VCU Health™
MCV Hospitals and Physicians

Central Virginia VA Health Care System
Geriatrics Fellowship Comprehensive Curriculum

TABLE OF CONTENTS

GOALS OF THE FELLOWSHIP TRAINING PROGRAM

The overall goals of the Fellowship Training Program are to provide comprehensive individualized training to:

- Prepare individuals to meet the requirements for Certification in Geriatric Medicine
- Prepare individuals for the care of older patients
- Provide training in teaching, research, and administration

In order to accomplish these goals, the Geriatrics Fellowship Training Program includes the following components:

- **Geriatrics Curriculum**: A variety of educational conferences and reading assignments are provided to assist fellows.

- **Clinical Experience**: Fellows care for a spectrum of aged men and women in a variety of settings. The curriculum provides experience as a primary care provider and consultant to healthy, as well as acutely and chronically ill, elderly patients in outpatient, inpatient, long-term care, and home care settings.

- **Research**: Research opportunities cover a range of clinical investigations. Fellows may choose a research project in areas of interest and are guided by preceptors.

- **Teaching**: Fellows gain experience in teaching learners of different level and background.

- **Administration**: Fellows learn administrative requirements for research, curriculum development, and/or long-term care based on their interest.

INSTITUTIONAL RESOURCES FOR TRAINING & PATIENT CHARACTERISTICS

Central Virginia VA Health Care System

Training sites for the Geriatrics Fellowship Training Program within the VAMC include the following:

- **The Community Living Center (CLC)** is an 80-bed unit contiguous with the acute care hospital. Patients receive rehabilitation and/or skilled care. Most patients have multiple chronic conditions and are dependent in their activity of daily living (ADLs) and instrumental activities of daily living (IADLs). There is a wide range of clinical problems, from chronic medical problems to acute intercurrent illnesses. End of life care is also provided in the NHCU.

- **The Geriatric Health Care Center (GHCC)** provides multidisciplinary primary care and consultative care to geriatric outpatients. The patients' characteristics range from healthy older patients living independently in the community to patients with multiple chronic conditions dependent in some or all IADLs and ADLs. There is a wide range of clinical problems, from chronic medical problems to acute illnesses. Some patients have life threatening illnesses and are followed by home hospice.

- **The Osteoporosis Clinic** provides outpatient services by endocrinologists with expertise in metabolic bone disease. Most patients have osteopenia, osteoporosis, or Paget's disease at different stages.

- **The Memory Disorders and Evaluation Clinic (MDEC)** provides outpatient services by a neurologist who specializes in Memory Disorders. The patients are referred for memory disorders at different stages and severity.

- **The Erectile Dysfunction Clinic (EDC)** provides outpatient services by a nationally known geriatrician who specializes in erectile dysfunction (ED) of elderly males.

- **The Hospice/Palliative Care Unit** is a 9-bed unit that provides inpatient care to terminally ill patients who have a life expectancy less than 3 months or respite care for home hospice patients with a life expectancy less than 6 months.

- **The Home Based Primary Care Program (HBPC)** provides interdisciplinary primary care to patients that are home bound. Veterans admitted to HBPC typically have highly complex medical issues, are dependent in several ADL's and IADL's and many have complicated social circumstances. Each HBPC interdisciplinary team meets monthly to review new admissions or address concerns as a team. Currently HBPC is serving over 400 veterans and has 13 teams.

- **The Parkinson's Disease Research Education and Clinical Center (PADRECC)** provides multidisciplinary assessment and treatment to veterans with Parkinson's Disease or related disorders. There is a wide range of clinical problems observed, depending on the stage and severity of illness.

Virginia Commonwealth University Health System

Training sites for the Geriatrics Fellowship Training Program within **VCU** include the following:

- **Center for Advanced Health Management (CAHM)** is a centralized location for all outpatient geriatric services at single site. It will include House Calls, Fellows Clinic, CAHM Complex Care Clinic, CAHM-Geriatrics Clinics, and core conferences.

- **The Inpatient Geriatric Consult Service** provides expertise in the management of frail elderly patients in the hospital setting on a consultative basis.

- **The Inpatient Rehabilitation Unit** provides intensive inpatient rehabilitation (after stroke, hip replacement, etc).

- **The Geriatric Psychiatry Service** provides inpatient care to older patients with psychiatric illnesses.

- **Sitter Barfoot** will be the site for the longitudinal community nursing home experience.

FELLOW RESPONSIBILITIES

The clinical fellowship is one year in length. Fellows spend 12 months working on clinical rotations, thus allowing the fellow to be eligible for the certificate of added qualifications in geriatric medicine. A second year of fellowship may be available.

Clinical

- Eight weeks outpatient rotation in the following VAMC clinics: Geriatrics Health Care Center (GHCC) including procedures/acupuncture, GEM (memory), osteoporosis, podiatry, diabetes, lipid clinic and Parkinson's Disease Research Education and Clinical Center (PADRECC).
- Eight weeks at the VAMC Community Living Center. Fellows work with an interdisciplinary team that includes the attending, nurse practitioner, nurse, dietician, social worker and therapists.
- Twelve weeks at the Virginia Commonwealth University Health System (VCUHS) on the Consult Service. The fellow supervises the Internal Medicine residents and orthopedic interns and medical students
- Four weeks on Geriatric-psychiatry. Fellows do consults with the Geropsychiatry attending at VCUHS or VAMC.
- Four weeks hospice/palliative care at the VAMC.
- Four week rotation focusing on acute rehab needs of older adults spending one week on inpatient PMR consult service, one week on transitional care team, 2 weeks on the Skilled Nursing Facility at LCV, including didactics on NH administration during that time
- Four week rotation in Geriatrics Faculty Outpatient Practice working with VCU Faculty gaining exposure to the typical outpatient geriatric practice including primary care and consultative visits
- Four week rotation focusing on alternate site practices either housecalls or long-term care facilities depending on the interest of the fellow
- Throughout the year, fellows follow a cadre of outpatients with longitudinal clinics at GHCC one-half day and CAHM-Geriatrics one half day on alternate weeks
- Throughout the year fellows will follow a panel of Long Term Care patients at Lucy Corr Village, meeting monthly with faculty to review recerts, and as needed if acute problems arise
- Night call: During the year, fellows take night call (from home) for the VAMC nursing homes for a total of 6 weeks. While on VCU rotations fellows will be in the call cycle for the geriatrics and

continuum of care for a total of 6 weekends per year and 3 nights/month (home call). They will be first call, with the backup attending available.

Teaching

Fellows teach medical students and residents that rotate through geriatrics. They also teach the other members of the Interdisciplinary Team.

Fellows give lectures throughout the year. They present Journal Clubs and Case Presentations. Fellows also present a Geriatrics Grand Rounds at the end of the year.

Research and Quality Improvement

Fellows have the opportunity to familiarize themselves with on-going research projects, choose a mentor, and start a research project or collaborate in on-going projects. A research project is not required for one-year fellows.

Fellows are required to participate in Quality Improvement projects, in any clinical setting

Completing/reviewing evaluations and logging duty hours

Fellows sign on to New Innovations (https://www.new-innov.com/login) to complete/review evaluations and to log duty hours.

- Institution ID: *vcuhs*
- User ID: *the first letter of your first name followed by your last name* (for example, if your name is John Fred Doe, your user id would be jdoe, even if everyone calls you Fred)
- Password: *the same as your user id* (you should change that to something else - if you forget what you changed it to, let your Fellowship Coordinator know, and it can reset it for you.)

Click "Continue" on the next page - your home page will open up.

For logging duty hours, go to the link that says "Log my duty hours," and follow the instructions. If you are unable to log hours, let your Fellowship Coordinator know. They may still need to be configured for your program.

If your rotation requires you to do a procedure, you can log those in New Innovations as well. If there are no procedures listed, they may not be set up for your program or you may not need to log anything.

Also on the left, look under notifications and see if there is anything waiting for you to do. You may also check evaluations that have been completed on you by clicking on "My Evaluation Results."

EDUCATIONAL CONFERENCES AT VAMC

- **Core Curriculum Conference**: (2nd and 4th Tuesdays, 12pm) Covers the geriatric curriculum with faculty presenting core lectures on a variety of geriatric topics.

EDUCATIONAL CONFERENCES AT VCUHS

- **Core Curriculum Series**: (1st and 3rd Tuesdays, 12pm-3pm) This conference covers the geriatric curriculum with a combination of core lectures, Geriatric Board Review, Journal Club, and Case Conference, and QI project work sessions.
    - **Core lectures:** include lectures on Medical Direction based on the curriculum recommended by the American Medical Director's Association.
    - **Board Review:** Board review questions are discussed in preparation for the Board Exam. All the topics in the Geriatrics Review Syllabus are covered.
    - **Clinical Case or Morbidity/Mortality:** The fellow develops an answerable clinical question and searches the medical literature for the best available evidence. The fellow discusses how to apply the evidence to the care of the patient presented. Alternatively, a fellow presents a case of a patient who had an unexpected death, reviews the literature on the case, and starts a discussion on how the death could have been prevented.
    - **Journal Club**: Fellows present an interesting research article focusing on research methodology. Fellows are encouraged to present articles that also cover basic science topics. The fellows will present monthly.
    - **QI project work sessions:** the fellows will be able to discuss how their projects are going, work through any problems, discuss obstacles, prepare for possible conference submissions
- **Internal Medicine Grand Rounds:** (every Thursday at noon) departmental lecture series on wide variety of topics, including clinicopathology conference- please attend when on VCUHS rotations

ADDITIONAL EDUCATIONAL OPPORTUNITIES

- **Virginia Geriatrics Society Conference**: This highly successful CME conference is attended by a national audience. Fellows may take part in the planning or delivery of this conference and may attend.
- **American Geriatrics Society Annual Conference**: Fellows may attend. If possible can submit abstract on QI work or case for oral presentation or poster.
- Cultural competence modules at https://cccm.thinkculturalhealth.hhs.gov/
- Pain curriculum modules at http://www.POGOe.org

EVALUATION OF FELLOW PERFORMANCE

The fellows' milestones are evaluated by the attending at the end of each rotation; the attending gives the fellow feedback and the fellow is expected to ask for it. The attending is expected to complete the evaluation in New Innovation within two weeks of completion of the rotation.

