ANNUAL REPORT 2024–25

Better health outcomes for older adults living with complex health conditions and their care partners

seniors care network

Purpose

To lead the network of specialized geriatric services and advance integrated, person-centred care for older adults and their care partners living with frailty, dementia, and other complex physical, cognitive, social and mental health conditions in Central East Ontario

Vision

Better health outcomes for older adults living with complex health conditions and their care partners in our Region.

Values

- Person-Centredness
- Equity, Diversity and Inclusion
- Advocacy
- Knowledge-Driven
- Collaboration
- Innovation
- Integration
- Quality

Strategic Priorities

- Build Capacity Across the System
- Drive Clinical Excellence
- Advance Older Adult Health Policy
- Enabled by: Partnership, Engagement and Technology

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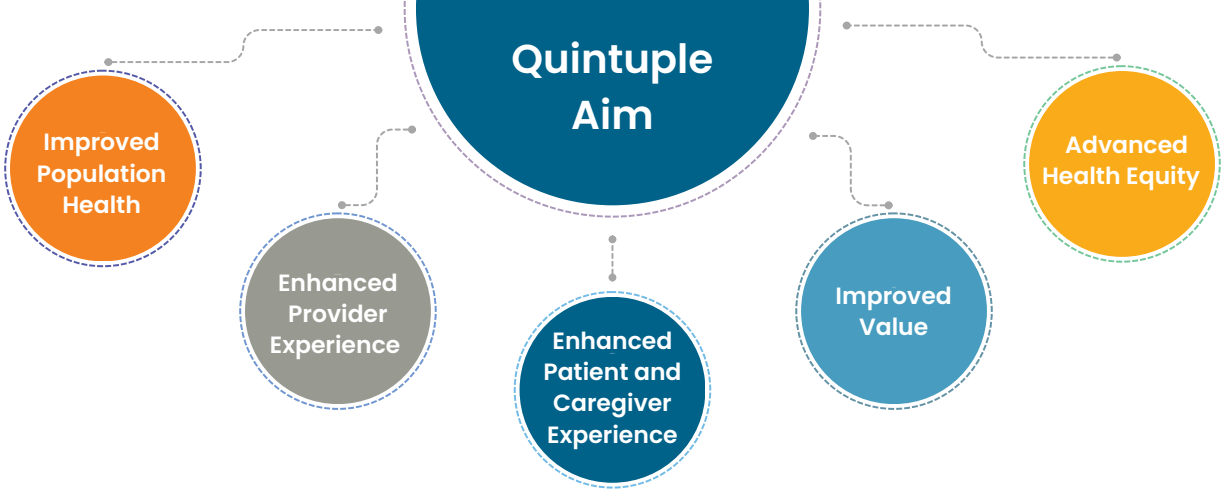
LEGEND

ADP	Adult Day Programs
ALC	Alternate Level of Care
BSO	Behavioural Supports Ontario
CE	Central East
CGA	Comprehensive Geriatric Assessments
CHC	Community Health Centre
ED	Emergency Department
EDI	Equity, Diversity, and Inclusion
EMR	Electronic Medical Record
GAIN	Geriatric Assessment and Intervention Network
GEM	Geriatric Emergency Medicine
ICP	Integrated Clinical Pathway
KLH-OHT	Kawartha Lakes Ontario Health Team
LTC	Long-Term Care
LOS	Length of Stay
MAID	Medical Assistance in Dying
MINT	Multispecialty Interprofessional Team
NPSTAT	Nurse Practitioners Supporting Teams Averting Transfers
OHAH	Ontario Health atHome
OHE	Ontario Health East
OPP	Ontario Provincial Police
PGLO	Provincial Geriatric Leadership Ontario
ROI	Return of Investment
SGS	Specialized Geriatric Services
SHN	Scarborough Health Network
SW	Social Work



Improved Population Health

GAIN
Geriatric Assessment & Intervention Network

~14600
Patients Seen

~26000
Visits

75%
% the 2000 older adults discharged from GAIN met their goals and/or demonstrated improved function*

85%
% of active GAIN client remained in the community

*Other reasons for discharge from GAIN include 1) situational change (e.g. patient moving elsewhere), 2) transfer to long-term care, 3) services declined by patient, or 4) death. It should be noted for reasons 1 through 3, some identified goals may have been achieved.

MINT® MEMORY CLINIC

~670
Unique Patient Served*
(resulting in early diagnostic clarification regarding memory concerns)
*Data from 4 clinics

~2660
Visits*

Enhanced Provider Experience

Developed specialized pathways to guide transitions and coordination between services and across specialized geriatric services (SGS) (e.g., Cognition Referral Pathway, **Clinical Frailty Pathways**, **AGS Cognitive Screening Toolkit)**

Led clinical and operational process overhaul to enhance efficiency at a GAIN team managed by Seniors Care Network. Reduced wait-times and Increased throughput **~25%** through process standardization, and the use of provider decision tools

Conducted the Central East SGS Provider Evaluation 2024-25. Results revealed that **90%** of participants would recommend working in SGS to others.

Developed the inaugural CE Adult Day Programs (ADP) Guidelines 2020 (with input from **17 providers operating across 44 sites**), describing acceptance criteria, elements of core programs & services and operational standards.

- Co-designed guidance and decision tools to advise **Hybrid ADP delivery during COVID across CE**. Evaluated the intra-COVID Hybrid ADP model (2021) and made revisions based on provider feedback.

