

THE BOSTON UNIVERSITY GERIATRIC CLERKSHIP SYLLABUS

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BOSTON UNIVERSITY MEDICAL SCHOOL GERIATRICS CLERKSHIP
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1. OVERVIEW

The purpose of this rotation is to provide training in geriatric medicine and home-care. You will participate in the direct primary care of the elderly in their homes, nursing homes and other settings while supervised and supported by an interdisciplinary faculty consisting of physicians and nurses, a social worker and a pharmacist.

2. GOALS

1. Incorporate a basic working knowledge of aging physiology to evaluate and manage syndromes or diseases unique to or more common in older persons.
2. Improve clinical skills of history taking and physical exams of older adults.
3. Develop an understanding of and facility in geriatric assessment of older patients including the use of screening instruments and an awareness of the importance of patient function in medical care.
4. Recognize the advantages of working collaboratively with an interdisciplinary health care team.
5. Develop physician skills in working effectively with other community resources dedicated to the care of older patients in all settings.

3. OBJECTIVES:

3.a. Knowledge

1. Demonstrate an understanding of the diagnosis, treatment, rehabilitation and convalescence from common geriatric diseases and syndromes such as cognitive impairment, delirium, depression, urinary and fecal incontinence, syncope, balance disorders, falls, fractures, immobility, pressure ulcers, iatrogenesis and sensory impairment.
2. Interpret physical findings based on an understanding that disease presentation in older patients may differ from younger patients.
3. Recognize the need to modify the history and physical examination based on a knowledge of sensory deficits and functional limitations.
4. Distinguish normal from pathologic aging.
5. Distinguish the roles and responsibilities of other team members, e.g., nursing, social work, physical therapy, nutrition and pharmacy.

6. Understand the roles and responsibilities of resources available through community agencies such as, visiting nurses, home health aides, home care agency case managers, home delivered meals, and adult day care.
7. Know cost/reimbursement issues related to #6

3.b. Skills

1. Effectively manage a variety of common geriatric syndromes/diseases.
2. Evaluate and incorporate cognitive, psycho-social and functional status into the overall assessment of the older patient.
3. Recognize problems related to pharmacotherapy such as adverse drug reactions, polypharmacy and non-compliance.
4. Acquire effective physical examination skills targeted at the diagnosis and management of common geriatric diseases (as described in Knowledge Objective #1)
5. Adapt management strategies to the needs, wishes and capabilities of older patients and their families.
6. Utilize appropriate technology while encompassing an awareness of the limits of these interventions in the context of individual patient values.
7. Communicate with older patients and their families utilizing effective, compassionate and respectful interpersonal skills.
8. Collaborate with other health care team members in the assessment, implementation and evaluation of care.
9. Effectively communicate with community resources on behalf of the patient and his/her family.

3.c. Attitudes

1. View the elderly as physically, psychologically, functionally, culturally and socially diverse.
2. Appreciate the heterogeneity and atypical presentation of, and response to, illness in older patients.
3. Appreciate the non-medical issues in caring for the older patient e.g., psychosocial, ethical-legal and economic.
4. Appreciate the roles of all elements of an interdisciplinary team.
5. Appreciate the value of community resources in providing care to older people living at home.

4. INSTRUCTIONAL METHODS

These will include

- Interdisciplinary team participation
- Home visits
- Visits to BUGS clinic and nursing homes and other community sites dedicated to geriatric patient care
- Independent learning and research in preparation of a case discussion paper

- Geriatrics Lecture Series
- Geriatrics Conference Series (Fridays)
- Medical Grand Rounds (Fridays)
- Standardized Patient Encounter (SPE)
- OnLine Curriculum
- Other conferences as scheduled

5. OPTIONAL READINGS

Unwin BK, Jerant AF. The Home Visit. American Family Physician 1999; 60: 1481-1488.

Miller KE, Zylstra, RG. The Geriatric Patient: A Systematic Approach to Maintaining Health. American Family Physician 2000; 61: 1089-1104.

Besdine RW, Rubenstein LZ, Snyder L. Medical Care of the Nursing Home Resident, Philadelphia: American College of Physicians, 1996: xiii-25.

6. CLERKSHIP STAFF

Kirstin Lindeman, Robinson 2700 638-6109

Denise Collins, Robinson 2700 638-6155

Lisa Norton, MD, Robinson 2016 638-6197

7. CLERKSHIP SCHEDULE

Visit schedules are posted on the white board outside room 2504. The white board will reflect any changes in the schedule. The schedule handed to you on Day 1 of the rotation is subject to changes. See LECTURE SCHEDULE and VISIT SCHEDULE in this syllabus.

8. ABSENCE OR TARDINESS

1. Please call Kirstin Lindeman at 638-6109 (or Fellowship Coordinator at 638-6155) as soon as possible - prior to planned departure time.

If you reach voicemail? Leave a message, AND:

2. Call/page the clinician with whom you were to work that day. See GERIATRICS SECTION PHONE LIST in this syllabus.

Please call in each day if you're sick (have an unexpected absence) more than one day in a row. Note - unexpected absences will be included toward the 3-day (5-day during interview season) absence limit.

8.a. Policy On Student Absences

Overview

Students are allowed to miss 3 days (5 days during interview season). Prior notification is required. The Education Training Program Coordinator must be notified by the first day of the rotation about scheduled absences. For a day that must be missed due to illness or an emergency, students must call in the night before or early a.m. of day to be missed. Note that illness/emergency absences will be included/counted toward the 3-day limit, as will days taken for Board exams.

Absences/Grading

If a student misses more than the allowed days, make-up of absences must be done in the form of a written paper to be arranged with the Education Training Program Coordinator. Papers must be turned in no later than 1 week after the end of the rotation. If a student does not submit a paper as required, the student will receive a Deficiency Low grade for the clerkship. Please see the Education Training Program Coordinator for the paper guidelines.

If the student's performance is felt to be inadequate, then the student will be asked to make up extra days. This will be at the discretion of the primary preceptor(s) and the Clerkship Directors. Any extra "make-up" days are done at the end of the year following the completion of Block 20. No exceptions will be made.

Lectures Are Mandatory.

Students are expected to attend all lectures. Much effort is made in putting the lectures together as part of the curriculum. Absences from lectures will be factored in to the student's final evaluation.

8.b. BUGS Weather Policy

Student activities during inclement weather:

The decision to cancel medical student visits (independent or with clinicians) due to inclement weather will be made by the Education Director and Clerkship Director(s), taking into account local conditions. The decision to cancel will be made by 6:30 a.m. and will be conveyed to the Education Coordinator. S/he will in turn leave a voice mail greeting on her phone line by 7:00 a.m. indicating that visits are cancelled. (Visits include: home visits and nursing home visits, and the Rogerson House Adult Day Health.)

Orientation, clinic sessions, Standardized Patient Encounters lectures, and conferences will take place unless the presenter/lecturer is unable to travel to the Campus. Students should contact the Geriatrics Education Office if they are unsure whether a presentation/lecture will occur.

