CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Coordinating Transitions in Complex Dementia and Multimorbidity Cases

Subject Expert:
Dr. Ivy Felicidad Oandasan, MD, MHSc, EMBA, CCFP, FCFP, Family Physician, Professor Department of Family and Community Medicine, University of Toronto
Panelists:
Carin Ann MacInroy, Patient and Caregiver Partnership Advisory Committee, CarePartners
Amanda Gerrits, RPN, Operations Manager, CarePartners

Host: Jennifer Campagnolo, CHCA
November 26, 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.

Reflect on What You Hear...

As you listen to the presenter and panelists, think about opportunities to improve peoples' transitions within healthcare, especially when care has multiple layers or is complex.

Where can the skills, knowledge and attitudes discussed today be tested or incorporated in your daily care or practice?

Canadian Home Care Association

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Introductions

Dr. Ivy Felicidad Oandasan, MD, MHSc, EMBA, CCFP, FCFP,
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Carin Ann MacInroy
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Coordinating Transitions in Complex Dementia and Multimorbidity Cases

Leveraging Today's Primary Care Transformation Efforts

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FACULTY / PRESENTER DISCLOSURE

- Relationships with commercial interests: None
- Grants/Research Support: None at this time
- Speakers Bureau/Honoraria/Employment:
  - Paid employee of the College of Family Physicians of Canada
  - Not on Speaker Bureau /No Honoraria for this presentation
- Consulting Fees:
  - EHP Consulting Am Paid Consultant but no fees for this presetaiton

By the end of this presentation:

UNDERSTAND WHY IT'S SO HARD **to** have continuous coordinated care**.**

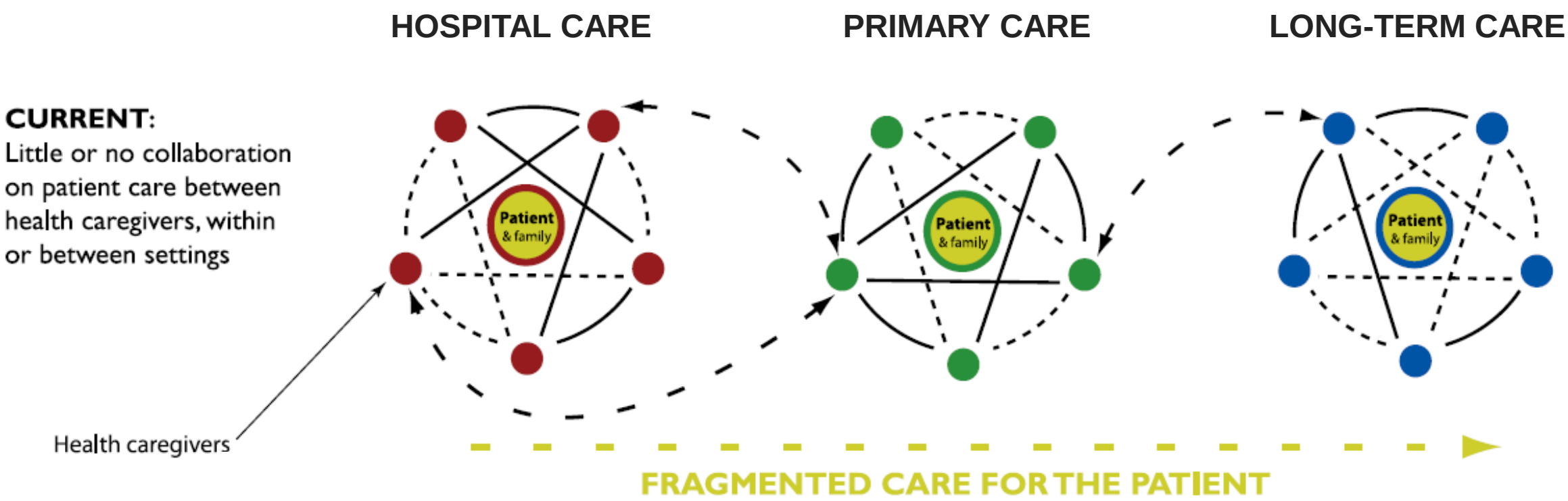
RECOGNIZE THE OPPORTUNITY to **lever primary care reform to support change**

IDENTIFY EDUCATIONAL OPPORTUNITIES to support team-based care

CALL FOR **NEW WAYS OF ORGANIZING** the healthcare system.


