

Year End Report 2011-2012



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

Better health outcomes for frail seniors

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Introduction

The RGP supports a network of 29 participating organizations in the GTA and surrounding areas. The Network participants are guided by Participation Agreements, which were developed as a foundation for expanding the RGP as well as a means of strengthening the understanding of the added value of RGP membership. The following year end report summarizes the RGP central office's activities which support this broad network. The individual hospital activities are found in the appendices, and reflect the work of seven funded hospitals.

The RGP also manages the Psychogeriatric Resource Consultation Program, which is described in a separate agreement with the Central East LHIN and focuses on the learning needs of those who are caring for people with dementia and other psychogeriatric problems within community service agencies, CCACs, and long-term care facilities.

Projects and one time initiatives funded through non-operational revenue are described separately through annual charters and agreements.

Priority #1: Advancing Senior Friendly Hospital (SFH) Care

The RGP began work on the concept of senior friendly hospital care in the 1990s and established a senior friendly hospital taskforce in 2006. Along with the RGPs of Ontario, we endorsed a five-domain framework that guides our work and approach to transform hospitals into senior friendly organizations. These domains are the processes of care; organizational support; emotional and behavioural environment; ethics in clinical care and research; and the physical environment. The Toronto Central LHIN has adopted the SFH Framework to guide its work on its IHSP priority to reduce functional decline in hospitalized seniors. The system level of interest in the concept of SFH has created a welcome opportunity to influence care of hospitalized seniors with a systematic approach.

Using the RGP's SFH Framework, the SFH Background Document and Hospital Self-Assessment Template as guiding blueprints, we will support the Toronto Central LHIN, the RGP Network as well as external organizations in the development of their senior friendly capabilities.

Expected Outcomes:

Enhanced senior friendly capacity across the LHINs, the RGP Network, and other interested organizations

1. RGP will be seen as a leading authority on SFH practice and processes regionally and provincially.
2. An updated www.SeniorFriendlyHospitals.ca website with increased utilization.
3. Enhanced collaboration and uptake of SFH practices and processes.
4. Publications on relevant aspects of SFH practices and processes.

Report on Activities:

- 1) Coordinated the provincial roll-out of Phase 1 of the LHIN-led Ontario Senior Friendly Hospital Strategy involving 14 LHINs, 5 RGPs, and the North East Specialized Geriatrics Services team. Summary reports describing SFH practices across 14 LHINs were generated in June 2011. These are currently available on each LHIN website.
- 2) Authored SFH summary reports for the Central West, Mississauga Halton, Central, Central East, and North Simcoe Muskoka LHINs, working in conjunction with the respective LHIN representatives. These reports are all available in one location at <http://seniorfriendlyhospitals.ca/reports-publications>.
- 3) A provincial roll-up of the 14 LHIN-wide SFH summary reports entitled *Senior Friendly Hospital Care Across Ontario: Summary Report and Recommendations*, was authored by the RGP in September 2011; <http://seniorfriendlyhospitals.ca/reports-publications>.
- 4) Co-chair a LHIN-led provincial Toolkit working group established in October 2011 and coordinated the development of enhanced Delirium and Functional Decline web-based modules for the Senior Friendly Hospital toolkit at www.seniorfriendlyhospitals.ca. Tools were rated by over 30 geriatric experts across the province.
- 5) Co-chair a LHIN-led provincial SFH Indicators working group established in October 2011, and coordinate work presently underway to identify indicators related to Delirium

and Functional Decline. Thirty clinical geriatric and data support experts across Ontario have been recruited to this process and a report will be generated identifying indicators and recommendations on implementation.

- 6) Presented a poster, "Senior Friendly Hospital Care in the Toronto Central Local Health Integration Network," at the Canadian Geriatrics Society 31st Annual Conference in Vancouver, April 14-16 2011.
- 7) Co-chaired the planning for a National Round Table meeting on Quality and Safety of Older People in Canadian Hospitals. Co-facilitated a workshop entitled "Elder Friendly Hospitals...Making This a Reality in Canada," at the Canadian Geriatrics Society 31st Annual Conference, April 15 2011.
- 8) Hosted a networking event on July 6 2011, inviting 29 network hospitals to a half-day SFH retreat. Participants engaged in facilitated discussions on practices and priorities within each the five SFH Framework domains.
- 9) Oral presentation on the Ontario Senior Friendly Hospital Strategy at the Ontario Hospital Association's HealthAchieve 2011 Conference, November 8 2011.
- 10) Oral presentation on "Senior Friendly Hospital Care Across Ontario," at the Ontario Long Term Care Association Applied Research Education Day, November 23 2011.
- 11) Hosted 3 geriatric staff from the Orbis Medical Center in Sittard, Netherlands, and arranged tours of RGP network hospitals: Sunnybrook Health Sciences Centre, Mt Sinai Hospital, and Northumberland Hills Hospital, December 5-6 2011.
- 12) Presentations, consultation and coaching support provided to hospitals on request to assist them in SFH-related implementation work: Sunnybrook Health Sciences Centre, Southlake Regional Health Centre, St Michael's Hospital, West Park Healthcare Centre, and Toronto Academic Health Sciences Network (TAHSN) Elder Care Planning Committee.
- 13) Co-lead a Council of Academic Hospitals of Ontario (CAHO) Adopting Research to Improve Care (ARTIC) project entitled Mobilization of Vulnerable Elders in Ontario (MOVE ON). Fourteen teaching hospitals are involved in the implementation of early mobilization protocols for hospitalized seniors.
- 14) Manuscript describing the SFH self-assessment process across the province in preparation.

Priority #2: SGS Renewal and Quality Improvement

The models of specialized geriatric service delivery supported by the RGP were developed in the 1990s and based on available evidence. Since that time, teams have incorporated emerging evidence through process improvements and made adjustments in their service delivery models. The health system in which SGS is delivered has, however, changed significantly. Our patients are now older and have more complex comorbidity. Instead of being admitted to long-term care homes, an increasing number of frail seniors are residing in the community with supports. Options for elective admission of patients to acute hospitals are now rarely available and ALC beds are increasingly filled with frail seniors with longer lengths of stay. For a critical period in the new millennium, there were no geriatric medicine trainees in the pipeline adding

to the already low availability of geriatric specialists to provide clinical consultation and education.

Recognizing that SGS could not provide direct service delivery to all the frail seniors in need, we identified capacity building as one of our earlier strategic priorities. As a result of the successful transfer of knowledge to partner providers, we have witnessed the emergence and proliferation of community-based teams, disease-focused teams and primary care teams that are better equipped to provide care to frail seniors.

These contextual changes in the system, along with the evolving profile of patients served by SGS teams, demands a reexamination of how SGS is best delivered and the role that it should play in the healthcare continuum.

Expected Outcomes:

Service improvement and alignment with current evidence on best practices

1. Increased satisfaction with services.
2. Increased integration with stakeholders.
3. Services are aligned with current evidence.
4. Performance indicators for specialized geriatric services.
5. Collaborative quality improvement initiatives.

Activities:

1. A Geriatric Emergency Management (GEM) stakeholder satisfaction survey was conducted. The perceptions of nurses, physicians, allied health professionals and management as they relate to GEM demonstrated the value placed on GEM by these stakeholders. Stakeholders reported high levels of satisfaction with the information and recommendations provided by the GEM nurses and the referrals that they recommend. Stakeholders acknowledged that GEM staff increase their ability to care for frail seniors and contribute to ED efficiency and ability to meet provincial targets in a way that is appreciated by their patients.
2. The Directors of Long Term Care Homes are routinely surveyed with regard to their satisfaction with the emergency mobile nursing services of the Nurse Led Outreach Teams (NLOT) managed by the RGP. The following quotation reflects Directors' opinions: *"We do value the tremendous support the outreach team has provided us and look forward to a continuous and strong connection toward achieving meaningful outcomes for our residents."* These stakeholders report that NLOT helps them to avoid transferring a resident to the Emergency Department, while improving the quality of care provided in the LTCH and building the confidence of LTCH staff to manage some emergencies themselves particularly in such areas as wound care, dehydration and end-of-life care.
3. The Geriatric Outreach Teams are now supported by an Annual Outreach Institute. In response to learning needs surveys and guided by the RGP's Geriatric Outreach Steering Committee, the 2011 Institute focused on service models, assessment tools, and the preparation of user friendly consultation reports and communications. Additional

workshops were convened on such topics as managing urgent & emergent need, polypharmacy, workplace safety and risk management. The seventy plus participants gave the event very positive satisfaction ratings and provided direction for next year's event.

4. A Nurse Led Outreach Team (NLOT) Training Institute was convened for NLOT staff across the province in February. Nearly 40 nurses from six LHINs convened for a day of network development and training on such topics suturing and glueing, wound care, medication management and polypharmacy, IV and PICC Line Management, bio-ethics and end of life care.
5. The 7th Geriatric Emergency Management Conference took place over 3 days in September 2011. Day 1 provided a training institute for new GEM nurses. Day 2 provided a day of lectures and discussion on the theme of the Senior Friendly Emergency Departments. Day 3 provided a series of practical workshops for GEM nurses on such topics as consent, capacity and advance directives, seniors and trauma, palliative pain management and wound care. The event drew more than 160 participants from across the province, from British Columbia, the United States and Singapore.
6. The literature was updated in three clinical areas:
 - a. Delirium
 - b. Transitions of care
 - c. Mobilization
7. The RGP established a Geriatric Day Hospital Steering Committee whose purpose is to: enhance the value of Geriatric Day Hospitals within the circle of care, in the context of the changing health system; review activity and establish targets/benchmarks; explore care delivery models and share best practices; and develop indicators that demonstrate the effectiveness of Geriatric Day Hospitals.
8. The RGP Outreach Steering Committee is using the Rockwood Clinical Frailty Scale as a descriptor for Outreach clients.

Priority #3: Serving as a Leading Authority on Frailty and Service Development for Seniors

No other organization has a mandate solely dedicated to the healthcare needs of frail seniors. As such, the RGP is in a unique position to serve as a leading authority on frailty. As a network of providers, we are able to bring a system perspective to service planning and development. The RGP leverages the social and intellectual capital embedded within our network, which is further enhanced by our academic linkages. Free of institutional biases and disease-specific objectives, our activities are driven by system goals and patient-centred care.

Expected Outcomes:

Increased recognition of the RGP as a leading authority

1. Increased involvement and influence on provincial, regional, and local councils/advisory committees.
2. Publication of reports and manuscripts in peer-reviewed journals.
3. Leveraged social and intellectual capital embedded within RGP network.

