Eisenberg Acute Care for Elders (ACE) Service

Welcome to the Eisenberg ACE Service!

The Eisenberg Service was developed and is staffed by Geriatric Medicine attendings with the specific goal to increase learners' knowledge of core principles in the care of hospitalized older adults. This teaching service was initially developed as one part of a larger teaching grant, the UT-SAGE (UT-Southwestern Aging and Geriatrics Education) Grant provided by the Donald W. Reynolds Foundation, whose stated goal was to "improve the quality of life of America's growing elderly population through better training of physicians in geriatrics." Care of acutely ill older adults emphasizes principles of patient safety and person-centered care. These principles benefit patients of any age, but when they are lacking, it is often the older patient population who suffers most. As our population continues to age, it is imperative that all future clinicians, regardless of specialty, have a better understanding of how to care for the acutely ill older adult.

Background on ACE Units

Acute Care for Elders (ACE) Units emerged in the early 1990s as a novel model of care aimed at addressing the problem of hospital-acquired disability (HAD) amongst acutely-ill older adults. Initial studies demonstrated that the ACE intervention could reduce HAD and improve physical function for older hospitalized adults without increasing costs compared to patients receiving usual care. Several subsequent studies have shown that the ACE model of care has other important benefits when it comes to caring for hospitalized elders, such as decreasing rates of delirium, falls, and pressure ulcers; improving patient, family, provider and nurse satisfaction; and even lowering per capita cost of care.

The ACE Unit on 12 Blue at Clements University Hospital began when the hospital opened in December 2014. The mission of this unit is threefold – (1) to provide the highest level of acute care to older adults admitted to our hospital through thoughtful interprofessional collaboration and by harnessing the methods of continuous quality improvement, (2) to disseminate best practices related to the care of acutely ill older adults throughout the UT Southwestern health system and beyond, and (3) to educate and train healthcare professionals how best to care for acutely ill older adults.

Faculty

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Last updated by Tom Dalton 6/3/2021

Eisenberg Service Learning Objectives

These learning objectives stem from national recommendations for geriatric competencies for internal medicine residents, geriatrics content on the American Board of Internal Medicine exam, and a 2018-2019 needs assessment of residents in our program.

Medication Management

- Goal: Learn to prescribe appropriately for older adults. Consider the physiologic changes of aging that affect pharmacokinetics and pharmacodynamics, drug-drug interactions, common side effects, and the risk for adverse events in the context of a patient's medical history and functional status.
- Goal: Learn to de-prescribe medications that are inappropriate or not indicated.
- Objectives:
    - Identify and use the Beers criteria and the START/STOPP criteria as resources to guide appropriate prescribing in older adults.
    - Use accurate calculations of renal function to correctly dose medications for older adults.
    - Demonstrate a thorough admission medication reconciliation, updating the medication list for adherence and over the counter and complementary and alternative medications.
    - Demonstrate a thorough discharge medication reconciliation, ensuring that all medications have an appropriate indication and that alternatives to high-risk medications are considered.

Cognitive, Affective, and Behavioral Health

- Goal: Learn to identify, evaluate, treat, and prevent delirium in hospitalized older adults.
    - Objective: Define delirium.
    - Objective: Describe the evidence for prevention and management of delirium.
    - Objective: Regularly use the Cognitive Assessment Method (CAM) to identify delirium in acutely ill older adults.
    - Objective: Identify and minimize delirium risk factors in each patient.
- Goal: Distinguish delirium from dementia with behavioral problems.
    - Objective: Define dementia.
    - Objective: List and describe types of dementia (Alzheimer's, vascular, Lewy body, frontotemporal, etc.)
    - Objective: Evaluate a patient for dementia.

Hospital Patient Safety

- Goal: Appreciate the hazards of hospitalization for older adults and describe ways to prevent common negative outcomes related to hospitalization (delirium, falls, catheter-related complications, medication errors, pressure ulcers, deconditioning, disability, etc.)
    - Objective: Define hospitalization-associated disability.
    - Objective: Describe the evidence for the prevention of hospitalization-associated disability.
    - Objective: Regularly evaluate fall risk, immobility, pressure ulcers, adequacy of oral intake, pain, urinary incontinence, constipation, and appropriateness of medications in hospitalized older adults and institute corrective measures as needed.
    - Objective: Regularly document the presence of and indication for indwelling bladder catheters in hospitalized older adults if necessary and discontinue use as soon as appropriate.