CHAOS
CONFUSION
FRUSTRATION

HEALTHCARE SYSTEM SILOS

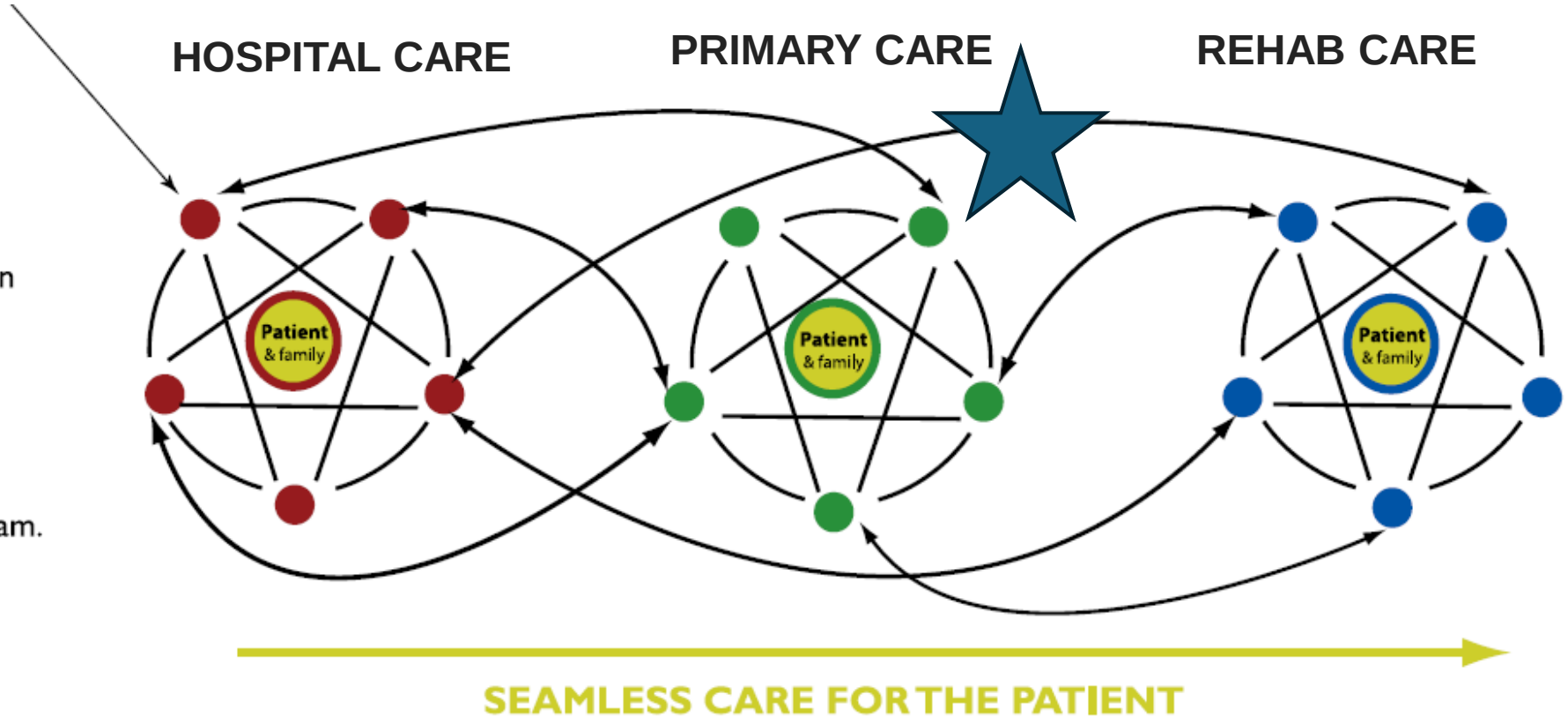


Continuous, Coordinated, Comprehensive Care

INTEGRATED CARE ACROSS SECTORS

GOAL:
Regular and frequent dialogue between all health caregivers, within and between settings as necessary.

All health caregivers see themselves as part of the patient's care team.



