GERIATRIC OUTREACH PROGRAM

What is the Geriatric Outreach Program?
The Geriatric Outreach Program provides interdisciplinary, non-urgent/non-crisis, comprehensive geriatric assessment of frail seniors with complex issues, in the senior’s home or place of residence (with the exception of long term care facilities).

The team provides recommendations toward preventing or minimizing disability and restoring seniors to their highest level of independence, and collaborates with community partners to promote continuity of care.

This service has the potential to delay institutionalization through the combination of assessment, recommendation, and follow-up activities to be performed by physician, community partners, and Outreach Team.

Referral is appropriate when an in-home assessment is needed to fully understand a client’s functional status.

Which clients are eligible for assessment?
- 65 years of age or older
- Resides within the area served by the Central West LHIN
- Referred preferably by a physician, Geriatric Emergency Management (GEM) Nurse, or nurse practitioner; however, referrals from community member agencies and clinicians, or in-patient units, supported by client’s family physician or attending physician, are welcomed.
- Has a family physician
- Has a valid OHIP card

What are the referral criteria? Clients experiencing two or more of the following:
- Recurrent falls/mobility issues
- Memory or cognitive challenges
- Multiple medication issues
- Nutritional concerns
- Difficulty managing daily activities
- Inadequate family or community supports
- Caregiver stress
- Environmental challenges
- Multiple medical problems
- Emotional coping challenges
- Behavioural disturbances
- Bladder or bowel concerns
- Suspected elder abuse/neglect
What are the exclusion criteria?
- Actively suicidal or psychotic needing crisis intervention
- Requiring immediate medical management, social or psychosocial crisis intervention, e.g., risk of eviction, crisis placement, and medical emergencies

Who are the Outreach Program team members?
Team members possess the expertise for assessment of complex, frail seniors.
- Geriatric Nurse, Social Worker, Occupational Therapist, Physiotherapist, and Geriatric Referral Coordinator
- Geriatricians and Geriatric Psychiatrist (for post-visit consultation)

What can my clients expect?
Once a referral is faxed to our office, clients or designated family members/friends can expect a timely telephone call from our Referral Coordinator to briefly review their concerns and discuss whether an Outreach visit will be beneficial for them. If your client is appropriate and agrees to a visit, usually a booking for the visit can be made during the same telephone call.

We usually request that clients have a trusted friend or family member with them during the visit. Visiting team members will usually discuss recommendations with the client at the initial or follow-up visit.

Recommendations may include linkages to community partners such as the CCAC, home support agencies, and transportation assistance, for ongoing services and support.

Clients and their families can expect a clear, transparent communication process and a holistic, comprehensive assessment of the senior in their home or place of residence. Recommendations will be made to modify identified risk factors.

What can I expect when I refer clients to the Outreach Program?
- Initial confirmation of receipt of referral which is available for download through the William Osler public website
- Final team report, summarizing assessment findings and recommendations
- Linkage with other community agencies where appropriate

Is there an additional cost for my clients?
No. This service is covered by OHIP.

If you have clients to refer or questions about the Program, please contact us.

The Geriatric Outreach Program for William Osler Health System located at

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