Hello, and welcome to your Inpatient Geriatrics Rotation!

Prior to your rotation, please review this document and be familiar with the required readings posted on the Internal Medicine Residency Geriatrics & Palliative Care Website (updated July 1, 2015).

In this rotation we hope you will learn a comprehensive approach to caring for elderly adults in the inpatient setting while appreciating the myriad of dangers elderly adults face when hospitalized. Patient assessments and plans of care will focus on core geriatric syndromes (Addendum A) and utilize concepts central to geriatric care: functional status assessment, prognostication, iatrogenesis reduction, care coordination, and transitions of care.

Goals and Objectives:
We hope to convey the following principles by the end of the rotation:

- Coordination of care helps reduce hospital length of stay, improves outcomes, and increases satisfaction; coordination of care occurs between generalist and specialist MDs, both inside and outside of the hospital, as well as with other services such as Case Management, PT/OT, pharmacy, and outpatient providers. Communication with the patient and family is essential.
- Daily medication review helps reduce iatrogenesis. Medication reconciliation on admission is imperative!
- An important role of the geriatric team is to advocate for older adults by magnifying their needs to their team, the nursing staff, and the broader healthcare system through constant reinforcement and reevaluation of goals of care.
- Preserving functional independence and minimizing function loss are major goals of geriatric care. Recognize that confusion, sensory loss, depression, fear, and instability contribute to loss of function.

Expectations:

- Evaluation of all new consults should include the following at a minimum:
  - Baseline functional assessment (report of IADLs and ADLs), Medication review, Geriatric ROS, Cognitive assessment (MiniCog, MMSE, or MOCA), Delirium assessment (CAM), Presence or absence of advanced directives, Identification of key family members or other decision makers and outpatient providers, Review of outpatient provider records (when available)
  - See Addendum B for additional details on performing an initial geriatric assessment
  - Record the date of consult, consulting team and attending, indication for consult, date of discharge, and discharge destination on the Geriatric Consult Log in the Palliative Care Office on 5 South.
- All consults are welcome!
  - Provide a comprehensive assessment and complete medical support to non-medical subspecialties. Partnerships with orthopedics and trauma are based on GWUH relationships or protocols.
    - Consults on surgical patients generally include management of primary medical problems and assistance with discharge planning in addition to classic geriatric concerns.
  - Provide a comprehensive assessment and support specific questions for medical services.
    - In general, we avoid commenting on “medical” problems (atrial fibrillation, gi bleeding, gerd), but may do so if there is an opportunity to teach geriatric physiology or if goals of care are addressed (ex: anticoagulation and recurrent falls).
  - Provide continuity of care for the frail elders who are part of the MFA Geriatrics and Internal Medicine communities.
    - Communication with outpatient providers on admission and discharge is critical.
  - Geriatricians follow patients through to the end of their life. As such, palliation of symptoms and decisions about goals of care, including cessation of life prolonging therapies are frequent consults.
- Recommendations should be discussed by phone or in person with the primary teams on a daily basis.
- Consults should be evaluated on the day of request and the attending geriatrician should be notified immediately of any urgent consults (such as pertaining to goals of care in a critically ill patient).
- All patients are welcomed as learning opportunities. Smooth hospital stays are as important to reflect upon as ones with less desirable outcomes!
Consultation Etiquette

1. We write notes daily, unless a “blank note” is recommended by the attending physician.
2. A “blank note” provides a 1-2 line summary of the patient, the indication for the consult, any pertinent updates, and any key changes in the plan.
3. Recommendations should be discussed by phone or in person with the primary team on a daily basis.
4. Addendum C provides a summary of two great references on consultation etiquette.

By the end of the rotation you should be able to:

1. Identify characteristics of elderly patients that differentiate their health care needs from younger adults.
2. Identify disease presentations that deviate from common patterns seen in younger adults.
3. Identify that disease specific management goals may differ for the elderly, for example A1C in diabetes.
4. Develop a customized care plan according to patient preferences and overall health and functional status.
5. Develop a differential diagnosis, work up, and management plan for common geriatric syndromes including but not limited to falls, memory impairment, dementia, delirium, gait instability, anorexia/failure to thrive, behavioral changes, and fatigue.
6. Identify and manage poly-pharmacy.
7. Identify when medications should be dosed specifically for the elderly, with specific reference to medications for pain, sleep, and agitation.
8. Manage the perioperative geriatric patient on the floor and in critical care settings to prevent common complications.
9. Recognize nutritional needs of an individual patient based on swallowing ability, extent of functional dependence, and other limitations such as diabetes, renal disease, drug-diet interactions etc.
10. Communicate effectively with other members of the interdisciplinary team.
11. Communicate with patients and family members to establish goals of care and advance care plans.
12. Learn to engage patients/surrogates in shared decision-making for difficult, ambiguous, or controversial situations.
13. Learn to act as a liaison between the health care team and patient/family members during care transitions.
14. Identify the appropriate level of care for a patient upon discharge based on their functionality.
15. Identify eligibility criteria for hospice services.
16. Identify common community resources for older adults including but not limited to geriatrics case managers, elder care attorneys, home health companies, home health aides, therapists, hospice nurses, community hospice inpatient units etc and how to connect patients with these resources.

