GERIATRIC MEDICINE CURRICULUM

University of Iowa Health Care
Veterans Affairs Hospital, Iowa City

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Report Absences to: Family Medicine Absence email list **and** absence phone @ 319-384-7776

Goal: Using interdisciplinary teamwork and the biopsychosocial model, residents will become proficient in the care of older patients across multiple settings.

Locations: Geriatric Assessment Clinics at IRL-E and the Iowa City VA, nursing facilities in Johnson County, IA

Preceptors: David Bedell, MD; Nicholas Butler, MD; Richard Dobyns, MD; Scott Larson, MD; Jason Wilbur, MD; Margo Schilling, MD.

Curriculum Overview:

1. One 2-week block rotation per year in the Geriatric Assessment Clinic (6 weeks total).
2. Longitudinal primary care of nursing home patients throughout residency; minimum of 2 continuity patients visited every 60 days.
3. Nursing home staffing scheduled with multidisciplinary team every 60 days after nursing home visits occur.
4. Self-study modules as assigned during geriatrics rotation.
5. "Difficult Geriatric Case" and Geriatric Journal Club presentations as assigned (2 per year; 6 total during residency).

Rotation Description

Residents will evaluate patients in an interdisciplinary setting and discuss their care with the interdisciplinary team. Residents will participate in the provision of interdisciplinary care management with a team composed of a geriatrician, clinical pharmacist, social worker, and nursing staff. Residents will work with the social worker to develop a discharge plans with appropriate home health services and clinic followup. Residents will work with the interdisciplinary team to provide continuing care to older patients receiving both consultative care and primary care services.

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During the rotation, residents will complete case-based online modules as assigned and are expected to attend Nursing Home Staffing at noon on Mondays unless urgent patient care precludes attendance. Additionally, residents will meet individually with one of the attending geriatricians to present a case and a brief educational topic related to the case.

Rotation Schedule

This is an outpatient rotation and is eligible for vacation and FM call. A sample schedule for this 2-week block is presented below. Most geriatric clinic activities will occur in the UI Health Care IRL Family Medicine Clinic with a few clinics at the VA. There may be variation in this schedule. Residents will receive their final schedule from Gretchen Schmuch prior to the start of the rotation.

	Monday	Tuesday	Wednesday	Thursday	Friday
8 AM – 12 PM	COC Clinic	GAC IRL	GAC IRL	VA Geriatric Clinic or GAC IRL	COC Clinic
12 – 1 PM	NH Staffing	Family Medicine Noon Conference	Residency Meetings	Geriatric Journal Club or Residency Meetings	Family Medicine Noon Conference
1 PM – 5 PM	GAC IRL or NH Rounds	VA Geriatric Clinic or GAC IRL	Admin time+	GAC IRL	COC Clinic

Key: COC – continuity of care; GAC – geriatric assessment clinic; NH – nursing home; IRL – Iowa River Landing.

* Various activities may include case studies and didactics through IGEC (see "Recommended Readings"), journal club prep time, a visit to Pathways Adult Day Program, home visits.

+ Administration time will be scheduled by coordinator, may vary and may not occur every week. It should be used to prep for journal club and case presentations, to complete online modules and to catch up on patient care duties.

Care of Nursing Home Patients

Family Medicine residents will be assigned at least 2 nursing home patients during the first month of training and will be expected to provide continuing care through the duration of their training experience. Residents will attend to new/acute medical conditions, provide continuing care of chronic medical, social and behavioral conditions and develop expertise with conditions unique to care in the nursing home, including principles of infection control, medical directorship, interdisciplinary team leadership and end-of-life care. FM-Psych residents will be assigned nursing home patients at the start of their second year and will be expected to provide continuing care through their third year. FM-Psych residents

have the option to provide on-going care to their patients after the end of their third year of residency.

Residents will visit their nursing home patients every 60 days as scheduled by the Family Medicine administrative service and provide longitudinal care via phone interactions with nursing home staff and patient visits as needed or scheduled. All visits will be documented briefly in the nursing home record and then fully documented in a telephone note in EPIC. Questions regarding patient care issues that require immediate supervisory input may be directed to the geriatric faculty via pager or EPIC messaging. Formal staffing will be provided at the scheduled time following the nursing home visit (e.g., "Nursing Home Staffing" with Drs. Bedell and Schilling) and will also occur about every 60 days. At this staffing, residents present their latest nursing home patient visits and discuss interval care issues. The staffing is supported by interdisciplinary faculty members and attended by a group of interdisciplinary learners. Nursing Home Staffing will occur every Monday over the noon hour.

