Year End Report
2014-2015
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**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 Ontario Senior Friendly Hospital Strategy has created a level of awareness and a welcome opportunity to influence care of hospitalized seniors in a systematic and collaborative approach.

Using the RGP’s SFH Framework, the provincial SFH Summary Report and Recommendations, and SFH Indicators, we will support the LHINs, the RGP Network and 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, provincially, and internationally.
2. An updated [www.SeniorFriendlyHospitals.ca](http://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-chaired the planning committee for the RGPs of Ontario 2014 Education Day, “The Nuts and Bolts of Geriatrics,” hosted in partnership with the Ontario Gerontology Association 33rd Annual Conference, April 9-10 2014 at the International Plaza Hotel – Toronto Airport.

2) Co-planned the 3rd Annual Provincial Senior Friendly Hospital Care Conference in partnership with the Ontario Hospital Association, June 12 2014 at the Radisson Admiral Hotel, Toronto Harbourfront.

3) Presented SFH activities at provincial and international venues, including: the RGPs of Ontario Annual Education Day (April 2014), Ontario Hospital Association 3rd Annual Senior Friendly Hospital Care (June 2014) and HealthAchieve (November 2014) Conferences, the Renal Administrative Leaders Network of Ontario Annual Meeting (September 2014), and the Erie St. Clair LHIN Older Adults Symposium (November 2014).

4) Co-chaired a provincial “SFH Indicators” implementation working group and led the implementation and feasibility evaluation of SFH quality indicators on delirium and
functional decline, involving a collaboration of 43 hospitals in 10 LHINs across Ontario. A report of this evaluation was generated and released September 2014. (http://seniorfriendlyhospitals.ca/sites/default/files/SFH%20Indicators%20Evaluation%20Report%20Final.pdf)

5) Continued to leverage opportunities (e.g. SFH indicators implementation) to build an Ontario SFH Collaborative to facilitate knowledge-to-practice activities and knowledge exchange and encourage participating hospitals to work together in sustaining and building upon successful SFH implementations across the province.

6) Chaired a Provincial Senior Friendly Hospital Steering Group with representatives from 14 Ontario LHINs, Health Quality Ontario, Registered Nurses’ Association of Ontario, and the RGPs of Ontario to provide support to the SFH strategy, discuss provincial SFH activities, and align SFH with other health system priorities.

7) Redesigned the Senior Friendly Hospital Toolkit and website (www.seniorfriendlyhospitals.ca) to optimize navigation and usability, and continued to expand its content to promote its use as a knowledge-exchange resource.

8) Provided in-kind clinical consultation for SFH initiatives undertaken by network and provincial partners.

9) Provided in-kind consultation for the World Health Organization Health Promoting Hospitals Age-Friendly Hospitals initiative.


11) Led a provincial 2014 SFH environmental scan to update progress on the SFH Strategy. One hundred thirty-five self-assessment surveys submitted by hospitals were reviewed and summarized. A provincial summary, 14 LHIN-level summaries and a report for each hospital were generated and released in March 2015 (http://seniorfriendlyhospitals.ca/reports-and-publications).

12) Through a $942,750 MOHLTC Health System Research Fund Capacity Award, the RGP developed the SFH ACTION (Accelerating Change Together In Ontario) training and implementation program to build SFH capacity throughout the province’s hospital system. Eighty-five hospitals applied through an initial expression of interest, and SFH ACTION cohort 1 will be launched in April 2015 with teams from 44 participating hospitals.
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) Conducted quality improvement initiatives across Geriatric Outreach Teams to improve stakeholder satisfaction and increase efficiencies. Working to improve the quality and timeliness of the assessment reports that are delivered to the referring physician following a comprehensive geriatric outreach team assessment.

2) Conducted quality improvement initiatives across Geriatric Day Hospitals to improve stakeholder satisfaction and increase efficiencies. Initiatives included: improving the efficiency and enhancing the inter-professional nature of the initial assessment process, improving the turnaround time for sending discharge summary reports to the referral source, improving the discharge planning process, reducing the number of inappropriate referrals, and reducing the number of no shows.

3) Reviewed performance indicators and metrics to identify opportunities for improvement for Geriatric Outreach Teams and Geriatric Day Hospitals. Data included: no-show, wait-times, referrals, admissions, visits, frailty levels.
4) A small working group of Day Hospital clinicians was formed to refine the existing functional problem list and identify ways to measure improvement in patient function.
5) Identified opportunities for collaboration with external stakeholders/other services. Informed the design of a new geriatric day hospital at West Park Healthcare Centre.
6) Hosted education events to train Outreach and Day Hospital staff on best practices and encourage collaborative learning.
7) Developed and implemented standardized referral forms for ambulatory specialized geriatric services.
8) Finalized general principles for a best practice outreach service model, using literature and expert consensus.
9) Collaborated with RGPs of Ontario to share quality improvement and service renewal practices for outreach services.
**Priority #3: Serving as a Leading Authority on Frailty and Service Development for Seniors**

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

**Expected Outcomes:**

**Increased recognition of the RGP as a leading authority**

1. Increased involvement and influence on provincial, regional, and local councils/advisory committees.
2. Publication of manuscripts and reports in peer-reviewed journals and online publication formats.
3. Increased diffusion of social and intellectual capital embedded within the RGP network.
4. Continue to contribute to regional and provincial system development

**Activities:**

**INTERNATIONAL**

1) June 10, 2014 - Hosted Herbert Habets, Geriatric Nurse specialist Geriatric Clinical Nurse Specialist/ Nurse Scientist, Senior Friendly Hospital Care at the Orbis Medical Centre, Sittard, Netherlands who delivered a webinar to our network “Senior Friendly Hospital Care in the Netherlands”

2) Editorial review “Towards Age-Friendly Hospital in Developing Countries: a case study of Iran” International Journal of Health Policy and Management.

3) MOHLTC from Singapore has requested a site visit to the RGP to learn about our work on SFH and SGS.

**NATIONAL**


2) Brain Medicine Area of Focused Competence, Royal College of Physicians and Surgeons proposal working group.


4) October 19, 2014 – Making the Connection PEI. Lessons learned from the Senior friendly hospital strategy implementation in Ontario (Keynote presentation).

6) TVN Technology Value Network Grant – engaged as a collaborator for Development, implementation and evaluation of an Improvement Collaborative for preventing, detecting and treating malnutrition in elderly acute care patients (Heather Keller, PI). This is directly aligned with our SFH work.

7) B Liu is a member of the subspecialty committee for geriatrics at the Royal College of physicians and surgeons of Canada. Royal College based education is about to undergo significant transformation with the launch of CanMEDS 2015 and transition to Competency by Design Educational framework.

8) Built a portal to support knowledge translation and dissemination of the MOVE ON initiative to other parts of Canada, initially targeting Alberta.

PROVINCIAL

1) April 8, 2014 – RGPs of Ontario Business meeting – B Liu was elected as the next chair of the RGPs of Ontario effective July 2014.

2) April 9, 2014 – RGPs of Ontario Education Day – Building Skills – The “Nuts and Bolts” of Geriatrics. Over 160 health professionals, from hospitals, CCAC, LTC and community sectors attended the day, which featured the following presentations:
   a. Tumbles, Muddled, and Dribbles: Demystifying Frailty – Causes, Assessment, and Treatment
   b. Falls: Organizing and Addressing the Top 100 Causes
   c. Optimizing Medication Use in Elderly Patients: Pearls and Pitfalls
   d. Role of a Periodic Health Exam in Flagging Frailty
   e. Discharge Communications as a Knowledge-to-Practice Process
   f. Nutrition Care: How do I Identify and Manage the Nutritional Risks of my Patients?
   g. Patients’ Tales: A View from the Other Side Mr. Lawrence Crawford
   h. Evidence-based Co-design and Health System Collaboration

3) HQO – QBP Community Homecare and Patient Functionality Expert Panel Members (B Liu and D Ryan).

4) Contributed expertise to BSO Governance Committee regarding the role of the Psychogeriatric Resource consultant in Central West and Mississauga Halton LHINs.

5) June 6, 2014 Mobilization of Vulnerable Elders in Ontario (MOVE ON) presentation to CAHO Council.

6) June 11, 2014 – Rehab Care Alliance provincial forum- featured assess and restore initiative highlights from each LHIN. Several funded initiatives leveraged RGP resources including the GiiC toolkit (WW), and mobilization strategy (Champlain LHIN and Central West).

7) June 12, 2014 – OHA and RGP held the 3rd annual SFH conference. Over 100 attendees participated. Overall rating was 3.64/4.

8) June 13, 2014 – Alzheimer’s Society of Ontario Dementia and Primary Care Symposium, planning committee (D Ryan).

