North East - Sudbury

Primary Care Integrated Geriatrics Teams

January 31st, 2025

Background: Target Population

What we Know:

WHO is Most At-Risk for ALC

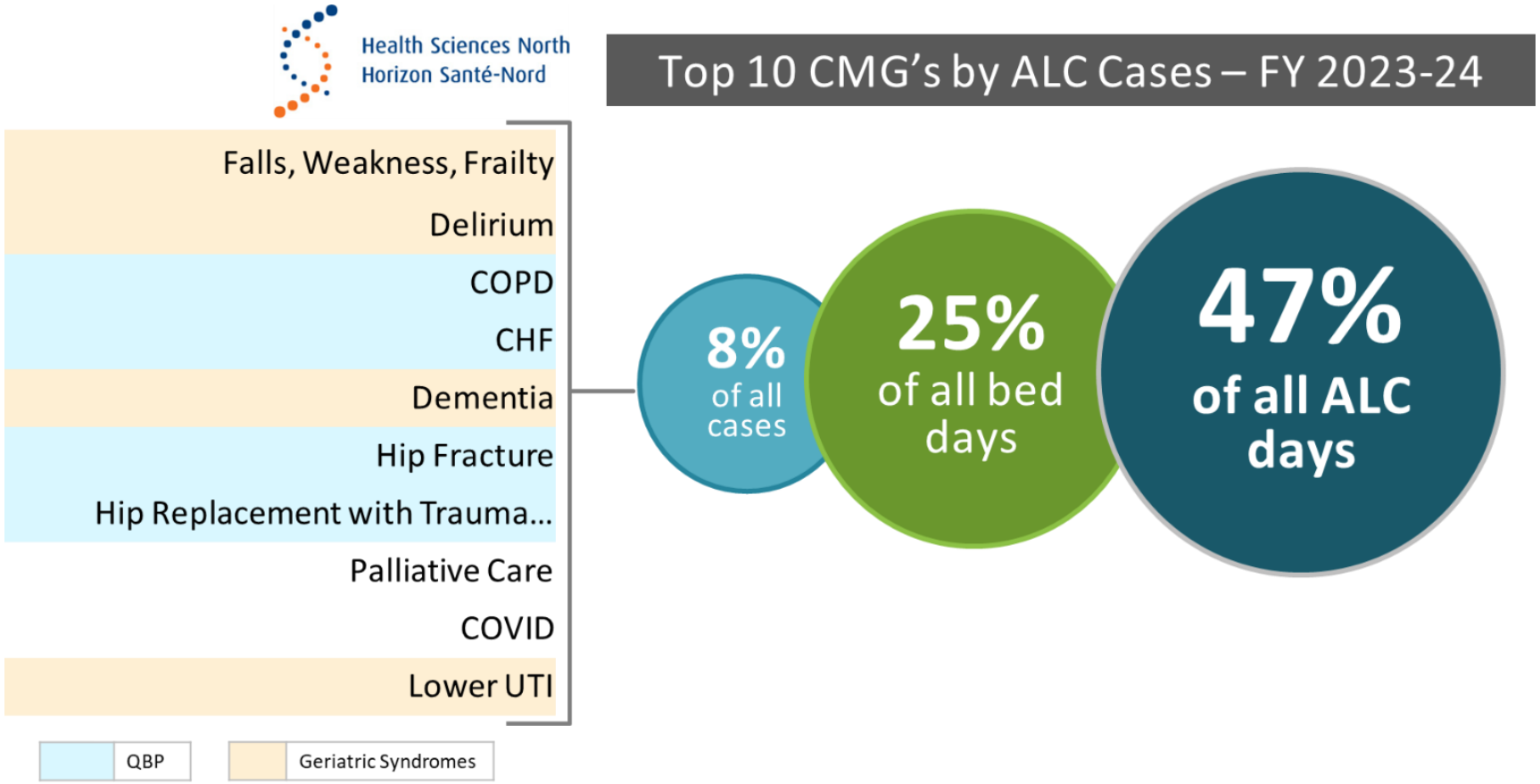
- Majority are **over the age of 65**, with increasing risk noted over the age of 75

Common Characteristics

- An **admitting diagnosis** that includes general medical illness (e.g., infections), falls & dementia;
- Presence of **functional or cognitive impairments**, and **multiple comorbidities**;
- Experience of **adverse events** during admission – functional decline, delirium, falls, social isolation;
- **Caregiver stress**

