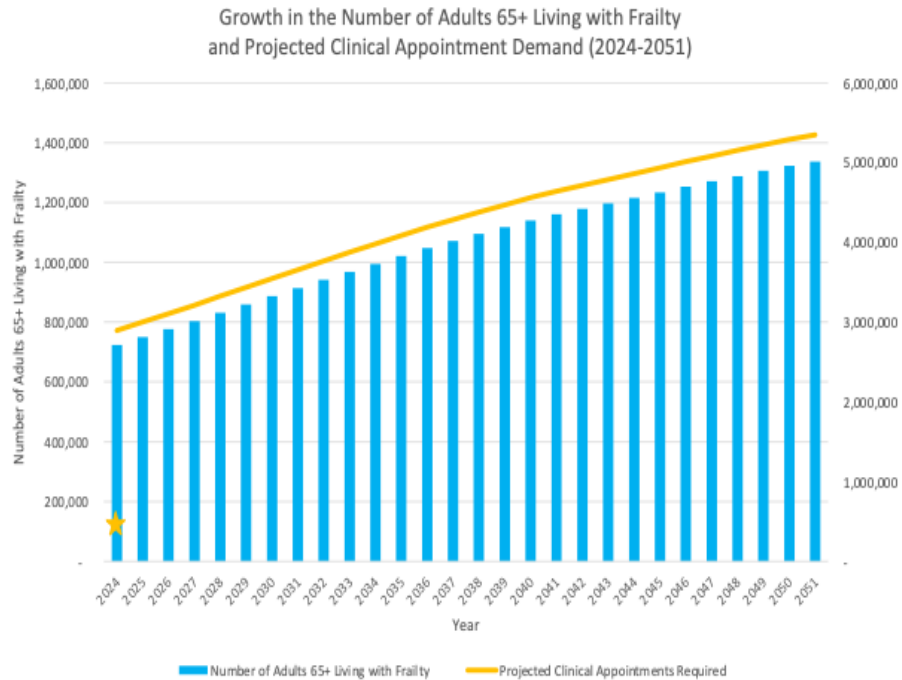
Older adults with frailty with 2 or more ED visits/per year^a

