Integrated Care Team for Older Adults - *Wrapping Team-based Primary Care around Complex Geriatric Patients in KW4 OHT*

KW4 ONTARIO HEALTH TEAM

- May 8, 2025
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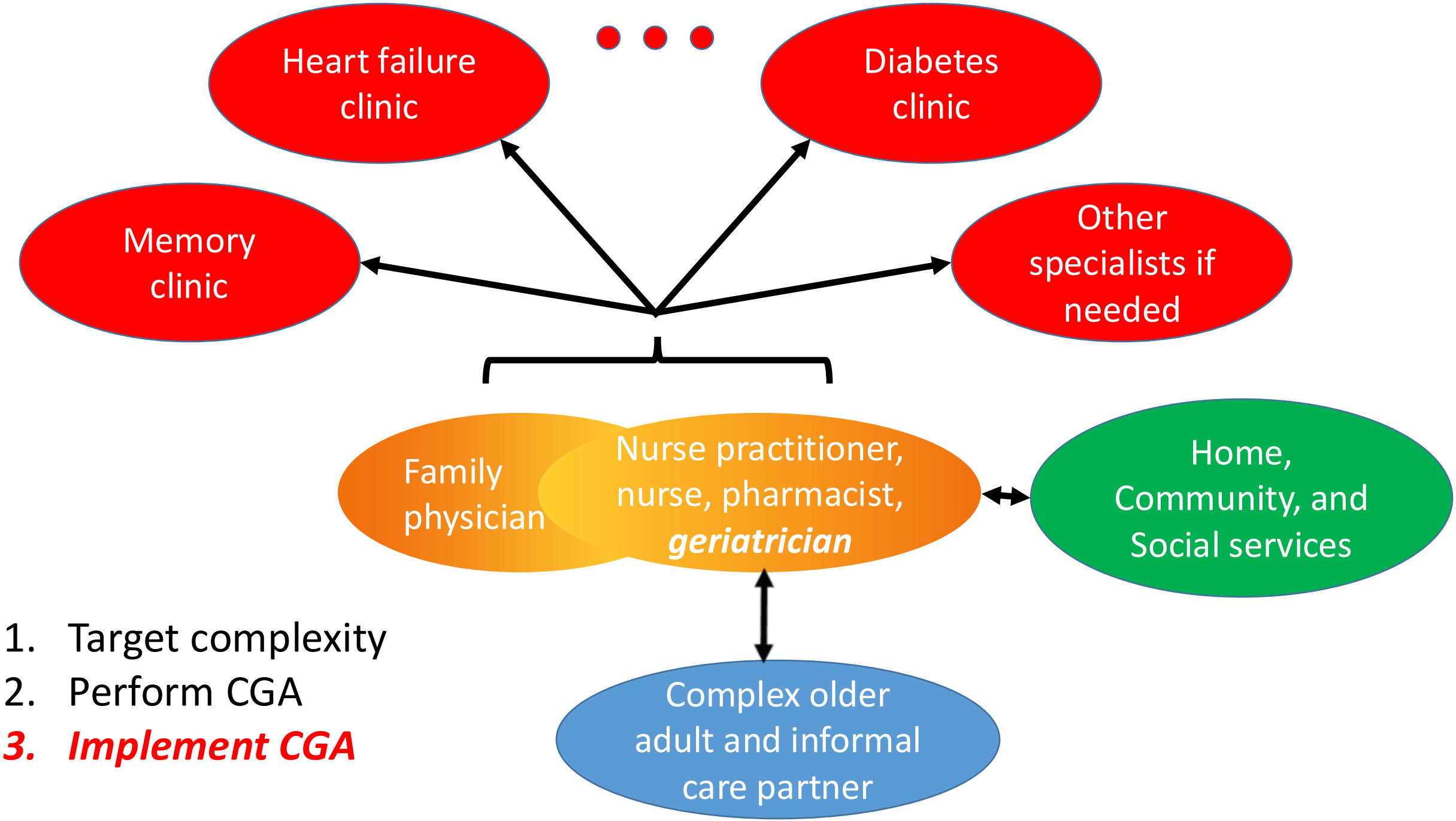
The Challenge of Population Aging