Report on Activities:

1. RGP continues to lead and support the senior friendly hospital toolkit and indicator working groups. The toolkit working group has achieved its deliverables, including two enhanced content areas within the <http://seniorfriendlyhospitals.ca> website to support hospital improvement plans in the identified priority areas of preventing functional decline and prevention of delirium.
2. Served on the Central East Regional Specialized Geriatric Services Governance Authority and the Central LHIN Primary Care Working Group and the Toronto Central LHIN BSO Advisory Committee.
3. Aligning with Health Quality Ontario (HQO) to support the Excellent Care for All Act (ECFA). We have engaged HQO in the indicator working group selection process and leveraged their expertise.
4. Issues of the RGP News and the PRCP Program Bulletins have been circulated. Service descriptions and service access utilities have been revised and refreshed. RGP staff have been invited as keynote speakers at local, regional and national conferences.
5. The Executive Director continued to serve as the program director for the postgraduate training program, and is a member of the royal college geriatric medicine examination committee.
6. The RGP websites including GEM (www.gem.rgp.on.ca), SFH (<http://seniorfriendlyhospitals.ca>), PRCP (<http://prcp.rgp.toronto.on.ca>), Giic (www.giic.rgp.on.ca), and RGPs of Ontario (<http://rgps.on.ca>) have been re-released as a redesigned integrated graphically themed portal.
7. The following manuscripts were prepared and/or published:
 - a. Ryan, D, Liu, B, Awad, M & Wong, K (2011). *Improving the older persons experience in the emergency room: towards the senior friendly emergency room*. Aging Health, 7(6) 901-909.

- b. Ryan, D, Puri, M. & Liu, B (2012) ***Comparing patient and provider perceptions of home and community based services: social network analysis as a service integration metric.*** Home Health Care Services Quarterly (submitted for publication Home Health Care Quarterly).
 - c. Stolee, P, Awad, M, et. al. ***A multi-site study of the feasibility and clinical utility of Goal Attainment Scaling in geriatric day hospitals.*** Disability & Rehabilitation, March 7, 2012. [Epub ahead of print]
8. Contributions to collaborative research initiatives locally, provincially, and nationally.
- a. D. Ryan is a co-investigator in the Canadian Emergency Team Initiative on Mobility in the ED. This is now a national multi-site ED research initiative.
 - b. Ryan, D. Emond, M. & Lamontaigne M.E. Social network analysis as a metric for the development of an interorganizational research network: The Canadian Emergency Team Initiative.
 - c. D. Ryan has been invited to join the national Centers of Excellence on Mobility in Aging Catalyst Grant Evaluation Team.
 - d. Falls MIA – B. Liu is a co investigator in a CIHR Team Grant for the development, testing and knowledge translation of innovative approaches to optimize gait and balance of older adults.
 - e. OP LTC vitamin D – B. Liu is a member of the data and safety monitoring board of a CIHR-funded “A Knowledge to Action Intervention for Long-term Care: A Feasibility Study Focusing on the Uptake of Osteoporosis and Fracture Prevention Best Practices”.

Projected Hospital Activity Data

Summarized in the table below is the forecast and actual activity data for 2011-2012.

	11/12 forecast	11/12 year end actuals												
OUTREACH TEAMS	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Acceptances/Admissions	364	399	300	487	160	159					211	212		
Active Clients	459	501	300	556	n/a	n/a					282	293		
Total Visits	554	603	450	915	450	732					500	499		
DAY HOSPITALS	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Approved spaces	15	15	13	13	20	20	15	15						
Inquiries/Referrals	n/a	n/a	160	224	275	231	50	82						
Acceptances/Admissions	155	177	124	125	275	220	48	78						
Attendances	2816	2937	2044	2083	3300	3405	1615	1681						
GERIATRIC CLINICS	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Acceptances/Admissions	761	643	500	818	430	438	58	54	n/a	n/a	380	378	450	587
Active Clients	1672	1309	1000	1468	n/a	n/a	150	95	n/a	n/a	1200	1027	870	1230
Total Visits (Initial, follow-up, home visits, etc.)	2583	1975	2000	3577	1000	892	285	215	2300	2491	1600	1385	875	1230
ACUTE GERIATRIC UNITS	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Beds			6	4					8	8			6	6
Inpatient Days			1314	734					1368	1400			2100	2001
Admissions			124	55					216	216			120	125
Separations			124	56					216	216			120	125
Discharge Days			1314	734					1368	1400			2100	2001
Occupancy Rate			60%	50%					94%	96%			96%	91%
Average Length of Stay			10.6	13.1					6.3	6.5			17.5	16
GRU & GATU	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Beds	32	32					25	25			45	45		
Inpatient Days	11036	10668					8219	8084			15580	15787		

	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals	11/12 forecast	11/12 year end actuals
Admissions	370	368					216	221			521	410		
Separations	372	365					218	221			501	403		
Discharge Days	12030	11712					8259	8210			14582	14693		
Occupancy Rate	95%	91%					90%	87%			95%	96%		
Average Length of Stay	32.4	32.1					37.9	37.1			29.1	36.5		
<i>GRU = Geriatric Rehabilitation Unit</i>														
<i>GATU = Geriatric Assessment and Treatment Unit</i>														
CONSULTATIONS	BAY	BAY	NYGH	NYGH	SHSC	SHSC	TRI	TRI	UHN	UHN	PROV	PROV	STM	STM
Patients Seen			530	489	400	514			250	401	220	288	450	587
GERIATRIC EMERGENCY MANAGEMENT	CVH	CVH	YCH	YCH	RVHS	RVHS	HRRH	HRRH	STM	STM				
GEM patients seen		25	448	492	709	841	451	439	356	439				
GEM patients assessed by telephone		2	40	206	405	359	83	80	140	174				
patients admitted (post GEM)		10	304	288	195	214	152	150	121	143				
patients discharged (post GEM)		15	144	239	516	527	293	284	235	296				
GEM sites: Credit Valley Hospital, York Central Hospital, Rouge Valley Health System, Humber River Regional Hospital, St. Michael's														
AGING AT HOME INITIATIVES														
TC LHIN LONG TERM CARE OUTREACH	2011-12 FORECAST		2011-12 ACTUALS											
Number of consultations	2,280		2,264											
TC LHIN GEM														
Number of clients seen by GEM nurse (in person and phone assessment)	5,934		4,836											

Variance explanations:

1. Baycrest Clinic - Method of data collection has changed since 10/11 (and 11/12 Budget). 11/12 budget included a portion of phone consultations whereas 11/12 Actuals only include face to face. Geriatrician vacancy continues.
2. SHSC Outreach - staff illness for month of Feb.
3. TRI Day Hospital - Quality improvement initiatives looking at access and flow along with aligning with RGP's definition of spaces (from 20 to 15 spaces) has resulted in our ability to be exceed year end targets for the number of patients assessed and the number of patients admitted for FY 2011-12.
4. TRI Clinic - while the physician vacancy continues to be unfilled, recruitment efforts to fill physician vacancy continue, working in collaboration with UHN and Mount Sinai.
5. UHN Clinic -Falls and Memory Clinic
6. UHN AGU - In September 2009 the Inter-professional model changed from a 10 bed AGU to an 8 bed ACE unit. Funding on this form reflect all geriatric service areas at TWH. Leadership changes to allow for one Director and one Manager to have responsibility for geriatric services have led to better tracking of staffing associated with provision of services and thus FTE's have increased to reflect this better tracking. In 2011-2012 we have reduced our clerical support by 1.0 FTE. Effective July 2011 UHN changed the ACE unit with dedicated beds to a Mobile ACE service so activity is reflected in the Consultation team data. This reflects only 1 quarter of data. Effective August 2011 UHN implemented a HELP program at TWH and thus have added a net 1.5 FTE additional support for this program.
7. UHN ICT - As of November 2010 UHN expanded the consult team so it now reflects volume at 3 sites (TWH, TGH & PMH). Effective Q2- 2011-2012 (July 2011) UHN realigned the geriatrics Inter-professional service to a Mobile ACE service which is activated by the consult team. Thus the consult numbers have increased.
8. CVH GEM - nurse started Feb 2012.
9. TC LHIN GEM - Reduced FTEs especially in Q3 which reduced the number of clients seen annually.

Appendices

Appendix A: Service Information

What are “specialized geriatric services”?

Specialized geriatric services are a range of health care services, which diagnose, treat and rehabilitate frail seniors with complex and multiple medical, functional and psychosocial problems. Specialized geriatric services are provided on a consultative basis by interdisciplinary team of health professionals in a variety of home, ambulatory, acute-care, long-term care and rehabilitation hospital settings. The goal of specialized geriatric services is to reduce the burden of disability by detecting and treating reversible conditions and recommending optimal management of chronic conditions.

Psychogeriatric Resource Consultants (PRCs) provide help to caregivers and teams to develop, implement and evaluate care plans and programs which will be effective in enhancing the mental health of the clients and managing difficult behaviours associated with a dementing illness or other acquired brain injuries. A full description of the PRC program is detailed in a separate Service Agreement with the Ministry of Health & Long-Term Care,

What is the target group for “specialized geriatric services?”

The focus of specialized geriatric services is the frail older person whose health, dignity and independence are at risk due to:

- Multiple and complex medical and psycho-social problems
- A recent unexplained breakdown in health and function (or high risk for such breakdown).
- Risk of losing the capacity for independent living

Definition of Specialized Geriatric Services

Specialized Geriatric Services are health care services that diagnose, treat and rehabilitate frail seniors with complex medical, functional and psychosocial problems. An interdisciplinary team of health professionals with expertise in geriatric care provide these services in ambulatory, community and inpatient settings on a consultative basis.

In collaboration with primary care providers, these specialized geriatric services provide a continuum of care that optimizes the function and independence of frail seniors and supports aging in place.

Outreach

Comprehensive assessments in the older person's home or long-term care facility are conducted by one or two health care professionals in geriatric medicine, nursing, social work, psychiatry, physiotherapy or occupational therapy. Other health professionals in psychology, pharmacy, recreation therapy, nutrition, and speech language pathology may be involved if needed.

Outpatient geriatric clinics

Clinics are used to assess, treat and monitor older persons who can travel to the hospital. Some persons receiving RGP Outreach visits may have their first contact with a geriatrician in a clinic setting.

Geriatric Day Hospitals

These hospital-based ambulatory programs provide diagnostic, rehabilitative or therapeutic services to persons living at home or in a long-term care facility. Attendance is usually two days per week for several months.

Acute Geriatric Units/Acute Care of the Elderly Units

These are inpatient hospital units in an acute care setting for persons who require short-term diagnostic investigation and treatment.

Geriatric Rehabilitation Units (GRUs)

These are inpatient units in chronic hospitals for persons who require an individualized assessment and rehabilitation program for a period of one to three months.

Geriatric Assessment and Treatment Units (GATU)

Inpatient units for persons with complex medical conditions who require an individualized assessment and rehabilitation program for a period of four to six weeks.

