CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care

Applying the Comprehensive Geriatric Assessment in Integrated Team-Based Care

Presenter:

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Clinician Researcher, Lawson Research Institute

Panelists:

Dr. Grace Park MD CCFP MBA, Clinician Scientist, Geroscience, Fraser Health Authority; Co-Founder and Physician Lead, Pacific Regional Network for Healthy Aging

Laura Harrison, MSc OT Reg. (Ont.), Clinical Navigator; Behaviour Supports Coordinating Office, Toronto Central Region – VBM Intake/Triage, Baycrest

Host: Jennifer Campagnolo, CHCA

April 29, 2026

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.

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Introductions

George Heckman MD MSc FRCPC
Associate Professor, Western University
Clinician Researcher, Lawson Research Institute

Dr. Grace Park MD CCFP MBA
Clinician Scientist, Geroscience,
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Co-Founder and Physician Lead, Pacific
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Applying the Comprehensive Geriatric Assessment in Integrated, Team-Based Care

George Heckman MD MSc FRCPC
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Clinician Researcher, Lawson Research Institute
April 29, 2026

I acknowledge the Anishinaabek, Haudenosaunee, and Chonnonton Nations, on whose traditional lands I live and work.

I also acknowledge that much of the quality of life and privilege I enjoy today stem from the opportunities afforded to German Protestants brought in by the British to settle the lands around Lunenburg (E'se'katik being the original Mi’kmaw place name), Nova Scotia, but at the expense of the local Metis who were ultimately deported with the Acadians.

Disclosures – George Heckman

- interRAI (www.interRAI.org)
  - Fellow: interRAI Canada
  - Vice Chair, interRAI Instrument and Systems Development Committee

- Research funding: Health Excellence Canada, New Frontiers Research Fund, Public Health Agency of Canada, Heart and Stroke Foundation, CIHR, Alzheimer's Society, Servier, Mespere Life Sciences

- Honoraria (unrestricted talks > 4 years ago): Servier, Novartis, Pfizer, Home Care Assistance

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Italian hospitals collapse: Over wa

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50 French hospitals hit by long patient delays or summer closures

The health minister has admitted 'there are difficult situations to address' as one health union claims four people have died while waiting for emergency care

tal wards are suffering especially as a result of summer staff shortages ricochet64 / Shutterstock

st 2024 - 14:46 MODIFIED Thursday 22 August 2024 - 14:50

Telegraph-Journal
@TJProvincial
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Bed blockers are biggest obstacle to safe, timely care: Horizon tj.news/new-brunswick/...

For many, the term 'bed blocker' is a derogatory term that fails to take account of the fact that it is a person who is being talked about, with their own personal circumstances, and not just a statistic. Use of the term does not take in account the myriad of factors that contribute to the person being unable to leave the hospital environment,

Being delayed in hospital isn't fun for anyone...

Common mechanisms of ALC

1. Someone is hospitalized
   - Often for preventable reasons: COPD, HF, falls and fracture

2. Complications (often preventable) happen in hospital
   - Delirium
   - Functional decline

Schulich
MEDICINE & DENTISTRY

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Alternate Level of Care in Canada: Multiple Indicators of Frailty

Costa *et al. BMC Health Services Research* 2012, **12**:172
http://www.biomedcentral.com/1472-6963/12/172

BMC
Health Services Research

RESEARCH ARTICLE Open Access

Acute care inpatients with long-term delayed-discharge: evidence from a Canadian health region

Andrew P Costa[1,2*], Jeffrey W Poss[1,2], Thomas Peirce[2] and John P Hirdes[1]

Abstract

Background: Acute hospital discharge delays are a pressing concern for many health care administrators. In Canada, a delayed discharge is defined by the alternate level of care (ALC) construct and has been the target of many provincial health care strategies. Little is known on the patient characteristics that influence acute ALC length of stay. This study examines which characteristics drive acute ALC length of stay for those awaiting nursing home admission.

Methods: Population-level administrative and assessment data were used to examine 17,111 acute hospital admissions designated as alternate level of care (ALC) from a large Canadian health region. Case level hospital records were linked to home care administrative and assessment records to identify and characterize those ALC patients that account for the greatest proportion of acute hospital ALC days.

