Primary Care Integrated Geriatric Teams

Provincial Geriatrics Leadership Office Webinar
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Changing Accountability

Baycrest

Accountable for:

- Quality of care and experience of referred patients
- Funded volumes

NORTH TORONTO Ontario Health Team

NORTH YORK TORONTO HEALTH PARTNERS
COMPASSIONATE NORTH YORK

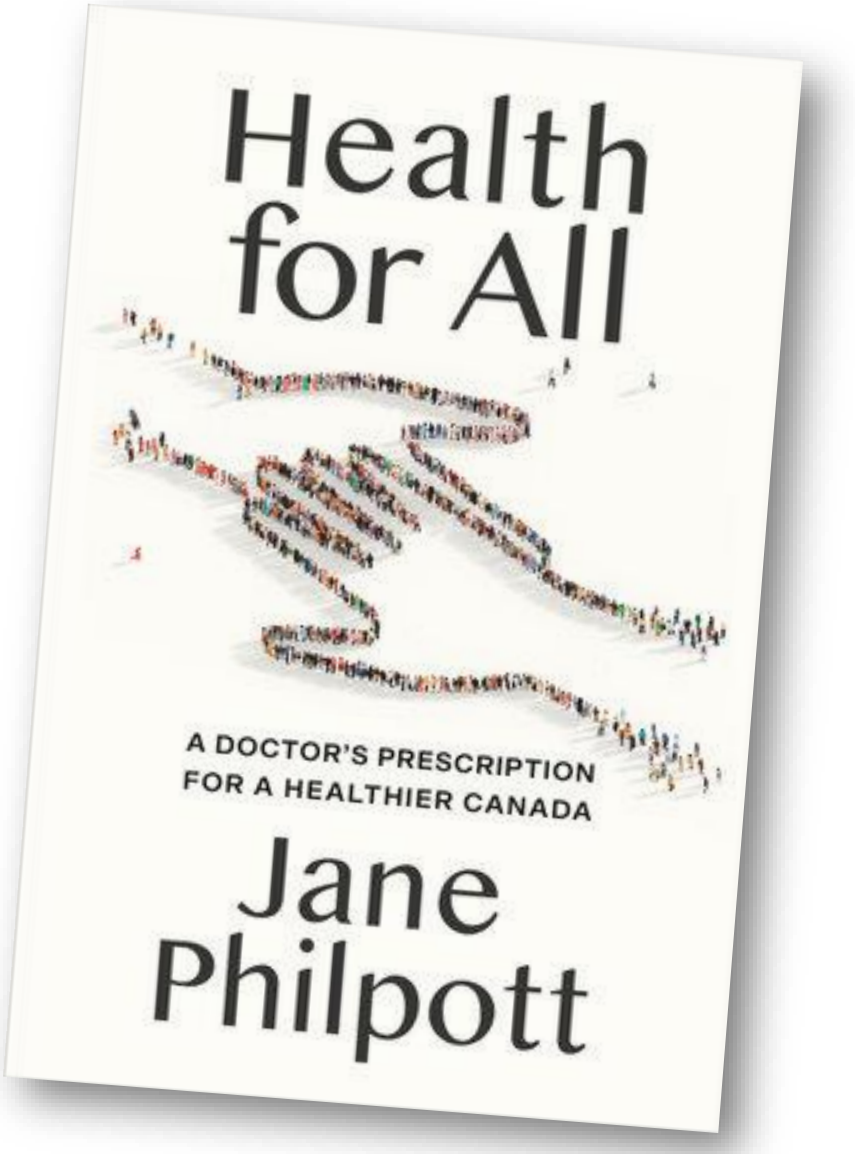
Accountable for:

- Health outcomes of a population
- Total cost of care

Strategic Goal: **Work with primary care** to enhance access to exceptional dementia care.

Primary Care Homes are the heart of an integrated system

- … staffed by a team… trained to function as an integrated team…
- … your electronic medical record is collated in one place… care team members can access that information…
- … specialist physicians are available to see you when they make regular visits to the primary care home.



