An Introduction for Fellows, Residents, Students, and Other Trainees

The Training Mission of MDC

1. To teach the fundamentals of geriatric psychiatry, cognitive assessment, and social work management in a setting responsive to the clinical and psychosocial care needs of older adults and their families.

2. To create an integrated understanding of the pathophysiology and treatment of late-life neuropsychiatric disorders, through training in appropriate use of diagnostic and therapeutic modalities based on biological, psychological, and psychosocial paradigms.

3. To provide comprehensive consultation (professional opinions and advice about diagnosis and treatment) on request by a patient’s physician, and to support and educate families, other caregivers, and primary care physicians in provision of optimal care.

4. To promote collaborative management of older adults, through active outreach and communication with other providers.

Clinical Focus

1. Comprehensive assessment and care planning for mental disorders in older adults.

2. Limited ongoing treatment services for selected patients and families.

3. Cognitive impairment is the reason for referral for most patients.

Alzheimer’s disease is the most common diagnosis, with or without cerebrovascular and other co-morbid conditions, and many patients have associated mood or behavior changes (apathy, depression, agitation, aggression, psychosis, or anxiety). Frontal and fronto-temporal dementias and Parkinson-related diseases (typical PD with psychopathology and/or dementia; Lewy Body dementias; vascular parkinsonism; progressive supranuclear palsy and other dementias with extrapyramidal signs) comprise the majority of non-AD neurodegenerative disorders we see. Younger patients with early-onset familial and sporadic AD and other dementias are also seen. Sleep apnea and rarer primary sleep disorders may be first recognized here because of neuropsychiatric complications (atypical depressions, frontal-executive impairments, rapid decline in primary dementing diseases, nocturnal behavioral disorders).

Some older adults with other forms of psychopathology (treatment-resistant depression, vascular depression, other subcortical diseases, schizophrenia, bipolar disorder, complications of serious medical illness) and occasional neurologically- or medically-disabled younger adults (brain tumor, severe non-CNS disorders) may also be seen.

4. Caregiver stress and burden, family conflicts, and problems with the current living situation are common with our patients and are a focus of evaluation and management.
**Organization of Services**

**The Patient’s Path**

1. **Initial referral and clinical triage:** By telephone, fax, or email to the MDC social worker, Teresa Holder (teresah@u.washington.edu, 206-598-4080).
2. **Scheduling of initial visits:** PSR/scheduling staff (206-598-7792) after initial clinical triage by social worker. The PSR supervisor, Clemen Katiraie (katiraie@u.washington.edu) is in charge.
3. **Scheduling of follow up appointments:** Please try to schedule these before the patient leaves the clinic; obtain a packet of f/u request slips for your office, and have patient/family take it to the front desk before they leave.
4. **Visit length:** Typically 1-2 visits needed to complete the initial assessment; first visits are scheduled for 90 minutes, follow ups for 60 minutes.
5. **Ancillary evaluations:** Laboratory tests, neuroimaging (usually non-contrast MRI dementia protocol and brain perfusion SPECT, done at HMC), neurocognitive testing (referred to private neuropsychologists when needed), specialty medical evaluation and/or treatment (e.g. sleep disorders clinic, specialty medicine or neurology), or other (e.g. nutrition, foot care). For neuroimaging, complete a requisition; MA or PSR will schedule with HMC PSR.
6. **Treatment planning and continuity of care:** A major goal is to support primary care doctors in managing dementia, due to limited capacity in our clinic. This requires that other doctors involved in care always get copies of our reports and telephone/in person communication is also sometimes required.
7. **Linkage with inpatient psychiatry:** Few patients from MDC need or qualify for admission to UW Psychiatric Services (Central Intake, 598-6195) since ECT is no longer done at UWMC and 7N discourages admissions of agitated dementia patients. Most (rare) admissions go to Northwest Geropsych, some to HMC, Swedish, or other facilities.
8. **Telephone calls.** The department policy is that residents and fellows are responsible for the care of their own patients with attending backup as needed. Please let your patients and families know how to reach you and what to do in case of emergency. If you change a medication or other plan by phone or email, please add a short ORCA note.