Results: ALC patients waiting for nursing home admission accounted for 41.5% of acute hospital ALC bed days while only accounting for 8.8% of acute hospital ALC patients. Characteristics that were significantly associated with greater ALC lengths of stay were morbid obesity (27 day mean deviation, 99% CI = ±14.6), psychiatric diagnosis (13 day mean deviation, 99% CI = ±6.2), abusive behaviours (12 day mean deviation, 99% CI = ±10.7), and stroke (7 day mean deviation, 99% CI = ±5.0). Overall, persons with morbid obesity, a psychiatric diagnosis, abusive behaviours, or stroke accounted for 4.3% of all ALC patients and 23% of all acute hospital ALC days between April 1st 2009 and April 1st, 2011. ALC patients with the identified characteristics had unique clinical profiles.

Conclusions: A small number of patients with non-medical days waiting for nursing home admission contribute to a substantial proportion of total non-medical days in acute hospitals. Increases in nursing home capacity or changes to existing funding arrangements should target the sub-populations identified in this investigation to maximize effectiveness. Specifically, incentives should be introduced to encourage nursing homes to accept acute patients with the least prospect for community-based living, while acute patients with the greatest prospect for community-based living are discharged to transitional care or directly to community-based care.

Keywords: Delayed discharge, Alternate level of care, Vulnerable elderly, Length of stay, Acute care, interRAI

Background

Delays in discharge from acute hospitals are a critical challenge for many health care systems in industrialized nations. These delayed discharges are hospital episodes where a patient exceeds the length of stay deemed medically necessary. They are commonly associated with, though not exclusive to, older adults [1-3]. Delayed discharges represent a minority of hospital cases, yet they often have a substantial influence on patient flow throughout the hospital. This influence includes emergency department crowding (access block), cancelations of day procedures, and poor coordination of sub-acute and community care resources [4,5]. Mounting delays and their influence on overall health system capacity has lead to public pressure and targeted policy activity [1,6-11]. Although delayed discharges have a negative influence on

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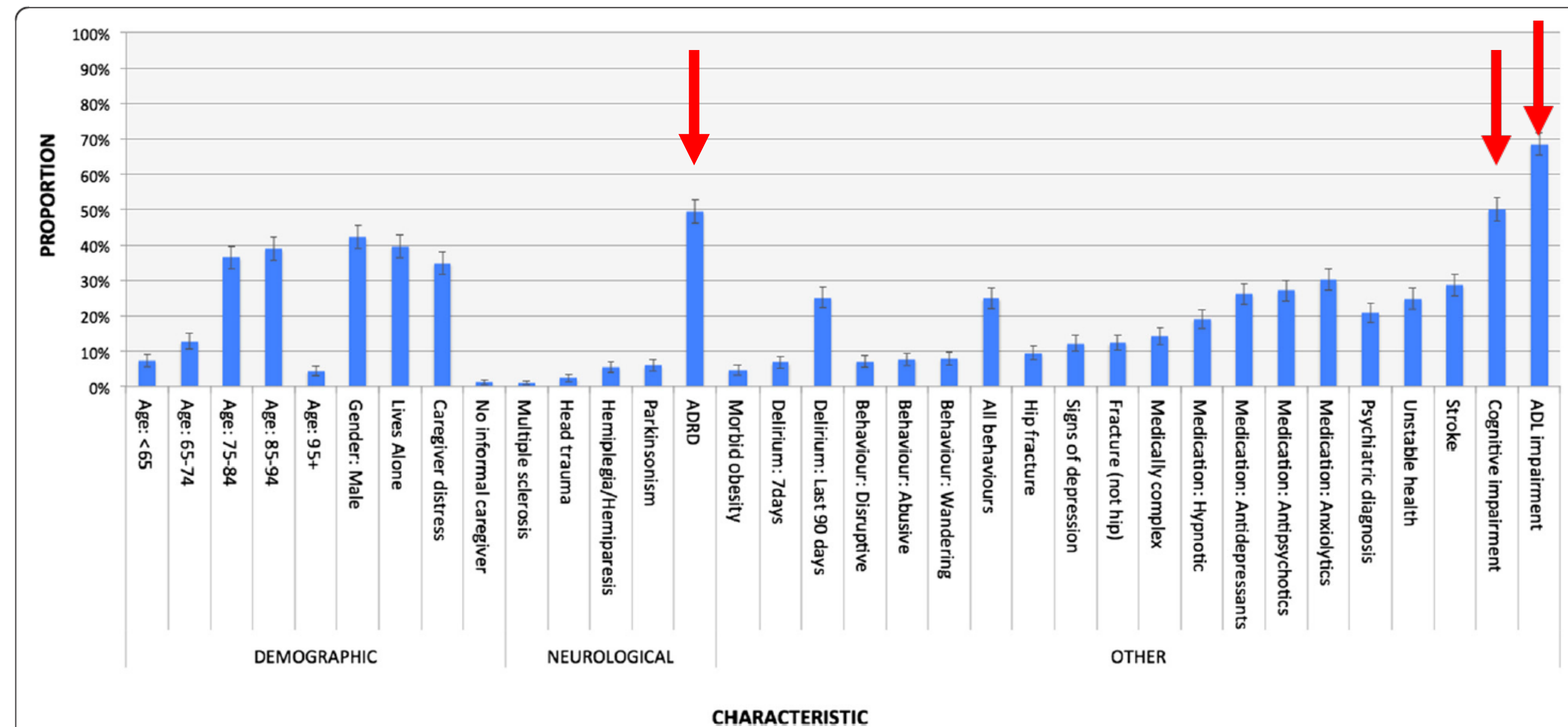
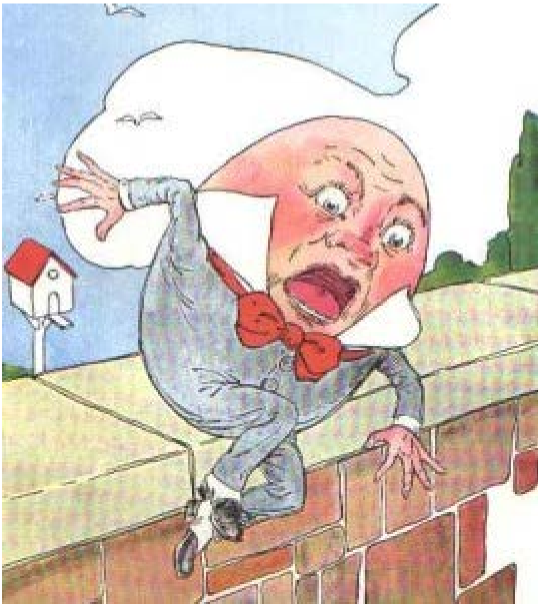


