ORIGINAL RESEARCH

Transforming Care for Older Adults Living with Complex Health Conditions in Ontario Post-Covid: Conference Proceedings and Recommendations

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ABSTRACT

The virtual conference 'Transforming Care: Supporting Older Adults Post-COVID in Ontario' was held in October 2021. It was organized by Specialized Geriatric Services (SGS) East and held over three half-days. The guiding themes included: The Need, The Innovation, and The Transformation. Over 500 participants heard from ~50 clinicians, researchers, administrators, older adults, care partners, and community partners. The pandemic uncovered and exacerbated existing issues and pushed us to explore new ways to support older adults living with complex health conditions. The following key priorities were identified: older adults and their care partners call for personalized care experiences, and a lifespan approach to care delivery; aging in the community remains the most common preference; an integrated community care system that supports aging at-home should be prioritized; care delivery by SGS interprofessional teams and specialists is paramount to providing comprehensive care; building health human resource capacity should be a system priority; and promising innovations should be scaled and spread.

Evidence shows that we cannot return to status-quo; post-pandemic planning of both who we serve and how we serve needs to be anchored in system renewal, not just recovery. Renewal means integrating lessons learned during the pandemic into the redesign of our systems of care. Investments in innovative, upstream strategies that support home and community-based care, and target health promotion and prevention are necessary. The provincial and regional infrastructure of SGS has the expertise and capacity to assist Ontario Health Teams in responding to the evolving health and social needs of this population.

Key words: older adult, frailty, pandemic recovery, specialized geriatric services, virtual conference, aging at home, seniors, health policy

INTRODUCTION

The conference, 'Transforming Care: Supporting Older Adults Post-COVID in Ontario' ('Transforming Care'), was held in October 2021 on Zoom. It was organized by Specialized Geriatric Services East—a collaborative group of clinicians and administrators who support older adults living with complex health conditions across Ontario Health East region—in partnership with Provincial Geriatrics Leadership Ontario, the provincial infrastructure for clinical geriatrics care. 'Transforming Care' was split into three half-days. The objectives included: describing the current need, profiling integrated care models, and exploring post-COVID recovery including system transformation. Figure 1 provides an overview of the Transforming Care conference participants.

Specialized geriatric services (SGS) are those services focused on older adults living with complex health conditions (including frailty), distinguished by greater specialization and the use of interprofessional teams and inter-organizational collaboration in service delivery.

During the conference, 518 participants heard from 48 SGS clinicians, administrators, researchers, community partners, older adults, and care partners on what integrated care looks like for older adults living with complex health conditions in Ontario (Appendix A). The following sections highlight key learnings, emerging themes, and the implications of these themes for practice, policy, and research.

RESULTS

Day One: The Need

The first half-day of 'Transforming Care' focused on the needs of older adults living with complex and chronic health conditions. Anne-Marie Yaraskavitch (care partner), explained that:

> "Older adults and their care partners need a system that is designed to ensure they experience seamless transitions across different care providers and settings, is easy to access, provides navigation when older adults and care partners have questions or need assistance, and is based on the philosophy that every door is the right door."

Designing services for optimal delivery is incomplete without considering and responding to the experiences of older adults; design must include user experience as a bedrock for how services operate, how they are connected to primary care, and what the relationships are amongst SGS providers.

Kelly Kay provided context on the needs for older adult care, referencing Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs: A Scoping Review[1] (see Figure 2).

Care providers must have clear responsibility for delivering interventions, accountability in the follow-up and follow-through of the care plan, and be able to share patient information relevant to treatment across the care team in a timely manner, ideally with a single electronic medical record to which all providers can access and contribute.

Kay described how using frailty estimates and assumptions generated from the Provincial SGS Asset Mapping Initiative can inform gap analyses, strategic investments, training and knowledge translation initiatives, recovery planning, and health system transformation efforts.[2] Kay also encouraged providers to move from the language of 'need' to one of 'requirement': this shift in language will help SGS providers to consider the requirements for treating each individual, as opposed to a generic need to consume services, which may imply judgment on those accessing services to manage their health.

