CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Integrated Dementia Care:
Equipping Teams for Early Recognition and Action

Teaching Presenters and Discussants:

Dr. Robert Lam MD, MS, CCFP, FCFP (Care of the Elderly), Home-Based Primary Care Team Unison Health & Community Services

David Pham, Pharmacist, Unison Health & Community Services

Elisa Nicolau, Case Manager, Ontario Health at Home

Host: Jennifer Campagnolo, Canadian Home Care Association

March 27, 2025

Canadian Home Care Association

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Reminders

- Say “Hello!” and introduce yourself via the chat! Remember to select “Everyone”.
- Use the chat function if you have any comments or are having technical difficulties.
- Captioning is available and can be activated through your Zoom options.
- Microphones are muted. **Please use the Q&A function to ask the panelists questions.** We will be taking time to answer any questions at the end of the presentation.
- This session is being recorded and will be available at **https://cdnhomecare.ca/chca-project-echo-integrated-seniors-care**
- Remember not to disclose any Personal Health Information (PHI) during the session.

Project ECHO ISC

Canadian Home Care Association

Project ECHO

Integrated Seniors Care

Project ECHO Integrated Seniors Care, in partnership with the Canadian Medical Association, will enhance the competencies of home care and primary health care providers to meet the holistic and diverse needs of Canadian seniors with complex chronic conditions in home and community settings.

Project ECHO ISC

Mild Cognitive Impairment, Dementias

Canadian Home Care Association

Project ECHO

Integrated Seniors Care

Integrated Clinical Practice Approach to Educational Content:

- Early Identification and Assessment
- Collaborative Care Planning
- Team-Based Care Delivery
- Shared Decision-Making and Communication
- Engaged Persons, Family and Caregivers
- Holistic Safety and Risk Management

With a focus on the:

SKILLS

KNOWLEDGE

ATTITUDES

needed by primary care

and home care providers

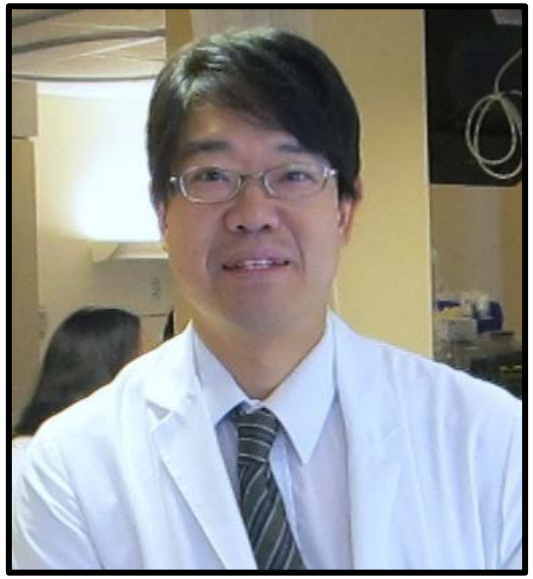
Early Identification and Assessment

Canadian Home Care Association
Project ECHO
Integrated Seniors Care

An integrated approach to early recognition and assessment of dementia for seniors living at home can ensure:

- Improved quality of life and outcomes for the person
- Enhanced coordination of services across primary and home care
- Better support for family and caregivers
- Empowered and active decision-making by the person and designated family

Introductions



Dr. Robert Lam MD, MS, CCFP (Care of the Elderly)
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Associate Professor of Family Medicine
Department of Family & Community Medicine, University of Toronto

Elisa Nicolau
Case Manager
Ontario Health at Home

David Pham
Pharmacist
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Community Services

Canadian Home Care Association
Project ECHO
Integrated Seniors Care

CANADIAN HOME CARE ASSOCIATION/CMA
ECHO PROJECT WEBINAR

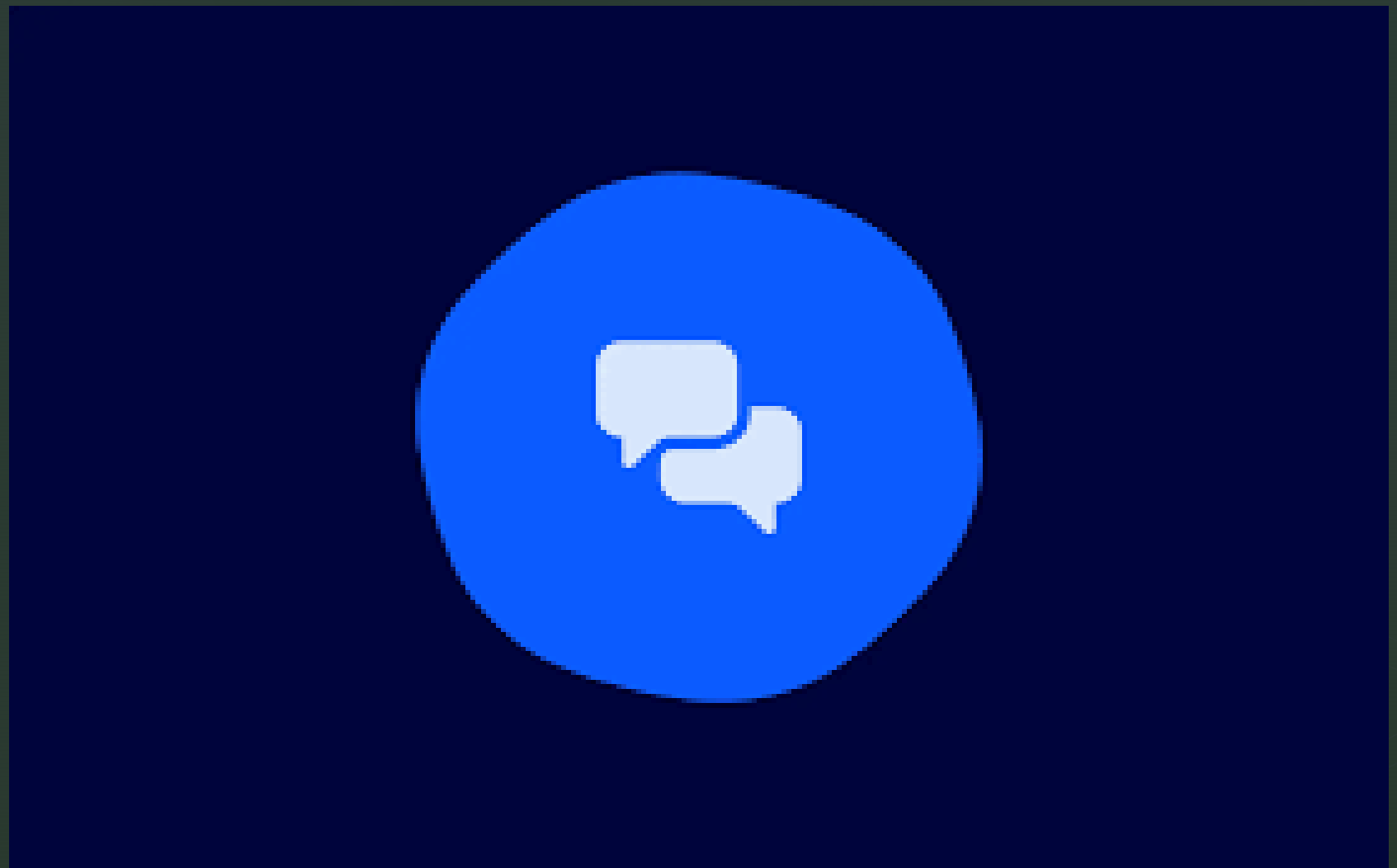
Thursday, March 27, 2025, 12 noon – 1 pm.

