TORONTO WESTERN HOSPITAL GERIATRICS ROTATION GUIDE

WELCOME TO OUR GERIATRICS ROTATION!

Block 5 – October 19 to November 15, 2015

Dear Medical Students, Residents, and Fellows,

We would like to take this opportunity to welcome you to the Geriatric Medicine rotation at the Sinai Health System (SHS) and the University Health Network (UHN) Hospitals. We hope you enjoy your time with us.

This detailed orientation manual has been prepared to help you understand how the rotation and clinical services are structured and how to get the most out of this learning experience. The guide starts by outlining the philosophy and components of geriatric assessments. It then provides a detailed orientation to the various elements of our multi-site and multi-component rotation that you will be exposed to including the Interprofessional Inpatient Consult Service, our Outpatient Clinics and Community Programs.

Accompanying this document are your detailed rotation schedules that have been personalized for you. If you see any conflicts or need to make any changes, please contact Libby Mendonca at extension 17-6641 or LMendonca@mtsinai.on.ca. Mount Sinai Hospital (MSH) Family Medicine residents will have received their personalized schedule and orientation materials from Ms. Paula Da Rocha.

Furthermore, we have also enclosed essential articles and other documents in your orientation package that should help facilitate your learning on this rotation.

Your rotation schedules and orientation materials mentioned above are located on our website for easy access at http://www.mountsinai.on.ca/education/geriatrics/resident-resources-and-schedules.

We are always looking to improve this rotation and so we always welcome any comments or feedback you could provide.

Welcome once again and enjoy your geriatrics rotation!

Yours Sincerely,

Dr. Vicky Chau, MD, MScCH, FRCPC
Geriatrics Education Coordinator
Sinai Health System & University Health Network

Dr. Samir K. Sinha, MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System & University Health Network

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## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Contacts</th>
<th>Office:</th>
<th>Pager:</th>
<th>Home/Cell:</th>
</tr>
</thead>
<tbody>
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THE UNDERLYING PHILOSOPHY OF GERIATRICS ASSESSMENTS

Although there is a list of learning objectives for this rotation, our ultimate goal is to provide you with an opportunity to learn how to perform Comprehensive Geriatric Assessments (CGAs).

The CGA can be defined as “a multidisciplinary diagnostic process intended to determine a frail elderly person’s medical, psychosocial, and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up” (Rubenstein, 1982).

In other words, one of the most important goals of a Geriatrician is to identify a frail older person’s abilities and those diseases/illnesses that limit their abilities. We then make recommendations related to the delivery of a person’s health and social care and identify any rehabilitation goals that might minimize limitations and maximize a person’s abilities and overall quality of life.

During this rotation at the Mount Sinai and University Health Network Hospitals, you will gain experience in conducting CGAs with the support of an interprofessional team amongst older patients in a variety of inpatient, outpatient, and home-based settings.
COMPONENTS OF A COMPREHENSIVE GERIATRICS ASSESSMENT

When requested to see an older patient in consultation, Geriatricians always look beyond the admitting diagnosis to complete a broader assessment that also encompasses the full medical, psychosocial, and functional capabilities and limitations of the individual in order to develop an overall plan for treatment and long-term follow-up that supports the work of their primary care providers during a hospital admission or within the context of their community living situations.

While an inpatient medical team may rightfully focus around the main admitting diagnosis – e.g. pneumonia – the Geriatrician looks to address other potential geriatric syndromes that may complicate an admission or preclude a durable return to the community. Oftentimes, this will require additional collateral information from caregivers and/or health care professionals. The issues we often focus on in our assessments include amongst other things:

1. **Problems Common to Older Adults** *(Delirium/Dementia; Falls; Polypharmacy; Incontinence; Weight Loss, Acute/Chronic Pain, Failure to Thrive, etc.)*
2. **A Recent Decline in Functional Abilities or Mobility Issues**
3. **Diagnostic/Treatment Challenges**
4. **Complex Social Issues** *(Caregiver Burnout, Elder Abuse etc.)*
5. **Goals of Care and/or Disposition Planning** *(includes assessment and referrals to Outpatient Clinics and Home-Based Services, such as the House Calls Program)*

There are many ways to organize a CGA. The following framework is one way to organize and document your assessments. Please see the resident resource website for a CGA template.