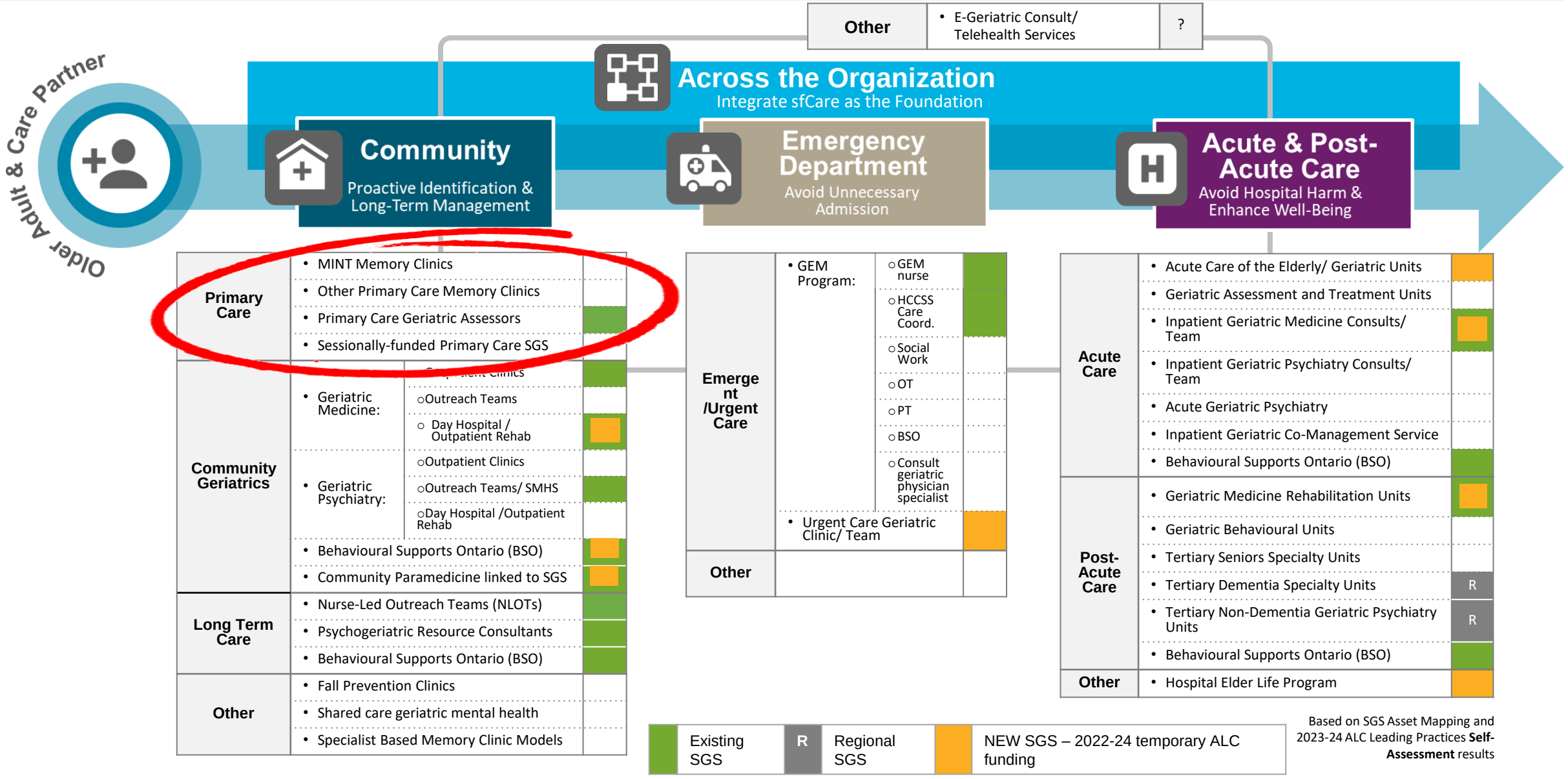
Target Population – Local Data

A review of relevant local data informs an understanding of the demographic and clinical characteristics of the population most at-risk of/being designated ALC.



