



Response Guide

Assistance for applicants to

**'Ontario Health 2023-2024 Expanding and Enhancing
Interprofessional Primary Care Teams' Expression of Interest**

Prepared by: Provincial Geriatrics Leadership Ontario

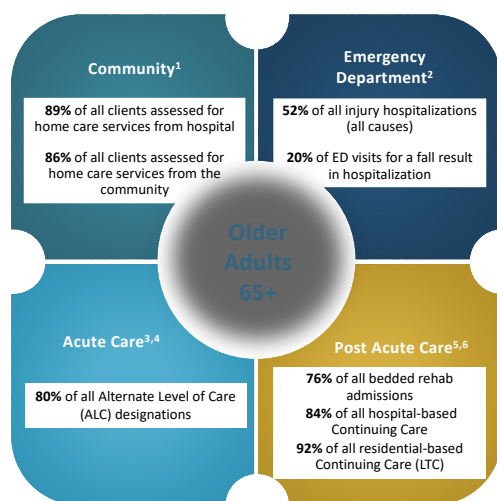
Date: June 1, 2023

Introduction

On May 18, 2023, Ontario Health launched an Expression of Interest (EOI) to expand existing interprofessional care (IPC) teams and/or create up to 18 new teams in communities with the greatest need.

These multidisciplinary teams are intended to:

- provide direct care to vulnerable and marginalized people;
- provide direct care to those without a family doctor;
- help patients avoid having to visit emergency rooms and experience long wait times; and
- increasing preventive care and screening procedures.



Ontario Health's 2022/23 Business plan identified that improving equitable outcomes and experiences for older adults was an area of focus. Currently, older adults are disproportionately represented among individuals designated Alternate Level of Care (ALC) in Ontario's hospitals. Further, the Canadian Institute for Health Information has identified that 1 in 9 new long-term care residents potentially could have been cared for at home. There is an opportunity, through this initiative to better support the many efforts underway in primary care to support older adults to remain living at home.

Evidence suggests that the integration of geriatric expertise in IPC teams is a key design element for clinical services that work well for older adults. In addition, primary care practices have identified that support to manage the growing population of older patients living with increasingly complex health conditions is required.

This **EOI Response Guide** provides content to aid in the completion of the EOI template. Teams that are interested in focusing on addressing the needs of older adults in their community may find the following information can support their application. Please note: completed EOIs are due to Ontario Health **by 5 pm on June 16, 2023**. For information about the [EOI process](#), please consult Ontario Health directly.

Additional support is available through [Provincial Geriatrics Leadership Ontario](#).

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Below are some data sources and best practice documents you may wish to use to support your proposal. The following section provides resources and tips aligned with relevant sections of the EOI template.

Key Question	Resource
How can I identify my current older adult population and project future growth?	Frailty Estimates by census division, projected out to 2040
What does integrated care look like for older adults?	Scoping Review of the 13 design elements of integrated care for older adults living with complex and chronic health needs
How do you know when integrated care is happening at the team, organization, and system level?	Implementation Rubric for the 13 design elements of integrated care for older adults living with complex and chronic health needs
How can I determine what work needs to be done to be more supportive of older adults?	Senior Friendly Care Framework – Toolkit and Self-Assessment
What is the current state of specialized older adult care programs in my area?	2019-2022 Specialized and Focused Geriatric Services Asset Inventory by OH Region
How do I measure older adult health outcomes?	Performance, Implementation, and Measurement Framework for integrated older adult care
What are levers in the community to support older adults to live well in the community?	ALC Leading Practices Guide & Community Self-Assessment Tool
What is an approach to care that considers older adult needs and goals related to rehabilitative care?	Rehabilitative Care for Older Adults Living with/At Risk of Frailty: From Frailty to Resilience
What are the domains of care my older adult patients may require?	Ontario Collaboration for Aging Well's Consensus Statement on Frailty and Seniors Care Network's Frailty Screening Toolkit
What training will my team need to optimize care for older adults?	Provincial Common Orientation for older adult care
What do I need to consider when planning my service for older adults?	Age-Friendly Community Planning Guide

Interprofessional Primary Care (IPC) Team EOI

Relevant considerations and resources to plan and care for the older adult population are grouped by section numbers in Ontario Health's ['Expanding and Enhancing Interprofessional Primary Care Teams 2023-2024 Expression of Interest'](#) template.