9) Sep 10, 2014 - MOVE ON presentation to the new HQO CAHO ARTIC Operations Committee as an example of a successful project. The new HQO – CAHO partnership focuses on expanding ARTIC (Adopting Research to Improve Care) Program beyond the CAHO community into a provincial resource. The presentation was an opportunity to
highlight the role of the RGP network as a platform for dissemination of best practices within a network comprised of both community and academic hospitals.

10) October 29, 2014 Health Quality Ontario – Knowledge Exchange Series. Presentation on MOVE ON.

11) Release of Assess and Restore Guideline – Senior friendly hospital identified as an aligned initiative, upon which the Assess and Restore guidelines is built by standardizing and prioritizing specialized interventions for frail seniors to minimize adverse outcomes and health complications often associated with hospitalization. RGP invited to November 14, 2014 – MOHLTC- LHIN Leads round table meeting

12) November 3 - OHA HealthAchieve RGP's Geriatric session: "The Elusive Frailty Formula – Identifying frail seniors in the 1-5%". This session was rated 3.6/4.

13) November 20, 2014 – Health Quality Transformation conference- Poster presentation MOVE ON.

14) November 27 – RGPs of Ontario provided consultative input to Rehab Care Alliance work to date.

15) Consultation services provided to HQO Healthlink QUIP coaching initiatives.

16) Consultation services on sociotechnical/aging issues for OTN Telehome monitoring pilot study

17) Participation at the provincial assess and restore round table and the MOH/LHINs specialized geriatric/psychogeriatric services review process.

18) Participation in ongoing advisory groups: TCLHIN BSO Educational Consortium and the PRC-PC advisory group, TCLHIN NLOT steering committee, CLHIN Health Professions Advisory, Baycrest GTP/ILU working group, and Center for Learning Research and Innovation in LTC External Advisory Group, CELHIN Seniors Care Network Board.


20) RGP participated the MOHLTC Health Service Research Fund Showcase on Feb 23, presenting our work on SFH indicators

21) Participation on the expert panel for Nurse-Led Care Transitions Interventions: A Strategy to Improve Health System Integration and Performance, a project funded by MOHLTC HSRF.

LOCAL/REGIONAL

1) April 2, 2014 – Medical Grand Rounds Sunnybrook Health Sciences Centre – Delirium: Do you see what I see?

2) May 2014, RGP network meetings split into two streams – administrator meetings and webinars for front-line clinicians. The administrator stream will focus on system-related issues. This group strongly endorsed the value of meeting quarterly for this purpose.

3) May 22, 2014 – MH LHIN Regional Palliative Care Program proposal consultation.

4) Supporting North East Toronto Health Link (Better Care) in validation of a frail seniors identification algorithm and pathway for SGS involvement for flagged patients.

5) Hosted the combined university resident research day, introducing a very successful new format for the presentations. Six of the 9 awards were won by University of Toronto trainees.
6) June 19, 2014 - B Liu delivered the keynote presentation at the South West LHIN SFH Education and Networking Day.

7) July 1, B Liu, as U of T program director welcomed three new residents into the geriatrics subspecialty training program. With a fourth resident starting in January, we have a cohort of 10 residents in the program for 2014-15.

8) Toronto Academic Hospitals Science Network – Chief Nursing Executive Group host a seniors care committee. The committee is hoping to evolve into an active community of practice focused on seniors. The TAHSN CNE executive have asked B Liu to take a leadership role in this community of practice, aligning its activities with the pan-LHIN SFH strategy. D Ryan has provided guidance on community of practice principles and network analysis.

9) Aug 20, 2014 – professionalism workshop for undergraduate medical students, University of Toronto (D Ryan)

10) M. Awad and A. Tsang supervised York University students in the Health Management Policy program for the following RGP project – “Improving the Patient Experience for Frail Seniors”. The students were tasked to review and synthesize the current literature on the frail seniors’ experience with healthcare providers, report on the best practice approach to engagement, and identify patient-centred measures for engaging frail seniors in a Day Hospital.

11) October 20, 2014 – SGS Institute brought together 85 clinicians from 19 organizations to exchange knowledge and learn from experts on high risk screening, use of technology, oral health and quality improvement.

12) U of T Geriatrics Residency Program – full complement of four residents for 2015-16. Fifteen residents entering geriatrics training programs outside of Quebec next year


14) M. Awad completed the Rotman Advanced Health System Leadership Program sponsored by the TC LHIN. The program was delivered over six months and included a Preceptor Project.

15) Knowledge to practice consultation services provided to Dr. Jacques Lee’s EDU-RAPID research on pain management in the ED.

16) Consultation services provided on West Park’s Campus Development Planning on the design of geriatric day hospitals.

17) Consultation services provided to TOCCAC Clinical Collaboration Tool initiative.

18) Teamwork measurement and team development consultation services provided to CELHIN GAINetwork.

19) Teamwork measurement services provided to NE Toronto Healthlink Complex Patient Team Demonstration Project.

20) Telehome exercise coaching team invited to contribute to a Telehealth and rehabilitation workshop at spring 2015 Rehab Best Practices Conference.

21) Secured funding for CLHIN NLOT Repatriation Project continuation through this initiative NLOT, GEM and FLOW staff achieve greater integration through automated notification processes
22) CLHIN LTCH Directors/NLOT meeting convened to support OTN deployment in CLHIN LTCHs.

23) PRC Program of Toronto staff developed, deployed and evaluated a first curriculum for new LTCH Manager/Supervision on Dementia and Responsive Behaviors.

24) Provided subject matter expertise to the North Simcoe Muskoka Seniors Health Program Evaluation.


26) Supported the TCLHIN planning and implementation of Assess and Restore funding. The LHIN have selected a small group to guide this process that includes TC CCAC, Baycrest, and RGP. Tasked with recommending a plan for the use of approximately $1 million in annual funding over the next two years.

27) Toronto Academic Health Sciences Network (TAHSN) SFH Community of Practice retreat – used the SFH framework to guide its work focuses on collaborative approach to managing responsive behaviours. RGP is supporting the effort by brokering and fostering linkages with other groups also working in the same area. E.g. BSO, BSO educational consortium, PRC, Alzheimer society.

28) March 3, RGP hosted a webinar on CNAP for the network. A single access point to service offered by community service agencies. The service does not replace existing entry points to service, but complements them.

29) Conducted a current state review for North East Toronto Health Link (Better Care Committee).

30) Invited to an advisory committee and the primary care working group of the North West Toronto Health Link.

31) Provided teamwork measurement services to NETHL complex patient team and CELHIN GAIN teams.

32) Completed the CLHIN NLOT/LTCH repatriation initiative in which automated notification systems alert NLOT nurses to the status of LTCH residents in ED/Acute Care operational in all CLHIN hospitals.

33) Continued development of the role of PRC for primary care and co-chair of the TCLHIN BSO Educational Consortium.
Hospital Activity Data

Summarized in the table below are the activity data for 2014-2015 (forecast and year end actual).

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<td>8304</td>
<td>8016</td>
<td>11753</td>
<td>11906</td>
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<tr>
<td>Admissions</td>
<td>345</td>
<td>434</td>
<td>215</td>
<td>239</td>
<td>403</td>
<td>461</td>
<td>963</td>
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<td>18%</td>
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<td></td>
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<td>Separations/Discharges</td>
<td>345</td>
<td>426</td>
<td>215</td>
<td>237</td>
<td>403</td>
<td>461</td>
<td>963</td>
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<td>17%</td>
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<tr>
<td>Occupancy Rate</td>
<td>90%</td>
<td>92%</td>
<td>91%</td>
<td>88%</td>
<td>92%</td>
<td>93%</td>
<td>2.73</td>
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<td></td>
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<tr>
<td>Average Length of Stay</td>
<td>31</td>
<td>25</td>
<td>39</td>
<td>34</td>
<td>29</td>
<td>26</td>
<td>99</td>
<td>85</td>
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<table>
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<tr>
<th>CONSULTATIONS</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
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<th>14/15 forecast</th>
<th>14/15 actuals</th>
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<td>Patients Seen</td>
<td>580</td>
<td>668</td>
<td>600</td>
<td>793</td>
<td>400</td>
<td>416</td>
<td>600</td>
<td>688</td>
<td>2180</td>
<td>2565</td>
<td>18%</td>
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</table>