9. BU GERIATRICS SERVICES TEACHING SITES

BU Geriatric Services (BUGS) provides primary care for older adults in the clinic, the nursing home, and in the home.

Students will have home care experience and the opportunity to see patients in at least one other primary care site. Students may also have the opportunity to go to other sites listed below.

9.a. Primary Care Sites:

Home Care - The service visits approximately 550 patients in their homes in most areas of Boston responsible for certain defined geographical locations including such neighborhoods as the South End, Roxbury, Dorchester, Jamaica Plain, and South Boston.

Nursing Homes – BUGS staff cares for approximately 580 nursing home patients in several long-term care facilities at different locations in Boston.

Geriatric Primary Care Clinic – This clinic serves approximately 1200 elderly patients in the Ambulatory Care Center (2nd floor) at BMC.

9.b. Other Sites:

Patients are also seen at **Rogerson Adult Day Health Centers** and at the **Rogerson House (Alzheimer's Center)**. Other clinical teaching sites include: **Homeless Clinic**, associated with the Pine Street Inn and Elders Living at Home, with Kate Byrne and **BU Rehabilitation Clinic**.

Directions to Nursing Homes and other sites may be found on the Geriatrics Section's webpage at <http://www.bumc.bu.edu/geriatrics>

10. PROTOCOLS FOR HOME VISITS

Generally, two medical students will make home visits with a preceptor. Occasionally students from other disciplines or fellowship candidates will also accompany the preceptor. In addition, medical students will have an opportunity to make independent visits with another student (see next page). Adequate preparation before making a home visit will ensure maximum efficiency and effectiveness.

1. Before visiting the patient the chart should be reviewed - prior to visit - especially the problem list and the revisit form from the previous visit. In order to do this, please be sure to allow 15 minutes to review charts before your scheduled departure. (room 2504)
2. **The phlebotomy bag, EKG Machine, O2 saturation monitor or ear syringes may be needed for the visits** - please check with attending to obtain these items. All Physicians are responsible for their own phlebotomy bags. Students should not be asked to stock bags.
3. **During the home visit** while in the patient's home, act with consideration. If unexpected delays make it impossible to keep a home visit appointment, the patient must be notified. Neat appearance, including a shirt and tie for men, helps establish professional identity. Blue jeans and other informal clothes are not appropriate. **White coats are not worn, but ID badges should be.** Good hand washing should be performed both before and after examining the patient (antiseptic hand wash is provided in the equipment bags for this purpose). **Please turn off cell phones.**
4. If you have asthma, please be sure to bring your inhaler on home visits as you are often likely to encounter cats or dogs.
5. Be sure to bring your fit-tested mask.
6. If accidents (such as a needle stick) occur, you should depart from the home visit immediately and return to the Employee Health Office now located in the Preston Family building (F-5). (If it is after 4:30 p.m., you should proceed to the Emergency Department although this is rarely the case as students are not out on home visits that late in the day.)
7. Medical students assume the role of primary care provider during the approximately half-hour visit and are expected to:
 - a. Attend to the patient's acute and chronic medical and psychosocial problems. During visits for acute problems, the focus will be on that one problem with attention to associated chronic problems as necessary. Judicious and efficient use of time will be necessary to cover the patient's

new and pertinent chronic problems and ensure their appropriate management until the next visit.

- b. Review the patient's medications and document them on the logician chart summary sheets.. Assess compliance, inquire about side-effects and consider the possibility of drug interactions. Note any refills needed and discuss with the attending.
 - c. A health maintenance examination should be done as indicated if time permits during a routine follow-up visit.
8. **Patient Logs** can be found online at <http://dccwww.bumc.bu.edu/busmptlog> (See shortcut on the desktop). Select Geriatrics from the dropdown menu. Please keep logs up to date. These will be printed out at the end of the rotation and handed in to your preceptor to assist with grading. All patient encounters should be included and if you observed only it should be so noted. A separate paper log is included in the packet for the purposes of arranging independent home visits and does not need to be handed in.

11. PROTOCOLS FOR INDEPENDENT HOME VISITS

From the start of the rotation, as you make home visits with preceptors, you are to keep a **patient log** (<http://dccwww.bumc.bu.edu/busmptlog>) with names of all patients you have seen. Use this list to come up with possible follow-up visits for the following weeks. Check with your preceptors about appropriate patients. You (with a partner – note that students usually go out in pairs on independent visits) will be scheduled for at least one set of independent visits during the rotation, and you will be reminded ahead of time when these are scheduled. You are responsible for turning in a list of patients to be seen by ***at the latest*** 11:00 am the day before the visit).

1. **The patient must be called** the day before the scheduled visit unless specific directions on the front of the chart indicate it is best not to do so. This is generally done by the secretary, but on occasion students will be asked to do this. Visit Schedule forms are available in the office next to the AM charts, also in the student room. These should be filled out with the names of the patients on the running list you have prepared and turned in at least by 11:00 am. the day before the visit to the appropriate basket in Room 2603. Be sure that you also fill in your names and the planned date/time of the visit. Calling the patient is a common courtesy and helps avoid an unnecessary trip if the patient had made other plans for that day. If you are in touch with the patient regarding the visit and the patient refuses an offer to be seen, no more than gentle persuasion should be undertaken to reverse the decision unless there is a compelling medical reason to pursue the visit. Refusals for the home visit should be documented in the medical record.
2. **The location of the patient's home and the best route to get there should be checked** on a map. Before attempting entry to the patient's apartment or house, it may be necessary to follow specific instructions written on the front of the charts (e.g. obtain key from landlord in basement apartment).
3. **During a visit, if any problems arise or there are concerns regarding the patient's condition**, the preceptor or clinical nurse specialist should be contacted

by calling BU Geriatric Services (617-638-6100). Further interventions such as VNA referral, ER referral or f/u home visits can be discussed.

4. **After the independent visits, students are also expected to follow up** with the preceptor in person or by phone regarding the results of these visits. This follow-up must be done as soon as possible on the day of the visit. After you have been in touch with the preceptor, documentation on the patient's chart is to be completed and left in the appropriate shelf in Room 2603.
5. **If you use your own car** for Independent Visits (or for visits to community sites), you may keep track of mileage on the form included with your packet. The form is to be turned in at the end of the rotation, and you will be provided with a reimbursement.
6. Safety is important! Students should always go in pairs unless the patient's primary care doctor feels that the home is in a safe area for a single student to visit alone. Please review all visits with preceptors ahead of time. If at any time you feel uncomfortable or concerned about your safety, return to the office and call the patient if the visit was not completed. See attached BU Geriatric Services' Safety Policies and Procedures.

12. PROTOCOLS FOR NURSING HOMES

Students will be visiting patients in nursing home under the supervision of nurse practitioners or attending and generally will be in pairs.