PATIENTS DEFINE THEIR "TEAMS"

CRISIS

System Strain – Provider Burnout

Primary Care Crisis

“We can not just recruit our way out of this problem. We need to modernize how primary care is delivered to reflect the evolving needs of our population and those providing the care”

Dr. Kathleen Ross, CMA President , 2023

Primary health care typically includes prevention, health promotion, acute diagnosis, treatment, management of chronic conditions, and appropriate referrals to specialist care

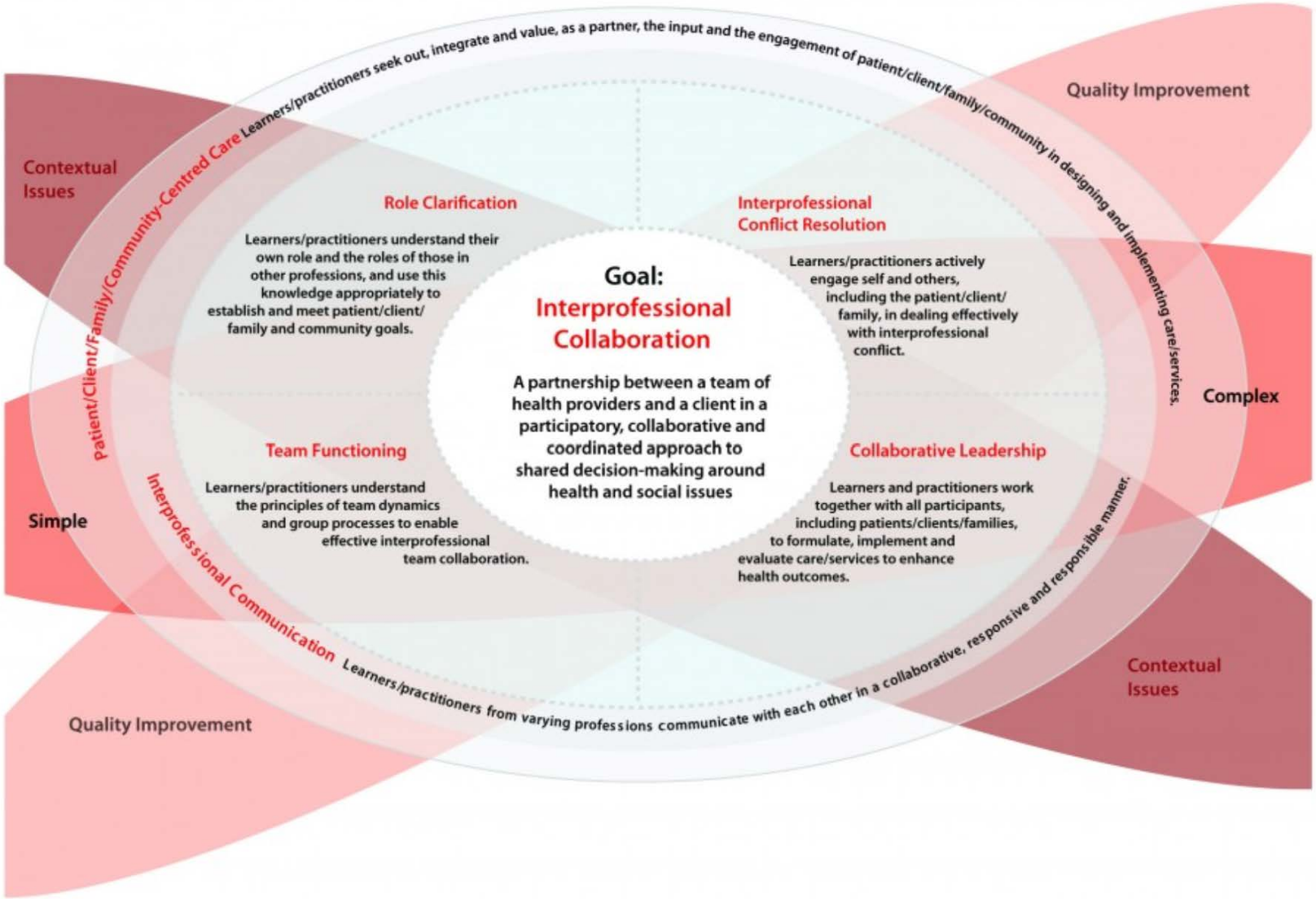
WHO PROVIDES PRIMARY CARE?