SECTION 1: ABOUT YOU

1.2 Governance Structure

- Adopt mechanisms of co-design for integrated care suited to older adults and other vulnerable populations. This includes means of preparing older adults for participation in co-design, methods for capturing experiences, development of scenarios to test changes, and co-production of solutions.¹
- Include a representative group of clinicians, administrators, community partners, and people with lived experience as part of your governance structure. Best practice is to include more than one person with lived experience in your governance structure.
- Make the process to join your governance structure simple and clear for older adults and care partners who want to support your service.
- Leverage other groups for membership (e.g. OH PFACs, OHT lived experience committees, and community organizations such as the Alzheimer Society) so that governance participants are connected back to your desired networks.
- Balance participation in governance among those who can attend meetings and those who may be more frail or who have reduced energy reserves where committee participation is not possible. Consider using engagement techniques (e.g. brokered dialogue²) to exchange insights with older adults living with frailty.
- Clarify how sub-committees connect to your governance table (e.g. consider older adults on your governance committee who will co-chair a sub-committee with lived experience, with regular report-backs to your governance table).

1.3 Team Composition and Model

This section informs the number of FTEs and type of health professionals you may wish to include on your IPC team.

¹ Grosjean, S., Gauthier-Beaupré, A., Poitras, E., Stümpel, J., van Munster, M. & iCARE-PD Consortium. (2023). A toolkit to facilitate the implementation of integrated care network for people living with Parkinson: A codesign approach. ICIC23. <https://www.youtube.com/watch?v=Hqhequ0YVgI>

² <https://www.longwoods.com/content/26947/healthcare-quarterly/toward-an-integrated-strategy-for-care-in-the-home-for-frail-elders>

Full Time Equivalents (FTEs)

PGLO recommends that older adults living with frailty should be provided with, a minimum, four scheduled frailty-focused primary care visits per year (in addition to usual primary care), delivered with the support of an interprofessional team. The information below informs various scenarios based on assumptions related to the frequency and typical duration of interprofessional geriatrics team visits.

The following table calculates several staffing scenarios to help you estimate your total human resource requirements.

Patients identified as frail (PF)	Frailty Focused Visits (FV)	Required Frailty-focused appointments (RFA)	Average IP team visit length (hours) (Adjust length depending on planned team activities)	Total time required (hrs) (TRT)	Annual total work hours (Scenario 1) ATWH 1	Annual total work hours (Scenario 2) ATWH 2	Total Human Resources FTE (Scenario 1) THR 1	Total Human Resources FTE (Scenario 2) THR 2
Number of patients living with frailty	Min. # required visits/yr	Total required frailty-focused appointments (per year)(PF x FV)		RFA x average visit length	(35hr/ww)	(37.5/ww)	TRT/ATWH1 (FTE)	TRT/ATWH2 (FTE)
1000	4	4000	1.5	6000	1820	1950	3.3	3.1
1500	4	6000	1.5	9000	1820	1950	4.9	4.6
2000	4	8000	1.5	12000	1820	1950	6.6	6.2
2500	4	10000	1.5	15000	1820	1950	8.2	7.7
3000	4	12000	1.5	18000	1820	1950	9.9	9.2
3500	4	14000	1.5	21000	1820	1950	11.5	10.8
4000	4	16000	1.5	24000	1820	1950	13.2	12.3
4500	4	18000	1.5	27000	1820	1950	14.8	13.8
5000	4	20000	1.5	30000	1820	1950	16.5	15.4

The FTE requirements depicted above do not necessarily require net-new resources. If your existing team already provides service to older adults, your expansion/enhancement may be a portion of the THR FTEs, reflecting a desire to increase your focus on this population. For example, if you already have a five-person IPC team that supports 3500 older adults living with frailty, your enhancement may be to increase your staffing by an additional 5 to 6 FTEs to carry out additional programming.

