

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

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Abstract

Care models integrating geriatrics into primary care are emerging across Ontario. Referred to as Primary Care Integrated Geriatric Teams (PCIGTs), their evidence-based approaches improve access to specialized care and support for older adults. Seven Ontario models were highlighted through webinars held in spring 2025, attended by nearly 200 participants. Presenters and participants identified promising design features, key learnings and supports needed to advance goal-aligned care for older adults. Relevant to primary care transformation, health system redesign and policy efforts in Ontario and beyond, PCIGTs can support primary care attachment, reduce pressure on acute services and promote aging in place.

Introduction

In 2025, Ontario's Government announced the Primary Care Action Plan, aiming to attach 100% of Ontarians to primary care teams (PCTs) (Ministry of Health 2025). This goal is dependent on team-based models along with embedded specialists. The integration of specialized geriatric expertise is particularly critical for older adults, with an estimated 776,000 Ontarians aged 65 years and older living with frailty (PGLO 2026), more than 330,000 living with dementia (Alzheimer Society of Ontario 2025) and more than 27,000 older adults experiencing serious mental illness (Warren et al. 2023). Primary care, as currently structured, experiences challenges supporting the comprehensive

assessment and interventions required to manage the complexity of these populations (de Levante Raphael 2022; Pham et al. 2025), who are also high users of health services and require frequent visits. Embedding geriatric expertise within primary care enables comprehensive assessment, interprofessional collaboration and the development and implementation of personalized care plans and creates capacity for improved care quality while increasing primary care attachment.

Models integrating specialized geriatric services (SGSs) into PCTs already exist. Early experiences suggest these models focus on the delivery of a multidimensional, comprehensive geriatric assessment (CGA) and tailored interventions. A CGA is considered the standard of care for older adults experiencing complex health conditions (e.g., dementia, frailty) and is a multi-domain, interdisciplinary process used to evaluate and respond to the biopsychosocial needs of older adults (Aggarwal et al. 2023; Dimitriadou et al. 2025). A recent review identified that high-quality interprofessional CGAs (e.g., conducted with interprofessional team members as well as physicians) supported comprehensive patient care, improved care coordination, enhanced diagnostic accuracy and increased patient and provider satisfaction (Nalla and Ehsan 2025). CGA delivered in primary care can help enhance access to specialized care and can build capacity in primary care for the ongoing care of complex older patients and their care partners.

In spring 2025, Provincial Geriatrics Leadership Ontario (PGLO) and the Regional Geriatric Program of Southwestern Ontario, entities coordinating geriatric services, provincially and regionally, held two webinars showcasing models referred to as Primary Care Integrated Geriatric Teams (PCIGTs) and later mapped common features against known design elements of integrated care for older adults living with complex health conditions (Horgan et al. 2020). From real-time feedback provided during the sessions by participants ($n = 199$) via Slido (slido.com), inductive thematic analysis was used to identify key audience themes and the supports required to advance the care of older adults in primary care settings. Our findings are relevant to decision-makers across multiple settings as well as policy makers.

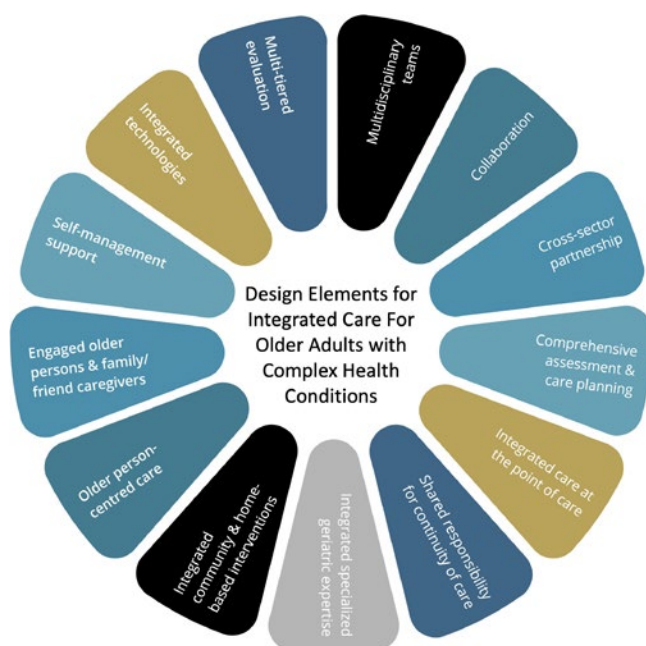
Promising Practices

An overview of seven models of PCIGTs is presented in Table 1, available online at longwoods.com/content/27860. Full recordings, presentation slides and presenter biographies are also available at <https://geriatricsontario.ca/resources/presentations-and-resources-models-and-examples-of-primary-care-integrated-geriatric-teams-resources/>.

