Outpatient Geropsychiatry:
VA Central California Health Care System

Site Coordinator: Neil Smith, D.O., Assistant Clinical Professor
Attending Faculty: VA MHC Faculty
Rotation Length: 12 months, part-time (1 month FTE)
Resident Training Level: PGY-2B/3A (Introductory Outpatient Year)

Patient Care
1. Residents are expected to learn how to perform a psychiatric interview and assessment informed by an understanding of aging issues. Specific objectives are:
   a. Learning how to utilize, deal with, and benefit from the presence of collateral sources of information.
   b. Gathering sufficient and appropriate information in order to arrive at a “longitudinal” picture of the patient’s functioning.
   c. Gathering information shedding light on what have been the patient’s coping mechanisms and strengths.
   d. Gathering information about how the patient has dealt with age-related issues such as physical decline, deaths, retirement etc.
   e. Gathering information that helps shed light on why this patient is presenting to a psychiatrist at this time.
   f. Developing effective strategies to gather information when the patient has limitations such as visual and hearing impairments.
   g. Demonstrating an appreciation that a wide range of psychiatric, neurologic and medical conditions may underlie the common presenting complaints of “depression”, “anxious” and “trouble with memory.”
   h. Assessing the adequacy of the support system for the patient, and to recognized caregiver stress, burnout and depression.
   i. Eliciting risk factors for suicide or homicide.

2. Residents are expected to develop a working differential diagnosis and to develop a plan for gathering the necessary information to move from a “differential” to a specific diagnosis. Specific objectives include:
   a. Becoming adept at using the Mini-Mental State Exam, i.e. learn how to administer and score in a reliable manner and how to still utilize this instrument in patients with limitations as visual or motor impairments.
   b. Knowing when to refer for more detailed neuropsychological testing, and how to make a good referral.
c. Effectively using collateral sources to elicit information helpful in refining diagnoses.
d. Knowing how to order and interpret appropriate medical exams and studies (imaging) needed to refine diagnoses.

3. Residents are expected to develop and carry out a treatment plan which logically flows from the diagnostic assessment. Specific objectives include:
   a. Recognizing when a patient needs case management services.
   b. Knowing when and how reporting to regulatory agencies is required, e.g. reporting of suspected abuse to Adult Protective Services and filing Confidential Morbidity Report for cognitive problems.
   c. Recognizing safety issues and the proper means of addressing these issues: e.g. wandering, presence of firearms, need for 24-hour supervision etc..
   d. Knowing when psychotropic medications are indicated, and to know how to safely initiate these medications.
   e. Knowing when psychotherapy is indicated, and to utilize psychotherapeutic techniques effective in this population.
   f. Demonstrating consistent concern and care for patients by responding to urgent phone calls from/about patients.
   g. Utilizing resources outside the VA as indicated for specific problems: e.g. Respite Care in dementia; Valley Caregivers Resource Center for legal issues and Alzheimer’s Research Center for perplexing diagnostic issues.
   h. Recognizing when patients are at heightened risk for suicide or harm to others, and knowing how to effectively intervene to lessen the risk or prevent.
   i. Allowing the patient to participate in the development of the treatment plan to the extent possible for that patient.
   j. Demonstrating that they consistently provide informed consent to patients.
   k. Assessing readiness for, and managing termination from treatment.

4. Residents are expected to “chart” their findings, impressions, and conclusions in the electronic medical record (CPRS) and are expected to perform required VA health screens/education as appropriate. Specific objectives include:
   a. Documenting the initial assessment utilizing the Mental Health Clinic Intake form, supplementing this when additional information needs to be included.
   b. Providing a five axis DSM-IV diagnosis in the initial assessment, with updates/changes as required by new findings.
   c. Documenting that lab and other tests (e.g. imaging studies) ordered have been reviewed, and interpreted.
   d. Writing progress notes whenever there is an encounter, whether for a regular, follow up appointment, urgent non-scheduled appointment, or a phone conversation.
   e. Completing any required Clinical Reminders which are due and which are among those Mental Health staff are expected to complete.
Medical Knowledge

1. Residents are expected to know the difference between normal, age appropriate changes or reactions, and pathologic changes or reactions. Specific things residents should know are:
   a. How normal age-related changes in cognition are different from pathologic changes.
   b. The difference between normal emotional reactions to age related changes versus pathologic reactions.
   c. The difference between normal bereavement and abnormal bereavement.

2. Residents are expected to know how to assess and manage patients with dementia. Specific objectives are:
   a. Knowing the diagnostic criteria (DSM-IV and NINCDS-ADRDA) for the major causes of dementia: Alzheimer’s Type; Lewy Body Dementia; Vascular Dementia and Fronto-temporal dementia.
   b. Knowing what tests, studies, assessments are needed to rule out reversible causes of dementia, and to help identify the particular type of dementia one is dealing with.
   c. Knowing when cholinesterase inhibitors are indicated, how to utilize them, and to know their common side effects.
   d. Knowing appropriate pharmacologic and behavioral interventions for the common mood and behavioral complications associated with dementia.

3. Residents are expected to know how the presentation of the common psychiatric disorders differs in the elderly. Specific objectives are:
   a. Knowing the difference, and treatment implications of “early appearing” geriatric depression v. “late onset” depression.
   b. Knowing the criteria for, and significance of “vascular depression”.
   c. Knowing how PTSD may appear late in life.
   d. Understanding the longitudinal course of schizophrenia and bipolar disorder especially as people with these disorders move into their geriatric years.
   e. Understanding how and why substance abuse is often overlooked in the elderly, and understanding how to recognize substance abuse problems in this population.

