Year End Report 2012-2013

REGIONAL GERIATRIC PROGRAM OF TORONTO

Better health outcomes for frail seniors

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Introduction

The RGP supports a network of 26 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 service plan outlines 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.

Activities:

1. Co-hosted a provincial conference, "Senior Friendly Hospital Care: The Imperative Need for Change" in partnership with the LHINs and the Ontario Hospital Association (April 2, 2012).
2. Presented poster on SFH Care across Ontario at the International Forum on Quality and Safety in Healthcare (April 18-20, 2012).
3. Chaired the planning committee for the RGPs of Ontario 2012 Education Day: "Sharing Innovations to Promote Senior Friendly Hospital Care: From Evidence to Bedside Practice," and participated on the planning committee for the Ontario Gerontology Association (OGA) 31st Annual Conference (April 25-26, 2012).
4. Continued to co-chair the planning committee for the RGPs of Ontario 2013 Education Day, and participated on the planning committee for the OGA 32nd Annual Conference.
5. Co-chaired the LHIN-led provincial "SFH Promising Practices" working group, implementing web-based clinical toolkit modules on Delirium and Functional Decline on the www.seniorfriendlyhospitals.ca platform (May 2012).
6. Presented keynote in the launch meeting of the Central LHIN SFH Network (June 18, 2012).

7. Hosted an open table session with the RGP Network on the role of Senior Friendly Hospitals and Specialized Geriatrics Services in the Ontario Seniors' Care Strategy (July 19, 2012).
8. Presented on the Ontario SFH Strategy and the priority focus of delirium at the Ontario Hospital Association's HealthAchieve 2012 Conference (November 6, 2012).
9. Co-chaired a national thinktank on safety standards for older patients in Canadian hospitals with publication in Healthcare Quarterly 2013.
10. Co-chaired the LHIN-led provincial "SFH Indicators" working group, which identified accountability indicators for hospital-acquired delirium and functional decline (report approved by LHINs in January 2013).
11. Presented on SFH at the Central East LHIN GAIN Network (March 4, 2013).
12. Co-chaired a sub-working group to guide the implementation and evaluation of the delirium and functional decline indicators – 41 hospitals across 9 LHINs have volunteered to participate.
13. Provided in-kind clinical consultation throughout the year for SFH initiatives undertaken by regional, national, and international partners: Sunnybrook Health Sciences Centre, Runnymede Health Centre, St. Michael's Hospital, South West LHIN SFH Network, Toronto Academic Health Sciences Network, McGill University Health Centre, Jewish General Hospital (Montreal), Age-Friendly Hospitals Working Group in the World Health Organization Health Promoting Hospitals Initiative, Bureau of Health Promotion, Department of Health, Taiwan.

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 co-morbidity. 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. The RGP Outreach Steering Committee worked collectively to improve the quality and efficiency of generating assessment reports to the referring physician at the end of the outreach assessment. A stakeholder satisfaction survey on the assessment report was conducted to identify best practices and improvement opportunities. A standardized assessment report format was created and positive feedback was received.
2. The RGP Outreach Steering Committee created a common referral form for Geriatric Outreach Services across all RGP affiliated organizations. This referral form is available at: http://rgp.toronto.on.ca/files/GeriatricOutreachReferralForm.pdf

3. The second annual Outreach Institute was held in May 2012 and focused on practice models, assessment tools, home safety, and medical reconciliation. Topics were identified based on system and clinical priorities, and the event created an opportunity to connect individuals across different organizations and disciplines.
4. The RGP Geriatric Day Hospital Steering Committee collaboratively conducted quality improvement initiatives to improve stakeholder satisfaction and increase efficiencies. A standardized patient/caregiver satisfaction questionnaire was created and rolled out across all Geriatric Day Hospital sites in Quarter 4.
5. The RGP Geriatric Day Hospital Steering Committee explored the collection of outcome data to demonstrate the effectiveness and value of day hospitals. The RGP conducted a preliminary statistical analysis on several outcome measures collected at one Geriatric Day Hospital and noted some statistically significant improvement in various measures such as goal attainment and level of balance.
6. The RGP reviewed the evidence on existing and emerging specialized geriatric services and created an updated service description summary for Geriatric Outreach Services and Geriatric Day Hospital Services.
7. The RGP continued to collect activity data for all Geriatric Outreach Teams and Geriatric Day Hospitals in the RGP network.
8. New and revised data elements were implemented on the RGP Registry & Referral System to enable better data output for specialized geriatric services. The new and revised data elements included: the frailty scale, reasons for outreach visit, and reasons for no-show.

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. Online publication of reports and manuscripts in peer-reviewed journals.
3. Leveraged social and intellectual capital embedded within RGP network.

Activities:

1. Maintained and increased our presence on key provincial and LHIN committees:
    - Central East LHIN - Founding member of the board of the Regional Specialized Geriatric Services Governance entity
    - Central LHIN – Member of the Health Professionals Advisory Group and Primary Care Action Group
    - Central LHIN – Member of the BSO Steering Committee
    - Toronto Central LHIN – Member of the BSO Steering Committee, BSO Community Behavioral Outreach Planning Group, and the BSO Educational Consortium
2. Supported provincial initiatives such as Behavioral Supports Ontario (BSO) and the Excellent Care for All Act:
    - The 8th Geriatric Emergency Management Conference (themes: cognition and responsive behaviors in the ED)
    - The 2nd Geriatric Outreach Institute was convened on the theme of BSO
    - The 2nd Nurse Led Outreach Services Institute was convened on the theme of wound care and suturing
    - A continuing medical education event was convened for Long-term Care attending physicians in the Central LHIN on the topics of Mobile Emergency Nursing and BSO services
3. Enhanced the profile of our network by providing opportunities for the network to present and share best practices.

4. Enhanced the profile of the RGP through conference presentations, posters and keynote talks:

    - Liu, B (2013) RGP Building a Network for Better Health Outcomes for Frail Seniors. Baycrest, Toronto, Ontario.
    - Liu, B (2012) Age-friendly hospitals in Canada. Asia-Pacific Conference on age-friendly cities and age-friendly economy, Taipei, Taiwan Province of China.
    - Liu, B (2012) The interprofessional approach in a senior friendly hospital, Taiwan Society of Health Promoting Hospitals, Taipei, Taiwan, Province of China.
    - Liu, B (2012) The Senior Friendly Hospital Strategy in Ontario. McGill University, Montreal, Quebec.
    - Liu, B (2012 Early Mobilization in a Senior Friendly Hospital. Jewish General Hospital, Montreal, Quebec.
    - Liu, B., Straus, S., Brown-Farrell, D., Izukawa, T., Ritchie, J., Sinha, S., Ramsden, R., Zorzitto, M., Johnson, C., Knights, D., Denomme, J., Almaawiy, U. (2012) Mobilization of vulnerable elderly in Ontario: MOVE ON. Poster presented at the Ontario Gerontology Association Annual Conference, Toronto, Ontario.
    - Liu, B (2012) Senior Friendly Hospitals – The Delirium Imperative: Prediction, Prevention and Measurement. Ontario Hospital Association Health Achieve Conference 2012, Toronto, Ontario.
    - Liu, B (2012) Case Study II. ARTIC: MOVE On. Ontario Hospital Association Health Achieve Conference 2012, Toronto, Ontario.
    - Liu, B (2012) Geriatric Giants: Dementia, Delirium, Falls & Polypharmacy (What's a Renal Social Worker to do?). Canadian Association of Nephrology Social Workers 34th Annual Conference, Toronto, Ontario.
    - Liu, B (2012) MOVE ON: An early mobilization initiative across Ontario Hospitals. Regional Geriatric Programs of Ontario Sharing Innovations to Promote Senior Friendly Hospitals. Toronto, Ontario.
    - Liu, B., Orridge, C (2012) Senior Friendly Hospital Priorities in Ontario Senior Friendly Hospital Care: The imperative need for change. Ontario Hospital Association, Toronto, Ontario.
    - Liu, B and Panel (2012) Leading Practices in Priority Areas: Mobilization of Vulnerable elders in Ontario. Ontario Hospital Association Senior Friendly Hospital care: the imperative need for change, Toronto, Ontario.
    - Liu, B., Brown-Farrell, D (2012) Promoting Mobilization and Preventing Falls Workshop. 5th Annual Brain Sciences Day for Family Physicians, Toronto, Ontario.
    - Liu, B (2012) Falls in the older person. Community Care Access Centre Symposium, Toronto, Ontario.

