Attachment in the Aging Era:

Preparing Primary Care Teams Through Training & Integrated Design

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Provincial Geriatrics Leadership Ontario

The Power of Primary Care Summit: Leading the Attachment Era Together
AFHTO Conference, October 15, 2026

Presenter Disclosure

- **Faculty:**
  - Kelly Kay, PhD
  - Meghan Peters

- **Relationships with financial sponsors:**
  - Kelly is an employee of Provincial Geriatrics Leadership Ontario
  - Meghan is an employee of City of Lakes Family Health Team

Ontario's Network of Specialized Clinical Services for Older Adults

Provincial
(Macro)

Regional Programs
(Meso)

Local Clinical Services
(Micro)

Provincial Geriatrics Leadership Ontario

Specialized Geriatric Services Central
Specialized Geriatric Services East
Specialized Geriatric Services North
Specialized Geriatric Services Toronto
Specialized Geriatric Services West

North Simcoe Muskoka Specialized Geriatric Services
seniors care network
RGPSE
Regional Geriatric Program of Eastern Ontario
St. Joseph's Care Group
North East Specialized Geriatric Centre
RGP Regional Geriatric Program of Toronto
Waterloo Wellington Older Adult Strategy
St Joseph's Health Care London
Regional Geriatric Program of Southwestern Ontario
RGP Central

Emergency/ Urgent Care Programs
Acute Care Programs
Rehabilitation & Post-Acute Programs
Community Geriatrics Programs
Primary Care Programs
Long-Term Care Programs

(Includes: geriatric medicine, COE, seniors' mental health/geriatric psychiatry, interprofessional SGS and SMH teams)

Sets **provincial direction**, enables system integration, provides backbone support, and ensures alignment across Ontario.

Translate provincial strategy into **regional action**, ensure coordination and consistency, and support providers.

Deliver **specialized care directly to older adults**, implement integrated models, and share experiences of day-to-day realities of patients and caregivers.

Bi-Directional Communication and Engagement

Leading Attachment in the Aging Era Together

- Why focus on older adults
- How do we prepare primary care teams to confidently attach and support older adults with complex needs?

Objectives

- Identify key competencies and training options for primary care teams to gain the knowledge and skills to support older adults with complex needs
- Examine transferable models that integrate geriatric expertise into primary care
- Apply design insights to strengthen attachment and aging-in-place strategies

Successful Attachment Requires Planned Support

An older adult living with frailty, cognitive changes and depression is newly attached to a primary care team. Her daughter is increasingly concerned about her mother's ability to live at home independently. Medications have accumulated, and recent falls have resulted in repeated urgent-care visits.

Why Attachment Looks Different in An Aging Population

- Needs cross medical, functional, cognitive, mental health and social domains.
- Changes may be subtle, interconnected and difficult to address in a standard visit.
- Older adults and care partners often navigate multiple providers and sectors.
- Unmet complexity appears elsewhere in the system: repeat visits*, emergency care, hospitalization and premature institutional care.
- **Attachment without adequate team capacity can relocate the pressure rather than resolve it.**

Older adults living with complex health concerns are not the “problem.” The challenge is that conventional care processes may not be designed for their needs.

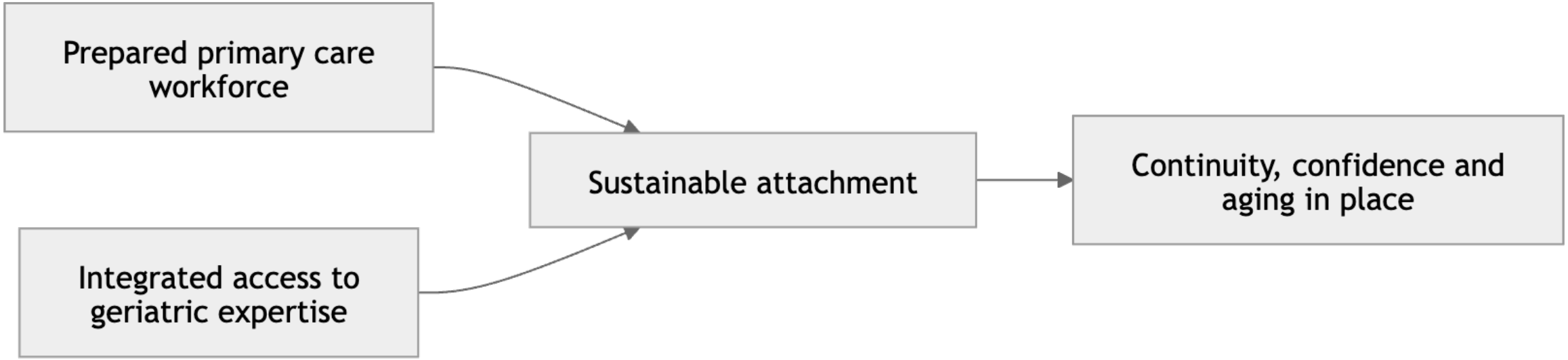
*up to 10-12 visits per year (ICES, 2023)

