

Integrating Geriatric Teams in Primary Care: Transforming Aging Care Through Collaborative Models in Ontario

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TABLE 1.
Primary Care Integrated Geriatric Team models in Ontario

Model name, region and host	Characteristics
<p>GPS East region (South East) Program host: LFHT</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Older adults living with frailty, direct referral to SGS by primary care <p>Team composition and full-time equivalents (FTEs)</p> <ul style="list-style-type: none"> COE physician, one half-day per month Funding for the COE physician is provided through an alternate funding plan, with support from Queen's University as a member of the Division of Geriatric Medicine GPS utilizes in-kind support from LFHT's multidisciplinary team and existing programs (e.g., a multispecialty, interprofessional team or MINT memory clinic and an embedded home care coordinator) <p>Core activities</p> <ul style="list-style-type: none"> In-person CGA by COE physician, primarily consultative in nature, with recommendations provided to the primary care team, and follow-up support as needed Virtual rounds occur monthly and enable the interdisciplinary team, including the COE physician, LFHT occupational therapist, embedded home care coordinator and community partners (including the Alzheimer Society, community paramedics and others) to provide recommendations and resource navigation to family physicians caring for older adults living with frailty LFHT supports the program with access to the EMR, physical space, patient booking (first-come-first-serve, with triage for urgent assessments as needed), appointment reminders and day-of-visit support (i.e., clinic nurse to collect vital signs) <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> Greater support to primary care with detailed recommendations for family physicians Expanded existing capacity within the primary care team with learning sessions on topics such as driving assessment <p>Integration features</p> <ul style="list-style-type: none"> Direct access, as needed, to specialized seniors' rehabilitation services at Providence Care Hospital Ongoing support is available via telephone or e-consult through direct message within the EMR

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<p>SOS East region (Champlain) Program host: Centretown CHC</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Older adults who face barriers, including social determinants of health and medical complexity, are referred by CHC programs, the community and local hospitals <p>Team composition and FTEs</p> <ul style="list-style-type: none"> 2.1 FTE Registered Nurses (RNs), 1.0 FTE community health worker, 1.6 FTE Nurse Practitioners (NPs), 0.1 FTE primary care physician <p>Core activities</p> <ul style="list-style-type: none"> Home visits, appointment accompaniment, CGA, chronic disease monitoring, case management, advocacy, social prescribing and system navigation Providing health teaching, ongoing support and making direct connections for patients with community providers <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> Reduced emergency department visits, addressed social determinants of health and client goals to stay at home <p>Integration features</p> <ul style="list-style-type: none"> Holistic assessments, trust-building among providers and greater support for complex patients across CHC programs
<p>PCIGT North East region (Sudbury) Program host: NESGC</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Older adults living with mild to moderate frailty, referred directly by primary care physicians <p>Team composition and FTEs</p> <ul style="list-style-type: none"> 2.0 FTE geriatric assessors (RNs with older adult care training) and clinical support staff In-kind contribution of pharmacy, SGS and community support service providers, with NESGC providing leadership, implementation and evaluation support to the team <p>Core activities</p> <ul style="list-style-type: none"> Early identification of risk factors, comprehensive assessment and coordinated approach for managing geriatric syndromes to proactively address health and social needs before crises emerge Patient-centred care planning at regular interprofessional rounds based on comprehensive assessment and goals of care Clear pathway to SGS <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> In the first three months, the PCIGT identified 50 patients and completed 27 assessments, most of which (85%) were conducted at home Most patients were managed within the PCIGT, with only 4% requiring referral to a geriatrician <p>Integration features</p> <ul style="list-style-type: none"> The PCIGT wraps existing community, primary care and SGS resources around patients, reducing fragmentation, duplication and reliance on acute care Capacity building among providers that optimizes clinical resources and allows work at full scope

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<p>PCGT Toronto region Program host: North Toronto Ontario Health Team</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Case-finding of older adults living with complex and chronic conditions. As needed, older adults can be attached to primary care or have interprofessional clinicians added to their primary care team. <p>Team composition and FTEs</p> <ul style="list-style-type: none"> In-kind contribution of pharmacy, geriatric medicine, nursing, primary care and community service providers (i.e., no net-new FTEs) <p>Core activities</p> <ul style="list-style-type: none"> Using the eFI, patient needs related to frailty are automatically identified and segmented in the primary care EMR eFI results are used to customize an interprofessional team assessment with pathways to access specialists (as needed) who see patients in their primary care setting A related initiative (Neighbourhood Care Teams or NCTs) further integrates primary care (often with a COE physician), social housing and care coordination and interprofessional team supports to tenants of nine Toronto Seniors Community Housing buildings <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> Interprofessional team assessments optimize the amount of time a geriatrician needs to see patients in-person NCT services are now accessible to over 1,000 tenants, integrate dozens of delivery partners and include programs such as diabetes education or MIINT memory clinics (for tenants reporting cognitive changes) with escalation to geriatrician support as required <p>Integration features</p> <ul style="list-style-type: none"> The primary care EMR houses documentation, which is accessible to patients through the digital portal of the primary care EMR
<p>ICT for older adults West region Program host: KW4 Ontario Health Team</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Older adults living with complex and chronic conditions, referred by primary care via Ocean eReferral or direct contact with the ICT by hospitals for patients at risk for or designated alternate level of care <p>Team composition and FTEs</p> <ul style="list-style-type: none"> Original funded team: 1.0 Registered Practical Nurse (RPN), 1.0 RN, 2.0 NP In-kind contribution of pharmacy, geriatric medicine, geriatric psychiatry and community service providers <p>Core activities</p> <ul style="list-style-type: none"> Standardized screening tool (the interRAI Check-up) used to gather preliminary data from patients and care partners. A pharmacist obtains a best possible medication history and, within one week, an NP completes a comprehensive chart review from all available sources (e.g., Client Health and Related Information System or CHRIS, Caseworks, Clinical Connect, primary care EMR) Patients are reviewed during biweekly rounds, and collaborative plans of care are developed with a focus on chronic disease management and access, including in-person appointments and required referral to community services <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> Primary care providers engaged with the ICT agreed that the ICT improved access to shared care for their patients (89%), and 67% agreed that the team prevented emergency department or hospital visits Most patients and care partners (85%) said the program made them more confident in managing their health (see Heckman et al. 2025) <p>Integration features</p> <ul style="list-style-type: none"> Reduces wait times for SGS appointments and increases primary care provider capacity to implement CGA recommendations Supports emergency department diversion and hospital discharge to the community; provides team-based follow-up support to primary care; and reduces the number of in-person appointments with geriatric specialists