- Ryan, D (2012) Building a Healing Community: Networking Professionals, Organizations and Just Plain Folks, Interprofessional Education Keynote Address, 3rd Annual Sunnybrook Interprofessional Education and Interprofessional Care Showcase, Toronto.
- Ryan, D. (2012) Building High Performance Mobilization Teams, University of Toronto, Health Science Centers initiative on Mobilization. Li Ka Shing Knowledge Institute, St. Michaels Hospital.
- Ryan, D. (2013) Aging and Community Paramedicine Services, Provincial Community Paramedicine Interest Group, York Region.
- Liu, B (2013) RGP Building a Network for Better Health Outcomes for Frail Seniors. Baycrest, Toronto, Ontario.
- Liu, B (2012) Age-friendly hospitals in Canada. Asia-Pacific Conference on age-friendly cities and age-friendly economy, Taipei, Taiwan Province of China.
- Liu, B (2012) The interprofessional approach in a senior friendly hospital, Taiwan Society of Health Promoting Hospitals, Taipei, Taiwan, Province of China.
- Liu, B (2012) The Senior Friendly Hospital Strategy in Ontario. McGill University, Montreal, Quebec.
- Liu, B (2012 Early Mobilization in a Senior Friendly Hospital. Jewish General Hospital, Montreal, Quebec.
- Liu, B., Straus, S., Brown-Farrell, D., Izukawa, T., Ritchie, J., Sinha, S., Ramsden, R., Zorzitto, M., Johnson, C., Knights, D., Denomme, J., Almaawiy, U. (2012) Mobilization of vulnerable elderly in Ontario: MOVE ON. Poster presented at the Ontario Gerontology Association Annual Conference, Toronto, Ontario.
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- Ryan, D (2012) Building a Healing Community: Networking Professionals, Organizations and Just Plain Folks, Interprofessional Education Keynote Address, 3rd Annual Sunnybrook Interprofessional Education and Interprofessional Care Showcase, Toronto.
- Ryan, D. (2012) Building High Performance Mobilization Teams, University of Toronto, Health Science Centers initiative on Mobilization. Li Ka Shing Knowledge Institute, St. Michaels Hospital.
- Wong K., Ryan D., Sakalaris V. & Liu B. (2012) Senior Friendly Hospital Care in Ontario, Canada: A survey of promising practices to support evidence-informed quality improvement strategies. Presented at Annual Meetings of the International Society on Geriatrics, Paris.
- Ryan, D. (2013) Aging and Community Paramedicine Services, Provincial Community Paramedicine Interest Group, York Region.
- Awad, M. (2012) presented at the 2nd RGP Outreach Institute on the "Integration of Frailty Data
- Wong K, Ryan D, Sakalaris V, and Liu B (2012). Senior Friendly Hospital Care in Ontario, Canada: A Survey of Promising Practices to Support Evidence-Informed Quality Improvement Strategies. Presented at the 17th Annual International Forum on Healthcare Quality and Safety, Paris, France.
- Wong, K (2012). A Summary of Senior Friendly Hospital Care Across Ontario. Presented at the RGPs of Ontario Education Day/Ontario Gerontology Association 31st Annual Conference, Toronto, Ontario.
- Wong, K (2012). The Regional Geriatric Program of Toronto and the Ontario Senior Friendly Hospital Strategy. Keynote Address at the Central Local Health Integration Network Senior Friendly Hospital Strategy Launch, Markham, Ontario.
- Wong, K (2012). The Regional Geriatric Program of Toronto and the Ontario Senior Friendly Hospital Strategy. Presented at the Toronto Academic Health Sciences Network Eldercare Community of Practice Meeting, Toronto, Ontario.
- Wong, K (2013). The Ontario Senior Friendly Hospital Strategy: Enhancing Care to Address Delirium and Functional Decline. Presented at the Central East Local Health Integration Network GAIN Network, Oshawa, Ontario.

- Wong, K (2013). Geriatrics, Frailty, and Function-focused Care. Presented at the Canadian College of Naturopathic Medicine Geriatrics Interest Group, North York, Ontario.

5. Provided leadership to geriatric medicine training program at the University of Toronto. Co-facilitated simulated patient "Transition to Clerkship" workshop for Sunnybrook undergraduate medical students.
6. Provided knowledge-to-practice assistance to frailty focused care providers and planners locally, provincially, nationally and internationally:
    - Presented a workshop on the Build-a-case method for the inaugural meeting of the provincial ABI Navigators Network meeting.
    - Led a one day workshop on Geriatric Emergency Management at the Annual Meetings of the Manitoba Geriatric Nursing Association, Winnipeg.
    - Presented on Psychogeriatric Resource Consultant in Primary Care Services for Taddle CreekFHT/Womens College Hospital and Sunnybrook Healthlinks Advisory Retreat.
    - Participated in the Toronto Central LHIN Primary Care Think Tank.
    - The RGP hosted Karen Hales, Director of Aging Services, Central Adelaide, Australia.
    - The RGP hosted a visit by five Singapore ED Health Professionals.
    - Assisted the Toronto Hostels Training Center in the development of a Aging and Homeless Curriculum.
    - Convened Provincial Community Paramedicine CREMSPlus Task Force.
    - RGP represented at the national TECHValue Net Knowledge Translation Camp.
    - RGP represented at West Parks Acquired Brain Injury Think Tank.
    - RGP represented at the Central LHIN BSO Kaizen Event.
    - RGP represented at the Central LHIN BSO Steering Committee.
    - Provided consultations on proposal writing REENA, TEGH Bridges Fund Application.
    - Conference Board of Canada, Editor for reports on interprofessional practice in primary care.

    During the year, the RGP received 177 requests from over 100 organizations.
7. Prepared manuscripts on key issues in frailty focused and senior friendly care.
    - Parke, B., Liu, B. et al. (2013). Enhancing Quality and Safety Standards for Older People in Canadian Hospitals: A National Collaboration. Healthcare Quarterly, 16(1), 23-29.
    - Ryan, D., Emond, M. & Lamontagne, M. (2013) Social Network analysis as a metric for the development of an interprofessional and interorganizational research team:

the Canadian Emergency Team Initiative on Mobility in Seniors after Injury. Journal of Interprofessional Care, (submitted for publication).

- Ryan, D. Barnett, R. et al. (2013) Geriatrics, Inter-professional Practice and Inter-organizational Collaboration: A Knowledge-to-Practice Process in Primary Care Teams, (accepted for publication Journal of Continuing Education in the Health Professions).
- Ryan D., Puri M. & Liu B. (2013) Comparing patient and provider perceptions of home and community based services: social network analysis as a service integration metric. Home Health Care Services Quarterly, 32(2), 92-105.
- Ryan, D, Liu, B, Awad M & Wong K (2012) Improving the older persons experience in the emergency room: towards the senior friendly emergency room. Aging Health, 7(6), 901-909.

8. Contributed to collaborative research initiatives locally, provincially, and nationally:
    - Co-PI – Mobilization of Vulnerable Elders in Ontario (MOVE ON) - Multisite, provincial quality improvement inititiave funded through Council of Acdemic hospitals of Ontario Adopting Research to Improve Care (CAHO ARTIC) program
    - Co-investigator Canadian Emergency Team Initiative on Mobility in the Emergency Department
    - Co-investigator Sunnybrook ED research group
    - Co-investigator GPA in the ED grant application
    - Co-investigator HWE grant - High Performing Interprofessional Teams Supporting Mobilization of Seniors in Hospital

Projected Hospital Activity Data

Summarized in the table below are the activity data for 2012-2013 (forecast and year end actual).