Figure 1 Characteristics of acute ALC patients waiting for nursing home admission, fiscal 2010-2011. Note: All confidence intervals are 99% (alpha = 0.01) unless otherwise specified. ADRD = Alzheimer's Disease and Related Dementias. See Table 2 for elaborations of the included characteristics.

Our system…



The intervention: Comprehensive Geriatric Assessment

Abellan 2010; Lafortune 2017; Franco 2023

Multidimensional interdisciplinary process focused on determining a frail older persons' medical, psychological and functional capacity in order to develop a coordinated and integrated plan for treatment and long-term follow-up

1. Comprehensive data collection and assessment
   1. Standardized: interRAI Home Care
   2. Narrative: 2022

2. Development of a comprehensive management plan
   - **Tailored to patient need and overall fitness / frailty**
   - **Ideally identify and mitigate potential stressors**

3. **Implementation** of the comprehensive care plan

If implemented and correctly targeted, CGA helps

- Improved prescribing
- Fewer hospitalizations
- Lower institutionalization rate
- Improved function, cognition
- Reduced falls
- Lower mortality
- Cost-neutral to cost-reducing

Contact with Geriatric Medicine Among Home Care Clients

Hogeveen JAGS 2023; Hogeveen UWSpace 2022

- Home care clients are frail, functionally impaired, with high needs
- Retrospective cohort of 196,444 long-stay HC clients 2012-2015
  - 92% had any contact with a physician in the 90 days post-assessment
  - 50% had ≥4 contacts
- Disciplines
  - 80% had any contact with family medicine (22% had ≥4 contacts)
  - Internal medicine (~20%)
  - Ophthalmology (~11%)
  - Cardiology (~9%)
- Geriatrician: 5.2% (wait list ~ months)
- Impact: 0.90 lower odds of ED visit; 0.82 lower odds of hospitalization