Team Composition

Integrated care teams serving older adults regularly deliver the following functions: assessment; planning; intervention; care coordination (including navigation); follow-up and follow-through support; and contribute to team and service evaluation. Typically, all team members should have the capacity to contribute to each activity (see [Competency Framework for Interprofessional Comprehensive Geriatric Assessment](#) and [Provincial Common Orientation to the Care of Older Adults](#)). Other considerations:

- When implementing integrated care for older adults, the most advanced degree of implementation is characterized by multidisciplinary, collaborative teams that

include a variety of health and social sector roles and that have the flexibility to include ad hoc team members, as patient needs arise. Such teams work best when staffed for assessment **and** intervention capacity.

- Core roles include: physicians (primary care and specialists), nurse practitioners, nurses, clinical pharmacists, occupational therapists, physiotherapists, social workers, behavioural support clinicians, and personal support workers (or other unregulated care providers).
- Older adult care also requires access to: dietitians, therapeutic recreationists, palliative care experts, and speech-language pathologists.
- Managing complex health and social care needs (e.g. frailty) may require team competency in addressing social, cognitive, mental and physical health needs. Resource: Ontario Collaborative on Aging Well's [Four Domains of Frailty](#).
- Under 'Description' in the EOI application, consider describing the team function each provider will fulfil in your program (e.g. RPN will screen the patient and collect collateral history, NP will conduct a physical assessment, synthesize information and lead care plan development, etc.).
- Dedicated administrative roles provide important functions such as: navigation support; appointment reminders, including instructions about what to bring for a successful appointment (e.g. food journal, medications list, bringing a care partner who can provide collateral information and take notes); patient orientation such as what to expect from the appointment (e.g. referral list, comprehensive care plan, who the clinical point of contact will be); and aftercare support. Administrative roles also support key team functions such as onboarding with digital health tools and the collection of data to support performance management.
- The most advanced degree of implementation is also characterized by integrated specialized geriatric expertise. Consider forming partnerships with existing geriatric services and specialists such as geriatricians, geriatric psychiatrists, and care of the elderly family physicians, all of whom have specialized training in complex older adult care. Resource: Your local [Regional Geriatric Program](#) can act as a resource for what services and providers are available in your region.
- Specialist roles include direct patient care for select complex patients and team capacity building (e.g. interprofessional case reviews, shared learning sessions).
- In the absence of available local specialist supports, consider:
 - eConsult and formal connections to specialists who are not in your catchment area for additional support.
 - [GeriMedRisk](#): a ministry-funded program that answers complex health, mental health, and pharmacy-related queries for older adult patients. The service includes multiple specialists who provide an interdisciplinary consult note along with a best possible medication history for optimizing medications. GeriMedRisk is available to prescribers over eConsult, by telephone, and fax.

1.4 Primary Care Model (also see Driver Diagram on page 11)

When developing an IPC team for older adults, best practice is to utilize the [design elements specific to older persons' care](#) for program design and evaluation.

You may also wish to leverage existing models of older adult-focused services, along with guidelines and standards to learn from experience and evidence. The following are examples of focused older adult programs currently delivered in Community Health Centres (CHCs) and Family Health Teams (FHTs).

Programs currently delivered by CHCs	Programs currently delivered by FHTs
Age Well Care for Seniors Falls Prevention Program First Step to Home, Seniors Group Foot Care Services Forever Young Seniors Geriatric Assessment and Intervention Network (GAIN) Home Care Services Memory Clinic Nursing Services Ontario Seniors Dental Program OT Services Practical Skills to Live Well as We Age SCHC Health & Wellness for Seniors Senior Programs and Services Seniors and Adults with Disabilities Seniors Health Care (various services) Seniors health promotion Seniors Online Together Physically Apart (SOTPA) Seniors' Wellness Program Seniors' WrapAround Program Stay Fit Program Support Services for Seniors and Vulnerable Persons	Age Friendly Check-In Aging at Home Program Art therapy for seniors Cognitive Assessments/Diagnosis of Dementia FoCuSed: Complex Vulnerable Services Coordination of Care Education and Support Falls Prevention Program Geriatric and Frail Elderly Program GAIN Geriatric Care Outreach Team Geriatric/Seniors' Program Geriatric psychiatry; Living Well with Memory Loss Healthy Aging/Older Adult Exercise Class Homebound Seniors Program Memory Loss Prevention Never too later Senior's Program Primary Care Memory Clinic Senior Support Services (CPHC) Senior's Aging Well Senior's Wellness Program Seniors Care Programs Seniors' Health Specialized Seniors Clinic Wellness Workshops and Programs – Red Flags of Dementia