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<p>SAS West Region (Brantford and Brant County) Program host: GRCHC</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Older adults requiring a CGA, referred by primary care to the Regional Geriatric Program Central's central intake service <p>Team composition and FTEs</p> <ul style="list-style-type: none"> 0.4 FTE clinical support staff, 0.8 FTE RN, 0.1 FTE occupational therapist, 0.6 FTE dementia resource consultant, 0.4 FTE COE physician, 0.2 FTE geriatrician <p>Core activities</p> <ul style="list-style-type: none"> After central intake prepares a triage summary, a pre-visit telephone assessment with the patient and care partner is completed before a 90-minute clinic or home visit appointment is conducted Comprehensive assessment, including a detailed history, medication review, physical assessment and cognitive testing Patients receive debriefing, counselling and referrals to specialized services and community supports, with follow-ups scheduled as needed <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> In 2024–2025, the team saw 309 new patients and provided 102 in-person follow-up visits and 67 virtual/telemedicine follow-up encounters <p>Integration features</p> <ul style="list-style-type: none"> Documentation is completed in the GRCHC EMR on a standardized template corresponding to the Competency Framework for Interprofessional Comprehensive Geriatric Assessment (Kay et al. 2017) and faxed to the primary care provider
<p>GOT Central region (Orillia and area) Program host: Couchiching Family Health Team (program is a spoke of the central hub of NSM SGS)</p>	<p>Population focus and referral pathways</p> <ul style="list-style-type: none"> Frail older adults requiring a CGA, referred by primary care to the NSM SGS central intake hub <p>Team composition and FTEs</p> <ul style="list-style-type: none"> 1.0 FTE clinical support staff, 2.8 FTE RN, 1.5 FTE occupational therapist, 1.0 FTE kinesiologist, 0.8 FTE NP, and 0.6 FTE geriatrician <p>Core activities</p> <ul style="list-style-type: none"> Prospective patients are triaged by urgency, and ranked as imminent actual risk (e.g., harm to self or others, increased healthcare utilization, cognitive decline with no supports), imminent potential risk (worsening falls, cognitive decline with supports, Parkinsonism) and low to moderate risk (geriatric syndromes such as incontinence, multi-morbidity, depression, polypharmacy, sleep disturbance, pain, etc.) Patients identified as imminent actual risk and those who are homebound may be seen at home within six weeks Completion of a CGA by an interprofessional team and the development of a patient-centred care plan by the GOT, which implements interventions to address concerns. Assessments completed in home or in office depending on need <p>Early outputs/outcomes</p> <ul style="list-style-type: none"> In 2024–2025, the team saw 914 new patients and provided 9,191 follow-up visits <p>Integration features</p> <ul style="list-style-type: none"> Complex patients are brought forward to weekly rounds with cross-sector partners that include the local hospital, GEM nurses, home care, community support services (Hospital to Home program), system navigation and NSM SGS Enhanced communication within the Couchiching family health team EMR between team members, referring physicians, home care, NSM SGS, administration, pharmacists and GEM nurses. Integrated support with NSM SGS related to leadership and advocacy, education services, geriatric mental health services, project work and research

CGA = comprehensive geriatric assessment; CHC = Community Health Centre; COE = care of the elderly; eFI = electronic Frailty Index; EMR = electronic medical record; GEM = geriatric emergency; GOT = Geriatric Outreach Team; GPS = Geriatric Primary Care Support; GRCHC = Grand River CHC; ICT = Integrated Care Team; KW4 = Kitchener, Waterloo, Wellesley, Wilmot, Woolwich; LFHT = Loyalist Family Health Team; NESGC = North East Specialized Geriatric Centre; NSM = North Simcoe Muskoka; PCGT = Primary Care + Geriatrics + Team; PCIGT = Primary Care Integrated Geriatrics Team; SAS = Seniors Assessment Service; SGS = specialized geriatric services; SOS = Seniors Outreach Service.