	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals
OUTREACH TEAMS	**BAY**	**BAY**	**NYGH**	**NYGH**	**SHSC**	**SHSC**	**TRI**	**TRI**	**UHN**	**UHN**	**PROV**	**PROV**	**STM**	**STM**
Acceptances/Admissions	399	167	487	498	160	154					212	261		
Active Clients	501	215	556	553	0	0					293	370		
Total Visits	603	262	915	936	540	853					499	455		
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	0	0	160	226	237	237	123	115						
Acceptances/Admissions	177	388	124	133	240	230	117	116						
Attendances	2937	5432	2044	2033	3300	3829	2522	2366						
GERIATRIC CLINICS	**BAY**	**BAY**	**NYGH**	**NYGH**	**SHSC**	**SHSC**	**TRI**	**TRI**	**UHN**	**UHN**	**PROV**	**PROV**	**STM**	**STM**
Acceptances/Admissions	643	436	818	882	430	435	50	134	0	0	378	295	450	613
Active Clients	1309	1052	1468	1615	0	0	100	181	0	0	1027	914	1000	1627
Total Visits (Initial, follow-up, home visits, etc.)	1975	1667	3577	3467	900	1057	250	280	2500	2482	1385	1177	1000	1627
ACUTE GERIATRIC UNIT/ACUTE CARE FOR THE ELDERLY UNIT	**BAY**	**BAY**	**NYGH**	**NYGH**	**SHSC**	**SHSC**	**TRI**	**TRI**	**UHN**	**UHN**	**PROV**	**PROV**	**STM**	**STM**
Beds			4	4									6	6
Inpatient Days			140	1572									2100	1686
Admissions			16	166									120	144
Separations			20	163									120	144
Discharge Days			140	120									2100	1686
Occupancy Rate			96%	108%									96%	77%
Average Length of Stay			7	1									18	12
GRU & GATU	**BAY**	**BAY**	**NYGH**	**NYGH**	**SHSC**	**SHSC**	**TRI**	**TRI**	**UHN**	**UHN**	**PROV**	**PROV**	**STM**	**STM**
Beds	32	32					25	25			35	35		

	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals	12/13 forecast	12/13 year end actuals
Inpatient Days	11096	10473					8219	8209			12279	11839		
Admissions	367	374					216	206			319	343		
Separations	364	375					216	209			313	353		
Discharge Days	11680	11680					8219	8204			11428	12601		
Occupancy Rate	95%	90%					90%	90%			96%	93%		
Average Length of Stay	32	31					38	39			37	36		
GRU = Geriatric Rehabilitation Unit														
GATU = Geriatric Assessment and Treatment Unit														
CONSULTATIONS	**BAY**	**BAY**	**NYGH**	**NYGH**	**SHSC**	**SHSC**	**TRI**	**TRI**	**UHN**	**UHN**	**PROV**	**PROV**	**STM**	**STM**
Patients Seen			530	539	400	596			400	408	220	222	500	613
GERIATRIC EMERGENCY MANAGEMENT	**CVH**	**CVH**	**RVHS**	**RVHS**	**MH**	**MH**	**HRRH**	**HRRH**	**STM**	**STM**				
GEM assessments (face to face)	920	659	709	497	448	571	439	456	356	442				
GEM telephone assessments	0	0	405	153	40	303	80	102	140	183				
Patients admitted (post GEM)	529	190	195	186	304	286	150	138	121	136				
Patients discharged (post GEM)	391	469	516	284	144	249	284	292	235	391				

GEM sites: *Credit Valley Hospital, York Central Hospital, Rouge Valley Health System, Humber River Regional Hospital, St. Michael's*

TC LHIN AAH GEM	**2012-13 Forecast**	**2012-13 Actual**
Number of clients seen by GEM nurse (in person and phone assessment)	3864	4460

Variance explanations:

Baycrest

Outreach:

Baycrest had a lower than average number of Outreach visits Q4 YTD. This was the result of several issues:
-There were a number of statutory and personal holidays taken in Q2 & Q3 where no clinical activities took place.
-Baycrest has updated its data collection process for Outreach visits, as a result has eliminated previous data redundancies and impoved the efficiency of reporting. Manually reported visits in the prior year were 603, where actual visits per the new IT reporting system were approx 340.

Day Hospital:

Beginning in Q1 2012, Baycrest implemented a more robust system to capture statistical data within the Day Hospital. Reported visits in the prior year were 2,937, where actual visits per the new IT reporting system were 4,074.
In addition, there has been an effort to increase the overall number of patient visits.

NYGH

AGU:

Please note that the closure of the 4 Acute Geriatric Unit (AGU) beds at North York General Hospital was effective September 10, 2012 and these beds are now being occupied by ACE patients. As such, the YTD actuals reflect the balance of Q2 results.

Sunnybrook Health Sciences Centre

Outreach:

- FTEs: 0.4 FTE saving due to the timing of a 0.5 FTE Occupational Therapist position being vacant for 11 months
  No of Visits: Visits increased due to diligence and reassignment of staff. Also in FY 2012/13 sick time was lower than previous years.

Consultations:

- FTEs: 0.3 FTE savings due to a 0.5 FTE Registered Nurse position being vacant for 8 months
- No of Patients seen: In FY 2010/11 the actual (1,090) included GEM (Nurse Clinician) stats whereas in FY 2011/12 the GEM stats were being reported separately as requested by RGP.

TRI

Clinics:

An additional memory clinic was added at the start of fiscal FY 2012-13 for the geriatrics program which has resulted in an increase in admissions and visits.

Geriatric Emergency Management

Credit Valley Hospital

- The GEM-NP at Credit Valley Site was orientating through the first two months of Q1. As a result, we expect volume increases in the remaining three quarters.

Rouge Valley Hospital:

- No GEM service in May, cases in May assessed by GAIN NP/Interim Manager. New temporary GEM nurse starts in June.

AAH GEM:

- GEM nurses activity exceeded the target due to better data reporting and full nursing capacity for the year.

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 in their home.

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

Total Home Visits: A contact for the purpose of an initial assessment and follow up visits. Each home visit with more than one discipline is counted as one visit. Telephone calls are not included (A home 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 Projected Deliverables

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

Baycrest Print date: 29-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**DTC modification of Falls Prevention Program** **The team is modifying the program to incorporate some more individualized interventions.**	Ongoing	DTC Falls Prevention Program is under review for individual intervention that can involve an IPC approach.
2.	**Review of COT model** **Looking at existing model of care and creating new service delivery model. Working with Geriatric Psychiatry Outreach Team and some primary care providers to explore possibilities.**	Ongoing	The new Integrated Community Care Team pilot project will incorporate many aspects of the COT model with the addition of primary care, CCAC and acute care services. This project in still in the developing stage and pilot implementation has begun.
3.	**GATU review of admission processes** **The GATU team is reviewing admission processes and will modify to best meet current needs. The goal is to improve time from receipt of application to decision point and admission, if required.**	Ongoing	
4.	**Geriatric Assessment Clinics Manual - Part one** **After reviewing all of our current processes and comparting to best practice, we will write a manual to ensure we have standardized practices within the Geriatric Assessment Clinics. We anticipate the completion of the review with the establishment of a list of processes to include in the best practice manual in this fiscal year.**	Ongoing	

Innovation / New models

#	Activity / Description	Status	Comments

1.	**COT Model revision** **We will use the information from the review of the model to choose a new model of service provision.**	Completed	See comments in COT Model review above
2.	**DTC Wellness Program** **The team will review results of snapshot comparison (see below) and use to review and revise model of care provision.**	Ongoing	
3.	**Geriatric Assessment Clinic process improvement** **Based upon our review (see above) we anticipate implementing at least one improvement/innovation within the GACs at Baycrest by the end of the fiscal year.**	Ongoing	

Activity Variance

#	Activity / Description	Status	Comments
1.	**Geriatric Assessment Clinics** **Unfortunately, we will continue to have a negative variance as we have not been able to recruit a mid-career geriatrician. We will hopefully have two extra clinics a week, but this will not yet bring us back to full capacity.**	Ongoing	
2.	**COT admissions and visits** **A 0.8 FTE RN vacancy as our program director left has impacted volumes for at least one quarter. COT RN has also been working in DTC. We anticipate a further negative variance for the next quarter while we train the new recruit. Unfortunately, this may overshadow the increase in DTC admissions and attendances we anticipated because of the increased attendance in the Falls Prevention Program.**	Ongoing	
3.	**GATU occupancy** **We anticipate a slight negative variance in GATU occupancy due to more than one outbreak on the unit this year. Unfortunately, these led to closure to admissions for a prolonged period each time.**	Ongoing	