Interprofessional Care Competency

Canadian Interprofessional Health Collaborative
Consortium pancanadien pour l'interprofessionnalisme en santé

Interprofessional Collaboration is taught because accreditation across most health care professions mandate it.

Primary Care Learning Contexts are not mandated



PRIMARY CARE

First Contact

Access and use of health services whenever necessary;

Comprehensiveness

Promotion, prevention, treatment and rehabilitation appropriate to the primary care context;

Coordination

Integration of all the care the user receives and needs with the other health services;

Continuity

Professional-subject-of-care temporal relationship, leading to the establishment of strong mutual trust.

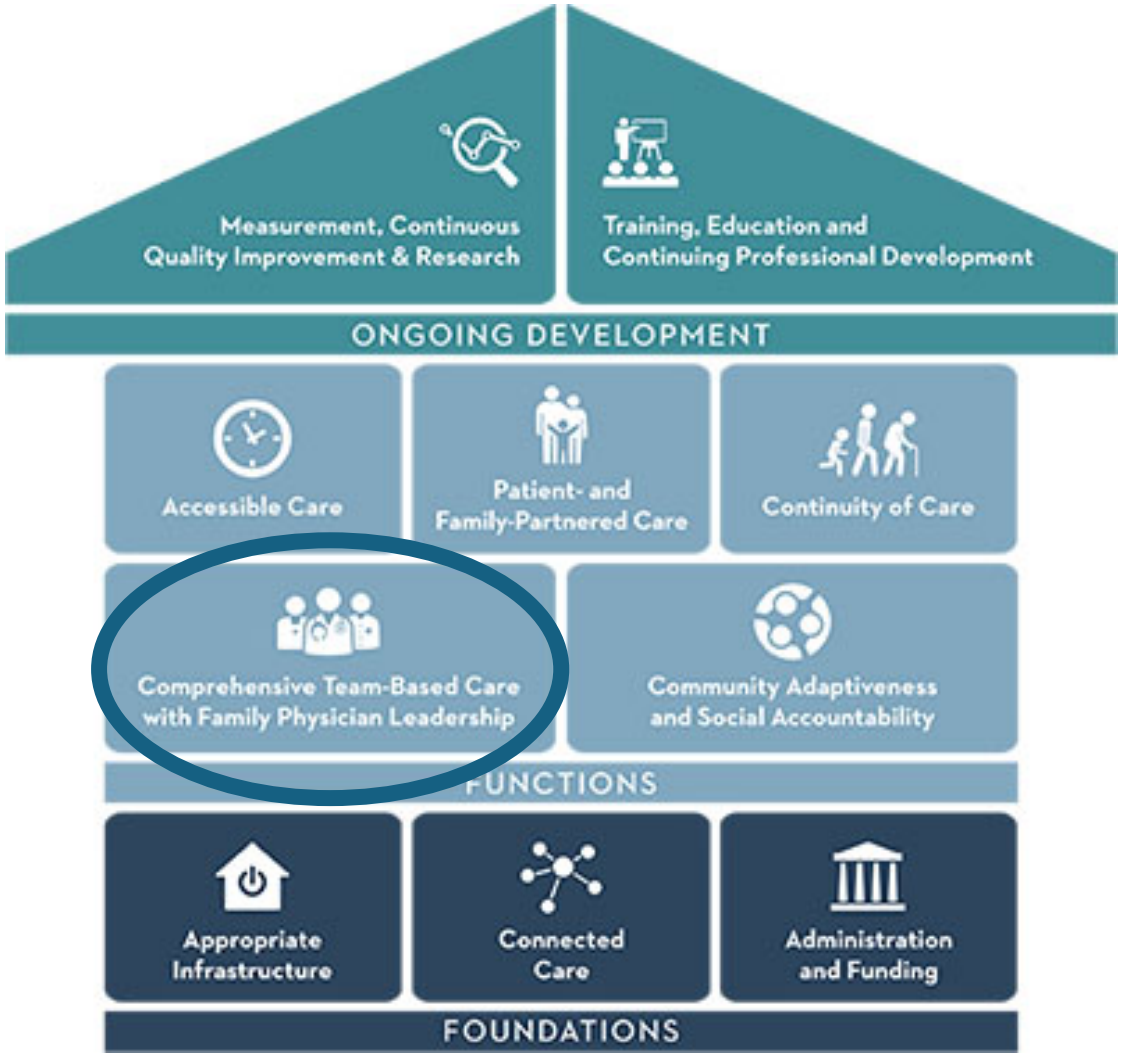
Prates ML, Machado JC, Silva LSD, Avelar PS, Prates LL, Mendonca ET,Costa GDD and Cotta RMM (2017) Performance of primary health care according to PCATool instrument: a systematic review. Ciencia & Saude Coletiva 22, 1881–1893.

