AGING CARE IN ONTARIO SUMMIT

(February 2024) - Final Report

Provincial Geriatrics Leadership Ontario

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

All photos by Jeff Speed, Photographer , Jeff Speed Photography

INTRODUCTION

On February 21, 2024, the Behavioural Supports Ontario Provincial Coordinating Office (BSO PCO) and Provincial Geriatrics Leadership Ontario (PGLO) convened partners from across Ontario to co-design an answer to the important question of “how to design the health and social care system we all want to age in?" Participants were charged with the task of envisioning such a system and starting to draft the road map to move Ontario’s health and social care system in this direction.

The event drew participants with lived and professional experiences from across the health and social care sector and participants were invited to bring their personal, professional and citizen experience to the discussion, not simply their titled organizational roles.

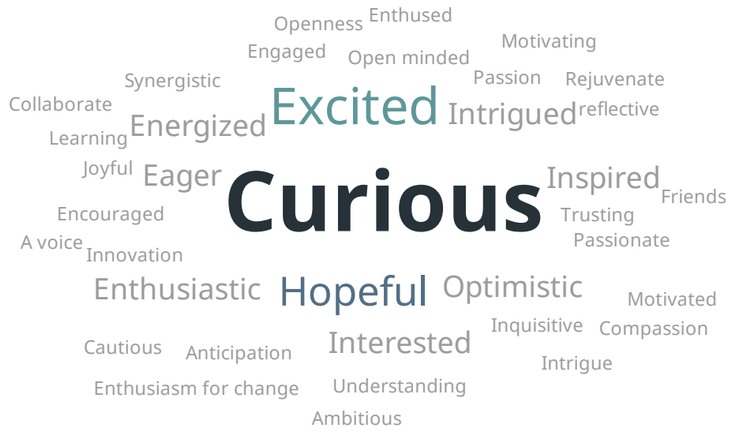
The session built on previous efforts from other organizations that have identified the need to work collaboratively as health policymakers and leaders to design a system and create a culture that rewards innovation and aligns incentives across with improved health outcomes[1]. At the forefront of organizers’ concerns was the ongoing issue of ALC rates in Ontario hospitals. As such, participants were prompted to come prepared to explore strategies for transitioning from ALC (Alternate Level of Care) to CLA (Collectively Leveraged Action), recognizing the urgency of addressing this challenge. Guided by previous work, the day’s participants also sought to empower citizens to demand changes that improve the outcomes that matter most to them and move to a citizen-centric approach to health service design.

Throughout the day participant-led discussions drew from various networks who are examining relevant questions and experiential evidence shared in program summaries supplied by attendees.

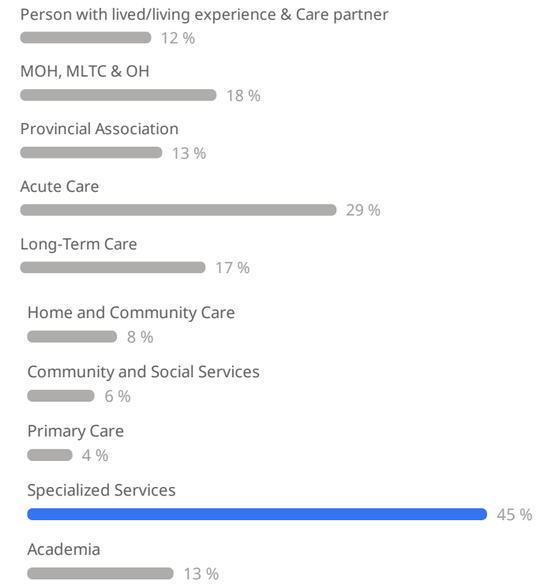
This Summit is considered the beginning of the conversation, one marking the start of a change process. The collective wisdom reflected in this report can help set direction and foster commitments, and includes the makings of a road map to achieve a health and social care system for older adult care in Ontario

[1]CD Howe Institute, 2024

PARTICIPANTS WERE ASKED FOR ONE WORD TO DESCRIBE HOW THEY WERE SHOWING UP



SECTORS OF HEALTH CARE PARTICIPANTS REPORTED WORKING IN



Behavioural Supports Ontario (BSO) provides behavioural health care services for older adults in Ontario with, or at risk of, responsive behaviours/ personal expressions associated with dementia, complex mental health, substance use and/or other neurological conditions. The BSO Provincial Coordinating Office advances the BSO initiative by measuring impact, spreading innovations and enhancing system integration.

PGLO is funded by the Ministry of Health to lead the provincial coordination of specialized physical, cognitive, social and mental health services for older adults and advances integrated, person-centred care for older adults living with complex health conditions, including frailty and dementia, and their care partners, in Ontario.

ENGAGING OLDER ADULTS AND LIVED EXPERIENCE ADVISORS

In keeping with a desired focus on the voices of impacted citizens, event organizers prioritized listening to input and direction from older adults, care partners and lived experience advisors. This was accomplished through:

- A pre-meeting with older adults, care partners and lived experience advisors to ascertain goals for the event and desired outputs;
- The co-development of system framing questions for use by health and social care system designers during the Summit; and
- Funded participation of six lived experience advisors (including older adults and care partners) at the February 21, 2024 event.

PRE-MEETING

A pre-meeting was held on February 7, 2024, with 20 older adults, care partners, and lived experience advisors. Participants were invited from the existing Provincial Older Adult and Care Partner Advisory Council (PGLO) and Lived Experience Advisor group (BSO). Staff from both BSO and PGLO facilitated the meeting.

Participants reflected on system gaps they had experienced in the current state of health and social care and support for older adults and care partners in Ontario. Through discussion, participants also generated themes and ideas reflecting system opportunities and goals to positively transform health and social care supports for older adults and care partners.

EXPERIENCED GAPS

- Lack of access to and awareness of specialized care and supports
- Fragmented care and support, lack of integration
- Lack of services and supports for care partner compassion fatigue
- Lack of innovative system planning and implementation
- Health human resource, capacity and workforce training needs
- Lack of tailored, practical and timely supports (particularly in community)
- Lack of prioritization of healthcare system, funding (sustainable) and policy gaps (specific to older adult needs)
- Social determinants of health and housing

SYSTEM OPPORTUNITIES

- Authentic integrated delivery of care and support services
- Enhanced care coordination and navigation for the person and amongst inter-agencies
- Access to enhanced and individualized community supports and resources
- Increased capacity building (education, ongoing specialized skill development, etc.)
- Co-design of modernized funding and policy reform (e.g. population focused/self-directed/flexible/sustainable community funding)
- Co-design of clinical and systems planning and partnerships that leverage the scale and spread of innovation and impact
- Co-designing in partnership with older adults and care partners
- Leverage technology and data utilization
- Increased inclusion and awareness

Participants also considered the question, “If you had a magic wand, what is one enhancement or change that you would make today to improve our healthcare system?” Responses included:

- Prioritization of my individual needs and preferences, considerate of current needs inclusive of “what matters most and what is most meaningful to me”.
- Aging optimally in place, ideally in my home environment.
- A health and social care and support system, considerate of me as a unique and whole person (i.e. physical, mental, emotional, social, functional, and cultural health and support needs).
- Timely access to ideal supports that promote health and wellbeing, while addressing my distinct needs with flexible levels of intensity.
- A system that embraces and prioritizes the Senior Friendly Care Framework and Dementia Friendly Care.
- An interconnected healthcare system that positions my voice and that of my care partner(s) at the centre, with seamless/inclusive communication and continuity of care.
- Supportive care transitions across all sectors that embrace individualized planning, navigation and specialized supports.
- An ongoing planning structure prioritizing active and ongoing partnership with older adults and their care partners, alongside healthcare and government partners.

SYSTEM FRAMING QUESTIONS

Ideas were refined into a set of **“System Framing Questions”** to guide health system design thinking. These questions were presented at the outset of the February 21, 2024 event to all participants, and made available on each table to support small group conversations throughout the day. Questions included:

- How will we actively engage and involve older adults and care partners, incorporating their various lenses, at every stage of co-design as experts-by-experience?
- Do we clearly understand, recognize, and respond to the diverse and unique requirements of each older adult alongside the needs of their care partners?

