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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
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Embedding proactive interprofessional comprehensive geriatric assessment into primary care

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NOVEMBER 5-8, 2025
RBC CONVENTION CENTRE WINNIPEG, MB

PRESENTER DISCLOSURE

George Heckman

Relationships with financial sponsors:

- **Any direct financial relationships, including receipt of honoraria:**

  N/A

- **Membership on advisory boards or speakers' bureaus:**

  N/A

- **Patents for drugs or devices:**

  N/A

- **Other:**

  Vice-Chair, Instrument and Systems Development Committee, interRAI Global; Fellow interRAI Canada

PRESENTER DISCLOSURE

Chantelle Mensink

Relationships with financial sponsors:

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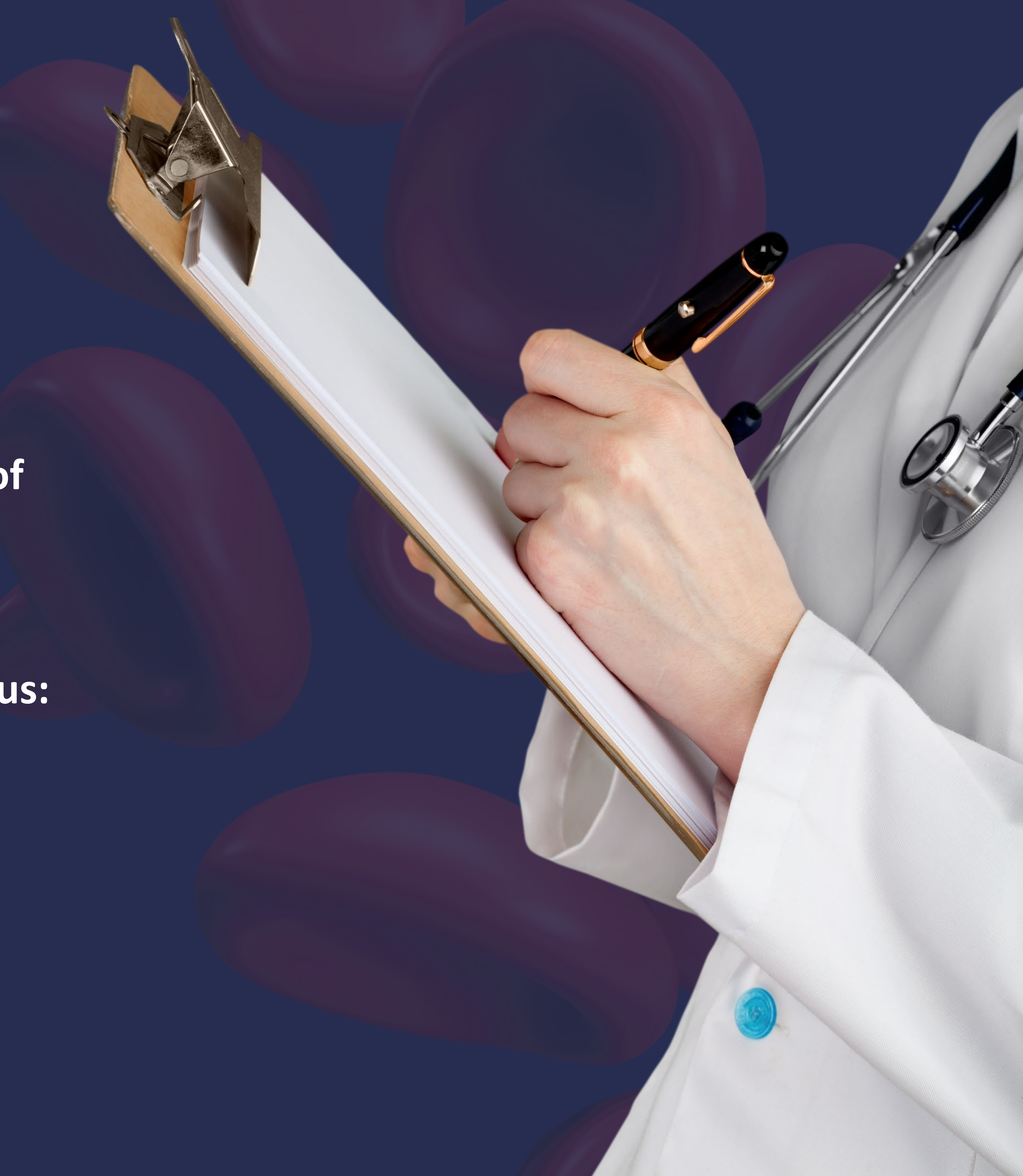


Latest Europe World EU Policy Business Travel

Italian hospitals collapse: Over

wa

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

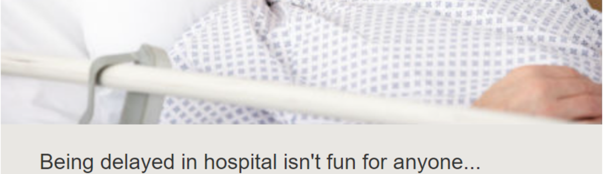
Telegraph-Journal
@TJProvincial

Follow

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

Copyright Gregoric

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,

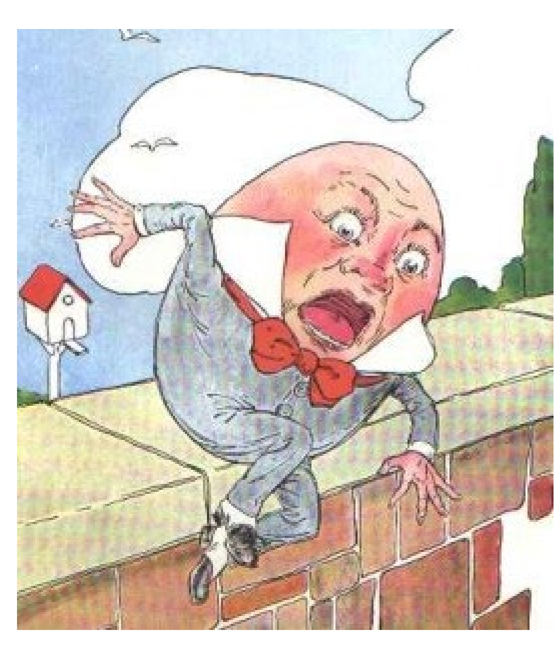


Being delayed in hospital isn't fun for anyone...

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

Our system in ~~a nutshell~~ an eggshell



Queen's Park

Ontario plans to build system that attaches patients to family doctor or nurse practitioner team based on postal code

By The Canadian Press

Published: April 10, 2025 at 8:10AM EDT

based primary health care

By Melanie Hnatiuk and Terri Potter, Ca

Published Jun 03, 2025 Last updated

10,000 Islanders will gain access to primary care with UPEI's medical home, says Health P.E.I.

UPEI's patient medical home set to open in fall 2025

Gwyneth Egan · CBC News · Posted: Jan 23, 2025 5:00 AM EST | Last Updated: January 23

There are "teams"...

GINO HARD

TORONTO MAPLE LEAFS

ELIMINATED

FROM NHL PLAYOFFS

And then there are TEAMS!

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…

High performing 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)

Organizing the teams for geriatric care

- Framework: Chronic disease management and prevention

- Integration: who is on the team and how do they interact which each other and community services to serve the patient?