Source: Intellihealth

SGS in Sudbury – 2022-24 OH ALC Investments

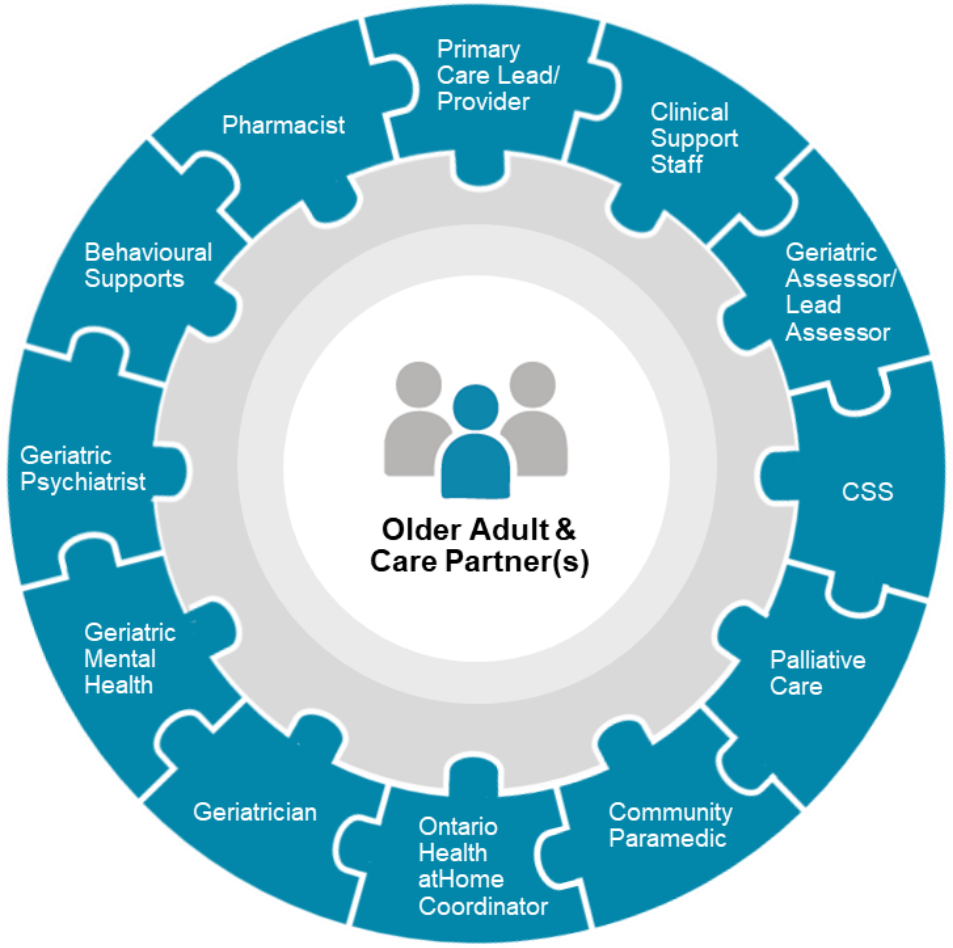


Based on SGS Asset Mapping and 2023-24 ALC Leading Practices **Self-Assessment** results

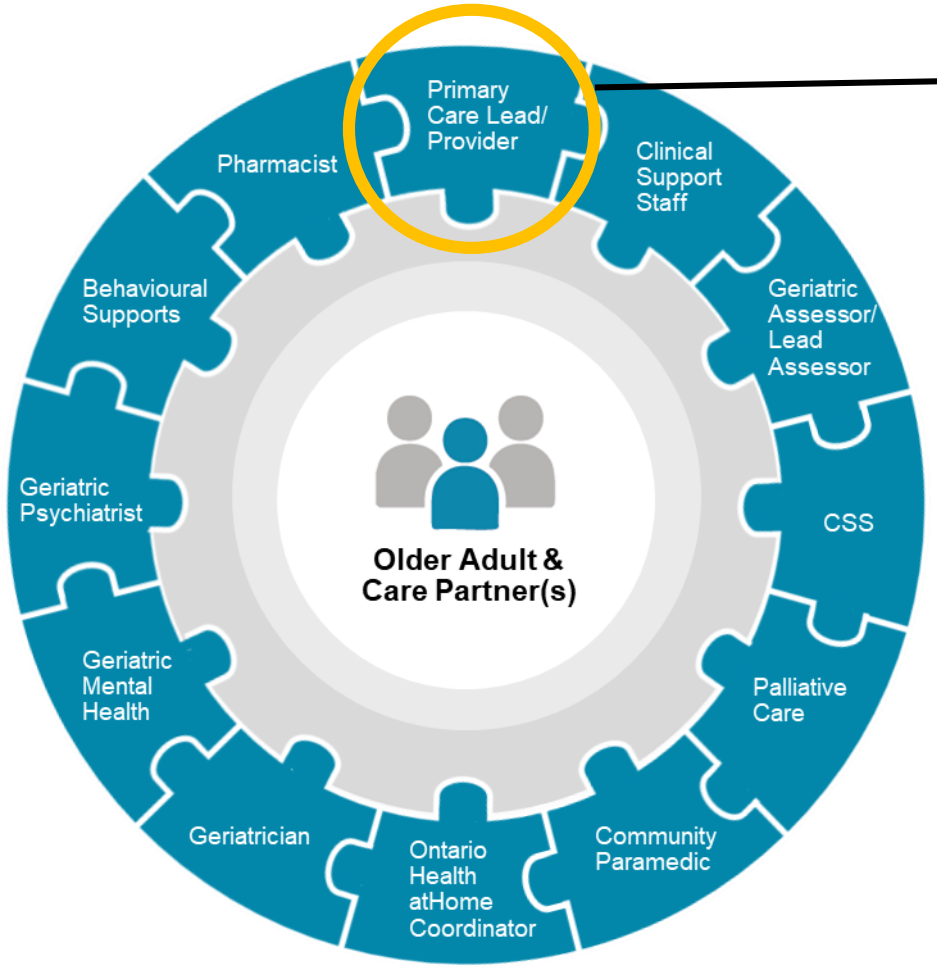
WHAT?:
Primary Care Integrated Geriatrics Teams