ENGAGING OLDER ADULTS AND LIVED EXPERIENCE ADVISORS

- Are we prioritizing and systematically addressing the challenges and gaps surfaced by older adults and their care partners, from access to delivery and self-management to follow-up and follow-through?
- Does this co-design recognize, reflect, and respond to the holistic (i.e. cultural, emotional, mental, linguistic, physical, and spiritual) care and support requirements of older adults and care partners across the continuum of care, including while they are waiting for services?
- Does this co-design integrate excellent examples in Ontario as well as other jurisdictions to add value, measure what matters most, and support aging in the right place for older adults and care partners?
- How are older adults and their care partners included as partners in our approach to goals-based care planning, considering their personal values and informed choices along their journeys?

PARTICIPATION AT THE SUMMIT

On the day of the Summit, Lived Experience Advisors played an active role in the following ways:

- Presented on the goals of the day from older adults, care partners, and other Summit participants, submitted in advance as part of the registration process.
- Presented the System Framing Questions to guide Summit discussions.
- System Framing Questions were printed at each table and used to guide generative discussions on what an older adult-centred system of health and social care supports.
- The six Lived Experience representatives who attended the Summit were an integral part in all system co-design and implementation discussions, allowing the distinct perspectives of older adults and care partners to be embedded in the work.

WHAT WE ALREADY KNOW

Opening speakers highlighted that Ontario is at a pivotal moment, making the day's conversation timely and important. There are approximately 2.6 million older adults aged 65 and older living in Ontario, and over 600,000 may experience frailty (including dementia and other conditions), necessitating supports for living at home. The proportion of older adults in the Ontario population will continue to increase for the foreseeable future. The population over age 85, a population significantly impacted by complex health conditions such as dementia and frailty, will increase rapidly, with increased life expectancy and the entry of baby-boom cohorts into this age group (starting in 2031). Older adults are the primary users of health services in every setting.

Until now, pressures related to Alternate Level of Care (ALC) and institutional solutions have dominated attention in the seniors' health policy realm and in funding decisions. There are also impending retirements and current health human resource shortages that are impacting older adults who require support at home and elsewhere. There are emerging, and not yet coordinated, efforts to identify innovative approaches to support living with dementia and complex health conditions associated with older age (e.g. frailty).

> There are approximately 2.6 million older adults aged 65 and older living in Ontario, and over 600,000 may experience frailty

There is new focus on supporting aging at home and in the community, and a recent commitment from Ontario Health to develop a provincial aging care continuum plan. At the same time, there is evidence that many older adults experience everyday ageism and these experiences may also be felt in our institutions and institutional processes. In some cases, processes to access services are unnecessarily complicated, and despite evidence-informed approaches to designing integrated older adult care, the Ontario health care system is not designed for older adults, which creates a central challenge to aging in place.

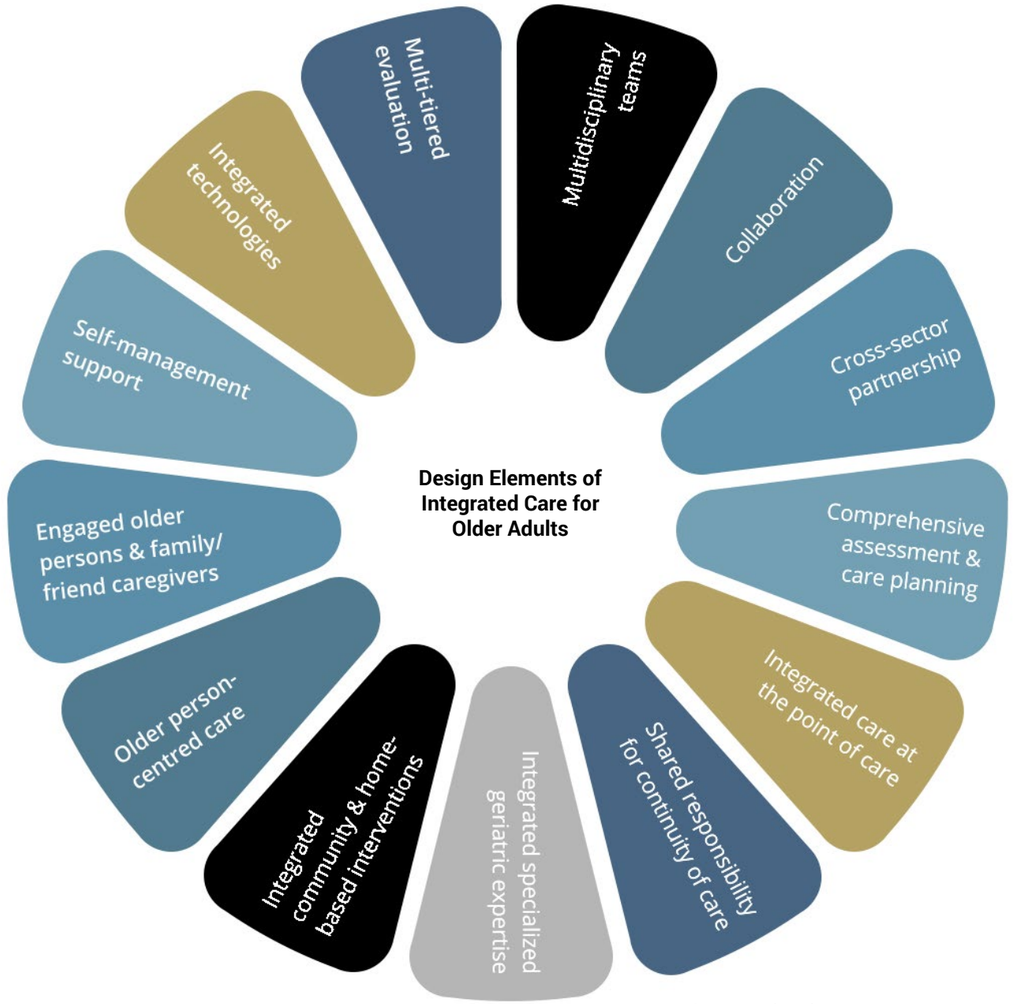
Current policy priorities are numerous and far-reaching and require leadership and coordination to ensure success. New indicators can also be used to better measure dimensions and indicators of aging well[2]. In addition, frameworks articulate enablers of integrated care at macro, meso, and micro levels[3] that can support the development of a health and social care system for older adult care in Ontario.

WHAT WE ALREADY KNOW

These activities include: aligning policy, regulation, funding, and partners in the aging care ecosystem; ensuring activities reflect what older Ontarians want; and leveraging the learning of other jurisdictions.

The Ontario Health vision includes comprehensive services and supports across care, lifestyle, housing, and social sectors, including long-term care and palliative care. Ontario Health also envisions wrap-around points of entry supported by integrated data and a system that is responsive to changes in care needs over time and older adults' circumstances. **See Appendix 1.**

[2]Iciaszczyk et al., 2024; Prorok et al., 2023
[3]PGLO, 2021



Horgan, Kay & Morrison (2021)

INNOVATION HIGHLIGHTS

Summit organizers were keen to highlight existing expertise and the many novel strategies already underway for mitigating hospital ALC rates through the implementation of new initiatives and cross-sector collaborations. To identify effective existing solutions, participants were invited to submit local, regional, or provincial innovations that have demonstrated efficacy in addressing ALC rates and that could be scaled and spread. A total of 40 posters, illustrating a variety of innovative approaches, were submitted and subsequently categorized into three principal themes: (1) system design, (2) care delivery, and (3) capacity building.

For a detailed listing of all posters, please refer to **Appendix 6** on page 28, organized according to the three primary thematic areas. Also see the accompanying report Compendium of Innovation Posters.

These examples underscore the importance of leveraging current knowledge and collaborative efforts to develop an evidence-based, action-orientated roadmap that aligns with existing models and services. It is imperative to amplify successful endeavors and ensure their integration with proven elements of effectiveness. Moreover, these examples highlight the significance of forging connections and fostering collaboration to enhance the seamlessness of healthcare services and improve patient experiences.