The Aging Reality: Attachment must consider complexity



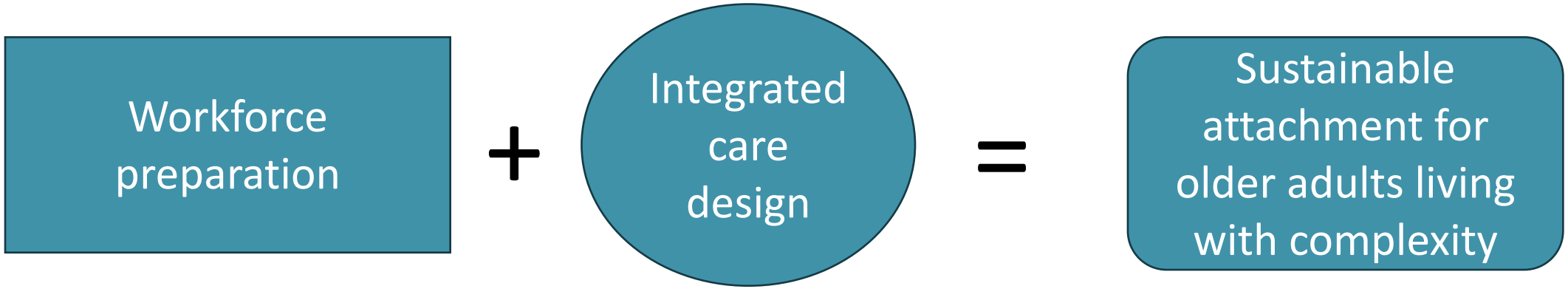
Reflection: What is currently your biggest challenge in caring for older adults with complex needs?

Preparing Primary Care Teams for Complexity



- How can we build on the expertise of primary care teams to recognize and respond to complexity?
- How can geriatric expertise be integrated as a support, without requiring one uniform model?