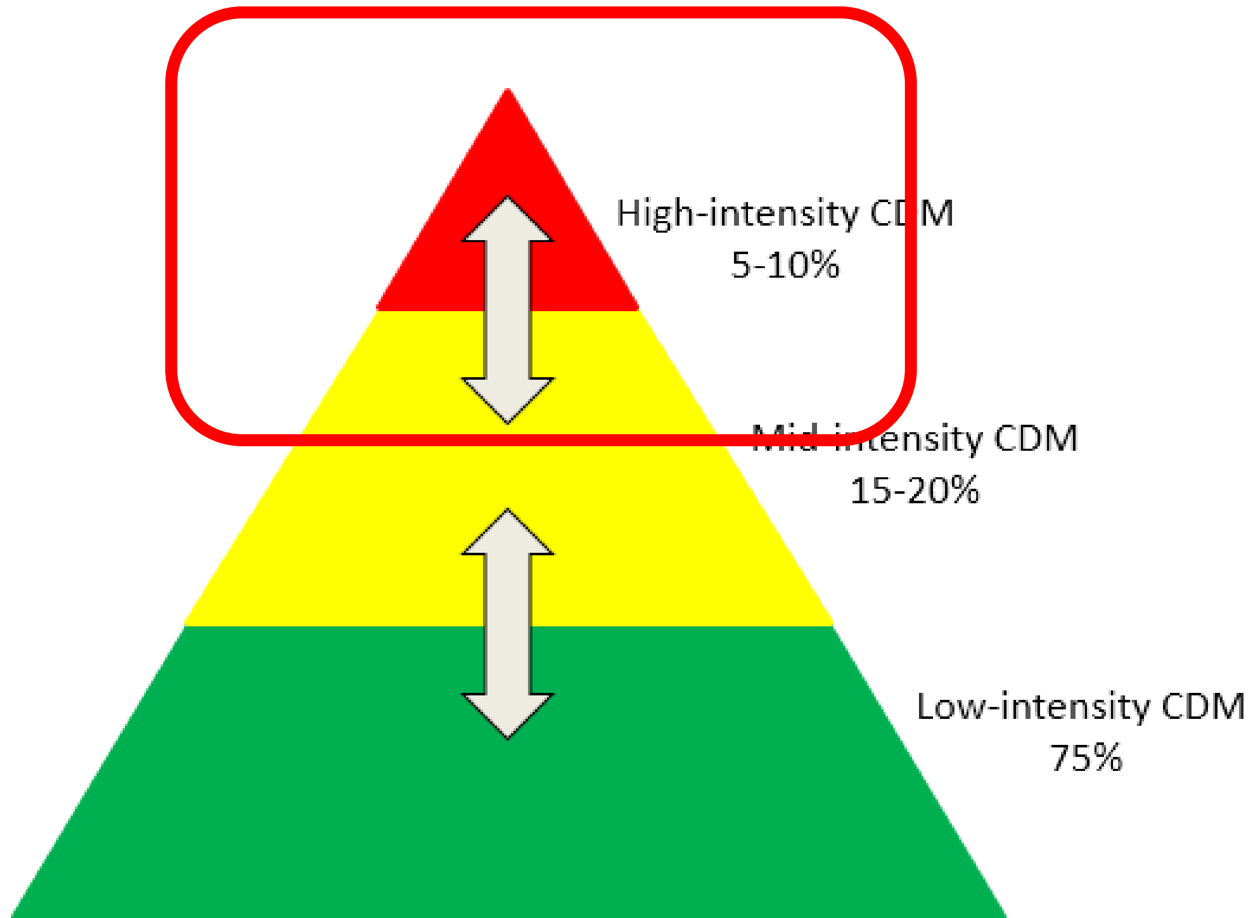
Can we do this within primary care?

