**Hospital Medicine Fragility Fracture & Consult Service (GME–HMFF) Rotation Primer**

**Rotation Overview & Primary Educational Focus**
The primary goal of this rotation is to develop knowledge and skills in perioperative medicine, geriatric fracture co-management, and inpatient consultative medicine. This rotation includes two distinct patient lists—primary fragility fracture patients and hospital medicine consults.

Residents are expected to:
- Perform perioperative risk stratification
- Coordinate with other treating specialties to co-manage comorbidities in the perioperative setting
- Provide clear, timely, and evidence-based consultative recommendations with effective written and verbal communication
- Supervise interns effectively during night shifts

**Team Structure:**
Day Team
- 1 Attending Physician (DHM faculty)
- 1 Supervising Resident
- Occasionally 1–2 M3 clerkship students
- Interdisciplinary team: PT/OT, Case Manager, Discharge Navigator, Pharmacists

Night Team
*Supervision:*
- Swing-2 Attending (7:00 PM – 11:00 PM, indirect supervision)
- Night-2 Attending (10:00 PM – 7:00 AM, indirect supervision)

*Residents:*
- 1 Supervising Resident (GME/HMFF resident, 7:00PM – 7:00 AM)
- 1 Night Float Intern (Night Float, 5:00 PM – 7:00 AM)
- 1 Admitting Intern (UK Wards, 7:00 PM – 7:00 AM)

**Workroom Location:**
- Resident workroom: Pav H602 (“BS Room”)

**Census Expectations:**
- Target primary HMFF census: ≤15 patients
- No patient cap on DHM consults
- If total census (primary + consults) exceeds 25:
    - Resident cap remains 15
    - HMFF Attending assumes primary for additional patients, divided at interdisciplinary meeting

**Primary Service (HMFF Fracture Patients):**

1. Admission Criteria
   - Primary HMFF admission criteria
     - Age ≥65
     - Fragility hip fracture (fall from standing)
     - Fracture type: femoral head, intertrochanteric, subtrochanteric, proximal femur
   - All other admissions:
     - Should be admitted to the appropriate surgical service with DHM consult
     - Admitted to a DHM team with surgical consult via the triage attending (ATP) if medicine admission is indicated
     - All Transfers from other services must go through the triage attending (ATP)—even if previously consulted

2. Handoff
   - Morning: Should be completed by no later than 7:00 AM (H602 — BS room)
     - Overnight supervising resident signs out new admissions and cross-cover updates
   - Evening:
     - Residents must remain in-house until 4:00 PM.
     - If patient care tasks are complete and there are no active issues, residents may leave at 4:00 PM but must:
       - Remain signed in as First Call Provider
       - And be available via Epic secure chat until 7:00 PM
     - If urgent concerns arise after a primary resident leaves (but before 7:00 PM), the resident on late shift should evaluate the patient.
   - Update **First Call Provider** at each shift

3. Typical Workflow

   *Residents should prioritize new admissions and consults based on clinical acuity and competing responsibilities.*
   - 7:00–8:45 AM: Pre-rounding (chart review, patient interviews and physical examinations as able)
     - Resident signs in as First Contact Provider for all primary HMFF patients
     - Resident briefly chart-checks consult patients
   - 9:00 AM: Interdisciplinary discharge meeting (Pav A, 9-200 Care Team Station)
   - After discharge meeting: Run the patient list with the attending
     - The resident and attending mutually determine which patients the resident will manage as primary and which patients the attending will manage as primary (if necessary)
     - Ideally, the resident will be primary for ~10 patients to allow time to evaluate new consults and admissions throughout the day

- After rounds: Enter orders, arrange discharges, perform procedures as indicated, update families, provide consultative recommendations to primary teams, and complete documentation

**Consult Service:**

1. Common reasons for consult include:
   - Perioperative risk evaluation/stratification
   - Chronic disease management
   - Medication optimization in perioperative setting
   - Acute medical concerns during surgical admission

2. Consult Expectations:
   As a consultant you provide recommendations; implementation and responding to nursing concerns are the responsibility of the primary team.
   - Residents are expected to evaluate new consults between 7:00 AM – 4:00 PM
   - New consults after 4:00 PM should be directed to the triage attending (Swing 2)
   - Residents should know the specific clinical question being asked and answer it to the best of their ability, providing brief rationale as appropriate
   - Provide clear, concise recommendations
     - Epic secure chat may be appropriate for straightforward concerns; in-person discussion or phone communication is preferred for complex issues.
   - Update documentation if recommendations change

   *If issues arise regarding role delineation or communication, notify your attending and Dr. Weaver.*

**VA Perioperative Clinic:**

During this rotation, residents will be assigned 1–2 clinic session in the VA perioperative clinic.

- Location: VA Main Lobby, First Floor, Hallway 3
- Time: Tues and Thurs, 1:30 PM – 3:30 PM
- Supervision: Dr. Taylor Walker

**Night Shift Expectations:**

The GME/HMFF supervising resident oversees both the Admitting Intern and Night Float Intern.

1. Admissions
   - Admissions should preferentially go to resident/teaching teams.
   - All orders and documentation must be completed prior to shift end.
   - The night team may admit up to 8 patients per shift:

- New overnight HMFF co-management admissions or new consults may be performed if directed by Swing/Night attending and count toward the admission cap of 8
- Admitting Intern: up to 5 admissions
- Supervising Resident: up to 3 admissions
- Staffing:
    - Before 10:00 PM → Swing-2 attending (via phone)
    - After 10:00 PM → Night-2 attending or discussion on morning rounds

2. Cross-Cover
    - The Supervising Resident provides cross-cover for HMFF primary patients and supervises the Night Float Intern
    - The Night Float Intern provides cross-cover for Teams 1–4
    - If a patient experiences a clinical change overnight this should be escalated to the Supervising Resident

*This table is meant to serve as a framework for prioritizing clinical changes*

| **Priority** | **Example** | **Action** |
|---|---|---|
| **Emergent**<br>(Immediate risk to life) | Cardiac arrest, unstable arrhythmia, severe hypotension, respiratory failure, new focal neurologic deficit, hemodynamically unstable GI bleed | Notify senior *immediately*. Activate RRT/code as appropriate |
| **Urgent**<br>(High risk of clinical deterioration or time-sensitive) | Chest pain, increasing $O_2$ requirement, tachycardia, severe HTN, new fever, hemodynamically stable GI bleed, new encephalopathy, change in code status | Start stabilizing measures (e.g., oxygen, fluids, diagnostics). Notify senior resident within 5–10 min, or sooner if you need assistance. |
| **Routine**<br>(Requires follow-up but not time-sensitive) | Pain management, mild lab abnormality | Inform senior as time permits or bundle updates during downtime |
| **Informational**<br>(No immediate action needed) | Stable overnight events, resolved issues | Include in morning sign-out |