Plan and Co-Design with OHTs and their Primary Care Networks

1

Team Supports

2

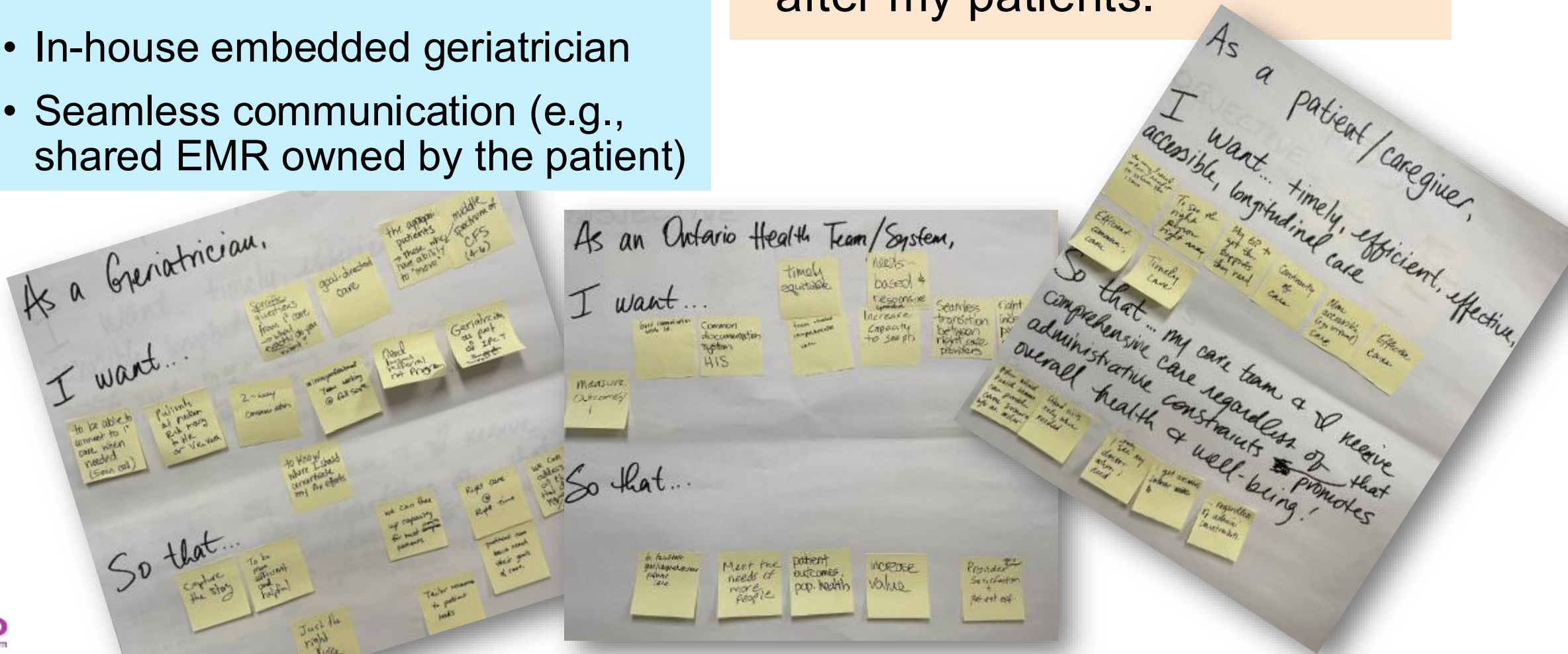
Neighbourhood Care Teams

Integrated Health Hubs

3

1. Team Supports to Primary Care in the Community

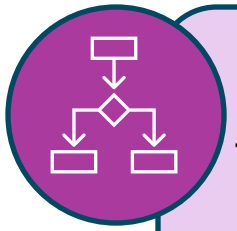
As a Family Doctor I want…	So that…
• Easy access to interprofessional teams • In-house embedded geriatrician • Seamless communication (e.g., shared EMR owned by the patient)	• I can spend more time looking after my patients.



NORTH TORONTO
Ontario HealthTeam

Primary Care / Geriatric Medicine / Team

Using co-design and quality improvement techniques we developed a care model with the following features:



Electronic Frailty Index to automatically identify segmented needs related to frailty

Interprofessional team assessment in a Family Health Group

Specialist attending the office

Documentation in the primary care electronic medical record

Quote

‘The work brings me back to my passion for working with teams, with experts, in close physical proximity… helps optimize communication, reduce extra work… this has huge benefits for my practice and my patients.’