Model of Care – Ideal State

The Standard of Care for Older Adults Living with/ at-risk of Frailty			
Core Elements of Care	Older Person & Care Partner Engagement		
	Equitable & Culturally Appropriate Care		
	Interprofessional Teams		
	Specialized Geriatric Expertise		
	Comprehensive Geriatric Assessment (CGA)		
	Evaluation		
Processes of Care	Early Identification		
	Comprehensive Assessment		
	Care Planning (includes Advanced Care Planning)		
	Intervention		
	Transitions		
Domains of Care	Cognition	Polypharmacy	Continence
	Social Engagement	Nutrition & Hydration	Pain
	Mobility & Falls	Delirium	Mood & Mental Health
	Skin Integrity	Function	Sleep



Staffing Requirements



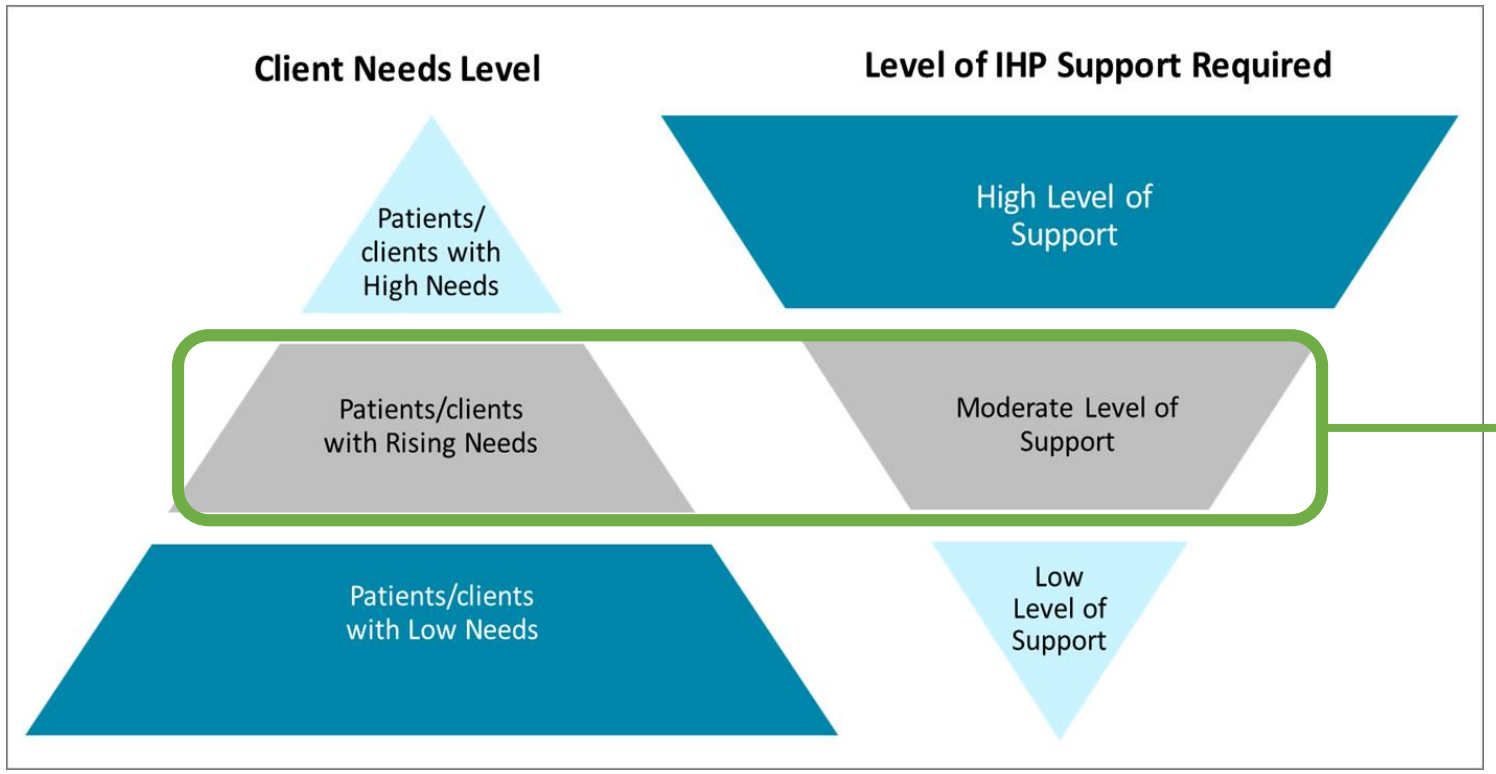
6-8 family physicians that will make up a new FHO focused on patients 65+