4. **Geriatric Rehabilitation occupancy** **As GR and GATU are on the same unit, we anticipate the same changes in occupancy.**	Ongoing	

E-health

#	Activity / Description	Status	Comments
1.	**Frailty outcomes database** **We are working on a shared database using the frailty outcome measure from Dalhousie. This is already being used in LTLD rehabilitation, but we plan to begin to use for DTC and GATU as well.**	Completed	We use the the clinical frailty scale on each client we see in ICCT and DTC . Our next step is to anlyse the data to better understand our patient population chacteristics
2.	**Revision of DTC assessment** **The team is working on a single, interprofessional assessment for all clients housed within our electronic health record. There is one major barrier to overcome, but we plan to have this implemented by the end of the fiscal year.**	Ongoing	For the Fall Prevention program, we have a single, interprofessional assessment form that is still currently in a paper format. We are contiuing to investigate the potential for an IPC assessment format in the Wellness portion of the DTC.
3.	**COT in home documentation** **We are working on upgrading the COT home visit computers to allow more data entry into the health record at the time of the visit. We are also planning to use Skype to provide feedback to medical residents on visits.**	Not achieved	There remain some outstanding issues with regard to the laptop equipment, size, speed and utility in the home environment. This objective is under review.

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	**nursing practice network** **Nursing from RGP services represented on the network.**	Ongoing	
2.	**Medical Education Committee** **Geriatrician sits on committee to promote SGS within education at Baycrest.**	Ongoing	
3.	**Learning Centre for Interprofessional Care** **Geriatrician led project within Baycrest. Seeing first students now entering "internships".**	Ongoing	

External partnerships

#	Activity / Description	Status	Comments
1.	**TC LHIN Falls prevention project Led by Baycrest DON. SGS and other Baycrest services will be promoted.**	Completed	This has been completed and delivered to the LHIN.
2.	**LHIN Behavioural Support Project Baycrest taking lead for pilot. Geriatric Psychiatry and Geriatric Medicine will be involved and will promote and advocate for SGS and frail seniors.**	Completed	The BSU has been implemented at Baycrest
3.	**RCPSC NSC Chair Baycrest geriatrician Chairing RCPSC National Specialty Committee for Geriatric Medicine for a further 2 year commitment.**	Ongoing	
4.	**RGP committees Baycrest membership on Day Hospital and Outreach Team committees.**	Completed	Membership continues on RGP committees

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	**First Baycrest Palliative Care Clinic Day - November, 2012 Continuing Education program for all health care professionals with an interest in PC. Intra-organizational program development but aimed at external organizations as well as internal staff.**	Completed	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	**Postgraduate Medical Training Anticipate ongoing rotations from GIM, GM, FM and COE programs in Medicine.**	Ongoing	

2.	**Allied health Professional students Will continue to have students from PT, OT, Nursing, Social Work from multiple colleges and Universities.**	Completed	Allied Health students placements for 2012/13 # of students: PT OT SLP SW Dietician Pharmacy
3.	**Beijing Medical students We will host a group of medical students from Beijing for several weeks. They will be in most of the SGS services at Baycrest, as well as other services that provide care to the frail elderly in our community.**	Completed	

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	**MOVE IT Anticipate completion of data collection on project in this fiscal year.**	Completed	MOVE IT and MOVE ON are both part of the same project undertaken in the province by the ARTIC Program (Adopting Research To Improve Care). Baycrest is one of a number of organizations that are participating. MOVE IT was the pilot and it was implemented on our Transitional Care Unit (3East). It is complete.
2.	**MOVE ON Anticipate starting data collection and doing intervention in this fiscal year**	Completed	MOVE ON is the larger study and it is still underway on two of our general CCC units (5W,5E). It will conclude next month as we are currently in the post-intervention data collection phase. All the data from both projects is sent to the MOVE ON coordinators. Once everything is analyzed for the entire project, each organization will be getting its own summary.

RGP affiliated primary/co-investigator initiatives

#	Activity / Description	Status	Comments

1.	**DTC "snapshot"** **Collection of data to describe DTC patient population summer 2012. Comparison to similar data collected in 2001 to see impact of model changes, etc.**	Ongoing	
2.	**GATU Evaluation** **Anticipate selection of metrics, creation of database, REB approval and initiation of data collection this fiscal year.**	Completed	Received REB approval for chart review of 100 patients. Metrics and attributes have been chosen and a database completed for comprehensive geriatric assessment of GATU patients. Data collection is ongoing.
3.	**ACT evaluation** **Outcome measures have been chosen. Database is underway. REB being requested. Anticipate interim results by end of fiscal year.**	Ongoing	
4.	**DTC evaluation** **Anticipate selection of metrics, creation of database, REB approval and initiation of data collection this fiscal year.**	Completed	REB received. Completed data collection and data analysis for DTC evaluation including admission and 4 month post discharge status. Study findings were presented to the DTC team. Some of the admission findings include 90% of patients using mobility aids, 85% using supports including 50% home care, 68 % reported low mood or depression and 51 % had a history of falls 6 months prior to attending the DTC. With respect to the Clinical Frailty Scale, 75% of patients fell within the categories of being Mildly Frail and Moderately Frail.

Other research collaborations

#	Activity / Description	Status	Comments
1.	**Frailty database** **Development of collaborative frailty outcomes dataset with Slow Stream Rehabilitation, GATU and DTC.**	Ongoing	Frailty index database is included in the SSR evaluation. Data collection completed for frailty index database. Frailty index database has been forwarded for analysis. Data analysis is ongoing.

Publications and presentations

#	Activity / Description	Status	Comments

1. **Presentations/Posters** **Anticipate presentation of three posters this year from SGS affiliated faculty.**	Ongoing	An abstract of the DTC titled "Characteristics of Patients Attending a Geriatric Day Treatment Center" was submitted to Gerontological Society of America.

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

North York General Hospital

Print date: 4-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**Geriatric clinical educator aging at home strategy** **Standardizing outreach reports for RGP & ORT in the 905/GTA. Geriatric Clinical/Educator continues to mentor and train new Geriatric Outreach teams (ORT) in Central LHIN: Southeast team (Markham Stouffville, Unionville Home Society), York Central, Humber River Regional Centre and Southlake Regional. This is the 5th year of this aging at home outreach project.**	Completed	The Geriatric clinical/educator continues to mentor and train new geriatric outreach teams is still ongoing.
2.	**Expansion of Geriatric Inpatient (ACE) Unit to 12 beds and closure of Acute Geriatric Unit (AGU)** **NP/Geriatrician model/co-management, collaboration along with Interprofessional team from admission, day to day medical care through to discharge from hospital.**	Completed	
3.	**Medical directive for foley catheter discontinuation approved for implementation in medicine and cancer care programs in Seprember 2012** **NP currently working with quality department to help reduce the urinary catheter insertions and catheter associated urinary tract infections.**	Completed	

4.	**Geriatric Integrated Care Collaboratives Model of Care** **Plans are underway to design and implement an integrated collaborative for Geriatrics focusing on the frail elderly with delirium.**	Completed	Focus changed to COPD & CHF
5.	**5 SE Model of Care** **32 bed unit reorganization to include: 12 bed ACE unit (NP/Geriatrician) collaboration in addition to 20 beds managed by a General Internist.**	Completed	
6.	**Ambulatory representative attending hospital weekly during unit based "goal rounds".** **Goal is to improve flow of patients through our system and ensure seamless continuity of geriatric patients.**	Completed	
7.	**NYGH Outreach Team collaboration with RGP** **NYGH Outreach Team is working with RGP to develop a satisfaction survey for all family physicians/referral sources with the goal of feedback regarding Outreach reports.**	Ongoing	
8.	**Day Hospital is holding mass orientation/screening for patients on wait list to identify appropriateness and prioritize admission** **This assists with treatment and discharge planning.**	Ongoing	
9.	**Day Hospital flow** **Trialling a decreased length of stay in Day Hospital to accommodate more patients and help manage wait list. To improve flow in hospital and decrease length of stay by creating a seamless priority admission for hospital referrals into Day Hospital.**	Completed	