No One Heathcare Professional Can Do it all?

The System must be designed to provide the care needed especially when faced with complexity & multi-morbidity

PATIENT'S MEDICAL HOME

A Person with Dementia with their Caregivers
Attached to a Family Physician who provides
Comprehensive, Coordinated, Continuing, Care



[The Patient's Medical Home | The College of Family Physicians of Canada]

TEAM PRIMARY CARE: TRAINING FOR TRANSFORMATION

"You can't just put people together and expect them to become a team"

Effective team-based care in Canada requires intentional training and coaching for effective collaboration. Government funding should be used to create a strong interprofessional primary care workforce as part of primary care reform strategies. Canada must move beyond pilot projects and share what's working across jurisdictions to quickly adopt team-based primary care nationwide.

Foundation for Advancing Family Medicine | Fondation pour l'avancement de la médecine familiale

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

RCPS Réseau canadien des personnels de santé | CHWN Canadian Health Workforce Network

Canada

Funded by the Government of Canada's Sectoral Workforce Solutions Program.

If health care providers are expected to work together … it makes sense that their education & training should prepare them for this type of working arrangement.

Romanow, 2002

Is Primary Care a CORE foundation for Canada's healthcare system?

CANADA HEALTH ACT

HOSPITAL FOCUSED – PHYSICIAN-CENTRIC – PROVINCE-DEFINED

TRANSFORM CANADA TO BE THE MOST PRE-EMINENT DESTINATION DEMONSTRATING "4C" PRIMARY CARE

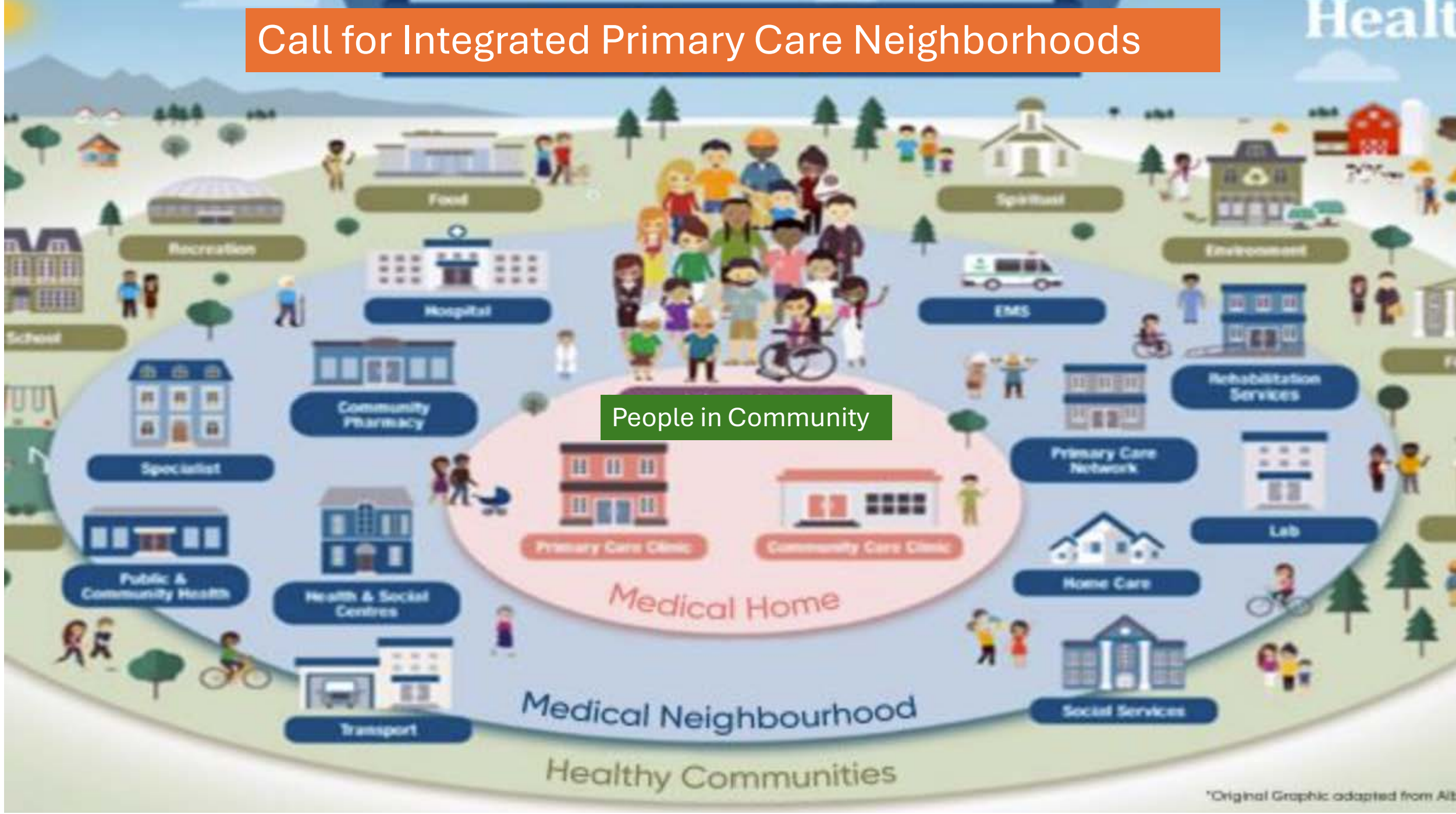
1ST Contact
Comprehensive
Continuing
Coordinated
Care