1. Students will go to nursing homes directly, using directions found in the student area. Check your schedules to know whom you are meeting and which nursing home you are meeting at. Directions to various nursing homes are provided in the Trainee Room.
2. Be on time.
3. All students should bring White coats, ID badges and medical equipment. In some cases you will be asked not to wear your White coat, and only wear your ID. Ask your preceptor at the Nursing Home what they prefer. The medical equipment to be brought includes:
 - Stethoscope
 - Reflex Hammer
 - Tuning Forks
 - Flashlight or Penlight
 - Oto/ophthalmoscope
4. The attending or the nurse practitioner will orient you to the home and the activities for the day, which will be either independent patient visits or joint visits with the preceptor. Students will be expected to obtain a complete history from multiple sources including the patient, the chart, nurses, nursing assistants, physical and occupational therapy, flow sheets, bowel and weight books and present this in a concise fashion to the preceptor.
5. Students are expected to be able to collaborate with the preceptor regarding assessment and plan

6. Students are expected to follow up with the preceptor to discuss any clinical issues raised or to discuss lab work pending or ordered at the time of patient visit.
7. Notes should be written to reflect the student's participation in the visit and to document the student's impression and clinical management suggestions. The notes must be done in Logician and should follow the protocol as noted in the Logician guidelines included.

13. PROTOCOLS FOR GERIATRICS CLINICS

The Geriatrics Ambulatory practice is on ACC 2, at the Harrison Ave Pavilion. Take a right turn out off the elevators and it is the first clinic on that hall. The attending will meet you at the clinic and orient you to your activities for the day. Generally students see 2 to 4 patients under the direct supervision of the attending,

- Please be on time and bring your white coat, ID, and stethoscope.
- All patient charts are on Logician. You should know your password and review the format for notes listed in the appendix.

14. PROTOCOLS FOR REHABILITATION CLINICS

Please arrive by 8:11a.m. if you are scheduled to go to the Transitional Care Unit (Evans 7), or by 8:30 a.m. at the outpatient clinic on the 2nd floor of the Preston Family building or inpatient rehab on 7 West [Harrison Pavilion].

Goals:

1. Develop an understanding of the issues related to Debility.
2. Develop an understanding of the care associated with patients who have undergone extremity amputation due to medical complications.
3. Learn to evaluate patients from a functional and cognitive standpoint to determine when a patient may benefit from referral to allied health professionals such as physical therapy, occupational therapy, and speech and language pathology.

15. INDEPENDENT LEARNING

15.a. Written Case Discussion

A written case discussion will be due the last day of the rotation. The case to be reviewed should be an actual patient encountered during the rotation for which a clinical question arose. Students can ask preceptors for ideas. This might be a patient you are interested in doing your follow-up Independent Home Visit on or it could be another patient altogether.

The format of the paper may be done in one of two ways. Remember the main goal of this paper is to address how you will manage a particular patient and his particular clinical issue while addressing the other non-medical factors involved such as compliance and family.

One way to approach the paper is to treat it like a straight EBM presentation. Keeping the patient and his case in mind examine a study presented about treatment method for this patient's clinical problem and explain how this study relates to your particular patient.

An alternate way to go about the paper is to review articles looking at several treatment options out there to treat your patient's clinical issue. Layout findings to discuss several treatment options and address which one you would use to treat your patient taking into account the whole picture. Think about the patient's living situation, mobility, and other issues affecting the value and feasibility of a treatment option for managing that patient's care.

In either case the below should be addressed:

1. Review of the case and pertinent clinical information
2. Review of the patient in the context of geriatric population i.e. typical or atypical
3. Identification of a clinical question that relates to the differential diagnosis of the patient's chief complaint.
4. Review of the literature to answer the question, including an overview of the epidemiology, pathophysiology, symptoms and management of the clinical problems being reviewed. Address the quality of information available. Text books are often out of date and are not preferred sources of information..
5. Answers the clinical question in regards to the initial case reviewed and discuss possible options for future clinical management.

All students are to include a bibliography

In the last week, a brief round table discussion will be held with all classmates to share findings. This is a non-graded informal chance for students to learn from each other. All are however required to attend.

The following is a list of possible topics to consider in preparing your case although this list is by no means complete. Discuss other potential topics with the geriatric fellow who will be advising you during the preparation of your case discussion.

<p>Musculoskeletal Disorders: osteoarthritis, gout, pseudogout, Paget's disease, hip fracture, polymyalgia rheumatica, temporal arteritis, deconditioning, spinal stenosis</p> <p>Cardiovascular: hypertension/hypotension coronary artery disease valvular heart disease congestive heart failure pacemakers arteriosclerosis of the extremities chronic deep venous insufficiency peripheral vascular disease</p> <p>Pulmonary Disorders: COPD, TB, pneumonia</p> <p>Metabolic and Endocrine Disorders: thyroid disease: hypo, hyper, nodules, diabetes, hypercholesterolemia, calcium metabolism</p> <p>Neurologic Disorders: Chronic degenerative dementias - hemorrhagic stroke, ischemic stroke, stroke complications and rehabilitation, Parkinson's disease, peripheral neuropathies, gait disturbances</p> <p>ENT otitis externa, sinusitis, parotitis, conjunctivitis</p> <p>Hematology megaloblastic anemia, B12, folate, pernicious anemia, multiple myeloma coagulation issues in the elderly</p>	<p>Hyperthermia/Hypothermia Syncope Nutrition: malnutrition/ wt.loss / obesity / anorexia Sleep disorders Alcoholism Elder Abuse Adverse drug reactions/polypharmacy/compliance Exercise in the elderly Skin disorders photoaging, benign/malignant tumors, psoriasis, venous ulcers, pressure sores</p> <p>Genitourinary disorders: BPH, prostatic cancer, urosepsis, asymptomatic bacteriuria, changes in sexuality, atrophic vaginitis, urinary incontinence</p> <p>Gastrointestinal Disorders: nonulcer dyspepsia, irritable bowel syndrome, fecal incontinence, diarrhea, diverticular disease, colorectal cancer, GI bleeding, chronic constipation</p> <p>Infectious Diseases: community acquired pneumonia, endocarditis herpes zoster, vaccines and immunizations influenza, nosocomial infections</p> <p>Perioperative Management of the elderly pre-/intra-/post-operative assessment and management, appendicitis, diverticulitis, cholecystitis, mesenteric infarction and ischemia</p> <p>Ethics Advance directives, living wills, proxies, etc.</p> <p>Ophthalmology cataracts, glaucoma, macular degeneration, diabetic retinopathy, macular degeneration</p> <p>Psychosocial Issues personality disorders</p>
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15.b. Clinical Paper assigned as a result of excessive absences

1) **Subject** – The topic must have a geriatric focus, directly related to a patient seen with your primary preceptor. Choose a focused question, generated from some aspect of the patient chosen. Review your topic with your preceptor to be sure your question is suitable.

EXAMPLE: You might have seen a patient with a dementia who is on Trazadone to control behavioral problems. The patient has had some improvement from the medication, but is also having side affects. The patient also has a history of falls and hip fracture. Here are a few possible questions:

In general, how advantageous has this medication been in the treatment of behavioral problems in dementia?

