Community and Home Care Rotation- UW Transitional Care Service

Description: This four-week block includes time spent at a number of long-term non-institutional care settings including home-care, adult day care and assisted living sites representative of geriatric community care. This experience introduces the fellow to a capitated case management system for frail, at-risk seniors living in the community and also attending adult-day care. Fellows will also spend time during their community care rotation participating in home care and care management through participation in the UW Transitional Care program and also the VA Transitions of Care program.

Supervisor: ________________________________

Supervisor contact information:
Phone: ________________________________
Pager: ________________________________

Goals
The Geriatric Fellow will demonstrate the rudimentary knowledge and skills necessary to participate in interdisciplinary team management of acutely- and chronically-ill and frail elderly in a less technologically sophisticated environment than the acute-care hospital, and appreciate the distinct aspects and challenges for providing care at home.

Objectives and Steps to Evaluate Competency in this Objective
The fellow will be able to
(Medical Knowledge)
- Recognize the gap in the current health care system for the homebound
- Explain the functions of home health agencies and other community service providers
- Describe the role of Medicare in regulating and financing home care and CMS demonstration projects
- Describe a physician house call in terms of the process and intended/perceived outcomes
As measured by 1) performance on in-service examination at seven months (target is score >80% on items specific to this objective), 2) global rating scales completed by faculty mentors at the end of the rotation

(Patient Care)
- Perform case reviews and home visits with the nurse practitioners regarding older adults with specific geriatric problems
- Provide medical care to home-bound chronically ill adults who otherwise would have limited access to comprehensive health care.
- Become familiar with team delivery of care providing for psychosocial, medical and functional needs
- Define key components of good care transitions including medication reconciliation, effective documentation, appropriate communication and patient/ family education
As measured by 1) global rating scales completed by faculty mentors at the end of the rotation, 2) multisource appraisals completed by SW and nursing

(Interpersonal and Communication Skills)
- Refine skills in interacting with patients, caregivers and family members via telephone care and triage
As measured by 1) global rating scales completed by faculty mentors at the end of the rotation, 2) multisource appraisals completed by SW and nursing

(Professionalism)
- Incorporate HIPAA required approaches into patient care to ensure confidentiality and privacy in patient care
- Participate as an active member of an interdisciplinary team and demonstrate respect and collegiality toward other disciplines
As measured by 1) multisource appraisals completed by SW and nursing

(Systems-based Practice)
- Describe organizational, administrative and financial aspects of care in a non-institutional setting (home care and care within assisted living facilities)
- Model the role of a geriatrician in providing consultation to nurse practitioners delivering care to patients whose primary care is provided by non-geriatricians (internists, family practitioners).
As measured by 1) global rating scales completed by faculty mentors at the end of the rotation, 2) multisource appraisals completed by SW and nursing

(Practice-based Learning and Improvement)
- To acquaint the Geriatric Fellow with mechanisms of quality assurance in a capitated managed care organization providing social and medical care to frail older adults
As measured by 1) A performance improvement project directed at care practices followed by staff at Care Wisconsin.

Type of Clinical Encounter
Home evaluation or assessment at area assisted living facilities with supervision by a geriatric nurse practitioner and/or geriatrician preceptor

Teaching Methods
Case-based learning (case discussions with faculty preceptor)
Individual study using listed references and web-based materials

Patient Characteristics/ Mix of Diseases
Patient’s seen on these services represent medically complex older adults typically older than age 75. Many of the patients have undergone recent care transitions from the hospital or nursing home.

Many older patients have one or more of the following chronic medical problems:
1. Delirium
2. Cognitive impairment/ dementia
3. Functional impairment with inability to perform one or more activities of daily living (ADLs)
4. Falls
5. Sensory impairment
6. Psychiatric Illness (e.g. depression, anxiety)
7. Cerebrovascular disease
8. Parkinsonism
9. Hypertension
10. Diabetes
11. Osteoarthritis
12. Chronic ischemic heart disease
13. Chronic obstructive lung disease

**Procedures**
Affective screening
Functional assessment using standardized tools
Small "office procedures" for primary care (e.g. cerumen removal, wound care)

**Bibliography:**

I have read and reviewed the goals and objectives for this rotation.

___________________________   ____________________________
Fellow Signature     Faculty Signature