Alignment of Model Features With Design Elements of Integrated Care for Older Adults

PGLO has previously identified 13 design elements for integrated care for older adults living with complex and chronic health needs (Figure 1).

FIGURE 1.
Design elements for integrated care for older adults with complex health concerns



Horgan et al. 2020. Used with permission.

These design elements describe key evidence-based features that offer the most promise for holistic, patient-centred care and provide a helpful framework to examine integrated models of geriatric services and primary care. While we did not formally evaluate the models described, we conducted preliminary mapping of key features noted across the seven models against these design elements to highlight commonalities and inform future service design and evaluation.

Multidisciplinary/interprofessional teams

All models described interprofessional team members and care of the elderly (COE) physicians, geriatricians and, in some cases, geriatric psychiatrists working collaboratively with primary care providers (PCPs). The composition of these interprofessional teams varied across the province, typically combining existing primary care and SGS staff, supplemented by in-kind staff contributions from community partners. All models included team members with specific training in the care of older adults. In teams that had access to new funding, targeted staffing investments were made to address priority needs.

Collaboration

Central to these models was collaboration among internal and external team members practising to their full scope. Their efforts coordinated patient care, streamlined processes and reduced duplication of services. The degree of collaboration varied from cooperation to integration (Weaver 2021) and opened up an area for further study to identify optimal approaches.

Cross-sector partnership

While all teams identified roles for partners across multiple organizations, these arrangements varied from ad-hoc to formalized partnership agreements outlining specific accountabilities (e.g., sharing of staff, common reporting). Arrangements with some host organizations, usually Family Health Teams or Community Health Centres, included clinical space, administrative support and interprofessional team members to support itinerant geriatric specialists working on site during scheduled clinics. Many supports were provided in-kind, introducing precariousness into models if organizational pressures require hosts to redirect these supports. Mechanisms for ongoing funding across models were identified as a requirement for sustainability.

Comprehensive assessment and care planning

A key feature of most models was providing community access to CGA. It should be noted that where only one interprofessional team member (e.g., a registered nurse) completed a multi-domain assessment of the older adult, the term “geriatric assessment” was preferred.

In most PCIGT models, teams completed the CGA or geriatric assessment *and* followed up on recommendations generated. This direct support for follow-up overcame previously identified challenges by PCPs related to actioning recommendations arising from a CGA.

Integrated care at the point of care

In these seven models, health professionals of different disciplines who were knowledgeable in geriatrics worked within primary care settings to deliver care. Most models incorporated interdisciplinary rounds (usually weekly), which provided a venue to discuss and plan integrated patient care. Rounds also supported the PCT's capacity to provide ongoing care for older adults by incorporating topical learning sessions for the whole team.

Shared responsibility for continuity of care

While some models functioned in a consultative fashion (e.g., limited follow-up appointments), most provided ongoing support either directly to patients or indirectly by being available for consultation by the PCP. We did not identify which modalities were most effective under what circumstances, presenting an opportunity for further study. In addition, the delivery of geriatric care services within the context of the primary care medical "home" preserved continuity by allowing for ongoing collaboration between specialized providers and PCPs. Communication was facilitated through the use of the primary care site's electronic medical record (EMR) for documentation in most models, and through simple mechanisms (e.g., messaging features, telephone calls and conversations during rounds). Models that did not have access to the primary care EMR suggested this as an important area for improvement and better coordination.