MAKE PRIMARY CARE ACCOUNTABLE

The OurCare Standard	Ontario's *Primary Care Act*
1. Everyone has a relationship with a primary care clinician who works with other health professionals in a publicly funded team.	1. **Province-wide:** Every person across the province should have the opportunity to have ongoing access to a primary care clinician or team.
2. Everyone receives ongoing care from their primary care team and can access them in a timely way.	2. **Convenient:** Every person should have access to timely primary care..
3. Everyone's primary care team is connected to community and social services that together support their physical, mental and social well-being.	3. **Connected:** Every person should have the opportunity to receive primary care that is coordinated with existing health and social services.
4. Everyone can access their health record online and share it with their clinicians.	4. **Empowered:** Every person should have the opportunity to access their personal health information through a digitally integrated system that connects patients and clinicians in the circle of care.
5. Everyone receives culturally safe care that meets their needs from clinicians that represent the diversity of the communities they serve.	5. **Inclusive:** Every person should have the opportunity to receive primary care that is free from barriers and free from discrimination.
6. Everyone receives care from a primary care system that is accountable to the communities it serves.	6. **Responsive:** The primary care system should respond to the needs of the communities it serves and everyone should have access to information about how the system is performing and adapting.

REVIEW, SHARE & RESPOND

Call for Integrated Primary Care Neighborhoods



CALL FOR PRIMARY CARE TRAINING FOR ALL HEALTHCARE PROVIDERS

First Contact, Comprehensive, Continuity, and Coordination

- 1. Primary Care Principles
- 2. Person/Family-Centred Care

Interprofessionalism

- 3. Communication
- 4. Role Clarification
- 5. Team Functioning
- 6. Conflict Resolution