Transitions of Care

- Goal: Work as part of an interdisciplinary team to facilitate safe and appropriate hospital discharges, taking into account a patient's clinical needs, functional status, personal values, and social and financial resources.
    - Objective: Lead multidisciplinary rounds each day with efficiency and an understanding of each team member's role and the information they require to do their job.
    - Objective: Describe the similarities and differences between the following terms: hospice, long-term acute care hospital, acute rehabilitation, skilled nursing facility, nursing home, assisted living, and home health.
    - Objective: Describe the Medicare system and the impact it has on acute care, post-acute care, transitions of care, and long-term disability.
    - Objective: Write discharge summaries that are concise but provide all pertinent information for the setting of care to which the patients are discharged.

Complex or Chronic Illnesses in Older Adults

- Goal: Prioritize and manage the care of acutely ill older adults by integrating the patient's goals and values, co-morbidities, and prognosis.
    - Objective: Assess a patient's baseline functional status on admission using the Activities of Daily Living and Instrumental Activities of Daily Living.
    - Objective: Estimate a patient's prognosis.
    - Objective: Demonstrate a goals of care conversation, implementing evidence-based techniques.
    - Objective: Determine whether each patient has decision-making capacity.
- Goal: Understand that caregivers are an integral part of taking care of the older patient with complex or chronic illnesses.
    - Objective: Identify each patient's primary caregiver and support system (as appropriate) and the level of assistance required.
- Goal: Identify and address barriers to communication that commonly affect older adults (e.g. non-verbal patients, hearing impairment, visual impairment, cognitive impairment.)
    - Objective: Obtain collateral information, including histories and goals of care, from the medical power of attorney or caregiver when necessary.
    - Objective: Assess and address hearing and visual impairment in each patient by ensuring that they have hearing aids and glasses as appropriate.

Wound Care

- Goal: Recognize, treat, and prevent pressure ulcers.
    - Objective: Stage a pressure ulcer.
    - Objective: Prescribe appropriate treatment for a pressure ulcer.
    - Objective: Implement pressure ulcer-prevention strategies.

Systems Based Practice/Interdisciplinary Teamwork

- Goal: Work effectively as part of an interdisciplinary team to optimize hospital-based care of the older adult.
    - Objective: Describe the role of the physical therapist, occupational therapist, dietitian, speech therapist, pharmacist, and social worker.
    - Objective: Appropriately consult physical therapy, occupational therapy, speech therapy, and nutrition.

- Objective: Interpret the recommendations of physical therapy, occupational therapy, speech therapy, and nutrition, and use them to optimize the patient's management.

Teaching and Learning Strategies

- Direct patient care
  - Prompts in note templates are intended to be instructive but do not necessarily have to be completed in full on each patient
    - H&P template = .gerihp
    - Progress note template = .geriprog
    - Discharge summary template = .geridc
- Attending physician teaching sessions
- *The Learner Folder* – Available at the link below (if you cannot access, please contact Dr. Dalton or your attending). This contains great articles and resources related to the learning objective above.
  - https://365utsouthwestern-my.sharepoint.com/:f:/r/personal/thomas_dalton_utsouthwestern_edu/Documents/Geriatric%20Medicine%20Learner%27s%20Folder?csf=1&web=1&e=WI8ez3
- Interdisciplinary team-teaching sessions (PT, OT, Speech, Nutrition, Nursing, Pharmacy, Wound Care)
  - Scheduled at 1:15 pm on Thursday each week
    - 1st Thursday – PT/OT
    - 2nd Thursday – NONE right now (seeking a willing wound care nurse)
    - 3rd Thursday – Pharmacist
    - 4th Thursday – Dietician
  - Designed to be only about 20 minutes in duration so that residents can give their undivided attention to learning (should be interrupted only in a true medical emergency). PLEASE actively engage in these sessions; come with questions to learn from and with your colleagues in other areas of health care.
- Resource notebook in the rounding room
  - Includes information pertinent the rotation (e.g. Short-CAM form, Beers list, START/STOPP list, MOCA, PT/OT information, ASPEN malnutrition criteria, wound staging information, etc.)
- Wound care box in the rounding room and wound care teaching trifold
  - Contains examples of various wound care supplies and their indications
- Opportunities to observe interdisciplinary team members in action
  - PT, OT, Speech, and Nutrition are all happy to have you shadow them as they evaluate and treat your patients.
  - Look under "Treatment Team" in Epic to find out who the therapist is, and reach out to set up a time.
- All team members are expected to attend the required conferences as dictated by the internal medicine residency program or clerkship directors including Morning Report, Grand Rounds, Noon Conferences and Weissler Conference.