**Providers**

1. MDC is a specialty service of the Department of Psychiatry and Behavioral Sciences, supported by the Department of Social Work; director/attending geriatric psychiatrist is Soo Borson (soob@u.washington.edu, 685-9453, pager 994-2124). Teresa Holder MSW (598-4080; pager 598-1198) provides social work counseling and services assistance to patients and families.
2. Medical assistant (MA) prepares visit paperwork, does vital signs, supports providers, helps with referrals to other services, schedules imaging, copies records as needed, facilitates consults on request.

*Please provide your pager, telephone numbers, and email address to Soo Borson, Teresa Holder, Shaune Demers, and Mehrnoush Tehrani (lead PSR) on your first day in clinic.*

**MDC Library**
See shelves above the desks occupied by Soo and Teresa. Several textbooks are available, including DSM-IV, a standard geriatric psychiatry text, a older women’s health text, neurology and neuropsychiatry texts, and some books for caregivers and general readers that may be loaned or recommended to families caring for an impaired elder.

**Parking**

Under the building; free with validation stamp from front desk staff.

**Mailboxes**

A labeled mail slot is available for your exclusive use in the mail room. Please check it each week – it has new patient information, lab results, outside medical records, MRI scans, letters, and other important information!

**Supervision**

MDC is a teaching service and all patients are seen in person by the attending (a Medicare requirement). The attending is present and available for supervision throughout the day on all scheduled teaching days, and can be paged or emailed at other times.

**Clinic Holidays, Cancellations, Vacations, and Sick Days**

Monday clinics are cancelled on Monday holidays; usually, new patients are not seen on days the attending is out of town (but follow up patients can be seen by the same resident or fellow without an attending on site). With experience, residents and fellows can see new patients in the absence of attending if necessary.

If you plan to take vacation or professional leave days during your rotation, you must inform the attending as soon as you know – and at least 30 days in advance, preferably earlier. UPOC requires that you complete a leave slip and give it to the lead PSR, Mehrnoush.

Please let the attending and PSR staff know when you will be post-call (no new patients during the following morning, and leave at 12; or, if HMC call, no clinic at all). Ideally you’ll set this up as soon as you have your call schedule – thank you! We ask that you don’t trade to take another resident’s call the night before clinic if at all possible, since a last-minute resident absence creates serious difficulties for elderly patients and the families who have had to rearrange their own schedules to come with them, and who usually have waited weeks or more to be seen.

If you are ill and cannot attend a scheduled clinic, please page Soo at 206-994-2124 as soon as you know you won’t be able to come in, and leave a message at the front desk (206-598-7792).

**Tips on Organizing a Visit**

1. A list of all your patients scheduled for the day should be in your box when you arrive in the morning. We like to briefly discuss patients before they are seen to set priorities for the visit and structure the time.
Initial assessments can be complex. Many families want and need more time than can be accommodated in a single session. Try to begin by addressing the urgent concerns of the patient and family, and strategize to manage those first. Second opinions and requests for diagnosis, often the presenting complaint, often mask less obvious problems with behavior, treatment failure, caregiver burnout, or dissatisfaction with previous care.

2. Patients are checked in at the front desk in MDC/UPOC when they arrive. When there is no MA, a PSR will weigh the patient and prepare the yellow clinic chart. (When there is an MA, full vitals are taken.)

3. The yellow chart contains a progress note where vital signs are logged in, any other records are filed, and a set of patient ID stickers are clipped on to use on consult, lab and imaging requests and prescriptions.

4. Please do your ORCA notes as soon as possible after you see the patient. ‘Word’ templates are available for new patient and follow up visits; these have been emailed to you.

**Patient and Family Assessments**

1. MDC uses a semi-structured evaluation procedure. Patients and families are asked to complete several forms prior to their appointment and to mail or bring them in for their appointments – check for them at the start of the visit (should be filed in the yellow chart). Additional measures, requisitions, and forms are in Soo’s office file cabinet. Please assemble your own set to save steps!