EDIA , Anti-Racism, Truth & Reconciliation, and Psychological Safety

- 7. Cultural Competency
- 8. Self-Management Support

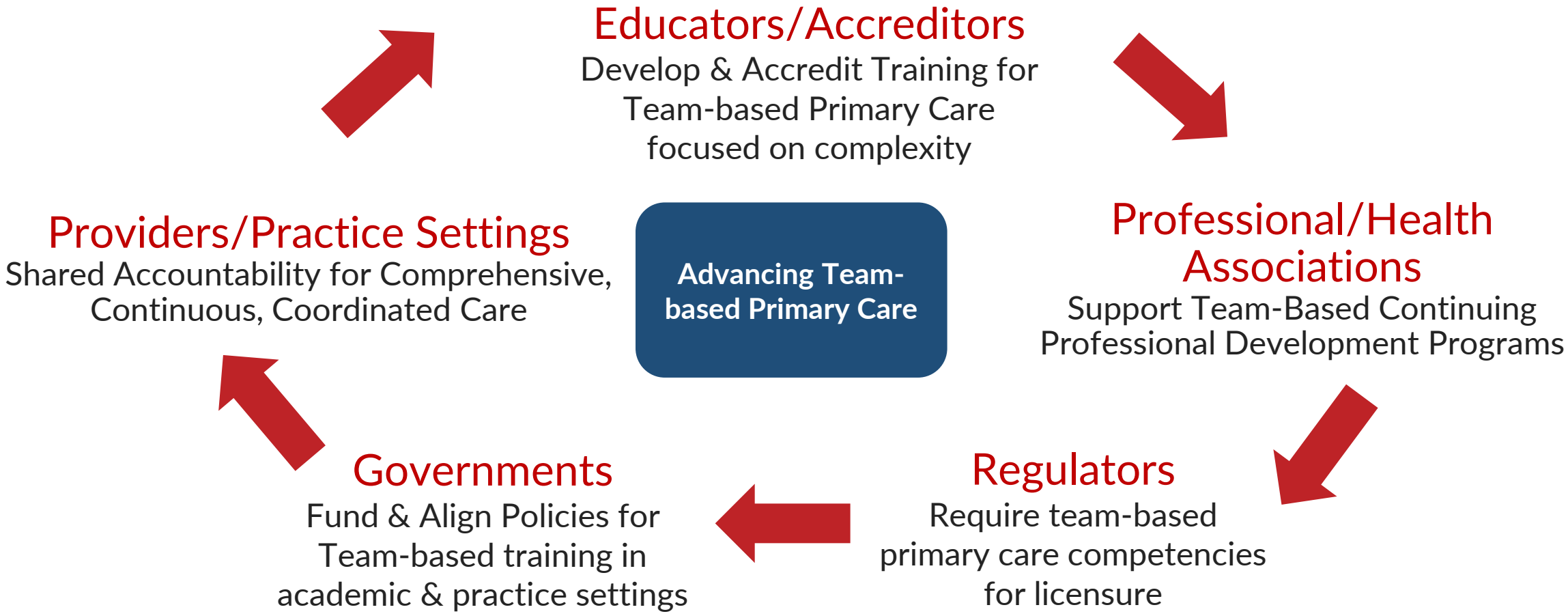
Social Accountability

- 9. Best Possible Care and Service
- 10. Partnerships

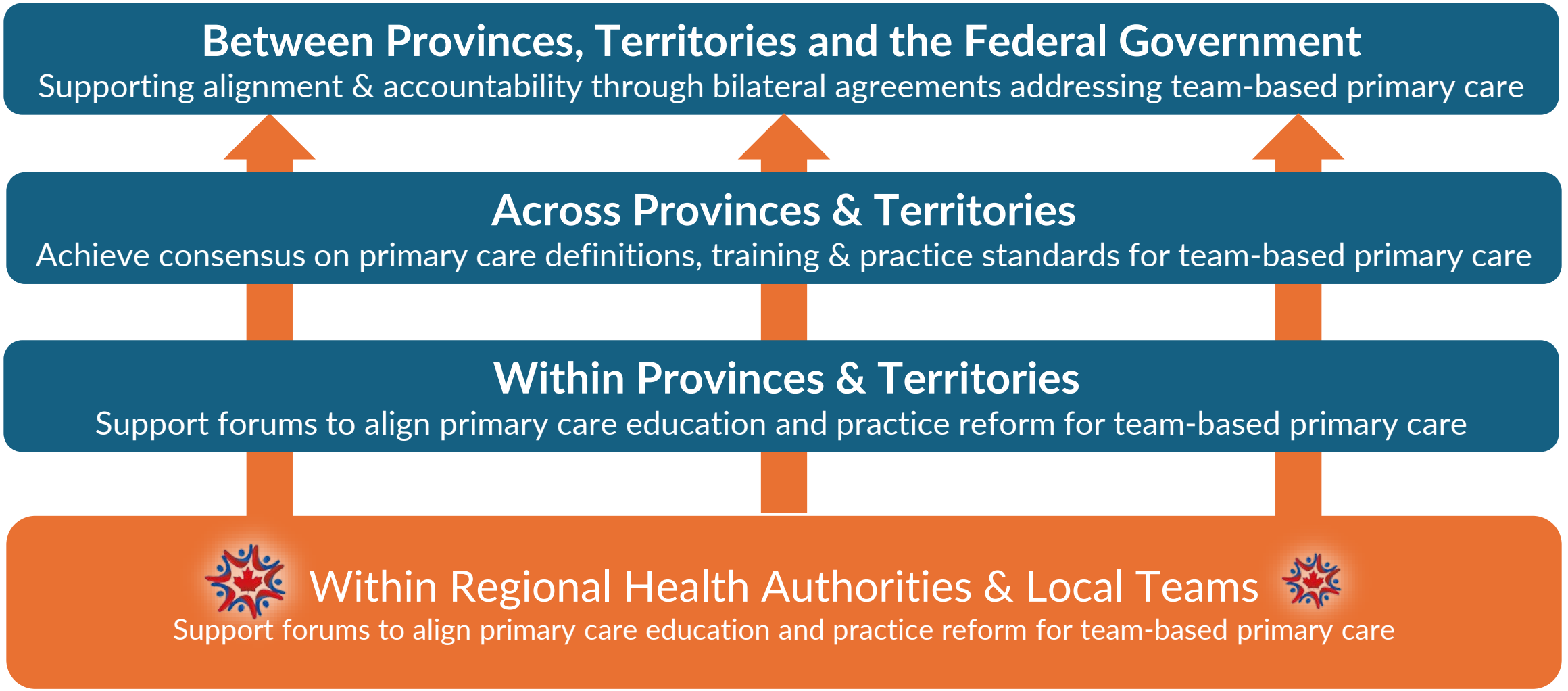
Requires Consensus across Professions (Accreditation/Regulation)

Nova Scotia

CALL FOR TEAM-BASED **TRAINING TO CHANGE BEHAVIOR**



Call for A Coordinated Primary Care Strategy



What can we do ?

Comprehensive

Continuous

Coordinated Care

1st Contact

SHARED RESPONSIBILITY


Coordinated
Confident
Well

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Thanks for all you do!

i.oandasan@utoronto.ca

Meet Mrs. Amina Khan

Current Care Coordination & Transition Challenges:

- **Fragmented Communication:** No shared care plan; ad-hoc coordination between primary care, home care nursing, PCPs, and specialists.
- **Variations in Home Care Services:** Staffing gaps, rotating PCPs, limited cultural/language alignment → refusals of care and reduced continuity.
- **Specialist Care Access Barriers:** 90-minute travel to specialists, long geriatric waitlist, frequent appointment confusion.

Meet Mrs. Amina Khan

Current Care Coordination & Transition Challenges:

- **Impact of Cognitive Decline:** Recognition of responsive behaviours, safety concerns, missed appointments, and strained relationships with caregivers and care provider teams.
- **Caregiver Responsibilities & Navigation Needs:** Daughter unsure how to request more support; cultural stigma around dementia; limited system navigation assistance.
- **Cultural & Language Gaps:** Interpreter use inconsistent; cultural values influence care acceptance and trust with providers.

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Panel Discussion

Q&A

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Upcoming TeleECHO Clinics

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cdnhomecare.ca/chca-project-echo-integrated-seniors-care

CHCA Project ECHO Integrated Seniors Care

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Strengthening Integrated Care Planning with interRAI-HC and CAPs
December 3, 12 -1pm Eastern
John P. Hirdes, Katarina R. Busija, Leslie Eckel

Navigating Autonomy and Safety in Complex Care
December 10, 12 – 1pm Eastern
Kerry Bowman, Olesya Kochetkova, Jean Johnston-McKitterick

Assessing Frailty in Complex Care: Balancing Risk, Judgment, and Care Planning
January 21 2026, 12-1pm Eastern
Dr. Kenneth Rockwood, additional panelists TBC