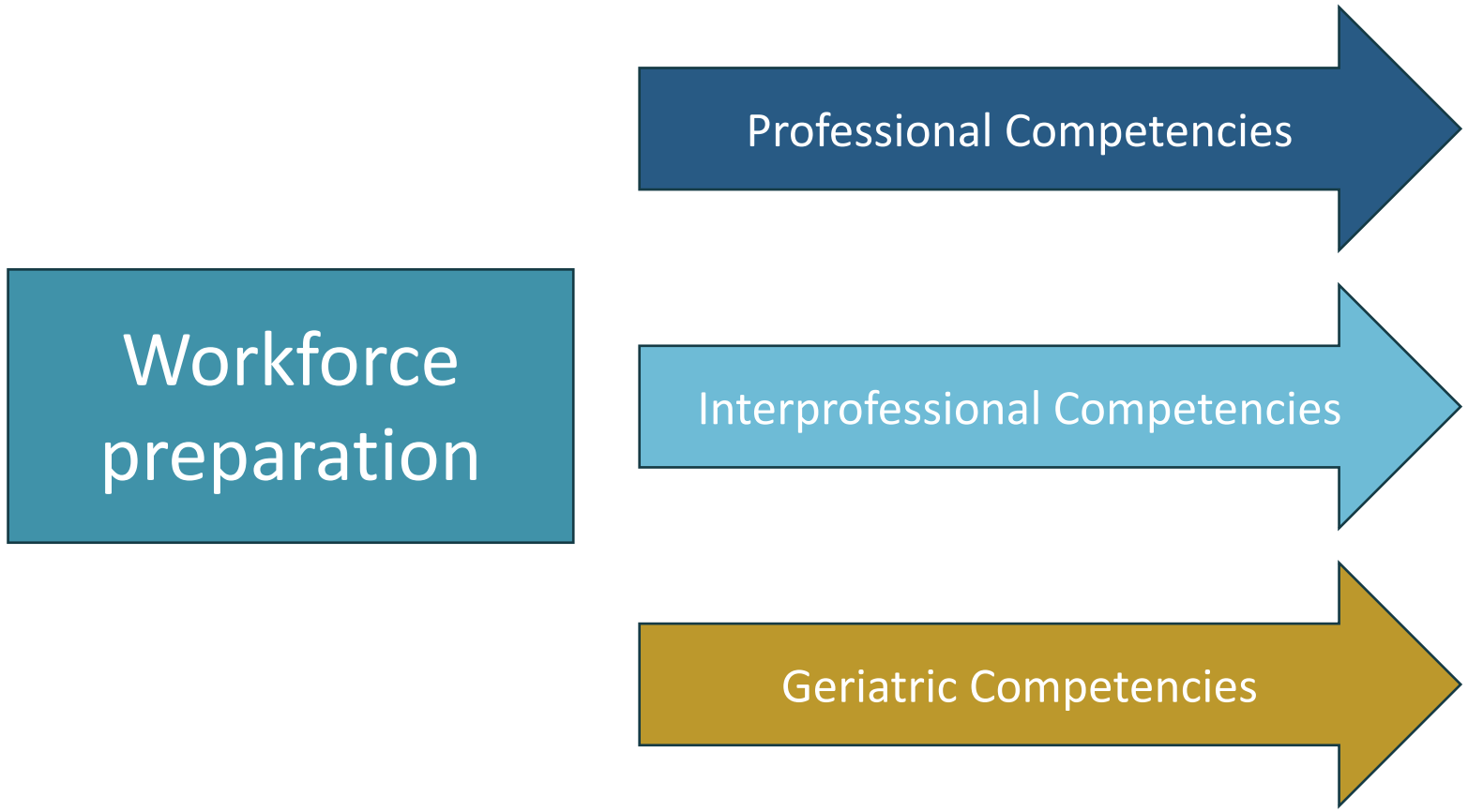
A Framework for Success



- Two things must evolve together:
  - Training alone is insufficient
  - Models alone are insufficient

- Sustainable attachment requires both

Workforce Preparation



Clinical Activities

- Frailty identification
- Dementia care
- Mental health in later life
- Medication Optimization
- Care partner engagement
- Risk assessment and management
- Community navigation

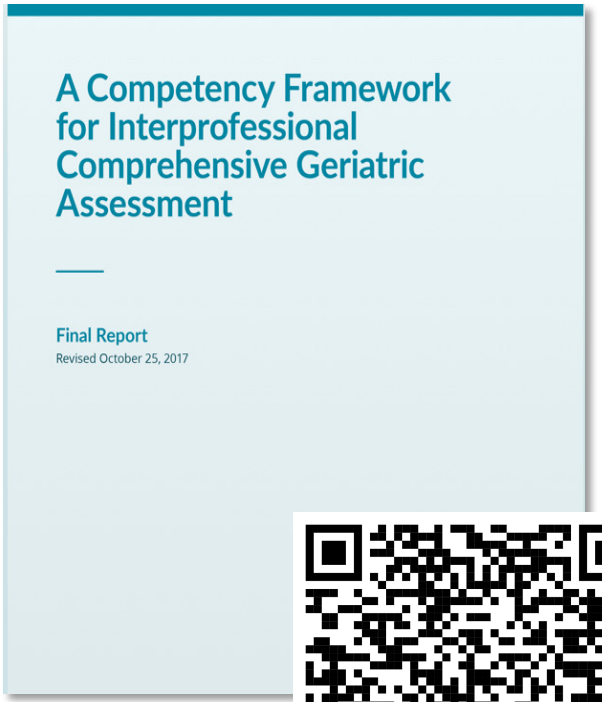
Workforce Preparation

Workforce preparation

Professional Competencies

Interprofessional Competencies

Geriatric Competencies



Supporting Workforce Preparation

The Provincial Common Orientation to the Care of Older Adults is a workforce training series for health and social care professionals.

Combining on-line content (self-paced) and 11 weekly 90-minute virtual (synchronous) sessions to discuss and apply content, facilitation is led by expert interprofessional geriatric assessors.

Topics are addressed through 27 interactive modules covering content ranging from normal aging, ageism and communication to screening, assessment, care planning and intervention across geriatric syndromes.



What We Learned From Training Primary Care Team Members

70
Interprofessional Team Members Trained

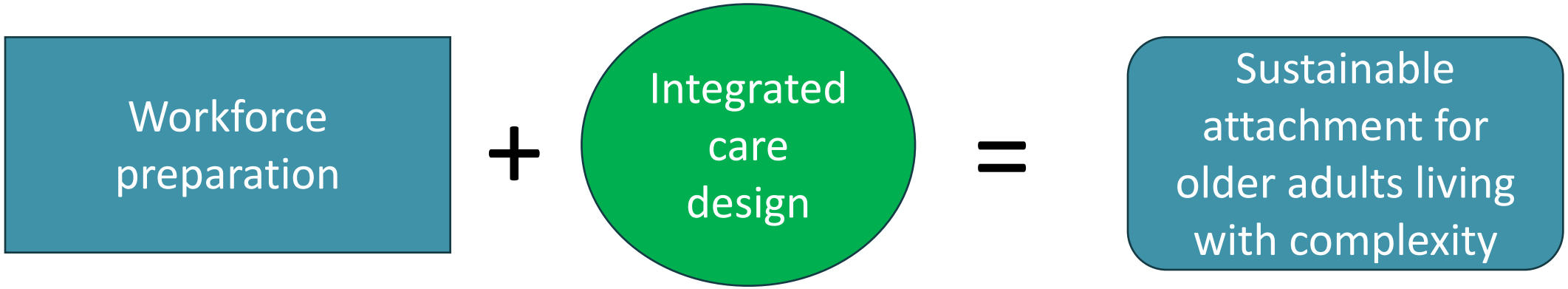
35+
Primary care practices participating

92%
Reported improvements in care

28%
Average increase in knowledge across 27 topics

- Knowledge gains matter—but the real objective is changing what teams notice, discuss and do.
- Our evaluation data highlights several reported practice gains:
  - Conducting more holistic assessments
  - Recognizing frailty and cognitive or mental health concerns earlier
  - Strengthening team discussions and referrals
  - Using more person-centred language and care planning