Funding to support approximately 2 FTEs

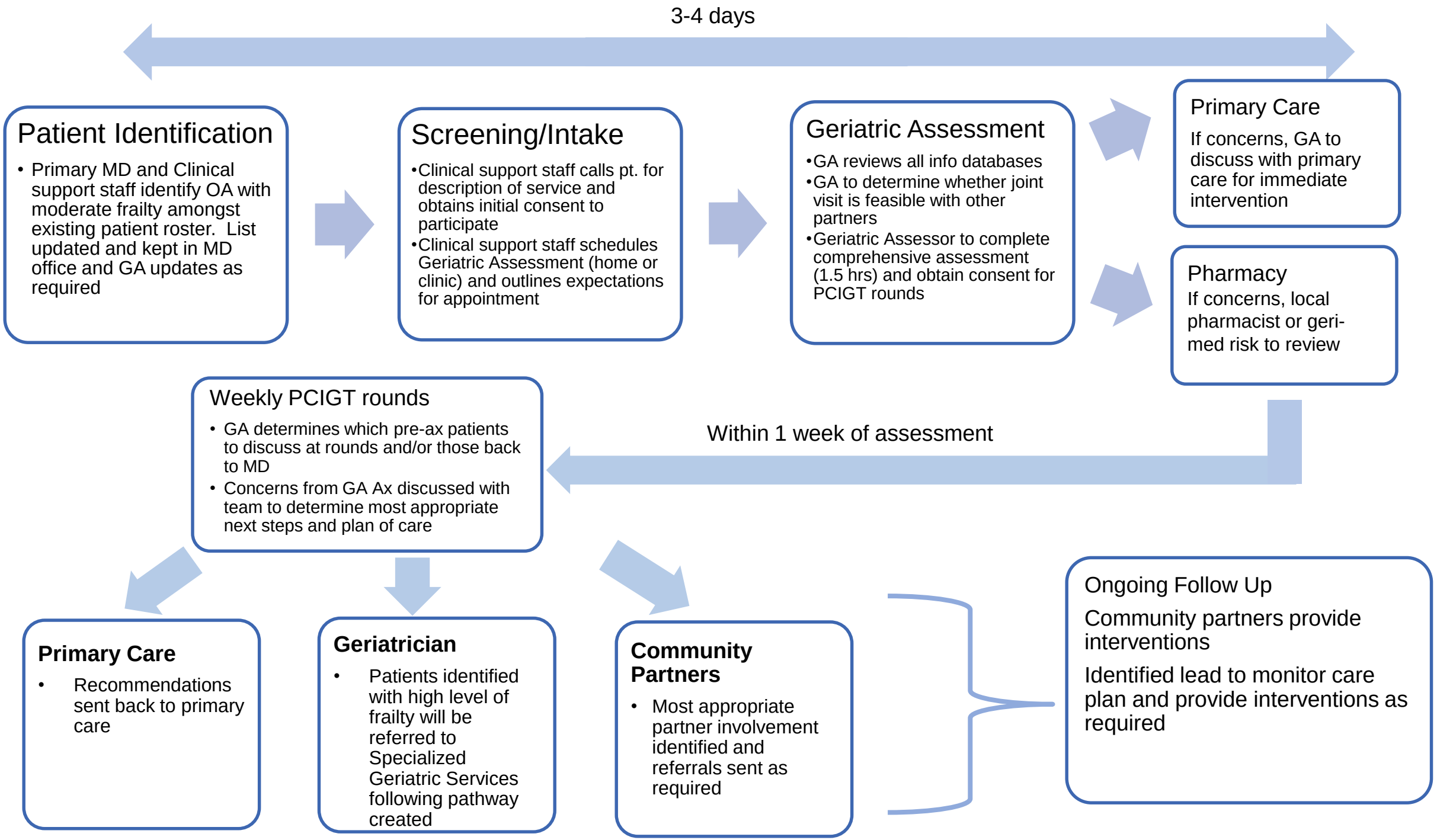
All other resources are in-kind staffing which includes weekly virtual rounds, co-design, implementation, and clinical service delivery.