Internal Consultation Teams

Multi-disciplinary teams provide consultation and assessment of patients in the participating organizations.

Geriatric Emergency Management (GEM)

Consultation by a specialized geriatric health professional in the emergency room providing: assessment, diagnosis, identification of “at risk” elderly, initiation of appropriate treatment, and linkages with community and primary care.

Psychogeriatric Services

Geriatric Psychiatrists provide assessment and treatment for those elderly persons who may have behavioural or psychosocial issues (i.e., depression, anxiety, psychosis). Although not one of the funded core SGS, psychogeriatric services are an important part of the continuum of service for frail seniors. At many sites, psychogeriatric services are provided in an integrated or collaborative model with SGS.

Appendix B: Activity Unit Definitions

Outreach Teams

Acceptances/Admissions: A person who has been officially accepted by the Outreach Team and will receive a visit.

Active Clients: A client who has received a visit during the reporting period.

Total Visits: A contact for the purpose of an initial assessment and follow up visits. Each visit with more than one discipline is counted as one visit. Telephone calls are not included (A visit is one face-to-face encounter between a client or family member and a health professional).

Day Hospitals

Acceptances/Admissions: A person who has been officially accepted into the Day Hospital for assessment, diagnosis, treatment or rehabilitation.

Active Clients: A client seen in the Day Hospital during the reporting period.

Approved spaces: The number of places in the Day Hospital.

Attendances: Clients attend on a regularly scheduled basis for 3 to 4 hours at each attendance.

Geriatric Clinics

Acceptances/Admissions: A person who has been officially accepted by the Geriatric Clinic for assessment, treatment, rehabilitation or monitoring.

Active Clients: A client seen in the Geriatric Clinic during the reporting period.

Total Visits: A visit for the purpose of assessment or follow-up. (A visit is one face-to-face encounter between a client or family member and a health professional).

Acute Geriatric Units/Acute Care of the Elderly Units

Beds: An acute bed designated by the hospital which is staffed and in operation.

Inquiries/Referrals: Any request for admission into the AGU/ACE.

Admissions: A person who has been admitted to an AGU/ACE bed.

Inpatient Days: A filled inpatient day in accordance with MOHLTC guidelines.

Average Length of Stay: Inpatient days divided by the number of separations.

Separations: The total number of discharges or deaths of patients in the AGU/ACE during the reporting period.

Occupancy Rate: Inpatient days divided by the [total number of Beds X the days in the reporting period] X100 (reported as a percentage).

Geriatric Rehabilitation Units/Geriatric Assessment & Treatment units

Beds: GRU/GATU designated by the hospital which is staffed and in operation.

Inquiries/Referrals: Any request for admission into the GRU/GATU.

Admissions: A person who has been admitted to a GRU/GATU.

Inpatient Days: A filled inpatient day in accordance with MOHLTC guidelines.

Average Length of Stay: Inpatient days divided by the number of separations.

Separations: The total number of discharges or deaths of patients in the GRU/GATU during the reporting period.

Occupancy Rate: Inpatient days divided by the [total number of Beds x the days in the reporting period] x 100 (reported as a percentage).

Internal Consultation Teams

Patients Seen: Total number of new patients who have been visited by the ICT either in a non-RGP inpatient unit or in the Emergency Department, but not in the AGU/ACE.

Geriatric Emergency Management

GEM Assessments: Total number of patients assessed face to face and by telephone.

Patients Admitted: Total number of patients admitted to hospital post GEM assessment.

Patients Discharged: Total number of patients discharged from hospital post GEM assessment (includes home, community, LTC, institutional transfer, death).



Appendix C: Hospital Deliverables

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Baycrest

Print date: 25-Jul-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Medication Reconciliation All Community Assessment and Treatment programs and Clinic services will have processes in place to support the organizational medication reconciliation program.	Ongoing	We have manual processes in place, but continue to work on converting to electronic process. This will continue to be an objective.
2.	Staff conducted safety inspections in Community Assessment and Treatment Program. Staff will utilize a customized workplace safety inspection tool to conduct monthly inspections, identify any client or staff risks, and participate in action planning to address risks.	Ongoing	Ongoing work on this. Current process and tool will need to be adapted in upcoming year based on current experience (PDSA!!)
3.	Community Outreach Team Client Recommendations The Physiotherapist and Occupational Therapist will complete the development of a shared recommendation form that will be provided to the client in their home folder at the end of service.	Completed	
4.	Day Treatment Client Goals The Day Treatment Wellness Path Program staff will develop and finalize a client-friendly format to provide clients with a goals summary at discharge.	Ongoing	Format continues to be updated and adjusted based on feedback (PDSA cycles ongoing)
5.	Day Treatment Program Review The Day Treatment leadership and team will develop a program to address the needs of clients in the community related to falls prevention and management.	Completed	DTC Team developed and implemented a falls prevention program. Has run 3 times and currently has a wait list.

<p>6. The GATU team will be collecting and reporting on the % of all patients' goals met. The GATU team will implement a method to systematically identify and document patient goals and review the goal status at discharge. A 75% achievement target had been set.</p>	Not achieved	
<p>7. The GATU team will identify one patient specific Mobility goal for each patient and will utilize GAS to score goal achievement. The GATU team members will be trained on how to effectively develop one goal related to the patient's mobility by utilizing the GAS methodology. On discharge, the GAS score will be assigned to this Mobility goal. The team will track and report on goal attainment with a specified target rate.</p>	Completed	This has been achieved. Team is also considering GAS as part of ongoing program evaluation.
<p>8. The GATU team is committed to improve on response time to referrals received and response time to admission of accepted patients. The GATU team will implement a quality improvement plan to reduce wait times for decision response to a referral and increase efficiency in the reviewing of referrals and in the pre-admission process.</p>	Completed	Reorganization of processes has led to a dramatic decrease in times.
<p>9. GATU will maintain an occupancy rate of 90%. Through increasing efficiency by reducing wait times and increased efficiency in the discharge process, GATU will strive to maintain 90% occupancy rate.</p>	Ongoing	ID Outbreaks impacted the occupancy statistics for the GATU, but progress continues to be made.

Innovation / New models

#	Activity / Description	Status	Comments
1.	<p>Falls Best Practice Model The Day Treatment leadership and staff will develop a program to meet the needs of clients in the community related to falls prevention and management.</p>	Completed	

<p>2. Post-Discharge Follow-up The Day Treatment staff will evaluate the Day Treatment Clients Follow-up Program in collaboration with the Baycrest Seniors Support Program for effectiveness, and submit an abstract to a relevant conference for presentation.</p>	Completed	Completed and poster presented twice.
<p>3. Rehabilitation Continuum The Day Treatment team will identify the role of its programs in the Baycrest rehabilitation service continuum in collaboration with the Rehabilitation Program staff.</p>	Ongoing	Work has been done to streamline referrals from rehab, GATU and SSR. These clients are now directly admitted from the referring programs. Processes have been reviewed to ensure fastest time to decision. More improvements will continue to be made

Activity Variance

# Activity / Description	Status	Comments
<p>1. Community Assessment and Treatment Program Indicators Day Treatment staff will participate in Mobility Big Dot Indicator Pilot Project as per Baycrest strategic imperatives.</p>	Completed	This has now been incorporated into DTC processes.
<p>2. Wait Time Data The Day Treatment and Community Outreach teams will report report data that facilitates the capture of wait periods from receipt of referral to first visit for each discipline (for COT) and to first contact by a team member and first date of participation in a program (for Day Treatment). Other data capture will include dates of decisions, referral sources, reasons for decline of applications.</p>	Ongoing	Tracking processes have been initiated. Continuing to work on them using PDSA cycles.

E-health

# Activity / Description	Status	Comments
<p>1. Mechanism to track wait time data for Geriatric Assessment Clinics The team will design and implement a new tracking system for referrals that will allow us to meet targets set for wait times.</p>	Completed	Tracking tool created and implemented. Baycrest is hoping to initiate a single point access process soon which should simplify the booking process for GAC.

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	Toronto Central LHIN Aging at Home Advisory Committee Medical Program Director for Ambulatory Services is Co-Chair of this committee, which will be re-born as a Seniors Advisory Committee once the AAH project is completed.	Ongoing	Committee on hiatus pending TCLHIN focus on senior friendly hospitals, falls prevention,etc.

External partnerships

#	Activity / Description	Status	Comments
1.	Nursing Practice Network Membership The Registered Nurse, Community Outreach Team, holds ongoing membership.	Ongoing	Continued membership and sharing of learnings.
2.	Toronto Central LHIN Health Professions Committee Executive Director, Residential and Aging at Home Program represents Baycrest.	Ongoing	Changes to titles but Baycrest continues to have representation on the committee
3.	SGS Central LHIN Network Committee Program Director, Ambulatory Services, RGP Day Treatment and Community Outreach represents Baycrest.	Completed	
4.	RGP Network Committee Executive Medical Director, Complex Care and Specialized Geriatrics Program and Program Director, Ambulatory Services, RGP Day Treatment and Community Outreach, represent Baycrest.	Ongoing	
5.	RGP Geriatric Outreach Teams Committee. Executive Medical Director, Complex Care and Specialized Geriatrics Program and Program Director, Ambulatory Services, RGP Day Treatment and Community Outreach represent Baycrest.	Ongoing	

6. Healthy at Home Steering Committee Executive Director, Residential and Aging at Home Program represents Baycrest.	Ongoing	Change in title, but Baycrest continues to be represented on this committee
7. GTA Rehabilitation Network Program Director, Rehabilitation Program, represents Baycrest.	Ongoing	
8. Stroke Network Program Director, Rehabilitation Program represents Baycrest.	Ongoing	
9. Partnerships with external nursing homes for Acute care Baycrest AGU (The ACT unit formerly 3E) has entered partnership with 10 local nursing homes to provide care for frail residents with acute medical conditions that can be managed here instead of at an acute care hospital.	Completed	

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Community Outreach Knowledge Sharing The Community Outreach Team members will participate in interprofessional knowledge sharing activities coordinated through the RGP Geriatric Outreach Teams Committee.	Completed	Team participated in educational program in May.
2.	Interprofessional Rounds The Day Treatment and Community Outreach Team members will participate in internal interprofessional rounds and will present one session at rounds on a relevant topic of interest.	Ongoing	
3.	Professional Development The Day Treatment and Community Outreach Team members will complete professional development activities as identified in their individual 2011/2012 learning goals and 2011/2012 team goals.	Ongoing	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	RN Preceptorship RN's in Community Assessment and Treatment Program and Ambulatory Clinics will provide ongoing preceptorship to B.Sc.N. and RPN students.	Ongoing	
2.	Graduate student teaching Day Treatment Physiotherapist: Small group structured clinical sessions: Summer/11-Gross Motor Function-4 University of Toronto students; Fall-Continuum of Care-4 University of Toronto students	Completed	
3.	Graduate student teaching Day Treatment Physiotherapist: University of Toronto Module 5 evidence-based practice assignment on Alzheimer's: Summer/11 for three months	Completed	
4.	Graduate student teaching Day Treatment Physiotherapist: coordination of Parkinson's large group structured session: 90 students: Summer/11: two hours x two days	Completed	
5.	Graduate student teaching Day Treatment Occupational Therapist: MSc University of Toronto: Field Work 3 Placement: April/12: four days per week for seven weeks	Completed	
6.	Graduate student teaching Day Treatment Occupational Therapist: other teaching assignments as assigned by University of Toronto in Fall/11	Completed	
7.	Therapeutic Recreation Teaching Day Treatment Recreation Therapist: Georgian College student placement as assigned in Fall/11	Completed	