Integrated Care Design



Key Objective: Bringing care closer to primary care

Integrated Care Design



Integrating Geriatric Teams in Primary Care: Transforming Aging Care Through Collaborative Models in Ontario

Kelly Kay, Katie Bingham, Melanie Briscoe, Cailin Campbell, Sandra Easson-Bruno, Jacobi Elliott, Nicole Gallagher, Amanda Gardhouse, Sean Goldhar, George Heckman, Allison Hewitt, Mark Lachmann, Heather MacLeod, Chantelle Mensink, Adam Morrison, Mihaela Nicula, Jagger Smith, Fran Wolfe and Kevin J. Young

Link to examples

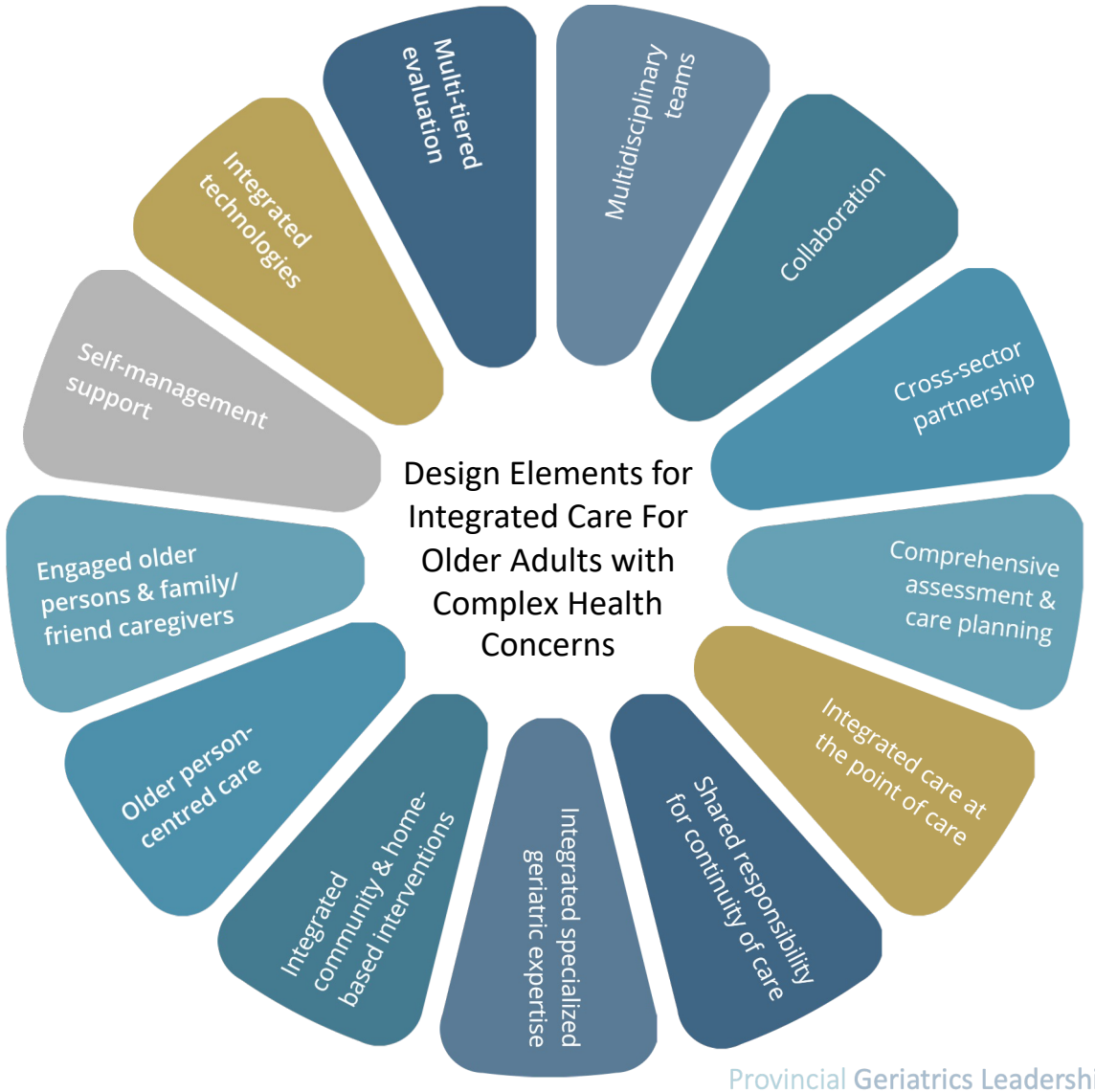
Integrated Geriatric Expertise into Primary Care

Integrated function	Possible model examples
Early identification	Screening, case finding or frailty pathways
Collaborative assessment	Geriatric assessor or interprofessional geriatric clinic embedded in primary care
Shared care	Primary care and geriatric specialists jointly supporting complex cases
Consultation	Rapid advice, eConsult, case conferencing or outreach
Navigation and coordination	Dedicated navigation between primary care, community and specialist services
Capacity building	Coaching, mentorship and case-based education

The structures may vary, but successful models make expertise easier to access, share and apply.