Integrated Dementia Care: Equipping Teams for Early Recognition and Action

Unison Home Based Primary Care Team

- Robert Lam, family physician
- Andrew Markiton, nurse practitioner
- Elisa Nicolau, care co-ordinator
- David Pham, pharmacist
- Avaleen Sargeant, receptionist

Please text in the chat box your name, occupation and location. Thank you!



Disclosures

- Dr. Lam has received honorarium from GlaxoSmithKline to speak at the 2023 Canadian Geriatrics Society and 2023 Nurse Practitioners Association of Ontario Annual Meetings.
- Dr. Lam is director of the Five Weekend Care of the Elderly Certificate CPD/CME Course, Toronto, ON.
- Dr. Lam is voluntary chair of the primary care special interest group and past-president of Canadian Geriatrics Society.

Integrated Dementia Care: Equipping Teams for Early Recognition and Action

1. Early Recognition & Assessment – Practical tools to detect dementia symptoms and enhance communication between home and primary care.
2. Integrated Care Strategies – Collaborative approaches to delivering person-centred, non-pharmacologic and pharmacologic interventions.
3. Caregiver Engagement & Support – Effective ways to assess caregiver needs, prevent burnout, and provide essential education and respite.

Overview

- Dementia 101. Review of cognitive assessments & dementia diagnosis, BPSD guidelines and PIECES approach and caregiver stress. Robert Lam
- Situations recognized, communication, and actions planned:
  - Care Co-Ordinator Elisa Nicolau
  - Pharmacist David Pham
- Take home messages Robert Lam
- Questions and answers.

Unmet Needs for Geriatric Medicine and Care of the Elderly Physicians Work Force in Canada

Kenneth Madden, MD, MSc, FRCPC[1], Deviani Maher, MD, FRCPC[1],
Manuel Montero-Odasso, MD, PhD AGSF, FRCPC[2], Robert E. Lam, MD, CCFP(COE)[3]

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https://doi.org/10.5770/cgj.24.555

ABSTRACT

Although the current low workforce availability of care of the elderly (COE) physicians, geriatric medicine specialists, and geriatric psychiatrists is undeniable, the ongoing demographic shift means this situation will only worsen. This evolving crisis is outlined clearly in the article "Updated Inventory and Projected Requirements for Specialist Physicians in Geriatrics" by Basu *et al.* found in this issue of the *Canadian Geriatrics Journal*.

Key words: geriatric medicine, workforce planning, geriatric services

Since 2020, the novel coronavirus[(1)] and its devastating effects on the older population in Canada has been cited as an example of an ongoing lack of community, social, and medical support for healthy aging.[(2)] In actuality, the profound impact of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) on the health of older adults in Canada has merely amplified structural inequalities and issues that have been described for many years. Although this crisis will pose many challenges, it also creates an opportunity to address a longstanding neglect of our older population. Issues such as social isolation, poor conditions in residential care, and a lack of intergenerational solidarity have been brought into stark relief, but an underreported structural deficit is a lack of physicians with specialized training in the specific care needs of older adults.[(3)]

in the *CGJ* in 2012,[(5)] as well as building on the Ontario Geriatric Specialist Physician Resource Inventory for 2018 published in the *CGJ* in 2020.[(6)] In brief, despite an increase of 25 per cent in the supply of both geriatricians and COE physicians over the last five years (not a small achievement), the population of older adults has increased by a third, vastly outstripping our efforts. As outlined in their 2030 projections. Basu *et al.* clearly demonstrate that this situation will only worsen in the coming years due to demographic shifts and physician retirements.

The executive of the Canadian Geriatrics Society believes that healthy aging and access to specialized care for older adults is a fundamental human right, and we will continue to advocate for improved access to care. Basu et al.[(4)] have provided us with an excellent summary of the evolving crisis in older adult care in Canada—and it is up to us to advocate for the needed changes to protect this vulnerable, underserved population.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

REFERENCES

1. Epidemiology Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention. [The epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) in China] [in Chinese]. *Zhonghua liu xing bing xue za zhi = Zhonghua liuxingbingxue*

Home visit office desk / lunch table.