Innovation / New models

#	Activity / Description	Status	Comments
1.	**Closure of 4 AGU beds** **Expand ACE to 12 beds. AGU patients to be seen at the Senior's Health Centre in the Geriatric Medicine (GM) clininc with a focus on specific diagnoses that will be determined.**	Completed	

2. **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	
3. **Geriatric Ambulatory ED collaborative initiative** **Enhance collaboration with the GEM Nurses, Nurse Practicioners, SHC ambulatory service in the Emergency Department (ED) with geriatric programme, inservices and communication regarding seamless patient care.**	Ongoing	
4. **Developing a stroke stream out-patient rehabilitation program in the Day Hospital to improve flow and assist with discharge planning at NYGH** **This is being done in collaboration with the Stroke Clinic, Cardiac Rehab Program at NYGH and the District Stroke Coordinator at Mackenzie Richmond Hill Hospital.**	Ongoing	

Activity Variance

#	Activity / Description	Status	Comments
1.	**Closure of AGU beds by September 2012** **Please refer to Ambulatory AGU and ACE expansion.**	Completed	

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.	**Osteoporosis & Fracture Prevention Clinic** **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).**	Ongoing	Please add-"patients being seen in the (hospital &) fracture clinic"....
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 and partnering. Part of initial assessment for new ACE model (link with short stay unit/med surgery clinic and GEM collaboration).**	Ongoing	
4.	**NP Scope of Practice** **NP group working with stakeholders to ensure full implementation of recent legislation changes to NP scope of practice.**	Ongoing	

External partnerships

#	Activity / Description	Status	Comments
1.	**Chronic Disease Self Management Program** **New community centre partnerships have been established by the Chronic Disease Self Management Program with the North York Family Health Team, Branson Cardiac Rehab Program, Prosserman Community Centre, North York Seniors Centre and Southlake Regional Hospital.**	Ongoing	
2.	**Central LHIN subcommittee in Chronic Disease Self Management and Prevention** **NYGH continues its participation in this committee.**	Ongoing	
3.	**North York Senior Centre and Day Hospital collaboration regarding CDSM** **Joint partnership (a bridging program) to enhance community integration of discharged Day Hospital clients while learning chronic disease self-management strategies.**	Ongoing	

4.	**Collaboration with RGP and Day Hospital** **To help standardize and develop quality indicators.**	Ongoing	
5.	**NYGH and North York Senior's Centre** **The Be Well Stay Well Program offered to the CDSMP workshop model.**	Ongoing	
6.	**Future participants to be re-instated between Black Creek Community Health Centre and NYGH** **NYGH awaiting new RN co-ordinator to be hired.**	Completed	
7.	**Geriatric Clinic for Parkinson's partnership with Parkinson's Society Canada (PSC)** **To present "Medications for Parkinson's Disease" to over 75 patients in the community for PSC summer education series on August 22, 2012.**	Completed	
8.	**Geriatric Clinic for Parkinson's collaboration with Baycrest Hospital** **To develop contents for a interactive web site to help patients understand their medications for PD management. Plan to release the site to the public in early 2013.**	Completed	
9.	**Consultation in the Seniors Care Strategy with the Central LHIN and NYGH/Elder Care** **This strategy is to establish sustainable best practices and policies at the provincial level with the focus on elderly seniors.**	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 Clinic Day** **Alignment with Access to Care; Integrated Care Collaboratives; MOVE-ON initiative. A new format designed to improve the knowledge and skills of front line staff to care for seniors in hospital.**	Ongoing
6. **Corporate Eldercare Orientation** **Eldercare, Consent and Capacity provided for all new staff.**	Ongoing
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.**	Ongoing

8.	**Academic lecturing** **Members of the Geriatric team continue to provide lectures to academic facilites on request related to care of the elderly.**	Ongoing	
9.	**Preceptorship in geriatrics for post PharmD pharmacist** **Specialty rotation provided for pharmacist undertaking Pharmacy and PharmD specialty training.**	Ongoing	
10.	**Submission of Day Hospital poster to the National Symposium on Integrated Care** **Future submission.**	Completed	
11.	**Geriatric services to participate in IPED training at SHC in the Fall 2012.** **Future participation in fall.**	Completed	
12.	**OT, PT & SLP of Living Well with Parkinson's, Geriatric Day Hospital or Geriatric Outreach Team will be receiving specialized Parkinson's Lee Silverman Training & Certification** **Will be receiving this specialized training & certification in the fall of 2012.**	Completed	
13.	**PD Clinic pharmacist will be teaching on "Pharmacological Management of Parkinson's Disease"** **To be done at the Annual Ontario Pharmacists' Association Geriatric Pharmacist Certification Preparation Course in November 2012.**	Completed	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	**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.**	Ongoing	
2.	**Acute Care NP Students** **Continue to precept ACNP students from the University of Toronto.**	Ongoing	

3.	**Family Practice Residents** **Continue to support the learning of family practice residents at NYGH during their Geriatric Medicine rotations.**	Ongoing	
4.	**Preceptoring of Geriatric Fellows** **Continue to build relationship with academic centres to attract Geriatric Fellows for their clinical placements. Care of Eldely Fellows do electives on ACE unit and clinics.**	Ongoing	
5.	**Precept Doctor of Pharmacy students from University of Toronto**	Ongoing	
6.	**Precept Pharmacy interns and other undergraduate pharmacy students from Univeristy of Toronto**	Ongoing	
7.	**Family practice resident rotation package** **The Geriatric Team is currently revising the training package provided to Family Practice Residents.**	Ongoing	Please change "Geriatric Team" to "Geriatrician"

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	**MOVE ON Project** **NYGH participating in a one year research project jointly with Sunnybrook Health Sciences Centre and St. Michael's Hospital in collaboration with CAHO. This CAHO ARTIC MOVE-ON project team is working collaboratively with 14 CAHO hospitals to use an interprofessional approach that focuses on early and consistent mobilization of older patients admitted to hospital.**	Ongoing	
2.	**ORT in collaboration with RGP** **Measuring frailty index of all ORT patients and reporting back to RGP for their research purposes.**	Ongoing	Please add: "Measuring frailty index (home bound status) of all ORT"....

3.	**Expectations Study** **Finishing final draft of paper to be submitted for publication. Abstract accepted for poster presentation at Family Medicine Forum 2012 (Nov 15-17, 2012).**	Ongoing	
4.	**Working with RGP and other Day Hospitals to standardize our Satisfaction Questionnaire**	Ongoing	
5.	**Working with RGP to improve the collection of statistics for client absenteeism**	Ongoing	
6.	**Impacts of education provided to patients at Living Well with Parkinson's Education & Exercise Program** **Will complete the first draft of study proposal by December 2012.**	Ongoing	
7.	**Impact of medication management via telephphone consultation at the Geriatric Clinic for Parkinson's** **Will complete the first draft of study proposal by December 2012.**	Ongoing	
8.	**Effectiveness of Enatcapone-Levodopa-Carbidopa in managment of wearing off in elderly patients with PD** **Will complete the first draft by October 2012.**	Not achieved	Terminated- will not proceed
9.	**Managing frail elderly patients with chronic non-cancer pain in an Outpatient Geriatric Day Hospital in an interprofessional team approach with Dr. Chan & Dr. Chu** **Planning stage.**	Ongoing	
10.	**Lewy Body and Parkinson's Dementia** **48 patients are enrolled. The study has received grant funding from September 2011 to August 2013. Preliminary results being compiled.**	Ongoing	

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. **Day Hospital is working on a narrative on interprofessional collaboration for a Cornell University publication on teamwork in Healthcare.**	Ongoing