Interdisciplinary nursing home team rounds occur at each nursing home monthly in a set rotation to review the care of residents' patients. Residents will be scheduled to attend these rounds at lest two times per year. Interdisciplinary case-based teaching occurs during chart review and at the bedside.

<u>Presentations</u>
Residents will present geriatric topics to peers, faculty members, and other interdisciplinary team members twice per year in two formats described here.

Difficult Geriatric Case Conference

Residents will present at the "Difficult Geriatric Case" Conference. The expectation is for the resident to select a geriatric patient who presents a clinical conundrum and who might benefit from a facilitated discussion among a group of interdisciplinary professionals. At the conclusion of the "Difficult Geriatric Case" Conference, residents will:

1. Understand the role of multidisciplinary assessment in the care of vulnerable older patients and learn to effectively facilitate a interdisciplinary team discussion.
2. Use the "Wisconsin STAR" method to determine how social, medical, pharmacologic, behavioral and personal factors all impact the health and function of vulnerable older adults.
3. Formulate a plan to improve the health of one or more vulnerable older adult patients presented during the case conference.

Geriatrics Journal Club

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Residents will be scheduled to present articles of their choice from peer-reviewed journals at a monthly geriatrics journal club. A critical analysis template will be provided and residents will also discuss the relevance of their article to clinical practice. An interdisciplinary team will be present to provide additional insights, clinical relevance and feedback to the residents. At the conclusion of the journal club, residents will:

1. Locate, appraise, and assimilate evidence from scientific studies related to care of older patients.
2. Determine the validity, reliability, strengths and weaknesses of the journal article they presented.
3. Apply what they learned from the article to the care of older patients.

<u>Competency Based Objectives</u>

Medical Knowledge

1. Residents will understand the unique healthcare needs of older patients.
2. Residents will understand the contributions of geriatricians; non-physician providers; nurses; psychologists, mental health specialists; social workers; physical, occupational and speech therapists; and pharmacists in an outpatient consultation and management service.
3. Residents will effectively use and explain the role of standardized instruments in the assessment of the health and healthcare needs of older patients.
4. Residents will identify appropriate community based services and long term care options for older patients.
5. Residents will describe the elements of effective drug use in older patients including the effects of age on drug pharmacokinetics and pharmacodynamics; the role of adverse drug effects on health; strategies to assess and promote compliance; and the role of the clinical pharmacist in the management of care programs for the elderly.
6. Residents will understand the principles of preventive health and describe methods of behavior modification and risk assessment.
7. Residents will maintain and expand knowledge of common diseases/geriatric syndromes encountered in long term care settings.
8. Residents will know and apply the basic approaches of the geriatric interdisciplinary team to the care of long term care patients

Patient Care (Clinical Skills)

9. Residents will successfully interview older patients across the spectrum of function and adapt their techniques to accommodate functional impairments, sensory loss, psychosocial features, and cultural characteristics.

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10. Residents will provide patients with effective counseling to achieve behavioral change.
    Establish a relationship with new nursing home patients, develop a patient panel, and provide compassionate, appropriate, and effective care for these patients in long term care settings for the duration of the fellowship.
11. Residents will develop clinical skills in patient assessment and management of a wide range of medical, social and end of life problems that are typically encountered in long term care settings.

Patient Care (Patient Management Skills)

12. Residents will effectively collaborate with the interdisciplinary healthcare team in the care of older patients.
13. Residents will appropriately obtain consultation and bring other clinicians into the assessment of the healthcare needs of older patients.
14. Residents will identify the professional disciplines that comprise the interdisciplinary healthcare team and apply the principles of interdisciplinary team work in the provision of care.
15. Residents will evaluate health problems, perform diagnostic services, and develop treatment programs for older adults across the spectrum of health and functional status, including (but not exclusive to) the following.