<p>8. Family Practice Residents FPRs attend DTC and COT as part of their monthly rotations at Baycrest. They also work on the AGU, and the participate in Geriatric Assessment Clinics and GATU. On average there are 2-3 FPRs each month</p>	<p>Completed</p>
<p>9. Geriatric Medicine Residents PGY4's in Geriatric Medicine do a 6 week rotation working on COT, DTC and the Apotex ICT. This is followed by 6 weeks on GATU and the CCC ICT. During this time they attend Geriatric Assessment Clinics related to the teams on which they are working. Many return to do PGY5 rotations in Psychiatry, Behavioural Neurology, Palliative care or Rehabilitation.</p>	<p>Completed</p>
<p>10. Geriatric Medicine Fellow The Baycrest and University of Toronto Fellow will spend 10-12 months on the various services at Baycrest. This will include AGU, GATU. COT.DTC. GAC ICT and rehabilitation. In addition they will have their longitudinal clinic at Baycrest. This will be for 8 months in this fiscal year as the fellowship begins Sept 1, 2011.</p>	<p>Completed</p>
<p>11. Care of the Elderly Fellows Each fellow completes 1-2 months on COT/DTC and GATU. They work regularly on the AGU. They have longitudinal geriatric Assessment Clinics at Baycrest. They may do rotations on rehabilitation and the ICT during the year they are here. This year we have two fellows</p>	<p>Completed</p>
<p>12. Internal Medicine elective residents PGY 2-3's in Internal Medicine spend a month at a time at Baycrest. During this time they have exposure to DTC, COT, ICT, GATU, AGU and sometimes rehabilitation. This year we will have had residents for 6 months</p>	<p>Completed</p>

EVALUATION & RESEARCH

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments
1.	MOVE-IT early mobilization in acute care project Baycrest is working with Sunnybrook, SMH and UHN/MSH on the implementation and evaluation of an early mobilization project for seniors admitted to acute care. In this case, ACT AGU is the unit to be studied. Medical Program Director for Ambulatory Services is the Baycrest Site co-investigator.	Ongoing	In final phase, ongoing data collection.

Other research collaborations

#	Activity / Description	Status	Comments
1.	Client Satisfaction Measurement The Baycrest Ambulatory Clinics will participate in the NRC Picker client satisfaction survey process on an ongoing basis. A client satisfaction survey tool will be identified and applied in the the Community Assessment and Treatment Program.	Ongoing	In process of choosing tool.
2.	Arts Based Parkinson's Program Funding for program extended through 2012.	Completed	
3.	Falls Prevention and Management Program A tool will be developed to measure the effectiveness of the new Falls Prevention and Management Program post-implementation.	Ongoing	
4.	Day Treatment/Seniors Support Program Post-Discharge Follow-Up Program The program will continue to be evaluated and an abstract submitted to one or more relevant conferences for presentation.	Completed	

5. Implementation of a mobility clinical indicator and the impact on quality of care Completed

Baycrest has adopted a mobility indicator. A pilot project is being completed to see the impact on quality of clinical care. Eventually this will be rolled out across the entire Centre, but we are using a quality improvement model through the pilot to create the best tools possible for roll out.

Publications and presentations

#	Activity / Description	Status	Comments
1.	Podium presentation-international conference World Physiotherapy Conference 2011: "Developing Geriatric Core Competency for Physiotherapists": Step 1-A Proposed Framework". Day Treatment Physiotherapist is co-author.	Completed	

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

North York General Hospital

Print date: 1-Jun-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Geriatric clinical educator aging at home strategy 1.Geriatric Clinical/Educator continues to mentor and train new Geriatric Outreach teams in Central LHIN: Southeast team (Markham Stouffville, Unionville Home Society), York Central, Humber River Regional Centre and Southlake Regional. This is the 4th year of this aging at home outreach project.	Ongoing	
2.	Further expansion of Geriatric Inpatient (ACE) Unit Proposed ACE model throughout the organization.	Ongoing	
3.	Collaborating with Information Services to implement an on-line referral system. At present in development with health records. This will be for all the outpatient ambulatory geriatric services for acute care to access outpatient services.	Ongoing	
4.	ACE Clinic Development This will be for patients discharged from the emergency department and the ACE unit.	Completed	
5.	Osteoporosis and Fracture Development Collaborative initiative between fracture clinic and geriatrician	Completed	
6.	Amalgamation of two memory clinics To provide more timely access to geriatricians and allied health services. This will reduce the wait list.	Completed	

7. Corporate catheter associated urinary tract infection project
 Ongoing
 NP currently working with quality department to help reduce the urinary catheter insertions and catheter associated urinary tract infections

Innovation / New models

#	Activity / Description	Status	Comments
1.	Ambulatory AGU Proposal to have an ambulatory AGU clinic to accomodate patients on the AGU wait list. The clinic will optimize and prevent admission to the hospital.	Ongoing	
2.	ACE Admissions Collaboration with the emergency department and the medicine/surgery clinic for ACE admissions.	Ongoing	
3.	E-care access between acute care and ambulatory care. Ongoing collaboration to maximize access to patient care information between ambulatory and acute care services.	Ongoing	
4.	Geriatric Ambulatory ED collaborative initiative Enhance collaboration with the GEM Nurses, Nurse Practicioners, SHC ambulatory service in the emergency dept with geriatric programme, inservices and communication regarding seamless patient care.	Ongoing	
5.	Geriatric Clinic for Parkinsons This is the only Geriatric clinic in Toronto that focuses on the care of frail elders with Parkinson's Disease and related disorders. Pilot outcomes for the PD clinic awarded 2nd prize in the NYGH Quality Fair April 2010	Completed	

Activity Variance

#	Activity / Description	Status	Comments
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| <p>1. Acute Geriatric Unit bed occupancy
 The increasing numbers of admitted patients in the emergency department waiting for beds has impacted our ability to directly admit patients into the AGU. As a result, this has affected our bed occupancy. With the ambulatory AGU proposal we are hoping to change this.</p> | <p>Ongoing</p> |
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LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	NYGH CPOE committee (Computerized Provider Order Entry) Geriatric team members continue to be involved in reviewing hospital based order sets taking into consideration our aging population and comorbidities.	Ongoing	
2.	Care of fracture clinic patients A) Continued planning in collaboration with Dept. of Surgery and Medicine (Geriatrics) around fast tracking BMDs for patients being seen in the fracture clinic to address secondary prevention. (see innovation starting Fall 2011) B) Central LHIN initiative around development of choice and changes in relation to CDSM and prevention.	Ongoing	
3.	Care of seniors in the ED Meetings underway with ED to look at how seniors are being cared for in the ED and any opportunities for improvement, partnering. Part of initial assessment for new ACE model. (link with short stay unit/med surgery clinic and GEM collaboration.	Ongoing	
4.	Leadership Retreat Leadership retreat conducted with RGP partners to look at corporate and community elder care planning.	Completed	

External partnerships

#	Activity / Description	Status	Comments
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<p>1. Partnership with RGP in the development of four new Outreach teams (initiative under the Aging at Home strategy) This team includes: Southeast team(Markham Stouffville, Unionville Home Society), Southlake and York Central, Humber River Regional. NYGH is the accountability lead for this initiative and continues to work closely with the RGP.</p>	Completed
<p>2. Chronic Disease Self Management Program New community centre partnerships have been established by the Chronic Disease Self Management Program with both the Black Creek Community Health Centre, Branson Cardiac Rehab Program, Prosserman, North York Seniors Centre and Southlake Regional Hospital.</p>	Completed
<p>3. Central LHIN subcommittee in Chronic Disease Self Management and Prevention NYGH continues its participation in this committee.</p>	Ongoing
<p>4. Fall Intervention Team Geriatric ORT and the Public Health Dept. working together surrounding FIT.</p>	Ongoing
<p>5. LHIN stroke prevention initiative Partnering underway regarding stroke prevention clinic and wellness training in collaboration with the cardiac rehab unit at the Branson/TRI.</p>	Completed
<p>6. Second Annual Five Weekend Care of the Elderly Course After the success of the pilot course in 2011, the second annual five weekend course for primary care practitioners has been set to commence January 2012. Organizing committee: Dr. Joyce Lee (NYGH), Dr. Rob Lam (TRI), Dr. Bachir Tazharji (TRI) and others.</p>	Ongoing

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Presentation at conferences, workshops, in-services The geriatric team members will continue to seek out opportunities to present at conferences and workshops locally and nationally.	Ongoing	
2.	Monthly Geriatric Seminars Partnership with pharmaceutical representatives in assisting with sponsoring monthly interprofessional Geriatric Seminars offered to staff across all sites.	Ongoing	
3.	Preceptorship for nursing and allied health students from academic facilities Ongoing partnership and geriatric education with academic facilities.	Ongoing	
4.	SPPICES Education Education sessions ongoing around Stability/Falls, Polypharmacy/Pain, Incontinence/Confusion, Eating/Nutrition and Skin Breakdown. Sessions are still being offered online through the internal learning management system for all new hospital staff. (My Learning Edge)	Ongoing	
5.	Geriatric Medicine/Psychiatry conference Planning underway for joint Geriatric Medicine and Psychiatry conference for 2012	Ongoing	
6.	Corporate Eldercare Orientation Eldercare orientation is for new staff. Consent and Capacity orientation is for new nursing staff.	Ongoing	

<p>7. Interprofessional education around geriatric issues A)Monthly in-services given by the 5SE interdisciplinary staff as it relates to geriatric related issues that commonly occur on the unit. B)MD's and NP's meet quarterly to discuss relevant topics of interest. C)Monthly geriatric seminars for all staff D)Education provided by ORT to local community organizations, public groups, GEM nurses</p>	Ongoing
<p>8. Academic lecturing Members of the Geriatric team continue to provide lectures to academic facilities on request related to care of the elderly.</p>	Ongoing
<p>9. Geriatric Blog Utilized as an education and dialogue forum for ICT members. During this upcoming year, the blog will be expanded to include Ambulatory Geriatric Services and medical, nursing, allied students during their placements.</p>	Completed
<p>10. Specialty traineeship in geriatrics for post PharmD pharmacist Specialty rotation provided for pharmacist who is undertaking post-PharmD specialty training.</p>	Ongoing