Enhanced Patient and Caregiver Experience

Older Adult Experience Survey Results

90%

of the participants would 'definitely recommend' GAIN to others

Co-developed a Provincially validated Older Adult Experience Survey:

- Led the implementation, data collection and analysis of the above survey across the GAIN Program.
- Participants gave an average overall experience rating of **~9.4 out of 10** to GAIN
- Led process reviews to infer that **100%** of the GAIN clients receiving comprehensive geriatric assessments (CGA) are connected with the relevant community and social support services based on their needs
- Led the implementation, data collection and analysis of the survey (adapted version) across CE ADP as part of the developmental evaluation of the Intra COVID Hybrid ADP Model (virtual, home-based and limited face-to-face programs & services)
- Led GAIN evaluations (2018 and 2019) inferring that ~100% of primary/involved caregivers are assessed for stress, and connected with support as a part of the CGA
- Partnered with the Ontario Caregiver Organization to develop the **Caregivers Needs Assessment and Support** Guidance document; developed a Standardized GAIN Social Work (SW) Assessment based on the recommendations.

Improved Value

Led the Central East Geriatric Emergency Management (GEM) Nurse Return on Investment (ROI) Evaluation 2023-24. Results indicated:

+354%

Positive ROI, indicating monetary benefits > program costs

$1.13M

Annual cost saving/GEM nurse, including reduction in ALC, inpatient admissions, and inpatient length of stay (LOS)

$8.6M*

Estimated annual cost savings in long term care (LTC) placements by GAIN

*Included are GAIN patients for whom a CFS of seven or higher was assigned, a population consistent with individuals living in LTC.

Advanced Health Equity

- Developed and disseminated the **Framework for Addressing Racism in Specialized Geriatric Services**
- Conducted the CE SGS Provider Evaluation 2024-25. Results revealed that 80% of the participants reported the completion of Equity Diversity and Inclusion (EDI) focused training.
- Re-designed the GAIN model to facilitate equitable access through:
  - Expanding GAIN services to semi-urban and rural areas (through the introduction of new community teams)
  - Including home-based services: Currently, **~73%** of the GAIN teams provide home visits enabling service to home bound older adults who would otherwise be unable to access specialized support. **100%** of teams provide virtual visits.

Message from the Executive Director and Board Chair of Seniors Care Network

This past year, Seniors Care Network made important progress in improving care for older adults through practical innovation, system partnerships, and a clear focus on evaluation and clinical impact.

Our work on frailty management continues to drive change across the region and beyond. The Frailty Pathways support early identification and better management of frailty in primary care, community, and soon, emergency and acute care settings. These tools aim to reduce avoidable hospitalizations and improve the ability of older adults to age well in the community.

We also expanded our evaluation efforts to better understand system performance and inform improvements. Highlights include a Central East SGS provider experience evaluation, and the process-mapping evaluation of the Durham MINT Memory Clinics.

EDI continues to be a priority, and our efforts are reflected through our collaborative projects focused on social prescribing, assessment supports to the vulnerably housed, and practices to prevent/address mistreatment and abuse of older adults.

Our team contributed to multiple regional and provincial initiatives— development of guidance on addressing caregiver needs and support, streamlining referrals and transitions across SGS, and advancing adult day program collaboration across Ontario Health East. We remain a trusted partner in shaping older adult policy and service design and continue to build capacity in the next generation of health leader by offering practicum placement.

We are proud of the impact achieved and grateful to our partners and stakeholders for their continued collaboration. Together, we're building stronger, more responsive systems for older adults and their care partners.

Rhonda Schwartz
Executive Director

Diane Duncan
Board Chair

Host Site for Practicum Placements

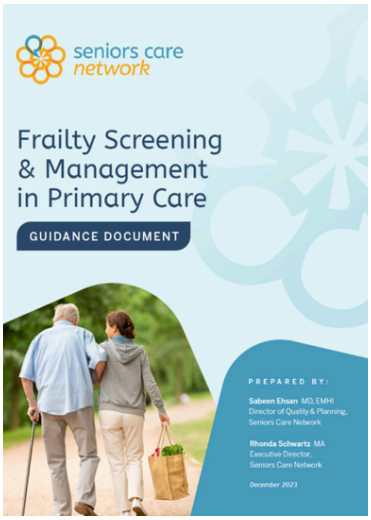
Seniors Care Network continues to support the next generation of health system leaders through practicum placements with the University of Toronto's Master of Health Informatics program. In 2024, we hosted Xin Yi Dong, who co-led the Central East Provider Experience Evaluation, supported the process-mapping evaluation of the Durham MINT Memory Clinics, advanced the organization's communications strategy, and led a redesign of out website to enhance user experience.

Training Needs Assessment Analysis

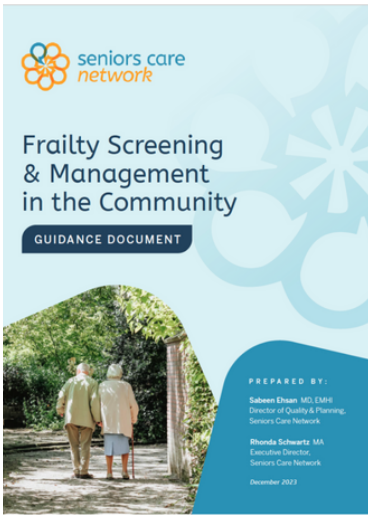
Our Training Needs Assessment was completed to determine the current gerontological training needs of health professionals working in SGS in the Central East. The intent was to formulate recommendations for ongoing improvement.