- Change in affect
- Acute change in cognition
- Dementing Illness
- Elder mistreatment
- Failure to thrive, frailty
- Falls, gait disorders
- Urinary retention or incontinence
- Immobility
- Functional dependency
- Inadequate Home support
- Loss of hearing
- Loss of vision
- Neurobehavioral disorders
- Pain
- Postural Instability
- Pressure sores
- Sleep disorders
- Weight Loss

Practice Based Learning and Improvement

16. Residents will use patient problems encountered in this experience as a stimulus for the development and achievement of learning goals to deepen their expertise or expand their knowledge of the biopsychosocial components of aging that impact health, including the demographic changes in the population, the basic science of aging and longevity, organ system changes with normal aging, psychological and social model of aging, and the implications of successful aging concepts for the preservation of function.
17. Residents will demonstrate their ability to, in a systematic way, analyze their personal practice patterns and seek to improve their own patient care and understanding of geriatric health problems.

18. Residents will utilize practice data to actively improve their own practice and patient management.
19. Residents will effectively use information technology to manage data, access online medical information and supplement their own education.
20. Residents will locate, review and disseminate to the interdisciplinary team, evidence from peer reviewed literature related to their patient's health problems.
21. Residents will use information technology to manage information, access on-line medical information and support clinical decision making in long term care settings.
22. Residents will facilitate the learning of students and geriatric team members in the interdisciplinary staffing for long term care patients.

Communication and Interpersonal Skills

23. Residents will provide humanistic geriatric healthcare that creates and sustains mutually beneficial provider-patient relationships.
24. Residents will document patient encounters appropriately in the medical record.
25. Residents will create and maintain a therapeutic and ethically sound relationship with their long term care patients.
26. Residents will work effectively with all members of the long term care team and interdisciplinary geriatric team to provide coordinated care.
27. Residents will use communication skills to provide an accurate and informative medical record of their long term care patient encounters.

Professionalism

28. Residents will demonstrate behavior that is consistently in the patient's best interest and show accountability.
29. Residents will apply principles of medical ethics in the assessment of competency, guardianship, advance directives, informed consent, and treatment refusal.
30. Residents will demonstrate respect, compassion, and integrity in all patient and colleague encounters.
33. Residents will be responsive to the needs of patients and colleagues in the long term care setting.
34. Residents will attend the required nursing home rounds and staffing.
35. Residents will visit their nursing home patients every 60 days as scheduled by the Family Medicine administrative service and provide longitudinal care via phone interactions with nursing home staff and patient visits as needed. It is the resident's to reschedule any missed encounters.
36. Residents will document nursing facility patient encounters accurately promptly.

Systems Based Practice

37. Residents will apply strategies for the delivery of preventive services across the spectrum of geriatric healthcare services.
38. Residents will provide effective use of community healthcare resources that accounts for patient preferences, recognizes the spectrum of services available to patients in the community, and effectively uses the financing programs that shape the delivery of care.
39. Residents will understand the services and the reimbursement systems for nursing facility-based long term care.
40. Residents will appreciate the complexity and communication problems that may arise when providing medical care across different health care settings and develop skills in providing transitional care at discharge junctures.

Evaluation and Feedback

1. Direct observation and feedback by faculty physicians in real-time during clinical activities and didactics.
2. Competency- and milestone-based faculty evaluations at the end of the rotation.

Recommended Reading

- Dursco SC, Sullivan GM (eds.). *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine.* 8th ed. New York: American Geriatrics Society; 2013. Chapter 6, Assessment, pgs 52-57.
- Dursco SC, Sullivan GM (eds.). *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine.* 8th ed. New York: American Geriatrics Society; 2013. Chapter 7, Multimorbidity, pgs 58-60.
- Rakel RE (ed.). *Textbook of Family Medicine* 7th ed. 2007: Chapter 7, Care of the Elderly, pgs 67-105.
- Geriatrics A t Your Finger Tips provided.
- Rueben DB, et al. *Geriatrics at Your Fingertips*. 2017 (updated annually). American Geriatrics Society. (Provided during orientation to residency.)
- Cases, lectures and more at Iowa Geriatric Education Center (IGEC) at https://www.healthcare.uiowa.edu/IGEC/
- Expanded information available with the AFP collection of Geriatric Care articles at http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=55
- Videos of gait disorders available at http://accessmedicine.com/content.aspx?aid=9107226 http://library.med.utah.edu/neurologicexam/html/gait_abnormal.html

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References

ACGME Program Requirements for Graduate Medical Education in Family Medicine, Revised July 2017. Accessed online at http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_2017-07-01.pdf?ver=2017-06-30-083354-350

Notes

Per ACGME, "Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of the older patient. (Core) IV.A.6.d).(1) The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases. (Detail) IV.A.6.d).(2) The experience should incorporate care of older patients across a continuum of sites."

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