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	<p>Clinical placement Supervise clinical placements for nursing and allied health students. Look at how the team can intergrate concepts of IPE/IPC during student placements on the geriatric service/unit.</p>	Ongoing	
2.	<p>Acute Care NP Students (Donna Ruffo) Continue to precept ACNP students from the University of Toronto.</p>	Ongoing	

3. Family Practice Residents Continue to support the learning of family practice residents at NYGH during their geriatric medicine rotations.	Ongoing
4. Preceptorship of Geriatric Fellows Continue to build relationship with academic centres to attract geriatric fellows for their clinical placements.	Ongoing
5. Doctor of pharmacy students Ongoing	Ongoing
6. Pharmacy intern Ongoing	Ongoing
7. Family practice resident rotation package The geriatric team is currently revising the training package provided to family practice residents.	Ongoing

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	Research Initiatives Day Hospital Goal Attainment Scaling research initiatives.	Completed	
2.	Aging at home strategy Outreach evaluation. ORT Steering Committee;ORT Network;RGP Accountability Meeting.	Ongoing	
3.	Model of Care for the elderly Continued ACE unit development. The ACE unit will be evaluated in fall 2011. Metrics have been developed in collaboration with the quality department.	Ongoing	
4.	Lewy Body and Parkinson's Dementia Multi-site study looking at response to rivastigmine on SPECT scanning. General PI: Dr. Mario Masellis, Sunnybrook. Site PI: Dr. Joyce Lee, NYGH.	Ongoing	

5. Expectations Study Ongoing
The role of Family Physicians in Dementia Care. Multi-site study investigating expectations of stakeholders (Geriatrician, Consultants, Neurologists, Family MDs, patients and families) as it relates to the Family Physician's role in Dementia Care. Site PI: Dr. Joyce Lee.

Publications and presentations

#	Activity / Description	Status	Comments
1.	Community education presentations and sessions r/t Geriatric programs and services. These include: Living Well with Parkinson's Memory Clinics, Chronic Disease Self Management, POWER), Osteoporosis Forum with Osteoporosis Canada, Aging at Home Strategy. NYGH continues to deliver community education and health teaching.	Ongoing	
2.	Global TV Global TV will be interviewing ACE team members to discuss how we deal with ALC issues, to be aired fall 2011.	Completed	
3.	Mercury toxicity and neuropsychiatric presentations in the elderly manuscript Manuscript is currently being prepared for publication to reflect the NYGH case report presented at the CGS in 2010.	Not achieved	
4.	Olanzapine IM use in elderly hospitalized patients Poster presentations at the May 2011 AGS annual meeting in Washington D.C.-final manuscript in preparation underway for publication.	Ongoing	

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Providence Health Care

Print date: 1-Jun-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Address Patient Flow in Geriatric Medicine Clinics Apply LEAN concepts to geriatric medicine and geriatric psychiatry clinics service model to eliminate waste and ensure value to the patient by implementing improved process and standard work.	Completed	Process Improvements include implementation of Meditech Community-Wide Scheduling of Patient Appointments, Signage and Way-finding, Patient Chart System, Treatment Room Layout, Service Delivery Model in clinics.
2.	Address Patient Flow in Geriatric Outreach Services Explore implementing a standard format for health professional consult reports focusing on key content and size.	Ongoing	GOT committee leading initiative towards standardization of Assessment/Consults and Reports within GTA GOT's.
3.	Address RGP Performance Indicators for 2011-2012 through quality improvement plans Examine the outcomes of newly implemented work processes and referral forms to support meeting indicators targets for Outreach Services and success in providing enhanced service value to the patient and family (i.e. Wait Time in Calendar Days).	Completed	Target and Performance Metrics for Geriatric Outreach were met. Outreach Team's Wait Time Indicator for referral to admission was 13 days which is less than the 25 calendar days target.
4.	Address Safe Mobility Further improvements are being made to our 'transfer tags' for patients to identify transfer method and assistance level. We will be implementing a falls prevention program that will involve falls risk screen tool; use of equipment to prevent falls in the elderly; and education to staff on appropriate interventions for high risk patients.	Completed	On admission and throughout the patients stay, we assess there mobility status and secure 'transfer tags' to their walker, wheelchair etc. A falls prevention program was trialed and implemented at Providence and audited for compliancy

<p>5. Address psychosocial and cognitive deficits Plan to design and implement a tool to screen for the 3Ds (delirium, depression and dementia). Plan to provide education to staff on treatment options for the 3Ds.</p>	Completed	<p>A trial screening tool has been developed and implemented to screen for delirium, depression and dementia</p>
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Innovation / New models

#	Activity / Description	Status	Comments
1.	<p>Explore opportunities to collaborate with the TC-CCAC Integrated Client Care Project to provide Geriatric Clinics and Outreach Services</p>	Ongoing	<p>Effective February 2012, collaborating with Providence Healthcare's newly TCLHIN funded Enhanced Adult Day Program to help meet the needs of high risk seniors (CCAC assessed RAI-HC score greater than 13).</p>
2.	<p>Support the Senior Friendly Hospital Provincial Strategy Incorporate best practices in a comprehensive plan for senior friendly care throughout the organization from design to care delivery and supporting avenues for knowledge sharing and collaboration. Host a strategic visioning session with a goal of developing a novel way of supporting frail/at risk elderly from inpatient to outpatient services.</p>	Completed	<p>“Deliver on our Quality Promise” is one of six strategic directions in Providence Healthcare’s five-year strategic plan, Time to Shine. The Senior Friendly Hospital Strategy is one of the key components of our Quality Promise.</p> <p>Established an internal Senior Friendly Hospital Steering Committee. Participated in RGP Network Committee Senior Friendly Hospital Strategy meeting (July 6, 2011).</p>

E-health

#	Activity / Description	Status	Comments
1.	<p>Expressed interest - To be a Test Site for 'InterRAI Preliminary Screener' This is the proposed screener assessment tool for the CHA (interRAI Community Health Assessment) as a part of Community Services Support Services Common Assessment Project.</p>	Completed	<p>Selected as one Ontario test site for inter RAI Preliminary Screener for Primary Care and Community Care Settings Canadian Study Version. Screened patients in Nov & Dec 2012 and provided summary data to Community Care Information Management (CCIM) for CSS Common Assessment Project.</p>
2.	<p>Engage in health service provider sector selection and use of common assessment tools for senior clients with mental health issues with TC LHIN.</p>	Ongoing	<p>Collaborating with Toronto Community Psychogeriatric Outreach Teams (COPT) Committee regarding future standardized assessments reports and Integrated Assessment Records.</p>

3. Implement processes to support use of the RGP electronic registry To record elderly client data using the Rockwood Clinical Frailty Scale as a global clinical measure of fitness and frailty in both Outreach Services and Geriatric Clinics	Completed	Geriatric Outreach Team data reflects patient frailty Scores of consistently 5 (Mildly Frail) and 6 (Moderately Frail).
4. Engage in Resource Matching and Referral Program hospital expansion study Study to include the Specialized Geriatric Outpatient Services for Older Adults	Ongoing	Actively participating in RM&R development and implementation for Outpatient Services - Geriatric Medicine & Psychiatry Clinics and Outreach Team patient referrals to TCCCAC. Plan to achieve 'Go Live Milestone' in 2012.

LEADERSHIP & PARTNERSHIPS

External partnerships

#	Activity / Description	Status	Comments
1.	Partnership with DECNET for Diabetes Management The RGP is partnering with Diabetes Education Community Network of East Toronto (DECNET) by providing space and marketing for outpatient diabetes management services.	Completed	Monthly on site DECNET Clinic.

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Implementation of Self-Management Initiatives Geriatric Outreach staff will be educated as Leader Trainers to facilitate outpatient pain and diabetes self-management sessions (i.e. Stanford University model in partnership with the Scotiabank Learning Centre).	Completed	Clinical Staff have been trained and are actively leading Chronic Illness Self Management sessions for patients and caregivers

<p>2. Distribution of Be Safe: a guide to home visits and off-site activities It is the key components of a staff safety toolkit for those professionals involved in home visits. The resource will continue to be distributed to interested service providers for free. Presentation opportunities at external venues will be sourced.</p>	<p>Ongoing</p>	<p>Distributed Be Safe at Providence Healthcare's Referring Professionals Open House on April 12, 2012.</p>
<p>3. Implementation of E-Learning Studies for staff education through a Learning Management System at Providence Healthcare</p>	<p>Completed</p>	<p>Providence has taken steps to implement e-learning modules for staff education. Examples include safe client handling, patient safety and incident reporting, fire safety, WHMIS annual review, Workplace Injury - Early & Safe Return to work, Disclosure & Reporting Policy.</p>
<p>4. Further developing a monthly 'Interprofessional Grand Rounds' to educate staff on a variety of topics related to geriatric rehabilitation in team settings.</p>	<p>Completed</p>	<p>The interprofessional team conduct monthly interprofessional rounds. There are opportunities for presentations from both external and internal groups. The sessions are interactive and well recieved by all disciplines.</p>
<p>5. Enhancing interprofessional placements for our students that include lunch and learn sessions. These sessions will include topics related to the geriatric population such as Consent and Capacity, Community Resources and the 3Ds.</p>	<p>Completed</p>	<p>There are regular lunch and learn sessions available to both staff and students in order to provide information to support best practice.</p>
<p>6. Implementing new practice consultants in OT and PT, specific to geriatrics. These staff members will lead our clinicians through reflective practice and other education sessions that are specific to geriatrics.</p>	<p>Completed</p>	<p>As of June 2011, practice consultants for both OT and PT have been implemented to support best practice for the geriatric population on all units at Providence. As of March 2012, developing a new Healthy Aging Program with the addition of 2 new clinical outpatient staff. Focus is on Falls Prevention for Older Adults.</p>

Training of graduate and undergraduate students

# Activity / Description	Status	Comments
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1. Support the Geriatric Rotation for Family Practice Residents Continue to encourage and schedule learning opportunities for physicians participating in Geriatric rotation in all Specialized Geriatric Services (GATU/GRU, Geriatric Clinics, Outreach, Pharmacy Home Visit and Scotiabank Learning Centre).	Completed	Provided 2,250 physician teaching hours.
2. Support students learning opportunities in Geriatrics Actively market availability of student learning opportunities so they can acquire the requisite skills, knowledge and attitude to provide evidence based case to frail elderly with complex contitions.	Completed	

EVALUATION & RESEARCH

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments
1.	Providence Healthcare and Baycrest are pursuing a collaboration to be co-investigators on a project. The project is titled 'Slow Stream Rehabilitation: Predictors of Outcomes 6-Months Post Discharge'.	Not achieved	Baycrest proceeded to conduct the research on their site.