Frailty Management: Supporting Aging Well in the Community

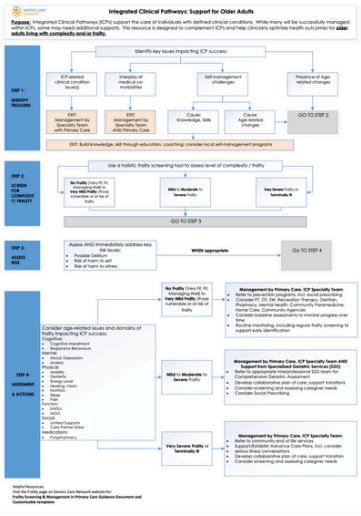
We continue to advance its population health approach to frailty management, recognizing the direct impact of early identification and intervention on reducing avoidable hospitalizations, alternate level of care (ALC) designations, and long-term care needs. Our Frailty Pathways offer an evidence-informed, practical framework for frailty prevention, screening, assessment, and management across various care settings. Notable resources developed include:



Holistic Approaches to Frailty Screening and Management in Primary Care



Holistic Approaches to Frailty Screening and Management in the Community



Integrated Clinical Pathway (ICP) Frailty Overlay: a primary care decision tree for chronic disease management in older adults living with frailty

Resources in progress include

- The Emergency Department (ED) Frailty Pathway
- Acute Care Frailty Pathway
- Frailty Screening and Management Protocols for Community Paramedicine

Frailty Management: Supporting Aging Well in the Community

Our expertise in Frailty Management was recognized through an invitation to present at the Ontario Health West Knowledge Exchange Session.

The presentation "The Role of Screening in the Care of Older Adults" sparked significant interest, resulting in consultations with Ontario Health Teams, hospital administrators, and care providers seeking our expertise in implementing frailty screening locally.

Kawartha Lakes Ontario Health Team (KLH-OHT) is an early adopter of the Primary Care and Community Frailty Pathways. The pathways have been successfully implemented across various primary care and community organizations/services.

The team delivered numerous presentations on frailty management, reaching diverse audiences including KLH-OHT, Durham Community Health Centres (CHC), Ontario Health East (OHE), Regional Geriatric Program Central, and local Alzheimer Society Chapters.

Central East Cognition Referral Pathway

Seniors Care Network collaborated with the Alzheimer Society of Durham Region, the Alzheimer Society of Peterborough, Kawartha Lakes, Northumberland and Haliburton, and GAIN Regional Leadership to develop a cognition referral pathway that would:

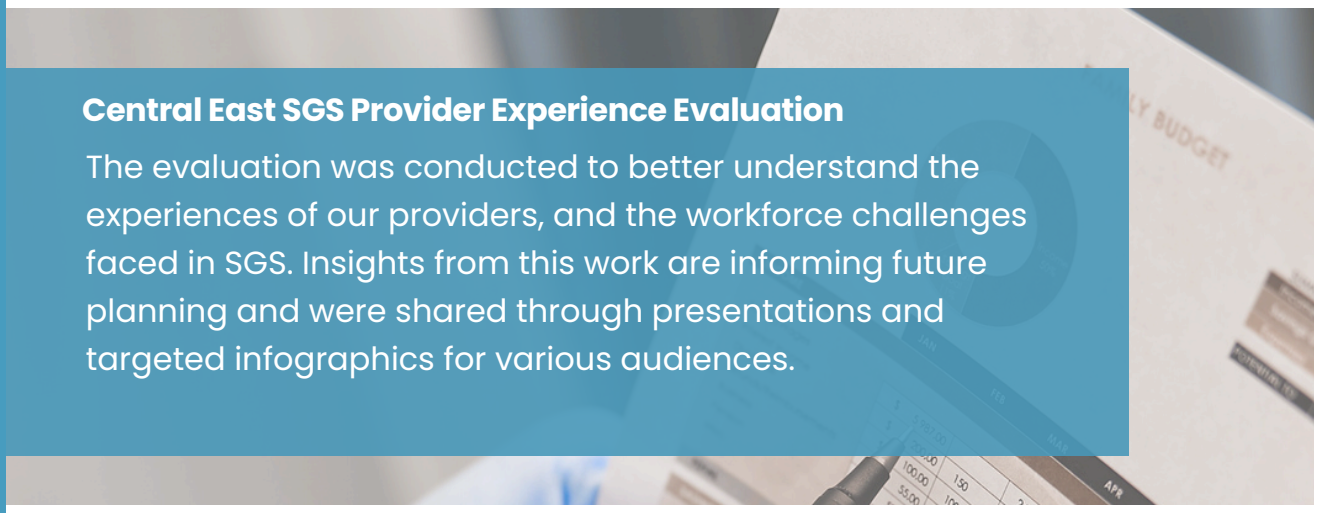
- facilitate referral appropriateness
- improve patient navigation
- streamline transitions across SGS

The pathway is being piloted at the Durham Community Health Centre (CHC) GAIN team.