- Intervention: Comprehensive Geriatric Assessment

- Quality assurance and sustainability

CDPM: Chronic disease prevention and management model

Wagner 1996; Scott 2008

Multidisciplinary care to optimize outpatient care and *prevent acute care use*

Self-care: enhance ability of patients and informal caregivers to self-manage, recognize and address exacerbations early, and seek timely outpatient support

System redesign

- Care integration and coordination across multiple conditions and care settings
- Invest in better access to community-based and multidisciplinary resources

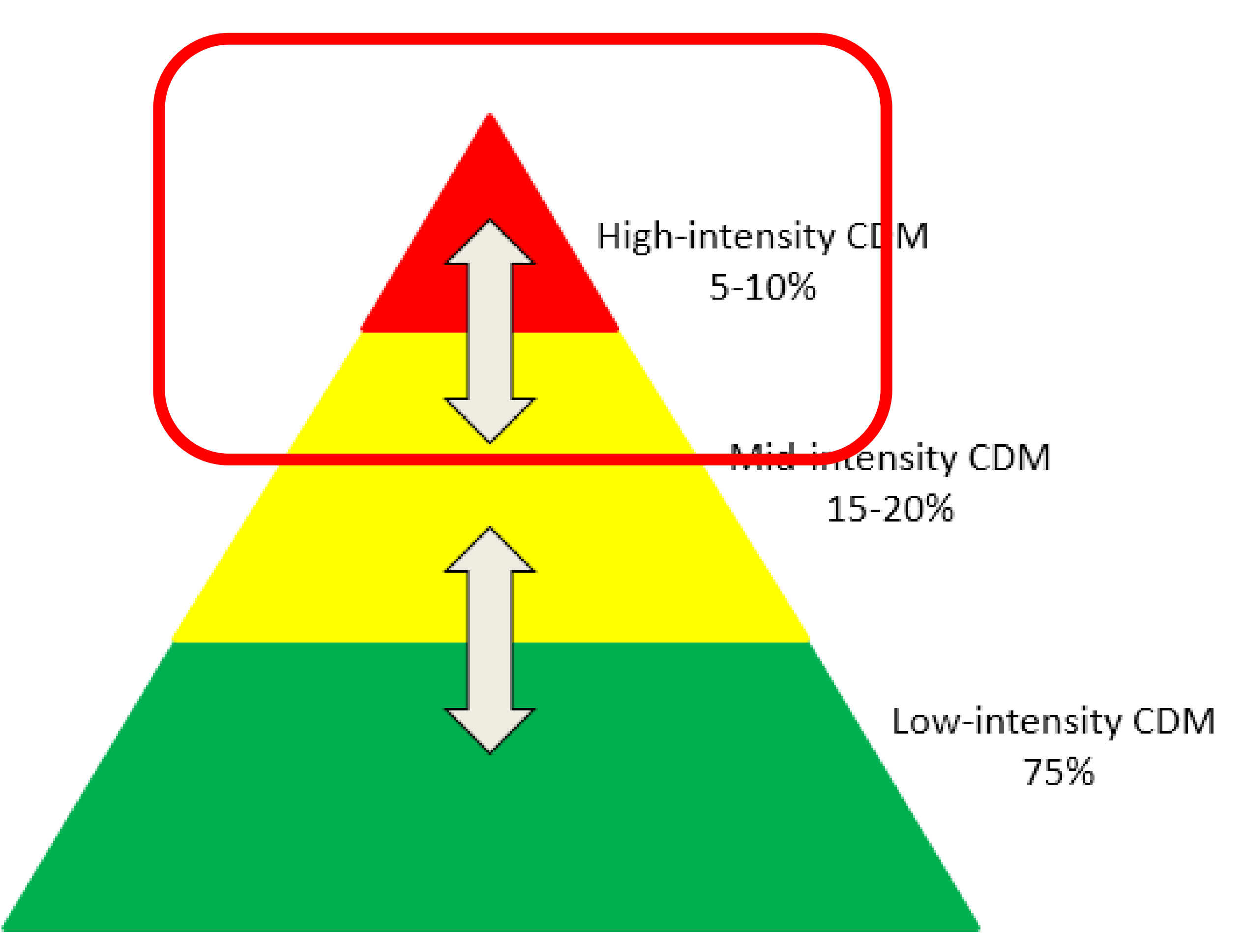
Clinical information systems

- Facilitate patient education, follow-up, information sharing and quality assurance
- Provide **evidence-based decision support** to patients, informal caregivers and providers

Implications of CDPM

- Patient and caregivers should get the care they need, ***no more, no less***
  - ***Not everyone needs a team at all times***
- This can/should be anchored in primary care
- This can/should be interprofessional
- ***How do we coordinate and assign care tasks among Health Service Providers?***

Requires risk stratification



<u>Resource implications</u>

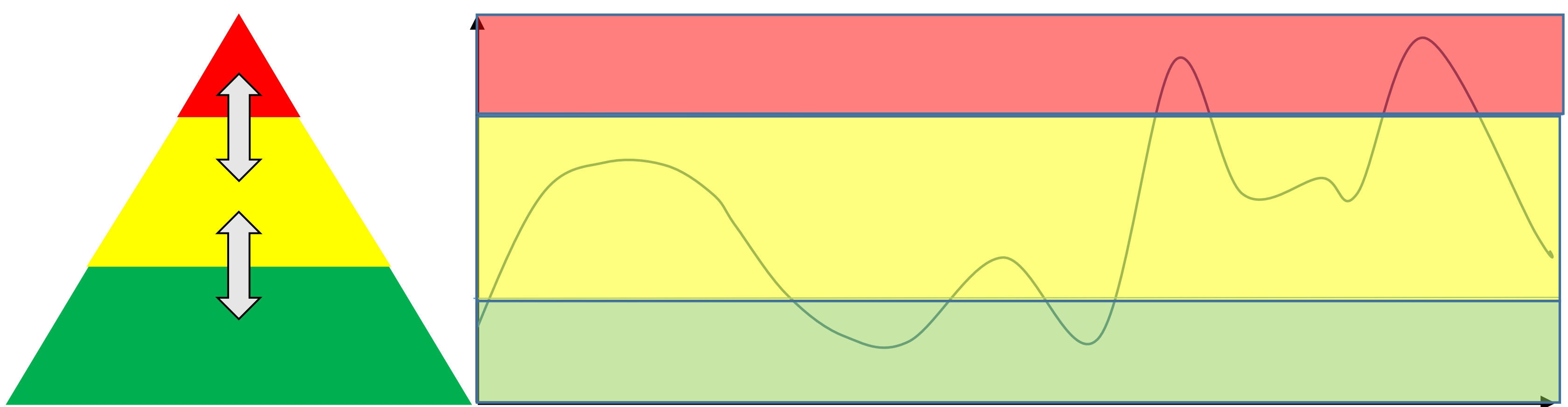
High-risk/high-intensity: Specialist services, case managers/ navigators, with high degree of integration, coordination, and follow-up including home visits

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

CDPM implies 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



The intervention: Comprehensive Geriatric Assessment

Abellan 2010

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

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

Can we do this in primary care?