1. **Patient Identification and Reason for Consultation**
2. **Past Medical History**
3. **Chief Complaint and History of Presenting Illness** *(includes brief summary of admission and hospital course)*
4. **Medication History** *(includes allergies, prescription & non prescription medications e.g. sleeping aids, vitamins and supplements)*
5. **Functional History** *(includes basic and instrumental activities of daily living)*
6. **Social History** *(includes current living situation, family and community supports, previous occupation and level of education, advance care directives, powers of attorney, and general financial situation, and recreational drugs e.g. alcohol and addictive agents)*
7. **Geriatric Review of Systems** *(includes functional review of cognition, mood, vision/hearing, falls, nutrition, bowel & bladder incontinence, pain, and sleep)*
8. **Cognitive Assessment** *(includes screening for Dementia, e.g. MMSE, MOCA and RUDAS; Depression, e.g. Geriatric Depression Scale; Delirium, e.g. Confusion Assessment Method where appropriate)*
9. **Physical Examination** *(includes orthostatic vitals and gait assessment along where appropriate)*
10. **Relevant Laboratory and Diagnostic Information**
11. **Impression and Plan** *(includes brief summary, impression, and usually no more than 5 recommendations)*

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SHS & UHN GERIATRIC MEDICINE PROGRAM

The SHS and UHN Geriatric Medicine program provides a comprehensive set of services for older adults across the inpatient, outpatient and community settings. However, learners spend most of their time on the inpatient geriatrics consultation service. There are three inpatient consultation services located on University Avenue, Toronto Western Hospital (TWH), and Toronto Rehabilitation Institute (TRI), respectively. Your primary learning experience takes place on the TWH inpatient geriatric medicine consultation service, based at TWH, 8 East Wing, Room 410.

This experience will be complemented by other clinical activities (e.g. ambulatory clinics), multidisciplinary rounds, and teaching opportunities to help you become accustomed to geriatrics and the various services available to older adults. Thus, it is important to review your personalized rotation (and if applicable, day-time on-call) schedule accompanied with this package on a daily basis. If you see any conflicts or need to make any changes, please contact Ms. Libby Mendonca at extension 17-6641 or via lmendonca@mtsinai.on.ca.

TORONTO WESTERN HOSPITAL INPATIENT GERIATRIC CONSULTATION SERVICE

The TWH Geriatric Consultation service is known as the Mobile Acute Care for Elders (MACE) Team. It is an interdisciplinary team comprised of a Social Worker (Helen Levin), Nurse Practitioners (Sandra Tully and Petal Samuel), Physiotherapy (Nadia Ianetta and Kyle Rhuttan), Occupational Therapy (Oriana Medeiros), and the Geriatrician (You!).

Day Time On-Call Schedule

Residents are assigned to the Day Time On-Call Schedule to receive consultation requests between 8am to 5pm from Monday to Friday, while the Staff Geriatrician and the Geriatric Medicine Fellow handle consults and calls after 5pm on weekdays and during weekends. You may be the On-Call Resident during clinic. If there are significant conflicts, please contact Ms. Libby Mendonca at extension 17-6641 or via lmendonca@mtsinai.on.ca.

Consultation Requests

New referrals can be received through a number of mechanisms. See Figure 1.

Figure 1. Consultation Requests

Direct Requests

As the On-Call Resident, you may receive direct requests traditionally through your On-Call Pager from medical and surgical specialties.

Commonly, the admitting team requests interprofessional expertise (e.g. Social Worker, Occupational and Physical therapy), as these health professionals are seen as advanced practice leads in Geriatrics. In these
instances, the On-Call Resident notifies the appropriate allied team member and completes a comprehensive geriatrics assessment.

