

Goals and Objectives

ACUTE CARE ROTATION FOR GERIATRICS FELLOWS

I. EDUCATIONAL PURPOSE

It is essential that fellowship-trained geriatricians learn how to properly provide medical care for hospitalized elders, and that they develop knowledge and skills in acute-care geriatrics beyond those of competent internists and family practitioners. The educational purposes of this two-month experience are: (a) to refine the fellows' knowledge of common problems leading to hospitalization (see "Mix of Diseases" below); (b) to learn and demonstrate a systematic approach to minimizing iatrogenic injury and in-hospital functional decline; (c) to become adept at and comfortable with collaborative decision making and prognostication, particularly as patients reach the end of life; and (d) to learn and demonstrate techniques of superb transitional care.

II. TEACHING METHODS

Fellows receive instruction in a variety of formats. Scheduled one-hour didactic lectures are given on Acute Care of Elders and Transitional Care. In addition, shorter didactic talks (20 to 60 minutes) are provided most days during attending rounds. These prepared talks cover topics that routinely arise on the inpatient service: strokes and post-stroke rehabilitation, aspiration pneumonia, anticoagulation, malnutrition, etc. Additional bedside teaching is provided daily by the attending geriatrician during work rounds. Fellows on the inpatient service also receive instruction when they are given real-time feedback during work rounds, or after leading a family conference.

III. MIX OF DISEASES

Common conditions precipitating hospital admission include pneumonia, delirium, stroke, myocardial infarction, urinary tract infection and urosepsis, geriatric "failure to thrive," COPD exacerbation, heart failure, and gastrointestinal bleeding. These acute problems typically occur on a background of chronic conditions, including diabetes mellitus, dementia, Parkinson's disease, hypertension, urinary incontinence, arthritis, and others. The UNMC Geriatrics inpatient team also serves as consultants for patients from the faculty practice who are admitted to surgical services, such as those who suffer hip fractures, those who require joint replacement, and those needing urologic procedures.

IV. PATIENT CHARACTERISTICS

Patients on the geriatrics inpatient service are those who are otherwise followed in the UNMC Geriatrics faculty practice. The panel comprises both community-dwelling elders and residents of assisted living facilities or nursing homes. The typical patient is a woman in her 70s, 80s, or 90s, but the patient panel includes a number of younger individuals (who are typically nursing home residents with serious and chronic neurologic or psychiatric disease). The ethnic, cultural, and socioeconomic mix represents the broader Omaha population of elders.

V. TYPES OF CLINICAL ENCOUNTERS

Most patients admitted to the inpatient geriatrics service are initially encountered in the Emergency Department, where the geriatrics fellow performs an admission history and physical examination, and writes admission orders. Fellows also follow their patients daily in the hospital, and handle calls from Nursing and other disciplines. At least once during their rotation, fellows are encouraged to make a supervised visit to the home of a patient they cared for earlier in hospital.

In addition to serving as inpatient primary physicians, geriatrics fellows provide geriatric consultation to patients on other – usually surgical – services. The Geriatrics team is usually asked to assist with either preoperative assessment and perioperative management, or “co-management” of geriatric medical problems.

Geriatrics fellows on the inpatient service operate under the same capping requirements as residents in internal medicine: The fellow will not be assigned more than five new patients on an admitting day, nor more than 8 new patients in a 48-hour period; the fellow will not be responsible for the ongoing care of more than 12 patients; and when supervising residents on the team, the fellow will not be responsible for more than 10 new patients per admitting day or more than 16 new patients in a 48-hour period. Fellows on the inpatient service share admitting responsibilities with an internal medicine resident. Historically, the cap has not been an issue, but should the issue arise, the hospital attending for the day on the geriatric medicine service would assume responsibility for all admissions that exceed the mandated cap during the work day (8:00am-5:00pm). It is the policy of Internal Medicine that after 5:00pm, the geriatric inpatient service admitting responsibilities are assumed by the internal medicine night call team.