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 ONLY AFTER 2 YEARS related to development of interprofessional teamwork

New Vision FHT Experience

- Five CDPM clinics were established within the FHT:

Diabetes	Hypertension	Heart Failure	Memory	Anticoagulation

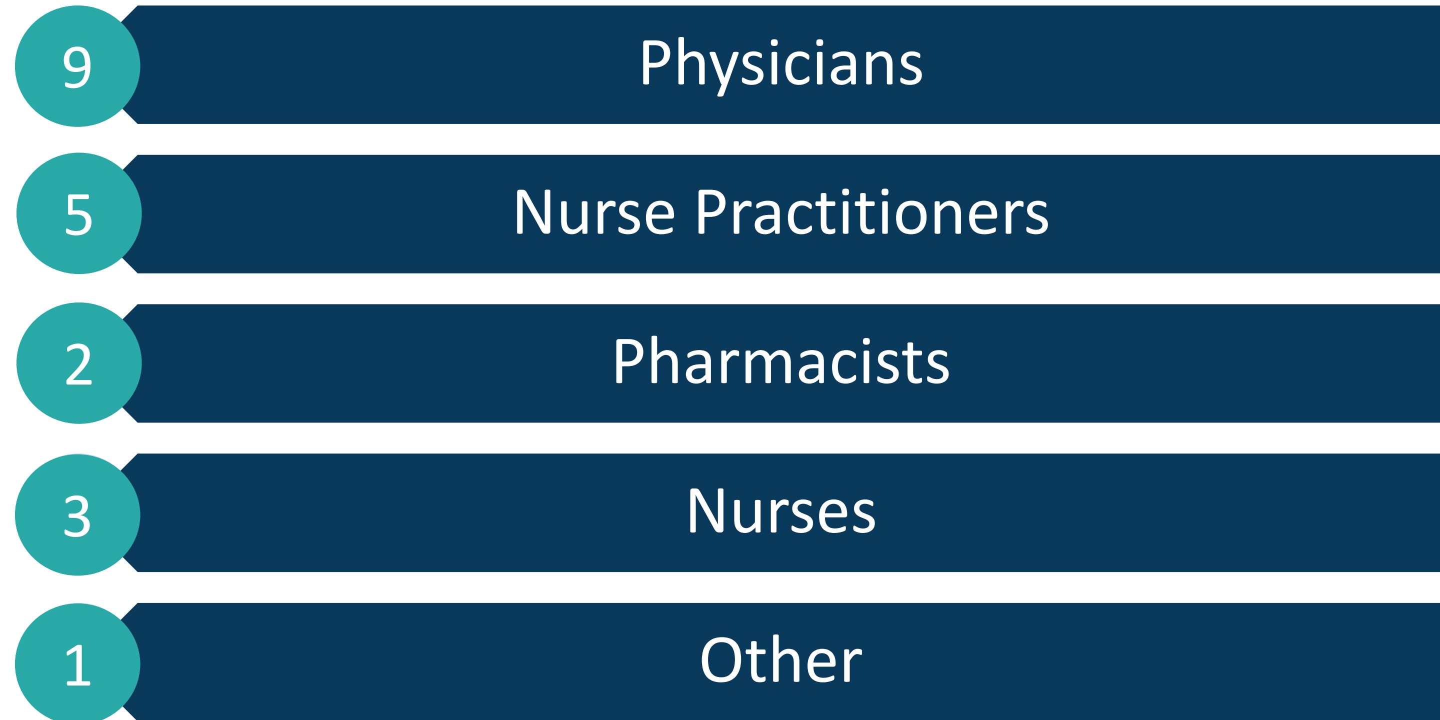
- Embedded geriatrician

- Case study to understand the evolution and function of new CDPM clinics within one FHT in southwestern Ontario

Brooks et al, BMC Fam Pract 2023

Methods

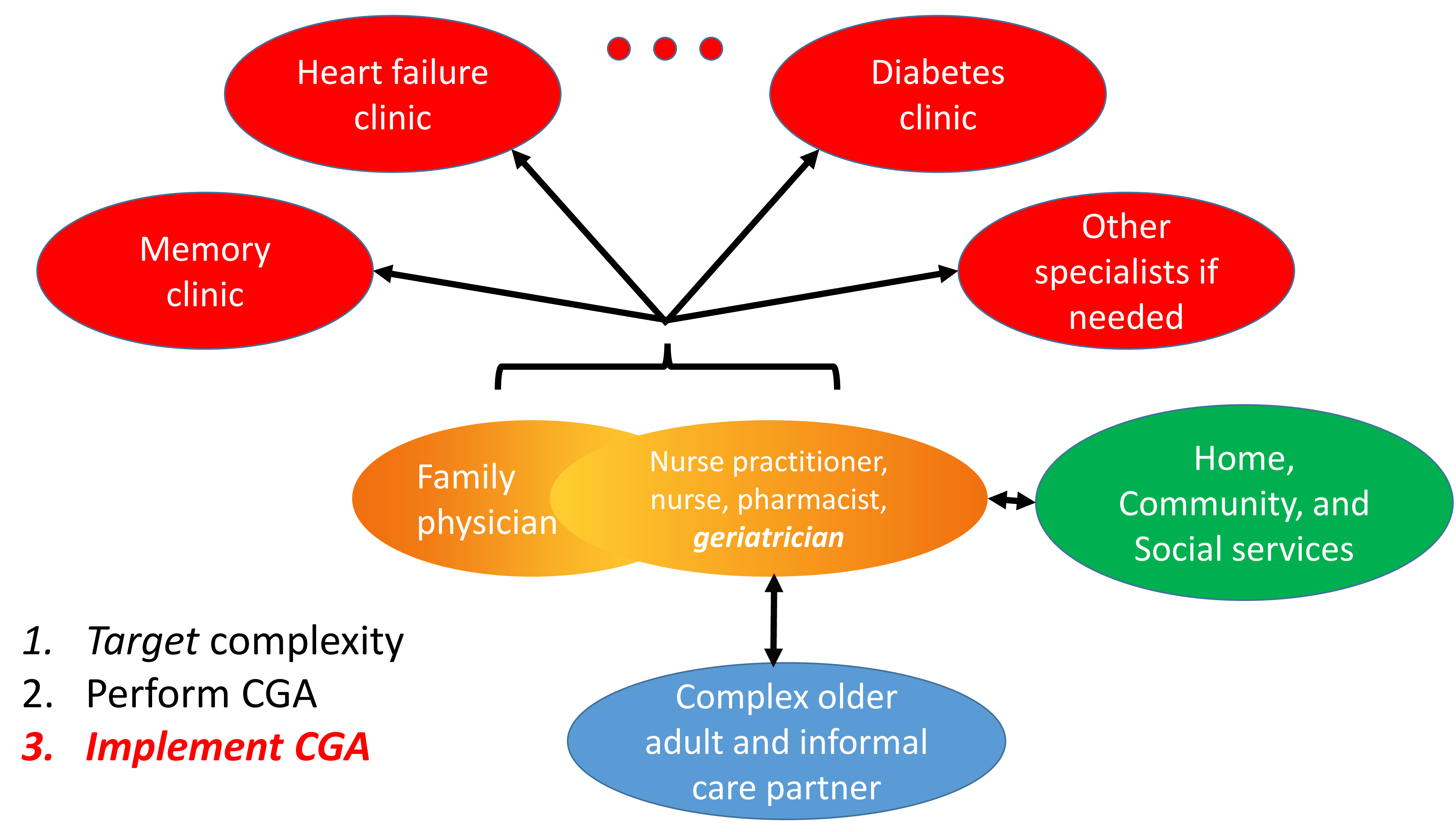
- In-depth individual interviews (n=20) were completed with a professionally diverse group of healthcare providers within the FHT



Laura Brooks, Zach DeVries, Jacobi Elliott, Paul Stolee, Veronique Boscart, George Heckman

Qualitative Analysis

- Clinicians as colleagues and not employees: freedom to develop role
- Opportunities for interprofessional teaching
- Program multiplicity created silos within the FHT between
    - Family MD and clinics
    - Clinics: patients classified by their « diseases »
    - FHT Sites
- Assessment burden: duplication/redundancy
- Clinic schedules and access tied to MD: bottleneck


Heart failure clinic
Diabetes clinic
Memory clinic
Other specialists if needed
Family physician
Nurse practitioner, nurse, pharmacist, *geriatrician*
Home, Community, and Social services
Complex older adult and informal care partner
1. *Target* complexity
2. Perform CGA
3. *Implement CGA*