Recognition Award

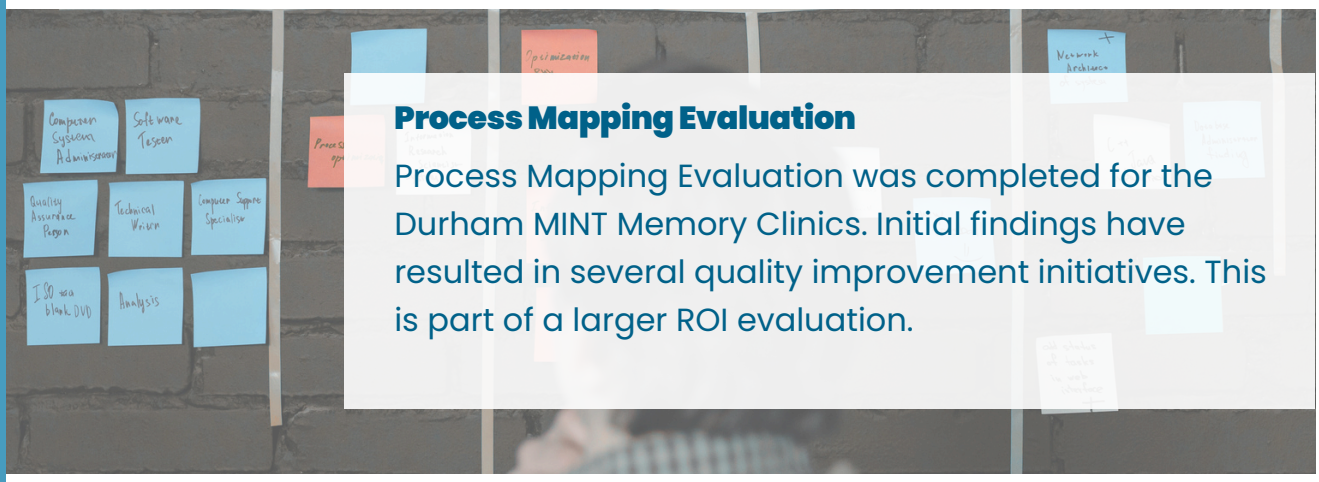
Under the leadership of Sabeen Ehsan, the CHC-Northumberland GAIN team received the 2024 *GAIN Driving Success Award*. The award recognizes innovation and successful implementation of processes and tools that have meaningfully improved service delivery.

Evaluation and Research



Central East SGS Provider Experience Evaluation

The evaluation was conducted to better understand the experiences of our providers, and the workforce challenges faced in SGS. Insights from this work are informing future planning and were shared through presentations and targeted infographics for various audiences.



Process Mapping Evaluation

Process Mapping Evaluation was completed for the Durham MINT Memory Clinics. Initial findings have resulted in several quality improvement initiatives. This is part of a larger ROI evaluation.

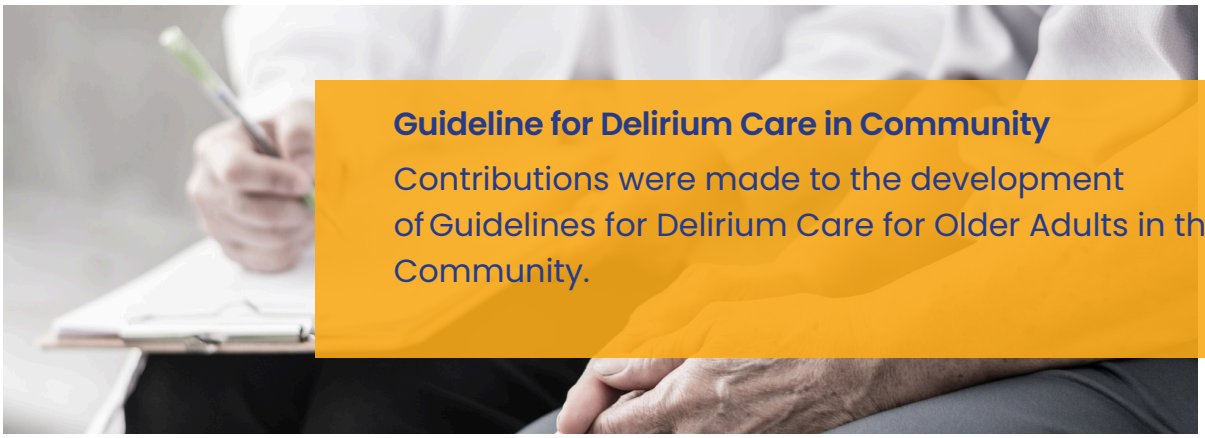
Barriers and Facilitators to Goal-Setting and Decision-Making

Stacey Hawkins completed research for the Canadian Frailty Network funded dissertation study focused on understanding the barriers and facilitators to goal-setting and decision-making with persons with dementia in SGS.

Research and Evaluation

Caregiver Experience Survey

A collaborative manuscript was developed for publication, detailing the development of an online caregiver experience survey tailored to SGS.



Guideline for Delirium Care in Community

Contributions were made to the development of Guidelines for Delirium Care for Older Adults in the Community.

GAIN Manuscript

A collaborative manuscript was initiated, highlighting the GAIN model.

Research and Evaluation

A total of 62 responses were received across Central East SGS. Some key results from the Central East SGS Provider Experience Survey include:

TEAM COLLABORATION

- 87% understand the roles and responsibilities of other team members
- 80% think team members show trust towards each other

BURNOUT/STRESS

- 66% experiencing burnout or have a high chance of getting burnt out
- 58% personal support workers/community support workers report experiencing burnout or have a high chance of getting burnt out; highest among participants

MORAL DISTRESS*

- 49% have a fair chance of experiencing or are experiencing moral distress
- 69% felt unable to provide optimal care due to client's inability to afford certain services like transportation, adult day program or private care
- 67% concerned with long wait time and lists

*Being addressed through the launch of educational modules on our Learning Management System

JOB EXPERIENCE

- 75% feel they have the tools/resources they need to do their job effectively
- 80% feel they can participate in decision-making regarding their work (flexibility regarding work schedule, hours, assigned activities)

PROFESSIONAL DEVELOPMENT

- 57% satisfied with ongoing training/education
- 64% satisfied with the training during the onboarding process
- 64% think they have the support and resources needed to develop and achieve career/educational goals

JOB SATISFACTION

- **7.5/10 satisfaction score**
- **90% would recommend others to work in SGS**

Research and Evaluation

Results of the **Central East GEM NURSE ROI Evaluation** were broadly disseminated and positively received by various audiences.