Longitudinal rotations:

- Geriatric Health Center/CAHM-Geriatrics: the fellow receives an evaluation every 3 months
- Community Nursing Home: the fellow receives an evaluation every 6 months
- At least semiannually, the Clinical Competency Committee (composed of the core faculty) meets to discuss the fellows' progress and evaluations. The program director then provides to the fellow structured feedback on performance, including appropriate counseling and other necessary remedial effort. The program director maintains records of the evaluation and counseling process.

At the end of the year the fellows do a 60 question in-service exam.

The fellows are also evaluated by the members of the interdisciplinary team (360 degree evaluation) and by patients if they complete the survey. The fellows also have the opportunity to evaluate each other.

At the conclusion of the fellowship the program directors prepares a written summative evaluation of the clinical competence of each fellow and verifies whether the fellow has demonstrated sufficient professional ability to practice competently and independently as a geriatrician.

FELLOW EVALUATION OF FACULTY MEMBERS AND PROGRAM

Faculty have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one fellow must participate in these reviews of the program.

Fellows are given the opportunity to evaluate each rotation in writing.

At the end of the year the fellows are required to complete a written evaluation of the program and of the faculty. The end of year evaluation is anonymous and will be opened after the fellows have left the program.

EDUCATIONAL GOALS BY ROTATION

Geriatrics Health Care Center, GHCC (VAMC)
Attending Physicians: Angela Gentili, MD and Laura Lawson, MD

Learning Objectives by Competency
At the end of the rotations the fellow will be competent with the following:

Patient Care

Render continuing care to a panel of geriatric patients with multiple and complex medical, psychiatric and social problems

- Demonstrate expertise in geriatric assessment and administering standardized instruments to assess cognition, mood, functional status and gait
- Provide health care services aimed at preventing health problems or maintaining health, including nutrition, exercise, screening and immunizations
- Recognize when it is appropriate to consult other services and work with other health care professionals to provide patient-focused care
- Use information technology (Medline and UpToDate) to support patient care decisions and patient education

Medical Knowledge

- Identify and treat geriatric syndromes common in the outpatient setting, including dementia, depression, delirium, falls, incontinence, osteoporosis, sensory impairment, pressure ulcers, and malnutrition
- Identify and treat in diseases that are especially prominent in the elderly including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, genitourinary (prostate disease, erectile dysfunction) and infectious disorders
- Define the pharmacologic alterations associated with aging, including changes in pharmacokinetics, pharmacodynamics, drug interactions, iatrogenic disorders, and issues regarding compliance

Practice Based Learning and Improvement

- Locate, appraise, and assimilate evidence from scientific studies related their nursing home patients and support their own education
- Facilitate the learning of medical students rotating in geriatrics and of other health care professionals of the interdisciplinary team

Interpersonal and Communication skills

- Effectively communicate with other health care professionals (nurses, social workers, therapists, dietician, and chaplain) who are members of the interdisciplinary nursing home teams

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team
- Demonstrate a commitment to carrying out professional responsibilities of the outpatient practice including starting the clinic on time, responding to patients and nurses requests promptly and completing notes and encounters within 24 hours of the visit
- Advocate for the patents within the health care system, demonstrating sensitivity and responsiveness to patients' culture, age, gender, and disabilities

System Based Practice

- Know how an outpatient practice at the VAMC differs from private practice.
- Understand how the VAMC controls health care costs (for example by using a drug formulary) and practice cost-effective outpatient care that does not compromise quality of care
- Manage outpatients through off-site communications (e.g. telephone, e-mail, fax, computer alerts)
- Coordinate the actions of multiple health professionals; including physicians, nurses, social workers, pharmacists, dietitians, and rehabilitation experts to improve health care and know how these activities can affect system performance

How Achieved & Supervision

- During the first or second month the fellow spends two to four weeks in the GHCC evaluating patients with different attendings. During this time the fellow also learns treatment of older men with erectile dysfunction. Throughout the fellowship the fellow follows about 80-90 patients longitudinally (1/2 day per week).
- Care provided by the fellow includes: geriatric assessment, basic care during acute and chronic phases of illness, promotion and maintenance of health, prevention of illness and disability, guidance and counseling, referral and coordination of care with other professionals. Dietitian, pharmacist, KT, SW and memory disorder specialists are available in the GHCC. Other specialties are available within the VAMC system. Fellows and other primary care providers in GHCC also evaluate their patients before surgery.
- Supervision of fellows
    - All new patients should be presented to the supervising attending. Return patients will be seen by, or discussed with the attending at such frequency to ensure that the course of treatment is effective and appropriate. All notes should have an attending as cosigner. If the patient was seen and/or discussed with the attending, the fellows should state that at the end of the note.
    - If the attending is on leave, the covering attending will be in GHCC and the fellow will present new patients and follow up patient as needed to the covering attending. The fellow should put the covering attending as cosigner for all the notes, as they need to be cosigned within 24 hours.
    - If the fellows see patients on half days different from their scheduled session, they will call their own attending for questions that can be handled over the phone, if they think the pt needs to be seen by the attending, they will present the pt to the attending in

GHCC. Again they should put their own attending as cosigner, unless they presented the pt to the attending in GHCC, then they should put him/her as cosigner.

Reading List

- Chapters from Geriatrics Review Syllabus
  - Demography
  - Biology
  - Psychosocial issues
  - Financing
  - Assessment
  - Cultural Aspects
  - Physical Activity
  - Prevention
  - Pharmacotherapy
  - Complementary Medicine
  - Elder Mistreatment
  - Perioperative Care
  - Geriatric Syndromes
- http://www.virginiageriatrics.org
  - Quick Consult: Falls, Medications to avoid in the elderly, Placement problems, urinary incontinence
- Driving and dementia
  - http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.page

For more details of how things work in GHCC, please see survival guide below.

Survival Guide to GHCC

How Things Work

1. The GHCC staff will measure and record the patients' weight, blood pressure, height and pain level on the vital sign sheet located on the inside left of the GHCC chart.
   - When you arrive in GHCC for your clinic session, get a copy of your scheduled patients from the reception area.
   - Take your first patient to the room assigned to you (with your name outside the door).
   - Patients are seen in the order of their appointment, unless there is an urgent care patient that needs to be seen first.
   - The GHCC chart contains an order sheet with the vital signs
2. After the patient is seen by the practitioner, the practitioner uses the order sheet to check off labs, x-rays, consults, procedures, etc. to notify the receptionist and nurses that they were ordered in CPRS.
   - The indication of x-rays must be recorded on the order sheet if they were ordered in CPRS
   - If the x-ray is STAT or "Read and Return," please check the appropriate boxes on the order sheet and indicate in CPRS that it is "Read and Return."
3. CPRS is used to renew old prescriptions and to write new ones
4. Narcotics prescriptions need a PIV card to be signed. If the patient has been or will be on opiates for > 90 days, you need to complete "Consent for long term opioids," you complete it like any other consent in Imed. The veteran should also get the handout "Taking Opiates Responsibly."
5. To get a glucometer for your patient write on the order sheet to give a glucometer. You will have to order the supplies (alcohol pads, lancets and lancet device, glucose test strips) under medications. Patients that are not on insulin are allowed only one glucose test strip a week (because of cost).
6. All consults are ordered using CPRS
   - All consults need to have the reason stated for the consultation
   - Routine consults (such as GU and Podiatry) may be impossible to schedule in less than 6-9 months without the provider contacting the consulted service
   - Consults available within the GHCC include: Social Work, Dietary and KT. Put the consult in CPRS and indicate on the order sheet if these consults are to be completed on the date of visit.
   - To screen for colon cancer, you can order annual hemoccults or colonoscopy every 10 years (if negative) up to age 80.
   - To order Medical Supplies (incontinence products, trach. care supplies, wound care supplies) go under Consults, Pharmacy Consult and click on Medical Supplies Order Form
   - To refer a patient for NH placement, place consult to SW for "Nursing Home Placement". The patient will also need within 30 days of the consult: CXR, CBC, UA, podiatry, nutritional evaluation, nursing evaluation. Evaluation by SW, dietician and RN can be done the same day.