Lessons learned

- Targeting matters to identify older adults most likely to benefit from team-based CGA
  - Move from fragmented disease/organ approach to a geriatric measure of risk
  - Primary care MD request and interRAI Preliminary Screener (AUA)
- Interprofessional ethos requires deliberate attention and time to develop
- Shared care planning and delivery: Family MD, APN, SW, geriatrics, pharmacy

Genesis of an Integrated Care Team for CGA in primary care

New Vision FHT

- 26,500 patients, 13% over age 65
- 15 Physicians, 3 NPs
- Clinical Pharmacist, Dietitians, Respiratory Therapists, Social Workers
- RNs, RPNs, MOAs, Admin. Staff/Health Outcomes Assessor
- 7 chronic disease programs:
  - Hypertension
  - Diabetes
  - Nutrition
  - Pharmacist Managed Anticoagulation Clinic (PMAC)
  - Lung Health
  - Heart Function Clinic
  - Primary Care Memory Clinic

Complex Care Program

- Proactive, *in-house* case-finding & comprehensive assessment

- Unique features:
  - NP-led, shared care (geriatrician, pharmacist, family MD)
  - Initial in-house case-finding and assessment template

- During pandemic, move to interRAI standardized instruments
  - Preliminary screener (AUA)
  - Check-Up Self-Report (CU-SR)
  - Embedded within EMR infrastructure (OCEAN, Practice Solutions)

- Heckman et al, Healthcare Management Forum 2025
  https://doi.org/10.1177/08404704241293051

Clinic Usage 1 year Pre- and Post-CCP

849

496

425

213

3%

23%

98

Total IHP Encounters

Total Visits

Visits with own GP

1 yr Pre-CCP

1 yr Post-CCP

Prescribing optimization

Example meds ***deprescribed/tapered***

- Opioids
- Benzodiazepines
- Estrogen
- PPIs
- Antiplatelets
- OTC (Gravol, Benadryl)
- Gliclazide
- NSAIDs

Example meds ***added/optimized***

- HF medications
- Vitamin D
- Actonel/Prolia
- Switch to less anticholinergic option
- Switch to more renally appropriate DM med

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

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

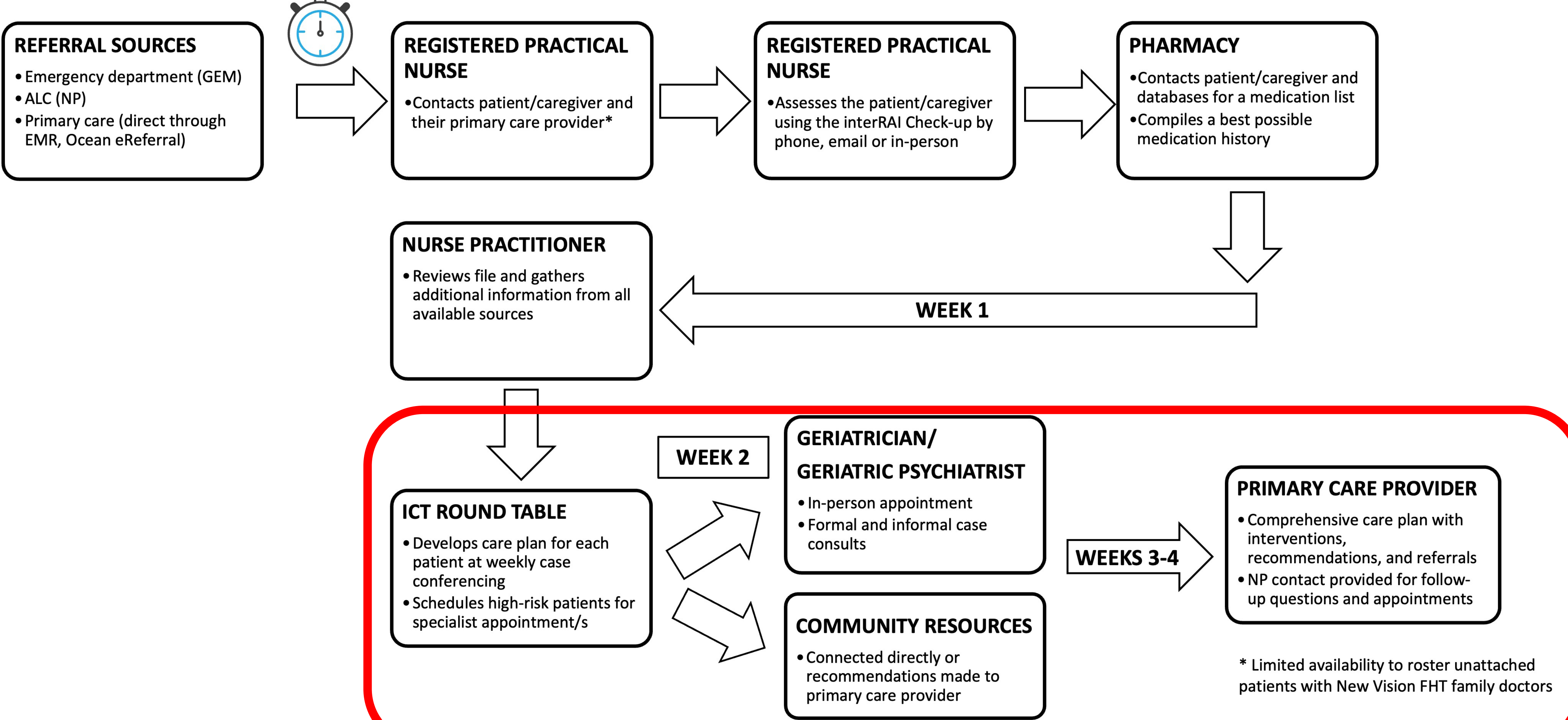
Meds stopped: NSAIDs, psychotropics, PPIs
Meds optimized: bone health, cardiovascular, acetaminophen