What are alternative medications for the treatment of behavioral problems in dementia?

What are alternative non-medication approaches to the treatment of behavioral problems in dementia?

How do psychotropic drugs affect risk of falls and fractures?

How do behavioral problems in patients with dementia impact on care givers?

What would be appropriate management of osteoporosis in this patient?

2) **Literature Review** – Your paper must cite at least three articles.

3) **Length** – At least 2 pages and adequate to discuss the question you have selected.

4) **Format** – Include a brief paragraph (no more than 3 or 4 lines) description of the patient, followed by the question you are answering. The rest of your report should be a discussion/description of your answer to the question, followed by how you would take care of the patient based on what you learned. At the end, include references. References must be cited within the text of the paper. Please use the *New England Journal of Medicine* citation format.

5) **Due date** – Your paper is due within one week of the last day of the geriatric rotation. **You must submit the paper to the Education Office no later than the Friday following the last day of the block. Late papers will receive a deficiency low grade.** The paper may be faxed or e-mailed as necessary.

Grading – Your paper will be graded pass/fail by the Clerkship Directors. A copy of your paper plus the Clerkship Directors' comments will be forwarded to your primary preceptor. Your grade for the rotation will be based on the quality of your paper along with your overall clinical performance on the rotation. **If you do not submit a paper as required, you will receive a deficiency low grade for the clerkship.**

16. ONLINE CURRICULUM

The goal of the online curriculum is to teach diagnosis, evaluation, and management of common cognitive disorders in the elderly using video clips, mock charts, and power point slide presentations. Over the first 2 weeks of the clerkship, students will evaluate Mrs. Casimira Rivera as she develops new medical complaints.

During each of the first 2 weeks, students will be **REQUIRED** to log into the “Geriatrics/Home Medical Care (Ongoing)” course, located at <http://courseinfo.bu.edu/>. Assignments will appear on the “Announcements” page. Students will be expected to complete 2 modules per week, as designated in the assignment. Each week is structured as follows:

1. View the video clips (if present) and read all mock chart information. Video clips can be viewed using “RealPlayer.”
2. Go through the power point slide presentations sometime before Friday.
3. On Friday morning, students will take a written 10-question test (multiple choice and true/false questions) at 11:15 am. These tests will focus on material that was covered in that particular week’s modules.

Please see section [17.d](#). for a description of grading

17. EVALUATION OF STUDENTS

17.a. Home Visits and other Sites

The student’s overall clinical competence will be based on the degree to which s/he demonstrates the knowledge, skills, and attitudes essential to the provision of excellent care. Physicians, nurses and other consultants with whom the student interacted will all participate in the evaluation process. The geriatrics section is piloting a new evaluation form for BUSM. The format will be similar to the old evaluation form but the criteria for evaluation will be based on a synthetic system. We welcome any comments.

The following clinical skills will be evaluated:

REPORTER

1. Interviewing
2. Physical examination
3. Written H & Ps
4. Oral case presentations
5. Reliability, responsibility
6. Respect for patients

INTERPRETER

7. Problem lists
8. Differential diagnosis
9. Interpreting basic labs, EKG
10. Awareness of own limitations

MANAGER

11. Diagnostic plans
12. Therapeutic plans
13. Benefit/Risk decision making

14. Basic procedures
15. Incorporates patient values in plans
16. Interactions with health care team

EDUCATOR

17. Self-directed learning
18. Critical reading skills
19. Teaching skills
20. Self reflection

17.b. Mid Session Feedback

Mid session feedback is required for all students. The purpose of this session is to provide students with suggestions for improvement and review of their progress in meeting the clerkship goals. All students meet with their primary preceptor for feedback after the first two weeks of the clerkship and sign off on a mid-session feedback form that must be turned in to receive your grade. Patient logs should be filled over the course of the clerkship and may be used during the feedback sessions.

The student's clinical performance constitutes 75 % of the final grade.

17.c. Standardized Patient Encounter

Students will be participating in a Standardized Patient Encounter (SPE) at the end of the Geriatric clerkship at the 19 Bradston Street Clinical Skills Center. This will involve three standardized patients/cases and will be focusing on communication skills. This is will count for 5% of the final grade and provide feedback on communication skills.

Please wear professional attire and ID for this experience. Directions to the site are available in the student room.

Participation is mandatory, and if you are unable to participate on the date scheduled, you will be asked to come back in a following block. Make up dates should be scheduled through the Education and Training Programs Coordinator.

17.d. Online Curriculum: Please see Section [16](#) for complete description

During the first 2 weeks of the clerkship, students will participate in an online geriatrics curriculum. Students will be **REQUIRED** to log into the "Geriatrics/Home Medical Care (Ongoing)" course, located at <http://courseinfo.bu.edu/>, to access the online curriculum, which consists of 4 learning modules. Prior to starting each individual module, students will watch video clips and read mock charts describing the patient's complaints. The modules consist of didactic teaching slides alternating with multiple-choice questions designed to reinforce key concepts. Answers given to these questions will not be graded. Students will complete 2 modules per week as outlined on the website.

At the end of each week, students will be tested on the content of these modules. Tests will contain 10 questions (multiple choice and true/false) covering material that is contained within that particular week's two modules. The exercise is graded on a pass/fail basis. In order to pass, students must achieve a score of **at least 70% on both tests**. If the student does not pass one or both of the tests, they can retake the tests during

weeks 3 or 4 of the clerkship. Successful completion of the online curriculum constitutes **5% of the final grade** of the rotation.

Participation is mandatory. As “CourseInfo” is available on the Internet, we expect students to complete all assignments. Failure to participate will result in an Incomplete grade. You will be required to complete the online curriculum in the following block.

17.e. Written case discussion – Please see section [15.a.](#) for complete description

The case discussion will be evaluated on the clinical question, the quality of the literature review and discussion of date and the final clinical recommendations. The written case discussion is 5% final course grade, and will be required to complete the clerkship.

17.e. Final exam

This will be based on lecture materials and will be 10% of the final grade.

18. EVALUATION OF PROGRAM

18.a. Evaluation of Lectures

Note - attendance at lectures/conferences is mandatory. There are green evaluation forms for you to complete following each lecture presented during the Geriatrics Lecture Series. These are green forms, which we suggest you keep in your mailbox in the student room.

18.b. Evaluation of Clerkship

There will be the standard course evaluation and a written course specific form for Geriatrics to be completed prior to finishing the clerkship. You will also have an opportunity to complete an evaluation giving us your feedback on the entire rotation. This will be done on the last day.