Admissions and Schedule

Criteria for admission to the Eisenberg Service:

- Patients age 70 (currently 65 for COVID-19 relief) or older **and**

- Patients should be community-dwelling (this includes patients who live in a private home or assisted living but excludes patients who live in nursing homes)

<u>or</u> any of the below

- Any patient who has a primary care provider in the UT Southwestern Geriatric Care Center, regardless of their age or place of residence
- Any patient whom the attending accepts as an admission to the service
- **In general, residents should accommodate admissions outside of the strict admission policies in order to promote a reasonable census size and learning opportunities for students and trainees while still adhering to work hour rules. If there are concerns or questions, discuss with the attending.**

Timing and procedures for admissions:

- Up to three admissions can come daily, **Monday – Friday between 7am and 5pm**. Only one patient can be accepted after 3pm if daily cap has not been reached; this is to ensure residents are able to adhere to duty hours.
- Direct admissions from the Geriatric Care Center can occur in coordination between the admitting clinic provider and the attending or resident on service. The admitting hospitalist and bed control must be made immediately aware of any direct admissions accepted by the team.
- We can accept transfers from other hospital services, but they must be approved by the attending, and the admitting hospitalist must be made aware.
- We do not admit or accept new patients on Saturdays or Sundays.
- The team cap is 12 patients. On Fridays, there is a soft cap of 10 patients, meaning we will not accept any new admissions above 10 patients in order to have a reasonable census for the weekend resident.
- **Residents should use the *<u>Geriatrics Admission Order Set</u>* when admitting patients. If you feel something should be added, omitted, or changed in the order set, please let Dr. Dalton know.**
- Residents and interns can work together to decide how to divvy up admissions and what the daily schedule looks like, but in general, this is what is expected:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Projected Duty Hours
Resident A	7 am – 7 pm Admit up to 3 patients before 5 pm (only 1 admit after 3 pm)	No admits (can leave as early as 3p if work complete)	7 am – 7 pm Admit up to 3 patients before 5 pm (only 1 admit after 3 pm)	ICU transfer prior to noon (can leave as early as 3p if work complete)	7 am – 7 pm Admit up to 3 patients before 5 pm (only 1 admit after 3 pm)	Off	Cover all patients 7 am until done (should be by 5 pm)	62
Resident B	ICU transfer prior to noon (can leave as early as 3p if work complete)	7 am – 7 pm Admit up to 3 patients before 5 pm (only 1 admit after 3 pm)	No admits (can leave as early as 3p if work complete)	7 am – 7 pm Admit up to 3 patients before 5 pm (only 1 admit after 3 pm)	No admits (can leave as early as 3p if work complete)	Cover all patients 7 am until done (should be by 5 pm)	Off	58

Rounds:

- Rounds will occur daily at 10am, following morning report, unless instructed otherwise.
- Each attending will handle daily rounding and teaching as they see fit. The residents should coordinate with the attending early in the rotation to determine how rounds will work, what is expected of each

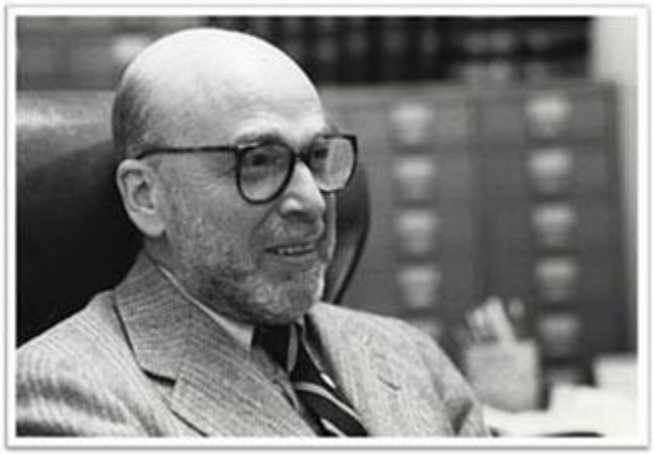
member of the team during and prior to rounds, and whether any time for teaching will be set aside in advance.
- ACE Interprofessional Rounds occur M – F at 11am. The whole team should strive to be present and ready to start at 11am. The resident should be prepared to help lead these rounds daily along with the Care Coordinator and Social Worker on 12 Blue.