OH West ALC Strategy opportunity 2023

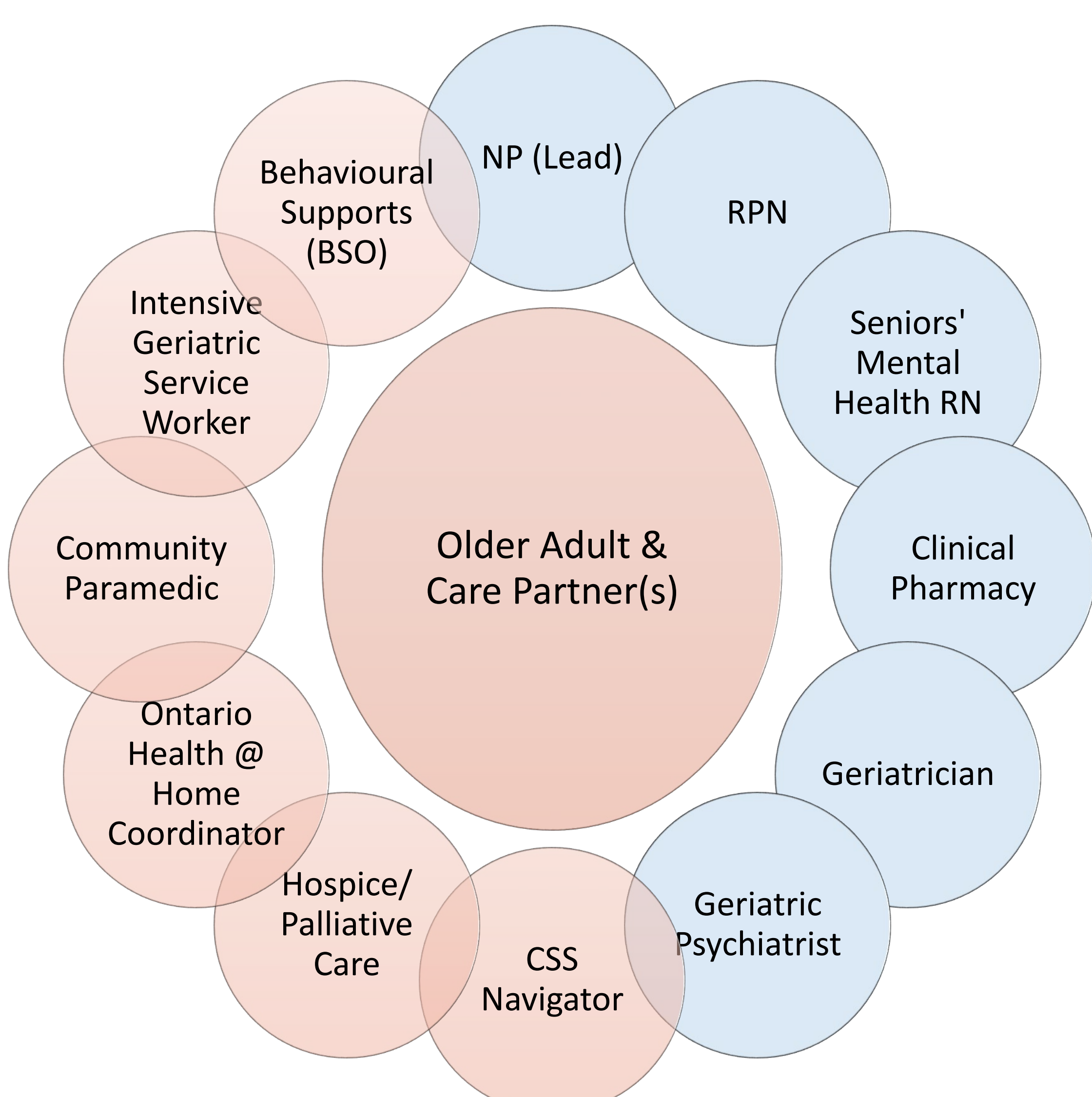
- 18% of KW family physicians have access to an interdisciplinary team
- 175 days is the average wait time to see a geriatrician

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

Process Map



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

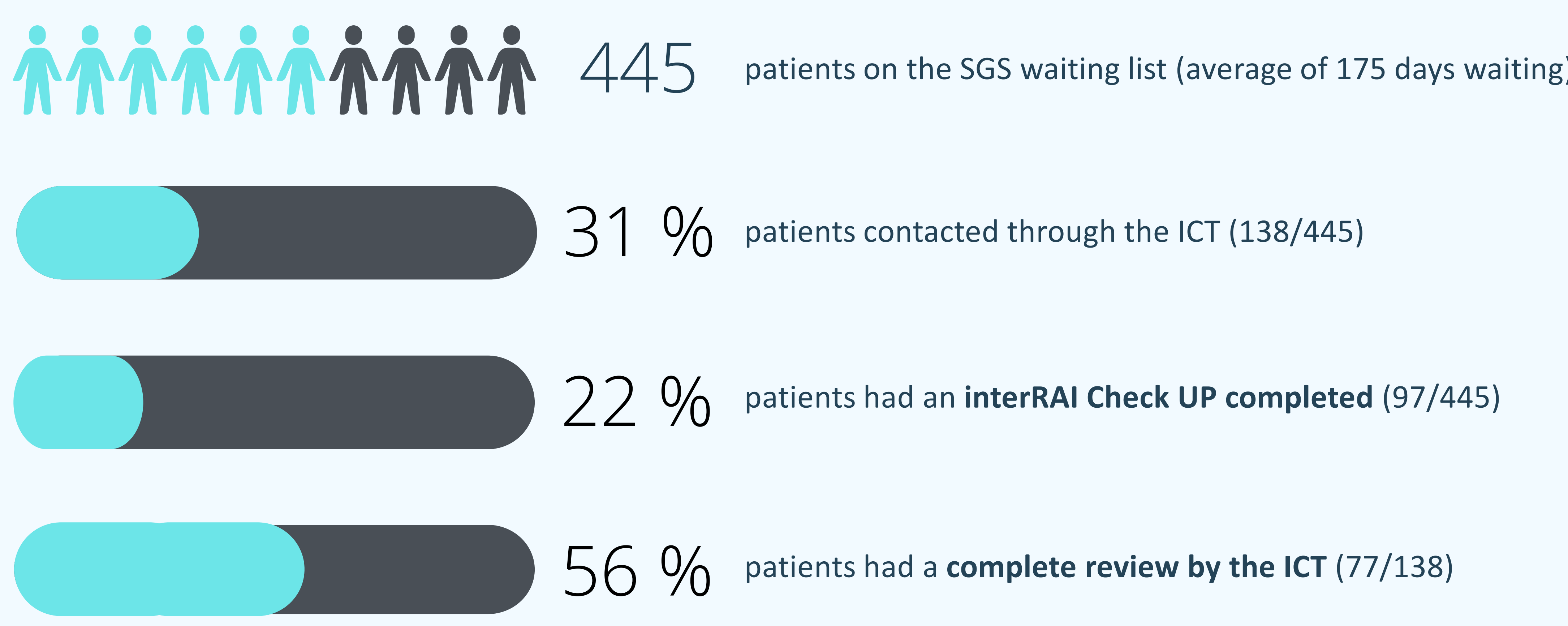
- Person-centered, not disease-centred
- CHF, COPD, Dementia, Diabetes, HTN, CAD, Chronic Pain and Osteoarthritis, Chronic Mental Illness, Chronic wounds, Cancer Survivorship, Stroke, Falls