Other considerations:

- Clarify what your proposed team can do and which services they cannot provide. Work with other partners in your area to enable warm hand-offs with complementary services your patients might need (e.g. community paramedicine, home care, community support services).
- Consider how a shared care model can enhance the scope of practice of your team of interprofessional providers, whether they are experienced or new to practice.
- Support IP team development by providing general orientation to the care of older adults, and ongoing training. Resource: PGLO's [Provincial Common Orientation](#) is

an 11-week standardized training for interprofessional older adult care providers your team may all wish to take as part of their orientation.

- Consider using [Frailty Estimates](#) to help identify future demand.

1.5 Ontario Health Team (OHT) and Community Partnership and Collaboration

- Describe how you will leverage your OHT to build partnerships with organizations and spread awareness of your IPC team's approach to older adult care.
- Consider how you can partner with services that are coordinated municipally (e.g. community paramedicine, age friendly programs, supportive housing etc.) to expand your program's reach.
- Investigate supports such as the [Ontario Collaborative for Aging Well](#) as additional mechanisms for addressing aspects of your program design.
- Describe how your team will integrate older adult care for those from Indigenous communities and use resources specific to those populations. For example:
 - [Canadian Indigenous Cognitive Assessment \(CICA\)](#); and
 - [Indigenous-focused dementia materials](#).

1.6.1 Community Consultation and Co-Design of Programs and Clinical Services

- There are resources specific to age-friendly planning and diverse populations (e.g. Black, Indigenous, other racialized communities, people living with disabilities, etc.) that may inform your submission, including:
 - [Creating a more inclusive Ontario: Diverse Populations Addendum \(Age-Friendly\)](#);
 - [Diversity & Inequality Considerations for Older Adults \(resource list\)](#);
 - [Caring for LGBTQ2S+ Elders \(resource list\)](#);
 - [Health and Indigenous Elders \(resource list\)](#);
 - [Lived experiences of aging immigrants \(report\)](#); and
 - [Other resource lists](#).

1.6.2 Patient, Family, Care Partner Consultation in the Community and Co-Design of Programs and Clinical Services

- Consider partnering with other organizations (e.g. municipal [Age Friendly Councils](#)) to embed engagement throughout your planning and implementation process.
- Ask for a letter of support from older adult group (e.g. [Age Friendly Council](#), [CARP Chapter](#)). This will help to demonstrate how you are connecting with older adults and care partners and create familiarity with how your program will fill a gap they experience in their day-to-day lives in the current system.

1.7 Physician Engagement

- Consider connecting with local [specialized geriatric service programs](#) for letters of support.

SECTION 2: ABOUT THE COMMUNITY

2.1 Population Health Status

- Resources:
 - Inspire PHC [Primary Care Data Reports](#) (population by OHT);
 - PGLO [Frailty Estimates](#) (population living with frailty by census division); and
 - [Canadian Frailty Network](#) (needs of older adults living with frailty).