Other research collaborations

#	Activity / Description	Status	Comments
1.	Sunnybrook/Providence Healthcare Patients Requiring Observation Pilot: Managing Patients with Delirium This pilot project will look at admitting patients that require observation (i.e. sitters) from the General Internal Medicine at SHSC to the Specialized Geriatrics Program at Providence Healthcare. There will be four specific metrics evaluating the project.	Completed	The pilot project supporting patients requiring a sitter for observation of patients with delirium was initiated, however there have been limited referrals due to the low numbers of patients that fit the criteria

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

St. Michael's Hospital

Print date: 1-Jun-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	ACE : Maintain current spectrum of service. Will continue to monitor data indicators.	Completed	Continue to monitor ACE bed indicators. Year end occupancy 91%. Ongoing challenge of ALC patients awaiting placement to LTC.

Innovation / New models

#	Activity / Description	Status	Comments
1.	St. Michael's Hospital- Elder Care Task Force led by hospital executive. RGP MD's & staff participate on the Elder Care Task Force offering specialized geriatric knowledge and experience.	Completed	RGP physicians & staff participating with initiative leaders Susan Blacker and Dr. Tom Parker in the SMH Senior Friendly Hospital Strategy. MD's, CLM, invited to join Senior Friendly Steering Committee.

Activity Variance

#	Activity / Description	Status	Comments
1.	GEM GEM: 0.4 FTE position remains vacant - waiting funding approval. This position is difficult to fill and to maintain, for example, last year had two nurses in this position who have left for full time GEM positions elsewhere.	Completed	GEM 0.4 FTE position vacant until October 11, 2011. Permanent full time GEM Nurse has recently resigned - currently seeking replacement
2.	Internal Consult Team Over the past 2-year period there has been a consistent increase in the volumes related to this service.	Completed	Very busy service - volumes continue to increase. 30.4% increase in the consult numbers as compared to last year.

<p>3. Elders Clinics There is a 10% increase in clinic volumes associated with the past year. An outreach geriatric clinic has been established at one of the hospital's family practice units (St. Lawrence Cente) located at 140 the Esplanade.</p>	<p>Completed</p>	<p>Clinic activity continually increasing. Dr.Zorzitto and Dr. Gilley providing clinics. Geriatric clinics established at two of SMH Family Practice sites.</p>
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E-health

# Activity / Description	Status	Comments
<p>1. Telehealth Dr. Zorzitto provides assessment via telehealth to Orillia and Beaverton areas 3 X per month.</p>	<p>Completed</p>	<p>Dr. Zorzitto continues to provide Telehealth assessments 2 X monthly. increased number of assessment requests.</p>

LEADERSHIP & PARTNERSHIPS

Local organization

# Activity / Description	Status	Comments
<p>1. Geriatric staff are represented on professional councils at all discipline levels.</p>	<p>Completed</p>	<p>RGP staff represented at discipline specific councils</p>
<p>2. Geriatric research associated with the SMH Li Ka Shing knowledge Institute Dr. Sharon Straus, Dr. Camila Wong and Dr. Arlene Bierman actively involved in research regarding geriatric issues.</p>	<p>Completed</p>	<p>Dr. Straus, Dr. Bierman and Dr. Wong remain actively involved in geriatric focused research. Dr Zorzitto & Dr. Straus involved in MOVE ON early mobilization study.</p>

External partnerships

# Activity / Description	Status	Comments
<p>1. TC-LHIN Mental Health & Addictions & Seniors Think Tank GEM NP providing St. Michael's representation</p>	<p>Completed</p>	<p>GEM NP represented SMH</p>
<p>2. University of Toronto, Faculty of Nursing, Advancing the Care of Older Adults CASPP education program development. GEM NP member of the education program development group.</p>	<p>Completed</p>	<p>GEM NP represented SMH</p>

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	University of Toronto teaching cross appointments for individual team members - medicine, nursing, physiotherapy, occupational therapy and social work.	Completed	Cross appointments maintained
2.	Seniors Month Throughout the month of June the geriatric staff provide and promote elder focused educational activities for both hospital and community workers.	Completed	RGP staff arranged for Seniors Month events offering education for staff and community health care providers. Events included a presentation "The Long Hello- The Other Side of Alzheimer's" and a Community Partners Day that included a display of available resources.
3.	Medical and Nursing Rounds Provides geriatric focused educational sessions to hospital physicians and nursing staff.	Completed	Geriatric focused SMH Medical Grand Rounds- presented twice this past year. Hospital wide Nursing Rounds were presented focusing on delirium and the IPPOD implementation in the ED.

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	Education provided by all disciplines - medicine, nursing, physiotherapy, occupational therapy, and social work.	Completed	University of Toronto graduate and undergraduate medical student education provided by geriatricians. Placement given to post graduate internal medicine and Primary Care students. Medical students supervision provided in the clinic setting. Students from outside U of T include - Elective Medical Students from McMaster University and the University of British Columbia. Other disciplines participated in student education related to specific disciplines- nursing, physiotherapy, occupational therapy.

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	RGP Initiative -Mobilization of Vulnerable Elders in Toronto (Move it). This mulitsite (Sunnybrook, Baycrest, Mount Sinai and St Michael's) early mobilization initiative that is targeted for implementation this fall. Dr. Zorzitto and Dorothy Knights RN are the St. Michael's steering commitee representatives.	Completed	MOVE ON early mobilization initiative commenced at SMH December 2011 with pre-intervention, screening & audits followed by education of patients & staff in March. In May post education with no interventions and exit interviews with staff & patients. Presently in the exit stage interviews with bi-weekly audits. VISA(Volunteers Ingaging Seniors in Activities) initiative has been introduced with 7 volunteers visiting with patients.

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments
1.	Geriatric / Trauma Research The Geriatric consult team in collaboration with St. Michael's Neurosurgery Department continues to follow every patient over 60+ years admitted to the Trauma service. Geriatric services provide a comprehensive assessment within 48 business hours of admission.	Completed	Geriatric / Trauma partnership continues to provide geriatric consultation on all admitted Trauma patients over 60 years of age.

Publications and presentations

#	Activity / Description	Status	Comments
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1. All disciplines will seek the opportunity to present and / or publish throughout the year.

Completed

GEM NP - Interprofessional Prevention of Delirium: Engaging Emergency Department Staff. Podium presentation given at the 40th annual scientific and educational meeting of the Canadian Association on Gerontology, October 2011.

GEM NP co-investigator on the Evaluation of Outcomes and Impacts of the Enabling teamwork, Interprofessional collaboration and Education (EnTICE) Project St. Michael's site.

Poster presentation St. Michael's Innovation Day Formative Evaluation of the Acute Care of the Elderly Unit at St Michael's Hospital.

Research, consultation and assistance to others

# Activity / Description	Status	Comments
<p>1. 1. Dr. Wong -research with geriatric patients on Orthopedics and General Internal Medicine.</p> <p>2. Dr Straus involved in research activities with national and international experts.</p> <p>1. Dr Wong is focusing on delirium in the frail post -op patient as well as looking at the effect of multiple room changes during a hospital stay on the GIM unit.</p>	<p>Completed</p>	<p>Dr. Wong supervised Residents in this research project- presented at the Canadian Geriatrics Society meeting in Quebec. Poster presentation at St. Michael's hospital Innovations Day.</p> <p>Dr. Straus, Director of Knowledge Translation, Li Ka Shing Knowledge Institute, is actively involved in geriatric research. One area of focus is evidence based mentorship.</p>
<p>2. RNAO Best Practice Guidelines Geriatric NP, CNS and Nurse Coordinator offer expertise and support to St. Michael's introduction of RNAO Best Practice Guidelines. Guidelines include Women's Abuse, Continence, and Delirium.</p>	<p>Completed</p>	<p>RGP nursing staff continue to support and educate staff in regards to RNAO Best Practice Guidelines.</p>

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Sunnybrook Health Sciences Centre

Print date: 1-Jun-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Maintain current spectrum of services and adjust according to population need.	Ongoing	
2.	Outreach team - process improvements. Implement Rockwood Frailty Scale data collection. Identify opportunities for efficiencies.	Ongoing	
3.	Geriatric Day Hospital Stabilize health human resources and team building with new staff. Identify opportunities for process improvements.	Ongoing	no vacancies
4.	Falls program Stabilize health human resources. Explore strategies to manage demand.	Ongoing	

Innovation / New models

#	Activity / Description	Status	Comments
1.	Support corporate senior friendly priority areas - functional decline, culture and physical environment. Continue to provide clinical expertise for planning and implementation of corporate priorities. our staff are providing leadership to the functional decline group, and clinical expertise to culture and physical environment.	Ongoing	

2. Apply for funding for innovative day hospital/clinic model - Geriatric Assessment Management and Evaluation (GAME). Support for quality improvement initiative to promote increased access and flow of geriatric patients.	Completed	application submitted
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LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	Corporate senior friendly hospital steering committee and subcommittees Provide clinical expertise in care of frail seniors	Ongoing	
2.	General medicine quality council Standing committee of hospital	Ongoing	
3.	Interprofessional Education Committee Standing committee of hospital	Ongoing	
4.	Emergency Department Quality Care Committee GEM nurse is a member of committee	Ongoing	
5.	Other discipline-related activities involving SGS staff SGS staff provide geriatric expertise and leadership to professional practice groups	Ongoing	

External partnerships

#	Activity / Description	Status	Comments
1.	Membership on SPRINT advisory committee Partnership with geriatric outreach team	Ongoing	
2.	GTA Rehab Network committee SGS Social worker is member on working group addressing referrals processes and flow	Ongoing	

3. Falls Intervention Team - Public Health Community Council Linkage with day hospital and falls program. Continue to support and strengthen relationship and complementary services for our shared falls clients.	Completed
4. RGP committees RGP Network, GEM nursing network, Accountability Steering Committee, Outreach team committee, Day hospital committee	Ongoing

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Continue to act as a resource through RGP Network to partnering institutions Host health professionals from other organizations for shadowing, skill development and information exchange	Ongoing	
2.	SGS staff to continue to act as a resource to Sunnybrook staff Participation in rounds, provide leadership in best practices in care of the elderly	Ongoing	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	Training for students from all health disciplines participate in observation, preceptorship or training Continue to host rotations for all health disciplines. Provide site visits on request from external partners.	Ongoing	

2. **Medical student and resident training** Ongoing
 We are a core site for geriatric medicine training. The U of Toronto Geriatric Medicine Residency program director is based here. We support this training program by providing the interprofessional teams that form the backbone of geriatric medicine educational experience. Training site will continue to be highly rated by trainees. Residents must attend home visit