Beaulieu et al CMAJ 2013

- 37 primary care practices in Quebec: 1457 patients with
  - 1 or 2 diabetes or CAD (25% overall)
  - 1 of URTI, UTI, gastroenteritis, back pain, pharyngitis, bronchitis)
  - Assessed care quality: QIs (UK and Canada), Overall composite score

- Results
  - Physician remuneration (salaried v. FFS): 27.0 (19.0 to 35.0)
  - Physician specialists on site: 19.6 (8.3 to 30.9)
  - Allied health care professionals on site: 15.3 (5.4 to 25.2)
  - Duration of follow-up/emergency appointment
    - Long (≥ 30 min vs. < 10) 18.6 (8.1 to 29.1)
  - Continuous professional development and/or quality assurance 7.7 (3.0 to 12.4)

Requires risk stratification/efficient targeting



Resource implications

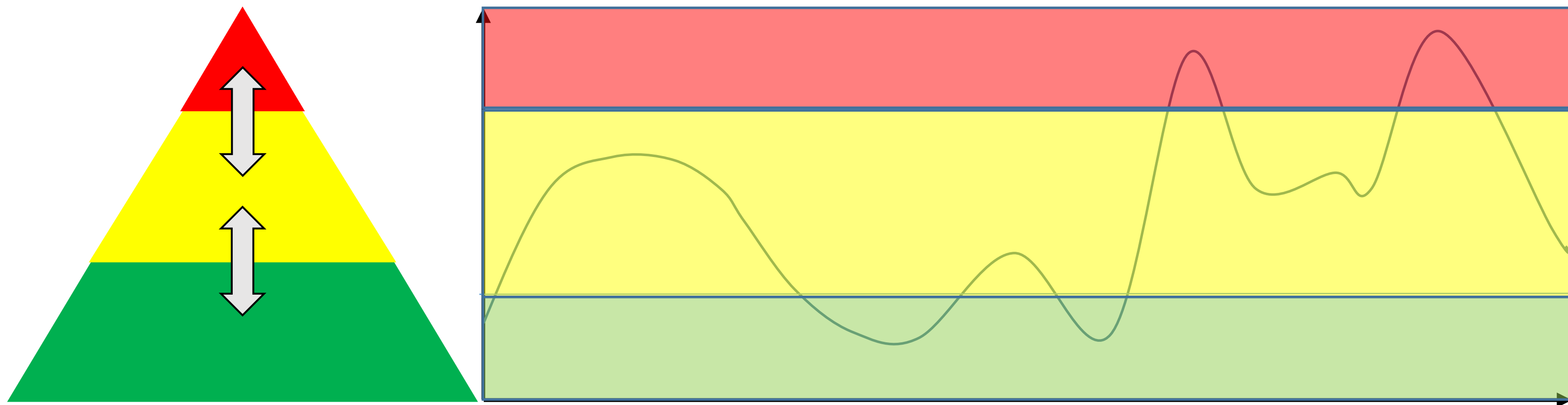
High-risk/high-intensity: Specialist services, case managers/ navigators, with high degree of integration, coordination, and follow-up including home visits

Mid-risk/mid-intensity: Primary care with nurse specialists / allied health, integrated with other medical specialties, located to facilitate access

Low-risk/low-intensity: RNs trained in self-care teaching with family MDs or NPs

ANTICIPATORY GUIDANCE

- Risk fluctuates over time and exacerbations happen
  - On their own schedule and NOT by appointment!
- When patient / caregiver calls, default SHOULD NOT BE “CALL 9-1-1”!
- Importance of promoting SELF-CARE skills!
- Availability of someone to take impromptu calls and assess situation
  - Nurse, OT, pharmacist, social worker



Geriatric Resources for Assessment and Care of Elders

Counsell et al JAMA 2007; Shubert JAGS 2016

GRACE intervention: Target older, low SE adults with frequent contact with health care