7. All progress notes are entered in CPRS
    - Please protect patients' confidentiality: Log out of a patients' record and the computer before leaving the exam room
    - You are strongly encouraged to enter the progress note while you are still with the patient.
    - Progress notes should be electronically signed the same day, only in exceptional circumstances can be completed within 24 hours of the visit.
    - All progress notes should have the attending name as a cosigner.
8. RTC order must be placed with clinically indicated date entered before veteran goes to front desk. Flag the order as "order request" to Ms. Lakeia Brown.
9. Complete the encounter form after the progress note in CPRS
10. Usually you are assigned only one room, when you are finished, you can give the chart to the PT and tell him to go to the reception desk to check out. Finish your note and the get next patient.
11. GHCC staff strives to interrupt providers as little as possible. Please check the box on exam room doors for messages, lab results, EKG's, etc. Please initial EKG and return to box or give to the nurse.
12. Medication renewals: You will receive alerts for medication renewals

Urgent Care (Unscheduled) Patients

1. In addition to your regularly scheduled patients, you will likely need to see one or more urgent care patients.
2. The Staff Nurse triages walk-ins

If the Staff Nurse feels that the patient needs to be seen, she will page the provider if the provider feels that the patient needs to be seen urgently (same day), he/she will ask the nurse to give a note to the MD in GHCC responsible for walk-ins. The note will contain the following information:

- Why the patient needs to be seen urgently
- What stat lab work/tests the provider has ordered if any
- Name of the provider

The MD in GHCC responsible for walk-ins can page the provider to get more information or tell the nurse that he/she will see the patient. A note will be placed inside the chart by the Staff Nurse with the reason for the urgent visit. If you feel overwhelmed you can ask for help (discuss it with your attending), but you cannot tell the PCP that called you that you are too busy to see the patient. Some important geriatric problems (like acute delirium) are seen mainly with urgent walk-ins.

3. An easy way to notify the patient's primary provider is to have the provider as an additional signer.

Nurse Practitioners (NP's) or Physician Assistant (PA) in GHCC

1. A NP or PA is assigned to GHCC and she sees her own patients, urgent care patients, and post-hospital follow-ups up to a maximum slots per day.
2. If she needs a MD consult, the MD in clinic at that time will provide the consultation.
3. When she is on leave, MDs will cover for her. Questions about her patients will be forwarded to the MD that was in clinic at the time of the patient's most recent visit.

Scheduled Leave

1. All providers must give at least 30 day notice of planned absences.
2. To notify the GHCC of planned absences, send an email message to the PD and Beverly Baker, stating the days that you plan to be on leave.
3. All patients who are scheduled for you on the day of your planned leave, must be rescheduled to be seen within 2 weeks of their original appointment.
4. Depending upon slot availability in your session, a makeup session may be required.
5. Notify the receptionist of the date you prefer to do your make up session. If that date is unavailable, the receptionist will let you know and you will have to choose another date.

Lab and X-ray results

1. You will receive the results of lab tests and x-rays as alerts. Make sure your alerts are on and check them daily. To turn on alerts, go to Tools, Options, Notifications, Lab results.
2. It is the provider's responsibility to interpret and act on the labs and x-rays.
3. Results are communicated to patients no later than 14 calendar days from the date on which the results are available to the provider. Significant abnormalities may require review and communication in shorter timeframes, and 14 days represents the outer acceptable limit. For abnormalities that require immediate attention, the 14-day limit is irrelevant, as the communication should occur in the timeframe that minimizes risk to the patient. The provider should call the patient.
4. To communicate non-urgent test results, type a note entitled "GHCC LAB RESULTS LETTER" Once the letter is signed it will be automatically printed and it will be mailed out by the GHCC staff.

Pharmacy

1. If you order a new medication and you think the patient needs to pick it up the same day, check "window" on the prescription and tell the patient to go to main pharmacy and tell the pharmacist he is there to pick up a prescription. If patient is not picking up the prescription the same day, put on the comments the day the patient will pick up the prescription otherwise after 24 hours it will be mailed.
2. To give a glucometer to your patient write a free text order for the nurse in GHCC, give it to the pt, and instruct on use. You will need to order supplies (lancet device, lancets, glucosticks, alcohol pad, insulin syringes).
3. To order restricted drugs you need to get the OK of the service the drug is restricted to and write in the prescription who approves it or you can place a consult under "Pharmacy Consult." Once the drug is approved they will mail it to the patient.

Alerts and E-mails

You will receive most of the information about your patients via alerts. Check your alerts every day. When you get an alert from a nurse, cosign the note and make an addendum saying how you will address the problem. If you want the nurse to do something (like call the patient back with instructions), make sure you put her as co-signer.

If you are off-station (VCUHS), you are responsible for following up the labs you ordered during your GHCC session. You can connect with the VA using the computer at the GERILAB. Your attending will help you with other issues on your patients while you are at VCUHS.

You can send e-mails about the patients via Outlook e-mail only if you encrypt the message. VISTA e-mail is encrypted so it can be used to discuss patients, as long as the patient name and SSN is not in the subject or title. On occasion you will get information about the patients in VISTA (from SW, therapist, pharmacist). Be aware that according to the Freedom of Information Act patients have the right to request copies of e-mails that discuss their care.

If you are doing an off-station rotation, you need to check your e-mail on the day that you are in the hospital for your clinic session and on those days that you are back at the VAMC.

Community Living Center (VAMC)
Attending Physicians: Hana Ayele, MD & Katherine Brennan, MD

Learning Objectives by Competency *(AGS milestones in italic)*
At the end of the rotations the fellow will be competent with the following:

Patient Care

- Be familiar with the role of a physician in nursing home care including: Assessment of a new patient admitted to the nursing home, performance of scheduled reviews, management of chronic problems and intercurrent illnesses, functional assessment, review of medications, assisting with *discharge planning*
- *Perform, interpret, and articulate the strengths and limitations of the commonly used cognitive, mood and other geriatrics tools*
- *Individualized LTC patients management considering prognosis, comorbidities, patient and caregiver goals & resources*
- *Demonstrate expertise in principles of geriatric rehabilitation, pressure ulcers and in providing terminal care*
- *Effectively assess a patient or resident's decision making capacity and elicit advance care directives*
- *Manage acute problems in LTC via telephone call*

Medical Knowledge

- Diagnose and treat geriatric syndromes common in the long-term care setting, including dementia, incontinence, pressure sores, nutritional issues and falls
- Recognize when it is appropriate to consult other services
- Administer and interpret standardized instruments assessing cognition, affect and gait in the longitudinal nursing home setting

Practice Based Learning and Improvement

- Diagnose and treat acutely and chronically ill frail elderly in an environment with fewer technological resources immediately available
- Locate, appraise, and assimilate evidence from scientific studies related their nursing home patients and support their own education

Interpersonal and Communication skills

- Effectively communicate with other health care professionals (nurses, social workers, therapists, dietician, and chaplain) who are members of the interdisciplinary nursing home teams

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team

- Demonstrate a commitment to the ethical principles pertaining to the provision or withholding of care, confidentiality of patients information, informed consent and business practices in the nursing home setting.

System Based Practice

- Be aware of OBRA and Joint Commission rules and regulations that the nursing home has to follow and learn about the operation of long-term care facilities
- Recognize the role of the nursing home in the spectrum of patient care (acute care, long term care, ambulatory care) and the type of patients who can benefit from long term care
- Become comfortable knowing which patients can be managed in nursing home vs. hospital settings (nursing home-hospital interface)
- Work effectively with Nurse Practitioners and recognize the strengths and limitations of theses staff in a nursing home setting
- Practice cost-effective nursing home care that does not compromise quality of care
- Understand the differences between nursing home care provided in the Veterans Administration Nursing Home versus facilities in the private and not for profit health care sectors

How Achieved

- The fellow spends about 8 weeks rotating in the nursing home, four weeks on the short term unit (1P) and 4 weeks on the long-term unit (1N).
- At the beginning of the rotation the fellow receives a list of patients that need scheduled reviews (also called recertifications). Recertifications are distributed between the NPs and the fellow.
- During the rotation the fellow does new admissions including orders. When writing the orders, the fellow reviews the medications and eliminates unnecessary drugs and prn drugs as much as possible.
- Rounds:
    - Work rounds are done by the NP and fellow. Times to be discussed with NP. Non-urgent issues are addressed during work rounds. If a patient wants to see the NP or doctor, the nurse will find out why and whether it is because of an acute illness or not. If the pt is acutely ill, she will page the NP (or fellow if NP not available). If it is not urgent, the nurse writes the info on the NP board. The NP checks the board every morning.
    - Attendings rounds are done by attending, NP, fellow and nurse every week or other week. New admissions, recertifications and patients with intercurrent illnesses are discussed. Geriatric assessment, medical management and medication review are discussed during attending rounds. The time and day of attending rounds is discussed at the beginning of the rotation.
- If a patient with an intercurrent illness needs acute care, he will be transferred to the medicine service. The attending writes a certification note and the patient is assigned a bed on acute medicine. The fellow pages the resident to explain why the patient needs to be transferred. If the patient is medically unstable and cannot wait for admission in the NHCU, he will be transferred to the ER. When the patient returns to the NHCU the NP will write the orders and a brief readmission note.
- If a patient has a fall, the nurse will notify the NP who will write a note entitled "NHCU provider post fall assessment."
- If the fellows performs a procedure (like knee steroid injection), he/she will need to complete the "Invasive procedure note" that reminds the provider to get consent and do the "time out" before performing the procedure. The note is not required for sharp wound debridement.
- Patient that are acutely ill are evaluated in the NH during working hours, while they are sent to the ER after hours. Pts that are hemodynamically unstable, for example have an acute CVA (less than 3 hours old), active GI bleed, or an acute abdomen can be sent to ER during working hours.
- Fellows may be expected to do some discharge orders and summaries.

Interdisciplinary rounds

- IDT: Room 1P-108
    - Wednesday at 10:30-12:00 noon: short term patients
    - Wednesdays at 1 PM: long term and hospice patients.
    - Thursdays at 2 pm: Memory huddle for long term patients
- Wound care rounds:
    - Tuesdays at 9 am starting on unit 1P – contact Carol Oliver RN, wound nurse
- Pharmacy rounds: Room 1P-108
    - Wednesdays at 2pm after IDT for long term patients
- Psychiatry rounds: Dr. Rosenblatt is available Tuesdays and Thursdays pm to discuss patients
- PM&R Rounds: Dr. Caruso is available on Wednesdays

The fellow is expected to present new patients at IDT to learn the principal of rehabilitation and interdisciplinary team training by working with occupational therapists, kinesiotherapists, recreational therapists, dieticians, nurse practitioners, nurses, social workers, and chaplain.