BOSTON UNIVERSITY GERIATRIC SERVICES
BOSTON MEDICAL CENTER

HOME CARE PROGRAM INFECTION CONTROL POLICIES

Eric Hardt, MD
Clinical Director, Geriatric Services

Clare Wohlgemuth, MS, RN, CS
Nursing Director, Geriatric Services

REVISED January 2004

BOSTON UNIVERSITY GERIATRIC SERVICES
BOSTON MEDICAL CENTER
HOME CARE PROGRAM
INFECTION CONTROL POLICIES

I. ROLE AND SCOPE

The Geriatrics Section of the Department of Medicine at Boston University and Boston Medical Center is a nationally recognized, clinically oriented program which provides care for frail and less frail elderly in their homes and in nursing homes and manages inpatient care, ambulatory care and provides geriatric out-patient consultation. In particular, the Section manages care at home for 530 frail, elderly residents of urban Boston, with an average age of 80; 70% are female. Many patients are poor (approximately 60% are on Medicaid) and members of minority groups (approximately 50% are non-Caucasian).

These patients suffer from a wide spectrum of illness severity and functional impairment: some are eligible for nursing home placement and able to remain at home only with extensive formal and informal nursing and personal care services, while others require little more than routine medical care. Formal services other than medical care, nursing consultation and social work intervention are provided by various certified home health agencies while informal services are often provided by family and friends. As a group, they are medically and functionally more frail than the general elderly population. The majority are homebound and require home nursing or personal care in addition to physician home care. Patients receive an average of 8 home visits annually and are hospitalized on average less than once per year.

For patients referred for primary care, **Geriatric Primary Care Clinic** is available. Criteria for geriatric outpatient management include moderate to severe dementia, behavioral problems, chronic pain, depression, chronic congestive heart failure, uncontrolled diabetes,

deconditioning with functional decline, malnutrition, medication non-compliance, psycho-social factors, recent changes in functional status or recurrent falls, and frequent hospitalizations. These patients must be able to use available transportation to attend clinic. Current census for this clinic is 1400 patients. This practice is located in the Yawkey Building on the Menino Campus. The Service has also established a geriatric clinic at the Roxbury Comprehensive Health Center.

Some patients are optimally managed in the home, especially those that have difficulty with ambulating, transferring, or keeping doctors appointments, due to confusion and lack of social supports, or those with recurring use of the emergency room. These patients may be best cared for by our **Home Care Program**. Our Service currently is providing care for approximately 530 frail homebound elders with a mean age of 80 years. These patients are managed by a collaborative practice of physicians, nurse case managers, a nurse practitioner, a social worker and medical trainees. For those patients who cannot be managed at home, Geriatrics Section physicians and nurse practitioners manage care for patients in 14 Boston area nursing homes.

The Geriatrics Section is responsible for the management of a **Geriatric In-Patient Service (Firm C)** located at the Menino Pavilion, Boston Medical Center. Primary medical care is given by staff attending physicians, the PA, geriatric fellows and medical residents receiving specialized training in the care of the geriatric patient. Consultation from the Section's clinical nurse specialists and clinical social worker is available.

The following policies apply to employees and trainees. All employees and trainees providing care in settings other than BMC will follow the policies of each institution.

II. EMPLOYEE HEALTH

Upon employment, and annually thereafter, all employees must make arrangements with Occupational Health to receive PPD testing.

All employees are required to receive all other immunizations as required by Occupational Health. Every employee is responsible for reviewing his or her immunization status with employee health on an annual basis.

Any employees who are at risk for exposures to blood or other potentially infectious materials are encouraged to receive a Hepatitis B vaccine. A record of Hepatitis B immunity, or an informed refusal is kept in the employee's occupation health file.

Any employee sustaining an exposure to blood or other potentially infectious materials must promptly report to Occupational Health Services or the Emergency Department if the Occupational Health Service is closed.

Any employee exposed to or infected with a potentially communicable illness must be evaluated in Occupational Health Services to determine if they are safe to provide direct patient care or other job related duties.

III. EDUCATION AND CONSULTATION

All employees receive a general orientation, which provides them with a basic understanding of their role in the surveillance, prevention and control of infection. In addition, all clinical staff members receive an annual in-service program reviewing Universal/Standard precautions, strategies of risk assessment and reduction as well as an update of infection control and employee health policies. Additional education sessions will be held as the need is identified.

Consultation by the Nurse Epidemiologist is provided on an ongoing basis to address infection control questions and concerns.

IV. PATIENT CARE ISSUES FOR HOME CARE PRACTICE

The home setting is considered a safer environment for frail elderly than the hospital setting but it is critical that health care providers take adequate precautions to decrease the risk of transmission of infections both to and from the patient. Many of our patients are immunocompromised by age, general debilitation, nutritional deficiencies and disease; therefore, are at increased risk. Hand washing, following the CDC Hand Hygiene Guidelines, is just as important in the home setting as it is in the hospital, LTC facility and ambulatory site as an effective method of infection control.

WASH YOUR HANDS BEFORE EXAMINING THE PATIENT

Since a medical history and physical examination cannot reliably identify patients infected with blood borne pathogens or other potentially infectious materials, Universal/Standard Precautions must be used on all patient visits. This practice necessitates the use of the following routine barrier precautions:

1) Gloves must be worn:

when coming into contact with blood or body fluids, mucous membranes and or non-intact skin of all patients.

when performing venipuncture or other vascular procedures

when handling items or surfaces soiled with blood or other body fluids

- 2) Gloves should double bagged and disposed of in the patient's trash.
- 3). Gloves must be changed after contact with each patient.

WASH YOUR HANDS AFTER EXAMINING THE PATIENT

Note: Antibacterial soap and paper towel kit as well as waterless soap is available should be carried in the home visit bag. Do not use the patient's personal soap and towel.

- 4) Masks and protective eyewear should be worn during procedures that are likely to generate droplets so as to prevent exposure of mucous membranes of the mouth, nose and eyes. The degree of exposure must be anticipated prior to the home visit so that the proper equipment is taken on the home visit. Protective masks are available in the medical supply closet.

IF YOU ARE ILL WITH AN UPPER RESPIRATORY INFECTION YOU SHOULD NOT MAKE HOME VISITS

V. RESPONSIBILITIES FOR CARE OF EQUIPMENT AND/OR MATERIALS DISPOSAL OF WASTE MATERIALS FOR HOME CARE PRACTICE

The bag must have a designated clean and dirty areas inside the bag. The dirty area is used to store items that are used patient to patient (BP cuff and stethoscope). The clean area is for items that are single patient use (including wound supplies).

The floor is considered a dirty area. **Bags should not be placed on the floor of the office, car or the patient's home. Bags in the car should be kept in a clean, secured place (either in the trunk or out of sight).** When you enter the patient's home, select the cleanest/most convenient work. If at all possible, place you bag on a clean wooden chair or table.

- 1) A disposable sharps container **must** be carried in the equipment bag at all times. Syringes and other sharp instruments are to be placed in the sharps container after use.