VI. PROCEDURES AND SERVICES

On occasion the geriatric fellow will perform procedures for their patients. These procedures are those typically performed by hospitalists or housestaff, such as thoracentesis, paracentesis, lumbar puncture, etc.

UNMC is a full-service, tertiary care medical center, with the expected range of services: radiology (including interventional radiology), diagnostic laboratory, cardiology (including echocardiography and cardiac catheterization capabilities), various surgical services, and rehabilitation disciplines (physical therapy, occupational therapy, and speech pathology).

VII. EDUCATIONAL RESOURCES

In addition to the formal didactic instruction described above, fellows have access to a number of web-based self-instruction materials, laminated reminder cards (“Pearl Cards”), and videotaped lectures. Attending geriatricians also provide numerous handouts (review articles, pertinent recent research papers, and educational summaries) to fellows on subjects that arise in the care of their hospitalized patients. Fellows are also directed to relevant passages in the American Geriatrics Society’s *Geriatrics Review Syllabus* or in chapters of major geriatric medicine textbooks.

VIII. METHOD OF EVALUATION OF FELLOWS’ COMPETENCE

Fellows’ competence is assessed by supervising attending geriatricians in the following manner: (a) Observation of the fellows’ performance of history-and-physical examinations, particularly during admissions from the emergency room and during work rounds; (b) Review of fellows’ medical orders; (c) Critique of fellows’ findings, impressions, and plans during work rounds; and (d) Observation of fellows’ behavior and communication skills during interactions with patients, families, and other staff. In addition, the geriatrics program solicits input from more junior members of the inpatient team (internal medicine house staff) on the competence and professionalism of the geriatrics fellows.

The attending geriatrician’s evaluations are documented in written form, and are reviewed at a quarterly faculty meeting, before being shared with the fellows.

IX. TEACHING PERFORMED BY FELLOWS

It is expected that geriatrics fellows on the inpatient rotation not only provide geriatric clinical care, but serve as teachers and role models for more junior members of the team. Fellows are expected to deliver at least one brief didactic talk on a subject of interest, and to actively participate in bedside teaching during work rounds. Fellows also serve as senior consultants to the house staff and students on the team. A particularly important role for fellows on the service is to assure that the team maintains its focus on essential, systematic geriatric issues (preventing injury and functional decline, nutrition, transitional care), while still addressing the individual medical problems of each patient.

The teaching provided by fellows is observed by the attending geriatricians and critiqued. Additional feedback is solicited from house staff and students on the team.

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GERIATRICS FELLOWS ON THE ACUTE SERVICE

FOUR DOMAINS OF CONCENTRATION

Prevention of in-hospital injury and functional decline
Skillful transitional care
Prognostication, goal-setting, making end-of-life decisions
Expert management of common diagnoses prompting admission (below)

COMMON DIAGNOSES TO MASTER

Heart failure
Acute coronary syndromes and AMI
Stroke
Pneumonia
DVT and thromboembolism
Hip fracture
Delirium
Fall evaluation
Failure to thrive, functional collapse

STEP-UP IN RESPONSIBILITY

Month 1: Get comfortable with the inpatient service
Month 2: Assume leadership for attending rounds

DAY-TO-DAY ON THE INPATIENT SERVICE

Role-model outstanding geriatric acute care of own patients
Monitor systemic geriatric issues on **all** patients on service, and speak up
Teach, formally and informally

ORAL PRESENTATIONS: BE A ROLE MODEL

New admissions

CC/HPI: emphasize functional effects of acute illness
PMH: include functional diagnoses
MEDS: include the method used to manage regimen at home
SH: function at baseline, who patient lives with, surrogates, code
PE: appearance, mental status, and mobility

Daily work rounds

Events: include eating, elimination, mobility, functional progress
PE: to include attachments
A/P: to include transitional care considerations