During a panel discussion on the lessons learned from the COVID-19 pandemic, Dr. Benoit Robert, Dr. Lindy Kilik, and Dr. Jenny Ingram provided examples of the lack of integrated care for older adults resulting from infection prevention and control not being balanced with health and social care needs as SGS clinicians and long-term care (LTC) staff were typically not included in COVID response tables. Both Robert and Ingram challenged visitor policies in long-term care and hospitals, highlighting the social isolation that developed when care partners who supported activities of daily life and implementation of care plans were prohibited from seeing their loved ones. This social isolation contributed to significant health decline for many older adults.[3]

The pandemic has had serious negative effects on the mental health of older adults globally.[4] Kilik highlighted the support she received from her organization to adjust to virtual delivery modalities for therapy, which allowed older adults to continue to receive treatment despite in-person restrictions. She explained, "The better you support your [health care providers], the better they can support their patients." Ingram and Robert echoed this, citing provision of personal protective equipment, staff support to conduct home visits with appropriate infection prevention and control training, and the efforts to continue to support older adults living with multiple conditions.

During the second panel discussion, speakers Dr. John Puxty, Dr. Sophiya Benjamin, Dr. Sina Sajed, and Charissa Levy shared their perspectives on what post-pandemic system transformation could look like. Comparing daily costs among hospital ($842 to $949/ALC bed), LTC ($126/bed), and community ($42) sectors,[5-6] Puxty urged the Ministry of Health to re-direct funding for new LTC facilities to

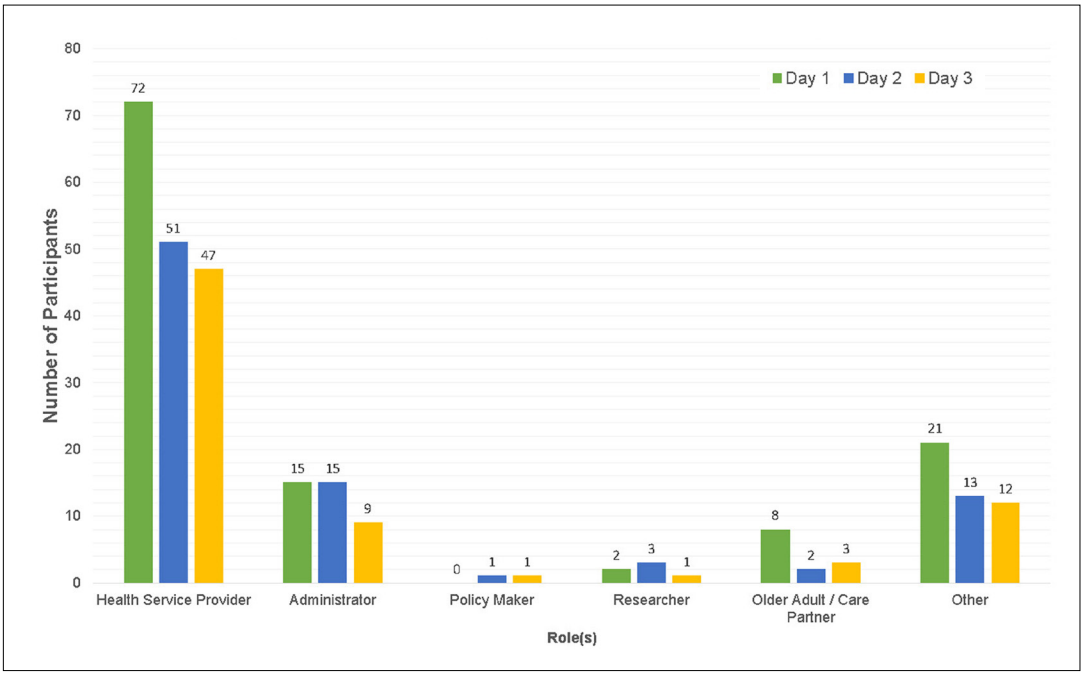

FIGURE 1. Transforming Care Conference participants

enhance community-based care. A significant proportion of LTC residents could continue to live in the community if provided with adequate support and rehabilitative services. Additionally, Puxty highlighted the importance of timely communication, care partner/family involvement, and use of simple technologies in the provision of person-centred care.

Benjamin explained that the closure of various mental health services during early waves of COVID led to decompensation among older adults living with mental health conditions.[7] Benjamin further described the limitations of virtual clinical assessments for LTC residents, emphasizing that in-person care is the 'gold standard'. Sajed re-iterated that community care is 'tragically underfunded', and an upstream approach is required to minimize specialist waitlists and delay LTC admissions. He further highlighted the importance of adequate funding for community-based interprofessional health teams in supporting general practitioners with training in the care of the elderly to keep older adults at home, and prevent avoidable emergency department visits, admissions to hospital, and premature institutionalization.