Integrated Geriatric Expertise into Primary Care

Integrated care design



What Differs and What Remains Consistent

Adapt to local context	Preserve across models
Team composition	Clear access pathways
Physical or virtual delivery	Defined roles and accountability
Referral and eligibility processes	Timely communication
Frequency of geriatric involvement	Interprofessional collaboration
Urban, rural or regional configuration	Older adult and care partner partnership
Funding and organizational arrangements	Connections across sectors

Design without dogma

Enabling Implementation

- Leadership commitment and protected implementation time
- Clearly defined roles, scope and pathways
- Relationships and trust across organizations
- Shared information and communication processes
- Ongoing education, coaching and opportunities to learn through cases

Attending to equity from the outset

- Who is most likely to remain unattached—or nominally attached but unable to benefit from care as currently designed?

Outcomes Observed

- Reduced or prevented ED Visits
- Increased access to evidence-informed geriatric-focused care
- Reduced specialist referrals
- Improved provider confidence
- Improved patient confidence
- Improved caregiver confidence

Applying Insights to Your Team

Think of an older adult with complex needs who might become newly attached to your team. Where would your current model work well—and where would it begin to strain?



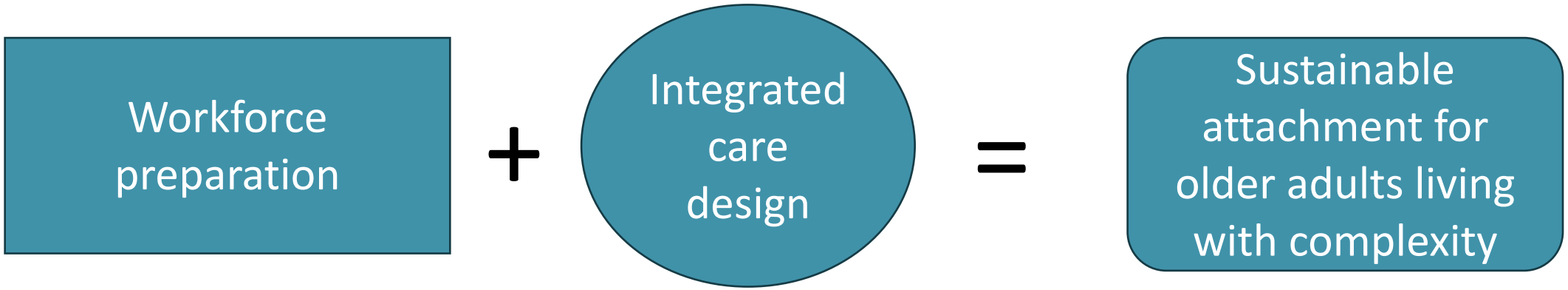
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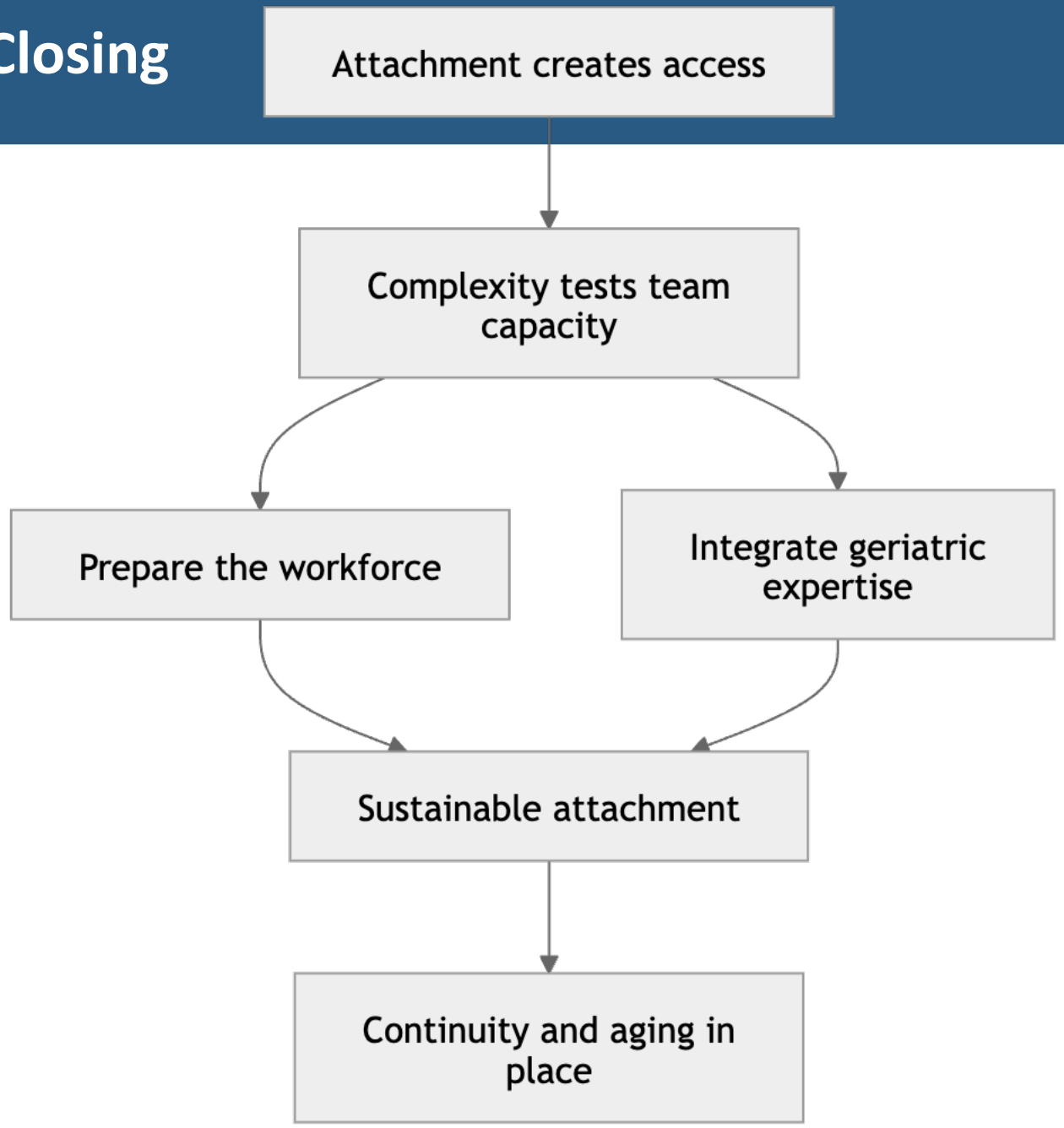
Workforce	Integration	Design	Equity
What must our team know or be able to do?	What expertise or partnership must be easier to access?	What process would need to change?	Who might still experience barriers?