Resources:

1. Required Reading: Links to core geriatrics literature are posted on the geriatrics rotation website hosted by Himmelfarb Library, accessible through the GW Internal Medicine Residency Website or directly at [http://libguides.gwumc.edu/geriatrics](http://libguides.gwumc.edu/geriatrics). Hardcopies are also available in the Palliative Care Office on 5 South. **Please review required literature prior to starting your geriatric consult rotation.**
2. Additional core geriatrics literature and online references have been identified and are available through the library website at [http://libguides.gwumc.edu/geriatrics](http://libguides.gwumc.edu/geriatrics). Many of these articles and resources can be accessed in hard copy in a binder located in the Palliative Care Office as well.
3. Geriatrics at your Fingertips aka the “Blue Book” – available for borrow anytime, located in the Palliative Care Office.
4. The DC Department on Aging provides links to helpful resources for seniors in DC: [http://dcoa.dc.gov/](http://dcoa.dc.gov/)
ADDENDUM A: Frequently Encountered Geriatric Conditions in the Inpatient Setting

Resources guiding the evaluation of each of these syndromes are available on the Inpatient Geriatrics Curriculum Website.

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ADDENDUM B: Recommendations for performing an Initial Geriatrics Consult
House-staff should focus on assessing the following, all of which help to formulate a sense of the patient’s functional ability and level of care. This information will also help with formulating prognosis and assisting with care plan development and care transitions. All referenced tools are linked on the Geriatric Curriculum Website.

- Assess functional capacity... At admission and globally over last six months:
  - Have they been in and out of skilled nursing facilities? Living independently in community?
  - Read the PT and OT notes!
  - Document independence or dependence in ADLs, IADLs using the Katz Index
- Assess fall risk, any recent falls and use of adaptive devices
  - Consider using the AGS Geriatric E&M Falls Assessment
- Assess mood; Consider geriatric dementia screens, PHQ-2 or PHQ-9; assess agitation
- Perform cognition assessment: Consider dementia vs delirium vs depression
  - Perform the MMSE, Mini-Cog, MOCA, CAM, Geriatrics Dementia Scale
- Assess nutrition and feeding
  - Albumin? Pre-albumin?
  - Swallowing performance? Diet restriction?
- Evaluate the patient for incontinence and skin care needs
  - Look at the Braden Scale listed in PowerChart in the Nursing notes section on Admission
  - Attempt to evaluate all wounds visually yourself, document in your note
- Identify Advanced Care preferences
  - Review Touch Works for advance directive documentation? Call outside PMD?
  - Call the nursing home for copies of advance directive documents
  - Identify and contact key decision makers
- Review medications
  - Have a heightened awareness for Poly-pharmacy
  - Review the med list daily to screen for Beers list drugs and new agents added by night-float
  - Re-perform your own medication reconciliation at the time of an initial consult from home meds to hospital medications, especially if patient has recently changed floors, units, or teams; check in Touch Works for medications as well. Call the pharmacy or nursing home if necessary.
- Begin planning for transition out of the hospital. You are an essential player in the patient’s transition!
  - Assess social supports at home and in the community:
    - What does the patient already have? What may be available? What will insurance provide?
  - Look in Touch Works for pertinent notes and assessments, such as Social Work notes from Geriatric, Oncology or ALS social workers/clinics.
- Identify financial concerns which may serve as barriers or supports to health
  - Ask the floor case manager about the patient’s insurance status.
  - Do they have paid care-givers at home? Medicaid waiver aides at home?
- Check the paper chart for documents which may have been sent from outside facilities, such as medication lists, advance directives, etc.
- Communicate with external providers
  - Call the nursing home or assisted living facility from which the patient came: Why did they send the patient in? What are their concerns? Did the patient need additional help in the last few weeks?
  - Call the outpatient provider for additional details on the social situation at home or health data.
  - Provide a verbal handoff to the receiving provider at time of hospital discharge for complex patients.
- Provide anticipatory guidance to family that is prognostically accurate and relevant to the patient’s disease.
- When selecting problems to chart on for your problem list, consider the geriatrics syndromes listed in the consult template review of systems, such as “Debility”, “Failure to Thrive”, “Delirium”, “Dementia” etc.
Addendum C: Consultation Etiquette

Two great resources on Consultation Etiquette are:
1. Palliative Care Fast Facts Consultation Etiquette (https://www.capc.org/fast-facts/266-consultation-etiquette-palliative-care/)

There are links to these resources on the Himmelfarb Library Website.

A brief summary of these resources follows:

**Consults should:**
1. Enhance the clinical care of the patient
2. Expand the knowledge of the requesting service
3. Utilize the expertise of the consultant

**As a consultant, you should:**
1. Remember you are providing a service to the requesting physician!
2. Clarify the nature of the consult request with the requesting service through an open-ended query: “How can we can be most helpful to you?”
3. See the patient and gather your own data.
   - Often the answer to the question the consultant is asked is not already in the medical record!
4. Communicate verbally or in person with the primary service before you document in the chart.

**Great Consultants are:**

**Brief * Accessible * Knowledgeable**

**Be Brief:**

Avoid long, preachy chart monologues. Instead provide a brief, but comprehensive differential diagnosis explaining your medical reasoning for the most likely diagnosis when applicable. Limit recommendations to < 5 and try to keep them specific. Provide exact medication dose / route / schedule and indication or the specific desired test.

**Be Accessible:**

Ensure your name is listed as the on-call consulting physician whenever you are on service and explain to referring services how to reach you. Indicate how you can be reached in your consult note (Please page the on-call physician under Geriatrics listed On Call through WebExchange. If there is no response within 15 min, please page the attending physician directly).

**Be Knowledgeable:**

Consult on the desired question and provide expertise for the consultant subspecialty. Recommendations should be discussed with the attending geriatrician before being made to the requesting team.