2.3 Strategic Alignment

To demonstrate alignment of your IPC team with provincial/regional priorities, consider:

- Ontario Health [business plan](#)
- Provincial Geriatrics Leadership Ontario [strategic plan](#)
- Ontario College of Family Physicians – Academic Detailing Services (Centre for Effective Practice) - [Older Adults](#)
- Regional Older Adult Strategies, for example:
 - [Waterloo Wellington](#)
 - [Southwest Frail Senior Strategy](#)
 - [Champlain Falls Prevention Strategy](#)

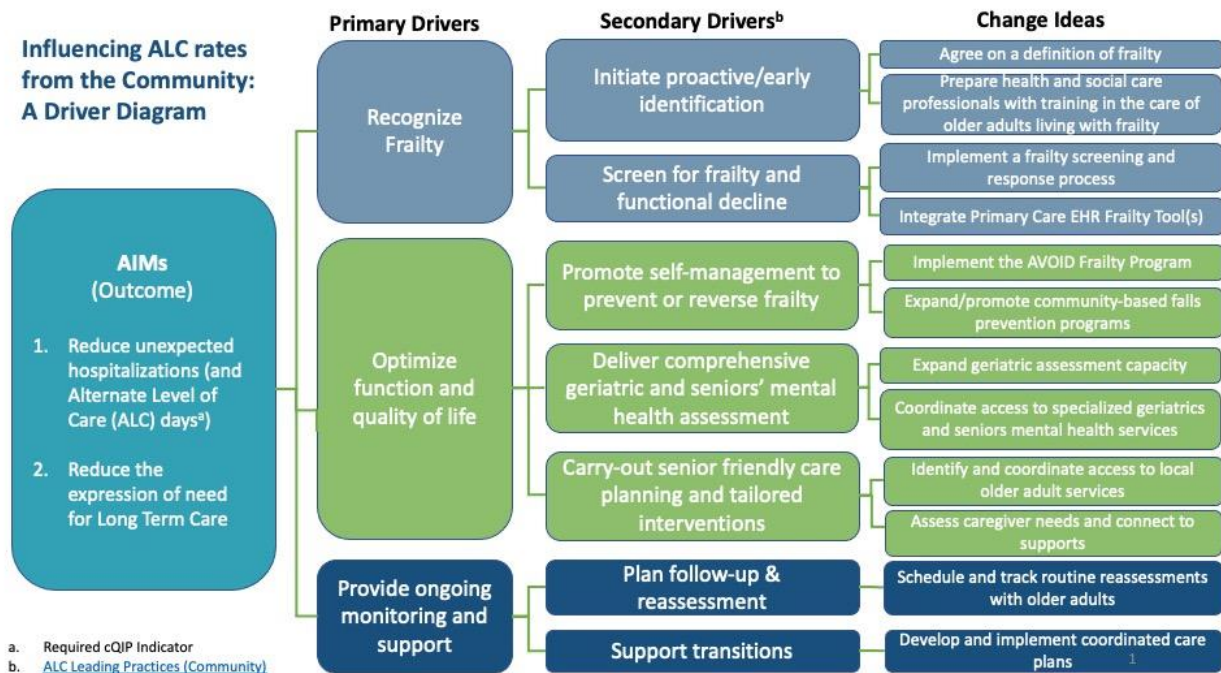
Provincial/OH Priorities	How an IPC team for older adults addresses these priorities
Reduce barriers to care for historically disadvantaged populations	Integrated (geriatric) care teams address demand and improve access. The number of older adults in Ontario is increasing, along with the number of older adults living with complex health conditions (e.g. frailty) requiring care by trained interprofessional teams with expertise in geriatrics and seniors' mental health.
Increase access to primary care through additional hours and/or days of availability	Integrated (geriatric) care teams are a population-based solution that bring clinicians with geriatric and seniors' mental health expertise to OHTs by embedding expertise in primary care practices across Ontario. The additional FTEs increase access and allow for flexibility in service delivery (e.g. virtual/hybrid models), including increased capacity for the home-based care needed by home-bound older adults.
Team-based models of care that maximize scope and how the team works together	Team-based models are proven models for the care of older adults. In Ontario, there are 86 geriatric and seniors' mental health outpatient/outreach teams, and more than 144 primary care team-based older adult programs. Teams combine competencies in interprofessional practice, discipline-specific competencies and competencies in the care of older adults to carry out collaborative assessments and implement synergistic interventions.
Integration and collaboration with primary care partners and OHTs and participation in	Organizations creating IPC teams focused on older adults can collaborate through the Ontario Collaborative for Aging Well . This group of more than 25 organizations is focused on sharing their expertise to contribute to population-based planning and service delivery for OHTs and primary