Referral Destinations

Target Population

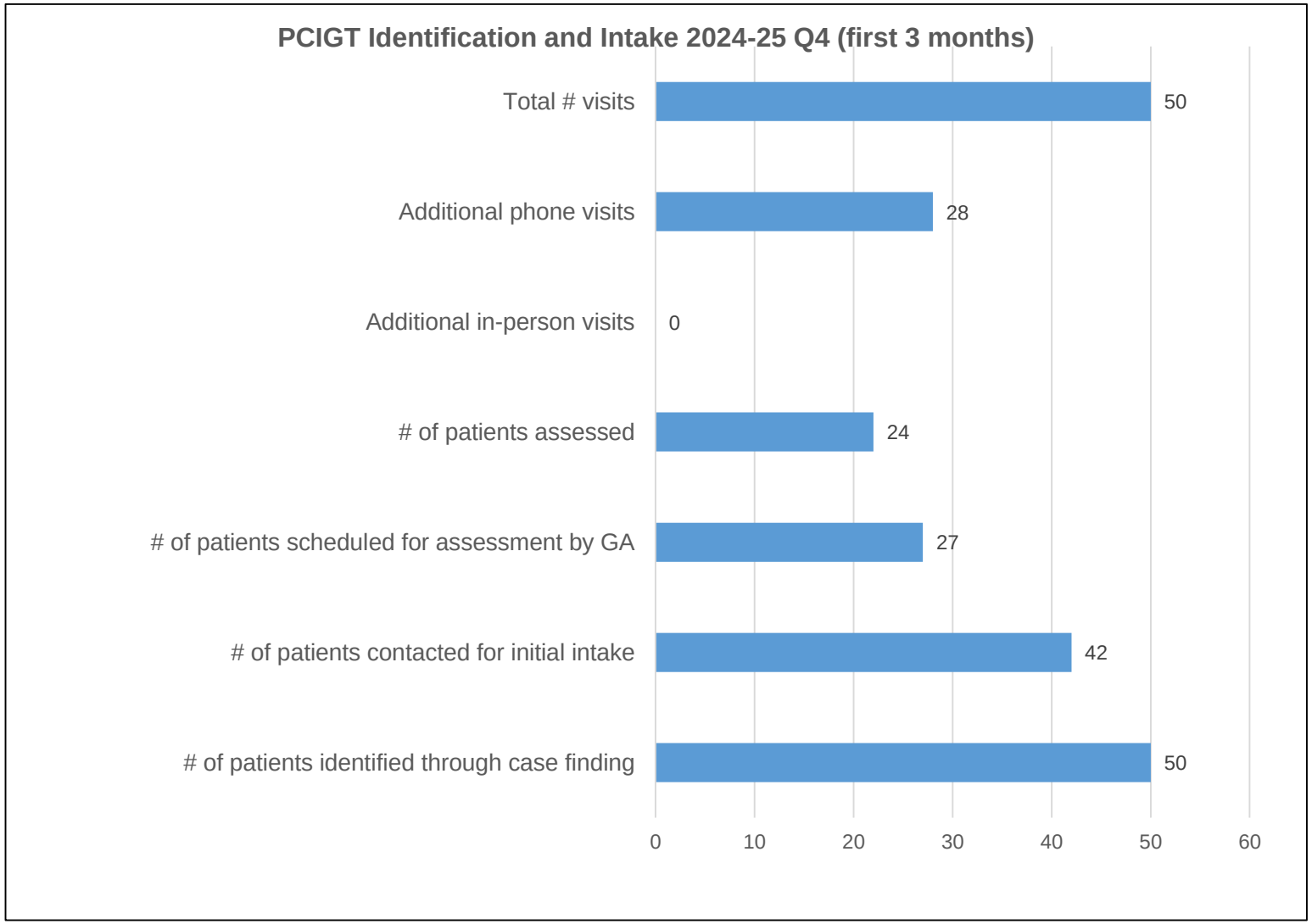


- Age 65+, experiencing:
- Functional or cognitive impairments;
- Multiple comorbidities;
- Falls, social isolation, and other conditions that benefit from proactive intervention;
- Polypharmacy; and
- Others?

