

UND GERIATRIC MEDICINE FELLOWSHIP CURRICULUM ACUTE CARE

LOCATION SITE

Sanford Medical Center Fargo
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INTRODUCTION

Acute Hospital Care is different for older adults than middle aged and young patients for several reasons. Firstly, older adults often experience atypical manifestations of disease. Some examples are UTI presenting as delirium or pneumonia presenting with abdominal pain rather than dyspnea. Secondly, older adults are victims of iatrogenic disease. Evidence of this problem includes safety issues such as falls or adverse medication events (AE's). Thirdly, loss of function is a huge concern. Only 40% of older patients recover their pre – hospitalization function, and even less do so if they enter the hospital with one or more functional impairment. Thus, multiple issues confront the Geriatrician as an acute care consultant or hospitalist.

Important health system issues confront the Geriatrician. The hospital patient population in some hospitals is nearly 50%. The oldest old are nearly twice more likely to be hospitalized than 65 – 84 year olds. Given this surge in elderly patients, hospital administrators are concerned about length of stay and re-admission rates. This concern escalates if the older patient is covered by a shared - risk contract for insurance whereby the health care system absorbs acute care costs when Medicare pays them a monthly stipend for total health care of a patient.

Acute upon chronic conditions is another element common to elderly. These overlaps often make diagnosis difficult. Furthermore, psychosocial issues can adversely impact an acute care episode. Nursing home placement and home health care are often new and perplexing issues for acutely ill elderly. New roles for caregivers emerge, sometimes tipping the scale towards care giver burn out.

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Table 1. Most frequent conditions causing hospitalization among older patients

Rank	Diagnosis
1	Heart failure
2	Pneumonia
3	Coronary atherosclerosis
4	Arrhythmias
5	MI
6	COPD
7	CVA
8	Osteoarthritis
9	Rehabilitation
10	Electrolyte disorder
11	Chest pain
12	UTI / urosepsis
13	Fracture
14	Medical device complication
15	Septicemia

Given the challenges to acute care of the older adult, fellows rotating on the acute care block will learn different models of acute care for elderly, geriatric assessment of hospitalized patients, iatrogenic disease, medication reconciliation and de-escalation, functional decline and trajectories of recovery, malnutrition, transitions of care, and other important principles of Geriatrics.

OBJECTIVES BASED ON CORE COMPETENCIES

Medical knowledge

1. Report evidence - based medical interventions for acute care conditions, deconditioning and transitions of healthcare.
2. Identify best practices to prevent iatrogenic disease.

Interpersonal and Communication Skills

1. Apply team – based communication skills
2. Know how to deliver bad news and discuss transition patient goals from curative to palliative care.
3. Recognize and address care giver burnout
4. Report consultant findings in a timely, respectful and appreciative manner.

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Professionalism

1. Serve as a key team member of an acute care team.
2. Enhance parsimony among team members.

Practice-Based Learning and Improvement

1. Identify on – going or initiate new quality improvement projects.
2. Assist house staff in reporting AEs.
3. Help reduce LOS and recidivism

Systems-Based Practice

1. Understand criteria for acute care admission and discharge
2. Know metrics of high quality older adult care (ACOVE, IHI – Hartford Age Friendly Hospitals)
3. Report epidemiologic facts about acute care morbidity and mortality in elderly
4. Identify different models of acute care for elderly.

Patient care

1. Utilize evidenced – based assessments and interventions
2. Facilitate admission and discharge processes,
3. Facilitate family meetings
4. Strengthen team based care

CURRICULUM

The curriculum entails both didactic and clinical experiences. Fellows are assigned to a hospitalist's teaching service and become both learner and educator with that team. Fellows are responsible for identification of evidence – based clinical practices and dissemination of these interventions to the team.

