GERIATRIC PRIMARY-CARE SUPPORT (GPS)

DR SEAN GOLDHAR, MD CCFP (COE), QUEEN'S UNIVERSITY

MAY 8, 2025

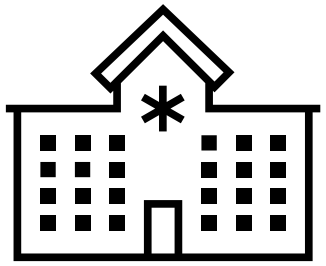
WHERE IT STARTED

- South-East region = high(est?) percentage of >65yo in Ontario

- Goal = provide integrated support to Primary-Care team for pts >65yo
  - Reduce wait-time & barriers to CGA
  - Improve collaboration & communication between "Specialist" and Primary-Care team
  - Build capacity within Primary-Care team
  - (Hopefully) reduce negative patient outcomes (falls, hospitalizations, etc)

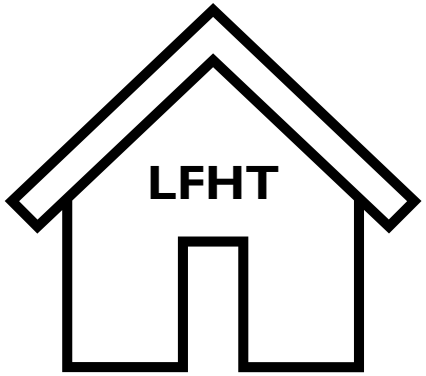
- Roll-out March 2023
  - Collaboration with Dr Mary Kate Gazendam (former MD-lead for LFHT Aging Well at Home program)

SERVICES OVERVIEW

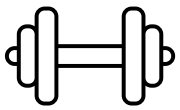


Providence Care Hospital (PCH)
Division of Geriatrics

Dr Goldhar



Loyalist Family Health Team



Seniors Day Rehab & Inpatient Geriatric Rehab

MINT Memory Clinic

Aging Well at Home team rounds

Embedded OHaH Care Coordinator

GPS MODEL

Direct patient care

I) In-person new consults at LFHT

- **1-2 half-days per month**
  - 2 new consults per half-day (1.5h each)
  - Usually re falls, frailty, cognitive impairment, parkinsonism, polypharmacy, etc.
- **Consultative** in nature
  - Full CGA
  - Recommendations to PCP re further workup, treatment, etc
  - May refer to rehab services at PCH
  - Generally no follow-up booked

Indirect patient care

II) E-consult or telephone consult

- Available any-time
- Usually respond within 1-2 days

III) Aging Well at Home rounds

- Monthly virtual rounds with interdisciplinary team

IV) Learning sessions

- Teaching to Primary-Care team on topics of interest in geriatrics
  - Consent/capacity, driving, etc

WORKFLOW

In-person new consults

PCP requests consult via e-form (in EMR)

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MOA for PCP books into Dr Goldhar's calendar (in EMR)

- If urgent, PCP messages Dr Goldhar directly (in EMR)

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LFHT Clinic Coordinator calls patient / family week before

- Confirm visit
- Bring medications
- (Usually) bring support person / family

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Dr Goldhar sees patient (at LFHT)

- Nurse does vitals
- Documentation directly in EMR
- Recommendations made to PCP
- +/- referral to services at PCH

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PCP follows-up with patient

- Can message Dr Goldhar for support as needed (in EMR)

WORKFLOW

E-consults

PCP messages Dr Goldhar a clinical question (in EMR)

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Dr Goldhar responds directly (in EMR)

Telephone consults

PCP messages Dr Goldhar to book a phone consult (in EMR)

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Phone call completed

WORKFLOW

Aging Well at Home rounds

AW@H Lead sets schedule and sends invites

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Team meets virtually (monthly)

- PCP provides patient summary
- Team discusses potential services, recommendations

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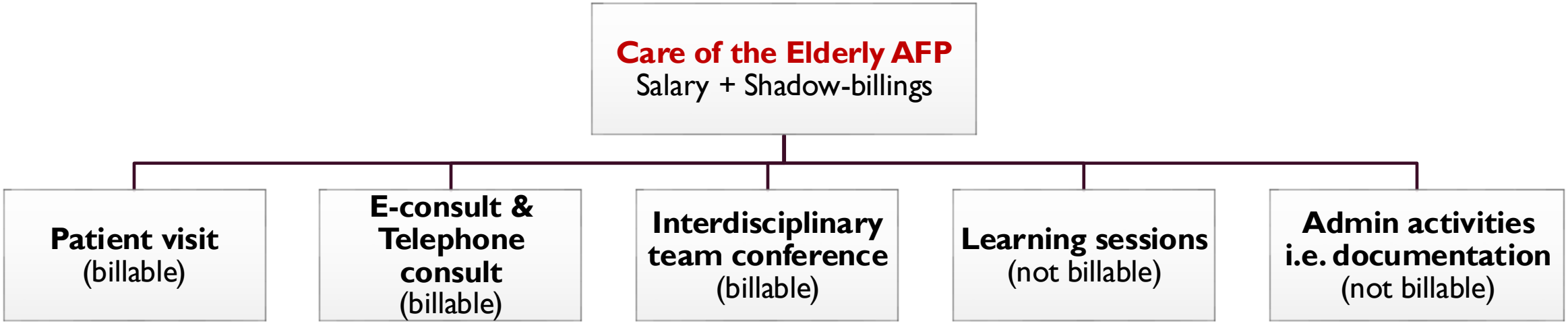
Discussion documented via e-form (in EMR)

AW@H rounds team members

- PCP
- COE MD
- LFHT OT
- Embedded OHaH Care Coordinator
- Community Paramedics
- Alzheimer's Society
- VON
- Other community partners

FUNDING FOR GPS MD



THANK YOU

- Kelly Kay

- LFHT
  - Dr Mary Kate Gazendam
  - Kelly Morris (Clinical Coordinator)
  - Reshelle Leonard (Nurse), Riley Saikaly (OT), Amelie Mills (OHaH CC), MDs, MOAs, etc.

- Division of Geriatrics, Queen's University
  - Dr Leah Nemiroff, Dr Michelle Gibson, Dr John Puxty