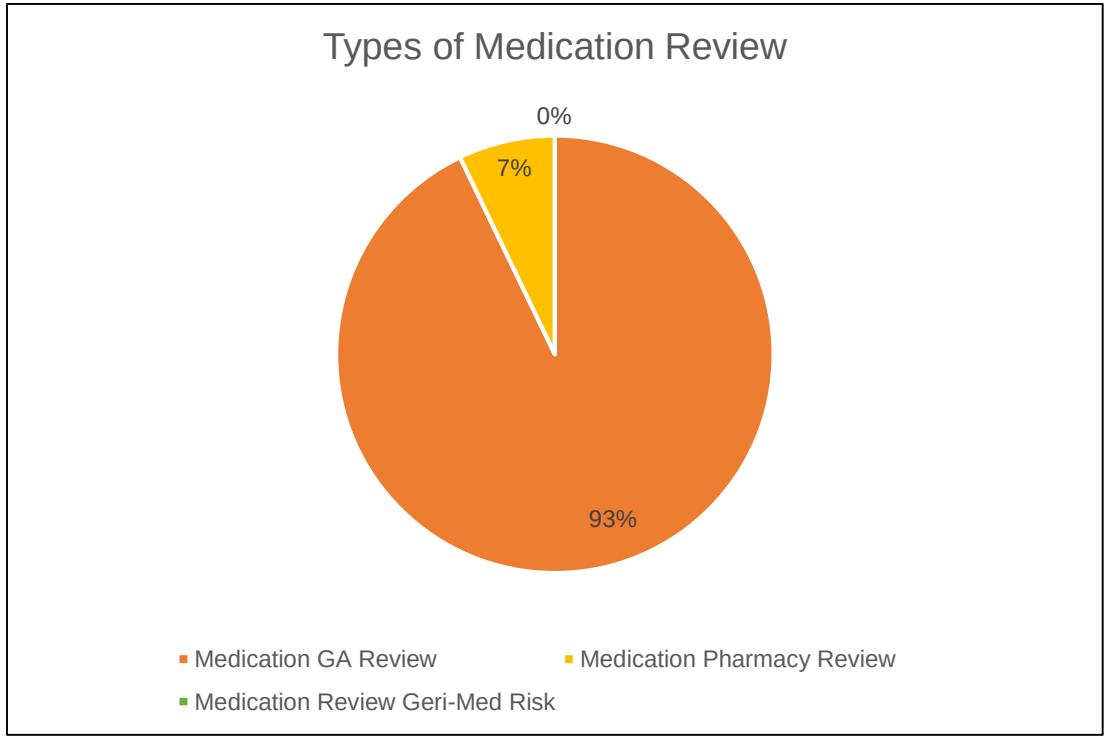

3-4 days
Patient Identification
• Primary MD and Clinical support staff identify OA with moderate frailty amongst existing patient roster. List updated and kept in MD office and GA updates as required
Screening/Intake
•Clinical support staff calls pt. for description of service and obtains initial consent to participate
•Clinical support staff schedules Geriatric Assessment (home or clinic) and outlines expectations for appointment
Geriatric Assessment
•GA reviews all info databases
•GA to determine whether joint visit is feasible with other partners
•Geriatric Assessor to complete comprehensive assessment (1.5 hrs) and obtain consent for PCIGT rounds
Primary Care
If concerns, GA to discuss with primary care for immediate intervention
Pharmacy
If concerns, local pharmacist or geri-med risk to review
Within 1 week of assessment
Weekly PCIGT rounds
• GA determines which pre-ax patients to discuss at rounds and/or those back to MD
• Concerns from GA Ax discussed with team to determine most appropriate next steps and plan of care
Primary Care
• Recommendations sent back to primary care
Geriatrician
• Patients identified with high level of frailty will be referred to Specialized Geriatric Services following pathway created
Community Partners
• Most appropriate partner involvement identified and referrals sent as required
Ongoing Follow Up
Community partners provide interventions
Identified lead to monitor care plan and provide interventions as required

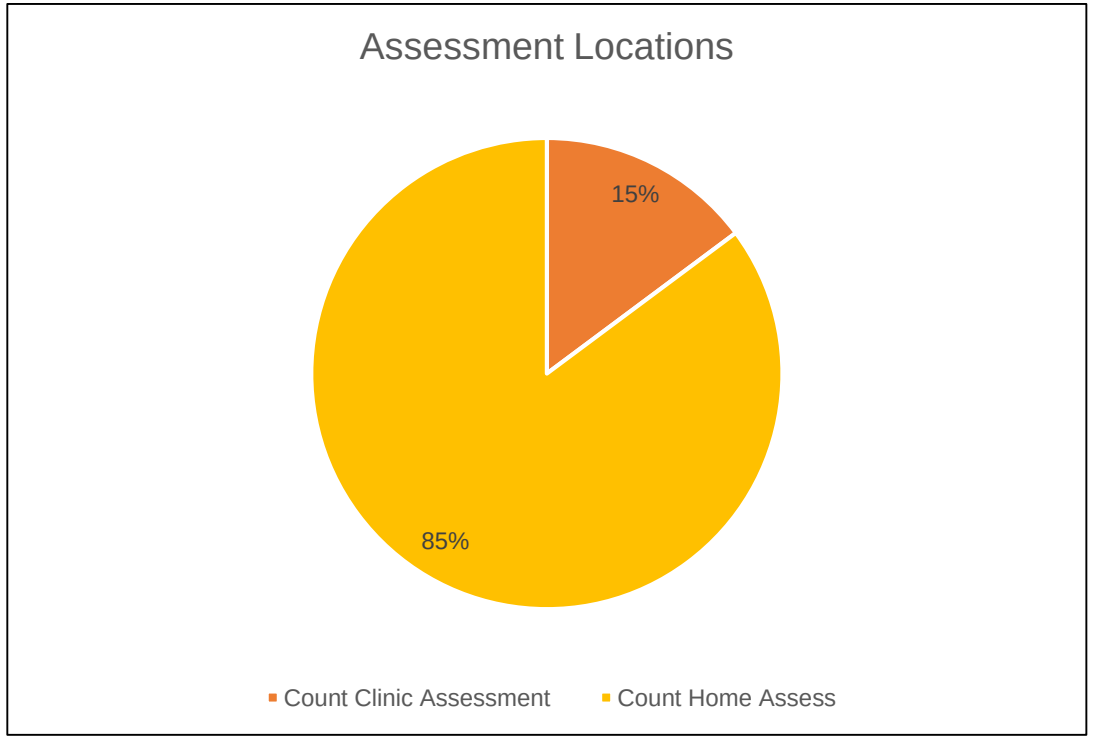
Results:
Primary Care Integrated Geriatrics Teams