**Automatic Requests**

**Orthogeriatric Hip Fracture Service**

Geriatrics sees all patients aged 65 years and over with hip fractures. These include those who have suffered fragility (low-trauma) fractures, and not peri-prosthetic or pathological fractures unless specifically requested. We take a proactive approach, as patients with hip fractures are at high risk for complications, such as delirium, and often have other undiagnosed or untreated issues like dementia and osteoporosis.

Generally, the Staff Geriatrician receives an automatic e-mail notification of new hip fracture referrals. The Geriatrician will then notify the On-Call Resident and Geriatrics team of the consultation request.

Patients with hip fractures are co-managed by Orthopaedics, the Orthopaedic Nurse Practitioners (Natasha), and Geriatrics. Occasionally, the Medical Consults team may be involved for medically complex issues to provide after hours supports. Overall, Geriatrics typically focus on geriatric-related issues, and the Hospitalist and/or Medical Consults team focus on medical-related issues. See Table 1.

**Table 1. Geriatrics vs. Hospitalist/Medical Consult Roles**

<table>
<thead>
<tr>
<th>Geriatrics</th>
<th>Hospitalist and/or Medical Consults</th>
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<tbody>
<tr>
<td>Cognition (e.g. Delirium, Dementia, Depression)</td>
<td>Perioperative Risk Assessment &amp; Optimization</td>
</tr>
<tr>
<td>Falls &amp; Bone Health</td>
<td>Medical management</td>
</tr>
<tr>
<td>Pain, Nausea, Constipation</td>
<td>o Cardiorespiratory issues (e.g. Afib)</td>
</tr>
<tr>
<td>Medication Rationalization</td>
<td>o Anticoagulation</td>
</tr>
<tr>
<td>Disposition Planning</td>
<td>o Glucose &amp; Electrolyte abnormalities</td>
</tr>
<tr>
<td></td>
<td>o Acute kidney injury</td>
</tr>
</tbody>
</table>

Please refer to the “Hip Fracture” primer and/or template assessment form for further details to help focus your consult.

**Other Requests**

**MACE Team**

Occasionally, the admitting team requests interprofessional expertise by directly requesting assistance from the allied health professional (as opposed to the On-Call Resident). In these instances, the allied health team member may request the On-Call Resident to verify a potential consult from the admitting team; and/or the team member asks the admitting team to consult the MACE service.

If there are any questions about the appropriateness of the consult, please speak with the consult staff geriatrician before communicating further with the referring service.

**Inpatient Geriatric Psychiatry Consultation Service**

To request a Geriatric Psychiatry consultation (Dr. Monica Scalco), residents directly call the General Psychiatry Consult Liaison Service at (416) 603-5847. A message is left containing the patient’s name and MRN, ward, referring MD, reason for referral, brief history, and the urgency of the consultation (‘urgent’, ‘today’, ‘can wait until tomorrow’).

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CONSULTATION LOGISTICS

Figure 3. Consultation Process

E-Mail Notification of New Referrals

Because we work in a collaborative interprofessional team, all new referrals are notified in person and via the TWH group e-mail notification. By now, you have received an e-mail asking you to save the group e-mail notification for TWH. In the e-mail notification, minimal identifiers are used, including initials, MRN, location, reason for referral and any geriatric issues identified.

Consultation – Review – Follow Up

When a consult is requested, each patient receives a CGA and is screened by the rest of the MACE interprofessional team. This ensures you receive appropriate allied health support for your overall assessment. Allied health members further supports their colleagues by becoming the main social worker, or therapist working with the patient during an admission and allows the older patient to receive the specialized care that they may require. Please note, geriatric allied health professionals do not become involved in Orthogeriatrics patients unless otherwise requested.

For CGAs, we use the blank yellow consultation notes to document our initial assessment and recommendations. Please see the resident resource website for a CGA template for guidance. Your consultation notes should always be stamped and/or labelled. It should also record the consultation date, and start and stop times of your assessment for accurate medical documentation.