PRINCIPLES FOR WORKING TOGETHER

As conversations progressed, participants repeatedly returned to concepts that reflect important principles for working together broadly. These broad principles include:

- **Community Engagement and Education:** Emphasizing the importance of engaging with older adults and community organizations to discuss and plan for aging care needs, as well as creating communication materials and online resources for broader engagement and education.
- **Partnership and Collaboration:** Committing to collaborate more with colleagues and partners across sectors to innovate and meet the needs of patients, families, and care partners, as well as strengthening connections with existing partners and exploring collaboration with new sectors and community partners.
- **Innovation and Transition Support:** Suggesting innovative ideas for improving transitions in care, exploring transitional care concepts and community-based solutions, and integrating lived experience into planning and decision-making processes.
- **Reflection and Action Planning:** Reflecting on ideas and conversations, incorporating commitments into work plans, and seeking alignment with colleagues and partners for integrated approaches to aging care.
- **Networking and Relationship Building:** Committing to forming new connections, solidifying networks of partners, and engaging with intention to build common goals and solutions together.
- **Leadership and Accountability:** Taking leadership roles in initiating actions, forming provincial secretariat, and committing to be positive and proactive agents of change in the aging care system.

SPARKING THE CREATION OF AN INTEGRATED PROVINCIAL HEALTH AND SOCIAL CARE SYSTEM FOR OLDER ADULTS

RECOMMENDATIONS FROM THE DAY

Through a crowd sourcing exercise, participants were invited to propose their boldest answer to the question "What is a core element of the roadmap for a provincial health and social care system in service of and co-designed with older adults and care partners?" Participants were invited specifically to "imagine you were ten times bolder – what would you recommend and what would be your first step?"

Using a modified Open Space Technology process, participants identified and documented ideas on cue cards that were shared with others, and then rated the ideas generated. Priority ideas (e.g. those receiving the highest scores) were assigned as table discussions for the afternoon. Participants self-selected their participation in discussion topics and joined table discussions across two sessions.

Each table discussion session resulted in a one-page summary that includes the topic, contributors to the topics, a summary of the discussion, key insights and next steps to advance the topic. Written summaries, cue cards and evaluation feedback were analyzed after the event, and eight priority themes were identified. These themes are reflected below as core elements of a Road Map to a Provincial Health and Social Care System for Older Adults and Their Care Partners and summarized in Table 1 on page 20.

1 PROVINCIAL AND REGIONAL COORDINATION & LEADERSHIP

Overarching, participants highlighted the need for a robust provincial entity, supported by regional leadership, to streamline efforts towards an integrated provincial health and social care system in service of and co-designed with older adults and care partners. Referenced more than 80 times throughout the day, participants drew parallels to other system infrastructures (e.g. Cancer Care Ontario), and expressed the need for leadership to drive strategy, decision-making, standards, coordination, integration, evaluation and accountability.

Core functions of a provincial umbrella entity could include:

LEADERSHIP, COORDINATION AND INTEGRATION: Develop a shared purpose, scope and strategy across sectors and ministries. Define a framework of key services and programs. Facilitate collaboration, coordination and integration of aging care initiatives across the province. Facilitate alignment with overarching goals and objectives and the integration of key activities (e.g. rehabilitative care, behavioural care, social support) across initiatives. Connect partners, including lived experience advisors (i.e. older adults and care partners) and foster cross-sectional integration.

ACCOUNTABILITY AND RESOURCE ALLOCATION: Establish a provincial accountability framework with provincial and regional oversight for aging care initiatives. Map existing assets, gaps and future requirements. Establish processes for funding allocation and resource distribution, including integrated funding approaches. Inform the effective allocation of resources to support aging care initiatives and achieve priorities at provincial, regional and local levels.

POLICY DEVELOPMENT: Develop and advocate for policies and regulatory vehicles that promote person-centred care, integration of services, and equitable access to care for older adults. Inform new and emergent policy (e.g. homecare modernization, long-term care transformation).

STAKEHOLDER ENGAGEMENT: Convene partners and lived experience advisors (e.g. older adults and care partners). Continuously engage with stakeholders from various sectors, including healthcare, social services, government, and community organizations, to foster collaboration and collective action.

DATA COLLECTION AND ANALYSIS: Define key performance measures for use at micro, meso and macro levels. Collect, analyze, and disseminate data related to aging care services and outcomes to inform decision-making and quality improvement efforts. Manage central repositories of information (e.g. innovative models, outcomes) and create a provincial dashboard to monitor and adjust strategy based on real time system performance.

QUALITY IMPROVEMENT AND EVALUATION: Create a provincial quality framework and evaluation framework. Establish quality standards and improvement initiatives to enhance the delivery of aging care services. Evaluate the effectiveness of initiatives and programs and monitor real-time system performance, enabling adjustments as needed.

CAPACITY BUILDING AND EDUCATION: Provide education and training opportunities for healthcare professionals, care partners, and community members to enhance their knowledge and skills in aging care.

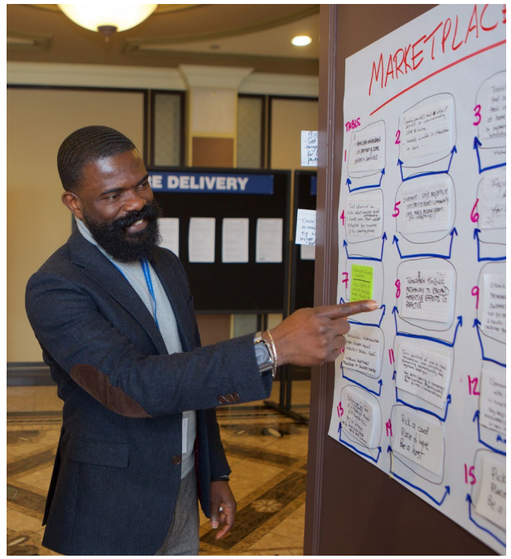
INNOVATION AND BEST PRACTICES: Identify and promote innovative practices and best practices in aging care, facilitating knowledge sharing and adoption across the province.

ADVOCACY AND PUBLIC AWARENESS: Advocate for the needs and rights of older adults, raise public awareness about aging-related issues, and promote positive attitudes towards aging and older adults.

COLLABORATION WITH OHTS AND LOCAL ORGANIZATIONS: Collaborate with Ontario Health Teams (OHTs) and local organizations to support the integration of aging care services and initiatives at regional and community levels. Support local leadership in their spread and scale of successful and impactful projects and models of care.

Participants envisioned a structure that prioritizes population-centric approaches, addresses gaps in care, and emphasizes the importance of cross-sectional integration for comprehensive service delivery.

2 HOLISTIC CARE AND SUPPORTS FOR LIVING AT HOME AND IN COMMUNITY



Participants recommended a major system re-orientation to focus primarily on non-institutional community-based care for all, particularly catering to the needs of an aging population. This envisioned system of holistic care and supports would include an assurance of access to services and supports regardless of health condition. Specific models were referenced as exemplars, such as: the Program of All Inclusive Care of the Elderly (PACE); Bradford House, a supportive housing service for vulnerable and at-risk older adults and seniors living with mental health and addiction issues as well as multiple physical health concerns; and Naturally Occurring Retirement Communities (NORCS).

POSTER ALIGNMENT EXAMPLE

Home and Community Care Support Services Central West: Behavioural Supports Ontario community nursing and care partner optimization

Participants also proposed a focus on creating inviting spaces for older adults within their local communities. Ideas included introducing innovative care approaches and environments that integrate housing and care services. Long-term care facilities were encouraged to become more actively engaged, and sites of older persons' centres where community-dwelling individuals can seamlessly access various services, including geriatric care, with an escalation mechanism for those requiring more immediate support. This was further articulated in the concept of distributed seniors' hubs, encompassing both virtual (e.g. Health 811) and physical spaces.

POSTER ALIGNMENT EXAMPLE

North Simcoe Muskoka Specialized Geriatric Services, VON, County of Simcoe & Bradford Greenhouses: An initiative to support the social participation of older adults

Key action ideas include implementing age-triggered (automatic) home-based assessments for those aged 65 and older to proactively assess needs and connect to community supports, integrating home and community care with institutional episodes of care (making early linkages), and enhancing support by incentivizing outcomes and bundled funding models. Other strategies involve creating navigation centres or seniors' wellness hubs with low barriers to access, neighbourhood care teams, and centralized intake for aging care services, while also rethinking care provision for those with neurocognitive disorders. Further ideas included implementing virtual long-term care options utilizing remote monitoring and on-demand care services supported by technology.

Participants repeatedly referenced their desire for a shift towards community-led care, as well as the removal of referral silos, and the exploration of virtual long-term care solutions.