Levy emphasized the system and patient-level benefits of rehabilitative services, which include enhancing function, improving independence, and optimizing quality of life, all of which contribute to lower LTC admission rates. Levy urged the Ministry of Health and Ontario Health Teams to invite rehabilitation services representatives to regional planning and decision tables. Levy also highlighted the need for a renewed, comprehensive Provincial Seniors Strategy, and a policy framework for rehabilitative services.

Day Two: The Innovation

Day Two of the conference was focused on innovative SGS programs and approaches to care for older adults. Gweneth Gowanlock (care partner) opened Day Two by sharing her experiences caring for her husband living with dementia. She highlighted several 'bright spots' of care she experienced, including the value of including care partners as part of the care planning process. Gowanlock identified creativity as a key approach to providing care for people living with dementia; the need for follow-through on referrals to ensure patients receive appropriate care and follow-up on treatment recommendations; and the value of dementia-friendly training so that providers can maintain the dignity of the patient while improving quality of life.

Dr. Mark Lachmann and James Meloche engaged in a discussion on the importance of SGS partnering with the community services sector. Meloche noted the expertise of many community agencies to address factors that lead to

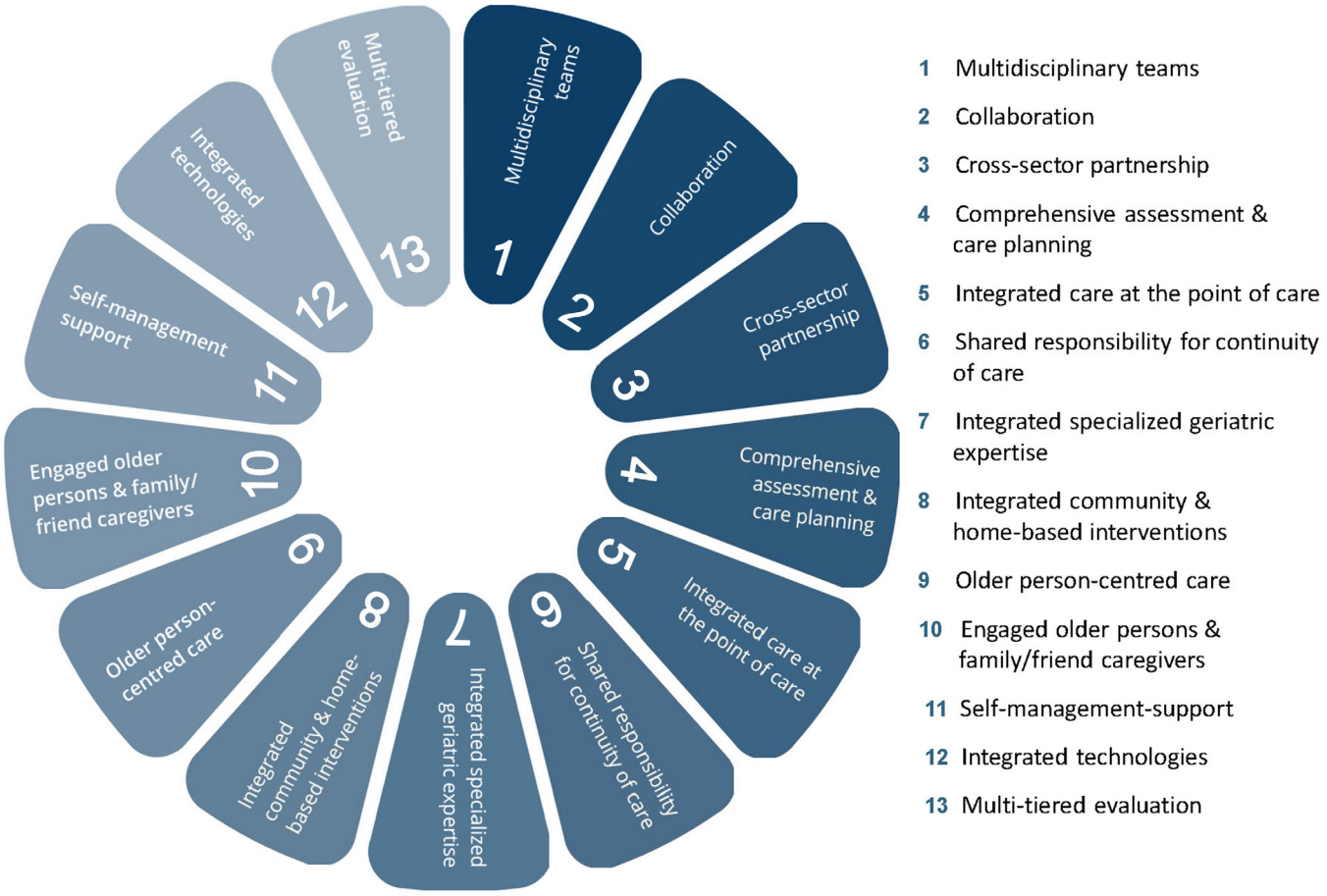

FIGURE 2. Design elements of integrated care relevant to the care of older persons living with complex and chronic health issues[1]

frailty. Staff in community agencies are oriented to the chronic needs of clients and their care partners, providing an essential link between primary care and the services that support older adults to live safely in the community in the long term. Lachmann also emphasized that specialist providers can learn from community agencies, who develop longitudinal relationships with their clients.

Presenters also highlighted the need for creative thinking and action within the health sector. Mathieu Grenier spoke about the growing partnerships between community paramedicine and SGS, emergency departments, and community-based health programs. Provincial community paramedicine representatives worked with provincial and regional SGS partners to develop core competencies for community paramedics. Key goals shared between community paramedicine and SGS include: health promotion, education, and prevention; reducing avoidable emergency department visits and hospital admissions; and keeping people safely at home longer.

Pam Howell emphasized the necessity of partnerships between disciplines and regions to support clinicians in their care of older adults living with complex and chronic conditions. GeriMedRisk is an interdisciplinary consult service for clinicians that includes specialists from geriatric medicine, geriatric psychiatry, geriatric pharmacy, and clinical pharmacology. It supports primary care as part of the circle of care, maintaining the medical home for older adults with providers they already know and trust, with a hospital diversion rate of 88.2%.[8] The GeriMedRisk program illustrates a digital health innovation that complements in-person care, providing timely advice and capacity-building for other clinicians while maintaining a patient's connection to their primary care provider.