4. Residents are expected to know how to assess and manage late onset psychosis. Specific objectives include:
   a. Knowing the medical etiologies of late onset psychosis.
   b. Knowing what sort of medical evaluation is required for late onset psychosis.
   c. Knowing psychopharmacologic and behavioral interventions for late onset psychosis.

5. Residents are expected to understand how aging affects psychopharmacolgy. Specific objectives include:
a. Understanding how aging affects the pharmacokinetics of the major classes of psychotropic medications and what adjustments in dosing are required.
b. Understanding how aging affects the pharmacodynamics of the major classes of psychotropic medications, and what adjustments in dosing are required.
c. Understanding the vulnerability of the aging brain to tardive dyskinesia.

6. Residents are expected to know the appropriate, accepted treatments for geriatric patients for the major mental disorders.

**Interpersonal and Communication Skills**

1. Residents are expected to work effectively as part of a multidisciplinary team, respecting other team members. Specific goals include:
   a. Presenting any urgent or critical clinical information to attending staff in a timely manner.
   b. Arranging time off in a clinically responsible fashion, i.e. ensuring adequate time for rescheduling if necessary and ensuring that any critical cases are “checked out” with “covering” individuals. This includes providing guidance to clerical staff regarding how and when patients should be rescheduled.
   c. Communicating any urgent needs for case management to the team case manager.
   d. Gaining an understanding of the roles of other mental health professionals, and dealing with these other individuals respectfully.

2. Residents are expected to strive for excellence in communication with patients and their families/caregivers. Specific goals include:
   a. Being responsive to patients’ questions about their conditions and treatment.
   b. Responding to legitimate family and caregiver inquiries about condition and treatment.
   c. Responding to phone calls from/about patients in a prompt fashion.
   d. Having a lack of complaints from patients and their caregivers, i.e. there should be no legitimate complaints about the resident from these individuals to the Patient Advocate, the Chief, Mental Health, the Chief of the Mental Health Clinic or to other clinical staff.

3. Residents are expected to communicate well with other medical providers. Specific goals include:
   a. Having communication (phone, email, letter etc) about medical issues or the plan of care, when necessary.
   b. Having communication with the referring party when there is lack of clarity about the reason for referral.
4. Residents are expected to read, and respond to email through the VHA email systems.

**Systems-Based Practice**
Residents are expected to demonstrate an awareness and appreciation that they work within the context of a larger health care system (the VHA), and that this system operates within the larger society which is characterized by issues and concerns about health care for the aged. Specific goals include:

a. Demonstrating knowledge about the relative costs of the various psychotropic medications prescribed, and appreciating the financial impact of their prescribing practices.

b. Understanding the important safety and communication benefits of the electronic medical record (EMR), in particular the VHA’s Computerized Patient Record System (CPRS), and appreciating how the VHA is on the worldwide forefront of development of the EMR.

c. Understanding the influence of the pharmaceutical industry in shaping public and professional perceptions of mental illness, and shaping perceptions about appropriate treatment.

d. Completing VHA Clinical Reminders for their individual patients, and appreciating the importance of these from the public health standpoint.

e. Having knowledge about the various organizations which provide education, assessment and support for those with dementia.

**Professionalism**
Residents are expected to act like professionals, not like “shift workers.” They are expected to demonstrating abiding concern for their patients, and to regard these patients are their ultimate responsibility. Many aspects of professionalism are embodied in the objectives listed above. Some which bear explicit mention are:

a. Showing respect for others’ time and money, by showing up on time for work and working diligently throughout the day.

b. Staying late or working through lunch when there are urgent patient problems.

c. Making diligent efforts to learn new things so that they might be known as excellent and up-to-date clinicians.

d. Making efforts to reschedule patients in a responsible fashion when a clinic must be cancelled.

e. Treating all patients with dignity regardless of cultural background, gender, socioeconomic status, sexual orientation, religion or lack of religion or disabilities.

f. Abiding by all pertinent VA-CCHCS Medical Staff Bylaws and VHA statutes.

g. Showing the utmost sensitivity to patient confidentiality and abiding by all relevant regulations in this area.
h. Following up on any ordered labs, consults or studies and responding promptly and appropriately to any abnormal findings or results.

**Practice-Based Learning and Improvement**

Residents are expected to learn clinical skills through treating patients and through directed learning activities. Residents learn from the cases they treat through evaluation of outcomes with these patients. In addition, residents learn best practices from accessing and assessing the existing medical literature. Specific goals include:

a. “Sending” all progress notes for co-signature to the attending psychiatrist for review (In turn, the attending psychiatrist will question, amend, and bring up for discussion any salient issues in these notes).

b. Presenting any unfavorable, unexpected, or wonderful outcomes for follow up cases during team rounds.

c. Performing at least two literature searches utilizing PubMed, including obtaining/reviewing and presenting relevant articles. These searches should be directed at specific questions regarding their actual cases.

d. Reading and presenting to the team at least one review from the journal Evidence-Based Mental Health which deals with a geriatric issues or problem.

e. Utilizing the Cochrane Library database to identify at least one review of relevance to one or more of their patients. They are expected to then read and summarize the review with respect to both the content and procedures of these reviews.