3 EDUCATION, CAPACITY BUILDING & WORKFORCE ENGAGEMENT

Participants identified the desired focus of developing skillful, confident, and compassionate health team members and identified several action areas related to education, capacity building and workforce engagement. Core ideas for action include a need to educate health professionals about baseline function, its significance and the purpose and application of such information in directing care plan development. Additionally, foundational education around dementia, frailty and, more generally, care for the older adult, should be prioritized across all health and social care professionals, and included in undergraduate professional training programs (including physician training programs).

Recommendations for a comprehensive education program targeting both professionals and the general public include information about available options and rights. More specific to health and social care professionals, including those engaged in system navigation roles, were recommendations for education and training that includes:

- Screening protocols;
- Assessment;
- Interview skills (including appropriate questioning techniques);
- Older adult mental health;
- Effective communication;
- Collaboration and teamwork;
- Diagnosis and addressing provider discomfort with diagnosis (where it is within provider scope); and
- Action planning and interventions.

Participants also sought standards and toolkits for health professionals similar to the Alternate Level of Care Leading Practices Guide, provincially endorsed older adult screening and risk assessment tools for use in primary care, and virtual care tools and dashboards.

Mentors, coaches, and educators who can facilitate skill development, knowledge enhancement and provide ongoing training and education were seen as essential; incentives to create a cadre of such roles should be prioritized.

Finally, infrastructure to support knowledge sharing among healthcare teams, including regional workgroups and frontline engagement in culture change conversations was highlighted as vital for delivering optimal care, supporting ongoing training and education and fostering a needed shift in mindsets from scarcity to abundance that can encourage innovative approaches to working effectively with available resources.

POSTER ALIGNMENT EXAMPLES

- **GeriMedRisk:** GeriMedRisk interdisciplinary consultation & education service
- **Behavioural Supports Ontario Provincial Coordinating Office & Centred for Learning, Research and Innovation at The Schlegel-University of Waterloo Research Institute for Aging:** Person-Centred Language initiative
- **Behavioural Supports Ontario Provincial Acute Care Collaborative:** Behavioural supports in acute care capacity building package
- **Behavioural Supports Ontario Provincial Acute Care Collaborative:** Prevention & reduction of restraint use in acute care
- **North Simcoe Muskoka Specialized Geriatric Services:** Regional education strategy
- **St. Joseph's Care Group:** Behavioural support capacity building in hospitals
- **Waterloo Wellington Older Adult Strategy:** Caring for indigenous older adults in Waterloo Wellington e-module
- **Waterloo Wellington Older Adult Strategy:** Making the most of your medical appointments workshop
- **Waterloo Wellington Older Adult Strategy and Canadian Mental Health Association Waterloo Wellington:** Palliative approach to care

4 REDESIGN OF FUNDING & ACCOUNTABILITY MODELS

Participants expressed the need to enhance accountability and effectiveness in health care services and focused particularly on flexibility, shared responsibility, and integrated partnerships. Ideas included establishing enablers of integrated care such as flexible funding models and incentives for partnerships.

Key action ideas include creating funding mechanisms that allow health service providers to adapt services fluidly to meet needs, creating shared accountability and reporting requirements between acute care and community (e.g. within the Ontario Health Team framework), and enhancing partnerships via integrated funding and services. Further, participants recommended physicians incentives tied to keeping patients out of the emergency department and the exploration of salary-based physician models. The need for investment in existing projects (e.g. sustainability funding) was noted. Participants also called for reflection on the proportion of funding allocated to institutional services (e.g. hospitals and long-term care) and sought reinvestment in the community.

Meaningful accountability translated to actions such as setting provincial targets for local and regional partners, fostering joint accountability across organizations and sectors, implementing single funding envelopes (with appropriate support for implementation), and transforming funding mechanisms to prioritize preventative efforts over reactive responses. Additionally, participants called for transparency regarding funding and clear mapping of resources towards desired **outcomes.**

POSTER ALIGNMENT EXAMPLES

- **North Simcoe Muskoka Specialized Geriatric Services:** Integrated geriatric mental health service
- **Alzheimer Society Peel, Trillium Health Partners & Halton Health Care:** A comprehensive approach to behavioural support in acute care

5 TRANSITIONAL CARE

Participants consider transitional care broadly. Where bedded levels of care were required, innovations in transitional care and a shift towards "reactivation centres" were recommended. Such centres were seen as more than just temporary holding areas for individuals awaiting long-term care, but rather culturally sensitive and home-like spaces focused on clear goals of care for each person and their care partners and related interventions (e.g. rehabilitative care, convalescent care, respite for care partners).

At other points of transition, participants sought integrated approaches between hospitals and community services, and warm hand-offs supported by roles with experience in older adult care (e.g. Geriatric Emergency Management teams, Hospital Elder Life Programs, and Behavioural Supports). For individuals living with dementia, Dementia Resource Teams (sometimes called DREAM Teams) and dementia resources consultants in emergency departments were offered as examples of appropriate hands-on, navigation **supports.**

Other action ideas include integrating care coordination and utilizing dashboards, as is done in the palliative care system, to enhance system monitoring, information sharing, and facilitate timely access to outpatient services. Suggestions were linked to the need to strengthen the knowledge base of home care providers about the care of older adults and care partners.

POSTER ALIGNMENT EXAMPLES

- **Parkwood Institute Mental Health – St. Joseph's Health Care London:** Collaborative transition planning creating a pathway for adults living with serious mental illness
- **Alzheimer Society of Chatham Kent & Chatham Kent Health Alliance:** Incorporation of a dementia resource in the emergency rooms
- **Bluewater Health and Alzheimer Society Chatham Kent:** Behavioural supports hospital navigator
- **North East Behavioural Supports Ontario & Alzheimer's Society:** Implementation of acute care Behavioural Supports Ontario recreational therapist
- **North Simcoe Muskoka Specialized Geriatric Services:** Behaviour success agents
- **North York General Hospital and LOFT Community Services: Behavioural supports:** integrated care at North York General Hospital
- **Rehabilitative Care Alliance & North West Seniors Care Program:** Implementation of primary care & emergency department post-fall pathways
- **St. Joseph's Care Group (Geriatric Assessment & Rehab Unit):** High risk geriatric remote care monitoring post discharge program

The image above is the final graphic recording - a dynamic visual representation of ideas, discussions, and key insights captured in real-time during the Summit on Aging Care in Ontario, held February 21, 2024 in Toronto, Ontario.

The work was created by graphic facilitator Lynne Dalgleish, who visually synthesized complex information into clear illustrations of the journey, using words, symbols, and imagery. These visuals enhanced participant engagement and understanding, making it easier to grasp the content and see connections between different elements of the discussions happening throughout the day.

This image, transforms participant ideas into visuals, provides a lasting record of the event, captures collective intelligence, stimulates further discussion and informs actionable outcomes.

6 INTEGRATION WITH PRIMARY CARE

Participants recommended the integration of primary care with various services as crucial for addressing the needs of an aging population, particularly those living with multimorbidity.

Action ideas include connecting existing health services with primary care, such as assisted living personal support workers who could collaborate with primary care to identify and respond to arising health issues. Other ideas included enhancing capacity building by better leveraging e-consult services and conducting complex case rounds with primary care, inpatient, and geriatric **teams.**

Additionally, supports for screening, early disease identification and response, and mechanisms to link individuals to a continuum of services and provide navigation support were highlighted.

Participants recommended integrating geriatricians and other geriatric and seniors' mental health-focused health providers directly into **primary care settings**, along with home care and behavioural support services, and providing in-the-moment specialist consultations through regionally coordinated hub-based systems. Removing gatekeepers (e.g. referral "silos") between services and fostering strong integration between primary care and geriatrics were noted as key strategies for supporting longitudinal and holistic approaches to older persons' healthcare.

POSTER ALIGNMENT EXAMPLES

- **Baycrest Hospital, University of Toronto Neurology, & Behavioural Supports Ontario Toronto:** Virtual Behavioural Medicine program
- **GeriMedRisk:** GeriMedRisk interdisciplinary consultation & education service

POSTER ALIGNMENT EXAMPLE

KW4 Ontario Health Team:
Integrated care team for older adults

7 SUPPORTS FOR SYSTEM AND SERVICE NAVIGATION & COORDINATED ACCESS

Participants identified an overarching goal to establish a "no wrong door" approach, where all encounters with the healthcare system enable seamless connection to appropriate supports. This goal involves cross-sectional integrations, early disease detection, and linking individuals to a continuum of services.