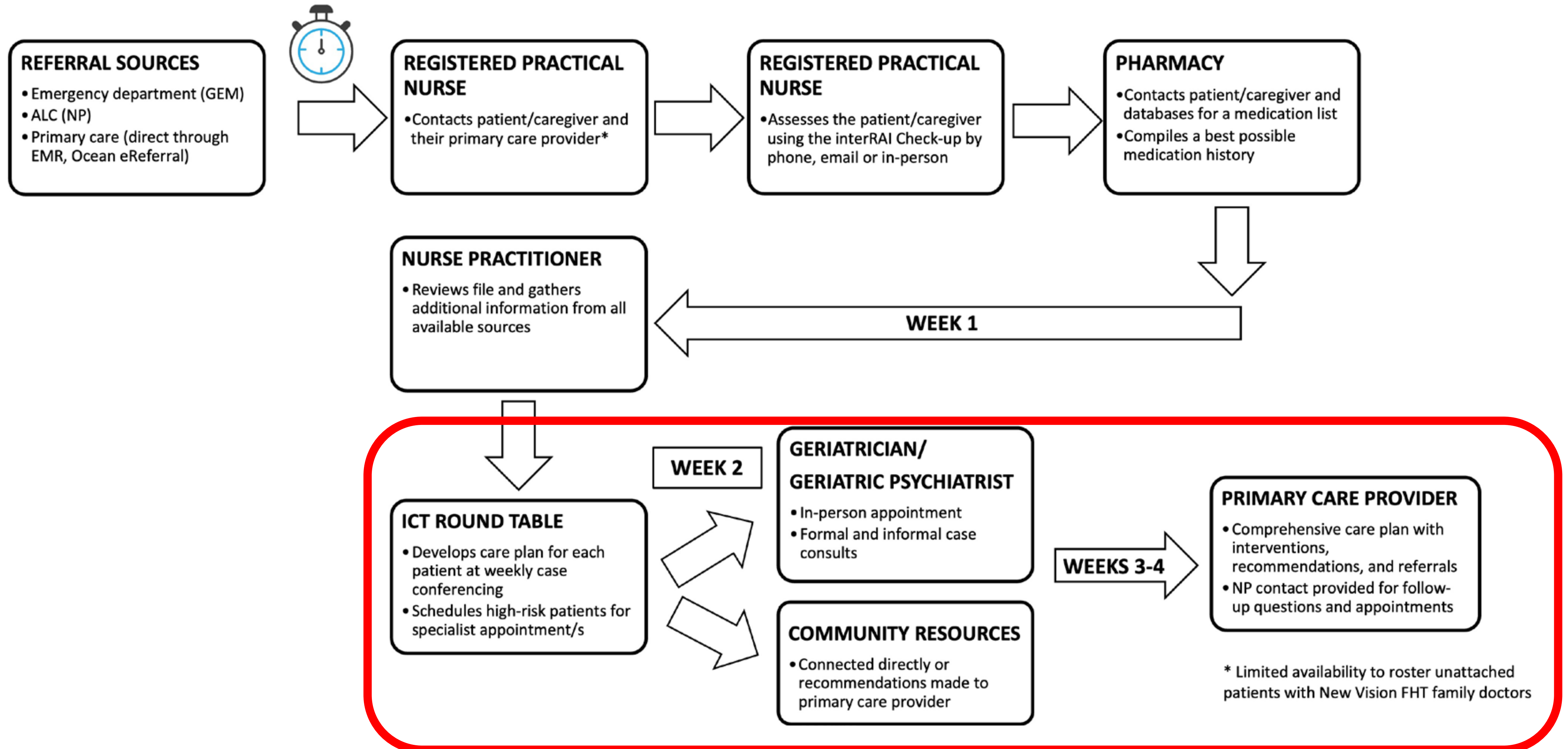
- Initial and annual in-home CGA by GRACE team: APN, SW
- Individualized care planning: team, geriatrician, pharmacist, PT, mental health SW, community services
- Annual and PRN meeting with patient's primary care physician to coordinate/adapt plan
- Weekly GRACE team meetings to ensure execution of plan and on-going case management (including at least monthly patient contacts)
- Coordination and continuity of care among all health care professionals and sites of care

