

**University of Michigan Health System
Internal Medicine Residency**

**Subacute Care Evaluation and Management Curriculum:
Geriatric Evaluation and Management Unit, Community Living Center**

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Rotation Goals and Educational Purpose

Internists must provide medical care for complex geriatric patients. As our population ages, internists are increasingly asked to respond to the special clinical needs of the older adult. During this rotation, residents will be introduced to the care and management of the frail older adult outside of the acute care or clinic settings. Faculty geriatricians will assist residents in understanding the aging process as it influences health and quality of life. The rotation provides experience in caring for both chronic biomedical and psychosocial conditions that pose a threat to the function, well-being, and independence of the older adult.

This rotation is mandatory for residents with a minimum one-half month assignment during HO 2/3.

Rotation Competency Objectives

In supplement to the University of Michigan Longitudinal Learning Objectives, the following provide an overview of the knowledge, skills, and behaviors promoted in this rotation.

- I.** Patient Care and Medical Knowledge
 - a. Core Knowledge – By completion of the rotation, residents should
 - i. Understand normal changes of aging.
 - ii. Reflect awareness of common clinical measures of physical, cognitive and psychosocial functioning.
 - iii. Describe assessment methods and treatments for common geriatric clinical syndromes – incontinence; falls, gait and balance problems; behavioral disturbances; immobility and pressure ulcers; memory loss and dementia; delirium; alteration of hearing and vision.
 - iv. Reflect knowledge of wound healing in the older adult, how to describe a wound, and how to select a treatment (e.g. debridement approach if needed and, dressing type).
 - v. Describe and recognize principles of medication prescribing for elderly patients with common medical disorders (e.g. heart failure, osteoporosis, stroke, Parkinson's disease, osteoarthritis, and kidney failure.)
 - vi. Reflect knowledge of common infections and infection control policies for residential geriatric facilities.

- vii. Describe assessment methods for psychosocial challenges seen in aging – changes of location and type of residence; elder abuse and neglect; depression and suicidal ideation; home safety; changes of sexuality; and substance abuse.
 - viii. Understand indications and eligibility guidelines for hospice care.
 - ix. Demonstrate knowledge of patient autonomy principles and shared decision making, including: determination of decision-making capacity, informed consent, advance directives, and other bioethical principles affecting end-of-life decisions.
- b. History, Physical Examination, and Medical Management
- i. Perform a patient-centered medical interview and physical, gathering data from multiple sources as necessary for assessment of functional status and focused care needs.
 - ii. Perform a comprehensive geriatric assessment including objective functional and cognitive assessment.
 - iii. Write an appropriately focused geriatric subacute care note, including relevant psychosocial needs and goal setting.
 - iv. Develop, prioritize, and justify differential diagnoses for frail elderly patients in the subacute care setting.
 - v. Under supervision, construct an appropriate post-discharge geriatric care plan for the common geriatric clinical syndromes noted above.
 - vi. Under supervision, provide symptomatic treatment of pain and distressing non-pain symptoms (e.g. dyspnea, nausea, and fatigue) consistent with patient-centered goals.
- c. Procedures
- i. Place urinary catheters when medically indicated.
 - ii. Under supervision, provide basic wound care.
 - iii. Administer and interpret a validated screening tool for dementia and for depression.

II. Interpersonal and Communication Skills

- a. Establish rapport with elderly patients and their families or surrogates, using patient-centered communication to enhance the physician-patient relationship.
- b. Adapt history-taking skills to the mental status, demeanor, and psychosocial presentation of the patient and family.
- c. Engage patients and their families or advocates in shared decision-making, utilizing family group discussions as needed; under supervision, determine decision-making capacity and engage in discussion regarding advance care directives.
- d. Under supervision, successfully negotiate appropriate communication for most “difficult” encounters, such as the despondent or confused patient or family.
- e. Effectively and considerately communicate with other healthcare professionals to promote care coordination (e.g. interdisciplinary team members during CLC stay, and hospital-based providers when transferring a patient requiring re-hospitalization).
- f. Generate written documentation that clearly articulates principles of geriatric assessment such as obtaining/providing information on acute events necessitating transfer; baseline medical history, medications, cognitive and functional status, advance directives; plan of care; and follow-up needed.

- g. When functioning as a consultant, communicate with referring physicians in a manner that supports the primary care relationship.