Karen Hicks spoke about innovation in health human resource training through the geriatric emergency management fellowship developed at her institution in 2018. This fellowship was created after recognizing the dual needs of further geriatric education and expertise in emergency departments, along with hiring challenges. The fellowship is an eight-week program that pairs nurses with experienced Geriatric Emergency Management nurses to improve capacity to better assess and plan for geriatric patients, increase the knowledge of in-patient and community geriatric services, and improve outcomes for older adults visiting the emergency department. A modest investment to backfill positions during the fellowship resulted in better trained nurses who could implement a framework for assessing older adults,[9] and increased referrals to appropriate outpatient and community services to support discharge.

Day 3: The Transformation

Day Three focused on what system transformation could look like. The day began with patient advocates Art Seymour and Catherine Ingram (care partners) sharing their perspectives and personal experiences with the health system. Ingram stated that, "Health systems and records are very fragmented and cumbersome, especially when needs are complex," highlighting the need for the integration of health information systems. Loneliness and delayed or no feedback on test results were among the areas of concern identified by Seymour.

Kelly Kay spoke about health system recovery, naming five core principles: planning should be co-designed; person-centred; integrated; consistent & timely; and holistic.[10] Provincial Geriatrics Leadership Ontario has also established the Older Adult and Care Partner Advisory Council, which connects the work of Provincial Geriatrics Leadership Ontario and issues of importance to older adults and their care partners.[11] Lastly, Kay highlighted the 'Resilience Project', a video series showcasing older adults sharing messages of resilience, hope, and experience from the pandemic. The project underscores older adults as having value, making contributions, and mattering to their families, friends, and society.[12]

During their presentation, Stacey Hawkins and Ronaye Gilsenan highlighted the importance of utilizing evidence-informed tools and methods to aid system transformation through real-time, adaptive learning. They explained that developmental evaluation is suitable for initiatives with high levels of innovation and/or complexity, fast-paced decision-making, and areas of uncertainty.[13] By leveraging developmental evaluation, system planners and Ontario Health Teams can support more meaningful engagement of stakeholders, facilitate transparent decision-making and support accountability, while allowing for a high degree of flexibility and judgment.