GRU = Geriatric Rehabilitation Unit
GATU = Geriatric Assessment and Treatment Unit
<table>
<thead>
<tr>
<th></th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
<th>14/15 forecast</th>
<th>14/15 actuals</th>
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<tbody>
<tr>
<td><strong>GEM</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>FTE</strong></td>
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<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
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<td>1.0</td>
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<tr>
<td><strong># of patients served</strong></td>
<td>690</td>
<td>1197</td>
<td>690</td>
<td>375</td>
<td>690</td>
<td>1005</td>
<td>690</td>
<td>526</td>
<td>966</td>
<td>453</td>
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<td><strong>Patients discharged</strong></td>
<td>449</td>
<td>811</td>
<td>449</td>
<td>282</td>
<td>449</td>
<td>748</td>
<td>449</td>
<td>351</td>
<td>628</td>
<td>319</td>
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<tr>
<td><strong>GEM</strong></td>
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<tr>
<td><strong>FTE</strong></td>
<td>1.4</td>
<td>1.4</td>
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<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
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<td></td>
</tr>
<tr>
<td><strong># of patients served</strong></td>
<td>966</td>
<td>898</td>
<td>690</td>
<td>611</td>
<td>966</td>
<td>835</td>
<td>966</td>
<td>720</td>
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<td><strong>Patients discharged</strong></td>
<td>628</td>
<td>641</td>
<td>449</td>
<td>364</td>
<td>628</td>
<td>567</td>
<td>628</td>
<td>391</td>
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</tr>
</tbody>
</table>

*CVH = Trillium Health Partners-Credit Valley Hospital*

*MH = MacKenzie Health*

*RVHS = Rouge Valley Health System-Centenary*

*HRH = Humber River Hospital*

*STM = St. Michael’s*

*MSH = Mount Sinai Hospital*

*SJHC = St. Joseph’s Health Centre*

*TEGH = Toronto East General Hospital*

*UHN = University Health Network, Toronto Western Hospital*
Appendices

Appendix A: Service Information

What are “specialized geriatric services”?
Specialized Geriatric Services (SGS) are a spectrum of hospital and community-based health care services that deliver CGA. They diagnose, treat and rehabilitate frail older persons with complex medical, functional and psychosocial problems. SGS are delivered by interprofessional teams of geriatric health care providers specifically trained to recognize and treat frail seniors with multiple and complex needs. Teams may compromise the following: physician, nurse, social worker, physiotherapist, occupational therapist, dietician, pharmacist and other health professions.

What is the target group for “specialized geriatric services?”
The target population for SGS is frail seniors whose health, dignity and independence are at risk due to:
- multiple complex medical and psycho-social problems
- a recent unexplained decline in health and/or level of function
- loss of capacity for independent living
Definition of Specialized Geriatric Services

The following core specialized geriatric services deliver comprehensive geriatric assessment that optimizes the function and independence of frail seniors and supports aging in place. Collaborating with community and primary care, these services are delivered in a variety of settings.

Outreach Teams
Comprehensive assessments in the older person’s place of residence are conducted by one or more health care professionals.

Outpatient Geriatric Clinics
Clinics are used to assess, treat, monitor, and follow older persons in a clinic setting.

Geriatric Day Hospitals
These ambulatory programs provide diagnostic, rehabilitative or therapeutic services to persons living in the community.

Geriatric Emergency Management (GEM)
Consultation by a specialized geriatric health professional in the emergency room providing: assessment, diagnosis, identification of “at risk” older persons, initiation of appropriate treatment, and linkages with community and primary care.

Inpatient Consultation Teams
Interprofessional teams provide consultation and assessment of patients in the inpatient setting.

Acute Geriatric Units/Acute Care of the Elderly Units
Inpatient hospital units in an acute care setting for frail older persons who require short-term diagnostic investigation and treatment.

Geriatric Assessment and Treatment Units (GATU)/Geriatric Rehabilitation Units (GRUs)
Inpatient units for frail older persons with complex medical conditions who following an episode of surgery/illness/injury, require an individualized assessment and rehabilitation program.

Geriatric Mental Health Services
Geriatric mental health professionals provide assessment and treatment for those older persons who may have psychiatric, behavioural, addiction, or psychosocial issues. Although not one of the funded core SGS, geriatric mental health services are an important part of the continuum of service for frail seniors. At many sites, geriatric mental health 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.

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

Day Hospitals

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

Inquiries/Referrals: Any request for admission into the Day Hospital.

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

Attendances/Visits: 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.

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.

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

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

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

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

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

Geriatric Rehabilitation Units/Geriatric Assessment & Treatment units

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

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

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

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

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

**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
## Program Development / Improvement

<table>
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<tr>
<th>#</th>
<th>Activity / Description</th>
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<th>Comments</th>
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</table>
| 1 | Review of GATU structure and alignment  
As part of the reconfiguration of Rehabilitation Services at Baycrest, the GATU will be moved and integrated expanded into the slow stream rehab unit. The service will continue as a fully integrated model. The staff and leadership will be participating in the program planning throughout 2014/15 | Completed  | The GATU beds that were designated beds on the High Tolerance Rehab unit were reconfigured and a new process and approach for intake of community-based admissions was developed. The approach will continue to evolve during the implementation of the Baycrest Clinical Services Plan in keeping with A&R principles. |
| 2 | Reconfiguration of Rehabilitation Services at Baycrest  
Baycrest is undertaking a year long reconfiguration of our rehabilitation program in order to develop a more fulsome program that targets the most complex geriatric rehabilitation clients, many of whom have significant cognitive issues. | Ongoing    | The first phase of the reconfiguration of rehabilitation services at Baycrest was successfully completed with significant results. Reducing LOS (ALOS decreased from 30 to 25 days in HTR) and enhancing the intake model and streamlining flow has resulted in improved access and flow. The process of reconfiguration will continue over the next year in the context of the implementation of the new Clinical Services plan and A&R. |
| 3 | Geriatric Clinic Process Improvement  
We have undertaken a lean exercise to review the current flow of work in the clinic area. This work will expand to include a review of space required and patient flow, secretarial activity and booking within the context of the move to central intake. | Not achieved | Due to a significant flood in the ambulatory care area in the Spring of 2015, the Geriatric Assessment Clinics were relocated to a temporary location and the space and process redesign was put on hold. During the next year with the development of an access and flow strategy an assessment of process improvement and redesign will occur. |

## Innovation / New models

<table>
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<tr>
<th>#</th>
<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
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</thead>
</table>
### 1. Integrated Community Care Team model

We will continue to develop and implement the processes for service integration/collaboration for the ICCT. This work includes establishing flow processes, building internal and external linkages and fully evaluating the new model. This work will be ongoing for 2013-2015.

Completed

During 14-15 the ICCT underwent significant process improvements and development and strengthening of internal and external linkages. The BRIDGES evaluation was completed in Spring 2015.

### 2. Implementation of One Stop Access for all Baycrest SGS programs and services

As part of the CSP at Baycrest, the SGS system will be an early adopter of the new central intake processes developed and implemented in 2014/15

Not achieved

During the next year Baycrest will be undergoing a realignment of the continuum of specialized geriatric services within the assess and restore mandate, and through a broader access and flow strategy will be implementing a central intake model.

### 3. Establishing the new Strategic Direction for SGS

Project underway to redefine the strategic direction and fit of the SGS at Baycrest in conjunction with the new Baycrest Clinical Services Plan under development. Implementation of some service changes will be undertaken over a multi-year timeframe.

Ongoing

A Clinical Services Plan was developed and launched during 14-15 and implementation will be commencing during 15-16.

### Activity Variance

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<th>Activity / Description</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Geriatric Assessment Clinics</td>
<td>Ongoing</td>
<td>The recruitment of an additional geriatrician is ongoing. Please also refer to Program Development/Improvement #3.</td>
</tr>
</tbody>
</table>

- It is anticipated recruitment for additional geriatrician support will not be completed until 2015.
- An evaluation of the Geriatric Assessment Clinics with further support from the inter-professional team should result in improved efficiency and reduction in wait times.
2. COT/Integrated Community Care Team (ICCT) admissions and visits
   We will review attendances and visits as we continue to implement the ICCT. It is expected that in 14/15 we will see an increase in visit numbers in particular, reflecting the increase in the ICCT staff providing service in the shared and primary care streams.

3. Day Treatment Centre
   A thorough review was conducted in 13/14 of the attendance and visit numbers for the Day Treatment Centre to better understand the collecting and validating of the data. The result of the review indicated the need for a re-alignment of expected and actual numbers that reflects the true activity in the DTC. These new targets are now integrated into our financial reporting structure.