III. Professionalism

- a. Understand and compassionately respond to issues of culture, age, sex, sexual orientation, and disability for all elderly patients and their families.
- b. Recognize the importance of psychological and spiritual support for elderly patients and their families.
- c. Reflect awareness of common ethical issues related to end of life care facing elderly patients, their families and caregivers.
- d. Sensitively respond to patient and family questions and decisions regarding advance directives, DNR status, futility, and withholding/withdrawing therapy.

IV. Practice-Based Learning and Improvement

- a. Exhibit self-directed learning through patient-centered learning and independent use of recommended resources.
- b. Use information technology to access and retrieve materials for self-education.
- c. Utilize clinical practice guidelines and current literature to generate appropriate geriatric and palliative care plans.
- d. Demonstrate improvement in clinical management of elderly patients by continually improving knowledge and skills during the rotation.

V. Systems-Based Practice

- a. Demonstrate understanding of the spectrum of care delivery systems available to the frail older adult, including residential facilities and home care resources.
- b. Coordinate bio-psychosocial care within multidisciplinary teams and during interdisciplinary care rounds, with team care participants including nurse, social worker, physical and occupational therapists, clinical pharmacist, dietician, recreation therapist, dentist, chaplain, psychologist and other providers.
- c. Coordinate transitions of care between inpatient and outpatient settings, maximizing quality of care and cost effectiveness by identifying and utilizing appropriate non-hospital care services.

Teaching Methods

- I.** Supervised Patient Care - The emphasis of this rotation is on experiential learning through supervised management of frail elderly patients who require subacute care inpatient services. Patient care experiences derive from the Community Living Center of the Ann Arbor Veterans Administration hospital. Geriatrician faculty lead patient-centered, case-based discussions for each patient. Residents perform initial evaluations and daily follow-up care under the supervision of a faculty geriatrician. Residents interact with referring physicians, nurses, geriatric medicine fellows, rehabilitation specialists, clinical pharmacists, chaplains and social workers while providing patient care; residents should consider all such interactions as opportunities for education. Patients present from the Veterans Administration Hospital and referral center sites.

II. Structured Didactics and Small Group Learning

- a. Geriatrics Clinical Conference – Mandatory for all rotating HO2/3 residents, weekly at noon on Tuesdays. Conference occurs at the East Ann Arbor Geriatrics Center conference room.
- b. Interdisciplinary rounds – Mandatory. Monday and Thursday afternoons at 1:15 PM. These patient-based team conferences include diverse collaborative clinical professionals. Participants include nursing, social work, physical and occupational therapists, neuropsychiatric care specialists, pharmacists, dieticians, dental professionals, and recreational therapists.
- c. Orientation to Physical Therapy – Mandatory. When scheduled during the first week.
- d. Geriatrics Chief's Rounds – Mandatory. 2nd Thursday at 9:30 AM with the attending of the month.
- e. Extended care management discussions – Afternoons, as scheduled by the attending. Topics can include palliative care, PM&R, and Medicare/Medicaid.
- f. Residents are expected to participate in multidisciplinary family meetings for their patients unless they have an irreconcilable conflict.
- g. Mandatory core residency noon conferences, Grand Rounds, VA Medical Service morning report, and continuity clinic continue throughout this rotation.

III. Special projects - Residents interested in formulating a clinical review, brief report, or other manuscript intended for submission for publication should contact the supervising attending or a Subspecialty Educational Coordinator (as above) ASAP during the rotation.

IV. Independent study and suggested resources

- a. Textbooks and manuals, available through the Taubman Medical Library
 - i. Hazzard's Geriatric Medicine and Gerontology. William R. Hazzard et. al, eds. New York: McGraw-Hill Professional, latest edition. [Note in particular the chapter on subacute care.]
 - ii. Geriatrics Review Syllabus: a core curriculum in geriatric medicine. Peter Pacala et al, eds. New York: American Geriatrics Society, latest edition. Access available at: <http://www.lib.umich.edu/hsl/resources/medicine/>
 - iii. Principles of Geriatric Medicine. Reubin Andres et al, eds. New York: McGraw-Hill, latest edition
- b. Clinical practice guidelines
 - i. American Geriatrics Society educational products: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_programs_products/
 - ii. University of Michigan Clinical Care Guidelines on osteoporosis, depression, and multiple chronic conditions are available at: <http://www.med.umich.edu/i/oca/practiceguides/>
 - iii. The Society for Healthcare Epidemiology of America (SHEA) guideline on Infection Prevention and Control in the Long-Term Care Facility is available at: <http://www.journals.uchicago.edu/doi/pdf/10.1086/592416>
 - iv. Another SHEA guideline regarding clostridium difficile in long term care are available at: http://www.shea-online.org/Assets/files/position_papers/SHEA_Cdiff.pdf