Outcomes

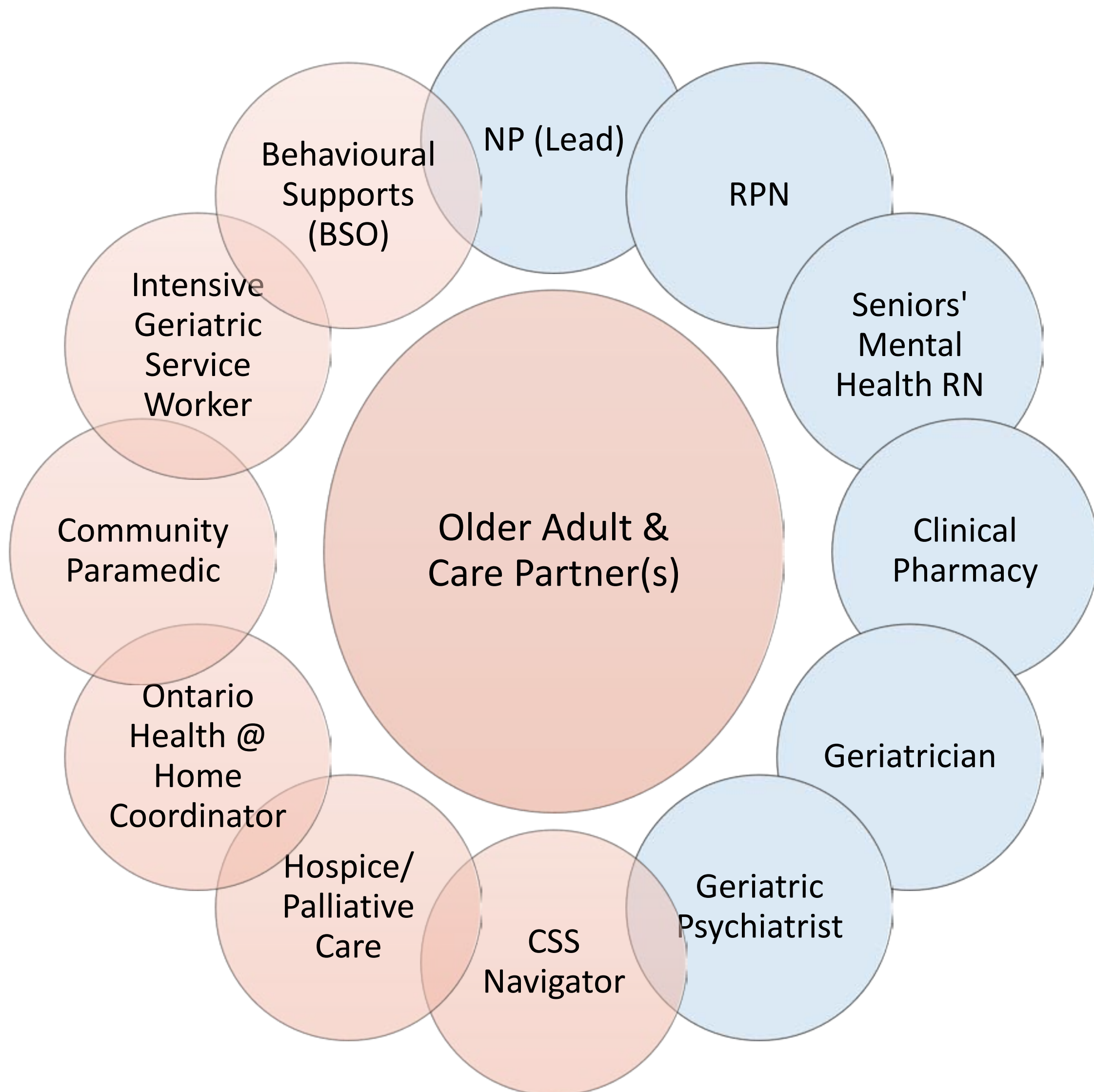
- Improved quality of life, mental health
- Reduced ED visits and hospitalizations (VA implementation 38% reduction in hospitalizations)

IMPACT EMERGED <u>ONLY</u> AFTER 2 YEARS related to development of interprofessional teamwork

KW4 Integrated Care Team



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 characteristics: Complex Care Program

	Total (76)	Man (22)	Woman (54)
Age (years)	81.8	82.9	80.3
ADRD	36 (47.4%)	11 (50%)	25 (36.3%)
Movement disorder	8 (10.5%)	4 (18.2%)	4 (7.4%)
Depression	20 (26.3%)	4 (18.2%)	16 (29.6%)
Coronary artery disease	18 (23.7%)	9 (40.1%)	9 (16.7%)
Hypertension	50 (65.8%)	15 (68.2%)	35 (64.8%)
Diabetes	29 (38.2%)	11 (50%)	29 (53.7%)
Atrial fibrillation	14 (18.4%)	6 (27.3%)	8 (14.8%)
Heart failure	13 (17.1%)	6 (27.3%)	7 (13.0%)
Stroke	18 (23.7%)	3 (13.6%)	15 (27.8%)
COPD/asthma	24 (31.6%)	7 (31.8%)	17 (31.5%)
Osteoporosis	36 (47.4%)	7 (31.8%)	29 (53.7%)
Incontinence (urine)	49 (64.5%)	13 (59.1%)	36 (66.7%)
Chronic renal failure	45 (59%)	17 (77.3%)	28 (51.6%)
Medications	12.8	11.6	13.3