Top 10 warning signs your patient may have dementia….text in the chat box.

Ten Warning Signs for Dementia Health Professionals Can Detect

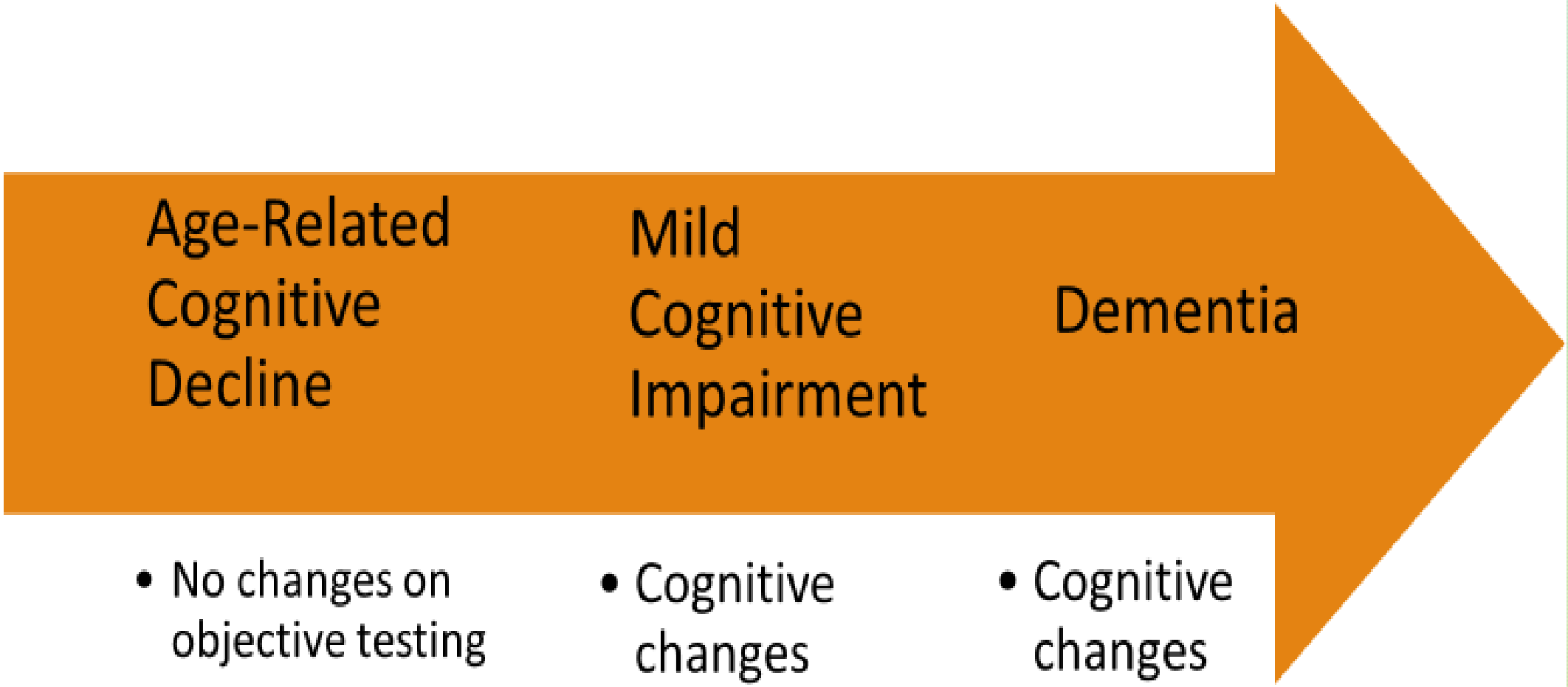
(OCFP / PIECES Canada, 2009)

1. Frequent phone calls/appointments – missing / wrong day.
2. Poor historian, vague, seems “off”, repetitive questions, stories.
3. Poor compliance meds/instructions.
4. Altered appearance / mood / personality / behaviour.
5. New passivity – Head turning sign (turning to caregiver for answer).
6. Decline in language skills.
7. Unexplained change in function.
8. Delirium – surgery/illness/meds.
9. Weight loss/dwindles/”failure to thrive”.
10. Driving concerns – accident / problems / tickets / family worries.

Five Weekend Care of the Elderly Certificate Course

https://www.cfp.ca/content/61/3/e135

- CPD course for family doctors and nurse practitioners.
- Course held annually for 5 weekends spread over 6 months from Jan – June.
- Registration link: https://event.fourwaves.com/2025/pages


Age-Related Cognitive Decline
Mild Cognitive Impairment
Dementia
• No changes on objective testing
• No functional changes from baseline
• Cognitive changes
• No functional changes from baseline
• Cognitive changes
• Functional impairment

DSM-5: Mild Neurocognitive Disorder

evidence of **modest** cognitive decline from a previous level of performance in one or more domains

cognitive deficits ***do not interfere with capacity for independence in everyday activities***

cognitive deficits do not occur exclusively in the context of a delirium

cognitive deficits are not primarily attributable to another mental disorder

DSM-5: Major Neurocognitive Disorder

evidence of substantial cognitive decline from a previous level of performance in one or more domains

cognitive deficits are sufficient to interfere with independence

cognitive deficits do not occur exclusively in the context of a delirium

cognitive deficits are not primarily attributable to another mental disorder

Functional Activities Questionnaire

1. Writing cheques, paying bills, balancing a cheque book.
2. Assembling tax records, business affairs or papers.
3. Shopping alone for clothes, household necessities or groceries.
4. Playing a game of skill or working on a hobby.
5. Heating water, making a cup of coffee, turning off the stove.
6. Preparing a balanced meal.
7. Keeping track of current events.
8. Paying attention to, understanding, and discussing a tv show, book or a magazine
9. Remembering appointments, family occasions, holidays, and medications.
10. Travelling out of the neighbourhood, driving, arranging to take buses.

