

Short Report on Models and Examples of Primary Care Integrated Geriatric Teams

Updated April 6, 2026

Introduction

On May 8 and June 10, 2025, Provincial Geriatrics Leadership Ontario (PGLO) and the Regional Geriatric Program of Southwestern Ontario (RGP SWO) hosted virtual sessions that included eight (8) presentations from different Ontario Health Regions, and audience interaction with 199 participants from primary care, specialized geriatric services and other settings. Key presenter and audience themes are briefly summarized below. To view the full session video, presentation slides and other resources visit <https://bit.ly/4crsTAu>

Themes Across Presentations and Participants

Enablers

- ✓ Integrated interprofessional (IP) teams and access to specialized resources
- ✓ Proactive & Flexible Models
- ✓ Partnerships & Co-Design
- ✓ Technology & Shared Documentation
- ✓ Scalable and Adaptable Models
- ✓ Patient and Provider Satisfaction

Timely Tidbits:

- Consider adding a budget line for geriatric medicine and geriatric psychiatry sessionals in proposals to support access to specialists.
- Access the free Provincial Common Orientation to the Care of Older Adults to help onboard new IP team members – see more at <https://geriatricsontario.ca/initiatives/provincial-common-orientation/>

Gaps Impeding Scale Up

Challenge Areas	Workforce & Capacity	Shortage of specialists and other health human resources, training gaps, burnout and overwork among professionals and caregivers.
	Technology & Communication	EMR Fragmentation, digital gaps, poor interoperability, limited access to tools, communication & navigation barriers
	Policy & Funding	No cohesive older adult strategy, time-limited funding, lack of scale up mechanisms
	Equity & Inclusion	Limited rural reach, cultural competency gaps, access for unattached patients
	Engagement	Variable primary care buy-in, lack of sustained community co-design, insufficient linkages to community services
	Spread & Evaluation	Few standardized toolkits, inconsistent data, limited evaluation frameworks

Highlights of Participant Feedback

Ideas

- ✓ **Integration and Collaboration:** Include community services and IP teams to address social determinants, reduce duplication and streamline geriatric care. Leverage cross-program assets.
- ✓ **Holistic Care:** Address both mental and physical health to provide comprehensive, person-centered care.
- ✓ **Digital Systems:** Improve digital communication and documentation to enhance information sharing, especially in underserved areas.
- ✓ **Scalability:** Assess successful pilots for broader implementation, adapting to regional needs. Create sustainable funding models.
- ✓ **Proactive Community Care:** Shift specialized resources into primary care to increase access and reduce hospital dependency.
- ✓ **Patient and Family Engagement:** Engage early during intake to improve care planning and team coordination.

Supports

Required supports

- Access and equity (e.g., rural)
- Advocacy
- Coordination
- Communication channels
- Expansion (e.g. models, teams)
- Funding and policy
- Implementation support
- Integration (e.g. community supports)
- Navigation and case management
- Leadership
- Technology and tools
- Training and workforce development