Focus on Access

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

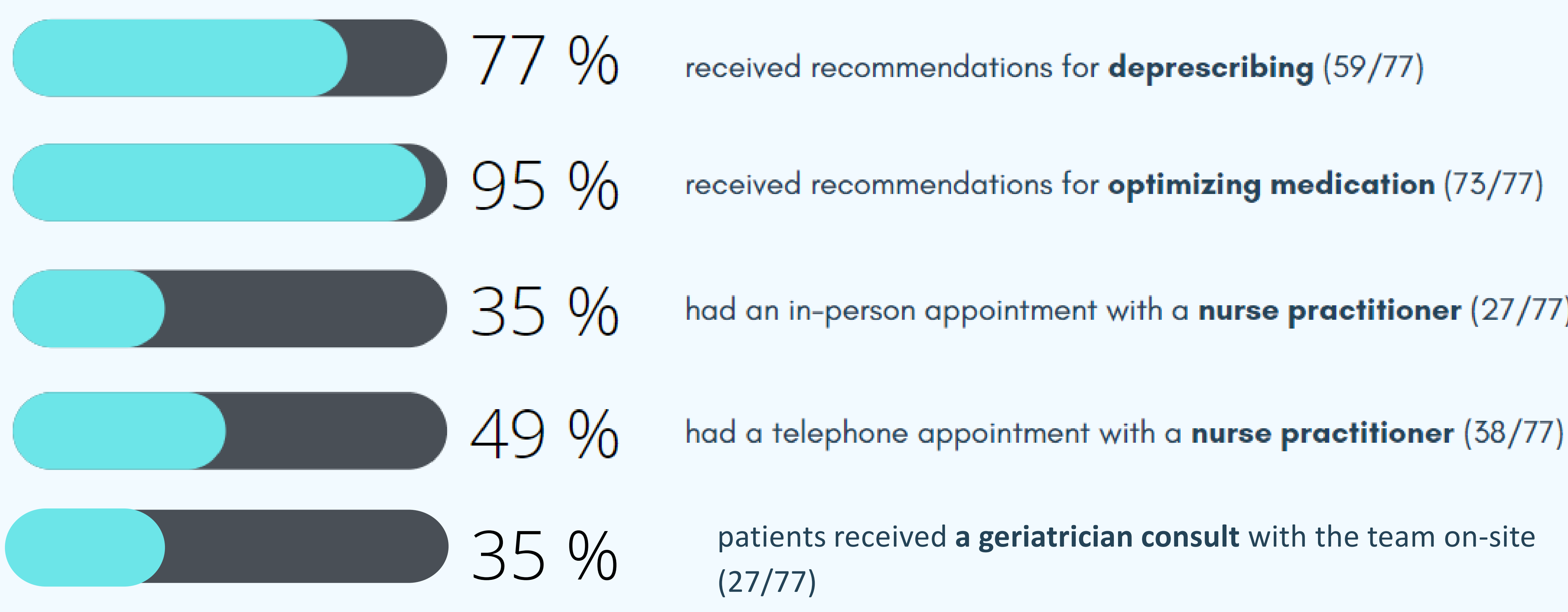
RESULTS – CLINICAL OUTPUTS

ENHANCED AVAILABILITY & REDUCED WAIT TIMES



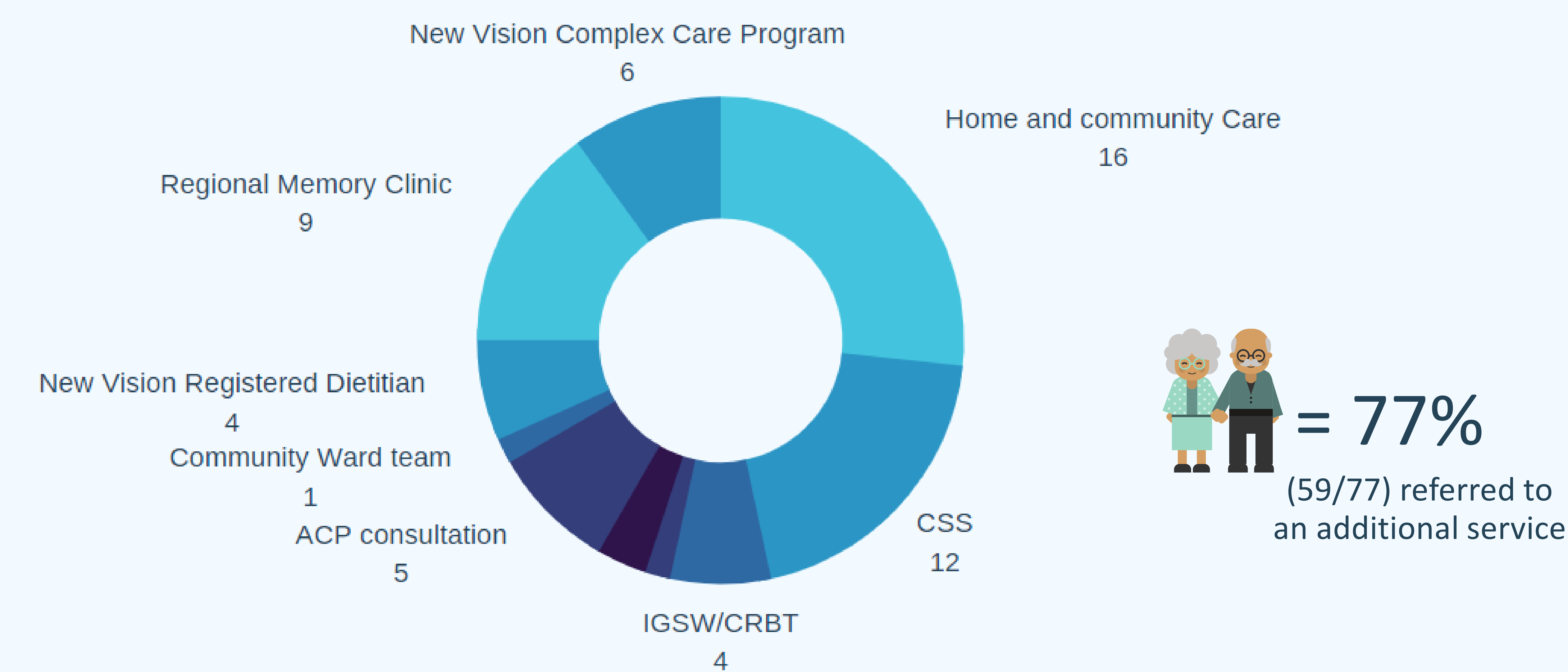
RESULTS – CLINICAL OUTPUTS

MULTIFOCAL PATIENT-CENTRED APPROACH



RESULTS – CLINICAL OUTPUTS

REFERRALS TO HEALTH & SOCIAL CARE PROGRAMS

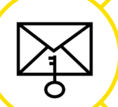


SUMMARY

IMPACTS FROM THE ICT PILOT

22% of the patients on the wait list were re-triaged by the ICT

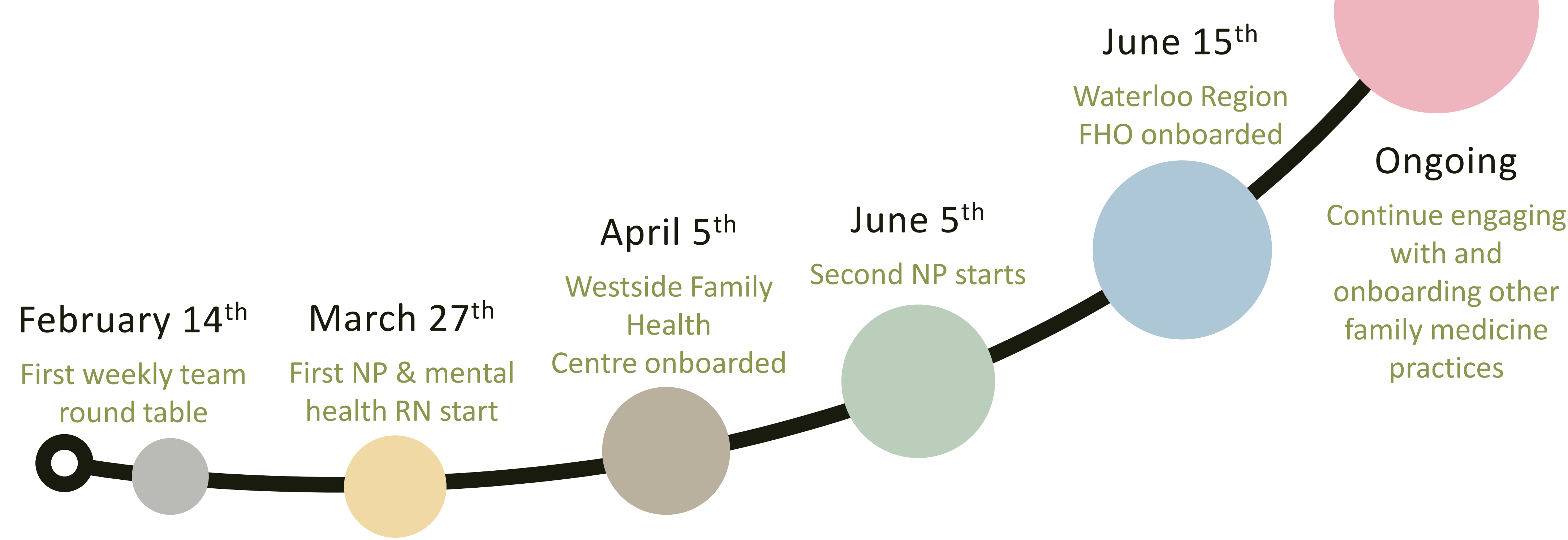
77% of the ICT patients were referred to at least one community resource


