GeriTraCCC Launches

On Monday, August 2, 2010, the new UCSF Geriatric Transitions, Consultation, and Comprehensive Care practice opens its doors. The goals of GeriTraCCC are to improve the care of frail older adults and help them and their caregivers achieve the greatest well-being. The practice will provide two valuable services: 1) comprehensive geriatric consultations for older adults, and 2) geriatric post-discharge care for older heart failure patients returning home from the hospital.

The GeriTraCCC Consult service specializes in helping adults 65 years and older with age-related problems. Older adults often experience any number of age-related concerns:

- confusion
- changes in mood or behavior
- depression or anxiety
- memory loss
- increasing weakness, weight loss, or frailty
- falling and trouble walking
- bowel or bladder incontinence
- questions about or problems with medications
- needing more caregiving help

The GeriTraCCC team—comprised of physicians, a nurse, social worker, and clinical pharmacist—are experienced in evaluating and addressing older adults’ full needs. Patients who are too frail to make an office visit may be seen at home by the physician on a case by case basis. GeriTraCCC will work collaboratively with the patient’s primary care provider and, as appropriate, the UCSF Memory and Aging Center and community agencies serving older adults. GeriTraCCC consultations are by referral only.

The GeriTraCCC Heart Failure Transitions service is a collaboration with the UCSF Heart Failure Discharge Planning nurse initiative (supported by the Gordon and Betty Moore Foundation), UC Home Care, Palliative Care, and UCSF Housecalls to improve the care of older adults with heart failure who are returning home from hospitalization at UCSF Medical Center.

Older adults with heart failure often experience a gradual decline in health and function. The time period after leaving the hospital can be particularly challenging for patients and their families due to:

- changes in medication doses
- new medications
- new symptoms that can be scary or hard to manage
- greater difficulty doing basic activities such as bathing, dressing, walking
- increasing needs for caregiving
- greater difficulty making it to a doctor’s office visit

For many heart failure patients with advanced illness, a trip to the doctor’s office is often extremely taxing not only for themselves but their caregivers. The GeriTraCCC Heart Failure Transitions service ensures that patients with heart failure who are sent home from the hospital
will receive a physician housecall within 48 hours of discharge. The GeriTraCCC physician will work closely with the patient’s visiting nurse and primary care doctor or cardiologist. The service will address the many challenges patients and caregivers face upon returning home with the goal of optimizing the patient’s well-being and quality of life, and reducing the need for emergency room visits and hospitalizations. GeriTraCCC will care for patients at home until they are able to return to their primary care doctor or cardiologist’s office.

GeriTraCCC was developed by Helen Kao, MD and Seth Landefeld, MD from the UCSF Division of Geriatrics with the generous support of the S.D. Bechtel Jr. Foundation and UCSF Medical Center. Dr. Kao brings a wealth of experience providing geriatrics and palliative care through UCSF Housecalls and the Over 60 Health Center in Berkeley, California, a unique geriatric community health center which provides care continuity for patients across multiple sites of care. Drs. Kao and Landefeld are leading on-going efforts to expand access to geriatric care in San Francisco.

GeriTraCCC Heart Failure Transitions services accept internal referrals only from UCSF Heart Failure Discharge Planning nurses.

GeriTraCCC Consult clinic is currently accepting referrals. Doctors may refer their patients to GeriTraCCC using a UCSF Referral Form (http://www.ucsfhealth.org) and faxing the request to (415) 353-2568.