Table 2: Summary of ideas and comments submitted by HCOE members

1. Processes of care (19 responses before editing):

#	Response
1.	Make home visits to frail patients a core practice by providing Home-Based Primary Care.
2.	We have a pharmacist service to assess meds of elderly patients. They have also reminded us to do appropriate blood tests and to stop unnecessary meds.
3.	15-20 minute appointments for seniors.
4.	Every elderly patient with polypharmacy is advised to use blister packs and constant communication with the pharmacy is key to avoiding interaction or side-effects.
5.	I have been seeing seniors at my clinic for many years and over the passage of time have evolved the following strategies: 1. Good back support custom made benches for seniors so that they can sit comfortably. 2. *Sage Seniors* directory (listing of community resources) for their ready reference. 3. Priority booking for my seniors, they are squeezed in no matter how busy the schedule. I have dedicated 6 spots per day for them only. 4. I refill only their meds for 6 months to save them a trip to the clinic. 5. Seniors get polypharmacy reviews once a year with my clinical pharmacist. 6. Seniors will soon be getting fall risk assessment at my clinic as an added service.
6.	Participation au plan Alzheimer (Bergman) du Québec. Surtout s'adapter aux troubles cognitifs
7.	Staff to remind them of appointment in the morning of the scheduled appointment.
8.	We have our own Aging at Home team: RN/ Administrator-specific for team/ clinical pharmacist and OT with dedicated time for AAH assessments. • Two physicians on team: 1. GP with senior focus practice 2. Geriatrician This FHT also has chiropodist and dietitian who will consult and do home visits as necessary. We use: MOCA/MMSE/Kingston/Frontal lobe battery/PHQ2/PHQ9/Verbal Reasoning/ Trails A & B/ ADL/IADL/ FAQ(funct activities quest)/orthostatic BP ax/Up and Go test We are also training RN to be dementia educator.

9.	La très grande majorité de mes ainés reçoivent des piluliers. J'enseigne, ce qui aide beaucoup à me tenir à jour.
10.	Referral for Geriatrics assessment program to maximise benefits
11.	Home visits in collaboration with CCAC - avoids duplication and allows just in time change in services: review goals of care/discussion of advance care planning for all frail seniors /document and obtain copy of POA documents and contact information. Involve allied health for home safety assessments.
12.	
13.	Always have all sizes of BP cuffs handy. Do a standing BP if any sign of frailty, to prevent iatrogenic falls. (If there's no evidence for this, we need a study - I have made many elders feel stronger and more functional doing this.)
14.	Offer telehealth visits with patients, families, and caregivers

2. Emotional and behavioural environment (19 responses):

#	Response
1.	My elderly patients have been told to phone when they need anything/ appointment and that they will be seen SAME or NEXT DAY. My day soon gets half filled with appointments which I mostly fit in the pm because I usually see my frail elderly pts in their homes. If I don't receive calls for appointments, my mornings are usually spent reviewing reports and hospital discharges and ER visit reports and then I initiate the home visits for the pm for follow ups on the pts who have issues to follow. If I am away, I am available for my staff by text messages. Any time a pt calls when I am out of town, my nurse practitioner colleague sees them in their home. She contacts me if she needs advice about medications. Routine 3 monthly bloodwork is the responsibility of my receptionist / assistant: she keeps a list of pts who need chronic disease management and she calls them to remind them of their blood work requisition. This is followed up by a visit the following week.
2.	Plan and allow more time with them e.g.at end of day or just book more time in the schedule to allow time to communicate.
3.	Advance Care planning completed with every patient and including Substitute Decision-Makers, organ donation permission, and Next of Kin contact information.
4.	Nurses assist the elderly patients with reviewing their list of medications, their glucometer usage, and their social history. We usually ask that they come with a companion friend or family member so to help with history taking and explanations given to patients.
5.	I find my staff is very polite anyways but with seniors we do go the extra mile to make them feel comfortable.