Reviewed and completed consultation notes are left in the patient chart. Additionally, we remove all carbon copies of the consultation and file the stapled consultation note in temporal order in red binder located in the Geriatrics Resident Office. This carbon copy ensures that the patient is seen and provides information to the inpatient consult team when needed. If the CGA template is used, please ensure that you photocopy your consult note and file it in the same manner described.

All geriatric medicine consults are typically completed and reviewed within 24 hours of receiving the consultation at a mutually convenient time between the Staff Geriatrician and the trainee. If the trainee is unable to see an urgent consult (e.g. acute delirium), the trainee should speak directly with the attending geriatrician to determine the appropriate next step.

Trainees follow the patients that they have seen throughout their hospital stay to provide continuity. Occasionally, you may pick up and/or a follow up a patient that you have not seen previously. Every time you assess your follow up patients, a progress note is written. Patients should be seen a minimum of twice a week (usually before consult rounds) or more frequently as the situation requires.

Consult Recommendations

All consultation recommendations are communicated with the referring service. We write “Geriatric Suggest” recommendations in the order sheet AND call the referring service. If the referring service is agreeable to our recommendations, we ask to input our orders directly into EPR. In the order sheet, we also note that our recommendations were agreed to by the referring service and entered into EPR. This provides education to the referring service, and helps avoids medical errors and delays in patient care.

For the orthogeriatrics hip fracture service patients, geriatric recommendations can be communicated to the
Orthopaedic Nurse Practitioner during the day and the Orthopaedic resident after 17:00.

**Sign Out Lists**

All TWH patients – new and follow up – are manually added and updated on the TWH Sign Out List. You are responsible for entering your patient’s information, the management plan, and any follow up issues identified. Please ensure that the Geriatric Medicine Consult Service Sign Out Lists are kept up to date on a daily basis. This ensures that issues are followed appropriately when trainees are away.

The TWH Sign Out List is accessible through EPR. On the top menu, click the drop down menu under “Patient Care Tools,” “Sign-Out Tool,” and then “Geriiatrics.”

Commonly, MACE allied health team members continue to follow patients after geriatric issues have been addressed. In these instances, you will sign off medically in the progress notes. The MACE team is also notified in person, and trainee indicates that Geri-Med has “xx Signed Off xx” in the sign out list. Once all team members have verified they have signed off, the patient is then “discharged” from the sign out list.

**MACE ROUNDS & EDUCATIONAL OPPORTUNITIES**

Multidisciplinary rounds occur during the week to ensure open communication about patient care related issues. See Table 2.

**Table 2. MACE Rounds**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
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<tbody>
<tr>
<td>Monday</td>
<td>11:00am – MACE Rounds</td>
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<tr>
<td>Tuesday</td>
<td></td>
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<tr>
<td>Wednesday</td>
<td>10:00am – MACE Rounds</td>
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<tr>
<td>Thursday</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>10:00am – MACE Rounds</td>
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</tbody>
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* MACE Rounds – 8 Fell, Conference Room

Consult and ward rounds are focused on patient-centred teaching. Additionally, there are opportunities for formal education while on this rotation. See Table 3.

**Table 3. Educational Opportunities**

<table>
<thead>
<tr>
<th></th>
<th><strong>Educational Seminars &amp; Rounds</strong></th>
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<tbody>
<tr>
<td><strong>Geriatric</strong></td>
<td><strong>MSH</strong></td>
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<tr>
<td></td>
<td>Geriatric Giants Seminar – Thursdays</td>
</tr>
<tr>
<td></td>
<td>Geriatric Psychiatry (Optional) – 1st Thursday</td>
</tr>
<tr>
<td></td>
<td>Geriatric Medicine Journal Club – Last Friday</td>
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<td></td>
<td>Allied Health Seminars – Monthly</td>
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<tr>
<td></td>
<td>Polypharmacy</td>
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<tr>
<td></td>
<td>Gait aids</td>
</tr>
<tr>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td><strong>GIM</strong></td>
<td>GIM Rounds – Daily</td>
</tr>
<tr>
<td></td>
<td>Medical Grand Rounds – Wednesdays</td>
</tr>
<tr>
<td></td>
<td>Osteoporosis Rounds – Thursdays</td>
</tr>
<tr>
<td><strong>Medical Consults Teaching</strong></td>
<td>Harvey Simulator Teaching Rounds – Mondays</td>
</tr>
<tr>
<td>(Orthopedic Residents Only)</td>
<td>Medical Consults Evidence-Based Medicine Rounds – Tuesdays</td>
</tr>
<tr>
<td></td>
<td>Medical Consults Staff Teaching Rounds – Wednesdays</td>
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</table>

