Geriatric Assessment and Support Clinic

Calgary West Central Patient Care Network – Dr. Diana Turner; Dr. Gail Ewasechko

Introduction

Medically complex seniors present a challenge for primary care physicians. They have multiple and atypical presentations of illness, limited social supports, unpredictable reactions to medication, and are nearing the end of their lives. Primary care physicians often lack the time, expertise, and clinical resources to manage this complexity of care. Additionally, Specialized Geriatric Services are unable to meet the volume of referrals they receive in a timely manner. To address this problem, and to support the patients, families and physicians of CWC PCN within the context of a primary care environment, the Geriatric Assessment and Support (GAS) clinic was created.

GAS CLINIC – PRIMARY CARE CENTER

The CWC Primary Care Centre offers a centrally located Geriatric Assessment and Support clinic that conducts comprehensive assessments for medically complex elderly patients. The team meets with elderly patients who typically have multiple health problems and may have limited access to resources and help. This clinic can help patients access medical and community services, provide support for personal needs and identify care gaps that need to be addressed. After an assessment and initial treatment at the clinic, ongoing care is provided by the patient's family physician.

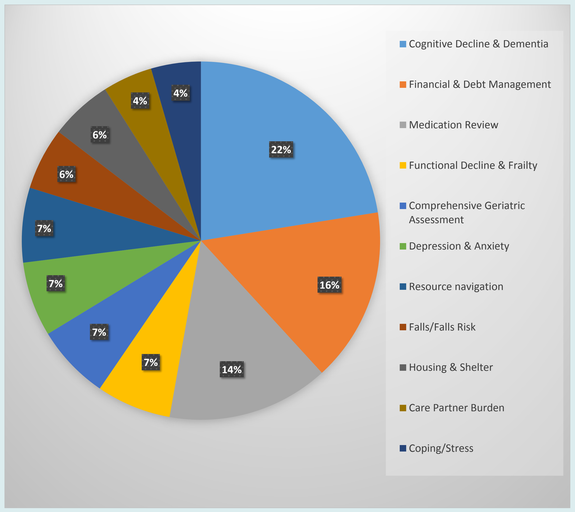
- The Geriatric Team consists of:
- Licensed Practical Nurse (1.0 FTE)
- Geriatric Nurse Consultant (0.8 FTE)
- Social Worker (1.0 FTE)
- Pharmacist (0.6 FTE)
- Physicians with special interest in seniors care (5 x 0.1 FTE)
- Consultant geriatrician (1), psychiatrists (0.25 x 0.1 FTE) and neurologists (2)
- Medical Office Assist (1.0 FTE)

Patients

65 years or older; or < 65 years old if physiologically aged with multiple comorbidities

Patients' families and care partners are invited to be involved

Top Reasons for Referral 2015



GAS Appointment – Triple Team

GNC/LPN

Obtain medical and social history; and collateral information

Assessment – cognition; mood; function; falls

Formulate potential care plan and interventions

Case conference with Pharmacist

PHARMACIST

Medication reconciliation and review

Assessment – adherence; risk; drug interactions

Formulate potential care plan and interventions

Case conference with GNC, and Physician

PHYSICIAN

Review with patient/family key points identified by the team

Physical assessment as needed

Provide final decision regarding care plan – medication, labs, diagnostic imaging, referrals; patient may be discharged or rebooked for follow-up (up to 5 visits) with the physician or team

TEAM

Referral to CWC PCN programs, or AHS/Community programs, Social Worker, Geriatric Psychiatrist, Consultant Neurologist/Geriatrician, or other Clinical Team Members as appropriate; Dementia Connect – Calgary Alzheimers Society; Just Like Home – Nurse Next Door & Home Instead

ROUNDS

Occur in conjunction with geriatrician/neurologist consultation appointment with a patient every 6 weeks