Provincial/OH Priorities	How an IPC team for older adults addresses these priorities
population-based planning and service delivery	care organizations that have identified older adults living with physical, cognitive, social, and mental health frailty as a priority population.
A commitment to a learning health system philosophy (using data and evaluation for continuous quality improvement)	<p>Organizations creating IPC teams focused on older adults contribute to and are supported by PGLO's learning health system philosophy which includes (and makes resources available in the following areas):</p> <ul style="list-style-type: none"> ○ Environmental scans (e.g. frailty estimates, applied research); ○ Participatory design (e.g. design elements of integrated care for older adults); ○ Iterative implementation (e.g. Alternate Level of Care Leading Practices implementation support); ○ Ongoing evaluation (e.g. older adult experience survey, evaluative framework); ○ Plan-Do-Check-Adjust cycles (e.g. clinical model implementation support); and ○ Broad, timely dissemination (e.g. webinars, newsletters). <p>Training resources may include:</p> <ul style="list-style-type: none"> ○ Provincial Common Orientation to the Care of Older Adults; ○ Multiple educational offerings delivered by specialized geriatric services across Ontario; and ○ Senior Friendly Care e-Learning Series.
Improve patient engagement (including diversity that represents the community served) and patient-centred care	Diverse older adults and care partners are included in the design and membership of the IPC team. Person-Centred Language is a cornerstone of program design. Ontario Caregiver Organization's ' Tools for Employers ' helps illustrate why and how care partners should be considered during design.
Support the principle of providing the right care in the right place	IPC teams for older adults with complex and chronic health conditions include, at minimum: interprofessional members; comprehensive assessment and care planning; integrated specialized geriatric expertise; and older person-centred care. There is significant evidence that clinical geriatric supports can positively influence outcomes for older adults living with frailty. Better integrated resources and capacity building are required to enable older adults to live at home safely for as long as possible with primary care as their medical home. Primary care integrated (geriatrics) teams are the model for a multiple chronic disease management strategy that supports the most complex patients in an evidence informed manner.
Be agile and responsive to the needs of the community over time and in crisis responses (including guidance or referrals to social service supports)	Flexible membership can help IPC teams respond to individual needs and arising issues. This can be enabled by developing collaborative organizational agreements that can enable the development of ad hoc flexible support networks that facilitate cross-sector partnerships (e.g. joined-up health and social services) and point-of-care co-delivery of interprofessional care (e.g. crisis services).

SECTION 3: ABOUT THE CLIENTS AND PROGRAMS

3.2 Proposed Programs and Services

The type of IPC team model you develop will reflect the work you wish to carry out on behalf of your priority population. For older adults living with frailty in your community, the image below offers several change ideas, linked to cQIP indicators that may assist applicants with describing the activities their IPC team will deliver.



Several detailed program descriptions (see tab 'services types' and 'success stories and narratives') for similar services can be found in the [Specialized and Focused Asset Inventory](#) (description, goals, staffing, etc.) to support completion of this section.

3.4 Digital Health Solutions and Provision of Care

- Many older adults see multiple providers for their chronic conditions. Investigate access to a digital solution that can organize their appointments all in one place as part of your integrated team.
- Consider how you will provide support for downloading tools and creating accounts for your patients and their care partners. Make low/no tech alternatives available for patients without a smartphone or laptop. **Resources:** [Leveraging Virtual Care Strategies in the Delivery of Comprehensive Geriatric Assessment \(CGA\)](#) and [Electronic Frailty Index \(eFI\)](#).

SECTION 4: IMPLEMENTATION

4.1 Implementation Plan

- Include how you will implement processes, people, and practices, what the ongoing implementation monitoring will look like, and how you will pivot as needed.
- Resource: [Implementation Rubric for Operationalizing Integrated Care for Older Adults](#) includes micro, meso, and macro implementation statements for all 13 design elements of integrated care for older adults.