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

RGP - Hospital Deliverables 2013-2014

Providence Healthcare

Print date: 8-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**To further enhance our Falls Prevention Program.** **To implement the use of falls mats on all inpatient units to minimize risk of harm to patients.**	Completed	Implemented Bed Mats, Standard Bed Alarms and Chair Alarms
2.	**Psychosocial/Cognitive Bundle (3D Screening)** **80% of all admissions will be screened for the 3 D's (Delerium, depression, dementia0** **Staff will discuss screens at team rounds and discuss action plans.**	Ongoing	
3.	**Geriatric Clinic Model** **Implement a new Geriatric Clinic model for Decision-Making in Dementia and Frailty Patients**	Ongoing	New Psychiatrist joined the interprofessional team July 2013. Actively recruiting additional Geriatricians and Clinical Staff to support launch of the model.
4.	**Patient Access and Flow in Geriatric Outreach** **Address Patient Access and Flow in Geriatric Outreach Services through a Modified Service model and application of standardized processes and reporting**	Completed	GOT incorporated newly developed standardized assessment tools and reports and processes into service model.
5.	**Performance Indicators** **Address RGP Performance Indicators for 2012-2013 through quality improvement plans**	Completed	Six Process Improvements were completed (i.e. Charts,Patient Treatment Rooms, Forms, Wayfinding, Equipment Storage, Reception Area)

6.	**Providence Healthcare Accreditation 2012** **Actively participate in the Providence Healthcare Accreditation 2012 for Ambulatory Care Services by Accreditation Canada.** **The Geriatric Outreach Team Pharmacist is taking a lead role in process improvements for Medication Reconciliation in Outreach Services, specifically the Pain Care Clinic initially due to the high risk medications used in this patient group**	Completed	Accreditation with Exemplary Standing - the highest rating

Innovation / New models

#	Activity / Description	Status	Comments
1.	**Barriatric equipment** **Enhancing barriatric equipment availability throughout the hospital by determining current inventory of equipment hospital wide as well as assessing the number or patients on admission with barriatric needs with the goal of putting a purchase plan in place.**	Completed	New equipment was purchased for inpatient and outpatient services.
2.	**Healthy Aging Clinic - Fall Prevention Program** **Collaborating within Providence Healthcare to develop a new Healthy Aging Clinic - Fall Prevention Program for the Geriatric Outpatient population. The integrated care model include the Geriatric Outreach Team Pharmacist as a core member of the new team**	Ongoing	Funding approved for new Healthy Aging Outpatient Clinic - June 2013
3.	**Hospital/Primary Care Collaboration model** **Exploring a co-design model of Hospital/Primary Care Collaboration to Manage Complex Frail Elderly in Community Practice - Consisting of onsite services to promote "two way flow" (clinic based or a short-stay assess and restore unit) or offsite (partners and satellite) with a focus on geriatric care, caregiver support and support for the client's family physician**	Ongoing	Actively collaborating with East Toronto Health Link.

4.	**Ontario Seniors Care Strategy** **Support the development of the Ontario Seniors Care Strategy being led by Dr. Samir K. Sinha**	Ongoing	
5.	**Community Behavioural Support Collaboration** **Explore opportunities to collaborate with the Baycrest Community Behavioural Support Outreach Team which is a part of the TC LHIN Behavioural Support Ontario Strategy**	Ongoing	Collaborating with the Community Behaviour Support Planning addressing patient flow and community supports.
6.	**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 venues for knowledge sharing and collaboration. Host a strategic visioning session with a goal of developing a novel way of supporting trail/at risk elderly from inpatient to outpatient services**	Ongoing	Expression of interest submitted to participate in Senior-Firendly Hospital Pilot Study to evaluate delirium and functional decline.

E-health

#	Activity / Description	Status	Comments
1.	**Resource Matching and Referral (RM&R)** **Actively participating in RM&R. Program expansion to include hospital outpatient referrals to the Community Care Access Centre from Geriatric Medicine and Geriatric Psychiatry Clinics and the Geriatric Outreach Team**	Completed	"Go Live" was successful in November 2012.
2.	**interRAI Preliminary Screener** **Plan to pursue implementation of the MOHLTC newly approved interRAI Preliminary Screener for Primary Care and Community Care for the interRAI Community Health Assessment (CHA) for Community Support Service Sector. It will support the identification of potential risk and/or need for greater care and further assessment for the older adult population**	Ongoing	

3.	**Streamline Assessment Processes Actively explore opportunities to streamline assessment processes by leveraging existing tools (i.e. inter RAI-CHA) through sector shared mechanisms for transferring information through systems like the IAR (Integrated Assessment Record) to reduce burden and enhance care delivery**	Ongoing	
4.	**Electronic Patient Record (EPR) Actively engage in Providence Healthcare's Electronic Patient Record (EPR) Strategy and Capacity Review**	Not achieved	The Strategy on hold.

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	**Enhancing patient flow through the continuum within the organization at Providence Healthcare. A collaborative strategy between inpatient and outpatient services and other key personel to implement strategies to enhance seamless flow through the continuum.**	Ongoing	The Transformation By Design (TbyD)initiative in the hospital has influenced the expansion of Geriatric Services both inpatient and outpatient.

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.**	Ongoing	DECNET re-located to a Satellite Storefront at Victoria Park and Danforth Ave. (Toronto)

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments

1.	**Implement use of Occupational Therapy Toolkit** **OTs will utilize Occupational Therapy toolkit which contains 72 evidence-based treatment guides and handouts for the older adult.**	Ongoing	
2.	**E-Learning Studies** **Implementation of E-Learning Studies for staff education through Learning Management System at Providence Healthcare**	Completed	
3.	**Evaluation of Team's Performance** **Implementation of a new process for the RGP TEAM to evaluate the TEAM's Performance using a standardized Interprofessional Team Work Tool "How Are We Doing" hosted on survey monkey**	Completed	

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	**Geriatric Outpatient Services Students** **Implementation of a new Geriatric Outpatient Services shadowing request process for students on geriatric placements in Providence Healthcare**	Completed	New process was implemented in May 2012.
2.	**Support the Geriatric Rotation for Family Practice Residents and International Physicians for Shadowing** **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**	Ongoing	

EVALUATION & RESEARCH

Other research collaborations

#	Activity / Description	Status	Comments

1. **Continence Management. Research based project for identifying continence issues related to mobility and strategies for improving continence management.**	Ongoing

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

St. Michael's Hospital

Print date: 3-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**Shared care model with St. Michael's Family Health Team** **Geriatric Monthly 2 half-day outreach clinics at two of the family health care team sites.**	Completed	
2.	**Exploring stronger shared care links with rehabilitation partners.** **Exporing stronger links with Bridgepoint Health & Providence Centre.**	Completed	Dr. Wong currently providing telehealth consultation to Providence Centre.
3.	**Indirect outreach** **Geriatric consultant to St. Michael's Family Health Team helping to support the primary care physicians with their 'Home Visiting for Homebound Seniors program'.**	Completed	Geriatric 2 half-day outreach clinics at two of the St. Michael's primary care sites. Dr. D'Silva providing consultation to the SMH primary Care Home visiting program for home bound seniors.

Innovation / New models

#	Activity / Description	Status	Comments
1.	**St. Michael's Hospital Senior Friendly Hospital initiative.** **SMH initiative leads Susan Blacker & Dr. Tom Parker. RGP MD's, manager, and staff members of the Senior Friendly Hospital Steering committee.** **Corporate Objectives for year 1 include processes of care in delirium and functional decline.**	Completed	Implementation of delirium & functional decline as priority processes of care. Environmental audits of Code+ standards completed in 88 areas of the hospital. Review of geriatric specific services - external review arranged for Q1 2013. Educational needs assessment conducted.

Activity Variance

#	Activity / Description	Status	Comments

1.	**GEM** **Full time GEM resigned June 1, 2012. This has resulted in 0.4 FTE part time GEM for June, July & Aug 2012.** **Full time replacement to start end of August 2012**	Completed	Full GEM nurse complement - Full Time GEM nurse hired in August 2012 and the Part Time GEM nurse hired in September 2012.
2.	**Internal Consult Team** **Very busy service - volumes continue to increase.** **Geriatric partnership with Trauma Service continues for all clients over the age of 60-years.**	Completed	
3.	**Elders' Clinics** **Clinic volumes steadily increasing and will continue to grow with the additional of a new hire geriatrician (Dr. Karen D'Silva).** **Outreach clinics to Primary Care established for Monthly 1/2 day sessions at two sites within the SMH Department of Family & Community Medicine clinics.** **Dr. Zorzitto provides consultation to both Bridgepoint Health & St. Hilda's Retirement Home.**	Completed	Elders' Clinic volumes increase to grow with the addition of Dr. D'Silva to the team. Outreach clinics to primary care continues. Consultation to both Bridgepoint Health & St. Hilda's Retirement
4.	**6-bed ACE** **Ongoing challenge of ALC patients waiting for placement to LTC.**	Completed	Ongoing challenge with placement issue related to the ACE beds.

