Hello all!

Thank you for being a part of our GITC program!

The GITC care model is a specialized ambulatory clinical service center for older adults providing primary care using an interprofessional team approach to developing and implementing a plan of care. Team members work with patients, families, and caregivers, and link patients with needed treatments, community-based services and health information. Studies in community settings and Veterans Affairs medical centers have demonstrated that geriatric patients cared for in interprofessional models have improved mental health status and better maintained health-related quality of life over time than patients in traditional care.

Goals of a geriatric interprofessional team visit include:

- Establishing common goals and a cohesive treatment plan.
- Delivering multidisciplinary team management to ensure that patients receive comprehensive assessments and interventions for the disabling illness and associated comorbid conditions, as well as for the specific impairments and environmental factors that can affect activities and participation.
- Working as a unified team to accomplish enhanced patient outcomes and satisfaction with care.

These goals are accomplished by the IP team through evaluation of the patient's:

- Demographics
- Social support
- Place of residence
- Medical comorbidities
- Severity of illness
- Current treatments (pharmacologic and non-pharmacologic)
- Mobility assessment
- Safety concerns
- Nutrition
- Cognition and functional status

The roles, responsibilities, and/or educational preparation of each team member are described below.

Thank you for your dedication to learning in the GITC!

Drs. Bhattacharya, Burkhardt and the Interprofessional Team.
Patient
If the patient is the leader in decision-making, he or she gains a sense of control and responsibility. Finding out what the patient wants can be a prime mechanism for solving potential problems, generating trust and improving mutual satisfaction in the patient-team relationship.

Attending Physician (MD or DO)
Attending physicians lead the clinical decision-making for patients under their care. They provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements. The physician coordinates and helps provide medical care for the patient, including initial comprehensive assessment, ongoing evaluation, and discharge planning. They apply his/her knowledge of geriatric syndromes and pharmacology to provide appropriate care to patients of both outpatient clinics and residents of nursing and skilled nursing facilities.

The attending physician works cooperatively with other members of the care team, using his/her expertise to guide the process of providing appropriate care to patients. Physician communication with residents and families is vital, including presentation of information about a patient’s status and prognosis to facilitate decisions regarding care.

Clinical Pharmacist (PharmD)
Doctoral degree prepared. With the establishment of Medicare Part D, the role of the clinical pharmacist in the care of the aged patient was solidified as a provider of medication therapy management. The clinical pharmacist takes responsibility for their patients’ medication-related concerns. They ensure that their patients’ medications are the most appropriate, the safest possible, the most effective, and are used correctly based on pharmacokinetic and pharmacodynamics changes that occur with aging. All this is accomplished in collaboration with the care team while identifying, resolving, and preventing medication-related problems (see Helper & Strand, 1990). Additionally, the clinical pharmacist is able to tailor the patient’s medication management system to enhance medication adherence.

Occupational Therapist (OT)
Masters degree prepared. Doctorate education also available (DOT or PhD). Professional focus is on upper body, ADL management and improvement, wheelchair seating specialists, sometimes memory preservation or improvement. An example of OT referral would be for basic ADL deficient restoration. Another example would be teaching energy conservation techniques in the COPD patient.

Physical Therapist (PT)
Doctoral degree prepared (DPT – Doctor of Physical Therapy). The PT professional examines individuals and develops a treatment plan designed to promote the ability to move, reduce pain, restore function and prevent disability. Common areas addressed include joint range of motion and strength, physical endurance, balance, coordination, gait and overall mobility. Treatment approaches include exercise prescription, manual
therapy, modality use, gait training, and patient education. Patients are often referred to PT for fall risk screening, post-fall evaluation, strengthening, low back and neck pain, peripheral joint pain, sports-related injuries and a variety of other conditions and treatments. Common physical therapist practice settings include hospitals, private practices, outpatient clinics, home health agencies, schools, sports and fitness facilities, work settings, nursing homes, and rehabilitation hospitals.  
http://www.apta.org/aboutpts/

Social Worker (SW)
Bachelors or Masters degree prepared [BSW; MSW]. In LTC, the social worker focuses on social history, cognitive and affective issues, family needs, admission and discharge facilitation, and day-to-day social and financial needs/problems of LTC residents. They fulfill the heavy demand for communicating with families. In community settings, social workers focus on information and referrals, resources, advocacy, and education. In clinical practice, they focus on working with clients with diagnoses that may include: depression, anxiety, adjustment disorders, grief and loss, personality disorders. Practice from a strength’s perspective. Therapeutic approaches can include CBT (cognitive behavioral therapy), REM (rational emotive therapy), Family Systems Therapy, EMDR (eye movement desensitization and reprocessing), Mindfulness Based interventions, and Narrative Therapy. They are guided in their practice by the NASW (National Association of Social Workers) Code of Ethics.

REFERENCES:
GRS 8: American Geriatrics Society, 2014
GITTS: Geriatric Interdisciplinary Team Training (GITT) Series
http://www.apta.org
http://www.socialworkers.org/pubs/code/default.asp