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0

- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

Cognitive Tests

MiniCog: The Mini-Cog is a rapid 3-minute instrument that can increase detection of cognitive impairment in older adults.

MMSE

MoCA: Better than MMSE for detecting mild cognitive impairment, more sensitive to executive dysfunction

Clock Drawing Test: Evaluates general executive functioning of the frontal lobe and visuospatial abilities.

RUDAS: minimizes the effects of culture and language on assessment, and is useful for patients whose first language is not English

Frontal Assessment Battery: Frontotemporal dementia

Trail Making Test: motor processing speed, executive functioning, and cognitive flexibility in switching attention between competing sets of stimuli

Frontal Assessment Battery (FAB) https://www.psychdb.com/cognitive-testing/fab		PsychDB
Patient Name:	**Administered by:**	**Date:**

Instructions
The FAB is a brief cognitive and behavioural battery that can be used at the bedside to assess frontal lobe functions. The FAB has validity in distinguishing frontotemporal dementia from other types of dementias such as early-stage Alzheimer's. The total maximum score is 18, with higher scores indicating better performance.

Reference
Dubois, B., Slachevsky, A., Litvan, I., & Pillon, B. (2000). The FAB: a frontal assessment battery at bedside. *Neurology*, *55*(11), 1621-1626.

1. Similarities (Conceptualization)		
"In what way are they alike?": • **A banana and an orange** (answer: fruits) • **A table and a chair** (answer: furniture) • **A tulip, a rose, and a daisy** (answer: flowers)	If the patient says, "they are not alike" (total failure) or "both have peels" (partial failure) help the patient with a prompt by saying: "both a banana and an orange are…" However, credit 0 points for the first item. Do not help the patient for the last two items after this.	**3 correct** (3 points) **2 correct** (2 points) **1 correct** (1 point) **0 correct** (0 points)
2. Lexical Fluency		
"Say as many words as you can beginning with the letter 'S,' any words except surnames or proper nouns." The time allowed is 60 seconds	If the patient gives no response during the first 5 seconds, say: "for instance, snake." If the patient pauses for 10 seconds, prompt them by saying: "any word beginning with the letter 'S.'" Word repetitions or variations (i.e. - "shoe," "shoemaker"), surnames, or proper nouns are *not* counted as correct responses.	**>9 words** (3 points) **6 to 9 words** (2 points) **3 to 5 words** (1 point) **<3 words** (0 points)
3. Motor Series ("Luria's Test")		
Tell the patient: "Look carefully at what I'm doing." The examiner, seated in front of the patient, performs alone **3 times** using the left hand the series of Luria motions of "fist–edge–palm." **Prompt the patient: "Now, with your *right* hand do the same series, first with me, then alone."** The examiner performs the series **3 times** in total with the patient **Now tell the patient: "Now, do it on your own."** Observe the patient's actions	**FIST**  **EDGE** (Bird's Eye View)  **PALM** (Bird's Eye View) 	**Patient performs 6 correct consecutive series alone** (3 points) **Patient performs at least 3 correct consecutive series alone** (2 points) **Patient fails alone, but performs three correct consecutive series with the examiner** (1 point) **Patient cannot perform three correct consecutive series even with the examiner** (0 points)