89% of the ICT participants would like to see the ICT continue

↓ need for geriatrician follow ups and ↑ the geriatrician's capacity for new consults

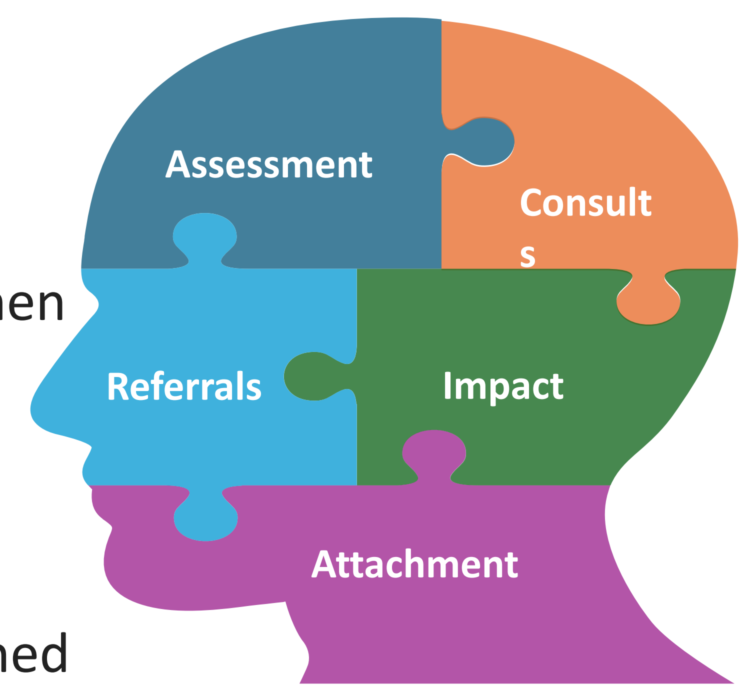
Potential to reduce ED visits by 50%, optimize medications, and prevent ALC

Expansion: 2023/24



Organization	# of Physicians, Offices	Roster	Aged 65+
Westside Family Health Centre	7 physicians, 1 office	11,063	1824
Waterloo Region FHO	11 physicians, 2 offices	16,000	2250
Frederick Street Medical Clinic	7 physicians, 1 office	4,525	1203

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

Your tables are your team

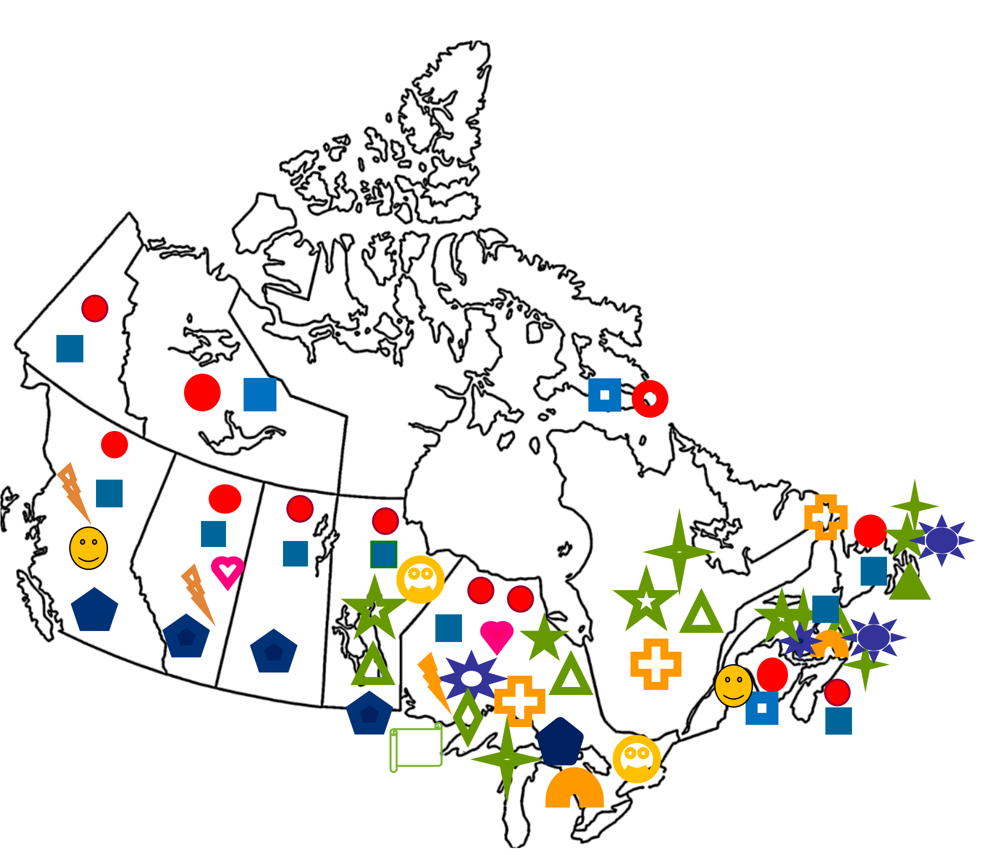
interRAI: www.interRAI.org

- interRAI founded in 1994 as not-for-profit collaborative aiming to use cross-national comparisons and scientific methods to improve care of long-term care residents.

- Canada
  - 1994-96: Katherine Berg (Berg Balance Scale), John Hirdes
  - 2025: 47 fellows (Nova Scotia, New Brunswick, Quebec, Ontario, Saskatchewan)

- >35 countries, >135 fellows
- >2300 scientific publications

Use of interRAI Instruments in Canada



Solid symbols refer to implentations that have been mandated by government
Hollow symbols refer to research, pilot studies, or implementation planning underway

- RAI 2.0/ interRAI Long Term Care Facilities
- RAI-Home Care
- RAI-Mental Health
- interRAI Community Mental Health
- interRAI Emergency Screener for Psychiatry
- interRAI Brief Mental Health Screener
- interRAI Child/Youth Mental Health
- interRAI Intellectual Disability
- interRAI Palliative Care
- interRAI Acute Care/Emergency Department
- interRAI Contact Assessment
- interRAI Community Health Assessment
- interRAI Subjective Quality of Life
- interRAI Campus Assessment Tool

- 25+ million assessments
- 6+ million unique individuals
- 600K+ new assessments/year
- About 7 billion data points
- Longitudinal & linkable

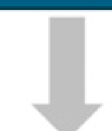
- 1.8 million MH assessments on 400K unique Canadians

interRAI Instrument

Reliable and valid items
Validated algorithms and outputs

- Risk and outcome scales
- Collaborative Action Plans
- Quality Indicators
- Case Mix

Manuals and training support



Software product from licensed vendor

Clinical Use

- Point of care assessment
- Clinician rating based on multiple sources of information
- Clinician friendly software outputs
- Immediate clinical feedback of assessment results
- Care planning, risk appraisal, service allocation
- Repeated assessment for outcome measurement

Management Use

- Person-level data aggregated to organization
- Real-time or periodic internal reporting and trend analysis using vendor software
- Risk adjusted quality indicators for accreditation, quality improvement
- Case-mix classification and weights to inform funding, staffing, program evaluation

Policy Use

- Population level data for public reporting at regional and organizational levels
- Need analysis, forecasting, planning
- Resource allocation and eligibility criteria
- Near real-time, quarterly, or annual reporting through regional or national systems managed by designated agencies (e.g., CIHI)