- c. General websites
 - i. The University of Michigan Geriatrics Center online education site has numerous assessment tools, learning resources, and clinical content summaries:
http://www.med.umich.edu/i/geriatrics_center/UMGeriatricsCare/index.htm
 - ii. American Geriatrics Society: <http://www.americangeriatrics.org/>
- d. Core clinical journals (free access available through the Taubman Medical Library)
 - i. Journal of the American Geriatrics Society
 - ii. Clinical Geriatrics
 - iii. Annals of Long Term Care
- e. Other online resources
 - i. Society of General Internal Medicine core geriatric modules (including falls, memory assessment, and urinary incontinence):
http://www.sгим.org/impak/members_online/members/login.asp?non=Y&tp=cmeexam/start.asp¶m=
 - ii. US Veterans Administration and Summit, Stanford University Medical School overview of End of Life Care: <http://endoflife.stanford.edu/>
 - iii. The University of Maryland School of Medicine hosts an online course for medical residents in End-of-Life and Palliative Care. Access the curriculum by registering at: <http://134.192.120.12/canRes/htdocs/login.asp>
 - iv. Death and dying is approached in a thought-provoking documentary produced by Bailey Barash, a freelance television producer and journalist. The video, “203 Days” chronicles the death of Sarah, age 89. The video demonstrates roles of hospice providers and family in Sarah’s care, and highlights common end-of-life care decisions. Consider the associated discussion questions on the website before and after viewing the 27 minute long video (which can be started and stopped as needed.) <http://fitsweb.uchc.edu/Days/days.html>
 - v. Residents are encouraged to access the most recent versions of the Johns Hopkins Internet Learning Center geriatrics modules, available using the ambulatory care login and selecting “Internal Medicine Curriculum.” On the home page, link to the “Available Modules”: <http://www.hopkinsilc.org/> Recommended modules include: Dementia; Home visits: community resources; Home visits: elder abuse; Home visits: Medicare; Osteoporosis; Palliative Care.

Evaluation Methods

Formative face-to-face feedback to residents by attending geriatricians occurs at rotation completion. For each half-month, attending geriatricians complete online competency-based evaluations of each resident. The evaluation is shared with the resident, is available for on-line review by the resident at his/her convenience, and is sent to the residency office for internal review. The evaluation is part of the resident file and is incorporated into semiannual performance reviews for directed resident feedback. Residents also complete a service evaluation of the rotation faculty monthly.

Rotation Schedule

First day protocol: Report to the physician work area in the Community Living Center of the Ann Arbor VA by 8 AM for orientation by Dr. Hogikyan or designee. If the first day of the rotation is on a weekend or holiday, report by 8:30 am.

Call duty: Beeper call from home Q 3 days, with indirect faculty supervision.

Continuity Clinic: General medicine continuity clinic continues during this rotation. Discuss your continuity clinic schedule with your attending and Dr. Hogikyan.

VA Subacute Care Evaluation and Management Service Schedule
Geriatric Evaluation and Management, Community Living Center

	Monday	Tuesday	Wednesday	Thursday	Friday	Sa/Sun
AM	8 AM work rounds 9 AM patient care 10:30 Morning Report	8 AM work rounds 9 AM patient care 10:30 Morning Report	8 AM work rounds 1 st Wednesday only: 8:30 AM orientation to PT 9 AM patient care 10:30 Morning Report	8 AM work rounds 9 AM patient care 2 nd Thursday only: 9:30 AM Chief's Rounds 10:30 Morning Report	8 AM work rounds 9 AM patient care 10:30 Morning Report	Patient Care and integrated faculty rounds
PM	12:00 Noon Conference 1:15 Interdisciplinary Rounds	12:00 Noon Geriatrics Clinical Conference (EAA Geriatrics Center) OR 12:00 Noon Conference 1:00 Attending Rounds	12:00 Noon Conference 1:00 Attending Rounds	 1:15 Interdisciplinary Rounds	12:00 Internal Medicine Grand Rounds 1:00 Attending Rounds	