---

### E-health

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<th>Comments</th>
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<tr>
<td>1</td>
<td>ICCT documentation</td>
<td>Not achieved</td>
<td>We are working on adding goal-based documentation (already used in DTC and Geriatric Rehabilitation) for the new team. This will require some programming changes to our electronic health record.</td>
</tr>
<tr>
<td>2</td>
<td>Implementation of New Data Collection Processes for RGP</td>
<td>Completed</td>
<td>Full implementation of data submission for the ICCT and DTC into the RGP portal was completed in 14-15.</td>
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### LEADERSHIP & PARTNERSHIPS

#### Local organization

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<tbody>
<tr>
<td>1</td>
<td>Medical Education Committee</td>
<td>Ongoing</td>
<td>Achieved and ongoing in 15-16.</td>
</tr>
</tbody>
</table>
2. **Learning Centre for Interprofessional Care**
   Geriatrician led project within Baycrest. Seeing first students now entering "internships".

3. **Nursing Professional Practice Committee**
   Committee provides leadership for nursing practice across the campus including the implementation of the BPSO activity (5 frail senior best practice guidelines)

<table>
<thead>
<tr>
<th>Status</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Completed</td>
<td>The Nursing Professional Practice Committee was established, and Baycrest achieved BPSO status from RNAO in Spring 2015.</td>
</tr>
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</table>

### External partnerships

<table>
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<tr>
<th>#</th>
<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>LHIN Behavioural Support Project&lt;br&gt;Baycrest taking lead for pilot.&lt;br&gt;Geriatric Psychiatry and Geriatric Medicine will be involved and will promote and advocate for SGS and frail seniors.</td>
<td>Completed</td>
<td>During 14-15 Baycrest was the LHIN lead for the Behavioural Support for Seniors Program.</td>
</tr>
<tr>
<td>2.</td>
<td>RCPSC NSC Chair&lt;br&gt;Baycrest geriatrician Chairing RCPSC National Specialty Committee for Geriatric Medicine until July 2014. Also sits on Internal Medicine Specialty Committee and Examination Committee.</td>
<td>Ongoing</td>
<td>Achieved and ongoing until July 2015.</td>
</tr>
<tr>
<td>3.</td>
<td>RGP committees&lt;br&gt;Baycrest membership on Day Hospital and Outreach Team committees.</td>
<td>Ongoing</td>
<td>Baycrest participates on the RGP Day Hospital and Outreach Team committees.</td>
</tr>
<tr>
<td>4.</td>
<td>Senior Friendly Hospital Indicator Working Group&lt;br&gt;Administrative leadership (in collaboration with the RGP) for the pilot project to provincially field test the feasibility of the delerium and functional decline indicators</td>
<td>Completed</td>
<td>Baycrest participated in the Senior Friendly Hospital Indicator Working group during 14-15.</td>
</tr>
<tr>
<td>5.</td>
<td>Provincial Rehabilitation Alliance&lt;br&gt;Participating in the Outpatient/Ambulatory Working Group and the Definitions Working Group to ensure that frail seniors rehabilitation needs are considere and factored into planning</td>
<td>Ongoing</td>
<td>Baycrest continues to participate in the Rehabilitation Care Alliance Outpatient/Ambulatory and Definitions Working Groups.</td>
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</table>

### EDUCATION & CAPACITY BUILDING
### Continuing education of health professionals

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</thead>
</table>
| 1 | Annual Pollock Medical Clinic and Grobin Ethics Day  
   Education day planned by Geriatricians, Family Medicine, Nursing, and Geriatric Psychiatry.  
   Aimed at Primary Care Physicians and Allied Health Professionals. Held first Friday of June each year.                                                                                                             | Completed  | This is an annual event.                                                                      |

### Training of graduate and undergraduate students

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<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
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</table>
| 1 | Postgraduate Medical Training  
   Anticipate ongoing rotations and electives from GIM, GM, FM and COE programs in Medicine.                                                                                                                     | Ongoing  | Baycrest participated in ongoing rotations and electives from GIM, GM, FM and COE programs in Medicine.                                                      |
| 2 | Allied health Professional students  
   Will continue to have students from PT, OT, Nursing, Social Work from multiple colleges and Universities.                                                                                                       | Ongoing  | Baycrest continues to support nursing and allied health education through offering student placements.                                                       |
| 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. The program was a great success in 2013 and participation in 2014 is anticipated. | Completed | Baycrest hosted Beijing Medical Students again in 14-15.                                                                                                    |
| 4 | Elective Clinical Clerks  
   We have had a steady group of clinical clerk elective students coming from McMaster and U of T. During their electives they participate in most of the RGP SGS services.                                    | Completed | Baycrest hosted Elective and Selective clinical clerks from McMaster and UofT during 14-15.                                                            |

### EVALUATION & RESEARCH

RGP Coordinated

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Baycrest - Page 5
Baycrest piloted, evaluated and sustained the Confusion Assessment Measure (CAM) on the rehabilitation units during 14-15.

**RGP affiliated primary/co-investigator initiatives**

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<tbody>
<tr>
<td>1.</td>
<td>BRIDGES Evaluation</td>
<td>Completed</td>
<td>The Bridges evaluation was completed in Spring 2015.</td>
</tr>
<tr>
<td></td>
<td>BRIDGES evaluation of the new model of specialized geriatric/primary care support (ICCT initiative)</td>
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**Other research collaborations**

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<th>Activity / Description</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>1.</td>
<td>Frailty database</td>
<td>Not achieved</td>
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<tr>
<td></td>
<td>Ongoing work on collaborative frailty outcomes dataset with Slow Stream Rehabilitation, GATU and DTC.</td>
<td></td>
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<tr>
<td>2.</td>
<td>Capacity Building Evaluation</td>
<td>Ongoing</td>
<td></td>
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<tr>
<td></td>
<td>Established a comprehensive model (initially referred to as i-HAT) to build capacity across the campus (LTC Home and Retirement Home) through the implementation of Interact and other practice enhancements to prevent transfers to acute care for frail seniors with PPH's. Model under evaluation expected to continue throughout 2014/15.</td>
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**Publications and presentations**

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<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Presentations/Posters</td>
<td>Completed</td>
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<tr>
<td></td>
<td>Anticipate presentation of three posters this year from SGS affiliated faculty.</td>
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</table>

**Research, consultation and assistance to others**

<table>
<thead>
<tr>
<th>#</th>
<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
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</table>
1. CCC neuroleptic utilization and the impact of a KT intervention
   MPD for DTC/GAC/ICCT will work with MPD from CCC on project to look at impact of KT intervention on prescribing practices in CCC.

Ongoing

The baseline data collection and KT intervention was completed in 14-15. The post study data collection is ongoing with completion anticipated in early 5-16.
## SERVICE

### Program Development / Improvement

<table>
<thead>
<tr>
<th>#</th>
<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Living well with stroke education in Day Hospital. Link with Heart and Stroke Foundation to provide standardized stroke education to Day Hospital clients.</td>
<td>Not achieved</td>
<td>Team was certified with Living Well with Stroke education. However, they have not received any referral from NYGH stroke clinic. Therefore, we have not provided standardized stroke education due to low number of patients with stroke at DH.</td>
</tr>
<tr>
<td>2</td>
<td>Take Knowledge Home Program to help clients remember and strategize information learned in Day Hospital. Evaluation to begin via satisfaction questionnaire in collaboration with RGP.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>New model of Geriatric Physician service delivery. Build capacity and expedite care provision.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Improve coordination with 4 Central LHIN teams related to the integration of service. Within ambulatory setting, standardization of “warm hands off”, communication with CCAC to improve communication.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Memory clinic new form. Assessment form being developed for use with family/patient for them to complete for initial assessments and follow-up.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Integration of assessment tools in PD clinic. QUIP-RS and NMS Screening tool will be used with PD patients in the clinic and Living Well with Parkinson’s program.</td>
<td>Completed</td>
<td></td>
</tr>
</tbody>
</table>
7. Develop an improved referral process from fracture room to Osteoporosis/Fracture prevention clinic. Revise directive between NYGH and Osteoporosis Canada. Completed

8. Define patient flow and continuum of care for Elder Care strategy. Map out patient flow to identify gaps and opportunities. Completed

9. Geriatric Day Hospital and Better Living Centre partnership regarding falls prevention and standardized seated exercise classes with patients discharged from Day Hospital. To provide continuum of care following discharge from Day Hospital to clients attending the Better Living Centre standardized seated exercise classes. Completed

10. DH assessment tools. The DH has modified their pain scale and replaced their current QOL questionnaire with the SF12 QOL scale. Completed

### Innovation / New models

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<tr>
<th>#</th>
<th>Activity / Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Team collaboration around strengthening the eldercare strategy across NYG and the LHIN. Two committees struck to focus on: a) Defining the continuum of eldercare continuum b) Geriatric education and building on our academic foundation</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Geriatric Mobile ACE Philosophy. Planning phases to looking at improvement in care of elderly across all hospital programs by providing timely/effective intervention.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Development of an Interprofessional Clinical Teaching Unit. This is being done in collaboration with the Faculty of IP Learning and the Medical Program, Geriatrics.</td>
<td>Completed</td>
<td></td>
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</tbody>
</table>
4. ADL room renovation in Ambulatory clinic setting.
   ADL room renovation in the ambulatory clinic to improve assessment of performance not just on clinical impression.