Your package also includes a selection of review articles on the common topics in geriatric medicine. Please visit [http://www.mountsinai.on.ca/education/geriatrics/resident-resources-and-schedules](http://www.mountsinai.on.ca/education/geriatrics/resident-resources-and-schedules) for further
resources. If you are interested in additional formal teaching, please speak with your attending.

**OTHER ROTATION LOGISTICS**

**TWH Geriatrics Residents’ Office**

The TWH Geriatrics Residents’ Office is located on 8 East Wing, Room 410. The door lock code is **2341**. This is your workspace, which has been equipped with one networked computer and a phone. Trainees may also leave their belongings while seeing patients. **Please keep this space neat and tidy; and ensure the door is locked behind you if you are the last one to leave the office at any time.**

**Orthogeriatrics Residents**

Orthogeriatrics residents spend two weeks on the inpatient Hospitalist service focusing on perioperative assessment and management of geriatric orthopedic patients; and two weeks on the Geriatric Medicine service focusing on geriatric assessment and management of surgical patients. This experience is complemented by the TRI Falls Prevention Clinic and/or the Geriatric Day Hospital Program (see below). The Staff Hospitalist provides orientation to the Hospitalist service on the first day of the rotation.

**Physiatry Residents**

Physiatry residents spend two weeks at the SHS inpatient geriatrics consultation service to gain exposure to acute geriatric care. The resident then spends 6 weeks on the inpatient geriatrics consultation service in the rehabilitative setting with a large proportion of their time spent on the Geriatric Rehabilitation Unit. This experience is supplemented with additional ambulatory care, rehabilitative programs, and community experiences. The TRI Staff Geriatrician provides orientation to the TRI service when the resident begins their TRI post acute care experience.

**Weekend Call**

Orthopedic and Physiatry residents participate in 1 weekend home-call shift (Friday 17:00 until Monday 08:00) throughout their rotation, which provides coverage for both the SHS and UHN Hospitals. The Weekend On-Call Resident’s main contact is the Weekend On-Call Staff Geriatrician, so the resident is responsible for contacting the Staff Geriatrician on call and exchanging contact information prior to their weekend shift.

Residents are usually on-call with a PGY4 or PGY5 Geriatric Medicine resident (who covers city-wide call) and the Staff Geriatrician. Geriatric Medicine residents are first call to new consultation requests and patient care issues. Additionally, the Staff Geriatrician is usually first to receive weekend notifications of new hip fracture patients at SHS and TWH. The Staff Geriatrician will notify residents of new hip and/or surgical consults that will be seen and reviewed over the weekend.
There are various outpatient and community services available to the older adult population at the SHS and UHN. See Figure 4. During your geriatrics rotation, each trainee receives as many clinic experiences as possible to complement their inpatient experience.

**Figure 4. SHS & UHN Geriatric Ambulatory Clinics**

If you are scheduled for clinic, please arrive on time as patients have been scheduled for you in advance. If you are unable to attend clinic, please notify the attending staff. Please also ensure you obtain a SHS and/or UHN dictation code at the beginning of your rotation.