4.2 Capital Needs

- Frame accessibility for older adults as a multi-dimensional approach:
 - Physical (e.g. ramps and aids to enter and exit your space, improvements so older adults can easily navigate doors with mobility aids, etc.).
 - Visual (e.g. clear signage, fewer flyers and posters that may distract your patients with cognitive health concerns, and population-specific posters that direct your patients to community services if your team has a dedicated space.
 - Consider wayfinding signs for your patients to know they are in the right place for your program if multiple programs operate in the same location.
- Resources:
 - [Senior Friendly Care Self-Assessment Tool](#);
 - [Age-Friendly Community Planning Guide](#);
 - [Dementia Friendly Communities Ontario](#); and
 - [Code Plus](#) – Physical Design Components for an Elder-Friendly Hospital (may also be applicable to community settings).

Appendix 1

Methodology for Calculating HR Requirements of Interprofessional Geriatrics Teams

Step 1: Calculate the required number of frailty-focused appointments

PF: Patients identified as frail (two approaches to estimating)

PFi: Number of attributed patients identified as frail (OHT Primary Care Data Reports³),

OR

PFii: Estimated prevalence of frailty by census division (PGLO Frailty Estimates⁴)

FV: minimum scheduled frailty-focused primary care visits/year (min is 4)

RFA: required frailty-focused appointments per practice (per year).

$$[PFi \text{ OR } PFii] \times 4FV = RFA$$

Ex. 1500 patients x 4 frailty-focused visits per year = 6000 required frailty-focused appointments per year (per practice)

Step 2: Calculate the total required time to meet the demand for frailty-focused visits per practice.

TRT: Total time required for the required frailty-focused appointments per practice.

Note: On average, an interprofessional frailty-focused visit (non-specialist) is 1.5 hours, but the time may vary depending on the activities your team intends to carry out (e.g. screening, assessment, treatments and interventions, follow-up, home visiting). Therefore

$$TRT = RFA \times 1.5 \text{ hours (or usual visit length)}$$

Step 3: Calculate the total human resources (number regardless of discipline) in FTEs required to meet the demand for frailty-focused visits per practice.

THR: Total human resource requirement is the number of total staff required to meet the total time required for frailty focused appointments.

ATWH: Annual total work hours may vary by organization. For example

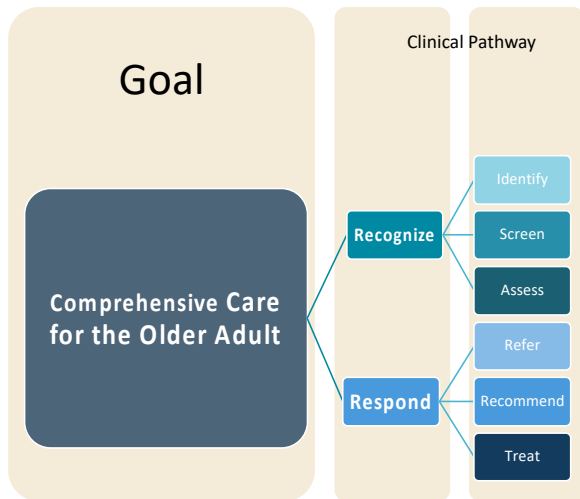
³ <https://www.ontariohealthprofiles.ca/ontarioHealthTeam.php>

⁴ <https://geriatricsontario.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region/>

Hours per work week	Annual Total Work Hours (ATWH)
35	1820
37.5	1950

Therefore: $THR = TRT/ATWH$

The type of health professionals you will hire will depend upon the nature of the program you plan to implement. All health professionals should have the capacity to recognize and respond to the needs of older adults, within their scope of practice.



Recognize and Respond is a foundational tenet of comprehensive care for the older adult.

This means that regardless of professional role, everyone plays a role in **recognizing** clinical conditions unique to older adults and **responding** by integrating geriatric evidence, contextual elements, senior friendly principles and individual goals.