Research Use

- Secondary analysis of deidentified data
- Linkage to other health care databases
- Epidemiological, health services, applied practice, clinical studies, pragmatic trials
- Development of new decision support tools
- On-going refinement of interRAI systems
- Data sharing agreements with researchers subject to national privacy laws

interRAI Check-Up

- New assessment system to reach “healthy” populations
  - Primary care, seniors centres, seniors housing, open on-line access, patient-reported outcome measures, light care home care clients
  - No need for clinician to administer
    - Can be self administered or lay interviewer
  - Could used by person alone or with caregiver

UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES
School of Public Health and Health Systems

Validity of interRAI Check Up Self-report

Geffen et al. BMC Geriatrics (2020) 20:260
https://doi.org/10.1186/s12877-020-01659-9

BMC Geriatrics

RESEARCH ARTICLE Open Access

"Establishing the criterion validity of the interRAI Check-Up Self-Report instrument"

Leon N. Geffen[1], Gabrielle Kelly[2*], John N. Morris[3], Sophie Hogeveen[4] and John Hirdes[5]

Abstract

Background: Low and middle-income countries have growing older populations and could benefit from the use of multi-domain geriatric assessments in overcoming the challenge of providing quality health services to older persons. This paper reports on the outcomes of a study carried out in Cape Town, South Africa on the validity of the *interRAI Check-Up Self-Report* instrument, a multi-domain assessment instrument designed to screen older persons in primary health settings. This is the first criterion validity study of the instrument. The instrument is designed to identify specific health problems and needs, including psychosocial or cognition problems and issues related to functional decline. The interRAI Check-Up Self-Report is designed to be compatible with the clinician administered instruments in the interRAI suite of assessments, but the validity of the instrument against clinician ratings has not yet been established. We therefore sought to establish whether community health workers, rather than trained healthcare professionals could reliably administer the self-report instrument to older persons.

Methods: We evaluated the criterion validity of the self-report instrument through comparison to assessments completed by a clinician assessor. A total of 112 participants, aged 60 or older were recruited from 7 seniors clubs in Khayelitsha, Cape Town. Each participant was assessed by one of two previously untrained, non-healthcare personnel using the Check-Up Self-report version and again by a trained assessor using the clinician version of the interRAI Check-Up within 48 h. Our analyses focused on the degree of agreement between the self-reported and clinician-rated versions of the Check-Up based on the simple or weighted kappa values for the two types of ratings. Binary variables used simple kappas, and ordinal variables with three or more levels were examined using weighted kappas with Fleiss-Cohen weights.

Results: Based on Cohen's Kappa values, we were able to establish that high levels of agreement existed between clinical assessors and lay interviewers, indicating that the instrument can be validly administered by community health workers without formal healthcare training. 13% of items had kappa values ranging between 0.10 and 0.39; 51% of items had kappa values between 0.4 and 0.69; and 36% of items had values of between 0.70 and 1.00.

Conclusion: Our findings indicate that there is potential for the Check-Up Self-Report instrument to be implemented in under-resourced health systems such as South Africa's.

Keywords: interRAI, Validity, Geriatric assessment, Comprehensive assessment, South Africa

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- 112 participants age 60+ in Khayelitsha South Africa
- Interviewed by trained lay-older adult health workers
- Reassessed by clinician in primary care clinic
- Good overall criterion validity in relatively healthy older persons

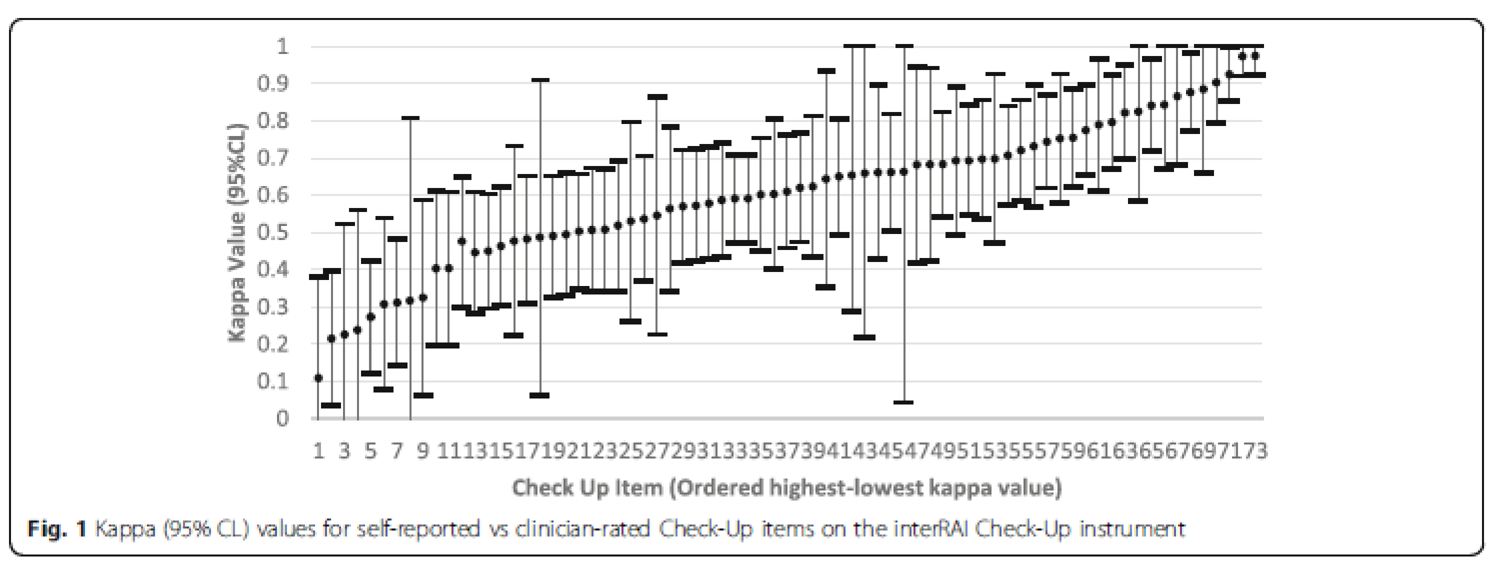

Fig. 1 Kappa (95% CL) values for self-reported vs clinician-rated Check-Up items on the interRAI Check-Up instrument

Canadian Pilot of interRAI Check Up Self-report

Iheme et al, J Am Med Dir Assoc . 2022 Jan;23(1):117-121.

- Psychometrics, feasibility, and acceptability
- Random assignment to self-administered vs lay interviewer
- 184 older adults in diverse service settings
  - CSS, retirement home, seniors housing, seniors' activity centres, retirement community
  - Diversity in culture, education, health status
  - Ontario and Nova Scotia
- Predictors of any difficulty
  - Problems with phone use
  - Poor self rated health
  - Advanced age

You will simulate a case review

70 yo W referred for cognitive and mood concerns after discharge by endo for "non-compliance"

Social history: Divorced, 4 children, Lives in 2 story home with son; daughter recently died
-No hx smoking or substance use
-English is her second language

Past medical history:
-Sjorgen's Syndrome, Type 2 diabetes, HTN, TIA
-OA and DDD, Insomnia

Meds
- Bromazepam 6mg qhs
- Irbesartan 300mg OD; ECASA 81mg OD, HCTZ 25mg, Rosuvastatin 10mg OD, Amlodipine 10mg OD
- Admelog 60u pre meals, Basaglar 60units qHS, Metformin 500mg at supper
- Arthrotec 75mg BID PRN, Rabeprazole 20mg OD
- Docusate sodium 100mg BID

Check Up Self-Report

- AUA 6/6
- DIVERT 4/6
- CHESS 1/5
- ADLH 2/6
- IADLH 2/6
- CPS2 4/8
- Self-rated mood 7/9
- Pain scale 1/4
- Making economic trade-offs (meds)

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

Thank you!