Dana Corsi introduced the *Alternate Level of Care Leading Practices Guide*.[14] Currently ~80% of patients designated alternate level of care in Ontario are older adults.[14] The guide provides evidence-based approaches to improve patient outcomes, lower the length of stay, reduce alternate level of care rates, and improve patient flow. Key recommendations include: embedding senior-friendly care as essential care across the organization; assessing older adults for risks that may lead to delayed transitions in care; avoiding hospital-acquired harm and enhancing well-being; and supporting better engagement with families and care partners. The guide also includes a self-assessment tool that can be used to determine readiness for organizations, including Ontario Health Teams.

The next session explored virtual care strategies, with an emphasis on what could work post-COVID. Melanie Briscoe and Kelly McIntyre Muddle shared Provincial Geriatrics Leadership Ontario's Virtual Care Toolkit 2020,[15] which recommends a 'risk-based approach' that considers each patient and family's unique circumstances (e.g., access to virtual modalities and services, mobility and transportation barriers) and health requirements (e.g., need for urgent assessment or intervention) to determine the most suitable mode of care delivery in ambulatory SGS.

Krista Dineley and Hyemi Lee described the hybrid care delivery model at the Geriatric Assessment and Intervention Network. They explained the benefits of virtual care during the pandemic (e.g., involving additional care partners during visitor restrictions), and shared practical tips and resources to facilitate virtual cognitive and neurological assessments.[16]

Taryn MacKenzie and Dr. Shirley Huang concluded the session by describing the hybrid care model within Geriatric Medicine Clinics. Findings of the COVID-19 Geriatric Medicine Clinic Provider, Client, and Care Partner Experience Surveys show that a majority (66%) of the respondents preferred a single, longer, in-person (two to three hour) visit than shorter, multiple appointments. Similarly, the majority (54%) of respondents preferred a combination of in-person and telephone appointments, despite challenges associated with the delivery of virtual care.

During the final session, Donald Drummond and Duncan Sinclair summarized the key findings of their Ageing Well report.[5] Drummond reiterated that, since its onset, the pandemic has uncovered and exacerbated the long-standing inadequacies in our LTC system. LTC in Canada is largely institution-based, which contrasts with the preferences of older adults, the majority of whom want to age in the community.[17] As indicated in the Report, ~10 to 25% of LTC residents could continue living in the community with appropriate home care, a less expensive option than hospitalization and LTC. Canada spends significantly less on home care (0.2% of Gross Domestic Product) than on LTC (1.3% of Gross Domestic Product).[5] Canada can draw from the policies employed by other developed countries and revisit the disparities in community and institution-based health-care funding. Many approaches can be adopted to support older adults in the community, including communal living options (e.g., Oasis Senior Supporting Living in Kingston, Ontario), promotion of socialization and physical activity to enhance independence, adopting a holistic approach towards care, and a collaborative, system-wide effort to drive transformation. In response to a question regarding the challenges faced with navigating the health-care system, Drummond expressed that, "If we need this much navigation, it means we don't have a system in which all of the components are connected to one another."

CONCLUSION

The conference identified priority issues for system planners and policy makers. Existing deficiencies in our health system were exacerbated during the pandemic, forcing SGS providers to innovate. Table 1 summarizes top recommendations for Ontario's health system transformation. System transformation requires SGS to apply lessons learned during the pandemic and integrate the experiences of older adults, care partners, clinicians, and administrators into service design and delivery. Provincial and regional SGS networks have the expertise to aid Ontario Health and Ontario Health Teams in responding to the existing and emerging needs of the older adult population.

Aging in the community remains the most common individual preference, highlighting the need for upstream strategies that enhance health promotion and community-based supports for older adults even as their requirements change. Increased investments in home and community-based care, as opposed to institution-based care, are necessary. Evidence suggests that home and community-based care is significantly less expensive—and more preferred—than hospital and LTC-based care. Ontario should build upon age-friendly communities and hospital models successfully implemented in other jurisdictions.