Sixty Day Recertifications Notes

- Change location to G&EC Proxy (for billing and work load tracking purposes)
- Any event since last recertification—i.e. ER visits, ASIH, COPD exacerbation, etc.
- Review with nursing any change in mental, functional, and psychosocial status
- Review all meds, make sure they have an appropriate indication and they match the problem list (for example, a pt on a PPI for GERD, must have GERD on the problem list)
- Document any pressure ulcers and their progress
- Document the necessity of restraints (double side rails are restraints)
- Document need for Foley catheter in problem list (urinary retention, stage 3 or 4 sacral ulcer), if no longer needed, remove.
- Review PRN meds and their effectiveness, if not used, discontinue them.
- All antipsychotics must have a target behavior for indication (for example hallucinations, aggressive behavior) and must be titrated down if the patient no longer has the target behavior. If they are not titrated down there must be documentation of the reason why.

- If a patient is on an antipsychotic drug, the Abnormal Involuntary Movement Scale (AIMS) must be performed to document side effects of the drug.
- Review code status and update advance directive note at least once a year
- Review need for rehab and progress
- Review bowl and bladder continence status
- Review weights for several months and document plan for unexplained weight loss
- Review health maintenance status

Admission and annual recertification also require: Oral exam, cognitive function, depression screen, advance directive note. We do not use MMSE because it is copyrighted.

Discharges

- Place free text order in CPRS at LEAST 1 day before discharge ex: "Make discharge appointment for Mr. X on 5/13/09 1pm" – the clerk will make the clinic appointment.
- Review and update outpatient medication, make sure it lists only the medications you want the patient to go home with.
- Print and sign narcotics prescriptions
- Type "clinician" and will pop up the note "PATIENT DISCHARGE INFORMATION/CLINICIAN"
- Do the discharge summary. The must be completed by Friday each week, even for those patients that expired on the unit. If the patient is discharged, please complete the discharge summary upon discharge for agency referral process.

Services available in the NH

- Morning lab draw
- Phlebotomy for labs ordered the same day, put the order in and ask the clerk to call the IV team. Urgent labs should be "immediate collect". Do not order "ward collect" unless you want to draw yourself.
- IV team will also place an IV, NH patients can have IV fluids and IV abx, but if they are not medically stable and need frequent monitoring should be transferred to medical floor.

Helpful CPRS hints for NH patients

- Use free text only for nursing orders
- To order glucosticks, go to medications and order "Glucose test strips" or "Precision QID" and put as schedule "AC HS"
- For diabetic patients on Aspart before meals, consider ordering Aspart low dose prn QHS so the nurses know what to do if BS is high in the evening. Also try to cut down the number of glucosticks done daily if possible.
- To order hemoccults, go to labs and order "hemoccult"
- When ordering narcotics, state "for pain for 14 days" otherwise they will expire in 3 days

Handoff

- Required on Friday to on call MD and during the week as needed on sicker patients
- To get a list of short term patients for handoff CPRS – Tools – More – Shift Handoff –Provider-type name of NP - Submit

Night Call

- The fellows take call for the whole CLC and palliative (1Q and consults) according to the call schedule. You DO NOT take call for outpatients.
- Call is from home. The fellow as the option to request remote access to connect with the VA and review the patients' charts from home.
- When a fellow is called about a sick patient, the fellow should inquire about the patient's advance directives (code status, is the patient to be treated in the NH only or can be transferred to the ED, etc.) and the vital signs.
- If a patient is acutely ill and needs to be seen by the physician, the fellow will tell the RN to send the patient to the ED and inform the NOK. The fellow will talk to the ED attending. The fellow should remind the ED attending that it is his responsibility to call the family if the patient is admitted. If the patient goes to the ED and comes back, the NP will notify the family during working hours about the outcome of the ED visit. If any ED attending does not want to accept the patient or is rude, the fellow should call the attending on call.
- Since July 07, the nurses have been allowed to take verbal orders and the fellow can also refer the nurse to the standing orders we have for indigestion, hypoglycemia, constipation, diarrhea and fever. The nurses have the instructions on how to place standing orders: Go to orders, MENU (GUI ADD NEW ORDERS), Admission/inpatient orders, long term care, standing orders.
- The nurses cannot give D50 IV push; therefore a patient that needs D50 needs to go to the ED.
- The fellow should not hesitate to page the attending on call if he needs advice on what to do. The fellow should keep a copy of the confidential home telephone lists (attendings, other fellows) at home.
- The fellow writes a note regarding the call he received. The note should be done as soon as possible and within the next working day at the most. The note should have the attending, NP and fellow taking care of that patient as cosigner, it should also have the attending on call as cosigner if that attending was called about the patient.
- The fellow is expected to answer his pager as soon as possible, at the most within 10 min from the time the nurse pages him (it can take few minutes for the page to go through).
- If a fellow is called for an accident (for example a fall), the nurse will call the fellow on call. The NP will write a note entitled "NHCU provider post fall assessment" next working day.
- The person receiving a critical lab result must write a "CRITICAL TEST RESULTS NOTE", even if to say that no action is necessary and why.
- Telephone numbers to call the NH: first dial the operator at 675-5000, the extensions are:
    - 1N: 4641, 3915, 4202
    - 1P: 4642, 3918, 3920, 3886, 3081
    - Only extensions that start with a 5 or 6 are direct extension, for example Dr. Gentili's extension is a direct number: 675-5428.

Supervision

- New patients will be discussed and seen by the responsible attending no later than 72 hours after admission. The fellow will write an admission note within 48 hours of admission. The attending will document his/her involvement in the care of the patient in the medical record by writing a progress note or an addendum to the fellow's progress note.
- Although decisions regarding diagnostic tests and therapeutics may be initiated by the fellow, these decisions will be reviewed with the attending at intervals in the context of patient care rounds.
- The attending will be identifiable for each patient care encounter. Extended care patients will be seen by, or discussed with, the attending at such frequency as to ensure that the course of treatment is effective and appropriate.
- All discharges will usually be approved by the attending in advance, except where established protocols govern specific types of discharges.
- Fellows are required to notify the patient's attending, in a timely fashion independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient's course including unexpected death, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition Attending or their designee are expected to be available and responsive, either by phone or pager, for fellow consultation, 24 hours a day for their term on service, their on-call day, on their specific patients.
- If the attending is in clinic, the fellow should inform the attending about non-urgent issues by e-mail of having the attending cosign a progress note. For more urgent issues, the fellow should page the attending and if the attending does not respond promptly (15 min), the fellow should contact the back-up attending. The backup attending is the other team NHCU attending or the NHCU Medical Director if the other team attending is not available (on leave, on medicine, doing make up clinic etc.)

Reading List

- Chapters from Geriatrics Review Syllabus and www.geriatricsatyourfingertips.org:
  - Psychosocial issues
  - Financing
  - Pharmacotherapy
  - Nursing Home Care
  - Geriatric Syndromes
  - Common Geriatric Diseases, Disorders & Health Concerns
- http://www.virginiageriatrics.org
  - Quick consult falls, PEG tube, unrealistic expectations, urinary incontinence
- http://interact2.net/tools_v3.aspx
  - Interventions to Reduce Acute Care Transfers
- http://www.hpm.umn.edu/nhregsplus/index.html
  - Nursing home regulations

Palliative Care/Hospice (VAMC)

Learning Objectives by Competency *(AGS milestones in italic)*

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Be familiar with the principals of palliative care for patient with life threatening illnesses.
- *Discuss with patients and families/caregivers the risks and benefits of nutritional supplementation, enteral tube feeding, and parenteral nutrition, particularly in patients with advanced dementia or near end-of-life*
- *Counsel patients and families/caregivers about the range of options for palliative and end of life care*
- *Individualize pain control utilizing the most effective pharmacologic and nonpharmacologic strategies based on the etiology and chronicity of the patient's pain*
- *Prescribe pain medications with instructions and methods to prevent common complications including constipation, nausea, fatigue and opioid toxicity (myoclonus and hyperalgesia), using equianalgesic dosing conversion and opioid rotation when needed*
- *Assess manage, and provide anticipatory guidance for patients and families/caregivers for common non pain symptoms during severe chronic illness or at the end of life*
- *Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship*

Medical Knowledge

- Expand knowledge base on diagnosis and treatment common symptoms at the end of life
- Recognize the role of psychological, cultural and religious issues related to death and dying

Practice Based Learning and Improvement

- Utilize the resources available in the hospice setting to appropriately manage end of life symptoms
- Locate, appraise, and assimilate evidence from scientific studies related to their palliative care and hospice patients and support their own education

Interpersonal and Communication skills

- Practice culturally sensitive shared decision-making with patients and families/caregivers in the context of their health literacy, desired level of participation, preferences and goals of care.
- Effectively lead a family/caregiver meeting to address goals of care
- Skillfully discuss and document goals of care and advance care planning with individuals and/or their family members/caregivers across the spectrum of health and illness
- Provide compassionate care while establishing personal and professional boundaries with patients and family members/caregivers
- Work effectively as a member or leader of an interprofessional health care team (NP, nurses, social worker, psychologist, pharmacist, therapists, dietician, and chaplain)

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team
- Demonstrate a commitment to the ethical and legal issues especially pertinent to end-of-life, including limitation of treatment, right to refuse treatment, advance directives, confidentiality, competency, guardianship, designation of surrogate decision maker for health care

System Based Practice

- Recognize the role of palliative care in the spectrum of patient care (ambulatory care, acute care, long term care, and hospice) and the type of patients who can benefit from palliative care.
- Become comfortable knowing which patients should be referred for hospice care
- Work effectively with Nurses and NPs and recognize the strengths and limitations of these staff in a hospice setting
- Understand the differences between home hospice, palliative care in the acute setting and nursing home and in the inpatient hospice unit
- Identify patient and family/caregiver needs and refer to appropriate local community resources
- Describe the services provided by Medicare Parts A, B and D, the Hospice Benefit, and by Medicare and Medicaid for patients who are "dual eligible," including the basics of the patient's fiscal responsibility for each

How Achieved

The geriatrics fellow spends about 4 weeks rotating in palliative care.