E-health

#	Activity / Description	Status	Comments
1.	**Telehealth assessment - Orillia** **Dr. Zorzitto provides telehealth assessment 2X monthly. The number of consultation requests are increasing resulting in a wait list at this Orillia site. Other remote sites have expressed interest.**	Completed	Dr. Zorzitto providing telehealth consultation to Orilla and Midland sites. Dr. Wong provided support to Outreach team at Providence via telehealth consultation.

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments

1.	**Professional councils at specific discipline levels** **RGP MD's and staff are represented at the various discipline specific councils.**	Completed	
2.	**Geriatric research associated with the St. Michael's Li Ka Shing Knowledge Institute.** **Dr. Sharon Straus, Dr. Arlene Bierman & Dr. Camila Wong actively involved in research regarding a number of geriatric issues.**	Completed	Dr. Sharon Straus, Dr. Arlene Bierman & Dr. Camila Wong published numerous research outcomes in peer reviewed scientific journals.

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	**University of Toronto - cross appointments** **Individual RGP team members maintain U. of T.cross appointment: Medicine, nursing, physiotherapy, occupational therapy & social work.**	Completed	
2.	**Medical & Nursing Rounds** **Medical Grand Rounds are delivered with a specific geriatric focus at least twice per year.** **RGP RN's will present at Hospital-wide Nursing Rounds**	Completed	St. Michael's geriatric team members presented at both medical and nursing grand rounds.
3.	**Seniors Month** **RGP staff will arrange for geriatric educational sessions for staff and community health care providers.**	Completed	
4.	**Introduction of 'Gentle Persuasion Approach'** **Geriatric CNS introducing educational sessions on gentle persuasive approach to hospital health care providers.**	Completed	Geriatric CNS presented GPA at Nursing Grand Rounds and to the medical Residents as well as provides education on this topic throughout the hospital.

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments

1. **Education is provided by all disciplines of St. Michael's specialized geriatric services.** **University of Toronto graduate and undergraduate medical students education is provided by geriatricians.** **Placement given to post graduate Internal Medicine and Primary care students as well as medical student supervision provided in the clinic setting.** **Other disciplines within the RGP service participate in education and mentorship of students.**	Completed	
2. **Geriatric Core Training Program** **Core Training Programf or geriatric medicine trainees**	Completed	

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	**Mobiliztion of Vulnerable Elders - Move ON** **This multi site (Sunnybrrok, Baycreat, Mt. Sinai, St Michael's) initiated in December 2011. SMH leads Dr. Zorzitto & Dorothy Knights RN** **The focus this year will be on sustainability** **SMH introduced VISA (Volunteers Ingaging Seniors in Activity)**	Completed	Volunteers Involving Seniors in Activites (VISA) implemented April 2012 has provided 592 hour of service to date.

Other research collaborations

#	Activity / Description	Status	Comments
1.	**Trauma / Geriatrics investigational focus** **Dr. Camila Wong along with physicians from Sunnybrook supported by AFP innovations fund conducting research focused on Geriatics / Trauma.**	Completed	

Publications and presentations

#	Activity / Description	Status	Comments

1. **All disciplines will seek opportunity to present, and / or publish throughout the coming year.**	Completed	

Research, consultation and assistance to others

#	Activity / Description	Status	Comments
1.	**Dr. Camila Wong engaged in geriatric research with on Orthopedics, the Trauma Service and General Internal Medicine.** **Investrigating the Coordinator / Collaborative role of Residents in GIM and Geriatric medicine.**	Completed	
2.	**Dr. Sharon Straus is involved in research activities with national and internal experts.**	Completed	
3.	**RNAO Best practice Guidelines Geriatric CNS & Geriatric Nurse Coordinator involved in sustainability of Best Practice Guidelines - Delirium and Continence.** **Geriatric CNS educating staff on dementia care.**	Completed	Geriatric nurses supporting RNAO Best Practice initiatives at St. Michael's. Geriatric CNS taking a lead in educating staff on managing dementia care / Responsive Behaviours.

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

Sunnybrook Health Sciences Centre

Print date: 22-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**Maintain current spectrum of services and adjust according to population need.**	Ongoing	Staffing numbers remain same at present
2.	**Outreach team - process improvements. Implement Rockwood Fraily Scale data collection. Identify opportunities for efficiencies.**	Completed	Working on Q.I. initiatives
3.	**Geriatric Day Hospital Stabilize health human resources and team building with new staff. Identify opportunities for process improvements.**	Completed	Working on Q.I. initiatives
4.	**Falls program Stabilize health human resources. Explore strategies to manage demand.**	Completed	increased to provide program 2x/week

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.**	Completed	

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.**	Not achieved	

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**	Completed	
2.	**General medicine quality council** **Standing committee of hospital**	Completed	
3.	**Interprofessional Education Committee** **Standing committee of hospital**	Completed	
4.	**Emergency Department Quality Care Committee** **GEM nurse is a member of committee**	Completed	
5.	**Other discipline-related activities involving SGS staff** **SGS staff provide geriatric expertise and leadership to professional practice groups**	Completed	

External partnerships

#	Activity / Description	Status	Comments
1.	**Membership on SPRINT advisory committee** **Partnership with geriatric outreach team**	Completed	also acting as a resource to IMPACT Clinic
2.	**GTA Rehab Network commitee** **SGS Social worker is member on working group addressing referrals processes and flow**	Completed	

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, Accoutnabiltiy 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 developement 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 We are a core site for geriatric medicine training. The U of Toronto Geriatric Medicine Residency progam 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**	Ongoing	

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**	Completed	
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.**	Completed	

Other research collaborations

#	Activity / Description	Status	Comments

1. **Caregiver Study** **Collaborating with McMaster University researchers on caregiver in dementia study**	Completed

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

Toronto Rehabilitation Institute

Print date: 3-Jul-2013

SERVICE

Program Development / Improvement

#	Activity / Description	Status	Comments
1.	**Expand dialysis program between Toronto General Hospital (TGH) and Toronto Rehab Institute.** **Capital development at Bickle Center will free up 12 dialysis spots for dialysis at University Center; review currently being conducted on use for the 12 dialysis spots; timing depandent on Bickle's capital development.**	Ongoing	New model of care for Bickle and Toronto Rehab dialysis patients developed and will be implemented once minstry approves Bickle's functional plan.
2.	**Addition of 2 new specialized nursing roles.** **The 2 new specialized nursing roles will be rolled out between Q3 and Q4 FY 2012-13 with the focus on managing the increasing medical acuity of Geriatrics inpatients and on managing/reducing transfers out to acute care.**	Ongoing	Clinical nurse specialist in Geriatrics Rehab program has been hired January 2013; Nurse practitioner role is pending
3.	**Additional geriatric outpatient clinics.** **A new memory clinic has been added at University Center.**	Completed	New memory clinic added.
4.	**Enhanced pharmacy services within Geriatrics program.** **Pharmacy services within the Geriatrics program has been enhanced to support increase medical acuity Geriatrics patients.**	Completed	Pharmacy services has been enhanced within Geriatrics program.

5. **Develop expertise in palliative care Develop plan to determine best practices in area, identifying gaps, needs, and priorities.**	Ongoing	Palliative care initiative has been achieved through establishing relationship with UHN's non-cancer palliative care team; monthly palliative care rounds; and clinical consults with palliative care team as needed. Needs assessment completed with staff, next phase of initiative involves training and education of top areas identified for stasff.
6. **Determine and communicate uniqueness of the geriatrics program. Determine what is unique about the geriatrics program and communicate it both internally and externally.**	Ongoing	

Innovation / New models

#	Activity / Description	Status	Comments
1.	**Implement process improvement initiative in Geriatrics Day Hospital to increase access and responsiveness. The Geriatrics Day Hospital has changed its model of care to increase access and the throughput of patients within the program. The new model has been implemented in Q2 FY 2012-13 and will be evaluated in Q3 and Q4.**	Completed	New model of care for Day Hospital has been complete.
2.	**Implementation of persons centered care. First phase to establish working committee to personalize the person's living area to their identity and to incorporate the "person" into the care plan.**	Ongoing	Have met with external consultants to understand potential opportunites of areas that we can implement.
3.	**Balance, Falls, and Mobility clinic expansion to Geriatrics program. Novel partnership between the Research Mobility Team and the Neuro Rehab Program and is an innovative model of care that integrates researchers and clinical practitioners within a patient care clinic. The clinic aims to maximize balance, mobility outcomes and reduce fall risk of patients.**	Ongoing	Relocation of Toronto Western's falls clinic to Toronto Rehab effective April 2013. Next phase is to review and evaluate potential outpatient streams (including the Balance, Falls, and Mobility clinic) for Geriatric patients.