6.	Palliative care is a big part of my practice since the average age of my pts is 88-92 yrs. These people actually DO NOT like the hospital environment (they fear going to hospital even for minor procedures or blood tests as they may have vision issues, hearing difficulties as well as mobility and driving issues). Therefore, anything that can be done at home for them is welcomed with gratitude. They also often need their FP to explain to them what the specialist told them about their health and prognosis; they need repetition and clarification and reassurance again and again.
7.	Tenter de mieux former le personnel d'accueil et de faire mieux que les boîtes vocales. Toujours, si permission de l'aîné, avoir numéro d'une autre personne pour confirmer les rdv. Mieux former via une infirmière régionale du plan Alzheimer toutes les infirmières et les md aux difficultés cognitives et au REPÉRAGe des pertes d'autonomie en première ligne.
8.	Suggest family member accompany them
9.	Our office is open, warm space. Seating has arms for mobility. RN always inquires if they need glasses or if they are able to hear well enough to ask to repeat (get hearing assistive device) when testing.
10.	I do home visits. It's amazing what I find and what I learn! I give my cell to all patients over 80 (don't promise immediate response but I try) if they have urgent issues outside office hours. Seniors are the only patients I do phone med refills for and review periodically with pharmacist to ensure all meds are taken properly. I try to ask for POA and end of life plans while they are healthy.
11.	Numéro de pharmacie sur la première page du dossier... Liste de problèmes et liste de médicaments à jour et au devant du dossier. Prévoir au moins 30 minutes par patient. Laisser parler le patient même si c'est long, gérer le besoin de s'exprimer des aidants naturels et du patient, faire du "rôle modeling" au besoin sur la façon de parler avec un patient en perte cognitive. (Par exemple, ne pas l'interrompre à tout moment pour l'orienter ou corriger l'inexactitude de ses propos...
12.	I think at an age where MCI or dementia is likely, say 70 or 75, it is essential to have a younger contact person's name and number on the chart. As a locum, I work at many places that don't have this information, so it is difficult to talk to someone else about the patient's cognition. Very awkward.
13.	Large text prescription pads
14.	Large business card on a 5 x 7 card stock – clients and families often put on door of fridge – phone number easy to read and lists names of interprofessional team members and disciplines on the back
15.	Facilitate leaving a message if need be with uncomplicated answering services
16.	Offer adaptive phones for the hearing impaired or online booking processes

17.	Kindness goes a long way. Extra time. Think about disabled parking for patient and family member – be proactive.
18.	Basic- avoid paternalistic attitude.
19.	Intake form asks for contact info, if over sixty someone a generation younger, and I tell them I want to still be their doctor in 20 years so I need someone to call if I suspect they've developed some dementia. The intake form specifically asks if it's okay to give health information that most wouldn't consider private (not STD's etc) and most say yes. Of course, when they lose their wits it becomes null and void if they say no. I also add ADLs and IADL's to the intake, and will probably update annually for things like that. I'm used to housecalls where such issues become immediately apparent, so always try to make sure the office doesn't become a place to hide important problems.

3. Senior-friendly physical environments (20 responses):

#	Response
1.	Changing from fluorescent to nonfluorescent lights can be more relaxing for all. Home-like items such as flowers. Pets can be of help.
2.	A pillow on the examining table. Chair next to BP machine (in my office anyway... people can't always get up on the table).
3.	Wheel Chair accessible rooms. Change-elevation exam bed. Sit-on Weigh scale.
4.	There are no stairs needed to reach the office. The doors of the clinic are larger so to accommodate wheel-chairs. All exam tables have rubberized footsteps.
5.	We have high benches and stools in exam rooms, myself and my nurses are there if need be to help them on or off the exam table and help them get dressed as well.
6.	Stool with a handle and a high-low barrier free bed. Automatic door openers, call bell in the washroom.
7.	Pas d'escaliers Salle d'attente adaptée RDV plus long “Pocket talker” (assistive listening device) Table d'examen qui se baisse et se lève Loupe
8.	I bought an exam table with hydrolic lift. It’s a massage therapy table which costs a fraction of what the medical- exam tables cost, and work just as well.
9.	Adjustable exam beds. Ramp access.