GEM Nurse Return on Investment Evaluation

The **Geriatric Emergency Management (GEM) Nurse Program** consists of advanced practice nurses who deliver emergency comprehensive geriatric assessment (eCGA) and interventions to older adults living with complex health conditions and frailty in the Emergency Department (ED).

The GEM Nurse program has been implemented in nine hospital locations within the Central East Region of Ontario.

Between 2023 and 2024, we conducted an outcome evaluation of the Central East GEM Nurse Program at **5 different levels** using the **Phillips Return on Investment (ROI)** Methodology. A case control group was identified to isolate program effects. The full Evaluation Report can be found on our website.

Terry Li, BHSc MHI & Stacey A. Hawkins, MA, CPG, PhD(c), 2024

5 ROI

+354.27%
monetary savings > than program costs

$1.13 million
savings per GEM Nurse, per year

4 IMPACT

Intangible Outcomes:

- **Gerontological knowledge in ED and hospital staff**
- **Patient satisfaction with ED care**

Tangible Outcomes:

- **Hospital admissions, in-patient and ALC** (-161 and -99 admissions/year)
- **In-patient LOS after admission** (-8.37 hours/patient)
- **Rate of becoming ALC after admission (≤ 30 days from admission)**
- **Linkages with Specialized Geriatric Services and Community Programs**

3 APPLICATION

Requisite GEM Nurse clinical skills are regularly being applied, including:

- **Screening** and prioritizing need for GEM services
- Performing geriatric assessments
- Development of **goal-based care** plans for patients
- Advocating for **appropriate discharge** and connecting patients with hospital and community supports
- Effectively conducting **follow-up**
- Educating ED staff to appropriately refer patients to GEM

2 CONFIDENCE

Majority of ED staff (76.93%) indicate high or very high ratings of **confidence in ability to refer to the GEM Nurse**

GEMs are confident in:

- **Performing targeted geriatric assessments (94.4%)**
- **Advocating for appropriate disposition of ED service users (100%)**
- **Effectively referring patients for appropriate community based services (100%)**
- **Effectively conducting follow-up with patients (88.9%)**

1 REACTION

GEM Nurse Program Buy-In:

- Makes a difference in patients' care (100%)
- Contributes to **safe discharge** and/or decreased **length of stay** for ED patients(100%)
- Reduces unnecessary **ALC** occupancy (88.9%)
- Is of high **quality** (88.9%)

ED Staff Program Buy-in:

- Makes a difference in patients' care (89.28%)
- Contributes to **safe discharge** and/or decreased **length of stay** for ED patients (92.85%)
- Reduces unnecessary **ALC** occupancy (92.14%)
- Is of high **quality** (82.1%)

0 INPUT

Program operates on weekdays for **~8 hours**.

Majority of time is allocated to clinical work, including providing specialist clinical services for older adults living with complex health conditions and frailty and documenting the encounter.

All GEMs are certified **specialists in gerontology (GNC(c))** through the Canadian Nurses Association, and have accumulated additional professional healthcare experience working with geriatric populations.

Majority of GEMs are master's-prepared or are in the process of completing their master's degree.

Key Highlights

In 2024-25, we continued to build and strengthen partnerships to better support older adults across our region

Older Adult Advocate Resource Development

In Peterborough, Seniors Care Network worked alongside GAIN Regional, Alzheimer Society of Peterborough Kawartha Lakes, Northumberland and Haliburton, the Ontario Provincial Police (OPP), and other local partners to implement an Older Adult Advocate resource. This initiative is designed to support older adults who may be experiencing physical and/or financial abuse.

Mission United Pilot Project

We also partnered with Mission United and GAIN Regional in a pilot project to provide Comprehensive Geriatric Assessments to vulnerably housed older adults with memory concerns. Mission United is a social service and primary health care HUB for those experiencing homelessness. The collaboration showcases an integrated model comprising of primary care, mental health and SGS.

Social Prescribing Assessment & Care Plan Template

In response to the growing interest in Social Prescribing, Seniors Care Network developed practical resource outlining key components of a Social Prescribing Pathway tailored to older adults. The team also developed a comprehensive **Social Prescribing Assessment & Care Plan Template** and provided evaluation consultation to the Community Health Centers of Northumberland Social Prescribing Program.

Communication Strategy

We advanced its communications strategy through a redesigned website with a dedicated page on **Frailty**, expanded social media presence, and regular newsletters—ensuring that information and resources are more accessible to partners, providers, and the community.

Communications Strategy

Our vision is "Better health outcomes for older adults living with complex health conditions and their care partners in our Region."

Land Acknowledgement

We acknowledge that the Central East Region of Ontario is situated on the traditional and treaty territories of the Mississaugas of Scugog Island First Nation and the Williams Treaties First Nations, including Curve Lake, Hiawatha, Georgina Island, Beausoleil, and Rama First Nations. We recognize and honor the enduring presence, stewardship, and contributions of Indigenous Peoples to this land. We remain committed to reconciliation, meaningful action, and supporting the health, wellness, and self-determination of Indigenous communities.