E-health

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<tbody>
<tr>
<td>1</td>
<td>EMR records ambulatory services. Increasing efficiency by not printing and putting physician consultation notes in each patient chart to maximize EMR.</td>
<td>Completed</td>
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</tbody>
</table>

LEADERSHIP & PARTNERSHIPS

Local organization

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</thead>
<tbody>
<tr>
<td>1</td>
<td>Access to care from SGS clinics and ORT. Collaboration with CCAC teams to help increase access to services and awareness of geriatric ambulatory services.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Accountability lead for Aging at Home Strategy. Aging at home funding being managed by NYG.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Geriatric psychiatry ORT and St. Elizabeth partnership. To have St. Elizabeth nurse accompany psychiatry on ORT visits with Dr. Anne Ferguson.</td>
<td>Not achieved</td>
<td>Not achieved secondary to St. Elizabeth no longer an active service as they were dismantled. No more mobile crisis team.</td>
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</table>

External partnerships

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<tr>
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<tbody>
<tr>
<td>1</td>
<td>MOVE-ON Plus. Partnership with other CAHO hospitals to continue with original work of MOVE-ON.</td>
<td>Ongoing</td>
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</tr>
</tbody>
</table>
2. Consultation to external hospitals and organizations. Dr. Chan provides expert knowledge to hospitals within our catchment/LHIN regarding development of programs and best practice models.

3. Improving integration with CCAC
   a) Dedicated CCAC manager for ambulatory services
   b) Work with NYG Health Records to insure depart summaries are faxed to primary care physicians

4. Family physician involvement during in-patient admissions. Look at process improvement and communication with family physician while patients in acute care (i.e. involvement in family meetings and in planning discharge of complex patients).

5. Sharing and defining Elder Care resources. Link with community partners to identify what additional resources exist for our patient population at NYG to facilitate access to care.

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**EDUCATION & CAPACITY BUILDING**

**Continuing education of health professionals**

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<tbody>
<tr>
<td>1.</td>
<td>Elder care orientation. Collaboration with NYG orientation committee to have eldercare orientation for all staff, physician, volunteers and students. This project would include a focus on professional staff, MDs and students in addition to support staff.</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
2. Teaching curriculum for staff, physicians and volunteers.
   a) Yearly combined geriatric rounds with other subspecialties
   b) Participation in both the Family Medicine Clinic Day and 5 Chiefs conference
   c) Collaborate with NYG Family Practice undergraduate director to include more geriatric topics into teaching sessions
   d) Educational material to be placed on NYG My Learning Edge
   e) Expanding geriatric rounds via OTN/webinar

Training of graduate and undergraduate students

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<tbody>
<tr>
<td>1</td>
<td>Geriatric resident teaching in ambulatory care (clinics, ORT, DH). Provide residents with an expanded IP educational opportunity in the ambulatory setting.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ACSM II Teaching (Art and Science of Clinical Medicine). Provide medical students the opportunity to refine physical examination and assessment skills on the frail elderly in hospital setting.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Pharmacotherapy in older adults. Involved in course design and implementation at the Faculty of Pharmacy, UofT for 3rd year entry level Pharm-D students.</td>
<td>Completed</td>
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EVALUATION & RESEARCH

RGP Coordinated

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<tbody>
<tr>
<td>1</td>
<td>SFH strategy around early detection of delirium in hospital setting. Completed research and now waiting for results so that implementation strategies can be integrated onto in-patient ACE unit and 5 SE Medicine.</td>
<td>Completed</td>
<td></td>
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<tr>
<td></td>
<td>Phase II Medication Research Study looking at Haldol. Looking at prescriptive patterns and safety of IM antipsychotic use in hospital.</td>
<td>Ongoing</td>
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<tr>
<td>3.</td>
<td>Day Hospital standardized discharge satisfaction questionnaire. Implementing questionnaire into DH setting with all patients.</td>
<td>Completed</td>
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</table>
## Program Development / Improvement

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<tbody>
<tr>
<td>1</td>
<td>To further enhance our Falls Prevention Program Hospitalwide. To develop a 5 year strategy to increase patient safety, decrease pain and optimize comfort by enhancing our beds and mattresses</td>
<td>Ongoing</td>
<td>Hiring of additional staff and marketing campaign in progress.</td>
</tr>
<tr>
<td>2</td>
<td>Patient Access and Flow in Geriatric Medicine and Psychiatry Clinics, and Outreach To improve patient access and flow in Geriatric Services through an interprofessional consult model</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Health Information Management (HIM) Actively engage with Health Information Management (HIM) to improve processes and create standard work for Geriatric Services patients' health information management</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Service Indicators Address RGP performance and activity indicators for 2014-2015 through improved data collection and continuous quality management.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Quality Improvement Plan To increase capacity and number of referrals in the RGP.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Physician Recruitment for Geriatric Services To work with the V.P., C.M.O. and Chief of Staff to continue to recruit new Geriatricians to improve access to Geriatric and psycho-geriatric services.</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
7. Partnerships
   To strengthen existing partnerships and develop new partners and community stakeholders to improve the RGP's referral base and service delivery.

   Ongoing

   Strong relationship with Falls Prevention Clinic. Patients have been referred between the 2 programs.

8. Wayfinding
   To improve ease of access to Providence Healthcare programs

   Ongoing

   Task force in place to improve signage and floor mapping for easily location of geriatric programs.

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<th>Innovation / New models</th>
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</tbody>
</table>
| 1. | Falls Prevention Clinic
   Falls Prevention Clinic now open to inpatient referrals on the Inpatient Geriatric Units. Referrals will then be accepted from other inpatient units in the hospital and from the community in Q3. | Completed | Fully opened to community, acute care and inpatient referrals. |
| 2. | Senior-Friendly Hospital Expression of interest submitted to participate in the SFH Pilot Study to evaluate delirium and functional decline. 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. Priority setting and planning, action plans and outcomes are shared at the Quality & Safety Committee (Senior Friendly Hospital Provincial Strategy) | Not achieved | |
| 3. | Pharmacy Home Visit Collaboration
   A Project Charter for Medication Reconciliation in the Providence Outpatient Stroke Clinic was developed and approved. The collaboration includes the Geriatric Outreach Team pharmacist, the Providence Healthcare retail pharmacy and the patients of the Outpatient Stroke Clinic | Completed | |
4. Advancing the Integration of Health Care through Health Links
Collaborating on the TCLHIN CSS (Community Support Service) Health Links Working Group which is tasked with enhancing community capacity to connect complex and at risk clients to services to increase access, improve coordination and enhance care management.
Manager of Partnerships is working to Integrate CCPs into all inpatient/outpatient programs. Manager also coordinating and promoting use of TIP to better serve community clients.

5. Access and Flow for Community Older Adults with responsive behaviours
Collaborating on the Community Outreach Planning Committee to help create recommendations and vision for future state. (Community Behavioural Support Ontario Strategy - TCLHIN)
Not achieved

6. Community Health Navigators
Follow up of geriatric patients within 48 hours of discharge from inpatient units by Community Health Navigators started in 2013.
Completed
CHNs follow up within 48 hours and 1 month for geriatric inpatients.

7. Geriatric Pathways
To develop and implement pathways to create seamless admission to geriatric programs (RGP/community to inpatient) and from inpatient geriatric programs to RGP.
Ongoing
Pathways for referral from inpatient/outpatient and vice-versa have been discussed and currently operating. Next step will be to formalize pathways.

E-health

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<tbody>
<tr>
<td>1.</td>
<td>Ontario Telemedicine Network (OTN) Video Conferencing</td>
<td>Ongoing</td>
<td>Manager of Partnerships coordinating and promoting use of TIP to better serve community clients.</td>
</tr>
<tr>
<td></td>
<td>OTN currently implemented and will be looking to create opportunities to improve patient access to diagnoses and treatment, support opportunities for professional collaboration (with community partners/GPs/Specialists) and networking, and enhance learning opportunities. Also, enhance internal capacity to use OTN resources.</td>
<td></td>
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</tbody>
</table>
2. Enhanced use of technology
   To start discussions of improving efficiencies of data collection through the use of standardized assessment forms via tablets for use in the community.