- Older adults have complex health needs due to multimorbidity, disability, geriatric syndromes
- Healthcare is fragmented, hard to navigate, access to required resources difficult, and caregivers are overwhelmed
- These older adults face high rates of acute care use, delirium, functional decline, ALC days
- Solutions deployed (TCUs, increasing LTC beds) are inadequate

Comprehensive Geriatric Assessment

- Multidisciplinary diagnostic and treatment process to understand the medical, psychosocial, and functional strengths and needs of an older person with complex needs.
- Goal: develop a coordinated plan to maximize overall health

- Threats to efficacy
  - SGS wait times, resource limitations
  - Limited primary care capacity to implement CGA recommendations
  - Health system fragmentation



1. Target complexity
2. Perform CGA
3. ***Implement CGA***

Essential features

- Embeds expertise for CGA into primary care, and builds capacity to implement and adjust the plan
- Interprofessional and shared care
- Patient and caregiver centered and flexible
- Promote self-care and provide case management
- Access: phone, email, timely – early intervention prevents crises
- Strong connection with community resources
- Support ED and hospital transitions
- Fewer follow-ups by specialists increases their capacity for new consults

Outcomes Heckman et al, Healthcare Management Forum 2025

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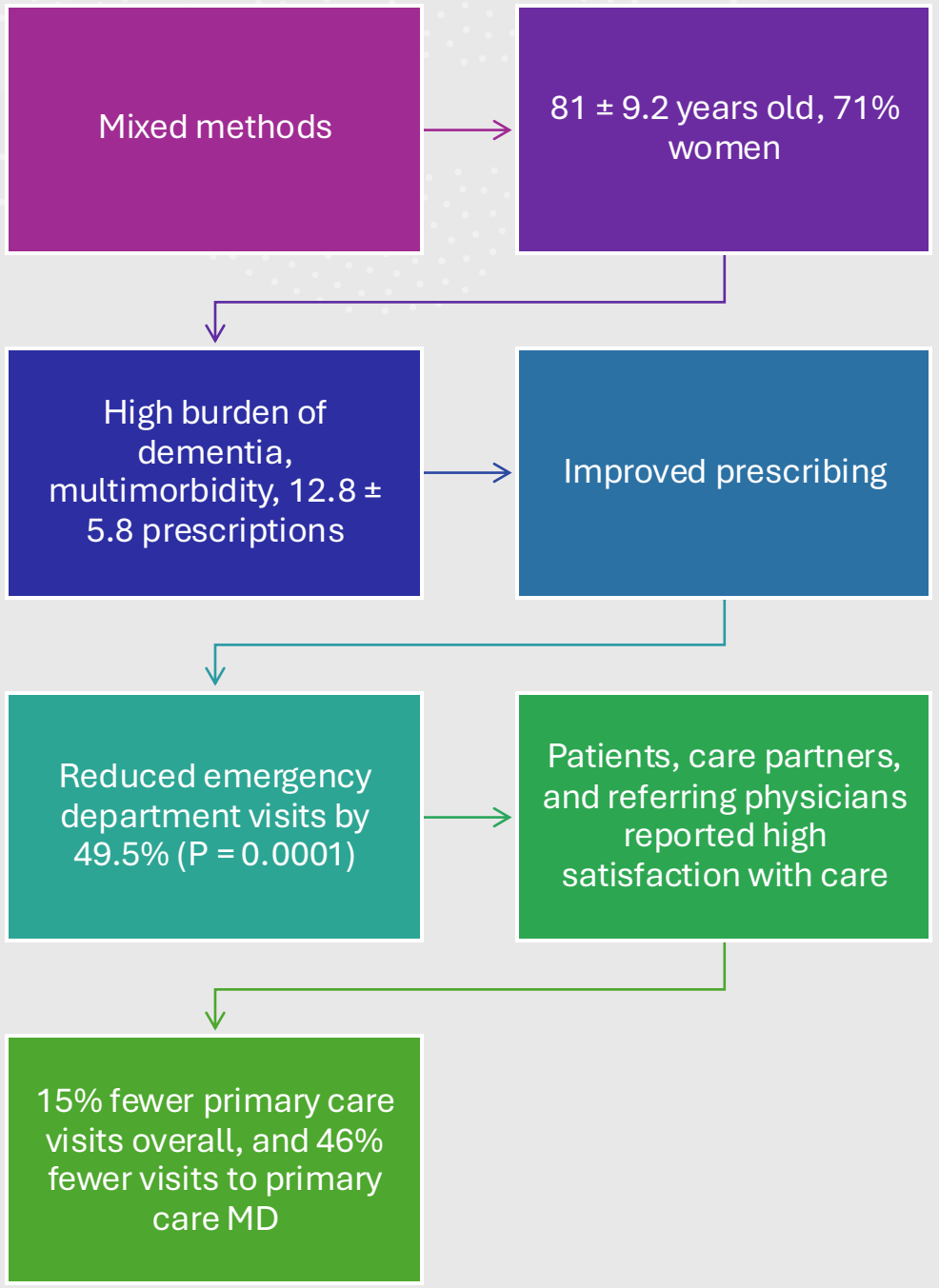
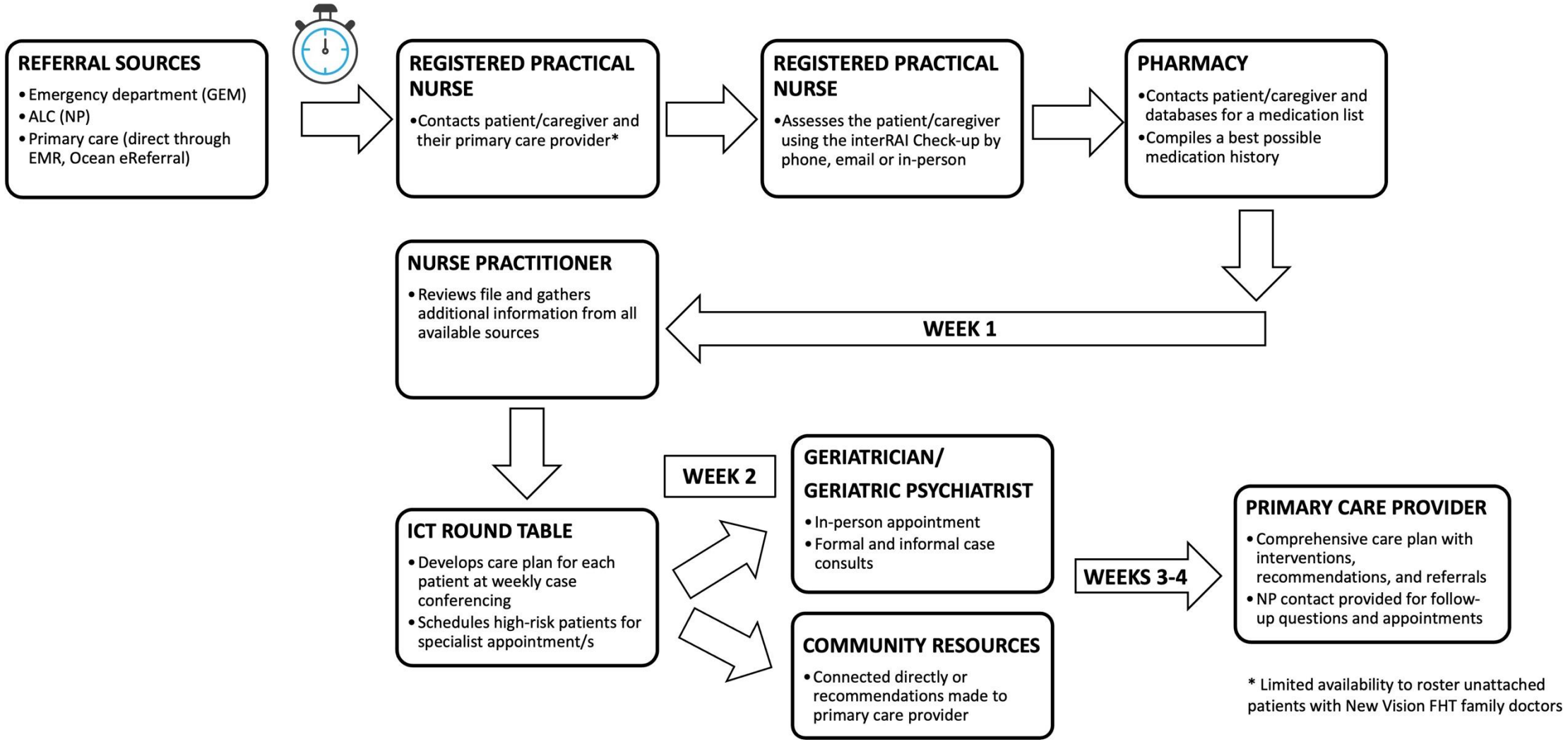