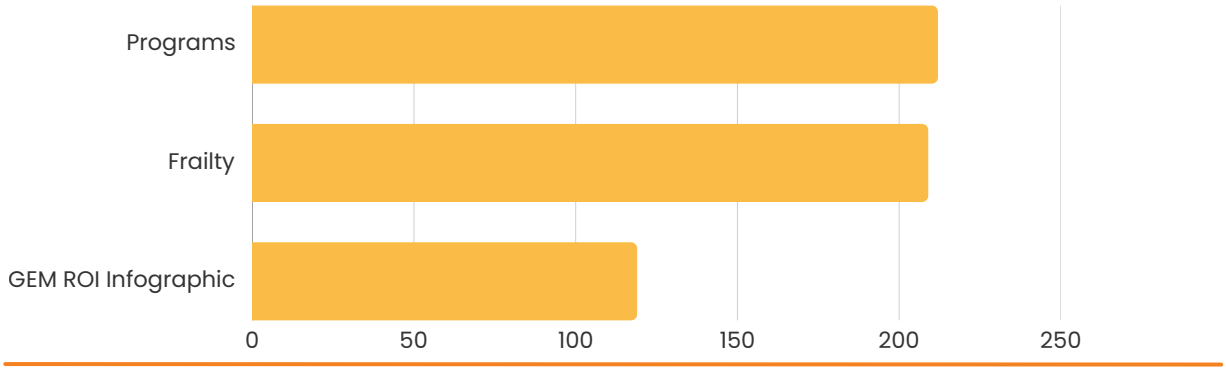
↑144%
% of Page Views Increase

↑19%
% of Avg. Session Duration Increase

↓20%
% of Bounce Rate* Decrease
* bounced rate: % of visitors left the site after only viewing 1 page

Data comparison between April 1-Jun 11, 2025 and April 1- June 11, 2024

Top Visited Pages (from April 1 - June 11, 2025)



As a partner to all Ontario Health Teams in the Region, our team members provided technical and subject-matter expertise in SGS, population health management, evaluation, and performance measurement.

SGS East

As a partner in SGS East we continue to collaborate with the Regional Geriatric Program of Eastern Ontario (Champlain) and the Centre for Studies in Aging and Health at Providence Care (South East) to advance coordinated care for older adults across Ontario Health East.

Last year, SGS East organized a **Leadership Forum**. The forum established a shared understanding of leadership competencies in SGS, and was attended by 90 senior leaders, decision-makers, health system planners and lived experience advisors. Our team presented at the forum, delivering a well-received session on *"Identifying the Leader's Roles in Specialized Geriatric Services"*, and we co-led the analysis of forum findings.

Ontario Caregiver Organization

Seniors Care Network partnered with the Ontario Caregiver Organization to develop a practical, primary care-focused **guidance document** for identifying and supporting caregivers of older adults through a holistic four-step approach.

Adult Day Programs

In its continued leadership of the Central East ADP Committee, we supported collaboration across 17 providers at 44 sites. Building on this foundation, we initiated a broader partnership with Champlain and South East regions, resulting in the launch of the Ontario Health East ADP Guidelines — strengthening support for more than 55 ADP providers across the region.

Examples of our collaborative work include the **CE Intra-COVID Hybrid Guidelines**, **Central East Region ADP Guidelines** and the **Ontario Health East Region - ADP Guidelines**.

Provincial Geriatrics Leadership Ontario

Seniors Care Network had an active presence on 12 Provincial Committees and/or Working Groups and frequently partners with PGLO and SGS entities on various projects.

Geriatric Assessment and Intervention Network

GAIN Regional Leadership team continued to lead advancements in service access, standardization, and clinical innovation. Last year GAIN teams served a total of ~14600 patients, amounting to ~ 26000 visits. GAIN implemented the OCEAN eReferral system across all teams — integrated into three different electronic medical records (EMRs) —enhancing referral consistency and tracking. The team led a region-wide approach to opportunistic case finding for falls in outpatient settings, embedding identification protocols directly within electronic medical records. To improve service access, the Durham Region GAIN team optimized waitlist utilization by analyzing system capacity, reviewing data, and redirecting referrals where appropriate. Additionally, standardized triage guidelines were introduced to prioritize high-need older adults, ensuring timely access to care.