Frailty client

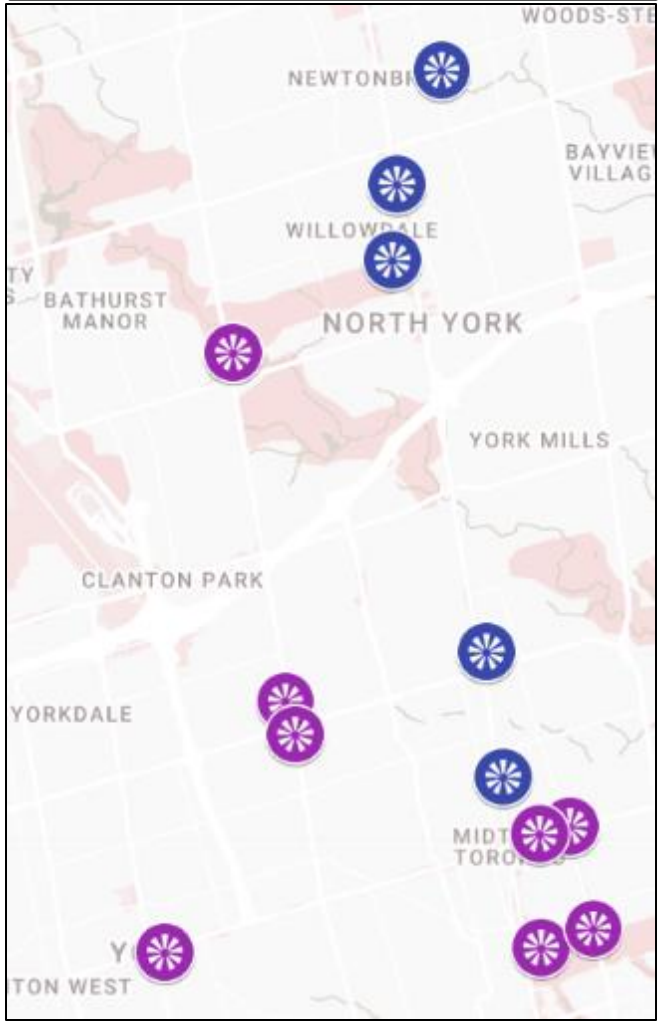
- KD-67 yrs married male, lives in a 2 story home, drives, walks large dog
- Self employed – Software Developer-Retirement soon?
- PMHx- HTN, Asthma, Benign Essential Tremor (left hand/dominate) OSA(untreated),Dyslipidemia, DDD, OA (knees)R heel tendonitis, BPH
- Medications- 8 prescribed and 2 Vitamins-vials- BPMH
- ROS- Decreased hearing, Poor sleep, Pain(shoulders/foot), Fall, ETOH(beer), Nocturia, Low mood
- PHQ9-8; Frailty score 4; GAD 7-3; MoCA 20/30-(↓recall, attention)
- Referral to Geriatrician- Recommendations-Treatment for OSA, Mood, Respirology, Specialized Brain Ultrasound (Tremors), Hearing test

2. Neighbourhood Care Teams in 8 Buildings

- Accessible to 900+ Tenants; 300+ active users
- Tenants co-design the care and services
- 11 delivery partners; structures for collaboration.
- 75 Tenants connected to primary care

Escalation Supports	Geriatrician
Care support Team	Diabetes Education
Building Core Team	• Family Doctor • Care Coordinator • Allied and Nursing

Purple locations currently have NCT.



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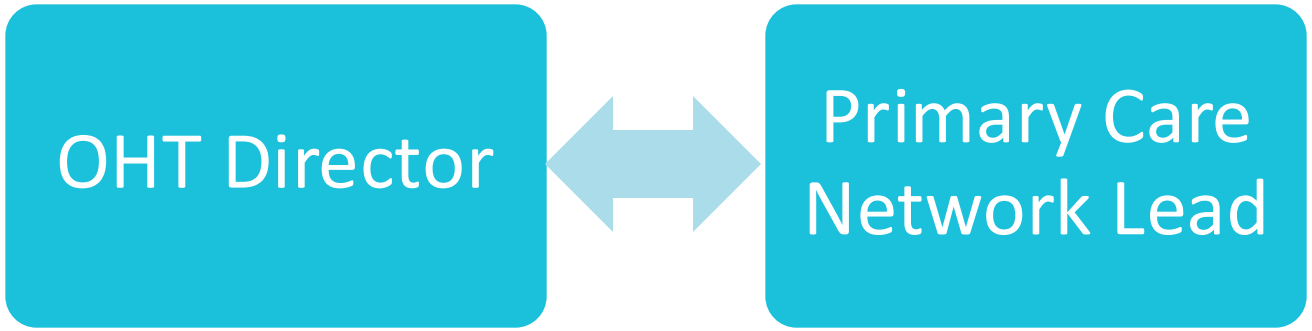
Connect with Your Primary Care Network



Suggest Adding Specialist Sessionals to Proposals

SPECIALIST SESSIONALS / COLLABORATING PHYSICIAN(S)	NUMBER OF SESSIONALS or FTE	RATE
Specialist Sessionals (FHT only) *Please enter # of sessionals -->*	**52**	$ 760
Collaborating Physicians (NPLC only) *Please enter NP FTE # -->*		$ 12,396
Other *(please specify)*		