Functional Activities Questionnaire

1. Writing cheques, paying bills, balancing a cheque book.
2. Assembling tax records, business affairs or papers.
3. Shopping alone for clothes, household necessities or groceries.
4. Playing a game of skill or working on a hobby.
5. Heating water, making a cup of coffee, turning off the stove.
6. Preparing a balanced meal.
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8. Paying attention to, understanding, and discussing a tv show, book or a magazine
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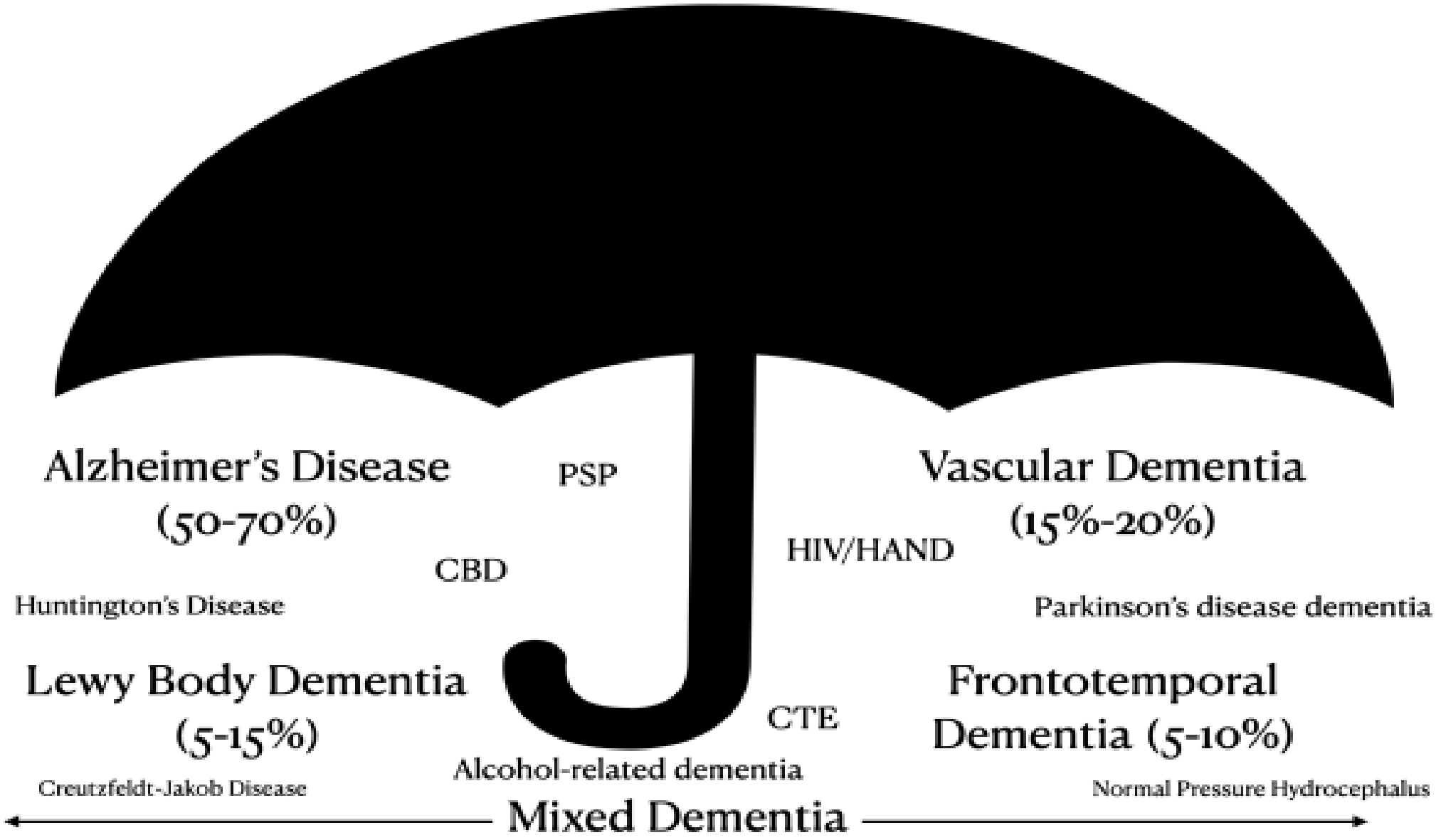
10. Travelling out of the neighbourhood, driving, arranging to take buses.

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0

- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

The Umbrella of Dementia



Drug	Predominant Route of Elimination	Starting Dose	Minimal Effective Dose	Usual Dose
Donepezil (Aricept)	Hepatic	2.5-5mg Qam	5mg Qam	10mg Qam
Rivastigmine (Exelon) - oral and transdermal options	Renal	1.5mg BID	3mg BID	4.5-6mg BID
Galantamine (Reminyl)	Hepatic – some renal	8mg Daily	16mg Daily	16-24mg Daily
Memantine (Ebixa) - NMDA receptor antagonist	Renal	5mg Daily	10mg BID	10mg BID

- **Start low dose and reassess for side effects prior to dose increase every 4-6 weeks**

Linda Lee et al. COGNITION-ENHANCING DRUGS IN DEMENTIA: TIPS FOR THE PRIMARY CARE PHYSICIAN. CGS Journal of CME. VOLUME 1, ISSUE 1, 2011.

Cholinesterase inhibitors (CI) - Donepezil, Rivastigmine, Galantamine

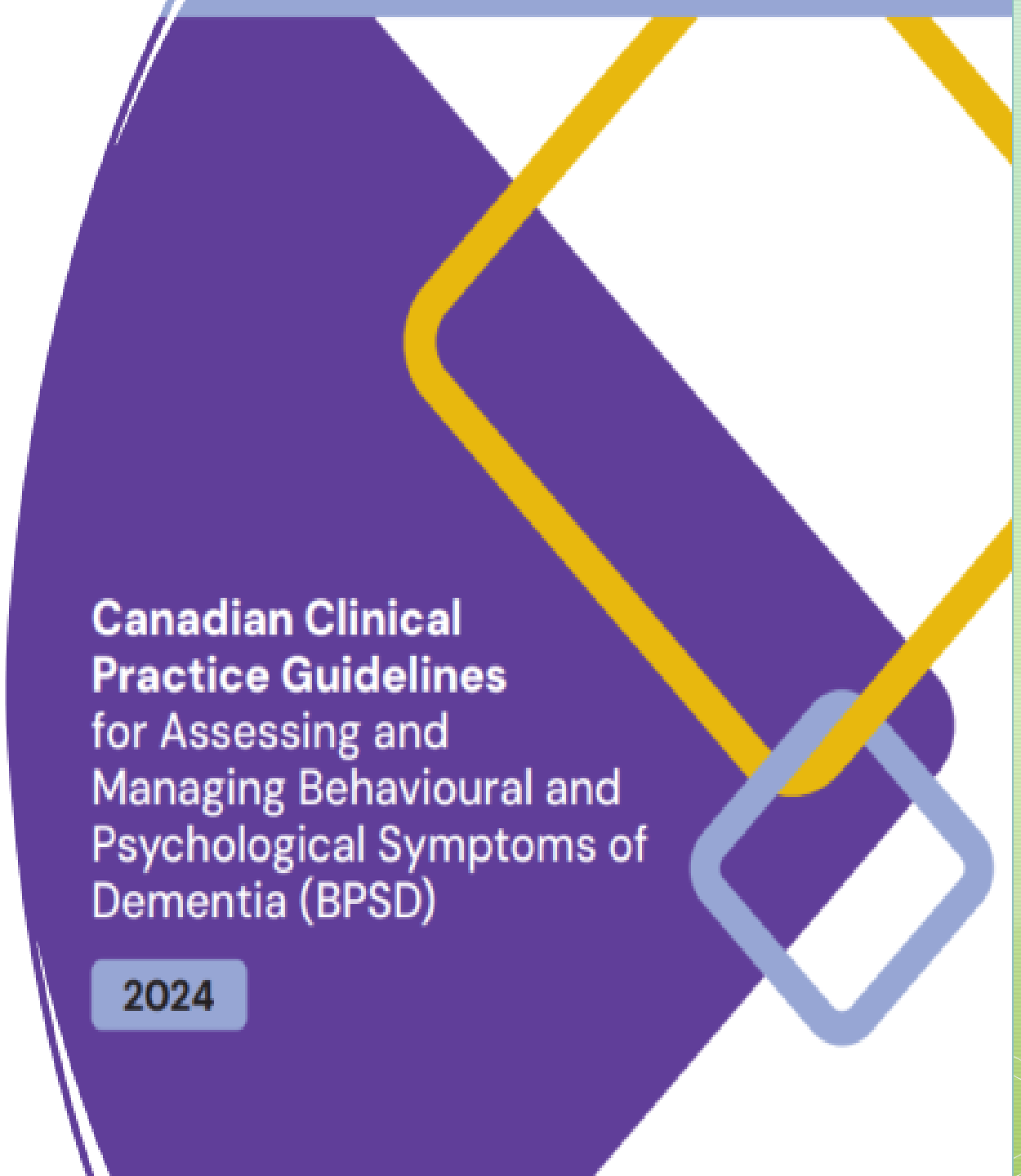
- Indicated for mild – moderate AD, LBD, PPD, mixed vascular. NOT FTD.
- Decision to start should be made on an individualized basis – set realistic expectations and review the patient and consider SE profile
- Decision to stop is just as important:
  - Severe disease or no meaningful benefit
  - Intolerable SE – monitor weight
  - Non-adherent
  - When stopping – taper slowly