Results: Quantitative

Heckman 2025

Outcome	Total (n=76)	Men (n=22)	Women (n-54)
Geriatrician encounter - Consult - eReview	63 (82.9%) 54 9	 16 3	 38 6
New community referrals	40 (52.6%)	12	28
Meds deprescribed \#	32 (42%) (0.85)	10 (1.05)	22 (0.76)
Meds optimized \#	46 (60.5%) (1.05)	12 (0.95)	34 (1.09)
ED visits (1 year before)	1.33	1.32	1.33
ED visits (1 year after)	0.67	0.69	0.66

Meds stopped: NSAIDs, psychotropics, PPIs
Meds optimized: bone health, cardiovascular, acetaminophen

Effective interprofessional teams

Miller & Cohen-Katz, Fam Syst Health 2010

- Interprofessional care: collaborative team-based person-centered
- Requires that participants relinquish some professional autonomy so that all clinicians work to full scope of practice.
  - Accountability to each other and to the patient
- Advance practice nurses are an established element of successful teams
- Physicians often perceived as resistant to this, emphasis on **physician**/patient relationship

Wranik et al. Health Policy 2019

Contandriopoulos et al BMC Fam Pract 2018

O'Reilly et al PLoS One. 2017

Gocan et al JRIPE 2014

According to Miller and Cohen-Katz...

Lessons Learned

Building Block	Explanation	Notes
Oversight	Decision-maker-level participation is required to troubleshoot barriers, with staff from multiple organizations working together	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
Shared 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	Full-scope of practice improves efficiency and ultimately “flow”
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	NP, CNS 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, HC, CHA
Patient-Centred	Ensure patients can express their needs alongside clinician referral; use a palliative approach and a goals of care lens	Self-report Check-Up done prior visit reduces in-clinic assessment burden
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

Thank you!

Meet Mrs. Lillian Chen*

Background and Living Situation

- 76-year-old widow; lives alone in a bungalow in Markham, ON; wishes to remain at home.
- Retired teacher; values privacy, routine, and independence.
- Daughter nearby (20 min) assists with groceries, rides, and check-ins; son out of province.
- Daughter increasingly strained; feels guilty raising safety concerns.
- Receives nursing (diabetes) and personal support 2x/week; care coordination unclear.
- Withdrawn from local seniors program; no emergency plan for falls or confusion.

Medical History and Functional Status

- Vascular dementia (mild-moderate), type 2 diabetes, hypertension, osteoarthritis, urinary incontinence, CKD.
- Two falls in 6 months; one caused a minor wrist fracture.
- Increasing difficulty with medications, meals, shopping, transport, and appointments.
- Needs help with bathing and dressing cues; toilets and transfers independently.
- Knee pain limits gait, stamina, stairs, and outings.
- Weight loss, poor appetite, expired food, inconsistent walker use suggest declining safety.

* This case study is based on real-world events and experiences but is a composite scenario, with names and identifying details changed to protect privacy and confidentiality.

Meet Mrs. Lillian Chen*

Current Concerns

- More forgetful; missed medications and GP visits over 3 months.
- Confusion episodes; calls daughter feeling "mixed up" and tired.
- Rising blood sugars and late refills; unsafe medication management.
- Home safety: bruising, throw rugs, difficulty with microwave.
- Withdrawn, poor hygiene, evening anxiety; concerns re mood and self-care.
- Occasional suspiciousness; worsening cognitive symptoms.

Caregiver and Team Perspective

- Daughter questions home safety; unsure how to access more support.
- Physician concerned re missed visits, declining self-management; wants broader review.
- Nurse notes weight loss, variable glucose, bruising, inconsistent walker use.
- PSW notes reduced hygiene, withdrawal, difficulty with appliances.
- Pharmacist flags late refills and possible medication confusion.
- Family repeats info to multiple providers; no clear care coordinator.

Challenge

- How can the team support independence without overlooking gradual decline — and how might each discipline's assumptions shape decisions about risk, capacity, and quality of life?
- Beyond safety risks, what must the team assess, prioritize, and share to build a person-centred plan for living well at home?

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Discussion / Q&A

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Upcoming TeleECHO Clinics

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

CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care

New series starting soon!

Integrated Approaches to Palliative Care

Thank you for taking a moment to complete the survey!