~14600

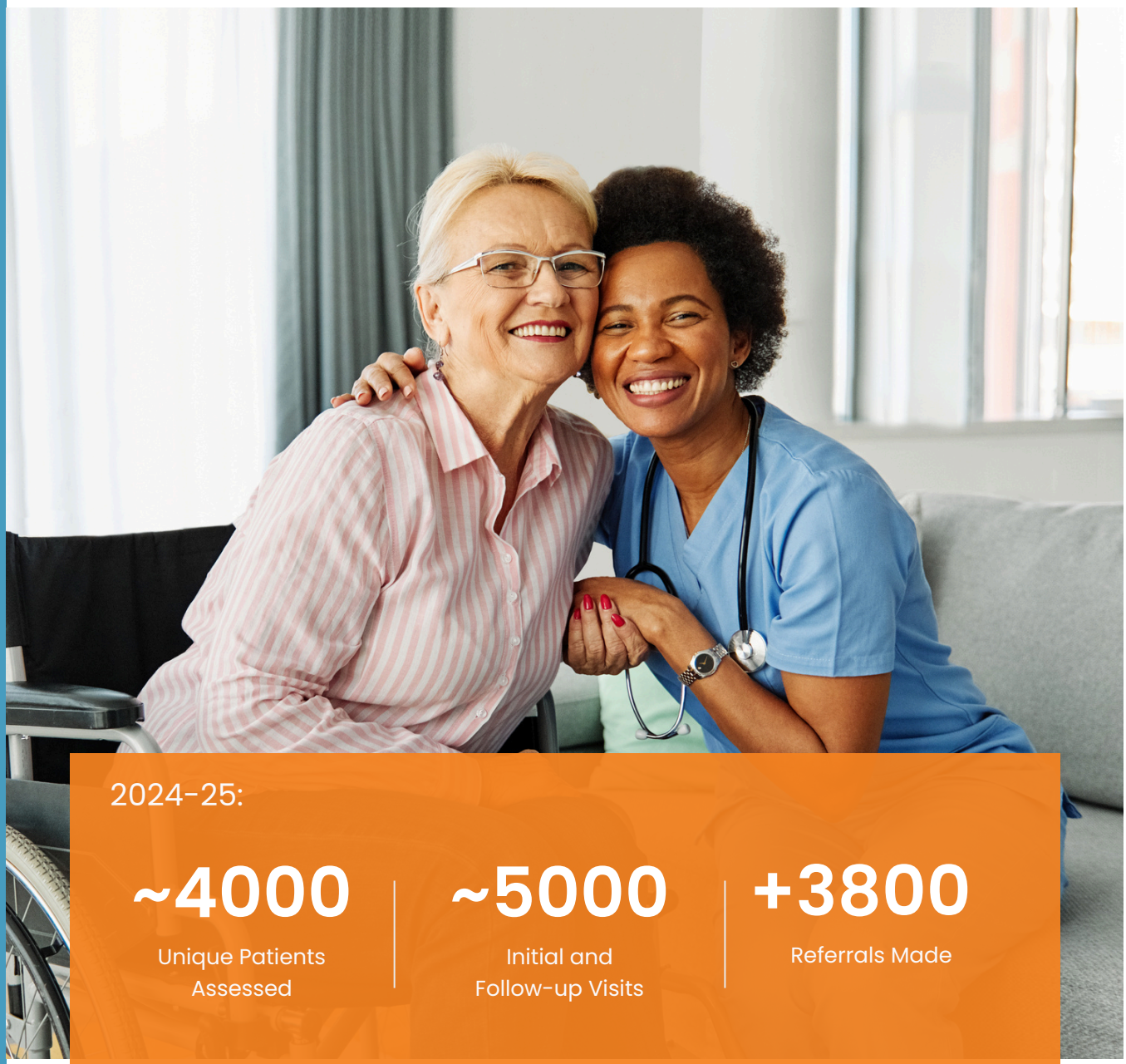
Total Patients Seen

~26000

Total Visits

Geriatric Emergency Management

Central East GEM nurses continue to play a pivotal role in the provision of care to older adults in the emergency department. In 2024-25, GEM nurses assessed ~4000 patients amounting to ~5000 initial and follow up visits. Over 3800 referrals/service connections were made, with the majority of the referrals being to Ontario Health at Home, GAIN and primary care.



2024-25:

~4000
Unique Patients Assessed

~5000
Initial and Follow-up Visits

+3800
Referrals Made

Primary Care MINT Memory Clinics

Primary Care Collaborative/MINT Memory Clinics continue to be an important component of the Dementia Strategy in the Region. Last year, ~ 670 unique patients were seen amounting to ~2660 visits.

~670
Total Unique Patients Seen

~2660
Total Visits

Senior Friendly Care Committee

End PJ Paralysis
The Committee supported knowledge-sharing around the "End PJ Paralysis" campaign, a global initiative to combat deconditioning and immobility in hospitalized older adults.

Local hospitals—Peterborough Regional Health Centre, Lakeridge Health, and Scarborough Health Network (SHN)—made progress toward achieving Age-Friendly Health Systems Recognition through the Institute for Healthcare Improvement.

ALC-to-LTC Order Set
The Committee also contributed to the development of an ALC-to-LTC order set to be implemented in EPIC (an EMR).

Nurse Practitioners Supporting Teams Averting Transfers

Efforts to support ED diversion and improve care coordination continued across the region. Collaboration with Scarborough retirement homes led to an expanded role for NPSTAT in supporting ED diversion from these settings. Emergency diversion protocols were maintained and refined to reduce hospital admissions and ensure appropriate care within LTC homes across Central East Interdisciplinary collaboration with LTC home teams was strengthened to optimize resident care plans and improve health outcomes. Nurse Practitioners also conducted primary and secondary assessments for Medical Assistance in Dying (MAID).

Behavioural Supports Ontario

Several key activities were undertaken to support program operations and future planning.

How-to documents were created and updated to guide Program Office functions, including revisions to the orientation package and checklist.

Additional resources specific to BSO CE were developed to promote consistency and sustainability in practices.

The team also compiled results from the Pulse Check survey to inform priorities for the 2025 calendar year.

As part of the ongoing Scarborough realignment, all 22 LTC homes and the SHN BSO team transitioned to support from the Toronto Central Behavioural Supports Outreach Team, with the official transfer date pending confirmation from OHE and Ontario Health atHealth (OHAH).

LOOKING AHEAD

In the year ahead, Seniors Care Network will continue to build momentum through the development and implementation of new frailty pathways tailored to ADP, ED, and Acute Care, further embedding proactive identification and management of frailty across the continuum of care.