- During the rotation the fellow does new admissions (including orders) of palliative care patient assigned to him/her, daily notes, recertifications (if needed) and palliative consults. He/She will be expected to do discharge orders and summaries.
- Discuss rounds schedule with the attending.
- Huddle with the night nurse is daily at 9 am in 1Q conference room.
- Daily rounds are done daily after huddle. Each patient's status and discharge planning is discussed.
- Daily notes:
    - Review the medications daily to make sure they are appropriate. Medication can be changed during rounds using the Bull (computer on wheels). Oral medications should be stopped if the patient cannot swallow or is actively dying. Please close attention to diabetics with the goal of avoiding hypoglycemia. To avoid night calls, please specify what to do for high BS, for example: Aspart 4 Units prn for BS > 350.
    - Daily notes address symptoms, change is status and any change in medications and communication with healthcare POA/family.
    - Complete MedShares hospice patient list for the on call MD and for rounds next day. Do not order labs in the afternoon if you will not be able to f/u on the results. If late labs are absolutely needed, let the on call MD know.
    - The person receiving a critical lab result must write a "CRITICAL TEST RESULTS NOTE", even if to say that no action is necessary and why.

- On Friday, be sure orders are in for weekend coverage of suspected symptoms, especially for bowels, pain and any associated symptoms of disease. Provide updates to patient and family members.
- During working hours (8AM-4:30PM) the fellow pronounces pts that expire, informs the NOK and asks about autopsy, then writes the "Death note". After hours night float pronounces the patient and calls the NOK. The fellow does the D/C summary.
- If a patient falls, the NP or fellow write the note "POST EVENT PROVIDER EVALUATION". If the pt falls at night or week-ends, the note is written next working day.
- Consults: The response to the consult has to be attached to the original consult request all the responses will link for ease of tracking.
    - Palliative care and geriatrics consults are discussed with the attending on palliative care. Attending rotates every 1-2 weeks.
- The geriatrics fellow is responsible for palliative care consults and rounds on palliative care patients. Work is shared with the palliative fellow when available.
- The titles for the consults are:
    - Palliative Consult note
    - Geriatrics Consult (for non-palliative care consults)
- Discharges:
    - Place free text order in CPRS at LEAST 1 day before discharge ex: "Make discharge appointment for Mr. X on 5/13/09 1pm" – the clerk will make the clinic appointment.
    - Review and update outpatient medication, make sure it lists only the medications you want the patient to go home with.
    - Print and sign narcotics prescriptions
    - Type "clinician" and will pop up the note "PATIENT DISCHARGE INFORMATION/CLINICIAN"
    - Do the discharge summary. The must be completed by Friday each week, even for those patients that expired on the unit. If the patient is discharged, please complete the discharge summary upon discharge for agency referral process.

Reading List

- Chapters from Geriatrics Review Syllabus:
    - Palliative Care
    - Persistent Pain
- http://www.virginiageriatrics.org
    - Quick consult: PEG tube decisions, patient decision making impaired, unrealistic expectations
- EPERC Fast Facts: http://www.eperc.mcw.edu/ff_index.htm
- Stanford End of Life Curriculum: http://palliative.stanford.edu
    - Please complete modules on home hospice, prognostication and transition to death prior to starting palliative care rotation if possible

Neurology/Parkinson's Disease Research Education Center (VAMC)

Learning Objectives by Competency
At the end of the rotations the fellow will be competent with the following:

Patient Care
- Identify and perform an accurate history and physical exam that is appropriate for patients with dementing illness, Parkinson's disease and neurologic disorders common in older patients
- Develop skills in managing common neurological problems in older patients
- Identify the appropriate laboratory, radiographic and other studies indicated to provide appropriate management and diagnostic testing of neurologic conditions

Medical Knowledge
- Expand knowledge of the pathophysiology, etiology and treatment of dementing illness, Parkinson's disease and neurologic disorders common in the geriatric population
- Access and critically evaluate current medical information and scientific evidence relevant to older patients with neurologic disorders

Practice-Based Learning and Improvement
- Develop evidence-based strategies for filling gaps in personal knowledge and skills in the care of older patients with neurologic disorders
  Become familiar with the necessary work up prior to referral to a neurologist

Interpersonal and Communication Skills
Develop skills in sensitive communication with older patients with neurologic disorders

Professionalism
- Demonstrate respect and compassion in interactions with colleagues, patients, families and all members of the health care team

Systems-Based Practice
- Practice cost-effective healthcare and resource allocation of neurologic disorders
- Understand and utilize the multidisciplinary resources necessary to care optimally for older hospitalized patients with neurologic disorders

How Achieved & Supervision
- For two weeks, fellows attend the PADRECC, Memory Disorders and Neurology Clinics
- Evaluation and management of each patient are discussed with the attending

Reading List
- Chapters from Geriatrics Review Syllabus 30 Dementia, 31 Behavioral Problems in Dementia, 32 Delirium, 27 Gait Impairment, 57 Neurologic Diseases and Disorders
- Articles provided by the attending at the beginning of the rotation

Bone Clinic (VAMC)

Learning Objectives by Competency
At the end of the rotations the fellow will be competent with the following:

Patient Care
- Identify and perform an accurate history and physical exam that is appropriate for patients with osteoporosis and other bone disorders
- Develop skills in managing osteoporosis and Paget's disease in older patients
- Identify the appropriate laboratory, radiographic and other studies indicated to provide appropriate management and diagnostic testing of osteoporosis

Medical Knowledge
- Expand knowledge of the pathophysiology of osteoporosis, clinical presentation, use of diagnostic tools and management
- Access and critically evaluate current medical information and scientific evidence relevant to older patients with bone disorders

Practice-Based Learning and Improvement
- Develop evidence-based strategies for filling gaps in personal knowledge and skills in the care of older patients with bone disorders
- Become familiar with the necessary work up prior to referral to an endocrinologist

Interpersonal and Communication Skills
- Develop skills in sensitive and effective communication with older patients with bone disorders and their families

Professionalism
- Demonstrate respect and compassion in interactions with colleagues, patients, families and all members of the health care team.

Systems-Based Practice
- Practice cost-effective health care and resource allocation of bone disorders in older patients
- Understand and utilize the multidisciplinary resources necessary to care optimally for older hospitalized patients with bone disorders

How Achieved & Supervision
- Each fellow spends a ½ day per week in the osteoporosis clinic during his/her GHCC month or elective month
- Evaluation and management of each patient is reviewed with an endocrinology attending Use and interpretation of bone densitometry is reviewed
- At the end of each session, the clinic's attendees meet to discuss interesting cases

Reading List

- Chapters from Geriatrics Review Syllabus: 29 Osteoporosis and Osteomalacia, 47 Endocrine and Metabolic Disorders
- Articles provided by the attending at the beginning of the rotation

Home Based Primary Care (VAMC)

Attending Physicians: Martha Dommisse, MD, Natalie Paneranda, MD and Elise Sideris, MD

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Demonstrate expertise in managing frail, homebound older patients in the home setting with limited technology
- Devise effective patient-centered strategies that comprehensively evaluate and manage the medical, functional and social issues in the home setting

Medical Knowledge

- Diagnose, manage the special needs of homebound patients with multiple medical, social and functional problems
- Appropriately and selectively administer/interpret standardized instruments assessing cognition, affect and gait

Practice Based Learning and Improvement

- Identify community resources useful to enhance the quality of life of patients and families
- Understand the pivotal role of family in caring for frail elderly persons at home and the community resources required to support both patient and family.
- Practice medical decision making that incorporates the patient's values and preferences to fullest extent possible

Interpersonal and Communication Skills

- Effectively interface with other health care providers and ancillary services to serve as the geriatric patients' ultimate patient advocate

Professionalism

Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team.

System Based Practice

- Practice cost-effective home care that does not compromise quality of care
- Coordinate the actions of multiple health professionals in the home setting
- Demonstrate knowledge of the funding sources for homebound patients

How Achieved

- The fellow is an active participant of an interdisciplinary team that visits patients in their homes
- The fellow will visit home bound veterans that are part of the Home Based Primary Care (Attendings)
- The team meets weekly to discuss patients and interesting cases

- The fellow follows house calls patients that are admitted to the hospital and reports the status to the house calls team at the weekly meeting
- The fellow, with the team, develops a treatment plan
- The fellow researches clinical questions that arise related to house calls patients and provides educational information to the team
- The attending teaches the fellows the principles of home care

Helpful Hints

- Weekly IDT meetings:
  - At the VAMC Home Based Primary Care IDT meeting are every Wednesday at 9AM in room 1P-108

Supervision

- Patients seen during house calls are discussed with the attending.