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	Continue to participate in outreach evaluation Support quality improvement processes to improve efficiency and clarity of documentation.	Ongoing	

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments
1.	Support multisite early mobilization project Sunnybrook is the lead site for this project. Developing implementation toolkit for MOVE IT (Mobilization of Vulnerable Elderly in Toronto). Co-lead for MOVE ON (Mobilization of Vulnerable Elderly in Ontario) proposal to CAHO	Ongoing	7 of the 10 inpatient units implemented the intervention
2.	PRISE study - identification of safety events in senior inpatients Continue to analyse and interpret data, provide clinical expert advice to project.	Completed	
3.	Team meetings study - Standardized Assessment of Clinical Evaluation Report (STACER) Collaborating on this multisite project. St. Michael's (Camilla Wong) is PI.	Ongoing	REB approval obtained

Other research collaborations

#	Activity / Description	Status	Comments
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1. Caregiver Study
Collaborating with McMaster
University researchers on caregiver in
dementia study

Completed

2 focus groups completed

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Toronto Rehabilitation Institute

Print date: 1-Jun-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Expand dialysis program between Toronto General Hospital (TGH) and Toronto Rehab Institute to include Geriatric Day Hospital Patients. In progress with University Health Network (UHN) integration initiatives.	Ongoing	In development, pending Bickle development. Trial of dialysis patients from UHN coming to Toronto Rehab's Day Hospital has been piloted.
2.	Implement process improvement initiative in the outpatient services to increase access and responsiveness. Environmental scan planned for Q2.	Ongoing	Scan completed; new model of care developed and aiming for implementation in summer of 2012.
3.	Focus on preparation to achieve successful transition of Geriatric Rehab Program outpatient services and inpatient clinics move safely into the University Centre (UC) redevelopment by Spring 2012.	Completed	

Innovation / New models

#	Activity / Description	Status	Comments
1.	Review/revise Toronto Rehab's a comprehensive post fall assessment and develop post fall assessment tools to meet specific needs of older adults for reducing falls risk. Workgroup struck and current state (needs) analysis underway.	Completed	Post fall assessment tool was tweaked and the stratified assessment was adjusted; falls checks were implemented for 3 continuous shifts post fall.
2.	Develop and implement a comprehensive appraisal of specialized services in Geriatric Psychiatry.	Completed	Completed site visits both outside GTA and one conducted internationally (in Australia).

3. Develop a new interprofessional self medication awareness program for the Geriatric Rehab in-patient services.	Ongoing	Pending implementation of enhanced pharmacy resources.
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Activity Variance

# Activity / Description	Status	Comments
1. Continue to monitor inpatient and outpatient activity and access indicators.	Ongoing	Being reviewed with team on a quarterly basis.

E-health

# Activity / Description	Status	Comments
1. Continue to implement and evaluate enhancements to the Electronic Patient Record (EPR) in collaboration with the Shared Information Management System (SIMS). To be aligned with UHN integration activities.	Ongoing	Ongoing; corporate launch recently initiated.
2. Coordinate Behavioral Neurology weekly multi-site clinical e-rounds. Rounds include international participants.	Ongoing	

LEADERSHIP & PARTNERSHIPS

Local organization

# Activity / Description	Status	Comments
1. Lead the implementation of elements of the Senior Friendly Hospital framework at Toronto Rehab/UHN.	Completed	Senior Clinical Director of Geriatrics Program is co-chair of steering committee of Senior Friendly Hospital strategy at UHN.
2. Geriatric Rehab Program Community Advisory Group (CAG). New 2011/12 membership on the CAG group with representation from the community, patients/families and staff.	Ongoing	

3. Implement GIM Outreach Pilot at the University site to improve patient flow with aim to reduce the number of 911 calls, emergency room and acute care re-admissions from inpatient rehab. A collaboration between UHN (TGH and Toronto Rehab) and Mount Sinai Hospital.	Ongoing	Review resulted in the approved hiring of clinical nurse specialist to manage and reduce transfers out.
4. Geriatric Program Patient Care Planning Team.	Ongoing	
5. Toronto Rehab's Revolutionizing Nursing Steering Committee (new). Geriatric Rehab Program Manager is a member.	Ongoing	
6. Continue to explore Toronto Rehab's falls prevention strategies with TGH.	Ongoing	

External partnerships

#	Activity / Description	Status	Comments
1.	RGP Accountability Steering Committee and Network.	Ongoing	
2.	RGP Psychogeriatric Resource Consultant Program in partnership with RGP of Toronto.	Ongoing	
3.	Alzheimer's Society of Toronto. Membership on CAG.	Ongoing	
4.	Alzheimer's Society of Canada and Canadian Association of Occupational Therapists. Joint project looking at safety for persons with dementia living in the community. Advanced Practice Leader is a working group member; Webinars will be launched in January 2012.	Completed	
5.	Toronto Central LHIN and Toronto Central CCAC. Integrated Client Care Project and Enhanced Seniors Services Project. Geriatric Rehab Program Manger is a member.	Completed	

<p>6. CCAC and Toronto Rehab's Geriatric Psychiatry Service. Working Group developed to focus on flow of Geriatric patients across the system to address complex behaviors. Members from Geriatric Rehab Program Leadership team members of the working group.</p>	Ongoing	
<p>7. CCAC and Toronto Rehab's Neuro and Geriatric Rehab Program. Working Group developed to address patient flow and implementation of new CCAC initiatives at University Centre. Geriatric Rehab Program Manger is a member of the working group.</p>	Ongoing	
<p>8. Partnerships designated within the Toronto Long-Term Care Mental Health Framework (July 4, 2006) to provide Psychogeriatric Outreach Services. Partners include Lakeside Long-term Care Centre, Castlevew Wychwood Towers, Mon Sheong Long-term Care Home, Fellowship Towers and Belmont House Retirement Home.</p>	Ongoing	
<p>9. UHN, Toronto Rehab, and Mount Sinai Hospital. Joint collaborative to align and optimize outpatient services across sites.</p>	Ongoing	Review of services across sites completed; reviewing opportunities to align services.
<p>10. National Institute for Care of the Elderly (NICE), a nationally funded centre for excellence in knowledge translation. Geriatric Rehab Program team member is a member.</p>	Ongoing	
<p>11. Partnerships with various organizations as part of Geriatric Rehab program CAG. Canadian Diabetes Association, Mount Sinai Hospital, Alzheimer Society of Toronto, Toronto Central CCAC, St. Hilda's Retirement Residences, Castlevew Wychwood Towers, St. Christopher's House, Home for the Aged, Psychogeriatrics Research Consultant.</p>	Ongoing	

12. Work with Baycrest and CAMH to explore future of long stay patients and system change (building on the TC-LHIN Centralized Intake and Referral Process to Access Specialty Mental Health Hospital Bed).	Completed	Work in this area revolved to the launch of the behavioural support unit.
13. Sunnybrook Health Sciences Research and Ethics Board. Geriatric Rehab Program Manger is a member.	Ongoing	
14. Canadian Dementia Translation Network. Geriatric Rehab Program. Acting Medical Director is a member.	Ongoing	
15. Canadian Colloquium on Dementia. Acting Medical Director is the president.	Ongoing	
16. Affiliation with the University of Toronto.	Ongoing	

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Biannual Canadian Conference on Dementia in collaboration with Toronto Rehab's Marketing and Communications department and Conference services. National conference with the next one to be in October 2011 in Montreal.	Completed	
2.	Biannual Alzheimer Symposium in collaboration with Toronto Rehab's Marketing and Communications department and Conference services. Alternates with Geriatrics Medicine Conference with the next one to be in March 2012.	Completed	
3.	Geriatrics Medicine Conference. Alternates with the Biannual Alzheimer Symposium.	Ongoing	
4.	Driving for Seniors at Toronto Western Hospital.	Completed	

5. Train the trainer sessions for new unit at Providence on 3 Ds (Dementia, Delirium, Depression). Advanced Practice Leader for Geriatric Rehab Program will conduct the sessions.	Completed	
6. Webinars with partnership Alzheimer's Society of Canada. Webinars will be conducted in January 2012.	Completed	
7. Canadian Dementia Resource and Knowledge Exchange webinar on responsive behaviors. Webinars will be conducted in July 2012.	Completed	Webinars conducted in July 2011.
8. Webinar for launch of 'Living with Alzheimer's Disease' book with participants across the country. Advanced Practice Leader and Occupational Therapists from the Geriatric Rehab Program contributed to the new edition.	Completed	
9. Ask the Expert event in collaboration with the Alzheimer Society of Canada.	Not achieved	The Alzheimer Society changed plans and as a result this series was not offered.
10. Presentations at local, national, and international conferences.	Ongoing	
11. Articles in local, national, and international publications.	Ongoing	
12. Best practice rounds for Geriatric Rehab Program.	Ongoing	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	Nursing student clinical placements.	Ongoing	
2.	Allied health student clinical placements.	Ongoing	
3.	Interprofessional education placements.	Ongoing	

4. Undergraduate medical students.	Ongoing
5. Post-graduate medical residents.	Ongoing
6. U of T summer mentorship program placements.	Ongoing
7. Ad hoc international student visits.	Ongoing

EVALUATION & RESEARCH

Other research collaborations

#	Activity / Description	Status	Comments
1.	Does participation in a hospital creative arts program positively affect mood of the geriatric hemodialysis patient? Recreation Therapist for Geriatrics is the principle investigator.	Ongoing	Data analysis underway.
2.	Dialysis in the Elderly.	Ongoing	
3.	Effects of chemotherapy on cognition in the elderly. Physician for Geriatrics is an investigator.	Ongoing	

Publications and presentations

#	Activity / Description	Status	Comments
1.	Various publications.	Ongoing	
2.	Various internal and external presentations.	Ongoing	

Research, consultation and assistance to others

#	Activity / Description	Status	Comments
1.	Clinical Research Committee for U of T division of Geriatric Medicine. Acting Medical Director is the chair.	Ongoing	

2. Toronto Dementia Research Alliance. Acting Medical Director sits on core committee.	Ongoing
3. Ontario Brain Initiative Dementia Working Group. Acting Medical Director is a member.	Ongoing
4. Ontario Health Study Cognition Working Group. Acting Medical Director is a member.	Ongoing
5. Canadian Prevalence of Neurological Diseases Scientific Advisory Committee. Acting Medical Director is a member.	Ongoing
6. Interprofessional Collaborative Practice in Geriatric Rehabilitation: Comparison of Face-to-Face and On-Line Discussions to Teach Team-Based Care.	Ongoing
7. Trainee and student research.	Ongoing

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

University Health Network

Print date: 26-Jul-2012

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	Enhance senior's services at TWH. Evaluate and implement opportunities for further collaboration with Falls Clinic & General Internal Medicine programs.	Completed	
2.	Incorporate "Senior Friendly" ideas for all UHN planning processes. Ensure all new planning initiatives are undertaken with the Senior Friendly Framework in mind.	Completed	Have implemented a Seniors Friendly Executive Steering Committee at UHN/TRI
3.	Compile and analyze monthly RGP stats To monitor & evaluate efficient functioning of GEM resources, Geriatric initiatives and bed days & LOS of patients on ACE unit.	Completed	

Innovation / New models

#	Activity / Description	Status	Comments
1.	Evaluation of Geriatric Emergency Management initiative Evaluate implementation of a geriatric triage team in ER consisting of nursing and AH to enhance patient care in the ER, community and in the in patient area.	Completed	Ongoing evaluation through RGP
2.	Enhancement of current Falls Prevention clinic Working in collaboration with St Christopher's house and Toronto public health to conduct Fall prevention programs in the community	Completed	Pilot program and evaluation completed with Public Health Unit. Data is currently being compiled and analyzed.