OH West ALC Strategy opportunity 2023

- 18% of family physicians have access to an interdisciplinary team
- 175 days is the average wait time to see a geriatrician

- Deploy ICT to support additional FHOs
  - Add geriatric psychiatrist
  - Integrate additional community services into program and develop new care and referral pathways

Process Map


REFERRAL SOURCES
• Emergency department (GEM)
• ALC (NP)
• Primary care (direct through EMR, Ocean eReferral)
REGISTERED PRACTICAL NURSE
•Contacts patient/caregiver and their primary care provider*
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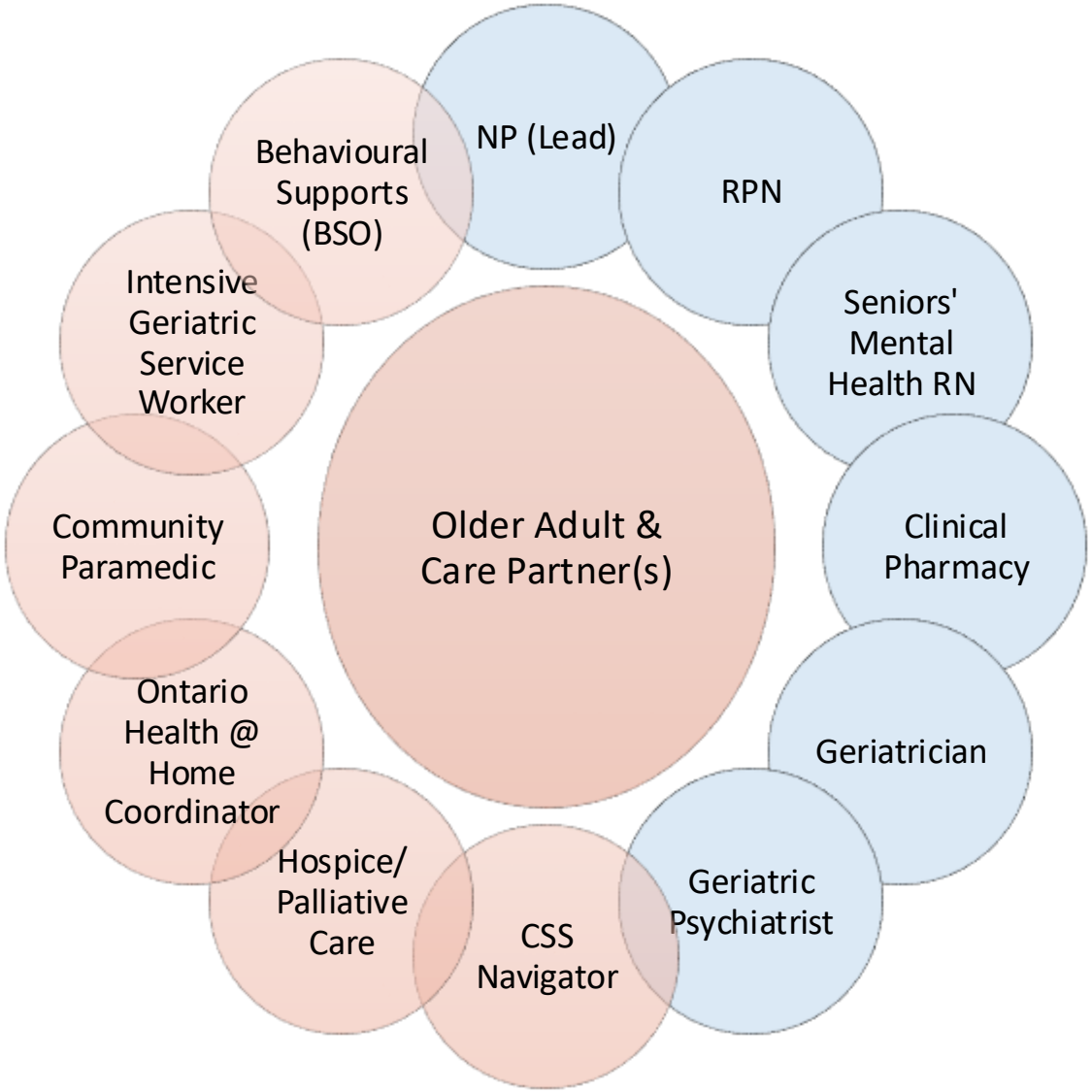
•Assesses the patient/caregiver using the interRAI Check-up by phone, email or in-person
PHARMACY
•Contacts patient/caregiver and databases for a medication list
•Compiles a best possible medication history
NURSE PRACTITIONER
• Reviews file and gathers additional information from all available sources
WEEK 1
WEEK 2
ICT ROUND TABLE
• Develops care plan for each patient at weekly case conferencing
• Schedules high-risk patients for specialist appointment/s
GERIATRICIAN/ GERIATRIC PSYCHIATRIST
• In-person appointment
• Formal and informal case consults
COMMUNITY RESOURCES
• Connected directly or recommendations made to primary care provider
WEEKS 3-4
PRIMARY CARE PROVIDER
• Comprehensive care plan with interventions, recommendations, and referrals
• NP contact provided for follow-up questions and appointments
* Limited availability to roster unattached patients with New Vision FHT family doctors