Care delivery by both SGS interprofessional teams and specialist physicians is paramount to providing comprehensive, holistic, and personalized care for older adults living with complex conditions. Building health human resource capacity, while supporting the well-being of care partners, should be a system priority. Additionally, promising innovations should be scaled and spread. The conference was primarily focused on Ontario's health-care system. However, the learnings and recommendations can be applied to other jurisdictions with similar contexts within Canada and internationally.

Ontario's health system transformation should be based on the principles of co-design, person-centredness, integration, consistency and timeliness, and holistic care. Reverting to the pre-pandemic system is not post-pandemic recovery.

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TABLE 1.
Top five recommendations to transform post-Covid older adult care

1	Leverage SGS infrastructure and expertise by including SGS clinicians and administrators at key decision tables.
2	Promote aging-in-place by investing in cost-effective, preventative & rehabilitative community-based services.
3	Build health human resource capacity to spread models of team-based, interprofessional geriatric care.
4	Expand proven innovations (e.g., hybrid service delivery, integrated health information systems, GeriMedRisk, etc.) to enable equitable access to specialized services, and improve client and provider experience.
5	Use co-design methodologies to embed the perspectives of older adults, care partners, clinicians, and service providers to address priority issues, such as system navigation.

Art Seymour, Blayne Mackey, and Anne-Marie Yaraskavitch. The perspectives of older adults and care partners shaped the conference and should be centred in all future health system transformation efforts.

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on conflicts of interest disclosure and declare there are no conflicts of interest.

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REFERENCES

1. Horgan S, Kay K, Morrison A. Designing integrated care for older adults living with complex and chronic health needs: a scoping review [Internet]. Provincial Geriatrics Leadership Ontario; 2020. Available from: https://rgps.on.ca/wp-content/uploads/2020/11/PGLO-Scoping-Review-FINAL.pdf
2. Kay K, Corsi D, Morrison A. The current state of specialized older persons' care: a detailed look at specialized geriatric services in Ontario [Internet]. Provincial Geriatrics Leadership Ontario; 2022. Available from: https://rgps.on.ca/wp-content/uploads/2022/04/SGS-Asset-Mapping-Report-2017-2020-Final.pdf
3. Marrocco FN, Coke A, Kitts J, Ontario's Long-Term Care Covid-19 Commission: Final Report [Internet]. April 2021. Available from: https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf
4. Tyler C, McKee G, Alzueta E, *et al*. A study of older adults' mental health across 33 countries during the COVID-19 pandemic. *Int J Environ Res Public Health*. 2021 May 11;18(10):5090. doi:10.3390/ijerph18105090
5. Drummond D, Sinclair D, Bergen R. Ageing well [Internet]. Kingston: Queens University; November 2020. Available from: https://www.queensu.ca/sps/sites/spswww/files/uploaded_files/publications/1%20Ageing%20Well%20Report%20-%20November%202020.pdf
6. Home Care Ontario. Facts & Figures—Publicly Funded Home Care [Internet]. 2014. Available from: https://www.homecareontario.ca/home-care-services/facts-figures/publiclyfundedhomecare
7. Canadian Academy of Geriatric Psychiatry and Canadian Coalition of Seniors Mental Health COVID Committee. Mental health care in long-term care during COVID-19: position paper [Internet]. 2021. Available from: https://ccsmh.ca/wp-content/uploads/2021/01/COVID-19-Mental-Health-in-LTC-Web.pdf
8. Trew M, Conn D, Rabheru K, *et al*. CAGP-CCSMH Annual Scientific Meeting Book of Abstracts: Building Resilience in Seniors' Mental Health in Canada October 25-26, 2019, Banff, Alberta. *Can Geriatr J*. 2020;23(1):88-115. doi:10.5770/cgj.23.415
9. Regional Geriatrics Program of Ontario. A competency framework for interprofessional comprehensive geriatric assessment: final report [Internet]. October 25 2017. Available from: https://rgps.on.ca/wp-content/uploads/2019/03/A-Competency-Framework.pdf
10. Provincial Geriatrics Leadership Ontario and Rehabilitative Care Alliance. Pandemic recovery planning enhancing care for older adults in Ontario [Internet]. 2021. Available from: https://rgps.on.ca/wp-content/uploads/2021/07/2021-Pandemic-Recovery-Older-Adults-Infographic-FINAL.pdf
11. Provincial Geriatrics Leadership Ontario. Engaging older adults and setting the direction of PGLO—the Older Adult and Care Partner Advisory Council [Internet]. 2022. Available from: https://rgps.on.ca/news/engaging-older-adults-and-setting-the-direction-of-pglo-the-older-adult-and-care-partner-advisory-council/
12. Provincial Geriatrics Leadership Ontario. Celebrating the leadership and resilience of Ontario's older adults [Internet]. May 23 2022. Available from: https://rgps.on.ca/news/celebrating-the-leadership-and-resilience-of-ontarios-older-adults-on-the-international-day-of-the-older-person/
13. Dozois E, Langlois M, Blanchet-Cohen N. DE 201: a practitioner's guide to developmental evaluation [Internet]. The J.W. McConnell Family Foundation and the International Institute for Child Rights and Development; 2010. Available from: https://mcconnellfoundation.ca/wp-content/uploads/2017/07/DE-201-EN.pdf
14. Ontario Health. The Alternate Level of Care (ALC) Leading Practices Guide: preventing hospitalization and extended stays for older adults [Internet]. September 2021. Available from: https://quorum.hqontario.ca/Portals/0/Indicators-and-change-ideas/ALC%20Leading%20Practices%20Guide%20v1%202021%20(2).pdf?ver=2022-03-30-133617-273
15. Virtual Care Task Group. Leveraging virtual care strategies in delivery of comprehensive geriatric assessment (CGA) [Internet]. A decision tool kit prepared by the Virtual Care Task Goup. Provincial Geriatrics Leadership Ontario. February 2021. Available from: https://rgps.on.ca/wp-content/uploads/2021/02/2021-Mar-2-Final-Report-Tool-Kit-Formatted.pdf
16. Al Hussona M, Maher M, Chan D, *et al*. The Virtual Neurologic Exam: Instructional Videos and Guidance for the COVID-19 Era. *Can J Neurolog Sci*. 2020 Sep;47(5):598–603.
17. Government of Ontario. Aging with Confidence: Ontario's Action Plan for Seniors [Internet]. November 2017. Available from: https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf

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APPENDIX A. Conference presenters

Topic	*Presenter*
Lived Experience	Anne-Marie Yaraskavitch ~ Older Adult/Care Partner Representative, Provincial Geriatrics Leadership Ontario Steering Committee
Lived Experience	Blayne Mackey ~ Caregiver
Evidence: Integrated Care for Older Adults	Kelly Kay ~ Executive Director – Provincial Geriatrics Leadership Ontario
Moderated Panel: Lessons Learned	Benoît Robert ~ Chief Medical Officer – Perley Rideau Veterans' Health Centre Lindy Kilik, Ph.D., C.Psych ~ Neuropsychologist, Seniors Mental Health (SMH) Program, Providence Care Hospital (PCH) and Queens University Dr. Jennifer Ingram ~ Founder – Medical Director & Principal Investigator – Kawartha Centre ~ Redefining Healthy Aging
Moderated Panel: What's Needed to Support this Population	Dr. John Puxty ~ Geriatrician and Chair of the Division of Geriatric Medicine, Queen's University; Director of the Centre for Studies in Aging and Health Dr. Sina Sajed ~ Family Physician & Primary Care representative, Seniors Care Network (Central East LHIN) Charissa Levy ~ Executive Director – Rehab Care Alliance Dr. Sophiya Benjamin MBBS, FRCP(C) ~ Associate Clinical Professor in the Department of Psychiatry & Behavioral Neurosciences at McMaster University
Lived Experience	Gweneth Gowanlock – Caregiver
Collaboration with Community Services Sector	James Meloche ~ CEO – Community Care Durham Dr. Mark Lachmann ~ Physician Lead, Bridgepoint Campus of Sinai Health; Geriatric Psychiatrist; Assistant Professor, Division of Geriatric Psychiatry, University of Toronto; Investigating Coroner, Province of Ontario; Medical Director, Geriatric Psychiatry, Provincial Geriatric Leadership Office
Community Paramedicine	Mathieu Grenier ~ Deputy Chief of Quality Improvement and Professional Standards – County of Renfrew Paramedic Service
GeriMed Risk	Pam Howell ~ Pharmacist – GeriMedRisk & Bruyère Continuing Care, Ottawa
GEM Fellowship	Karen Hicks ~ Advanced Practice – Peterborough Regional Health Centre
Integrated Care	Dr. Frank Molnar ~ Medical Director, Regional Geriatric Program of Eastern Ontario – Professor of Medicine, University of Ottawa Dr. Kevin Young ~ Medical Director of Integrated Care – Waypoint Centre for Mental Health Care Dr. John Puxty ~ Geriatrician and Chair of the Division of Geriatric Medicine, Queen's University; Director of the Centre for Studies in Aging and Health Sandra Easson-Bruno ~ Director, North Simcoe Muskoka, Specialized Geriatric Services Program, Waypoint Centre for Mental Health Care
Behavioural Supports Ontario	Brandi Flowers ~ Regional Manager – Geriatric Assessment and Intervention Network (GAIN) and Community Behavioral Supports Ontario Clinicians Kaitlin Loudon ~ Project Manager – Behavioural Supports Ontario Home & Community Care Support Services Central East Nancy Lesiuk RN BScN ~ Regional Lead & Manager Geriatric Outreach – Behavioral Supports Ontario – Champlain Kelly Davies ~ Psychogeriatric Resource Consultant Lanark, Leeds & Grenville, Seniors Mental Health Behavioural Support Services, Providence Care Kim Schryburt-Brown MSc, BScOT, OT Reg. (Ont.), ~ Clinical Resource Project, Consultant Seniors Mental Health Behavioural Support Services, Providence Care Community
Adult Day Programs	Sabeen Ehsan ~ Director of Quality & Planning – Seniors Care Network Natasha Poushinsky ~ Project Manager, Champlain Dementia Network Margaret Camp ~ Recreation Therapist, Brain Injury Association Peterborough Region (BIAPR) Gillian Barrie ~ Director – Clinical Services – Alzheimer Society of Durham Region Jennifer McDonnell ~Supervisor – Adult Day Program – Conant Branch Oshawa Seniors Community Centres