**Obtaining Consultations and Studies**

1. UWMC providers: Arranged by written consult requests. Complete this form and give it to the MA/PSR. Social work consults are requested directly with Teresa Holder.

2. Outside consultations: Arranged by faxed consult request. Complete it and give to the MA/PSR to fax.

3. Order forms for f/u visits, laboratory tests, imaging studies, Rxs and doctors’ order forms for medications and other treatments for patients living in long-term care facilities, and other procedures are available in the file cabinets in Soo’s office, mail room, and lunchroom. Please keep some in your own office for convenience.

**Referrals for Research Studies**

We serve as a referral source for several dementia-related studies. Talk to the attending.

**ORCA Notes**

1. Use templates if they help you.

2. Dictate initial evaluations if you prefer; follow up notes must be typed in electronically. Make liberal but ethical and accurate use of copy and paste features! The following list can be used for reference:
   - For dictated notes - your name; attending’s name; patient’s name and U#; Memory Disorders Clinic – Consultation, or Initial or Follow-up Visit.
   - Visit ID: time spent with the patient and/or family, who (name, relationship) came with the patient. Note who provided the history and whether the patient was seen alone and/or with collateral informant, and whether the informant was interviewed separately.
CC list: all relevant provider names and addresses, including those from whom a new consultation is requested. In ORCA, use the “Modify” button to add cc’s.

Name of requesting provider (for initial consults) and reason for the request – what the doctor wants from us. Address and phone of requesting doctor if appropriate. (It helps later on when we need to contact the physician.)

Purpose of visit and/or chief complaint - patient and/or caregiver.

History of present illness or interval history.

Current problem list (intake) or note new or no new problems (follow-ups).

Current medications, including prescription and over-the-counter drugs, vitamins, minerals, and botanicals (intake); note any changes (follow-ups).

Past psychiatric and medical history (intake only).

Relevant social and family history, including familial disorders (intake only unless updated at follow-up).

Medical and behavioral review of systems - pertinent positives and negatives.

Family/caregiver concerns - from form and interview, and relevant observations about the caregiver and his/her interactions with the patient (intake). Any changes should be noted in follow-ups.

Functional assessments - Functional Assessment Questionnaire and/or Lawton-Brody Physical Self-Maintenance and Instrumental ADL, completed by the caregiver (intake). Note changes in follow-ups.

Short Behavioral Inventory (adapted from Neuropsychiatric Inventory) - completed by the caregiver (intake). For follow-ups, note changes in previous symptoms or emergence of new ones; the scale need not be repeated unless it helps to paint the picture of a patient who has changed.

Physical examination - weight, BP and P with orthostatic change if indicated, T if febrile; general observations. Apparent nutritional status, neurological screening examination, focused medical exam when relevant. Note any impairments of hearing, vision, and mobility.

Mental status examination (appearance, behavior [cooperativeness, engageability, pathological behaviors, suspiciousness, motor activity], speech [amount, spontaneity, fluency, communicative detail, articulation, responsiveness to context], thinking [ability to concentrate, organization, process, content, preoccupations, distortions, distractibility], signs of psychotic experience [hallucinations, delusions, suspiciousness], affect and mood, insight and judgment [awareness of deficits, understanding of the purpose of the visit, ability to self-monitor], and intellectual function [Mini-Cog, MMSE, Trails A/B].

Assessment/formulation – this is a paragraph synthesizing the most relevant issues and open questions, including problems/diagnoses that were the focus of assessment or treatment during the visit or that modify treatment; non-diagnostic information important in treatment planning (e.g. caregiver stress); and level of functional impairment.

Major DSM-IV diagnoses.

Recommendations/Plans, including obtaining missing information (e.g. medical records), labs, imaging, or neuropsychological tests, additional consultations requested, coordination of care with other providers, referral to clinic social worker, caregiver interventions, initial treatment recommendations (e.g. adult day program, respite care, medication start, stop, or change, counseling interventions, etc) and components of assessment deferred to the next visit, when relevant.