- 2).Sharps containers must be carried on the "dirty" side of the equipment bag. Full sharps containers should be disposed of in the receptacle located in the work room on Robinson 2 (2606).
- 3) All blood specimens must be transported back to BMC in the plastic container labeled " BIO-HAZARD", that is carried in the equipment bag. It is not acceptable to transport specimens in rubber gloves or plastic bags. You not only put yourself and your colleagues at risk but also the general public if you were to accidentally drop or break a test tube. during transport. The plastic container must be carried on the "dirty" side of the equipment bag.
- 4) The equipment bag must be stocked with a "Body Fluid Clean-Up Kit". Directions for use are clearly stated on the bag. Kits are stocked in the medical supply closet.
- 5) If driving to the home visit, equipment bags should be carried in the trunk of the car.
- 6) Additional educational material concerning the home visit and infection control in the home is available in the Geriatric Services office.

VI Surveillance and Prevention of Vaccine Preventable Nosohusial Respiratory Tract Infections: Influenza and Pneumococcal Pneumonia Plan and Policy

BOSTON UNIVERSITY GERIATRIC SERVICES SECURITY GUIDELINES

The safety, security and health of all BU Geriatric Services employees, trainees, and patients are of primary importance and concern.

Safety Guidelines found in this policy are drawn from a number of sources including: the OSHA Guidelines for Workplace Violence Prevention Programs for Health Care Workers in Institutional and Community Settings, material provided by the Visiting Nurses Association of Boston, and expertise derived from safety consultants. A range of resource materials related to community safety can be found in the Office of the Administrative Director.

Guidelines While in the Community:

- Before leaving for home visits, plan a route that allows for travel on major roads. Even if they are shortcuts, avoid dark and deserted places, secluded alleys, entrances, vacant lots, and parks.
- Walk on the sidewalk as close to the curb as you can, and against traffic so that you are better able to see oncoming activity. Observe windows and doorways for loiterers.
- Avoid lingering outside of buildings, especially in isolated areas.
- Identify yourself to appropriate trades people and police in the community.
- Do not accept or give rides to strangers and/or patients and their families.
- Be alert, develop an awareness regarding your immediate environment, and convey the idea that you know where you are going and that you are “in charge.”
- Do not enter the area if there is unrest in the neighborhood.
- Never give your name, home address, or telephone number to strangers.
- Do not visit an unknown patient if approached by a stranger. If the person says it is an emergency, call 911 for him/her.
- Yell "FIRE" instead of "HELP" or “POLICE” and scream if in an uncomfortable situation.

- Neighborhoods change. If it looks as if an area is becoming unsafe, discuss it with the Home Care Program Leaders and/or B.U. Geriatric Services Management.
- Dress in a professional manner. Do not wear expensive watches, jewelry, or articles of clothing.
- Carry only a small amount of cash and limited numbers of credit cards.
- It is recommended that you wear your BMC Identification. There is some evidence that a medical badge provides a certain amount of “safe passage.”
- Schedule all home visits in the morning, if possible. There should be no occasion when a staff member is out making visits after dark.
- All visits are to be confirmed by the office before the provider leaves to make visits for the day. If a patient does not answer the door, use your cell phone to gain admission. If this fails, return to office and place a call to the emergency contact listed in the medical record. Document as a “not at home visit” and the follow-up.
- It is good to always have one hand free, even if it means making two trips to carry bulky loads.
- Do not enter a home if you feel uncomfortable. Call the Office and have the Team secretary call the patient and reschedule the visit.
- If you are visiting in a high-rise building use the following precautions when using an elevator:
 - Get on the elevator and stand close to the buttons. Locate the alarm button and push if necessary.
 - Look inside the elevator before entering. Do not enter if in doubt.
 - If the elevator is broken, use the stairs with caution.
 - Do not enter the elevator if there is no light.
- Use of pepper or chemical sprays are discouraged. They provide a false sense of security, are usually difficult to access when needed, and have a limited shelf life.
- **Always let someone in the office know what your schedule is.**

Guidelines Related to Transportation

- Keep your car in good working condition. Have enough gas for the day.
- Lock car doors and windows at all times.
- Do not leave items of value or perceived value where they can be seen in car.
- Do not park in an isolated area or where groups of people are loitering.
- Check the back seat of your car before entering.
- Know where gas stations are.
- If you are taking public transportation, sit near a door. While not the best location in terms of theft, it is the best location in terms of personal safety.

Revised 5/04

BU GERIATRIC SERVICES HOME CARE SECURITY POLICY

Purpose

The purpose of this policy is to establish uniform security procedures for the Home Care Program

Policy Statement

The Home Care Program recognizes that there is a certain level of risk in any home visit. Unlike hospital or office encounters, the home care clinician has little control over the environment in which the patient is seen. More often than not, the risk is not associated with the patient but with others in the household or the community.

BU Geriatric Services' mission is to address the special needs of the diverse geriatric and homebound population of the City of Boston. This means caring for patients living in a wide range of neighborhoods, including areas where crime is high relative to the City as a whole.

Although there is inherent risk in the work that our home care providers do, the Program is still obligated to make reasonable efforts to limit the level of risk, and to ensure that staff are not put in situations of substantial and unacceptable risk.

Procedures:

I. Steps to minimize risk in the course of day-to-day activities

- Safety guidelines will be maintained and distributed to all home care staff as well as all trainees making home visits.
- Any clinician or trainees making a home visit must carry a cell phone. The Program maintains a cell phone for use by any individual who does not have his or her own.
- A person going out on a home visit should always let someone else know.
- If a clinician or trainee feels uncomfortable in a home situation, s/he should leave.

II. Procedure to be followed in instances where a staff person or trainee believes a home visit was or would be dangerous

In any instance where a staff person or trainee believes that a home visit was or would be dangerous, s/he should discuss the issue with other members of the patient's care team, and then with the Home Care Leaders. An appropriate forum for discussion will often be the weekly Home Care Team meeting, which all home care staff attends. Discussion should include assessment of risk and appropriate strategies for dealing with the perceived risks. Strategies may include but are not restricted to

- Devising a contract with patient or family (e.g., son cannot be at home when visit takes place, or a particular behavior must stop).
- Attempting to have the patient, family or friends intercede in a way that will reduce the security risk.
- Calling Adult Protective Services (if the patient him or herself is at risk).
- Obtaining more information from other agencies that serve the patient
- Prohibiting trainees from making visits.
- Making a request to management for a security service to escort the clinician to the visit.
- Changing the constitution of the patient's health care team if it can be done without seriously impacting the efficiency of the geographically-based home care teams.
- Prohibiting staff or students from visiting the home, and discharging the patient from the home care program (always a last resort).

Any situation that is thought to be a security risk must be documented in the medical record.

III. Involvement of the Management Team

Security issues or concerns of low risk may be discussed and resolved without the notification or involvement of the Geriatrics Management Team. However, the Home Care Leaders must involve the Geriatric Section's Management Team if a security issue has any of the following characteristics:

- it involves potentially criminal activity
- it involves firearms
- a threat has been made against a member of the care team
- the certified home health agency or other community provider has made a decision to discontinue service to the patient
- it involves mental illness or substance abuse
- the Home Care Leaders are recommending that the constitution of the care team change or that the patient be discharged from the home care program

The management team will review the situation as well as approve or modify any recommendations made by the Home Care Leaders. Management will, when appropriate, request consultations from BMC Security, BMC Risk Management, the BMC ethicist, and/or the Geriatric Section's security consultant.