LPN, GNC + 5GNCs embedded in community offices, SW, Physicians, and referring MD

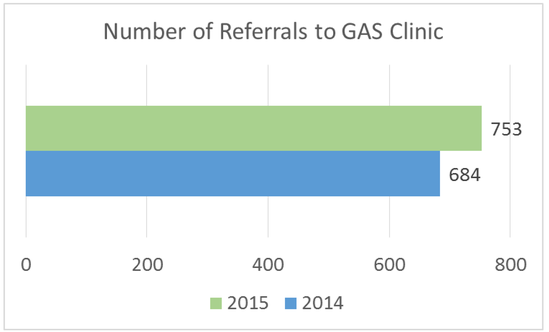
1-3 patients presented at rounds for review

OTHER RESOURCES

Geriatric Nurse Consultants +5 embedded in community offices

Clinical Services Manager

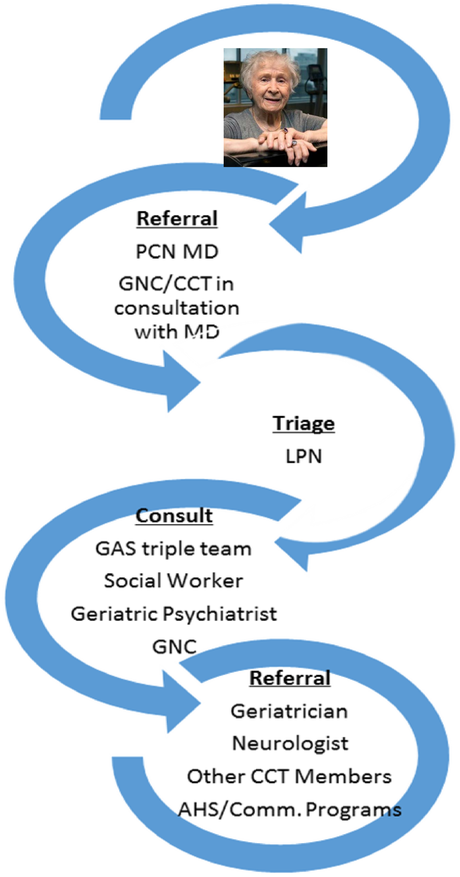
Director, Collaborative Care Team



Benefits of Comprehensive Geriatric Assessment

- Reduces access barriers: patient avoids multiple appointments with excessive transportation requirements
- Comprehensive, coordinated care planning: interdisciplinary diagnostic support focuses on the whole person
- Increased compliance through patient/family/care partner education
- Reduced caregiver stress and burnout
- Improves quality of life: supports function at home; delays transfer to continuing care facilities
- Systems navigation: reduces fragmented medical specialty and health system care; supports transitions of care
- PCN Physician support: provides diagnostic and decision making support for family physicians
- Reduces need for admission to more costly acute care services

GAS Referral Schematic



Short Term Objectives/Outcomes

Patients

1. Stabilization of health
2. Increased awareness and ability to manage health conditions
3. Increased knowledge of resources and community programs to optimize function
4. Increased knowledge and awareness of PCN model of care
5. Increased patient satisfaction with PCN model of care

Care Partners

1. Decreased stress/burnout
2. Increased knowledge of resources and community programs to support both patient and care partner

PCN Physicians

1. Increased ability to provide comprehensive care to patients with complex geriatric needs
2. Decreased risk of losing rapport with patients who may receive an undesirable diagnosis
3. Appropriate use of clinical time - within scope of practice
4. Increased physician satisfaction with GAS clinic
5. Increased awareness of the role of GAS clinic

Long Term Objectives/Outcomes

1. Coordination of care for medically complex patients
2. Improved self-management of medically complex conditions
3. Improved health for patients and care partners
4. Improved quality of life in patients
5. Increased ability to be a sustainable comprehensive family practice
6. Improved health system utilization – decreased Emergency Department visits, decreased length of stay in hospital

CONCLUSIONS

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