Key Takeaways – Attachment in the Aging Era

1. Older adults with complex needs are central to the attachment challenge
2. Workforce preparation matters
3. Integrated geriatric design works
4. Training and model design must evolve together
5. **Every primary care team can take one practical step forward! And many already are!**



In Closing



Come Learn With Us!



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Family Health Team
Équipe de santé familiale

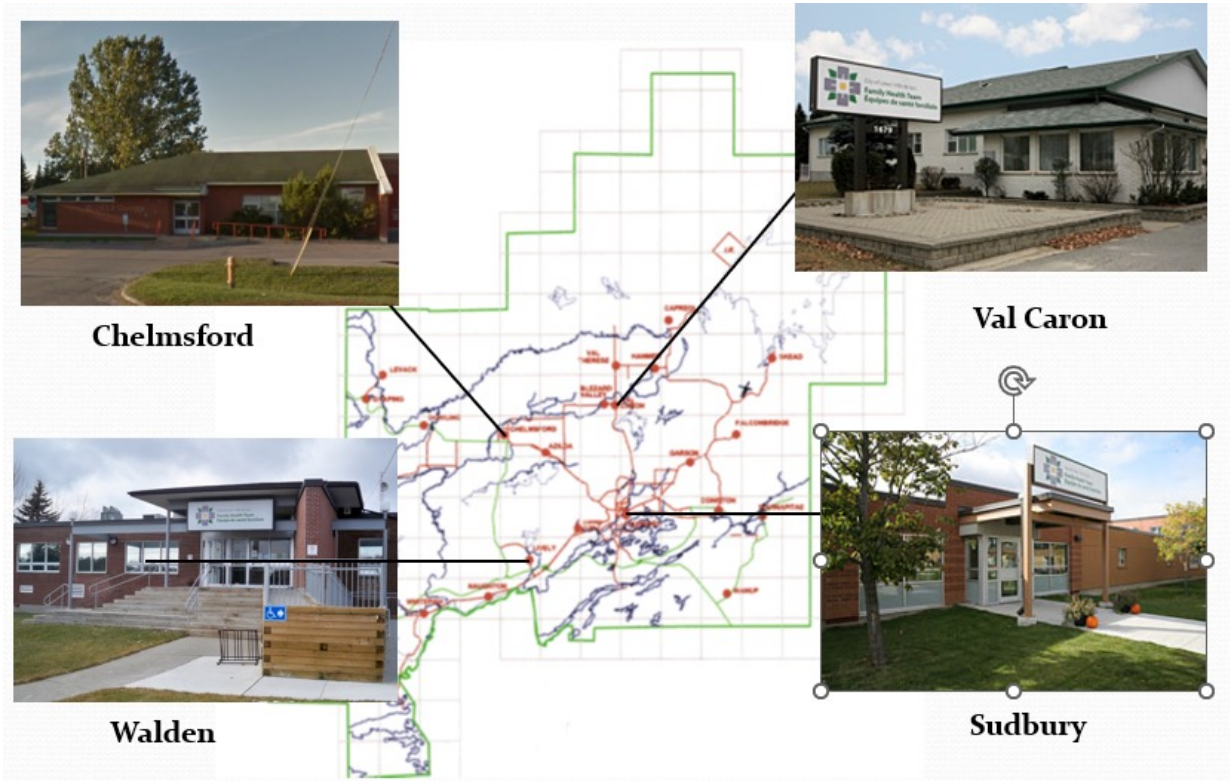
City of Lakes Family Health Team

Transforming Geriatric Care Through Team Based Innovation

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City of Lakes Family Health Team Overview