Identification and Intake



Clinical Outcomes





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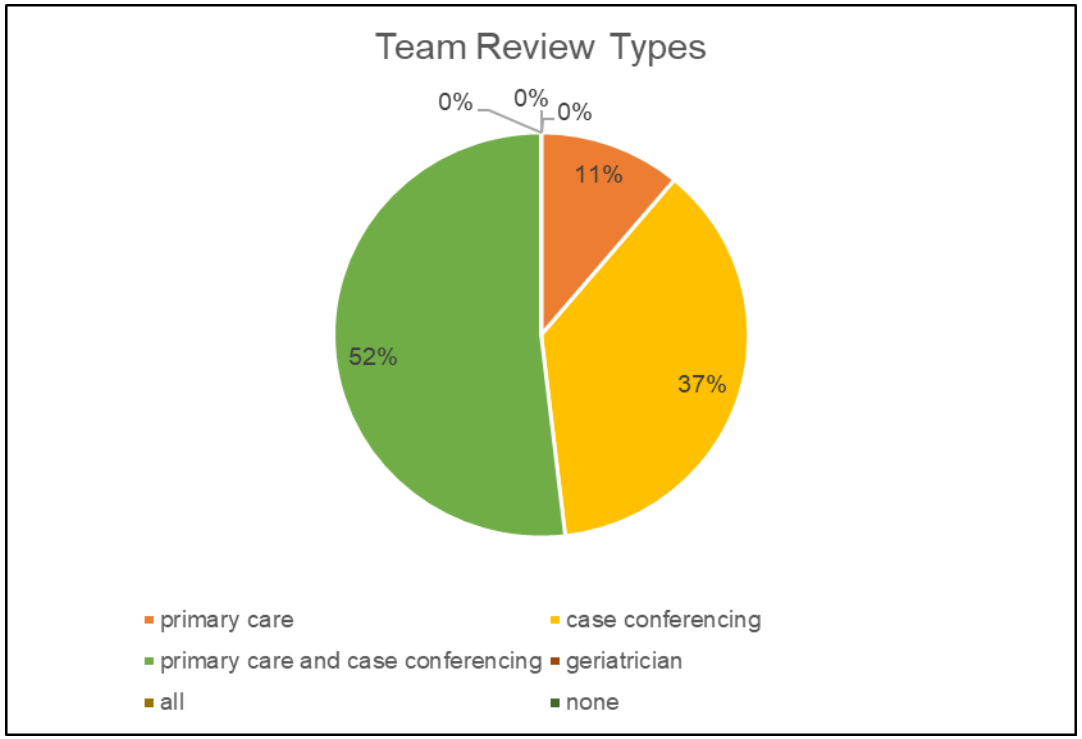

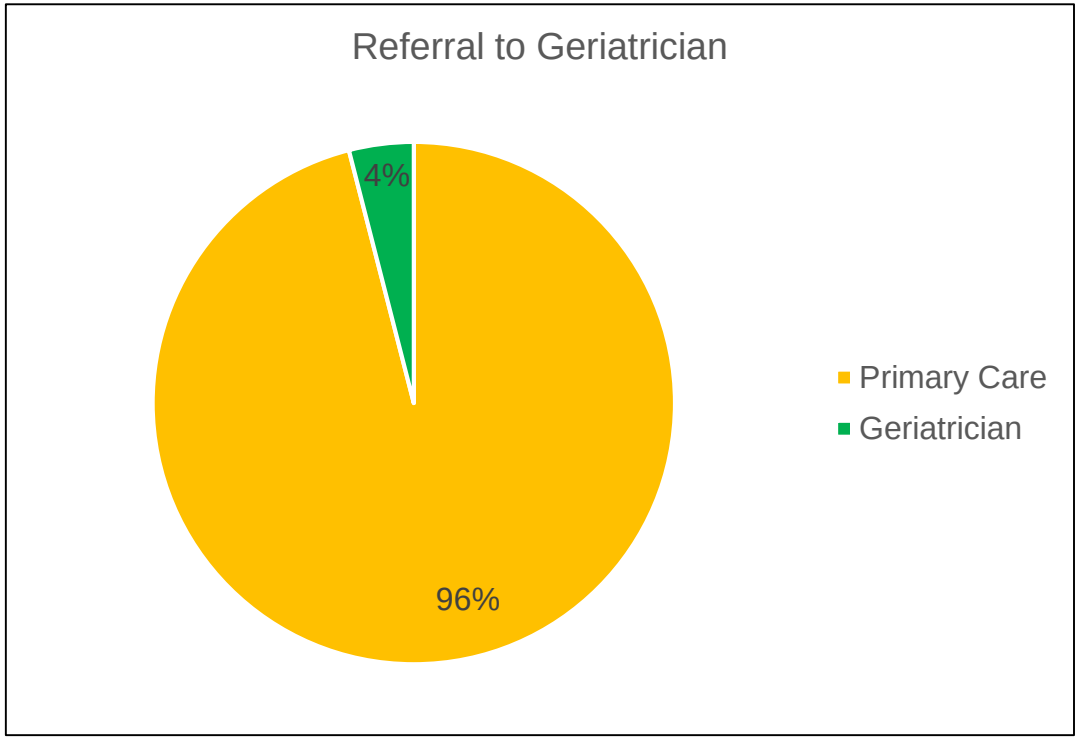

Next steps:
Primary Care Integrated Geriatrics Teams

Model Expansion:

- Increase physician complement to 2 Primary Care MD's with future state increase to 6-8 MD's
- Expand incoming referral sources to Community Partners and develop formal referral pathways
- Recruitment- other health care providers, additional admin support
- Adopt a formal model to identify frailty utilizing existing EMR technology/support from clinical staff
- Collaboration with Ontario Health Teams for future funding and expansion opportunities