Days off and duty hour adherence:

- Residents and interns must have one day off per week for a total of 2 days off in a 2-week rotation. **Adherence to all duty hour regulations as dictated by the internal medicine residency program is absolutely expected and required. If you feel you have violated or will violate any duty hour restriction, then you must inform the attending on service and/or Dr. Dalton immediately.**
- In general, residents will work the first Saturday and Sunday of the rotation and have the second weekend off. Interns will split Saturdays and Sundays, ensuring at least 2 days off over a 2-week period.
- Medical students must receive at least one day off a week, on average, for a total of 4 days off in a 4-week rotation. Days off will be at the discretion of the residents and the attending. In general, students will work M-F and one weekend day with each attending in order to get adequate feedback. The weekend in which attendings switch, the medical students will be off.

Fellows on Eisenberg (needs to be updated)

Fellows will meet early in the year with Dr. Dalton to discuss the ACE Unit model and the ongoing QI programs on 12 Blue and hospital wide. Fellows will continue to attend the monthly ACE Meetings and will have the opportunity to engage in a QI project if they choose to. Patient safety and transitions within the health care system will be priorities for the fellow on their Eisenberg rotation. Observed teaching will be a priority as well.



Seymour Eisenberg, M.D. (September 19, 1918 – January 5, 1999)

The Eisenberg Service is named in memory of Dr. Seymour Eisenberg, a UT Southwestern faculty member for 48 years and the first Section Chief in Geriatric Medicine. Dr. Eisenberg graduated from Bowman Gray School of Medicine in 1944. From there he moved to Boston City Hospital for internship before completing his residency at Parkland Hospital in 1950. Though he originally planned to move back to North Carolina and open a private practice, he instead joined the faculty in 1950 and became "one of the most distinguished teachers in the history of medicine in Dallas" (Dr. Mark Feldman, Vice-Chair, Internal Medicine, 1999). As the first physician at UTSW to take an interest in the burgeoning field of geriatrics, he recognized that special needs within this population were unmet - "There will be 32 million Americans over 65 by the year 2000," Eisenberg said, "and the elderly tend to develop multiple chronic illnesses against the background of aging changes. Currently their needs are inadequately met except for acute illness." With the rise to CEO of another geriatrician, Dr. Ron Anderson, the two worked together to improve care for older adults in Dallas County – "The elderly are the most rapidly growing population in Dallas County," said Dr. Anderson, "We need to provide them a continuum of care. Psychosocial and socioeconomic issues have to be dealt with. If not, when an elderly patient is discharged they'll be back. Hospitalization is an easy answer. Sometimes it takes more care to keep people out of the hospital. Hospitalization is dehumanizing." They worked together to establish a core gerontology center that took a geriatric team approach to health to improve outpatient care, prevent hospitalization, and prevent institutionalization after hospitalization, often the outcome of inadequate geriatric care. In addition to his work at UT Southwestern and Parkland Hospital, Dr. Eisenberg also established a nursing facility at the Dallas VA and headed the VA geriatrics section for many years.

Dr. Eisenberg was well-known for his teaching - "I'm a bedside clinician who listens. That's what I do best. And I train young physicians to do that and enjoy what they do. Listening to the patient is an important part of geriatrics." Dr. Feldman estimated in 1999 that Dr. Eisenberg trained 1000 internal medicine residents and thousands of medical students. His son, a sports writer in Baltimore, described him as a warm and gentle person with a terrific sense of humor and "a strong set of priorities – family first, medicine second, and pro football third." He retired at the age of 80 and died a few months later after being admitted to Zale-Lipshy for a minor operation. His memorial service was packed with former students, a testimonial to his contributions. "There is a blossoming coordinated effort in this school to improve geriatric care," Dr. Eisenberg said in 1983. This Eisenberg ACE Service, as well as the rest of The Reynolds UT-SAGE initiative, continues his vision for the training of physicians in geriatric care at UT Southwestern.

Sources:
Center Times, May 1983
Baltimore Sun, January 24, 1999
Dallas Morning News, January 8, 1999
UT Southwestern News, December 9, 1983

SAGE

UT Southwestern Medical Center

Last updated by Tom Dalton 6/3/2021