deprescribing.org | Cholinesterase Inhibitor (ChEI) and Memantine Deprescribing Algorithm

Moore A, Patterson C, Lee L, Vedel I, Bergman H; Canadian Consensus Conference on the Diagnosis and Treatment of Dementia. Fourth Canadian Consensus Conference on the Diagnosis and Treatment of Dementia: recommendations for family physicians. Can Fam Physician. 2014 May;60(5):433-8. PMID: 24829003; PMCID: PMC4020644.
Linda Lee et al. COGNITION-ENHANCING DRUGS IN DEMENTIA: TIPS FOR THE PRIMARY CARE PHYSICIAN. CGS Journal of CME. VOLUME 1, ISSUE 1, 2011.

Home visit in winter.

BPSD in Alzheimer's disease and related dementias



CCSMH | CCSMPA
Canadian Coalition for Seniors' Mental Health | Coalition canadienne pour la santé mentale des personnes âgées

cagp | acgp

Agitation

- Citalopram - moderate severity agitation (Strong recommendation, low-quality evidence).
- Suggest against - trazodone, sertraline, mirtazapine, and fluoxetine (Conditional recommendation, low-quality evidence)
- Suggest against - paroxetine, fluvoxamine, and tricyclic antidepressants

Severe Agitation

- Aripiprazole, brexpiprazole or risperidone for the treatment of severe agitation (Conditional recommendation, moderate-quality evidence).
- Quetiapine for the treatment of severe agitation if symptoms are refractory to other treatments, or in cases where other treatments are not tolerated due to extrapyramidal side-effects. (Conditional recommendation, low-quality evidence).
- Recommend against using olanzapine for the treatment of agitation except for potential use as short-term emergency treatment of severe agitation (Strong recommendation, low-quality evidence).

Top 10 behaviours that (may) respond to medications…..text in the chat box.

Top Ten Behaviours responsive (perhaps!) to medication

- Physical aggression
- Verbal aggression
- Anxious, restless
- Sadness, crying, anorexia
- Withdrawn, apathetic
- Sleep disturbance
- Wandering with agitation/aggression
- Vocally repetitious behavior due to depression or pain
- Delusions and hallucinations
- Sexually inappropriate behavior with agitation

Top 10 behaviours that do NOT respond to medications….text in the chat box.

Top Ten Behaviours not (usually) responsive to medication

- Aimless wandering
- Inappropriate urination and defecation
- Inappropriate dressing and undressing
- Annoying perseverative activities
- Vocally repetitious behavior that is not depressive equivalent
- Hiding/hoarding
- Pushing wheelchair bound co-patient
- Eating in-edibles
- Inappropriate isolation
- Tugging at/removal of restraints (question any use of physical restraints)

Non-pharmacologic interventions to consider based on the individual needs of the PLWD:

Outdoor activities	Music	Cognitive stimulation (e.g. orientation, reminiscence, art therapy, games)	Environmental modifications
Massage and touch therapy	Occupational therapy	Social interactions	Exercise
Multidisciplinary care planning	Psychotherapy	Reminiscence therapy	Animal therapy

PIECES

Physical

Intellectual

Emotional

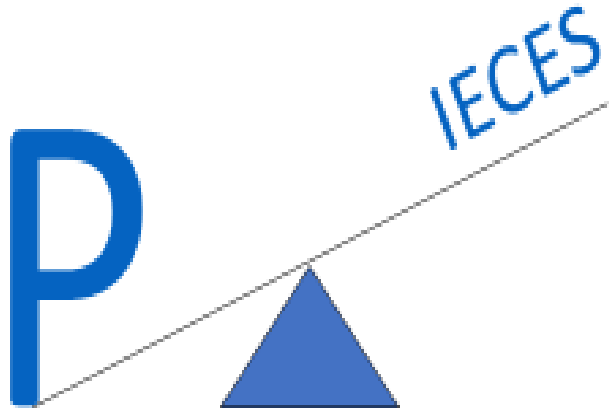
Capabilities

Environment

Social

Each health discipline tends to be "letter-centric"