The Team: KW4 ICT for Older Adults



Standardized tool, self-report

Primary Care focus and engagement

- Communication - embedding where possible
- Needs assessment
- Resource support - IT, admin

Flexible model - right provider, right time, right patient

Integration with Community Resources

- Bi-weekly Round Table
- Hypercare
- Digital Integration (CHRIS, Caseworks, Clinical Connect, Primary Care EMR)

Chronic Disease Management

- Person-centered, not disease-centred
- CHF, COPD, Dementia, Diabetes, HTN, CAD, Chronic Pain and Osteoarthritis, Chronic Mental Illness, Chronic wounds, Cancer Survivorship, Stroke, Falls

Focus on Access

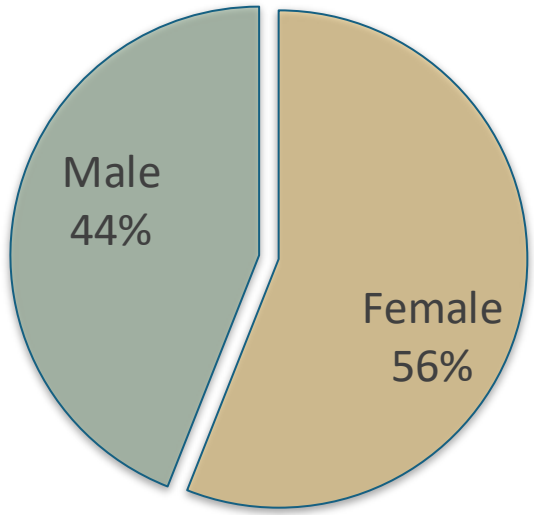
- Enhanced primary care access reduces caregiver burnout, improves community provider effectiveness, reduces ED visits, improves hospital transitions

Patient Profile

A typical ICT patient has frequent primacy care visits, ED visits, and hospital admissions. They live with:

- Multiple co-morbidities
- Progressive dementia with behaviours
- Care partner burnout
- Poor social support and system navigation needs
- Frequent falls
- Polypharmacy requiring optimization / deprescribing