Reading List

- Chapters from Geriatrics Review Syllabus: Community-based care
- P. Boling: Introduction to House Calls
- Beales, J & Edes, T: Veteran's Affairs Home Based Primary Care. Clin Geriatr Med 25 (2009) 149–154 (provided at beginning of rotation)
  Devor, M: Home Care Syllabus (provided at beginning of rotation)

Inpatient Geriatric Psychiatry (VCUHS)

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Perform skillful evaluation of psychiatric problems in older patients hospitalized for medical or surgical illness, including focused psychiatric interview and formal mental status examination
- Prescribe psychotropic medications appropriately in the medically ill population
- Accurately assess patients' capacity to make health care decisions

Medical Knowledge

- Expand knowledge of the pathophysiology, etiology and treatment of older patients with psychiatric disorders including dementia, depression, delirium and suicidality
- Understand ethical and legal issues especially pertinent to geriatric medicine, including capacity evaluation for healthcare decision making, guardianship, right to refuse treatment, and wills Understand the pharmacology and pharmacokinetics of commonly used psychotropic drugs in older patients
- Access and critically evaluate current medical information and scientific evidence relevant to older patients with psychiatric disorders occurring in the setting of acute medical and surgical illness

Practice-Based Learning and Improvement

- Develop evidence-based strategies for filling gaps in personal knowledge and skills in the care of older hospitalized patients with psychiatric disorders
- Become familiar with the necessary work up prior to referral to a psychiatrist

Interpersonal and Communication Skills

- Develop skills in sensitive and effective communication with older patients with psychiatric disorders

Professionalism

- Demonstrate respect and compassion in interactions with colleagues, patients, families and all members of the health care team

Systems-Based Practice

Practice cost-effective health care and resource allocation of psychiatric disorders in older patients

- Understand and utilize the multidisciplinary resources necessary to care optimally for older hospitalized patients with psychiatric disorders

How Achieved & Supervision

- The fellow works with the gero-psychiatrist on the inpatient service (VCUHS)
- The fellow first independently evaluates the patient and then discusses each case with the attending gero-psychiatrist during rounds
- The fellow will round with the interprofessional team, including psychology, pharmacy, SW
- While on the geropsychiatry rotation, fellows are strongly encouraged to attend sub-specialty conferences (i.e. Psychiatry Grand Rounds, weekly psychopharmacology reviews)

Reading List

- Chapters from Geriatrics Review Syllabus: 35-40 Geriatric psychiatry
- UpToDate
- Jordan F. Karp, MD, and Charles F. Reynolds 3rd, MD Pharmacotherapy of Depression in the Elderly: Achieving and Maintaining Optimal Outcomes Primary Psychiatry. 2004;11(5):37-46 link: http://www.primarypsychiatry.com/aspx/articledetail.aspx?articleid=671
- Stable resource toolkit: http://www.cqaimh.org/stable_toolkit.html

Rehabilitation Medicine (VCUHS)

Attending Physicians: Arline Bohannon MD, & Saima Habib MD

The fellow will spend one week on inpatient rehabilitation consults, one week on the rehab unit, and 2 weeks at Lucy Corr Village on the skilled nursing unit.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Identify and perform an accurate history and physical exam of patients with disabilities that need rehabilitation
- Prescribe basic adaptive equipment and gait aids for the older adult
- Formulate a rehabilitation program for common disabilities seen in older adults

Medical Knowledge

- Be able to discuss the basic principles of rehabilitation medicine as they apply to the older adult
- Access and critically evaluate current medical information and scientific evidence relevant to older patients with disabilities

Practice-Based Learning and Improvement

- Develop evidence-based strategies for filling gaps in personal knowledge and skills in the care of older patients that need rehabilitation to improve functional status
- Become familiar with the necessary work up needed prior to referral

Interpersonal and Communication Skills

- Develop skills in sensitive and effective communication with older patients with disabilities.

Professionalism

- Demonstrate respect and compassion in interactions with colleagues, patients, families and all members of the health care team.

Systems-Based Practice

- Practice cost-effective health care and resource allocation of older patients with disabilities
- Understand and utilize the multidisciplinary resources necessary to care optimally for older hospitalized patients that need rehabilitation

How Achieved & Supervision

- Fellows learn the principles of rehabilitation medicine during their Nursing Home rotation, working with the attendings and the therapist. Use of assistive devices is reviewed with attending and therapist

- Fellows learn about functional assessment and the Functional Independence Measure working with Occupational Therapists
- Fellows can also spend extra time with therapists during their elective time or NH administration month

Reading List

- Chapters from Geriatrics Review Syllabus: 15 Rehabilitation, 27 Gait impairment, 28 Falls
- Brummel Smith: Rehabilitation, from: Cassell, Geriatric Medicine, an evidence-based approach. 4th Ed. 2003 Springer

Longitudinal Nursing Home Rotation (Lucy Corr)

Attending Physicians: Arline Bohannon, MD & Saima Habib, MD

The longitudinal nursing home experience takes place at Lucy Corr Village. Each fellow will be assigned to a particular long term care unit and panel of patients. Together with the attending physician and nurse practitioner, geriatric fellows collaborate on providing longitudinal medical care to a panel of 10-15 long term care residents.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Use specialized skills required to effectively perform a physical examination and eliciting medical, social and functional history in the nursing home
- Effectively assess a patient or resident's decision making capacity and elicit advance care directives
- Practice medial decision making that incorporates the patient's values and preference to the fullest extent possible

Medical Knowledge

- Diagnose and manage patients with multiple medical problems and functional disabilities
- Administer and interpret standardized instruments assessing cognition, affect and gait in the longitudinal nursing home setting

Practice Based Learning and Improvement

- Diagnose and treat acutely and chronically ill frail elderly in an environment with fewer technological resources immediately available
- Design and implement quality improvement projects and understand how they may potentially impact the quality of care in nursing facilities

Interpersonal and Communication skills

- Work collegially and effectively with nurse practitioners and members of the interdisciplinary team

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team
- Demonstrate a commitment to the ethical principles pertaining to the provision or withholding of care, confidentiality of patients information, informed consent and business practices in the nursing home setting.

System Based Learning

- Demonstrate the skills needed to work effectively following the federal and state regulatory requirements for attending physicians in long term care.
- Understand the differences between nursing home and extended care provided in the Veterans Administration network versus facilities in the private and not for profit health care sectors

How Achieved & Supervision

- The attending will be identifiable for each patient care encounter. Nursing Home patients will be seen by, or discussed with, the attending at such frequency as to ensure that the course of treatment is effective and appropriate.
- Although decisions regarding diagnostic tests and therapeutics may be initiated by the fellow, these decisions will be reviewed with the attending at intervals in the context of patient care rounds.
- Fellows are required to notify the patient's attending, in a timely fashion independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient's course including unexpected death, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition.
- Attending or their designee are expected to be available and responsive, either by phone or pager, for fellow consultation, 24 hours a day for their term on service, their on-call day, on their specific patients.

Reading List

- Chapters from Geriatrics Review Syllabus: 3 Psychosocial Issues, 5 Financing, 6 Pharmacotherapy, 15 Nursing Home Care, 17-31 Geriatric Syndromes, 38-56 Common Geriatric Diseases, Disorders & Health Concerns
- http://www.virginiageriatrics.org
    - Quick consult falls, PEG tube, unrealistic expectations

Inpatient Geriatric Medicine Consult Service (VCUHS)

Attending Physicians: Sarah Hobgood MD, Peter Boling MD, Arline Bohannon MD, Kate Rackson MD, Brittany Craven MD

The inpatient geriatric medicine consult service rotation is a subspecialty consultation service. In general, geriatric medicine consultation is provided to mainly surgical patients but may include medical and inpatient psychiatric patients with multiple, complex chronic and acute illness. The fellow works closely with the attending physician in providing direct patient assessment and care, geriatric consultation and coordination of care. The fellow also works closely with pharmacy team that rounds daily with the team. The fellow also pre- rounds and supervises the interns, residents and medical students that round on the consult service.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Gather and synthesize essential and accurate information to define each patient's clinical problem(s)
- Acquire and refine skill of medical management of acute care patients
- Sharpen decision-making skills with respect to caring for patients with complex medical, surgical and cognitive problems
- Demonstrate expertise in completing Pre-operative Evaluation and Management
    - Understand and Implement Various Guidelines for Risk Stratification
    - ACC/AHA algorithm and guidelines for qualitative assessment
    - Revised Cardiac Risk Index (RCRI) for quantitative risk assessment
    - Diabetes management
    - Understand Nutritional Markers
- Demonstrate expertise in addressing goals of care:
    - Define advanced directives, Living Will, POA, Written Directives
- Establish Code Status
- Ideal Hospital Discharge

Medical Knowledge

- Evaluate and manage common geriatric syndromes and hospital hazards
- Delirium
    - Diagnosis including differentiating from dementia and depression (CAM vs. MMSE, mini-cog vs. GDS)
- Polypharmacy
    - Understand importance of med reconciliation
    - Identify and calculate physiologic influences to med dosing
    - Identify drug-drug and drug-disease interactions
    - Identify inappropriate medications in the elderly

- Basics of Pain Management in the Elderly
  - Recognize under and over treated pain in elders
  - Utilize verbal and nonverbal pain scales
  - Understand and recommend narcotic equivalent doses
  - Understand alternative routes of analgesia

  Deconditioning and Frailty
  - Identify frail elders and their capacity
  - Determine pre/post hospital functional status and implications
  - Appropriate destinations of discharge (home health, SNF, Rehab, Long Term Care)

Interpersonal and Communication Skills
- Work effectively with members of the interdisciplinary team
- Understand the role of a geriatric consultant
  - Understand and defining the consultative question
  - Understand difference between signing off vs. shadowing
  - Demonstrate sensitivity and responsiveness to the age, culture, gender and disabilities of patients and their caregivers

Practice Based Learning and Improvement
- Coordinate care and maintain continuity when patients are transferred between home, acute care hospital, and nursing homes

Professionalism
- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team

System Based Learning
- Understand the interface between acute medical units and subacute medical units, transitional care, and long term care facilities
- Coordinate care and maintain continuity between primary care clinicians

How Achieved & Supervision
- The geriatric consult attending will make clinical rounds with you, write and sign daily notes. Timing of rounds may vary but if there are clinical questions that are complex, please feel free to contact the attending prior to rounds. Teaching may be in the form of organized talks, walk rounds, or case-based discussions. Please bring questions to rounds!
- All new consults are discussed with the attending during rounds.