EDI remains a strategic priority. Seniors Care Network will deepen its commitment by integrating EDI principles into program design, partnerships, and care delivery approaches.

We will further strengthen our commitment to capacity building by formally launching modules through the Learning Management System on our website. Upcoming topics will include GAIN orientation materials (developed by GAIN Regional Leadership), and frailty management. Additionally, a comprehensive Return on Investment analysis for the GAIN program will be conducted, offering valuable insight into the value of specialized geriatric services.

A Regional Frailty Conference is also on the horizon, bringing together stakeholders to share best practices, innovations, and lessons learned in frailty care.

APPENDIX

Seniors Care Network 2024/25 Work Plan Outputs

Strategic Direction	Activities (Tactics)	Outputs	Evidence
Build Capacity Across the System	1. Convene and Chair (co-chair) relevant SGS committees	1. # of meetings per committee	35 • CE ADP - 3 • OHE ADP – 13 • sfCare – 8 • GAIN (Governance) – 3 • SGS East – 8
	2a. Analyze the Training Needs Assessment for SGS East	2a. Training Needs Assessment analyzed	Completed
	2b. Develop and deliver training and/or workshops related to knowledge implementation	2b. # of trainings and/or workshops delivered	18 • KLH OHT – (3) population level management of frailty • CHCN Social Prescribing • Peterborough Elder Abuse Resource Network • OHE – Frailty • Leadership Forum • GAIN Learning Management System • DCHC GAIN Frailty training • Consultations with Central East, South East OHW hospital decision makers re: ED and acute care frailty pathways (7) • Ontario Health West Waterloo Wellington Frail Working Group (2)
	3. Led the development of frailty and caregiver needs management decision trees	3. # of pathways developed	8 • ED • Acute Care • Community Paramedicine - draft • Cognition • OHE ADP • ICP Overlay • Ontario Caregiving Organization (OCO) Social Worker Assessment • OCO Primary Care Caregiver Needs Assessment
	4. Develop funding proposals for SGS	4. # of funding proposals developed	2 • GAIN expansion • MINT expansion

APPENDIX

	Activities (Tactics)	Outputs	Evidence
Drive Clinical Excellence	5a. Continue to lead and participate in research projects	5a. # of research projects led/participated in	3 • GAIN manuscript • Caregiver Experience Survey • Understanding barriers and facilitators to goal setting and decision making in SGS
	5b. Provide subject matter expertise to OHTs	5b. % of Central East OHTs participating in	100%
	6. Manage GAIN and MINT teams at CHCN*	6. % of quarterly reports completed	• Quarterly reports were not completed as data was not available from the CHCN • GAIN and MINT were handed back to the CHCN as of January 1, 2025
	7. Develop evaluation work plans	7. # of evaluation work plans developed	7 • Durham MINT • Mission United • CHCN Social Prescribing • KLH OHT (3) • CE Provider Experience Evaluation
	8. Lead indicator development, data collection and/or analysis with SGS programs or OHT initiatives	8. # of performance management activities led	6 • GAIN (2) • GEM • CHCN Social Prescribing • KLH OHT • Mission United
	9. Lead, facilitate and/or support quality improvement initiatives	9. # of quality improvement initiatives led, facilitated and/or supported	7 • CHCN GAIN • GAIN Regional • Durham Realignment – Durham MINT – Durham CHC frailty • Scarborough Realignment • MINT • CHCN Social Prescribing

APPENDIX

	Activities (Tactics)	Outputs	Evidence
Advance Older Adult Policy	10. Support sfCare initiatives	10. # of sfCare initiatives supported	3 • End PJ Paralysis • ALC LTC Order Set • Physical Environment
	11a. Participate on PGLO** and other provincial committees	11a. # of provincial projects staff supporting	11 • R. Schwartz and S. Hawkins are members of the PGLO Capacity Planning & Performance Measurement Working Group • R. Schwartz is a member of the PGLO Clinical Leadership Council • S. Ehsan is a member of the PGLO Capacity Building, Education and Research • R. Schwartz is a member of the PGLO SGS Administrators Committee • R. Schwartz and S. Ehsan are members of the PGLO Ontario Collaborative for Aging Well • R. Schwartz is a member of the Rehabilitation Care Alliance Older Adults Living with Frailty Task Group, System Evaluation Task Group and RCA/PGLO Coaching Series • S. Hawkins is a member of the Provincial GEM Working Group • R. Schwartz is a member of the Ontario Health East Palliative Care Leadership Table • S. Ehsan and R. Schwartz are members of the PGLO Integrated Clinical Pathways Task Group • R. Schwartz is a member of the Joint SGS Governance Working Group • R. Schwartz is a member of a provincial task group to review the Leading Practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care document with a goal of updating language and guidance to better assist OHTs and their member community organizations
	11b. Participate on SGS East projects/initiatives	11b. # of SGS East projects/initiatives supported	4 • Leadership Forum • Leadership Forum analysis • OHE ADP Guidelines • Communication Plan
	12. Disseminate approaches to social prescription for older adults	12. Approaches to social prescription for older adults disseminated	3 • CHCN • KLH OHT • Older adults focused social prescribing implementation considerations
	13. Develop and implement a communication strategy	13a. Communication strategy developed	Developed
		13b. % of communication strategy implemented	75% (website, newsletter, social media)

*Community Health Centres of Northumberland **Provincial Geriatrics Leadership Ontario

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