IV. Discharge from the Home Care Program

A decision to discharge a patient from the Home Care Program will be utilized solely in those very rare circumstances where all other reasonable means have been exhausted. The decision will only be made after consultation with BMC Security, BMC Risk Management, and BMC General Counsel.

V. Trainees

As preceptors, home care clinicians have a special obligation to ensure that students and other trainees remain safe. A level of risk that is acceptable to an experienced home care clinician may be unacceptably high for the trainee. Therefore, there may be instances where the Home Care leadership deems a particular home care situation as off limits to students, or even to residents and fellows.

VI. Related Documents:

- BU Geriatric Services Staff Security Guidelines
- Community Safety Resources

4/30/04

LOGICIAN DOCUMENTATION GUIDELINES

Login:

- Use your username and password on the first page
- Please click on the drag bar to “Location of care”. Find the location titled GERIDEPT. Please click on the appropriate subfolder listed under GERIDEPT depending on the site of care you are at and **this will ensure that your note is documented in the correct location:**
 - For Home Care, use “HC”
 - For nursing home, use “NH”
 - For clinic, use “CL”

Opening note template:

- For clinic, the note will be opened for you by the nurse or practice assistant. You just need to get to the patient’s chart and the note will be on hold.
- For home care and nursing home, you will need to open a note from scratch. To do this, first click on “open chart” in the toolbar on the left. **PLEASE START YOUR NOTE ON THE DAY OF VISIT.**
- Then enter the patient’s name or medical record number in the next screen. Click on the patient’s name once it is found. Then click on OK and this will open the Logician chart of the patient.
- On the toolbar above the list of documents there is an item called “UPDATE”. Click on this.
- You will then get a screen that asks you to choose the note template. Go to the binoculars and type GERI and this will open up on the right side of the screen options for template type.
 - For Home Care, choose “HC- follow-up” for a follow-up pt; choose “HC- comprehensive” for a new patient; choose “HC-Med Student Independent Visit” for when you go out on an independent visit without your preceptor.
 - For nursing home, choose “NH- follow-up” for a follow-up pt; choose “NH- Comprehensive” for a new pt or annual physical.
 - Once you have chosen the template you want click OK and you will be in the newly created note ready to go.

Writing your note:

For visits done with your preceptor:

- You may input information for: Vital signs, HPI, PAMDS, Histories, and ROS.
- For the physical exam and assessment, please free text both after the ROS. Do not use the PE and A/P forms—these forms the attendings must use. After ROS, free text the rest of your note:
 - Type “Med Student PE” and then document the exam
 - Then type Med Student A/P and document your assessment and plan.
- When you are done “.sign” the note to electronically sign your portion of the note.

For visits done independently:

- Free text your note. Use “.Med” to add the med list once updated to the end of your note.

Ending the note:

- Once you have signed your name, click on “END UPDATE” in the top right of the tool bar. Please make sure the “provider” listed is your attending. Please choose the PCP and any other provider whom you think needs to have the note routed to them (e.g. fellow, nurse case manager, NP). Once you have chosen who to route the note to, click on “done” and the note will be saved and routed to the appropriate providers. **IT IS REALLY IMPORTANT TO MAKE SURE THAT YOU ROUTE YOUR NOTE TO YOUR PRECEPTORS.**

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GERIATRICS SECTION PHONE LIST

General Geriatric Section Numbers	Phone	Fax	Room	
Administrative	638-8383	638-8387	2303	
Clinical	638-6100	638-6179	2603	
Firm Office	414-4096	414-4400	NIF6123	
	353-5045	353-5047	Main Campus	
Ambulatory Clinic	414-4639	414-4094	ACC 2	
	638-6168		2604	
Student Conference Room	638-6144		2504	
Large Conference Room	638-6169		2501	
Work Room			2606	
Small Conference Room	638-8391		2404	
Clinicians	Phone	Page	Fax	Room
Auerbach, Heidi MD	638-6136	1403	638-6179	2015
Bernstein, Erica MD ~ 2nd year Fellow	414-1680	1791	638-6179	2704
Bohac, Gery MD ~ Oncology Fellow	638-6199	1981	638-6179	2702
Brandeis, Garv MD	638-8945	7151	638-6179	2007
Brewer, Laura MS, PA-C	638-6107	7817	638-6179	2004
Brvant, Karen MD	638-8943	6107	638-6179	2008
Buczek, Joanna ~ Psvch. Fellow		3996	638-8542	DLG – 7
Burrows, Adam MD	474-0756 x 20	4715	474-0757	Upham's
Carr, Anne MS, RN, CS	638-6107	3299	638-6179	2013
Caruso, Lisa MD, MPH	638-6121	2527	638-6179	2104
Chao, Serena MD, MSc	414-1684	6104	638-6179	2712
Concilio, Katherine MS, RN, CS	638-6147	2807	638-6179	2203
Croopnick, Jonathan, MD ~ Oncology Fellow	638-6110	3290	638-6179	2702
Cullinane, Cindy MD ~ 1st year Fellow	638-6167	6356	638-6179	2701
Fabrizi, Catherine MS, RN, CS	638-6151	6477	638-6179	2202
Figura, Marva MS, RN, CS	638-6107	3788	638-6179	2013
Gagnon, Pam PA-C (firm C)	414-4909	8124	414-4400	NIF654E
Hardt, Eric MD	638-6176	8612	638-6179	2301
Harrington, Ellen MSW, LICSW	638-6137	9548	638-6179	2012
Hogan, Monica L. MS, RN, CS (Nursing Home)	638-6107	7817	638-6179	2102
(Home Care)	638-6113	6749	638-6179	2102
Khodeir, Maha MD, MPH ~ Beford VA	781-687-2349		781-687-3195	Bedford VA
Kimball, Pat MS, RN, C	638-6111	8086	638-6179	2201
Kirkland, Jim MD, MSc, PhD	8-8386 / 6015	1457	638-7124 lab	2300
Krairit, Orapitchaya MD, ~ 1st year Fellow	638-6142	3289	638-6179	2702
Levine, Sharon MD	638-6178	8584	638-6179	2006
McDonough, Ann RN ~ Clinic	414-7271		414-4094	ACC-2
McKeon, Brenda MS, RN, CS	638-6107	8377	638-6179	2013
McMackin, Naomi Turunen~ 1st year Fellow	414-1696	2364	638-6179	2702
Murrell, Erica PharmD	638-6112	7701	638-6179	2705
Mirza, Ali, MD				
Norton, Lisa MD	638-6197	1339	638-6179	2016
Oates, Dan MD ~ 2nd year Fellow	414-1685	4299	638-6179	2704
Owusu, Cynthia MD ~ Oncology Fellow		6105		2702
Perls, Tom MD, MPH	638-6688	5858	638-6671	2402
Rosenthal, George MD	638-6105	0250	638-6179	2009
Russell Matthew MD, MSc	638-6106	7762	638-6179	2016
Segal, Martha ~ Psvch Fellow	781-687-2626	0352		
Silliman, Rebecca MD, PhD, Chief	638-8383	1589	638-8387	2105
Sitapara, Ashish MD~ 1st year Fellow	638-6104	3287	638-6179	2702
Suen, Winnie MD, ~ 1st year Fellow	638-8942	2360	638-6179	2704
Takach, Pat RN, MA	638-6108		638-6179	2503
Terry, Lara MD, MPH	638-6677	5857	638-6671	2401
Wohlgemuth, Clare MS, RN, CS, DON	638-6141	6907	638-6179	2304
Administrative & Support Staff	Phone	Page	Fax	Room
Anastasi, Laura	638-8388		638-8387	2308
Arocha, Eduardo (temp)	638-6168		638-6179	2603
Caushi, Suela	638-8383		638-8387	2303
Foreman, Pam	638-6145		638-6179	2603
Kornetsky, David ~ Administrative Director	638-6149	6115	638-6179	2307
Lopez, Carmen	638-6154		638-6179	2603