APPENDIX A. (Continued)

Topic	*Presenter*
Central Intake	Jane McKinnon Wilson, BSc. Human Kinetics, MSc. Human Biology ~ Waterloo Wellington Geriatric Systems Coordinator & Waterloo Wellington Older Adult Strategy Lead – Canadian Mental Health Association Waterloo Wellington Jenny Siemon ~ Director, Regional Geriatric Program – Central Regional Geriatric Program Adam Morrison ~ Director, Policy and Planning – Provincial Geriatrics Leadership Ontario AnnMarie DiMillo RN, BScN ~ Program Manager – Regional Geriatric Program of Eastern Ontario
Lived Experience	Art Seymour ~ Patient Advocate Catherine Ingram ~ Patient Care Partner Representative – Provincial Geriatrics Leadership Ontario
Evidence: Informing and Shaping Post-Recovery Planning	Kelly Kay ~ Executive Director – Provincial Geriatrics Leadership Ontario Stacey A. Hawkins ~ Director – Research & Evaluation, Seniors Care Network; Administrative Lead, Geriatric Emergency Management (GEM) Program (Central East); Adjunct Professor and PhD Student, Ontario Tech University; Interdisciplinary Fellow, Canadian Frailty Network Ronaye Gilsenan, MA – Program Evaluator, Regional Geriatric Program of Eastern Ontario Dana Corsi ~ Geriatric Rehab Lead & Interprofessional Implementation Fellow, North East Specialized Geriatric Centre
Virtual Care	Kelly McIntyre Muddle ~ Coordinator, South West Frail Senior Strategy – Specialized Geriatric Services, St. Joseph's Health Care London Melanie Briscoe ~ Clinical Manager North East Specialized Geriatric Centre, Health Sciences North Krista Dineley ~ Nurse Practitioner – Lakeridge Health – Oshawa site – GAIN Clinic Hyemi Lee ~ Nurse Practitioner – Scarborough Health Network, General Hospital – GAIN Clinic Taryn MacKenzie ~ Advanced Practice Nurse – Geriatric Medicine Clinics/Community Geriatrics – The Ottawa Hospital/Regional Geriatric Program of Eastern Ontario Dr. Shirley Chien-Chieh Huang ~ Medical Director – Geriatric Medicine Clinics
Aging at Home	Donald Drummond ~ Adjunct Professor & Stauffer-Dunning Fellow, School of Policy Studies, Queen's University Duncan Sinclair ~ Professor Emeritus, School of Policy Studies, Queen's University