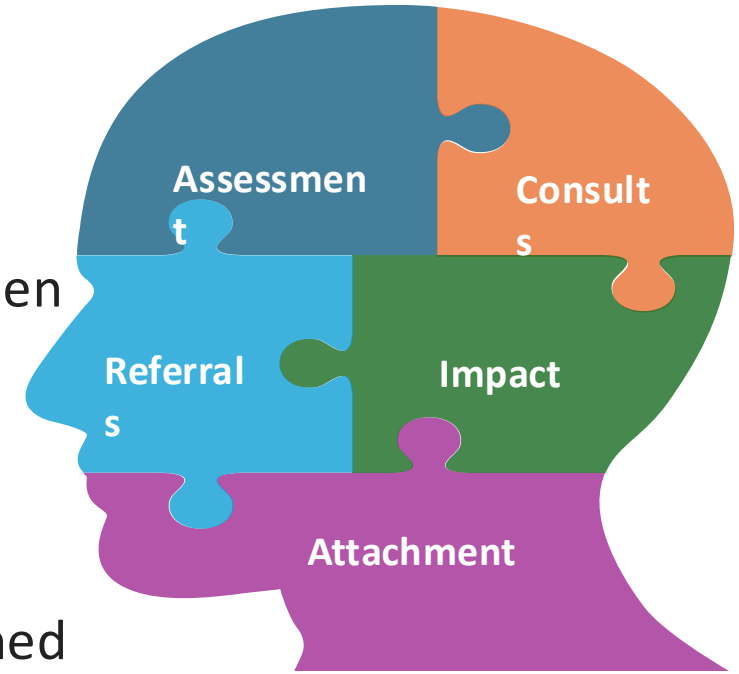
Average Age: 79 Years



KW4 ICT: Impact

Unattached Patients

- 3.7% of ICT patients unattached when referred
- KW4 unattached rates
  - 2.4% with age 65+
  - 1.7% with age 80+
- Promising means to divert unattached patients from hospital



Patient/Caregivers

- 43% agree/strongly agree they would have gone to ER without the KW4 ICT
- 85% said the program made them more confident in managing their health

Primary Care

- 89% agree the KW4 ICT helped improve access to shared care for their patient
- 67% agree the KW4 ICT prevented ED/hospital visits for their patients
- Exceeds PGLO standard planning assumption of 1.0 clinical FTE supporting 500 visits/year.
- ICT: 1 .0 FTE clinician offers 657 visits per year

Lessons Learned

Building Block	Explanation	ICT Model
Oversight	Decision-maker-level participation is required to troubleshoot barriers, with staff from multiple organizations working together	Monthly implementation committee with partners and system leaders
Co-Design	Embed a common purpose and consistent buy-in by designing the proposed model of care with partners from the outset	Worked with regional partners on goals and model of care
Culture	Providers must be willing to learn from each other, to share the responsibility for care, and to work towards a single care plan	Built upon New Vision experience with shared care programs
Adaptability	Partnerships, funding, and system priorities may evolve; the need for complex older adult care does not diminish	Regular checks with referral sources and adapted processes as needed
NP Leadership	NPs have the training and system awareness to lead multidisciplinary teams who have a shared responsibility for care	Hired NPs with leadership skills and support team to work at full scope
Standardized Instrument	Allows all providers on the team to use a common language for screening, assessment, and care planning	interRAI Check-up comprehensively captures health and social needs consistent with home care and CSS
Patient-Centred	Ensure patients can express their needs alongside clinician referral; use a palliative approach and a goals of care lens	Check-up completed prior visit reduces assessment burden to focus on patient
Project Management	Significant time and effort is required to develop, implement, sustain, and measure a shared care program	Dedicated implementation and clinical leads for all phases of the program

Accolades and impact

- KW4 ICT for Older Adults has been held up as an exemplar for primary care integration with SGS and CSS in Ontario.
  - Presented at AFHTO 2021, 2023, Canadian Academy of Geriatric Psychiatry ASM 2023, Canadian Geriatric Society ASM 2023.
  - Winner 2022 AFHTO Bright Lights Award (presented by Minister Sylvia Jones) for integration into non-team-based primary care.
  - Grants: $93,650.00 Health Excellence Canada; $450K over 2.5 yr from Canadian Centre for Caregiving Excellence (Azrieli Foundation).
  - Included in Provincial Geriatrics Leadership Ontario's asset mapping.
  - Paper published in Healthcare Management Forum 2024.
  - Promising Practice for Healthcare Excellence Canada
  - Workshop at upcoming FMF November 2025

The team continues to present at provincial and national conferences, with ongoing interest to adopt the KW4 ICT model in more jurisdictions.

Thank you

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