Activity Variance

#	Activity / Description	Status	Comments
1.	**Monitor the impact of ambulatory care integration at University Center and its impact on outpatient visits. New ambulatory care space at University Center opened in Q4 FY 2011-12.**	Completed	

E-health

#	Activity / Description	Status	Comments
1.	**Enhancements to EPR. Enhancements to EPR are being review with Toronto Rehab in order to algin Toronto Rehab's EPR with UHN's.**	Ongoing	UHN is currently investigating a new advanced clinical documentation system which would replace our current EPR system.
2.	**Analysis being conducted in looking at obtaining new EPR. UHN is currently in process of gathering requirements needed for a new EPR.**	Ongoing	UHN is currently investigating a new advanced clinical documentation system which would replace our current EPR system.

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	**Senior Friendly Hospital Steering Committee Senior Clinical Director of Geriatrics program is co-chair of Senior Friendly Hospital steering committee at UHN.**	Ongoing	
2.	**Implementing Nurses Improving Care for Hospitalized Elders education program (NICHE). Geriatrics Senior Clinical Director and clinical nurse educator sits on committee.**	Ongoing	

External partnerships

#	Activity / Description	Status	Comments
1.	**RGP Accountability Steering Committee and Network.**	Ongoing	

2.	**Baycrest Behavioural Support Unit (BSU) Planning Committee.** **Toronto Rehab is sitting on Baycrest's BSU Planning Committee as Baycrest is prepared to launch its new Behavioural Support Unit.**	Completed	
3.	**Partners include Lakeside Long-term Care Centre, Castleview Wychwood Towers, Mon Sheong Long-term Care Home, Fellowship Towers and Belmont House Retirement Home.** **Partners include Lakeside Long-term Care Centre, Castleview Wychwood Towers, Mon Sheong Long-term Care Home, Fellowship Towers and Belmont House Retirement Home.**	Ongoing	
4.	**UHN, Toronto Rehab, and Mount Sinai Hospital.** **Joint collaborative to align and optimize outpatient services across sites.**	Ongoing	

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	**Nurses Improving Care for Hospitalized Elders education program (NICHE).** **Training to be implemented in FY 2012-13.**	Completed	
2.	**Biannual Canadian Conference on Dementia.**	Ongoing	
3.	**Biannual Alzheimer Symposium.**	Ongoing	
4.	**Biannual Geriatrics Medicine Conference.**	Ongoing	
5.	**Crisis Intervention and Physical Skills Review Program.** **Staff in Geriatric Psychiatry Unit are trained on Crisis Intervention and Physical Skills training.**	Completed	Completed training in May 2012

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
1.	**Clinical placements for various health disciplines in collaboration with academic centers.**	Ongoing	

EVALUATION & RESEARCH

Other research collaborations

#	Activity / Description	Status	Comments
1.	**Research study on opioid use for geriatrics patients with mild cognitive impairments. Collaborating with research scientist in research study; currently in process of applying for CHIR grant funding.**	Ongoing	

Publications and presentations

#	Activity / Description	Status	Comments
1.	**Presentation at Toronto Rehab's MSK symposium. Occupational therapists co-presented "On road to safety – driving for the older adults post hip fractures"**	Completed	
2.	**Developed executive function learning module. Occupational Therapists developed executive function learning module as part of Cognitive Best Practice Group and Geriatric submodel for best practice in executive function.**	Completed	

RGP Year End Report

Year end report - Hospital Accomplished Deliverables

Hospital Deliverables 2012-13

University Health Network Print date: 3-Jul-2013

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 and General Internal Medicine programs.**	Ongoing	
2.	**Incorporate "Senior Friendly" ideas for all UHN planning processes. Ensure all new planning initiatives are undertaken with the Senior Friendly Framework in mind.**	Ongoing	
3.	**Compile and analyze monthly RGP stats. To monitor and evaluate efficient functioning of GEM resources, Geriatric initiatives and bed days & LOS of patients on ACE unit.**	Ongoing	

Innovation / New models

#	Activity / Description	Status	Comments
1.	**Nursing Led Outreach Team to LTC Continue to work with East Hub NLOT to enhance and co-ordinate NLOT services in TCLHIN**	Ongoing	

Activity Variance

#	Activity / Description	Status	Comments
1.	**Review integration of Geriatric Services at UHN. For better utilization of human and financial resources required for patient care evaluate opportunites to enahnce care across UHN sites including TRI.**	Ongoing	

E-health

#	Activity / Description	Status	Comments
1.	**Maintain Geriatric information on UHN intranet.** **For easy access to UHN staff to information regarding Geriatric services and referral process.**	Ongoing	

LEADERSHIP & PARTNERSHIPS

Local organization

#	Activity / Description	Status	Comments
1.	**Maintain leadership in Quality Initiatives** **Implementation of NICHE at UHN**	Ongoing	We have launched a 'Geriatrics 101' module which is required learning for all staff at UHN (clinical, clerical, housekeeping, HR etc...) We have completed our GIAPP survey and are awating the unit based results so education module priorites for each unit can be rolled out.

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.**	Ongoing	
3.	**Leadership in 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.**	Ongoing	
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.**	Ongoing	

EDUCATION & CAPACITY BUILDING

Continuing education of health professionals

#	Activity / Description	Status	Comments
1.	**Education for staff related to Geriatric Best Practices. Implementation of NICHE across all UHN sites**	Ongoing	See above
2.	**Mainpro-C CME Geriatric Course. Dr Lam continues to lead organization of (5 week) annual CME course for family physicians. It is partially funded by the College of Family physicians of Canada Continuing Professional Development Scholarship and the Canadian Geriatric Society**	Ongoing	Dr Lam is also looking at launching an innovative education program to support implementation of Falls Programs in FHT's.

Training of graduate and undergraduate students

#	Activity / Description	Status	Comments
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.**	Ongoing	
2.	**Continue monthly evidence based geriatric medicine presentation. Allied health & Nursing staff supervise geriatric medicine residents in training them in EBGM**	Ongoing	

EVALUATION & RESEARCH

RGP Coordinated

#	Activity / Description	Status	Comments
1.	**Evaluation of Geriatric Emergency Management Project Ongoing evaluation of GEM role including expansion of hours**	Ongoing	

2.	**Evaluation of LTC Mobile Outreach program** **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.**	Ongoing	

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.**	Not achieved	This project has completed the data collection and is in the analysis phase of research. The team recently presented their work at the National Geriatric Nursing conference in BC
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.**	Ongoing	
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. Preliminiary analyses will be conducted and a manuscript submitted for publication.**	Ongoing	
4.	**Falls Clinic Research** **Evaluation of Video as a tool to enhance Falls Prevention Training**	Not achieved	Falls program has been transferred to TR site so this research is currently on hold.

Other research collaborations

#	Activity / Description	Status	Comments

1.	**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**	Ongoing	

Research, consultation and assistance to others

#	Activity / Description	Status	Comments
1.	**Research on treatment of presssure ulcers using multidisciplinary teams in Ontario** **Dr. Alibhai is a co-investigator on this reserach project funded by the Canadian Patient Safety Initiative and the Ontario Ministry of Health and Long-Term Care. This study will begin recruitment of patients in long-term care facilities this year.**	Ongoing	

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

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GiiC geriatrics interprofessional interorganizational collaboration

GEM geriatric emergency management network

PRCP psychogeriatric resource consultatation program of toronto

sfH senior friendly hospitals