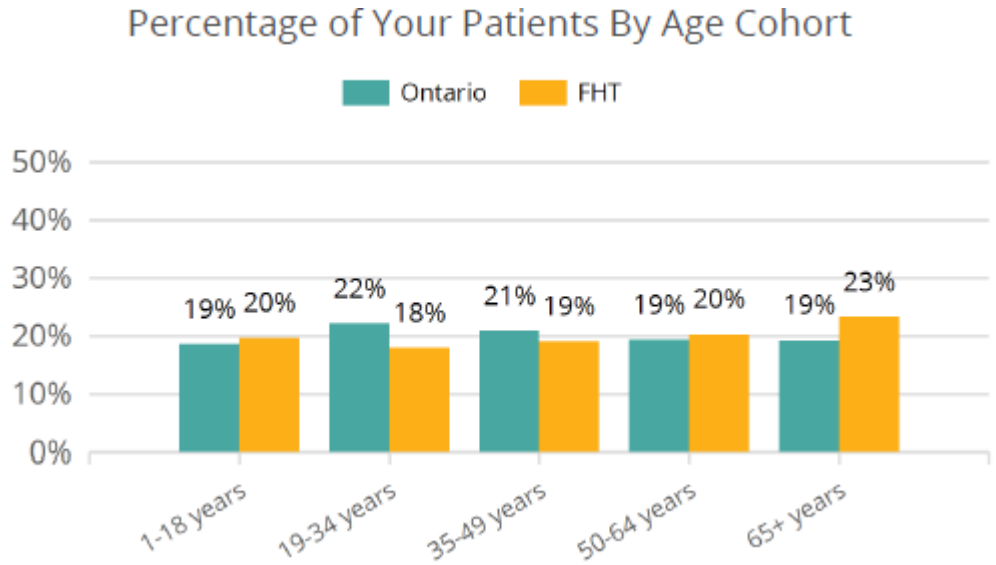
- 4 Sites located throughout the City of Greater Sudbury
  - 1 urban, 3 rural sites
- ~24,000 patients
- Team compliment:
  - 19 physicians
  - 6 NPs
  - 5 RNs + .5 RPN
  - 1 Virtual Care Coordinator
  - 1 Pharmacist
  - 1 Dietitian
  - 2 Social Workers
  - 1 Patient Navigator



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Family Health Team
Équipe de santé familiale

The Challenge: Growing Needs, Fragmented Care

- Increasing number of seniors living with frailty and complex health needs
- Long wait times for specialized geriatric services
- Complex navigation from primary care to other health care organizations and community partners



Key Question: How can we bring specialized geriatric expertise closer to patients in their "medical home"?