Bolstering of system and service navigation, which includes mechanisms of coordinated access to older adult focused services was recommended. Key ideas for action include service connectors that guide older adults toward available resources and that can be strategically placed in locations frequented by seniors, such as malls, seniors' centres, and housing facilities. Other ideas include establishing navigation centres in the community, centralizing intake for older adults to access services and information, removing "gatekeepers" between services, and fostering (or leveraging) an older persons' centre model that facilitates both social engagement and access to necessary care.

Participants emphasized creating a holistic, person-centric navigation system that meets the diverse needs of older adults.

For older adults and care partners, there were specific and detailed references to creating an aging well toolkit. With a working title of "Aging Well: A Guide for Everyone," and drawing from existing examples (e.g. Age Friendly Communities, Regional Geriatric Program Central's "Where to Start Guide") participants identified several preliminary content suggestions, such as:

- Advance care planning (including motivation/incentive to engage in advance **care planning[1]);**
- Telling your story (e.g. whole picture, **"My Personhood" summary[2]);**
- Preventative self-care;
- Things to ask a health professional;
- Language and acronym guides;
- Domains of care;
- Personal health information;
- Social prescribing;
- Referrals;
- Map of a typical service journey; and
- **Legal and financial matters[3].**

Participants recommended that resources be available in plain language, multiple languages, and multiple formats (e.g. YouTube videos).

1 - POSTER ALIGNMENT EXAMPLES

- **University of Ottawa, Yale University, Regional Geriatric Program of Eastern Ontario:** Geriatric 5Ms: A framework for explaining what geriatrics does
- **North Simcoe Muskoka Specialized Geriatric Services:** Integrated geriatric mental health service

2 - POSTER ALIGNMENT EXAMPLE

Behavioural Supports Ontario Provincial Coordinating Office:
My Personhood Summary©

3 - POSTER ALIGNMENT EXAMPLE

Waterloo Wellington Older Adult Strategy: Making the most of your medical appointments workshop

8 RECOGNIZING AND SUPPORTING THE RESILIENCE OF OLDER ADULTS

Participants recognized and supported the resilience of older adults and recommended a shift in philosophies of care towards asset-based, rehabilitation-focused approaches. These approaches recognize goals, abilities and strengths and focus on what matters most to individuals. Participants recommended approaches that value individual preferences and empower older adults and their care partners to express who they are and that focus on retaining or optimizing their everyday function.

POSTER ALIGNMENT EXAMPLES

- **St. Joseph's Health Care London:** 'Recipe for Success': Co-Designing strategies to enhance transitions
- **Behavioural Supports Ontario Provincial Coordinating Office:** My Personhood Summary©

Key ideas for action include establishing a determination of baseline function as part of the standard of care, adopting a mindset and service scheduling practices that enable listening and understanding individual needs, discussions about what matters most (i.e. goals of care), and implementing early age-triggered screening opportunities (e.g. at 65, 75 and 85).

Participants highlighted the need to instill a collective mindset and will among health care leaders to create the conditions for services that foster respect for diversity, understand and respond to each person's potential for recovery and goals of care, and enable connections with communities. Finally, the engagement of community members as experts in their own healthcare and as fonts of expertise for system redesign was seen as important to driving meaningful change.

POSTER ALIGNMENT EXAMPLE

Behavioural Supports Ontario Provincial Coordinating Office & Centred for Learning, Research and Innovation at The Schlegel-University of Waterloo Research Institute for Aging: Person-Centred Language initiative

Table 1 spells out specific key action areas for each of the core elements.

TABLE 1 ROADMAP TO A PROVINCIAL HEALTH AND SOCIAL CARE SYSTEM FOR OLDER ADULTS AND THEIR CARE PARTNERS

CORE ELEMENTS	KEY ACTION IDEAS
Provincial and Regional Coordination & Leadership	• Develop a provincial entity responsible for leading coordination & integration; accountability & resource allocation; policy development; stakeholder engagement; data collection & analysis; quality improvement & evaluation; capacity building & education; innovation & best practices; advocacy & public awareness; and collaboration with OHTs and local organizations
Holistic Care and Supports for Living at Home and in Community	• Implement age-triggered home-based assessments to proactively assess needs and connect early to community supports • Integrate home and community-based care with institutional episodes of care • Enhance support by incentivizing outcomes and bundled funding models • Neighbourhood care teams • Senior Friendly Spaces (e.g. Seniors' Wellness Hubs) • Virtual long-term care, including integrating remote monitoring and on-demand care services
Education, Capacity Building & Workforce Engagement	• Prioritize frailty and dementia education • Provide comprehensive education programs for health professionals and general public that address: screening, assessment, interview skills, older adult mental health, effective communication, collaboration & teamwork, diagnosis, action planning and intervention • Provincially endorsed standards, screening and risk assessment tools, virtual care tools, dashboards • Develop a cadre of mentors, coaches, and educators to facilitate skill development; establish an infrastructure to support knowledge sharing and learning
Redesign of Funding & Accountability Models	• Flexible funding models to allow Health Services Providers to adapt to meet needs • Shared/joint accountability across organizations/sectors, including shared reporting between acute and community sectors • Physician incentives tied to reduced Emergency Department use and salary-based models • Funding for preventive models • Transparency of funding and reflection on proportion of funding allocated to institutional services (e.g. hospital, long-term care) vs community
Transitional Care	• Warm handoffs supported by roles experienced in older adult care (e.g. GEM, HELP, BSO) • Transitional models (e.g. DREAM, dementia resource consultants); integrated approaches between hospital and community • Enhanced monitoring (e.g. dashboards)
Integration with Primary Care	• Connection of community services (e.g. Assisted Living PSWs) to primary care; removing gatekeepers between services • Leveraging e-consults and complex case rounds to provide support and build capacity; access to specialist consults through regional hubs • Supports for screening, early disease identification and response, and mechanisms to link individuals to a continuum of services and navigation support • Integrating geriatricians and other geriatric and seniors' mental health focused health professionals directly into primary care settings
Supports for System and Service Navigation & Coordinated Access	• Developed coordinated access mechanisms to older adult focused services; centralized information and referral services • Service connectors to guide older adults toward available resources, located in places that older adults frequent (e.g. older adult centres, malls etc.) • Community navigation centres or hubs that facilitate access to necessary care, as well as social engagement • For older adults and care partners: develop an aging well toolkit "Aging Well: A Guide for Everyone"
Recognizing and Supporting the Resilience of Older Adults	• Adopt approaches that value individual preferences and empower older adults and their caregivers to express who they are and that focus on retaining or optimizing their everyday function; create conditions for services that respect diversity; engage lived experience advisors in system redesign • Establish determination of baseline function as a standard of care; respond to each person's' potential for recovery and goals of care

SUMMARY OF KEY TAKEAWAYS & CALL TO ACTION FOR STAKEHOLDERS

At the conclusion of the Summit, participants were invited to share their 15% - one specific area where they have discretion and freedom to act and maintain momentum from the day. Specifically, participants addressed "What can you do personally without more resources or more authority – in the next 7, 14 or 30 days?" These responses are included in **Appendix 4**.

This event generated concrete action areas that participants can advance individually and collectively and that form the basis of future work. A desired outcome of the event was to craft a call to action for all participants, and indeed, the broader community of older adults, care partners and the health and social care professionals and policy makers that serve them.

CALL TO ACTION

There is work ahead of us but we are a group of health leaders who want to make change happen. Not one person said or insinuated that we can't.

As participants reflect on the February 21, 2024 Summit on Aging Care in Ontario, the pivotal role each of us plays as architects of change in Ontario's aging care landscape must be acknowledged. The core elements of a Roadmap to a Provincial Health and Social Care System for Older Adults and their Care Partners, identified by colleagues from across Ontario, serve as guideposts marking the path forward to a more holistic and compassionate approach to older adult care in this province.

In the short term, our focus is on practical actions we can do individually and collectively that will lay the foundation for transformative change. From establishing a provincial secretariat to guide our work to fostering deeper connections within our communities, Summit participants committed to tangible steps that will make a meaningful difference in the lives of older adults and their care partners. We invite all our colleagues across the continuum of care to join us in these foundational steps.