**Table 4. General Clinic Locations & Contact Information**

<table>
<thead>
<tr>
<th>Location</th>
<th>Contact</th>
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<tbody>
<tr>
<td>SHS (Drs. Goldlist, Ng, Sinha)</td>
<td>Ng/Sinha: Fourth floor, Room 457</td>
</tr>
<tr>
<td></td>
<td>Goldlist: Desk across Room 463</td>
</tr>
<tr>
<td></td>
<td>Stephanie Silva (416) 586-4800 x8563</td>
</tr>
<tr>
<td></td>
<td>Libby Mendonca (416) 586-4800 x6641</td>
</tr>
<tr>
<td>TWH (Drs. Berger, Goldlist, Liberman)</td>
<td>West Wing, Fifth floor</td>
</tr>
<tr>
<td>TRI (Drs. Alibhai, Berger, Chau, Liberman)</td>
<td>Ground floor, Outpatient Clinic Area</td>
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<tr>
<td></td>
<td>UC Outpatient Clinic Administration (416) 597-3422 x4200</td>
</tr>
</tbody>
</table>

**Geriatric Medicine Clinics**

At the Geriatric Medicine Clinic, trainees have an opportunity to complete a comprehensive geriatric assessment (75-90 minutes) in the ambulatory environment. Patients are seen for a variety of reasons but these are often similar to the inpatient consult service; however, patient acuity is of lesser intensity. One or two new patients will be booked for you to see. You may also spend 30-45 minutes each with one or more follow-up patients.

Geriatric Medicine Clinics are also multidisciplinary. At SHS, a Geriatric Pharmacist (Christopher Fan-Lun) supports the clinic. The Pharmacist initially reviews a new patient’s medication(s) and helps prepare a take home medication list for the patient at the end of the visit. During this time, the trainee can review the new patients medical records that were supplied in advance prior to their assessment. The Geriatrics Social Worker (Carmelina Marzialiano) and/or Geriatrics Physiotherapist (Natasha Bhesania) is also available for additional support and can be paged to assist you at the current and/or follow up visit. At TRI, a Geriatric Nurse (Ramona Gheorghe) and Geriatric Social Worker (Katie Stock) are available for additional support and can be located in the “Fish Bowl” area of the outpatient clinic.
**Memory Clinic**

The UHN Memory Clinic is a collaborative, multi-disciplinary clinic where patients with memory complaints are assessed by geriatric medicine, geriatric psychiatry, and behavioural neurology within an interprofessional team. Overall, three new patients are assessed in clinic. You will complete a medical assessment for one patient; and observe a detailed cognitive assessment and neurological (including mental status) examination. This is followed by a multidisciplinary case conference. Further details will be provided on the first day of clinic at **13:00h sharp**. Please refer to your Orientation Package for a more detailed introduction to the Memory Clinic.

**Falls Prevention Clinic**

The UHN Falls Prevention Clinic is a collaborative, multi-disciplinary clinic where older patients with one or more falls in the past year (or who are at high risk of falling) are assessed by geriatric medicine, nursing, and physiotherapy. The multidisciplinary team determines if the patient is an appropriate candidate for the 12-Week Falls Prevention Program that is run weekly by nursing and PT. Four new patients are assessed at each clinic. You will assess two new patients in clinic and learn how to take a focused falls history and relevant physical examination. Clinic orientation will be provided at **13:00h** sharp when you arrive to clinic. Please refer to your Orientation Package for a more detailed introduction to the Falls Clinic.

**Geriatric Day Hospital Clinic**

The UHN Geriatric Day Hospital (GDH) is a collaborative multidisciplinary clinic comprised of interprofessional members (including RN, OT, PT, SLP, SW, and Recreational therapy) and a Geriatrician. This interdisciplinary team assesses frail older patients with cognitive, functional, and psychosocial issues and determines if the patient is appropriate for the 12-Week GDH Outpatient Rehabilitation Program. The Outpatient Rehabilitation Program occurs twice a week for rehabilitation (e.g. group physiotherapy for falls prevention) with ongoing geriatric follow up. One to two new patients are typically assessed at each clinic.