Logistics of the Consult Service

What is the Pager #?

7433 (Virtual) - Assigned daily 7am-5pm to fellow or resident or covering attending if no fellow or resident on service. After hours and weekends the pager should be rolled to the "medicine consult attending" or pager 1501.

Where is the list?

The list name is CN Geriatrics-FAS. The list does not automatically populate. Patients must be physically added and removed (when a patient's chart is open, go to the top toolbar in Cerner, click "Patient", then "Add patient to a patient list", and choose the CN Geriatrics-FAS list.

How do we receive consults?

Via a direct page to 7433 (the old fashioned way) and via the electronic order found in Cerner. If an electronic order is placed, the virtual pager will be notified with patient name and MRN between hours of 7am and 5pm. The full order can then be reviewed under "power orders" in Cerner for details of time ordered, requesting team, and reason for consult. The Cerner message center should be checked each morning and after weekends for new consults that come in after hours that were non-urgent and haven't been seen overnight. To set up your Cerner message center to receive electronic consults under the "proxies" tab:

- From message center, click on "proxies" tab to left-hand side
- Choose "manage"
- Click "received" at bottom left corner
- Click "add" at bottom right
- Search for "consultmd"
- Choose "ConsultMD, INT MED: Geriatrics (#7433)"
- Indicate dates you would like to receive notifications of electronic orders
- Choose "grant all" on right-hand side
- Choose "accept and next"

Who calls/pages us?

Anyone can request a geriatric consult. The highest utilizers of the service currently are trauma, ortho, and neurosurgery. Please note trauma has instituted an automated geriatric consult on every patient. At the end of this orientation document is the recommended triage flow for geriatric trauma consults given the high volume. In general for the surgical services, the consult service provides management for acute medical issues (CHF, AKI, etc), co-management of chronic conditions, and also helps identify and manage geriatric syndromes (delirium, polypharmacy etc). We also provide help with transitions of care and goals of care (recs for levels of care at discharge, places to go) and often will lead family meetings when discussing goals of care. Medicine teams may also ask for a consult; these usually focus more on geriatric syndromes, dementia, and goals of care. Social work and primary services occasionally call to see if we want to do "the SNF admission note" for a patient on any inpatient service that is usually followed by geriatric services for primary care or that now wants to be followed by geriatric services once they leave the hospital. If census and timing are feasible, the NH admission note can be done. If residents are asked to do these they will need considerable education as to what a NH admission note should include.

Who is on the team?

3rd year medicine residents work Monday through Saturday, rotating through every 2 weeks. Usually there is one resident on service at a time. At times there are PGY-1s. M3 students will also be on

service for 4 week blocks. As on all nonessential rotations, the residents have their own clinics one full day a week, a mini-clinic another portion of the day, and conference at 3:00pm Tuesdays. They also attend outpatient morning report at 7:15 am all days except Tuesdays (this is mandatory). Occasionally orthopedic interns rotate on service (5 times a year for a 2 week rotation). We have geriatric pharmacists rounding with us as well. Drs. Emily Peron and Kacie Powers split the time. They will page in the morning the 7433 pgr to find out what time we are rounding and if any pre-rounding work needs to be addressed.

What do we say and when?
Following or during attending rounds (depending on the urgency of recommendations or need to transfer service), recommendations will be conveyed to the primary team via the contact information obtained at the time of the consult request. Whenever possible, this communication should occur verbally. At a minimum, a recommendation to review written recommendations should be sent via to the primary team via text page, with a request to confirm receipt of the page. The daily verbal conveyance of recommendations to primary teams should also include a discussion of patient disposition. Specifically, the consults team should inquire about the discharge plan and any Medicine-related issues (appointments, medications (medication reconciliation, obtaining medications), patient education, etc.) with which the consults team can assist to ensure a comprehensive, safe discharge. Every effort to communicate with the primary team should be made by the Geri Consult Team. Documentation of the time of discussion or other communication with the primary team should be written in the consult or follow-up note. Every note should conclude with how to contact the geriatric consult team (pager 7433).

Who puts in orders?
The primary team, although page the attending to discuss if an urgent safety issue.

What happens at discharge?
Given the complexity and sometimes long length of stay and ultimate SNF placement, geriatric services has followed several of the geriatric consult patients out of the hospital. In these situations, the consult team will try and provide the nursing home admission note to help with smooth transitions etc.

Who covers us and how do we sign out?
Overnight coverage for urgent consults and acute issues is provided by the in house Medical Admitting Attending. Over the weekend the Medicine Consult Attending (rounding with the geriatrics resident on Saturday and the medicine consult resident Sunday) covers the geriatric consult service. On Friday afternoon the geriatric consult team reviews the list and determines which patients should be actively followed by the Medicine Consult team over the weekend. The residents provide sign out to one another. The attending sends an email sign out to the covering physician over the weekend (carrying pgr 1501). At times verbal sign out is given depending on preference of the covering attending. Given the variability of the services and the coverage demands of the Medicine Consult Attending, only those patients with active acute medical issues should be followed over the weekend (AKI, volume status issues etc). We are trying to limit this to 5 or less patients. We then have been getting sign out from the Medicine Attending at completion of the weekend. Sunday evening or Monday morning the Medicine Consult Attending will page the Geriatrics Consult Attending to discuss if patients should be

shifted from one list to another. For example, 83 yo seen Saturday night for pre-op risk assessment by med consult team now s/p OR with delirium will likely be shifted to geriatric consult team on Monday morning.

Helpful Contacts/Info:
Orthopedics - Kristin Koblunicky and Lindsay Brooks, NPs on Main 11
Orthopedics Intern pager for floor coverage -9920
Trauma - several NPs for floor, majority of patients located on 9C or C7
STICU is now 2 teams, TICU and SICU with different team members including attendings
Neurosurgery - Annette Smith, Alison Hamrick, NPs on 11 West

Triage Flow Diagram for Trauma Consults:
All patients 65 and older receive an automated consult during their admission. Given the variability in numbers of consults, I would recommend the following

- see anyone over 80 first then
- see anyone with documented delirium and or dementia
- then see any 65 or over on floor who is NOT being discharged that day or the next
- then see any 65 or older that are in STICU and not intubated
- then see STICU/intubated patients

Aside from medical co-management other areas to cover on all trauma patients include geriatric screening:

- frailty
- cognitive impairment
- functional assessment
- med reconciliation including which meds to hold while inpatient etc for acute and chronic disease states

Other helpful hints

Orthopedics (Base = M11E, phone 828-9146)

- When hip or spine fractures and other acute function-limiting illnesses occur, older patients need surgery promptly to reduce prolonged immobility and related complications. In such cases we rarely pursue a "cardiac work-up" for ischemic heart disease before surgery. Rationale: other than prophylactic medication (e.g. beta blockers), the only other intervention available is cardiac cath and angioplasty which delays surgery a minimum of 10 days (bare metal stent) and usually 6 weeks (drug-eluting stent) because of required anti-platelet therapy and bleeding issues. Such delays are more risky for the bedfast patient than correcting the original surgical problem. Sometimes, a quick echo helps if there's clinical evidence of valvular obstruction, severe pulmonary hypertension, or other lesion that may compromise the patient's hemodynamic status intra-operatively
- DVT prophylaxis- Orthopedic attending surgeons' individual preferences influence residents' choices. Some physicians use aspirin only (rare now), many prefer warfarin

over low molecular weight heparin (some concern of peri-op wound hematomas with LMWH), now also the addition of DOACs.