Looking ahead, our ambitions remain bold and achievable. Expanding leadership initiatives, pioneering online resources, creating centralized hubs for information and services, and crafting age-friendly policy and legislation, are important shifts that can empower the requisite flexibility, innovation and accountability for sustainable change. Building on past innovations and the tremendous commitment among so many of our colleagues to excellence in the care of older adults and their care partners, together we will continue to push the boundaries of what is possible in aging care in Ontario, and beyond.

We urge our colleagues to carry forward the momentum generated from this Summit with unwavering determination. Each action, big and small, brings us closer to our shared vision of a brighter future for older adults across Ontario.

Now is the time for action. Let's roll up our sleeves and work together to make our vision of a provincial health and social care system in service of and co-designed with older adults and care partners a reality.

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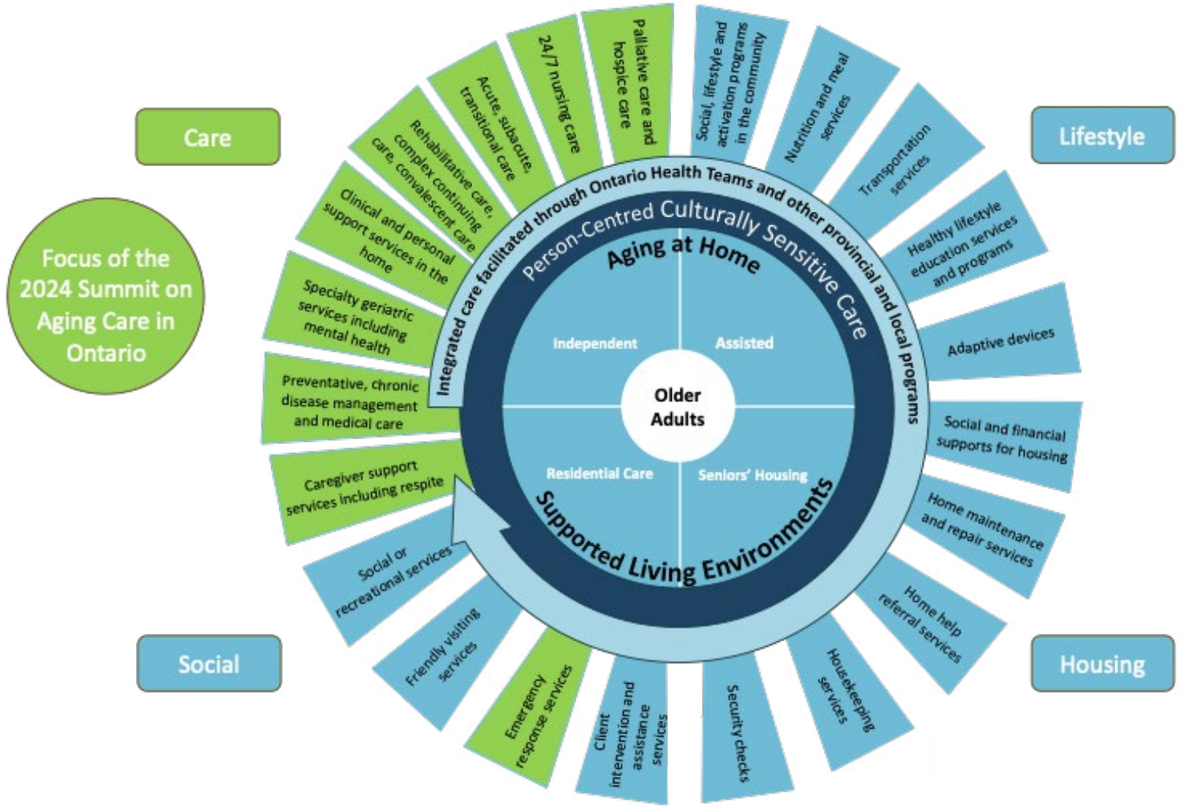
Executive Lead, Behavioural Supports Ontario Provincial Coordinating Office
Andrea.Lucas@nbrhc.on.ca

APPENDIX 1:
Aging Care Continuum Concept (Adapted)



Aging Care Continuum Concept
Adapted with permission from Ontario Health (2023)

APPENDIX 2:

Alignment of themes with participant generated ideas

THEME	SOURCE OF IDEAS	PARTICIPANT REFERENCES
Provincial and Regional Coordination & Leadership	Provincial coordination for older adults health and social care (Table 10); comments from cue cards	87
Holistic Care and Supports for Living at Home and in Community	Create spaces that attract seniors in the community (Table 2); Shift the majority of care (90%) to home and community (Table 5); Community integrates with acute care (Table 12); Neighbourhood care teams (in Social Housing) (Table 13); comments from cue cards	47
Education, Capacity Building & Workforce Engagement	Home care embedded in primary care settings (Table 1); Wherever an older adult accesses health and social care, understand their individual potential for recovery as the starting point (Table 4); Shift the Majority of Care (90%) to home and community (Table 5); Strong integration between primary care and geriatrics to support longitudinal care for better transitions and holistic care (Table 9); comments from cue cards	21
Redesign of Funding & Accountability Models	Flexible funding models (Table 7); comments from cue cards	21
Transitional Care	Transitional care space that supports seniors (Table 3); comments from cue cards	20
Integration with Primary Care	Home care embedded in primary care settings (Table 1); Strong integration between primary care and geriatrics to support longitudinal care for better transitions and holistic care (Table 9); comments from cue cards	19
Supports for System and Service Navigation & Coordinated Access	Create spaces that attract senior sin the community (Table 2); Shift the Majority of Care (90%) to home and community (Table 5); Aging Well – A Guide for Everyone (Table 6); comments from cue cards	17
Recognizing and Supporting the Resilience of Older Adults	Wherever an older adult accesses health and social care, understand their individual potential for recovery as the starting point (Table 4); Aging Well – A Guide for Everyone (Table 6); comments from cue cards	15

"Table" refers to the discussion tables generated via the modified open space Technology.

APPENDIX 3:

Detailed ranking of top 10 committed next steps

NEXT STEP	RELEVANCE	POTENTIAL IMPACT	ALIGN-MENT	SPECIFICITY	FEASIBILITY
Arrange meetings with relevant colleagues and organizations	9	8	9	Meetings crucial for collaboration and planning.	Feasible as it involves scheduling meetings and discussions.
Create communication materials and online resources	8	7	8	Essential for broader engagement and education.	Feasible, though may require resources for development.
Advocate for redeployment of hospital funding	7	9	7	Significant impact on funding allocation.	Feasible with advocacy efforts but may face resistance.
Collaborate with colleagues and partners across sectors	9	8	9	Essential for innovation and holistic approach.	Feasible with willingness to collaborate and coordinate.
Explore opportunities for provincial coordination	8	8	8	Vital for equitable distribution of resources.	Feasible with commitment to coordination and communication.
Suggest and implement innovative ideas	9	9	9	Innovation crucial for improving care practices.	Feasible with creativity and willingness to try new approaches.
Reflect on ideas and conversations	7	7	7	Important for learning and adaptation.	Highly feasible and essential for continuous improvement.
Strengthen connections with existing partners	8	8	8	Enhances collaboration and resource sharing.	Feasible with proactive communication and relationship -building.
Commit to forming new connections	8	7	8	Expands network for collaboration and support.	Highly feasible with proactive outreach and networking efforts.
Take leadership roles in initiating actions	9	9	9	Leadership essential for driving change.	Feasible with commitment and willingness to lead initiatives.

RATIONALE:

Relevance: Based on the importance of each step in addressing the challenges and goals outlined.

Potential Impact: The anticipated impact of each step on improving aging care, considering its potential to bring about meaningful change.

Alignment: The degree to which each step aligns with the overall objectives and values of improving aging care.

Specificity: How clearly defined and focused each step is in terms of its intended action or outcome.

Feasibility: Evaluation of the practicality and achievability of each step within the context of available resources and constraints.