<table>
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<tr>
<td>Local organization</td>
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<td>1.</td>
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</table>

<p>| External partnerships      |</p>
<table>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Canadian Hearing Society Geriatric Services is pursuing a partnership with an ENT physician to provide onsite services starting Summer 2013</td>
<td>Completed</td>
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</table>

<table>
<thead>
<tr>
<th>EDUCATION &amp; CAPACITY BUILDING</th>
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<tbody>
<tr>
<td>Continuing education of health professionals</td>
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<td>1.</td>
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</table>
2. Internal and external education
   To provide education to inpatient units of services offered by the RGP to increase awareness, referrals and strengthen linkages.
   To provide education to patients and caregivers, and external stakeholders and community partners on relevant topics regarding the geriatric population and RGP services.

3. Increased awareness and adherence to Infection Control Practices.
   Participate in Infection Control Education to be able to safely conduct outreach home visits.
   Use of equipment to maintain staff safety with regards to Infection Control.

4. On-going education of staff
   To improve competencies of staff as part of individual professional development, and to enhance services offered to patients/partners.

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Training of graduate and undergraduate students

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</thead>
<tbody>
<tr>
<td>1.</td>
<td>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 Geriatric Services (GATU/GRU, Geriatric Clinics, Outreach, Pharmacy Home Visit and Scotiabank Learning Centre).</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Support on-going education of students To create learning opportunities for students in various disciplines in geriatrics i.e. Shadowing in clinics, home visits, etc. To continue with UofT small group labs to support professional programs and universities.</td>
<td>Ongoing</td>
<td></td>
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<tr>
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<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Maintain current spectrum of services and adjust according to population need, resources, and hospital priorities</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
| 2  | Outreach team - process improvements  
Identify opportunities for efficiencies.  
Explore opportunities for increasing referrals.  
Improve communication/collaboration between CCAC and community service agencies.  
Standardize summary letters to referring physicians.  
Standardize documentation practices                                                                 | Completed |                                                                                            |
| 3  | Geriatric Day Hospital - process improvement  
Identify reasons for "no shows".  
Quality initiatives for improving no show rate, daily census, wait list, and documentation.                                                                 | Ongoing   |                                                                                            |
| 4  | Falls program - process improvement  
Explore strategies to manage demand.  
Continue telephone screening for all referrals. Suitability and/or commitment determined and alternate referral completed as necessary.  
Program offered 2 times per week to accommodate demand and wait list.  
Waitlist and other community programs reviewed regularly.                                                      | Completed |                                                                                            |
### Innovation / New models

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support corporate senior friendly priority areas - functional decline, culture and physical environment. Continue to provide clinical expertise for planning and implementation of corporate priorities. Support provided to corporate strategies to become leaders in Senior Care.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Enter partnership with FIT Sunnybrook and IMPACT clinic SGS offers support and resource to impact clinic actively involved in ICCP program development.</td>
<td>Ongoing</td>
<td></td>
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</tbody>
</table>

### LEADERSHIP & PARTNERSHIPS

#### Local organization

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<tbody>
<tr>
<td>1</td>
<td>Corporate senior friendly hospital steering committee and subcommittees. Provide clinical expertise in care of frail seniors</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>General medicine quality council Standing committee of hospital</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Interprofessional Education Committee Standing committee of hospital</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Other discipline-related activities involving SGS staff SGS staff provide geriatric expertise and leadership to professional practice groups</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ICCP Committee with CCAC Membership on ICCP committee</td>
<td>Ongoing</td>
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#### External partnerships

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</thead>
</table>
1. Membership on SPRINT advisory committee  
   Partnership with geriatric outreach team, Day hospital clinic  
   **Ongoing**

2. GTA Rehab Network committee  
   SGS Social worker is member on working group addressing referrals processes and flow  
   **Completed**

3. Falls Intervention Team - Public Health Community Council  
   Continue to support and strengthen relationship and complementary services for our shared falls clients  
   **Ongoing**

4. RGP Committees  
   RGP Network, GEM nursing network, Accountability Steering Committee, Outreach Team committee, Day Hospital Committee  
   **Ongoing**

5. Anne Johnston Health Station Project with AJHS have home exercise program  
   **Ongoing**

### EDUCATION & CAPACITY BUILDING

**Continuing education of health professionals**

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</tr>
</thead>
</table>
| 1 | Continue to act as a resource through RGP Network to partnership institutions  
   Host health professionals from other organizations for shadowing, skill development and information exchange | Ongoing | |

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</thead>
</table>
| 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**

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</tr>
</thead>
</table>
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.

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

### EVALUATION & RESEARCH

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<th>Status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Continue to participate in outreach evaluation</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Initiate quality improvement processes to improve efficiency and clarity of documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Continue to participate in day hospital evaluation</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Initiate quality improvement processes to improve efficiency and clarity of documentation.</td>
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</table>

**RGP affiliated primary/co-investigator initiatives**

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<tr>
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<th>Status</th>
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</thead>
<tbody>
<tr>
<td>1. Support multi-site early mobilization project</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>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.</td>
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</table>
**SERVICE**

**Program Development / Improvement**

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<th>Activity / Description</th>
<th>Status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Shared Care Model with St. Michael's Academic Family Health Team Geriatric Monthly 2 half-day outreach clinics at two of the family health care team sites.</td>
<td>Ongoing</td>
<td>Continue to finalize plan for having Geriatric Outreach clinic at St. James Town and 410 Sherbourne. Will plan to have it running for late summer/early fall.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Currently exploring possibility of geriatric outreach clinic at 3rd site.</td>
</tr>
<tr>
<td>2.</td>
<td>Exploring stronger shared care links with rehabilitation partners. Exporing stronger links with Bridgepoint Health. Two SMH Geriatricians providing consultation services.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Indirect outreach Geriatric consultant to St. Michael's Academic Family Health Team helping to support the primary care physicians with Bridges 'Home Visiting for Homebound Seniors Program'.</td>
<td>Ongoing</td>
<td>Continue to finalize plan for consult services for the SMART Seniors Home Visiting Program.</td>
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</tbody>
</table>

**Innovation / New models**

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</table>
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. The committee meets 5X yearly and addresses the five domains of the Senior Friendly Framework. Committee Chairs have been asked to provide objectives around Senior Friendly care to the strategic plan.

### Activity Variance

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</thead>
<tbody>
<tr>
<td>1.</td>
<td>GEM</td>
<td>Completed</td>
<td>Currently have full 1.4 FTE GEM position complement and should be able to meet GEM targets.</td>
</tr>
<tr>
<td>2.</td>
<td>Internal Consult Team</td>
<td>Completed</td>
<td>Very busy service - volumes of 50 - 60 consults per month. Geriatric partnership with Trauma Service continues for all clients over the age of 60-years.</td>
</tr>
<tr>
<td>3.</td>
<td>Elders' Clinics</td>
<td>Ongoing</td>
<td>Dr. Gilley will lead the team through a Quality Improvement Project using data, process mapping etc to improve wait times. She will also bring in knowledge gained through Ottawa Hospital's experience.</td>
</tr>
<tr>
<td></td>
<td>Clinic volumes continue to increase with higher proportion of follow-up to new patient visits. MD's have taken on the challenge to decease number of follow-up visits to open access for new patients. Two projects in place 1. Review of &quot;No Shows&quot; and 2. Review of GEM clinic patient referrals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>6-bed ACE</td>
<td>Ongoing</td>
<td>Review has been completed and recommendations will be presented to Senior Management for consideration.</td>
</tr>
<tr>
<td></td>
<td>Following last's years Geriatric External Review over the coming year consideration will be given to the ACE beds and the ACE model currently provided.</td>
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### E-health

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</table>
1. **Telehealth Consultation**  
Dr. Zorzitto provides telehealth assessment 3 X monthly. The number of consultation requests are increasing resulting in a wait list for the Orillia / Midland / Collingwood sites.

## LEADERSHIP & PARTNERSHIPS

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</table>
| 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 addressing a number of geriatric issues. | Ongoing   |          |

## External partnerships

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<th>Activity / Description</th>
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<th>Comments</th>
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</table>
| 1. | TCLHIN Palliative Care Strategy  
GEM Clinical Nurse Specialist participating on this committee sharing specialized geriatric expertise and knowledge. | Ongoing   |          |

## EDUCATION & CAPACITY BUILDING

## Continuing education of health professionals

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<th>Activity / Description</th>
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</table>
| 1. | University of Toronto - cross appointments  
Individual RGP team members maintain U. of T.cross appointment: Medicine, nursing, physiotherapy, occupational therapy. | Completed |          |
2. Medical & Nursing Rounds
   Medical Grand Rounds are delivered with a specific geriatric focus at least once per year.
   RGP RN’s will present at Hospital-wide Nursing Rounds

3. Seniors Month
   RGP staff will arrange for geriatric educational sessions for staff and community health care providers during Seniors Month June 2014.

4. Senior Friendly Hospital Education Committee
   Geriatric CNS is a member of the SMH Senior Friendly Hospital Education Committee providing expertise in specialized geriatrics. Has provided information on such topics as Dementia and the “Gentle Persuasive Approach” to address behavioral issues and also the topic of pain control in the elderly.

Training of graduate and undergraduate students

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<th>Status</th>
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<tbody>
<tr>
<td>1.</td>
<td>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 Geriatric Sub Specialty Residents, Internal Medicine Residents and Primary Care Residents. Supervision provided on the inpatient unit, the consultation service and the clinic setting. All geriatricians involved in ASCAM2 undergraduate education.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Geriatric Core Training Program Core Training Program for geriatric medicine trainees, internal medicine and family medicine trainees as well as CC3 in ambulatory care</td>
<td>Completed</td>
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<tr>
<td>1</td>
<td>Mobilization of Vulnerable Elders - Move ON</td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>This multi site (Sunnybrook, Baycrest, Mt. Sinai, St Michael's) initiated in December 2011. SMH leads Dr. Zorzitto &amp; Dorothy Knights RN Associated with the Move ON project SMH introduced VISA volunteer program to leverage the role of volunteers to improve and enhance the elder patient experience. The number of volunteers to this program continues to grow.</td>
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Other research collaborations

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<th>Status</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Trauma / Geriatrics investigational focus</td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>Dr. Camila Wong along with physicians from Sunnybrook supported by AFP innovations fund conducting research focused on Geriatrics / Trauma partnership.</td>
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</table>

Publications and presentations

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<th>#</th>
<th>Activity / Description</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>All disciplines will seek opportunity to present, and / or publish throughout the coming year.</td>
<td>Ongoing</td>
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</table>

Research, consultation and assistance to others

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</table>
1. Dr. Camila Wong engaged in geriatric research.
   Primary focus on the effects of the SMH Geriatric / Trauma partnership.
   Geriatric assessment and consultation for all trauma clients over the age of 60 years.
   In discussion with SMH Surgery department regarding geriatric consultation/assessment associated with pre-op for the frail elder patients.

2. Dr. Sharon Straus is involved in research activities with national and internal experts.
   Dr. Straus involved in a number of research projects with a focus on QI Indicators, Knowledge Translation & Evidence Based Medicine Outcomes.

3. RNAO Best practice Guidelines
   Geriatric CNS & Geriatric Nurse Coordinator involved in sustainability of Best Practice Guidelines - Delirium, Continence and Pain Control.
   Geriatric CNS educating staff on dementia care and use of the Gentle Persuasive Approach.
## Program Development / Improvement

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</table>
| 1. | Addition of 2 new specialized nursing roles  
   Clinical Nurse Specialist in place; recruitment for Nurse Practitioner completed.                                                                                                                                   | Completed|          |
| 2. | Additional geriatric outpatient clinics  
   With the addition of new geriatricians, new geriatrics clinics opened.                                                                                                                                                 | Completed|          |
| 3. | Palliative care Initiative  
   Ongoing palliative care initiative with monthly rounds, consultation with palliative care service and inpatient education sessions.                                                                                             | Ongoing  |          |
| 4. | Determine and communicate uniqueness of the geriatrics program. Determine what is unique about the geriatrics program and communicate it both internally and externally.                                                                 | Ongoing  |          |
| 5. | Enhancing persons centred care within Geriatrics Psychiatry program  
   Developed partnership with Ontario College of Art Design (OCAD) to investigate possible design changes which can be researched and implemented to enhance components of physical unit and environment | Ongoing  |          |
| 6. | Falls clinic enhancements  
   Falls clinic enhancements have led to increase in volumes and a decrease in wait list.                                                                                                                              | Completed|          |

## Innovation / New models

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</table>

Toronto Rehabilitation Institute - Page 1
1. Healthy Bowel Initiative  
   Program wide initiative using the bristol stool chart.  
   **Completed**

2. Nursing Care Delivery Review  
   Review and integration of recommendations in progress.  
   **Ongoing**

3. Falls Efficacy Scale International (FESI)  
   Implementing the FESI initiative. Integrating fear of falling and confidence in our falls prevention program.  
   **Completed**

4. Post Fall Assessment  
   Revision of post fall assessment for injury (for complex geriatric patients).  
   **Completed**

5. Geriatrician  
   Integration of geriatrician into interprofessional team in day hospital.  
   **Completed**

### Activity Variance

<table>
<thead>
<tr>
<th>#</th>
<th>Activity / Description</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monitor the impact of the development of new geriatrics outpatient services at University Center</td>
<td>Completed</td>
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<tr>
<td></td>
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<td></td>
<td>Ongoing monitoring as new services.</td>
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### E-health

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<th>Activity / Description</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Preparation for the implementation of Advanced Clinical Documentation (ACD) Enhancements to EPR are being review with Toronto Rehab in order to algin Toronto Rehab’s EPR with UHN’s.</td>
<td>Completed</td>
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<tbody>
<tr>
<td>2</td>
<td>Analysis being conducted in looking at obtaining new EPR. UHN is currently in process of gathering requirements needed for a new EPR</td>
<td>Completed</td>
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<td>Status</td>
<td>Comments</td>
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</tr>
<tr>
<td>1.</td>
<td>Implementing Nurses Improving Care for Hospitalized Elders education program (NICHE) Geriatrics Senior Clinical Director and clinical nurse educator sits on committee.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Senior Friendly Hospital Initiative Senior Clinical Director co-chairs Senior Friendly Hospital Initiative for UHN with a focus on delirium and functional decline.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Senior Friendly Hospital Indicators - Pilot Study Toronto Rehab along with Toronto Western has submitted an EOI to participate in the pilot study for the delirium indicator.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Psycho-geriatric outreach teams with Toronto Western Toronto Rehab and Toronto Western's psycho-geriatric outreach teams have integrated. Common forms have been developed for both teams as well as a combined business meetings on a quarterly basis.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>New organizational policy for delirium UHN Delirium initiative including 3 subcommittees looking at delirium education, communication and policy. Lesley Wylie co-chairing policy review committee.</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Assess &amp; Restore Funding Pilot funding to support two strategies, home adaptation and access to a specialized interprofessional assessment for frail elderly.</td>
<td>Completed</td>
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</table>

**External partnerships**

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<th>Activity / Description</th>
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</table>
1. **RGP Accountability Steering Committee, Network Committee & Day Hospital Committee.**
   - Completed

2. **Behavioural Support Ontario Project**
   - Ongoing participation with Behavioural Supports Ontario project.
   - 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.**
   - Completed

4. **Centralized Access Specialty Hospital Beds**
   - Geriatrics Psychiatry unit participates with CAMH and Baycrest with CCAC facilitating access to specialty hospital beds (behavioural beds). A new electronic referral system has been implemented.
   - Completed

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**EDUCATION & CAPACITY BUILDING**

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<tbody>
<tr>
<td>1</td>
<td><strong>Nurses Improving Care for Hospitalized Elders education program (NICHE).</strong> Ongoing</td>
<td>Completed</td>
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<tr>
<td>2</td>
<td><strong>Biannual Canadian Conference on Dementia.</strong></td>
<td>Completed</td>
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<tr>
<td>3</td>
<td><strong>Biannual Alzheimer Symposium.</strong></td>
<td>Completed</td>
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<tr>
<td>4</td>
<td><strong>Biannual Geriatrics Medicine Conference.</strong></td>
<td>Completed</td>
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</tbody>
</table>
5. Crisis Intervention and Physical Skills Review Program. Staff in Geriatric Psychiatry Unit are trained on Crisis Intervention and Physical Skills training. **Completed**

6. 5 Weekend Care of the Elderly 5-week course focusing on the care of the elderly. **Completed**

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<tr>
<th>Training of graduate and undergraduate students</th>
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<tbody>
<tr>
<td><strong># Activity / Description</strong></td>
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<tr>
<td><strong>Status</strong></td>
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<tr>
<td><strong>Comments</strong></td>
</tr>
<tr>
<td>1. Clinical placements for various health disciplines in collaboration with academic centers.</td>
</tr>
<tr>
<td>2. Completion of two IPE placements.</td>
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### EVALUATION & RESEARCH

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<th>Other research collaborations</th>
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<td><strong>Status</strong></td>
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<tr>
<td><strong>Comments</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>2. Exploring technological solutions to prevent falls and wandering. Toronto Rehab's Geriatrics program is working with the research department to find technological solutions to prevent falls and wandering in the elderly.</td>
</tr>
<tr>
<td>3. Experience of older adults transitioning to geriatrics rehab. Qualitative study using thematic analysis. Protocol submitted to a cap research fellowship competition. PI is Carol Skanes. Hope to improve the experience of patients transitioning from acute care.</td>
</tr>
</tbody>
</table>
4. **Automated Hand Hygiene Monitoring System**  
   Funded by the MOHLTC.  
   Demonstrating effectiveness of intelligent hand hygiene in hospital environments. TR is a test site for this initiative.  