e.g. Physicians can be "P"-centric

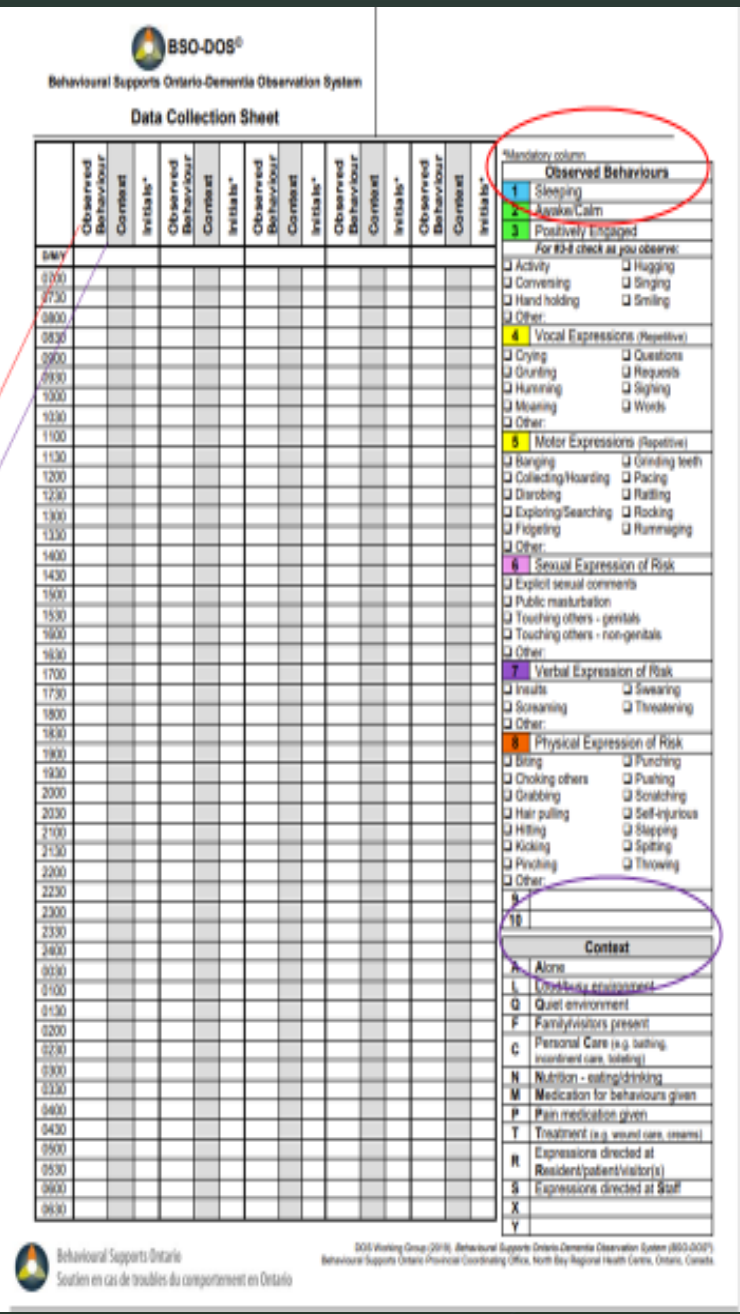


Behaviour Supports Ontario - Dementia Observation Scale (BSO-DOS)

Observed behaviour

Context

https://brainxchange.ca/BSODOS



BSO-DOS©

Behavioural Supports Ontario-Dementia Observation System

Data Collection Sheet

	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*
D/M/Y															
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*Mandatory column

Observed Behaviours

1 Sleeping

2 Awake/Calm

3 Positively Engaged

For #3-9 check as you observe:

- ❑ Activity
- ❑ Conversing
- ❑ Hand holding
- ❑ Hugging
- ❑ Singing
- ❑ Smiling
- ❑ Other:

4 Vocal Expressions (Repetitive)

- ❑ Crying
- ❑ Grunting
- ❑ Humming
- ❑ Moaning
- ❑ Questions
- ❑ Requests
- ❑ Sighing
- ❑ Words
- ❑ Other:

5 Motor Expressions (Repetitive)

- ❑ Banging
- ❑ Collecting/Hoarding
- ❑ Disrobing
- ❑ Exploring/Searching
- ❑ Fidgeting
- ❑ Grinding teeth
- ❑ Pacing
- ❑ Rattling
- ❑ Rocking
- ❑ Rummaging
- ❑ Other:

6 Sexual Expression of Risk

- ❑ Explicit sexual comments
- ❑ Public masturbation
- ❑ Touching others - genitals
- ❑ Touching others - non-genitals
- ❑ Other:

7 Verbal Expression of Risk

- ❑ Insults
- ❑ Screaming
- ❑ Swearing
- ❑ Threatening
- ❑ Other:

8 Physical Expression of Risk

- ❑ Biting
- ❑ Choking others
- ❑ Grabbing
- ❑ Hair pulling
- ❑ Hitting
- ❑ Kicking
- ❑ Pinching
- ❑ Punching
- ❑ Pushing
- ❑ Scratching
- ❑ Self-injurious
- ❑ Slapping
- ❑ Spitting
- ❑ Throwing
- ❑ Other:

9

10

Context

A	Alone
L	Challenging environment
Q	Quiet environment
F	Family/visitors present
C	Personal Care (e.g. bathing, incontinent care, toileting)
N	Nutrition - eating/drinking
M	Medication for behaviours given
P	Pain medication given
T	Treatment (e.g. wound care, creams)
R	Expressions directed at Resident/patient/visitor(s)
S	Expressions directed at Staff
X	
Y	

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

DOS Working Group (2016). *Behavioural Supports Ontario-Dementia Observation System (BSO-DOS©)*. Behavioural Supports Ontario-Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