APPENDIX 4:

Alignment of themes with participant generated ideas

PARTICIPANT COMMITMENTS/SUGGESTIONS		
AREA OF ACTIVITY	**SHORT TERM**	**MID TO LONGER TERM**
Provincial and Regional Coordination & Leadership	• Form a provincial secretariat • Engage partners and networks to build common goals • Champion conversations at local (organizational), regional & provincial levels	• Expand Provincial Geriatrics Leadership Ontario
Holistic Care and Supports for Living at Home and in Community	• Forge connections with community partners, including those outside of health care • Engage with partners to create solutions together	• Invite home care staff to work as partners in primary care hubs • Explore the development of an aging well online resources for older adults and families • Leverage OHTs to build seniors' hubs
Education, Capacity Building & Workforce Engagement	• Connect with partners to co-develop workshops about planning for aging • Connect with staff to better understand their needs and changes that would be impactful • Identify resources	• Change legislation to enable flexibility • Develop new indicator sets for older adult health and measure impact of innovative care models
Redesign of Funding & Accountability Models	• Use Seniors Design Framing questions in evaluation • Examine existing models (e.g. poster examples) connect with existing programs and spread successful models to my organization	• Integrated standardized education for all health professional students • Develop foundational geriatric knowledge among teams
Transitional Care	• Explore the implementation of existing models (e.g. DREAM)	• Leverage existing transitional spaces for additional programming (e.g. rehabilitation, respite) • Undertake co-designed improvement projects with patients and families
Integration with Primary Care	• Prepare newsletter articles for OHTs about Summit and its results • Learn more about shared care with primary care & specialists	• Implement shared care with primary care
Supports for System and Service Navigation & Coordinated Access	• Connect with academia to explore technology (e.g. GPS) solutions for navigation	• Central hub for information
Recognizing and Supporting the Resilience of Older Adults	• Embed lived experience into planning • Connect with older adults to better understand their needs and changes that would be impactful	• Stay connected with older adults through communication (e.g. newsletters, common website), networks and broad engagement

APPENDIX 5:

Post-summit evaluation

046

One word to describe your experience today

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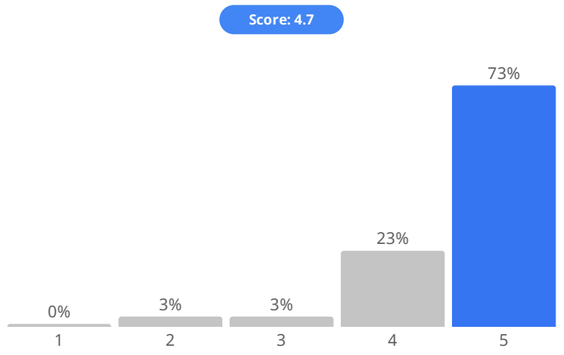
Overall, how would you rate your experience today?



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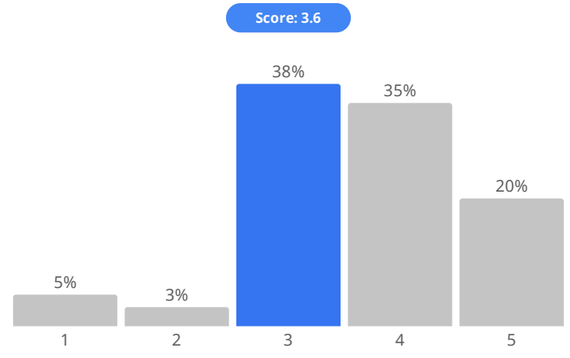
How well do you think we did in developing a roadmap for collectively leveraged action (CLA)?



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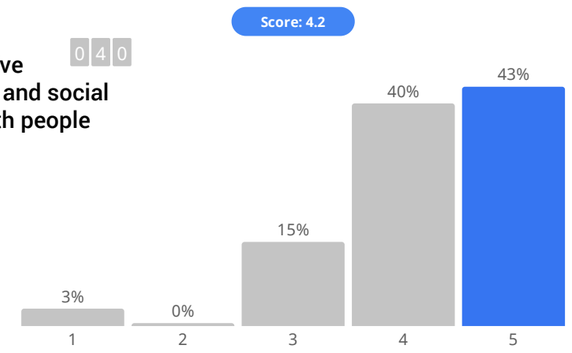
How well did the summit increase our collective commitment to our shared purpose: "a health and social care system in service of and co-designed with people aging in Ontario"?



APPENDIX 6:

Innovation poster list (with author organization)

SYSTEM DESIGN

- Behavioural Supports Ontario's provincial collaboratives (Behavioural Supports Ontario Provincial Coordinating Office & brainXchange)
- Behavioural support transition units (BSTU) – environmental scan (Behavioural Supports Ontario Provincial Coordinating Office & brainXchange)
- Collaborative transition planning creating a pathway for adults living with serious mental illness (Parkwood Institute Mental Health – St. Joseph's Health Care London)
- Direct access priority process (DAPP) update (Rehabilitative Care Alliance)
- Geriatric 5Ms: A framework for explaining what geriatrics does (University of Ottawa, Yale University, Regional Geriatric Program of Eastern Ontario)
- Indicator refresh (South West Behavioural Supports Ontario Operations Team)
- Integrated geriatric mental health service (North Simcoe Muskoka Specialized Geriatric Services)
- Path for hip (PATH4HIP) fracture for patients 65+ (Bruyère Continuing Care & The Ottawa Hospital)
- South west Behavioural Supports Ontario website user account functionality (South-West Behavioural Supports Ontario Operations Team)
- Waterloo Wellington delirium collaborative (Waterloo Wellington Older Adult Strategy, KW4 Ontario Health Team Frail Elderly Working Group)
- Website based indicator submission (South West Behavioural Supports Ontario Operations Team)

CARE DELIVERY

- A comprehensive approach to behavioural support in acute care (Alzheimer Society Peel, Trillium Health Partners & Halton Health Care)
- An initiative to support the social participation of older adults (North Simcoe Muskoka Specialized Geriatric Services, VON, County of Simcoe & Bradford Greenhouses)
- Behaviour success agents (North Simcoe Muskoka Specialized Geriatric Services)
- Behavioural supports hospital navigator (Bluewater Health and Alzheimer Society Chatham Kent)
- Behavioural supports: integrated care at North York General Hospital (North York General Hospital and LOFT Community Services)
- Behavioural Supports Ontario community nursing and care partner optimization (Home and Community Care Support Services Central West)
- Estimated health system costs avoided by Virtual Behavioural Medicine (Baycrest Hospital)
- Frailty identification and transition: accessing restorative care (St. Joseph's Care Group & Thunder Bay Regional Health Sciences Centre)
- GeriMedRisk interdisciplinary consultation & education service (GeriMedRisk)
- High intensity needs transitional support pilot (North East Behavioural Supports Ontario & Alzheimer Society)
- High risk geriatric remote care monitoring post discharge program (St. Joseph's Care Group Geriatric Assessment & Rehab Unit)
- Incorporation of a dementia resource in the emergency rooms (Alzheimer Society of Chatham Kent & Chatham Kent Health Alliance)
- Implementation of acute care Behavioural Supports Ontario recreational therapist (North East Behavioural Supports Ontario & Alzheimer Society)
- Implementation of primary care & emergency department post-fall pathways (Rehabilitative Care Alliance & North West Seniors Care Program)
- Integrated care team for older adults (KW4 Ontario Health Team)
- My Personhood Summary© (Behavioural Supports Ontario Provincial Coordinating Office)
- My Transitional Care Plan© (Behavioural Supports Integrated Team Collaborative)
- Paramedic post-fall pathway pilot (Rehabilitative Care Alliance)
- 'Recipe for Success': Co-Designing strategies to enhance transitions (St. Joseph's Health Care London)
- Virtual Behavioural Medicine program (Baycrest Hospital, University of Toronto Neurology, & Behavioural Supports Ontario Toronto)
- Wellness calendar (Waterloo Wellington Older Adult Strategy, Mapleton Senior Centre for Excellence, KW4 Ontario Health Team FE Working Group)

CAPACITY BUILDING

- Behavioural support capacity building in hospitals (St. Joseph's Care Group)
- Behavioural supports in acute care capacity building package (Behavioural Supports Ontario Provincial Acute Care Collaborative)
- Caring for indigenous older adults in Waterloo Wellington e-module (Waterloo Wellington Older Adult Strategy)
- Making the most of your medical appointments workshop (Waterloo Wellington Older Adult Strategy)
- Palliative approach to care (Waterloo Wellington Older Adult Strategy and Canadian Mental Health Association Waterloo Wellington)
- Person-Centred Language initiative (Behavioural Supports Ontario Provincial Coordinating Office & Centred for Learning, Research and Innovation at The Schlegel-University of Waterloo Research Institute for Aging)
- Prevention & reduction of restraint use in acute care (Behavioural Supports Ontario Provincial Acute Care Collaborative)
- Regional education strategy (North Simcoe Muskoka Specialized Geriatric Services)

Note: To see the complete posters, please see the report tilted, Compendium of Innovation Posters.