5. **Developing a research study: Music and Memory (iPod Project)**  
   Partnering with Dr. Tartaglia (Neurologist at Toronto Western) and Alzheimer's Society. Research project will look at the impact of personalized music on aggression during morning care.
# SERVICE

## Program Development / Improvement

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<tbody>
<tr>
<td>1.</td>
<td>Enhance senior’s services at UHN. For better utilization of human and financial resources required for patient care evaluate opportunites to enhance care across UHN sites including TRI.</td>
<td>Ongoing</td>
<td>Continue to look for opportunities to enhance senior services.</td>
</tr>
<tr>
<td>2.</td>
<td>Incorporate &quot;Senior Friendly&quot; ideas for all UHN planning processes. Ensure all new planning initiatives are undertaken with the Senior Friendly Framework in mind.</td>
<td>Ongoing</td>
<td>Continue to incorporate ‘Senior Friendly’ principles into new planning initiatives.</td>
</tr>
<tr>
<td>3.</td>
<td>Compile and analyze monthly RGP stats. To monitor and evaluate efficient functioning of GEM resources, Geriatric initiatives and bed days &amp; LOS of patients on ACE unit.</td>
<td>Ongoing</td>
<td>Continue to compile and analyze stats for efficiency review and resource planning.</td>
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## Innovation / New models

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<tbody>
<tr>
<td>1.</td>
<td>Nursing Led Outreach Team to LTC Continue to work with East Hub NLOT to enhance and co-ordinate NLOT services in TCLHIN</td>
<td>Ongoing</td>
<td>Ongoing refinement of the knowledge and care the NLOT team provides.</td>
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## E-health

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<tbody>
<tr>
<td>1.</td>
<td>Maintain Geriatric information on UHN intranet. For easy access to UHN staff to information regarding Geriatric services and referral process.</td>
<td>Completed</td>
<td>Completed and continues to be updated as needed.</td>
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<tr>
<td>Local organization</td>
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<td><strong>Activity / Description</strong></td>
<td><strong>Status</strong></td>
<td><strong>Comments</strong></td>
</tr>
</tbody>
</table>
| 1. | **Maintain leadership in Quality Initiatives**  
Implementation of NICHE across all sites of UHN | Ongoing | Ongoing focus on Quality Initiatives |
| 2. | **Maintain leadership in Quality Initiatives**  
UHN is participating in the pilot data collection of one of the senior friendly indicators- Delirium. | Completed | Pilot completed |

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<th>External partnerships</th>
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<tbody>
<tr>
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</tbody>
</table>
| 1. | **Continue participation in RGP Network committees.**  
Active involvement by RGP members to provide input to medical and administrative directors. | Ongoing |  |
| 2. | **Leadership in Geriatric evidence-based practice.**  
Barry Goldlist has been named editor in chief of Canadian Geriatric Society CME Journal. | Completed |  |
| 3. | **Leadership in Care of Elderly patients in Primary Care.**  
Dr Robert Lam is a member on the College of Family Physicians of Canada Health Care of the Elderly Committee. | Completed |  |
| 4. | **Leadership in the Care of Elderly patients in Primary Care.**  
Dr Robert Lam is participating in the new care of the Elderly Series in the Canadian Family Physician journal. | Completed |  |
| 5. | **Leadership in the Care of Elderly patients in Primary Care.**  
Dr Robert Lam is the Secretary-Treasurer of the Canadian Geriatrics Society and a member of their executive and foundation committees. | Completed |  |
### Continuing education of health professionals

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</thead>
<tbody>
<tr>
<td>1</td>
<td>Education for staff related to Geriatric Best Practices.</td>
<td>Ongoing</td>
<td>Continued education of staff on Geriatrics best practices</td>
</tr>
<tr>
<td></td>
<td>Implementation of NICHE across all UHN sites</td>
<td></td>
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<tr>
<td>2</td>
<td>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</td>
<td>Completed</td>
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### Training of graduate and undergraduate students

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<tbody>
<tr>
<td>1</td>
<td>Education for IP students related to Geriatric Best Practices</td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>Staff offer education in wound care, continence &amp; constipation to residents in geriatric programs, medical &amp; family practice units as well as to students from the IP team.</td>
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</tr>
<tr>
<td>2</td>
<td>Continue monthly evidence based geriatric medicine presentation. Allied Health &amp; Nursing staff supervise geriatric medicine residents, assisting in training in EBGM</td>
<td>Ongoing</td>
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### EVALUATION & RESEARCH

### RGP Coordinated

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<tbody>
<tr>
<td>1</td>
<td>Evaluation of Geriatric Emergency Management Project</td>
<td>Ongoing</td>
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</table>
2. Evaluation of LTC Mobile Outreach program
   Ongoing NLOT service to provide follow-up and outreach to LTC facilities to enhance care of elderly and prevent transfer to Hospital /ER.

### RGP affiliated primary/co-investigator initiatives

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</thead>
<tbody>
<tr>
<td>1</td>
<td>Research on Health Outcomes in Prostate Cancer in Elderly. Dr. Alibhai &amp; co-investigators are completing the final phase of follow-up this year of a prospective study funded by the Canadian Cancer Society. Delays in data analysis prevented two major papers from the first year of follow-up to be submitted for publication last year - these are to be submitted for publication published this year.</td>
<td>Completed</td>
<td>Physician related activities performed outside of TWH will no longer will be reported</td>
</tr>
<tr>
<td>2</td>
<td>Research on Health Outcomes in Acute Leukemia in Elderly. Dr. Alibhai &amp; co-investigators conducted a large, prospective study looking at quality of life and physical function in older and younger patients with acute myeloid leukemia. This past year, preliminary analyses were conducted, one paper has been published, and one-year results were presented at a major international scientific conference.</td>
<td>Completed</td>
<td>Physician related activities performed outside of TWH will no longer will be reported</td>
</tr>
<tr>
<td>3</td>
<td>Research examining the quality of bone health care provided to older men with prostate cancer on hormone therapy. Dr Alibhai and co-investigators will perform 2 studies, one local, and one provincial, examining aspects of the quality of bone health care being provided to older men with prostate cancer.</td>
<td>Completed</td>
<td>Physician related activities performed outside of TWH will no longer will be reported</td>
</tr>
</tbody>
</table>
4. Exercise trial research of 3 different exercise delivery models in men with prostate cancer. Dr Alibhai and co-investigators will open and complete at least 50% of the accrual and 25% of the follow-up to this 2-centre randomized controlled trial examining 3 different exercise delivery models in men with prostate cancer.

5. Trial of 2 different bone health education strategies to improve the quality of bone health care for men with prostate cancer on hormone therapy. Dr Alibhai and co-investigators will open and complete at least 50% of the accrual and 25% of the follow-up to this single-centre randomized controlled trial examining 2 different bone health education strategies to improve the quality of bone health care for men with prostate cancer on hormone therapy.

Other research collaborations

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<th>#</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Research on a pilot exercise study for middle aged and older people with acute myeloid leukemia Dr Alibhai and co-investigators completed this study last year, funded by the Leukemia &amp; Lymphoma Society of Canada. Results were analyzed, presented at a major international scientific conference and a paper was published in the Journal of Supportive Care in Cancer.</td>
<td>Completed</td>
<td>Physician related activities performed outside of TWH will no longer will be reported.</td>
</tr>
</tbody>
</table>
2. Research examining coping in younger and older patients after a diagnosis of acute myeloid leukemia. Dr Alibhai, with co-investigators, will conduct an in-depth qualitative analysis of interviews with younger and older patients who were diagnosed with and treated for acute myeloid leukemia to understand coping and how it differs by age group.

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<tbody>
<tr>
<td>1.</td>
<td>Research on treatment of pressure ulcers using multidisciplinary teams in Ontario</td>
<td>Completed</td>
<td>Dr. Alibhai is a co-investigator on this research project funded by the Canadian Patient Safety Initiative and the Ontario Ministry of Health and Long-Term Care. This study was completed this year. Data was analyzed and a report was submitted to the MOHLTC; it has also been submitted for publication.</td>
</tr>
</tbody>
</table>

Physician related activities performed outside of TWH will no longer will be reported.