- Surgery ICUs
  - ICU teams run the ICUs, post-op patients undergo rapid changes that are unfamiliar to medicine docs, surgeons often test and manage based on experience with these changes, we sometimes have substantial differences of opinion about management, including diagnostic testing, abx (some surgery teams are very conservative), fluid management. If you feel your concern is very important, don't rely on notes in the chart to carry your point, speak with the Nurse Practitioner, senior resident, or fellow or we can seek attending-to-attending conversation
- Inter-service Transfers from Surgical Services to Medicine.
  - Interservice transfers are often requested: "there are no active surgical issues". This has been a point of contention for years, particularly in post-op patients. The decision to transfer should be based on the following: is there a specialized nursing need that is better met on a surgery unit, is there need for daily attention from the surgeons, and are the medical management issues complex and rapidly changing such that order-writing and frequent visits by the medicine team will improve care

Reading List

- Chapters from Geriatrics Review Syllabus: 13 Hospital Care, 27 Gait Impairment, 28 Falls, 30 Dementia, 31 Behavioral problems in Dementia, 32 Delirium, 33 Sleep problems, 41-59 Diseases and Disorders
- Marcantonio et al Reducing delirium after hip fracture: a randomized trial. JAGS 49:516-522, 2001
- Goldman et al. Ten commandments for Effective Consultations Arch Intern Med 143, 1983, 1753-1755
- Pre-operative evaluation guidelines: http://site.acsnsqip.org/wp-content/uploads/2011/12/ACS-NSQIP-AGS-Geriatric-2012-Guidelines.pdf
- TQIP guidelines: https://www.facs.org/~/media/files/quality%20programs/trauma/tqip/geriatric%20guide%20tqip.ashx
- Plus readings sent via email at beginning of the rotation

Longitudinal Ambulatory Care Clinic Rotation (VCUHS)

Attending Physicians: Kate Rackson, MD & Sarah Hobgood, MD

The longitudinal ambulatory care clinic rotation will give the geriatric medicine fellow a chance to provide primary care to geriatric patients from a diverse milieu of cultural, economic and social background in a collaborative practice in VA setting and University Based clinic.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Demonstrate skill in evaluating and analyzing medical, functional and social issues in a heterogeneous population of community dwelling older adults
- Devise effective patient-centered strategies that comprehensively evaluate and manage the medical, functional and social issues in the outpatient setting
- Work together with the patient in developing appropriate evidence-based and individualized approaches to health care maintenance and cancer screening

Medical Knowledge

- Diagnose, manage and learn the special needs of outpatient geriatric patients with multiple medical, social and functional problems
- Appropriately and selectively administer/interpret standardized instruments assessing cognition, affect and gait

Practice Based Learning and Improvement

- Utilize diagnostic, preventative and restorative interventions so as to preserve the health and functional status of the community dwelling older adult.
- Identify community resources useful to enhance the quality of life of patients and families
- Practice medical decision making that incorporates the patient's values and preferences to fullest extent possible

Interpersonal and Communication Skills

- Effectively interface with other health care providers and ancillary services to serve as the geriatric patients' ultimate patient advocate

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team

System Based Practice

- Understand how an outpatient practice at VCUH differs from the VAMC practice
- Practice cost-effective outpatient care that does not compromise quality of care

- Coordinate the actions of multiple health professionals; including physicians, nurses, social workers, pharmacists, dietitians and rehabilitation experts to improve health care
- Demonstrate knowledge of the funding sources for outpatient care for older patients and how geriatricians interact with third party payers, including managed care organizations

Supervision

- Supervision of medical students
  - Medical students are students and are neither licensed physicians nor resident physician trainees.
  - Medical student notes are not acceptable in lieu of a fellow's note. The fellow needs to write his/her own separate note.
  - The supervising practitioner or attending is ultimately responsible for the evaluation and management of the patient and for the supervision of all trainees assigned to work with him/her. While some of the day-to-day supervision of medical students may be delegated to fellows, the attending retains medical-legal responsibility for the patient's care.
- Supervision of fellows
  - All patients are presented to the supervising attending. If the patient was seen and/or discussed with the attending, the fellows should state that at the end of the note.

Reading List

- Chapters from Geriatrics Review Syllabus
  - Demography
  - Biology
  - Psychosocial issues
  - Financing
  - Assessment
  - Cultural Aspects
  - Physical Activity
  - Prevention
  - Pharmacotherapy
  - Complementary Medicine
  - Elder Mistreatment
  - Perioperative Care
  - Geriatric Syndromes

https://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-Medication-Reconciliation.pdf AMA the physicians role in medication reconciliation

Falls recommendation Guide from AGS

- UpToDate

Geriatric Outpatient Faculty Practice (VCUHS)

Attending Physicians: Peter Boling MD, Saima Habib MD, Sarah Hobgood MD

The geriatric outpatient faculty practice rotation will give the geriatric medicine fellow a chance to work with multiple physicians providing both outpatient consultation on common geriatric syndromes including frailty, dementia, and polypharmacy as well as providing primary care to a large diverse patient panel in a high volume busy practice.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Demonstrate skill in evaluating and analyzing medical, functional and social issues in a heterogeneous population of community dwelling older adults
- Devise effective patient-centered strategies that comprehensively evaluate and manage the medical, functional and social issues in the outpatient setting
- Work together with the patient in developing appropriate evidence-based and individualized approaches to health care maintenance and cancer screening

Medical Knowledge

- Diagnose, manage and learn the special needs of outpatient geriatric patients with multiple medical, social and functional problems
- Appropriately and selectively administer/interpret standardized instruments assessing cognition, affect and gait

Practice Based Learning and Improvement

- Utilize diagnostic, preventative and restorative interventions so as to preserve the health and functional status of the community dwelling older adult.
- Identify community resources useful to enhance the quality of life of patients and families
- Practice medical decision making that incorporates the patient's values and preferences to fullest extent possible

Interpersonal and Communication Skills

- Effectively interface with other health care providers and ancillary services to serve as the geriatric patients' ultimate patient advocate

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team

System Based Practice

- Understand how an role of outpatient consultation differs from that of PCP

- Practice cost-effective outpatient care that does not compromise quality of care
- Coordinate the actions of multiple health professionals to improve health care
- Demonstrate knowledge of the funding sources for outpatient care for older patients and how geriatricians interact with third party payers, including managed care organizations

Supervision

- Supervision of medical students
  - Medical students are students and are neither licensed physicians nor resident physician trainees.
  - Medical student notes are not acceptable in lieu of a fellow's note. The fellow needs to write his/her own separate note.
  - The supervising practitioner or attending is ultimately responsible for the evaluation and management of the patient and for the supervision of all trainees assigned to work with him/her. While some of the day-to-day supervision of medical students may be delegated to fellows, the attending retains medical-legal responsibility for the patient's care.
- Supervision of fellows
  - All patients are presented to the supervising attending. If the patient was seen and/or discussed with the attending, the fellows should state that at the end of the note.

Reading List

- Chapters from Geriatrics Review Syllabus
  - Demography
  - Biology
  - Psychosocial issues
  - Financing
  - Assessment
  - Cultural Aspects
  - Physical Activity
  - Prevention
  - Pharmacotherapy
  - Complementary Medicine
  - Elder Mistreatment
  - Perioperative Care
  - Geriatric Syndromes
- http://www.virginiageriatrics.org
  - Quick Consult: Falls, Medications to avoid, Placement problems, urinary incontinence
- UpToDate
- https://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-Medication-Reconciliation.pdf
- AGS guidelines on Falls Prevention

House Calls/Nursing Home Elective (VCUHS)

Attendings: Housecalls- Linda Abbey, Amy Paul
Nursing Home- Adedayo Fashoyin, Saima Habib, Arline Bohannon,

The House Calls and Nursing Home Elective will allow the geriatric medicine fellow to take a deeper dive into alternate sites of practice. Based on the fellows preference they may split the elective how they choose. Working closely with attendings specializing in these areas of care, the fellows will gain insight and expertise in how best to take care of these vulnerable and unique populations.

Learning Objectives by Competency

At the end of the rotations the fellow will be competent with the following:

Patient Care

- Use specialized skills required to effectively perform a physical examination and eliciting medical, social and functional history in the nursing home
- Effectively assess a patient or resident's decision making capacity and elicit advance care directives
- Practice medial decision making that incorporates the patient's values and preference to the fullest extent possible
- Demonstrate expertise in managing frail, homebound older patients in the home setting with limited technology
- Devise effective patient-centered strategies that comprehensively evaluate and manage the medical, functional and social issues in the home setting

Medical Knowledge

- Diagnose and manage patients with multiple medical problems and functional disabilities
- Administer and interpret standardized instruments assessing cognition, affect and gait in the longitudinal nursing home setting
- Diagnose, manage the special needs of homebound patients with multiple medical, social and functional problems
- Appropriately and selectively administer/interpret standardized instruments assessing cognition, affect and gait

Practice Based Learning and Improvement

- Diagnose and treat acutely and chronically ill frail elderly in an environment with fewer technological resources immediately available
- Design and implement quality improvement projects and understand how they may potentially impact the quality of care in nursing facilities

Interpersonal and Communication skills

- Work collegially and effectively with nurse practitioners and members of the interdisciplinary team

Professionalism

- Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the interdisciplinary team
- Demonstrate a commitment to the ethical principles pertaining to the provision or withholding of care, confidentiality of patients information, informed consent and business practices in the nursing home setting.

System Based Learning

- Demonstrate the skills needed to work effectively following the federal and state regulatory requirements for attending physicians in long term care.
- Understand the differences between nursing home and extended care provided in the Veterans Administration network versus facilities in the private and not for profit health care sectors

How Achieved & Supervision

- The attending will be identifiable for each patient care encounter. Nursing Home or housecalls c patients will be seen by, or discussed with, the attending at such frequency as to ensure that the course of treatment is effective and appropriate.
- Although decisions regarding diagnostic tests and therapeutics may be initiated by the fellow, these decisions will be reviewed with the attending at intervals in the context of patient care rounds.
- Fellows are required to notify the patient's attending, in a timely fashion independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient's course including unexpected death, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition.
- Attending or their designee are expected to be available and responsive, either by phone or pager, for fellow consultation, 24 hours a day for their term on service, their on-call day, on their specific patients.

Reading List

- Chapters from Geriatrics Review Syllabus: 3 Psychosocial Issues, 5 Financing, 6 Pharmacotherapy, 15 Nursing Home Care, 17-31 Geriatric Syndromes, 38-56 Common Geriatric Diseases, Disorders & Health Concerns
- http://www.virginiageriatrics.org
    - Quick consult falls, PEG tube, unrealistic expectations