Minstrell, Mary	638-6685		638-8387	2400
Tavares, Kathy	638-6156		638-6179	2602
Walsh, Barbara	638-6102		638-6179	2603
Geriatric Education	Phone	Page	Fax	Room
Levine, Sharon MD	638-6178	8584	638-6179	2006
Lindeman, Kirstin ~ educational prgrm coordinator	638-6109		638-8387	2700
Siu, Irene ~ fellowship program coordinator	638-6155		638-8387	2700
Silliman Research Group	Phone	Page	Fax	Room
Clough-Gorr, Kerri MPH	638-6101		638-8312	2103
Dluzniewski, Paul	638-8998		638-8312	M001
Lash, Tim MPH, DSc	638-8384		638-8312	2100
Silliman, Rebecca MD, PhD, Chief	638-8383	1589	638-8387	2105
Thwin, Soe Soe	638-8986		638-8312	M002
Wang, Teresa	638-8944		638-8312	M002
Perls Research Group	Phone	Page	Fax	Room
New England Centenarian Study				
Andersen, Stacy	638-6679		638-6671	2400
Pennington, JaeMi	638-6683		638-6671	2400
Perls, Tom MD, MPH	638-6688	5858	638-6671	2402
Schoenhofen, Emily	638-6680		638-6671	2400
Silver, Margery Ed.D.	638-6678	5860	638-6671	2403
Terry, Lara MD, MPH	638-6677	5857	638-6671	2401
Kirkland Research Group	Phone	Page	Fax	Room
Cartwright, Andrew	638-6015		638-7124	X-810
Cartwright, Mark	638-6066		638-7124	X-810
Delagiorgou, Georgia "Geena"	638-6015		638-7124	X-810
Giorgadze, Nino	638-6015		638-7124	X-810
Kirkland, Jim MD, MSc, PhD	8-8386 or 8-6078	1457	638-8387	2300
Pirtskhalava, Tamar	638-6015		638-7124	X-810
Tchkonia, Tamara PhD	638-8271		638-7124	X-810
Thomou, Thomas	638-6015		638-7124	X-810
Elders Living at Home	Phone	Page	Fax	Room
Byrne, Kate MS, RN	414-1640	6139	638-6175	ACC Mezz
Mazzone, Joe	638-6139	6140		ACC Mezz
O'Brien, Eileen	638-6148		638-6175	ACC Mezz

TIMES OF DEPARTURE/ARRIVAL

For home visits, it is **IMPORTANT** you arrive to the Robinson Complex at least 15 minutes prior to departure time to review patient charts.

If you are running late to any of the sites, please contact Kirstin Lindeman (617-638-6109) **AND** your respective preceptor for the day.

Preceptor	Clinic	Arrive	Special Instructions
Heidi Auerbach, MD	ACC 2 nd Floor	9:00 a.m.	Go direct
Eric Hardt, MD	ACC 2 nd Floor	8:45 a.m.	Go direct
REHAB Outpatient w/ Simona Manasian, MD	Preston 2 nd Floor	8:30 a.m.	Go direct
Lisa Norton, MD	ACC 2 nd Floor	8:30 a.m.	Go direct
REHAB Inpatient w/ Feng Wang, MD	Harrison Pavilion 7 West	8:30 a.m.	Go direct
Preceptor	Nursing Homes/ Outside Sites	Arrive	
Ruth Ann Beskrowni	Rogerson Adult Day Health Center	9:30 a.m.	Go direct
Anne Carr MS, RN, CS	Varies, See Schedule	9:00 a.m.	Go direct
Lisa Caruso, MD, MPH	Goddard House Nursing Home	8:45 a.m.	Go direct
Monica Hogan, MS, RN, CS	Marina Bay Nursing Home	9:00 a.m.	Go direct
Kate Byrne, MS, RN	Elders Living at Home Program	9:30 a.m.	Go Direct - Meet Kate at PINE STREET INN
Diana Miller	Rogerson House – (former Boston Alzheimer’s Center)	9:00 a.m.	Go direct
George Rosenthal, MD	St. Joseph’s Nursing Care Ctr.	9:00 a.m.	Meet at Robinson 2504
Matthew Russell, MD, MSc	Park Place or Marion Manor (See Schedule)	10:00 a.m.	Go direct
Preceptor	Home Visits	Departure	Special Instructions
Karen Bryant, MD	Arrive prior to departure to review charts	9:00 a.m.	
Erica Bernstein, MD	Arrive prior to departure to review charts	9:30 a.m.	
Lisa Caruso, MD, MPH	Arrive prior to departure to review charts	8:45 a.m.	
Serena Chao, MD	Arrive prior to departure to review charts	8:45 a.m.	
Kathy Concilio, MS, RN, CS	Arrive prior to departure to review charts	8:30 a.m.	
Kimberly Dodd, MD	Arrive prior to departure to review charts	9:00 a.m.	
Catherine Fabrizi, MS, RN, CS	Arrive prior to departure to review charts	9:00 a.m.	
Eric Hardt, MD	Arrive prior to departure to review charts	8:45 a.m.	
Monica Hogan, MS, RN, CS	Arrive prior to departure to review charts	8:30 a.m.	
Patricia Kimball, MS, RN, C	Arrive prior to departure to review charts	9:00 a.m.	
Sharon Levine, MD	Arrive prior to departure to review charts	8:30 a.m.	
Lisa Norton, MD	Arrive prior to departure to review charts	9:00 a.m.	
Dan Oates, MD	Arrive prior to departure to review charts	8:45 a.m.	
Winnie Suen, MD	Arrive prior to departure to review charts	9:00 a.m.	
Prashant Wadhwa, MD	Arrive prior to departure to review charts	9:00 a.m.	
Clare Wohlgemuth, MS, RN, CS	Arrive prior to departure to review charts	9:00 a.m.	