19,986 (6%) ↑

Older adults with frailty readmitted to hospital within 30 days^a

9,986 (3%) ↑

DEVELOPING AN APPROACH TO FORECASTING - FRAILITY

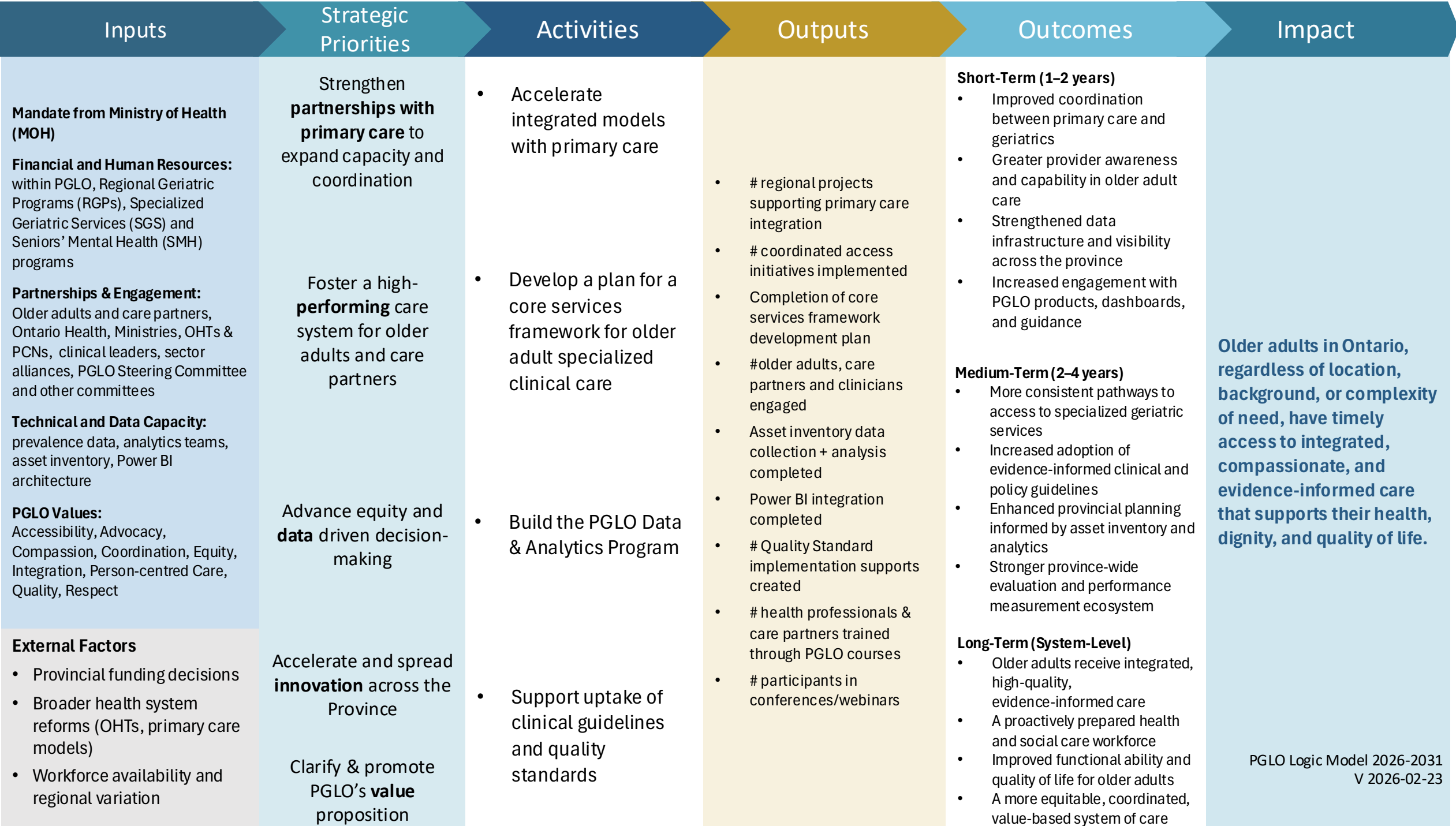


Projected Clinical Appointment Demand

- 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) ^b Specialized and Focused Geriatric Services Asset Inventory (PGLO) 2023-2024 ^c Frailty Estimates (PGLO, 2026)



Ontario's Network of Specialized Clinical Services for Older Adults

Provincial Backbone (Macro)

Regional Programs (Meso)

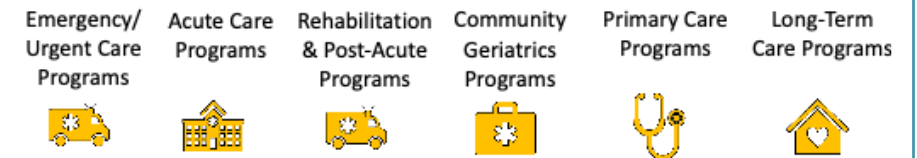
Local Clinical Services (Micro)



Sets **provincial direction**, enables system integration, provides backbone support, and ensures alignment across Ontario.



Translate provincial strategy into **regional action**, ensure coordination and consistency, and support providers.




(Includes: geriatric medicine, COE, seniors' mental health/geriatric psychiatry, interprofessional SGS and SMH teams)

Deliver **specialized care directly to older adults**, implement integrated models, and share experiences of day-to-day realities of patients and caregivers.

Bi-Directional Communication and Engagement

DETAILED DESCRIPTIONS OF NETWORK ROLES



	Entities	General Roles	Research/Evaluation Roles	Education Roles	Clinical Functions
Provincial (Macro)	PGLO	Provincial coordination and strategic leadership; convening; collective-impact backbone (vision, aligned activities, shared measurement, community engagement, policy, mobilizing resources); provincial planning, performance management and data/indicator stewardship; system capacity building and provincial knowledge/capability hub.	Provincial research agenda-setting; population-level analytics and dashboards; province-wide knowledge mobilization; enabling large-scale partnerships and evaluation frameworks.	Provincial orientation programs and resources (e.g., common orientation for care of older adults); system-wide capability building via hubs, communications and partnerships that reach macro-meso-micro audiences.	(Indirect) Establishes provincial guidance, core services framing and policy enablers that shape clinical delivery; supports spread and scale of integrated care models rather than delivering care directly.
Regional (Meso)	RGPs / RSGS	Regional strategic & operational leadership; coordination of specialized geriatric services across settings; KT and clinical service design; regional evaluation and indicator development; capacity planning (HHR); linking local-regional-provincial efforts including OHTs.	Applied research; development/validation/implementation of tools, pathways and models; contribution to indicator development, analysis and interpretation; workforce and utilization studies; academic/community research partnerships.	Coaching, mentoring, teaching and training through academic and community linkages; regional capability building for clinicians and partners; implementation support for provincial guidelines and best practices.	Coordinate and, in many regions, directly deliver specialized geriatric services (e.g., geriatrics, COE, seniors' mental health, interprofessional teams); ensure integrated transitions and consistency of practice across organizations.
Local (Micro)	Clinical Services	Point-of-care delivery; co-produced assessments and integrated care plans; team-based, person-centred care; coordination with primary/community care for safe transitions.	Practice-based research and QI; implementation studies/pilots of tools and models introduced by meso/macro; routine outcome data collection feeding regional/provincial indicators; clinician-academic collaborations.	Bedside and clinic-based teaching; case-based learning and mentorship for learners and providers; feedback loops to RGPs/PGLO on training needs and efficacy of tools; participation in regional education initiatives.	Comprehensive geriatric assessment; cognitive/behavioural assessment and intervention; rehabilitation-enabling care; medication optimization; discharge/transition planning; ongoing management for complex older adults and care partners.