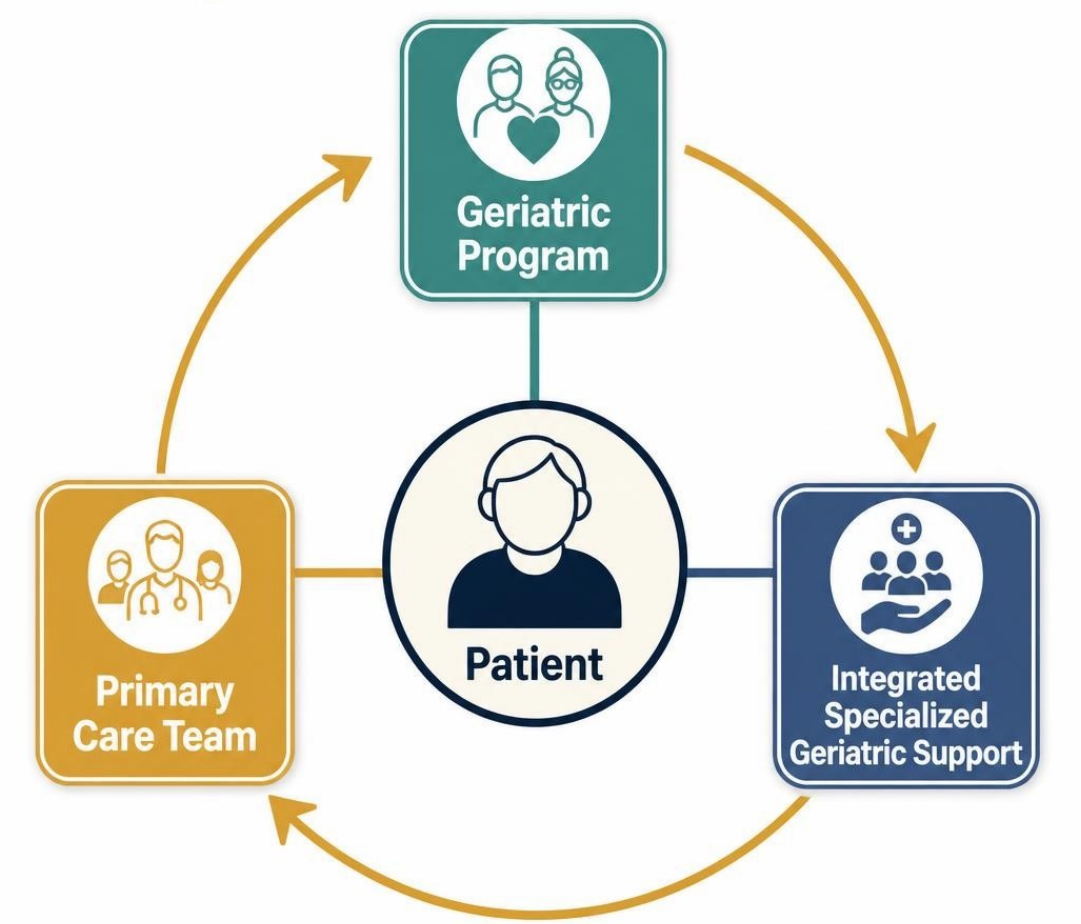
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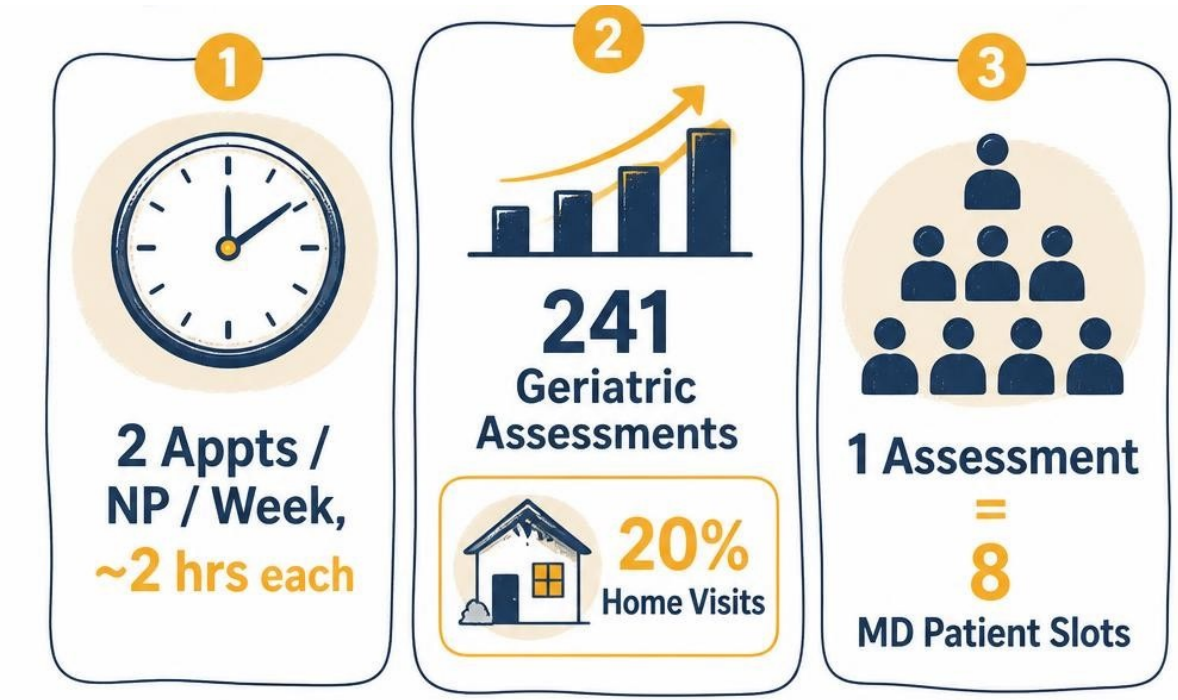
The Solution: Building Capacity Within Primary Care

- CoLFHT invested in:
  - Training 4 x NPs in Comprehensive Geriatric Assessments (CGA)
  - Full scope NP practices for all 6 NPs beyond geriatrics
  - Designing the geriatric model to include a role for all team-based care members including: Pharmacist, Dietitian, Social Worker, etc
  - Standardized geriatric workflows and digital tools
  - Strong community partnerships
- Continued Investment
  - 1 New NP currently training under the PGLO
    - Ensures program integrity and a built-in succession planning

Our Goal: Manage mild-to-moderate frailty within primary care and ensure patients remain connected to their primary care medical home

The Solution:
Building Capacity Within Primary Care





Why This Matters: Patient Impact





Why This Matters: Team Feedback





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Bringing the Geriatrician Into Primary Care

- Partnership with Northeast Specialized Geriatric Services
- Instead of referring complex mild-to-moderate frail patients, they are treated within primary care longer.
  - Geriatrician provides ½ day on site clinic monthly
  - Collaborative assessment completed with the NPs
  - Joint care planning
  - 1 hour of case conferences for all providers to present cases for specialized advice
  - Knowledge transfer and mentorship