Integrated specialized geriatric expertise

All models included direct access (either on-site or through telecommunication) to SGSs. Specialized geriatric expertise included physician specialists (e.g., geriatricians, geriatric psychiatrists), COE physicians (family physicians certified in care of the elderly) and interprofessional team members with training and experience in the care of older adults, who frequently acted as geriatric assessors. The SGS clinicians were usually part of a broader system of SGSs and connected to regional leadership and additional clinical expertise, usually through Regional Geriatric Programs or Departments of Geriatric Medicine. These regional connections provided education, training and implementation expertise and facilitated access to additional specialized care, enabling critical support for embedded clinicians and PCPs.

Several models also highlighted integration among different types of geriatric speciality care, such as the inclusion of geriatric psychiatry. This type of integration simplified access

for patients requiring care across a continuum of geriatric specialties. As one participant noted, "geriatrics includes geriatric psychiatry" (webinar participant, personal communication, May 8, 2026).

Integrated community and home-based interventions

Most models described the capacity to carry out home visits and fostered linkages with community service providers and home care agencies. Presenters noted that models serving older adults with increasing frailty required home visit capability, as these patients may be unable to attend clinic appointments. Home-based CGA for older adults can decrease healthcare system costs and avoid hospitalization (Singh et al. 2022). Fostering closer relationships with home care agencies was also noted as an opportunity for the continued development of PCIGT models.

Older person-centred care

All models highlighted the benefit of integrated geriatric teams that can focus specifically on the needs of older adults, and many drew inspiration from the 5M's model of geriatric care (mind, medications, multi-morbidity, mobility and matters most) (Molnar and Frank 2019). Although goal-based care planning approaches were not explicitly discussed, a CGA relies on eliciting the goals of patients and care partners to inform and tailor treatment plans. Approaches to goal-based care planning could be further explored in future evaluations of PCIGT models.

Engaged older persons and caregivers

All models described clinical practices that engaged the older adult and their care partners in assessments, interventions (e.g., carrying out mobility exercises) and care conversations. One model also described the involvement of older adults and care partners in the design of the model itself.

Self-management support

All models described approaches that include interventions to maintain independence and autonomy. Among older adults living with dementia, frailty or mental health conditions, self-management frequently required consideration of cognitive function and the interplay of chronic diseases, as well as the involvement of supportive care partners, where present.

Integrated technologies

In most cases, PCIGTs leveraged local digital infrastructure. This included documenting directly in the EMRs of the hosting primary care practice, facilitated by local EMR-related privacy agreements rather than formalized data sharing agreements. Integrating new technologies is an area of ongoing development in the care of older adults and may include remote monitoring and artificial intelligence-enabled tools.

Multi-tiered evaluations

Most evaluative activities were localized to each specific model, and, at present, there are no common metrics collected across PCIGTs. A robust quality assurance system and the identification and collection of common metrics would improve understanding of the impact of PCIGT models and are essential for optimizing the spread of these promising practices. Evaluations could focus on the successful identification of older adults with complex needs and, as demonstrated through a recent study, the impact of PCIGTs on overall primary care visits, prescribing/deprescribing, and emergency department visits or avoidance (Heckman et al. 2025) or other outcomes.

Webinar Participant Responses - What We Heard

During the webinars, we asked participants ($n = 199$), including at least 40 participants from PCT settings, to share ideas and identify supports required by their teams to advance the care of older adults in primary care settings. Figure 2 is an excerpt of a short report summarizing these key learnings found at <https://geriatricsontario.ca/resources/presentations-and-resources-models-and-examples-of-primary-care-integrated-geriatric-teams-resources/>.

We also asked webinar participants to identify other attributes that resonated with them about the models presented. Themes identified included flexibility and variety; integration

FIGURE 2.

Key learnings: ideas and supports identified by webinar participants (PGLO 2025) (excerpt used with permission)

Highlights of participant feedback			
Ideas	✓ Integration and Collaboration: Include community services and IP teams to address social determinants, reduce duplication and streamline geriatric care. Leverage cross-program assets. ✓ Holistic Care: Address both mental and physical health to provide comprehensive, person-centered care. ✓ Digital Systems: Improve digital communication and documentation to enhance information sharing, especially in underserved areas. ✓ Scalability: Assess successful pilots for broader implementation, adapting to regional needs. Create sustainable funding models. ✓ Proactive Community Care: Shift specialized resources into primary care to increase access and reduce hospital dependency. ✓ Patient and Family Engagement: Engage early during intake to improve care planning and team coordination.	Supports	Required supports • Access and equity (e.g., rural) • Advocacy • Coordination • Communication channels • Expansion (e.g. models, teams) • Funding and policy • Implementation support • Integration (e.g. community supports) • Navigation and case management • Leadership • Technology and tools • Training and workforce development

and collaboration; efficiency and workflow; access and outreach; funding and scalability; and tangible impact on outcomes. A detailed summary of additional participant responses is included in Table 2.

Conclusion

Our webinars highlighted examples of localized work underway to support primary care's efforts to care for an aging population. Recognizing the provincial goal of supporting enhanced attachment to primary care, this paper provides key examples and identifies the components of successful models that can support the attachment and care of older adults living with complexity and their care partners. While most models demonstrated alignment with published design elements of integrated care for older adults living with complex health conditions, this paper also provides additional insights into areas that could be further refined, scaled and spread. In addition, there are opportunities for primary care to

strengthen connections to Regional Geriatric Programs and the provincial network of geriatric services to garner critical support for emerging primary care-based models.

Future directions could include a focus on training, sustainable funding mechanisms, and technology and implementation supports. Emerging PCIGT models may provide new community training opportunities for interprofessional team members and medical residents, furthering an important shift to community-based models of geriatric care. Funding solutions may include the creation of alternate funding plans aligned to Primary Care Networks to foster recruitment of COE physicians and geriatric specialists, enabling reliable, accessible support for primary care, along with other funding packages to support these largely grassroots efforts. Technology and implementation supports can build on ideas presented in this paper, as well as future co-design and evaluation activities that could shape system transformation to address persistent wait times for SGSs and bolster primary care

capacity for older adult care. Work underway to build PCIGT models informs future requirements for core clinical services focused on older adults living with complex health conditions

and can ensure the availability of needed supports for aging in place in Ontario. **HQ**

TABLE 2.
Key themes identified by webinar participants (n = 199)

Question	Key themes
What resonated with you from the examples shared at today's webinar?	Flexibility and variety • In delivery models and services offered (e.g., attending appointments with patients) • Creativity, "thinking outside silos and boxes" Integration and collaboration • Engaging family and clients • Interdisciplinary, embedded teams with various expertise • Shared local documentation and communication systems (digital integration) • Collaboration with community partners • Integrated (holistic) approaches to care and comprehensive geriatric assessment Efficiency and workflow • Central point of contact • Utilizing pre-assessments and standardized assessments • Value of clinical intake to avoid service duplication • Need for ongoing supports Access and outreach • Value placed on outreach, home visits, multiple entry points, connections to partners to improve capacity and reach (including unattached patients). • Upstream, proactive care and ongoing supports • Funding and scalability • Concerns about underfunding; interest in hybrid billing to support specialist practice in primary care • Value of standardization, and desire to scale pilots (including in rural/Northwestern Ontario contexts). • Capacity building in primary care Tangible impact on outcomes • Belief that these models reduce alternate level of care risk, increase capacity, improve access and help older adults remain at home.
What supports do you and your team, or your local primary care colleagues, need to advance care of older adults in primary care settings?	• Training and education (e.g., behavioural supports, non-pharmacologic management, geriatrics, how to work as integrated teams, information about available community services, senior friendly care) • Communication and integration (e.g., improved communication channels between hospital and primary care, shared EMRs, broadly available common assessment instruments) • Workforce support (e.g., more specialists, more COE physicians, inclusion of mental health providers) • Funding and policy (e.g., stable base funding, compensation for primary care settings, administrative/overhead funding, clear models and frameworks with standardized resources adaptable to local needs, policy/government support to coordinate and remove barriers) • Social and community supports (e.g., legal aid, help with applications, support for navigation and case management, etc.) • Access and equity (e.g., rural communities, spread of what works) • Technology and tools (e.g., tools to engage patients and families in initial assessments, integrated EMRs to reduce duplicate documentation, access to home care records) • Implementation support (e.g., support to implement integrated models, support for program expansion and best practice sharing)

COE = care of the elderly; EMR = electronic medical record.

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