10.	Office is open space with Zen colors. Seats have arms for mobility. There is one procedure room with a bed that moves up and down.
11.	Table hydraulique (indispensable!)Oreiller (Pour corriger les cyphoses dorsales, pour avoir leur tête bien appuyée.) Balance avec une barre d'appui d'un côté et un comptoir de l'autre. 3 chaises (Le patient et le... ou le couple d'aidants naturels. De l'espace pour en tasser une lorsqu'il y a fauteuil roulant. Place pour l'ambulateur et la canne. Éclairage adéquat, au dessus de la table d'examen et au dessus du bureau. Aide à l'audition. Papier pour écrire lorsque malentendants, et pour dessiner des explications. Langue à long et à court manche pour remettre les chaussures après les examens. Miroir pour voir derrière les jambes sans les faire tourner. (Plaies, lésions...)
12.	One large room instead of many small. I get the patient from the waiting room, so immediately know their Get Up and Go which is almost as informative as a house call. The room is big enough for wheelchairs, walkers, families.
13.	Older patients need help checking in.;NO electronic devices to check in without assistance (due to sight, tremor and co-ordination issues) We have a "concierge," an older gentleman, who helps with checking in. Bathroom with support railings.
14.	Ensure there is de-icing in winter.
15.	Space for family, wheelchair, walkers etc. in the exam room, Handheld sphygnanomometer so I don't have to put my head in their lap and crane my neck into an unnatural position to see the numbers over by the exam table and can and even then sometimes can't because then my bifocals aren't matched up on my eyes. I put frailty and whatever else is needed on my problem list so specialists don't overmedicalize them

4. Organizational support for senior-friendly initiatives (e.g., your group practice, your local health authority) (16 responses):

#	Response
1.	Need to discuss more at our clinic and be more intentional in being Senior Friendly.
2.	We work in a group practice with an internist, a nutritionist and psychologist. We also refer to the geriatric department of the Jewish General Hospital each time we have a new case of fast progressing dementia.
3.	I have been working at supportive living sites since the last 6 years and I find that location is a great tool to help my seniors patients because I have a lot of resources through OT, PT and client care services in general.
4.	Plan Alzheimer du Québec.

5.	Geriatric team visits the nursing homes and elderly homes for support.
6.	CCAC Public Health Day Programmes
7.	For 5/7 years our clinic has held a party at local senior hall on our off day. - local Highland dancers, music, singers - physicians supplied money for light snacks and drinks - local retirement homes supplied trays of food - we made goody bags for each person take home- supplies donated by local companies and vendors, i.e., Ensure - local companies and pharmacies approached and often provided raffle prizes which was huge success - local *SNAP* paper took pictures Goal: promote socialization, community support.
8.	Aide de l'infirmière en place, aide du CLSC. Au besoin, appel à la Curatelle publique. Aide très précieuse des pharmaciens du territoire. Mon "Up to date" sur mon iPhone... Aide de la direction générale pour discuter avec les familles au besoin. Demandes de relocalisation assez tôt dans l'évolution pour éviter les transferts et multiples transits d'hébergement, mais pas trop tôt, pour qu'ils bénéficient le plus longtemps possible de leur environnement naturel. Il faut prévoir environ 1 an pour obtenir un hébergement en RI ou en CHSLD. Utilisation du centre de jour.
9.	We also need more physician involvement in home nursing, or at least the expectation of communication with home services.
10.	Give a prescription and an instruction sheet at the same time.
11.	Pharmacist: home delivery of meds. Aware of senior support in the community and provide information re: those services to patient and caregivers.
12.	collaboration with CCAC to have case manager embedded in home visiting primary care team

5. Ethics in care and research (8 responses):

#	Response
1.	I am currently working on evaluating need for osteoporosis medication in seniors and the decrease in fragility fractures at one site. I am collecting data and trying to streamline my approach to be more conducive to my patients, rather than following guidelines only.
2.	Plan Alzheimer du Québec.
3.	We respect patients values and interests and look out for their welfare. Goal: to maximize benefits and to avoid harm.

	Respect uniqueness. Respect diversity. Promote dignity. Thank you.
4.	Oeil attentif sur les aidants naturels et discussions pour éviter l'épuisement de ces personnes. Utilisation pour eux aussi du CLSC et des ressources communautaires. Ceci, même en CHSLD. Il y a encore des aidants naturels qui s'épuisent si on n'est pas attentifs. (Et même si on essaie de l'être) Implication des familles non seulement lors des entrevues, mais en CHSLD, pour tous les événements et décidions concernait leur proche.
5.	Demand proof of every change in models of care, especially the ones that come from the States, where bureaucrats have taken over healthcare with no proof of benefit.