3. LTC mobile outreach program Implementation of TCLHIN (west) funded LTC Mobile Outreach program in conjunction with RGP.	Ongoing	
4. Implement strategies to provide ACE environment across all GIM units. To ensure providing best care for geriatric patients	Completed	Have changed ACE unit which was focused on 1 unit to a Mobile ACE team which provide services and care across all units at TWH.

Activity Variance

# Activity / Description	Status	Comments
1. Participate in ongoing ED/GIM quality initiatives and planning. For ongoing accreditation & improved care for seniors and the frail elderly.	Ongoing	
2. Review integration of Geriatric Services at TWH. For better utilization of human and financial resources required for patient care	Ongoing	

E-health

# Activity / Description	Status	Comments
1. RGP registry To gather & compile data & stats on ACE unit, ICT, GEM and clinic utilization.	Completed	
2. Maintain RGP website on UHN intranet For easy access to UHN staff to information regarding RGP services & referral process	Completed	

LEADERSHIP & PARTNERSHIPS

Local organization

# Activity / Description	Status	Comments
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1. Maintain leadership in Quality Initiatives related to enhancing Geriatric Care Dementia network committee, Falls prevention committee, Restraint minimization committee, IP Skin and wound care committee, Patient centered care committee, Pain quality committee, Delirium, Dementia & Depression committee, GIM quality Committee	Completed
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External partnerships

#	Activity / Description	Status	Comments
1.	Continue participation in RGP Network committees. Active involvement by RGP members to provide input to medical and administrative directors.	Ongoing	
2.	Leadership in Geriatric evidence based practice Barry Goldlist has been named editor in chief of Canadian Geriatric Society CME journal	Completed	
3.	Leadership in the Care of Elderly patients in Primary Care. Dr Robert Lam is a member on the College of Family Physicians of Canada Health Care of the Elderly Committee	Completed	
4.	Leadership in the Care of Elderly patients in primary Care Dr Robert Lam is participating in the new Care of the Elderly Series in the Canadian Family Physician journal	Completed	

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	Education for staff related to Geriatric Best Practices. Early mobilization, Falls safety, Delirium, Dementia & Depression, restraint use, skin & wound care, pain control & other geriatric problems.	Ongoing	Ongoing efforts to enhance education. Plan to implement NICHE at UHN /TRI in coming year.

<p>2. Mainpro-C CME Geriatric Course Dr Lam is organizing the second (5 week) CME course for family physicians starting in January 2012. It is partially funded by the College of Family physicians of Canada Continuing Professional Development Scholarship and the Canadian Geriatric Society</p>	<p>Completed</p>	<p>Dr Lam is directing the second year of a CME course for family physicians that started in January 2011. The CME course is called The Five Weekend Care of the Elderly Certificate Course and the class size has increased to 28 participants. The course is endorsed by the University of Toronto's Department of Family and Community Medicine and Continuing Education and Professional Development, the Ontario College of Family Physicians and the Canadian Geriatric Society</p>
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Training of graduate and undergraduate students

# Activity / Description	Status	Comments
<p>1. Education for IP students related to Geriatric Best Practices Staff offer education in wound care, continence & constipation to residents in geriatric programs, medical & family practice units as well as to students from the IP team.</p>	<p>Completed</p>	<p>Ongoing efforts to enhance education. Plan to implement NICHE at UHN /TRI in coming year.</p>
<p>2. Continue participation in DOCH (Determinants of Community Health)Teaching course. RGP staff participates in teaching DOCH to first year medical students</p>	<p>Completed</p>	<p>2 DOCH student projects in the Falls Program</p>
<p>3. Continue monthly evidence based geriatric medicine presentation. Allied health & Nursing staff supervise geriatric medicine residents in training them in EBG</p>	<p>Completed</p>	

EVALUATION & RESEARCH

RGP Coordinated

# Activity / Description	Status	Comments
<p>1. Evaluation of Geriatric Emergency Management project Ongoing evaluation of GEM role including expansion of hours.</p>	<p>Completed</p>	

2. **Evaluation of LTC Mobile Outreach program** Completed
Specialized RN's added to the ER and working with the GEM nurse to provide follow up and outreach to ALC facilities to enhance care of elderly and prevent admission to ER.

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments
1.	Falls Clinic Research Active research protocol which received funding support from Krembil foundation to evaluate implementation of a community based Falls Program in partnership with Toronto Public Health.	Completed	Project with the Public Health unit is completed and data is currently being compiled and analyzed.
2.	Research on Health Outcomes in Prostate cancer in elderly. Dr. Alibhai & co-investigators are completing the final phase of follow-up this year of a prospective study funded by the Canadian Cancer Society. Two major papers from the first year of follow-up will be published this year	Completed	Dr. Alibhai & co-investigators have completed the final phase of follow-up this year of a prospective study funded by the Canadian Cancer Society looking at the impact of hormone therapy on older men with prostate cancer. Two major papers from the first year of follow-up have been published in a high-impact scientific journal. Several papers looking at secondary outcomes have also been published, including risk of falls and depression. A new project will begin looking at the impact of chemotherapy on older men with prostate cancer.
3.	Research on Health Outcomes in Acute leukemia in elderly. Dr. Alibhai & co-investigators are conducting a large, prospective study looking at quality of life and physical function in older and younger patients with acute myeloid leukemia. The study continues recruitment. Preliminary analyses will be conducted and a manuscript submitted for publication	Completed	Dr. Alibhai & co-investigators are conducting a large, prospective study looking at quality of life and physical function in older and younger patients with acute myeloid leukemia. Recruitment has been completed to this study. Follow-up of patients continues. Preliminary analyses of the first 104 patients has been conducted and a manuscript is in press at a scientific journal.

4. **EMNS research project “ Caring for Dying Residents in Long Term Care Homes” a qualitative study understanding the barriers to LTCH staff providing optimal care to residents at end of life.** Ongoing
- Funded by UHN Krembil Nursing Research. Principal Investigator-Jeannine McDonald, BScN, Co Investigators- Alison Graham, RN, Maria Lippa, RN , MN, Gladys Mokaya RN, MScN, Petal Samuel RN, MA Ed, Annabelle Bandurchin MHSc & Trisha Woodcock, RN

Other research collaborations

#	Activity / Description	Status	Comments
1.	<p>Research on a pilot exercise study for middle aged and older people with acute myeloid leukemia Dr Alibhai and co-investigators will complete this study this year, funded by the Leukemia & Lymphoma Society of Canada. Results will be analyzed and submitted for presentation to a major scientific meeting</p>	Completed	Dr. Alibhai and co-investigators have completed this study, funded by the Leukemia & Lymphoma Society of Canada. Results are being analyzed and will be submitted for presentation to a major scientific meeting as well as publication.
2.	<p>EMNS Research - "Caring for Dying Residents in Long Term Care Homes” a qualitative study understanding the barriers to LTCH staff providing optimal care to residents at end of life. Funded by the Krembil Nursing Award. Principal Investigator-Jeannine McDonald, BScN, Co Investigators -Alison Graham, RN, Maria Lippa, RN , MN, Gladys Mokaya RN, MScN, Petal Samuel RN, MA Ed, Annabelle Bandurchin MHSc and Trisha Woodcock, RN</p>	Ongoing	

Publications and presentations

#	Activity / Description	Status	Comments
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1. Canadian Geriatrics Society Dr. Goldlist is a member of maintenance of certification committee for this society	Completed	Dr Barry Goldlist is Editor-in-Chief of Canadian Geriatrics Society Journal of Continuing Medical Education. Dr. Alibhai is Senior Editor of the Canadian Geriatrics Society Journal of Continuing Medical Education.
2. Presentations Dr Goldlist speaking at National hospitalist conference and at Ontario Medical Directors conference.	Completed	
3. Cancer in the elderly Dr. Alibhai will be presenting on this topic to health professionals at a conference hosted by North York Hospital	Completed	Dr. Alibhai has presented on this topic to health professionals at various conferences, locally, nationally, and internationally
Research, consultation and assistance to others		
# Activity / Description	Status	Comments
1. Research on prevalence of pressure ulcers Ongoing nursing evaluation to prevent incidence of pressure ulcers in patients.	Completed	
2. Research on treatment of pressure ulcers using multidisciplinary teams in Ontario Dr. Alibhai is a co-investigator on this research project funded by the Canadian Patient Safety Initiative and the Ontario Ministry of Health and Long-Term Care. The study will begin recruitment of patients in long-term care facilities this year	Ongoing	Dr. Alibhai is a co-investigator on this research project funded by the Canadian Patient Safety Initiative and the Ontario Ministry of Health and Long-Term Care. The study continues to recruit patients in long-term care facilities this year and should finish recruitment next year.

3. Research in geriatric oncology

Dr. Alibhai is providing consultation and collaborating with colleagues in other cancer disciplines at the University Health Network, Sunnybrook Health Sciences Centre, and as part of the Cancer and Aging Research Group, an international organization of researchers interested in research in cancer in older adults

Completed

Dr. Alibhai is providing consultation and collaborating with colleagues in other cancer disciplines at the University Health Network, Sunnybrook Health Sciences Centre, and as part of the Cancer and Aging Research Group, an international organization of researchers interested in research in cancer in older adults. Dr. Alibhai co-lead a provincial symposium on the role of comprehensive geriatric assessment in older patients with colorectal cancer. Dr. Alibhai is also the English Canada national representative to the International Society of Geriatric Oncology.

RGP REGIONAL GERIATRIC
PROGRAM OF TORONTO

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GiiC geriatrics interprofessional
interorganizational collaboration

GEM geriatric emergency
management network

PRCP psychogeriatric resource
consultation program of toronto

sfH senior friendly
hospitals