APPENDIX 7:
List of Summit Participants

Katelynn Aelick, Project Coordinator, BSO Provincial Coordinating Office - North Bay Regional Health Centre

Uzma Aqbal, Project Manager, Mental Health, North Bay Regional Health Centre

Mohamed Badsha, Chief Executive Officer, Reconnect Community Health Services

Kristyna Barreto, Specialist, Capacity, Access & Flow, Ontario Health Toronto

Julia Baxter, Manager, Seniors Mental Health Outpatient and Outreach Services, St. Joseph's Healthcare Hamilton

Shikha Bedi, Lead, Capacity, Access and Flow, Ontario Health Central

Sophiya Benjamin, Co-Executive Director, Geriatric Psychiatrist, GeriMedRisk

Cathy Berges, Older Adult and Care Partner Advisory Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Kathy Borthwick, Older Adult and Care Partner Advisory Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Melanie Briscoe, Administrative Director, North East Specialized Geriatrics Centre

Monica Bretzlaff, Director, BSO Provincial Coordinating Office - North Bay Regional Health Centre

Caitlin Brandon, Manager Strategic Initiatives, Regional Geriatric Program of Toronto

Pam Chan, Director of Operations, Regional Geriatric Program of Toronto

Jo-Anne Clarke, Medical Geriatrician Director, North East Specialized Geriatrics Centre, North East Specialized Geriatrics Centre

Michelle Collins, Director BSO, Alzheimer Society Peel

Dana Corsi, ALC Advisor, Ontario Health

Lynda Davenport, Older Adult and Care Partner Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Julia Dean, Lead, System Strategy, Planning, Design & Implementation, Ontario Health West

Alison Denton, Program Manager, North West Regional Seniors' Care

Audrey Devitt, BSO Lead WW, St. Joseph's Health Centre Guelph

Gail Dobell, Integrated Systems Long-Term Care, Ontario Health

Donna Duncan, CEO, Ontario Long-Term Care Association (OLTCA)

Sandra Easson-Bruno, Director, North Simcoe Muskoka Specialized Geriatric Services

Jacobi Elliott, Director, St. Joseph's Health Care London

Martin Farrugia, Interim Director, Regional Geriatric Program Central

Bianca Feitelberg, Project Lead Partnerships & Innovation, Ontario Caregiver Organization

Joanne Fung, Senior Policy Advisor, Ontario Ministry of Health

Rhea Galbraith, Care of the Elderly Physician, North Bay Regional Health Centre

Rachael Griffin, Director, System Strategy, Planning, Design & Implementation, Ontario Health West

Evan Herbert, Manager, Ministry of Health

Paul Heinrich, President & CEO, North Bay Regional Health Centre

Debbie Hewitt-Colborne, Project Advisor, BSO Provincial Coordinating Office - North Bay Regional Health Centre

Nancy Hooper, Manager Geriatric Mental Health - LTC, North Simcoe Muskoka Specialized Geriatric Services

Salinda Horgan, Research Scientist, North Simcoe Muskoka Specialized Geriatric Services

Jacqueline Houston, Program Director, Baycrest

Allen Huang, Geriatrician, The Ottawa Hospital - RGP of Eastern Ontario

Andrea Iaboni, Geriatric Psychiatrist, Toronto Rehabilitation Institute

Lynsey James, Clinical Director, Transitional Care, Bruyère

Andrea Jewell, Clinical Director, Bruyère

Teresa Judd, Director of BSO, HCCSS Central West

Kelly Kay, Executive Director, Provincial Geriatrics Leadership Ontario (PGLO)

Scott Kerrigan, Chief of Staff, North Bay Regional Health Centre

Annalee King, Manager, Community Mental Health, North Simcoe Muskoka Specialized Geriatric Services

Sandra Kioke, Senior VP & CNE, WAHA

Brian Ktytor, Chief Regional Officer, North East & North West, Ontario Health

Mona Lancaster, Older Adult and Care Partner Advisory Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Joanne Laplante, VP Clinical Services, North Bay Regional Health Centre

Lisa Levin, CEO, AdvantAge Ontario

Charissa Levy, Executive Director, Rehabilitative Care Alliance

Barbara Liu, Executive Director, Geriatrician, Regional Geriatric Program of Toronto

Andrea Lucas, Vice President, North Bay Regional Health Services/BSO Executive Lead

Liz MacLennan, Older Adult and Care Partner Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Biju Mathai, Co-ordinator, SGS Regional Initiatives, Specialized Geriatric Services, St. Joseph's Health Care London

Kristen Mayhew, Program Assistant, Provincial Geriatrics Leadership Ontario (PGLO)

Rochelle McAlister, Senior Manager , WoodGreen Community Services

Katherine McCleary, Manager, Corporate Planning & PMO, Orillia Soldiers' Memorial Hospital

Jane McKinnon, Waterloo Wellington Geriatric Systems Coordinator, Canadian Mental Health Association WW

Alysha Mongraw, BSO Quality Improvement Facilitator, Home and Community Care Support Services, Central East

Adam Morrison, Director, Policy & Planning, Provincial Geriatrics Leadership Ontario (PGLO)

Hope Mugridge, Dementia Resource Consultant, Alzheimer Society of Chatham-Kent

Ellen Nemetz, Senior Policy Advisory, Priority Policy Unit, Strategic Policy Branch, Ministry of Health

Richard Norman, Geriatrician, Sinai Health/ University Health Network

Christina Pacheco, Acute Care Behavioural Consultant- BSO, Alzheimer's Society Peel

Lisa Peterson, Manager Specialized Geriatric Services, St. Joseph's Care Group

Helene Philibin Wilkinson, Consultant , North Bay Regional Health Centre

Natasha Poushinsky, Director of Strategy and Planning, Bruyère

Tammy Pulfer, Program Director, Regional Geriatric Program of Eastern Ontario

John Puxty, Director, Chair, Geriatrician, Centre for Studies in Aging and Health (CSAH), Providence Care; Chair, Division of Geriatrics

Dorothy Quon, Vice President, WoodGreen Community Services

Karen Redpath, Director, Clinical Services, Georgian Bay General Hospital

Shelley Richard, Lead, Long-Term Care, Ontario Health Central

Matin Salako, Geriatric Psychiatrist, North Bay Regional Health Centre

Lisa Salapatek, Executive Lead, Strategic Partnerships and Innovation, Ontario Caregiver Organization

Jennifer Sampson, Director, Seniors and Aging, WoodGreen Community Services

Suzanne Saulnier, Director of BSO , LOFT Community Services

Rhonda Schwartz, Executive Director, Seniors Care Network

Jacquie Seguin, BSO Regional Coordinator, Alzheimer Society of Chatham-Kent

Vicky Simanovski, Vice President, Health System Performance and Accountability, Ontario Health

Jagger Smith, Director, Ambulatory Clinical Services, Baycrest

Lise St. Marseille, Director, Mental Health, North Bay Regional Health Centre

Courtney Stasiuk, Project Specialist, BSO Provincial Coordinating Office - North Bay Regional Health Centre

Ron Stewart, Lived Experience Advisor

Carolyn Tan, Geriatric Medicine Resident, University of Toronto

Terry Tilleczek, Vice President, System Strategy, Planning, Design & Implementation, Ontario Health North East

Mario Tsokas, Lead, Capacity, Access & Flow, Ontario Health Toronto

Dejana Veljko, Lead, Capacity, Access & Flow, Ontario Health Toronto

Lisa VanBussel, Geriatric Psychiatrist, St. Joseph's Healthcare London

Erin Watson, Director, Specialized Geriatric Services, St. Joseph's Healthcare London

Anne-Marie Yaraskavitch, Older Adult and Care Partner Advisory Council Member, Provincial Geriatrics Leadership Ontario (PGLO)

Aging Care in Ontario Summit

[February 2024] - Final Report

Provincial Geriatrics Leadership Ontario

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay