BRIGHT LIGHTS AWARDS

2023

Nomination: 2. Optimising teams' capacity and creating efficiencies

Algonquin Family Health Team and Cottage Country Family Health Team

The Muskoka Geriatric Team (MGT): A joint collaboration between Cottage Country and Algonquin FHTs, supported with partnership in the North Simcoe Muskoka Specialized Geriatrics Program and physicians.

The Muskoka Geriatric Team was developed to optimize the health, independence and quality of life for at-risk seniors as well as increase the capacity for geriatric care in both Muskoka Family Health Teams. The team will strive to accomplish this through interdisciplinary assessments and consultation, advocacy, education, treatment, evaluation and community development of geriatric care. We will utilize existing services and adapt our practices to provide accessible, equitable care to seniors in need in Muskoka and surrounding area. The Muskoka Geriatric Team aims for excellence in community-based and in-hospital geriatric care through: Provision of specialized assessment and treatment. Education and knowledge transfer promoting evidence-based practice for geriatric care. Evaluation of services. Responsiveness to community needs. The team is a joint integration between the Cottage Country and Algonquin FHTs and was based on an idea generated from both boards of directors to promote equity in care through Muskoka and address a growing need to access specialized geriatrics in an area where few specialist physicians exist. Population for Inclusion: Seniors in Muskoka (and surrounding area- e.g. patients whom live outside of Muskoka but have a Muskoka primary care provider) whom are ≥ 65 years old or younger with geriatric-related condition. These seniors will have a frailty score of 4 to 6. They can be referred for various reasons including but not limited to: confusion, dementia, delirium, depression, frailty, recent functional decline, polypharmacy, falls, caregiver issues, risk to self/safety, responsive behaviours, anxiety, frequent ED visits and/or hospitalization. In order to ensure capacity within the team, patients will be discharged when: the reasons for the referral are met/resolved/stabilized, another team/provider is more appropriate to lead the patient's care, if the patient moves out of the service area, if the patient/SDM declines further follow up.

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