Dementia Caregivers in Canada

- More than 600,000 Canadians live with dementia
  - majority outside of LTC
- Every year, family caregivers in dementia provide >470 million hours of care (~235,000 full time jobs!)
  - 90% have an unpaid caregiver (spouse or adult child)
- Caring for persons with dementia is uniquely challenging
  - 1 in 4 require extensive assistance/ full dependence for ADLs
  - 1 in 4 exhibit responsive behaviours
  - 1 in 4 have signs of mood disorder
- Dementia caregivers more likely to experience stress

(Alzheimer's Society of Canada, 2024; CIHI, 2024)

SHN

University Health Network

Common changes and events that may cause grief and loss

- Caregiver no longer recognized by the person with dementia
- Person with dementia can no longer go out alone or be left alone at home
- Moving to a care residence or facility
- Declining health: more infections, less nutritional intake, difficulty swallowing
- Palliative care, dying process and death
- Period of bereavement and mourning
- Adjustment to the loss of the care-giving role

SHN

University Health Network

Top 10 signs your patient has caregiver stress…..text in the chat box.

Signs of Caregiver Stress

10 Signs of Caregiver Stress:

1. Denial
2. Anger
3. Withdrawing socially
4. Anxiety
5. Depression
6. Exhaustion
7. Sleeplessness
8. Emotional reactions
9. Lack of concentration
10. Health problems

(Alzheimer Society of Canada, 2024)

SHN

University Health Network

Practical Approaches to Assess Caregiver Stress

Caregiver Stress Screening Tools:

- *The Modified Caregiver Strain Index* (CSI)
- *Caregiver Burden Inventory* (CBI)
- *Neuropsychiatric Inventory Caregiver Distress Scale* (NPI-D)
- *Zarit Burden Interview* (ZBI)
  - 22-item version (full)
  - 12-item and 6-item version (short)
  - 4-item version (screening)

SHN

University Health Network

Community Resources for Caregivers

- Ontario Caregiver Organization
  - https://ontariocaregiver.ca/
  - Caregiver helpline/ online chat
  - Peer support
  - Resource linkage/ system navigation
  - Toolkits

- National
  - https://canadiancaregiving.org/

SHN

University Health Network

Care Co-Ordinator Elisa Nicolau

- Situation recognized:
  - Declining function starting to make living home alone difficult.
- Action plan:
  - Capacity for LTC placements.
  - Healthcare assessments faxed to MD/NP for completion.
  - Ask POA to start PSW trial.
  - Place contact information on fridge door.
  - Communicate with PSW agency supervisors.

Questions

Community Pharmacist
David Pham

- Situation recognized: unopened blister packs. Non-compliance.
- Action plan:
  - Blister packing medications to improve compliance.
  - One for one blister pack exchange (old one for each new) program.
  - Remove old/expired medication.
  - Home visit for education/counselling.
  - Device training (Libre sensors, BP monitor, turbuhalers, insulin injections.
  - Fax communication to family physician.

Questions

Unison Home Based Primary Care Team Referrals

- Send referrals to Avaleen Sargeant, receptionist.
- Unison HBPC Team Referrals, 1541 Jane St M9N 2R3
- **Email:** avaleen.sargeant@unisonhcs.org
- **Phone: (416) 645-2430**
- **Fax: (416) 217-1161**
- **Boundaries:**

  east-Ossington, west-Islington, north-Eglinton, south- Bloor

Take Home Messages

- Dementia is usually slowly progressive and can be difficult to recognize and requires communication between health care disciplines.
- 50-70% of dementia is Alzheimer's disease and cognitive enhancers may be helpful.
- Behavioural and Psychological Symptoms of Dementia (BPSD) require a "P.I.E.C.E.S." approach.
- Many behaviours cannot be treated with medications and require a non-pharmacologic approach.
- There are resources to help with caregiver stress.
- Consider joining the Canadian Geriatrics Society and hope to see you at the meeting in Toronto, May 29-31, 2025.

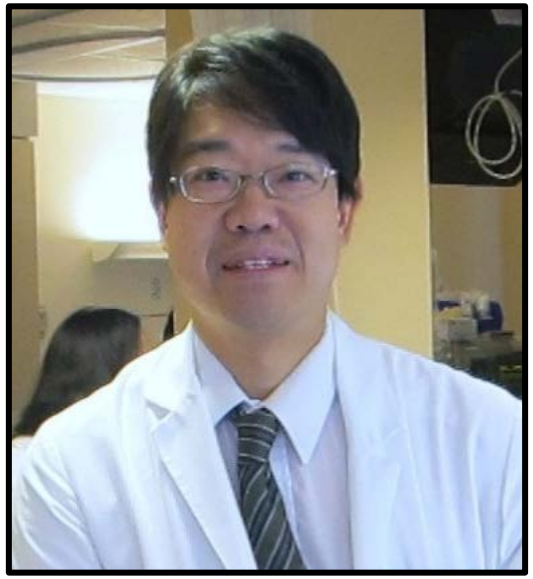
Questions

Canadian Geriatrics Society Annual Scientific Meeting

May 29-31, 2025 at Toronto Westin Harbour Castle Hotel

Canadian Home Care Association has been invited by the Primary Care Special Interest Group to speak about their challenges, goals and vision.

Discussion



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Canadian Home Care Association
Project ECHO
Integrated Seniors Care

Upcoming TeleECHO Clinics

Canadian Home Care Association | Project ECHO
Integrated Seniors Care

cdnhomecare.ca/chca-project-echo

Stay tuned for updates on our new series taking a deeper dive into integrated care for seniors living with dementia and MCI

Holistic Spirituality and Care at End of Life
June 11, 12 – 1pm ET
Simon Lasair, Saskatchewan Health Authority