DUTIES AND RESPONSIBILITIES

Fellows are assigned to one teaching hospital service (A – D) that involves a faculty member, senior resident, two interns, and a couple of medical students. Fellows meet at 7AM at the West Fargo Sanford Health hospital in the IM Residents offices (basement of the hospital) where they join their team for hand – off rounds from the night coverage team. Fellows join their team for clinical work rounds from 7 – 8 AM, and then they go see Geriatric consults. All patients 70 years and older on the team's service will be seen by the Fellow who will perform comprehensive geriatric assessment and create a health care management plan. Fellows will obtain verbal permission from patients to record their consultation for educational and clinical

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purposes. These video consultations will be reviewed by geriatrics faculty and feedback provided to the fellows. The geriatric plan is to be forwarded to the senior resident. Fellows will also meet with the care coordinator (with or without the faculty attending) and will communicate the discharge plan to the medical team. Additionally, fellows will work with the team to plan and execute family meetings. The fellow’s work product will be an admission and discharge consultation. The fellow will communicate the discharge plans to the patient’s PCP or follow up with the patient in the home or clinical setting. Fellows will identify and assist with ongoing or new quality improvement projects. They will also serve as teaching faculty, assisting in “professor rounds” and other forms of clinical teaching. Finally, fellows will attend noon time conferences as scheduled.

EVALUATION

Fellows are evaluated by a variety of means (see table).

COMPETENCIES	PATIENT CARE	MEDICAL KNOWLEDGE	PRACTICE BASED LEARNING	INTERPERSONAL COMMUNICATION SKILLS	PROFESSIONALISM	SYSTEMS BASED PRACTICE
EVALUATOR						
ATTENDING	X	X	X	X	X	X
PEER	X			X	X	
PROGRAM DIRECTOR*						
SELF**						
PATIENT/FAMILY MEMBER						
ALIED HEALTH PROFESSIONAL						
PARTICIPATION IN DIDACTICS						

*Milestones based evaluations performed quarterly **Evaluations performed semi-annually and annually

RESOURCES

Hazzard’s Geriatric Medicine and Gerontology, Chapter 16

GRS, 9th edition, chapters 17 – 19

Washington Manual

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GERIATRIC MILESTONES

Complete list of UND Geriatric Medicine Fellowship Curricular Milestones can be found in the handbook/website.

ROTATION SPECIFIC MILESTONES

Systems-Based Care for Elder Patients

General

29 Reduce iatrogenic events among elders in all settings through implementation of patient-specific and system-wide strategies to prevent falls*, immobility, delirium*, pressure ulcers*, incontinence*, malnutrition*, indwelling catheter use, nosocomial infections, deep vein thrombi, restraints, depression*, functional decline*. (NB: asterisk indicates additional competencies in syndromes or functional impairment section)

Hospital Care

42 Reduce iatrogenic events (see no. 29)

43 Recognize common and subtle presentations of delirium and manage appropriately

44 Perform preoperative assessments for older patients and document specific perioperative management recommendations to improve patient care and safety based on type of surgery and patient characteristics

Pressure ulcers

63 Recognize patient risk factors for pressure ulcers, and in high-risk patients work with an interprofessional team to develop a prevention plan

64 Stage pressure ulcers and demonstrate proficiency in describing their clinical characteristics (e.g., size, color, exudate)

65 Develop a treatment plan for pressure ulcers with an interprofessional team, incorporating the indications for surgical and nonsurgical treatments for ulcers (e.g., debridement, classes of wound care products and treatments, pressure relieving devices, etc.)

Hearing and vision disorders

67 Screen for hearing loss and recognize when referral is appropriate

68 Recognize common ophthalmologic conditions associated with aging, including changes of normal aging, cataract, glaucoma, age-related macular degeneration, and refer when appropriate to ophthalmology, optometry, and/or low-vision services

Urinary incontinence

69 Identify, evaluate, and treat the most common forms of both reversible and chronic urinary incontinence using nonpharmacological interventions where possible

70 Refer when appropriate for urologic or gynecologic evaluation including urodynamic testing, pessary evaluations, pelvic floor muscle training

71 Identify, evaluate, and manage urinary retention and incomplete bladder emptying including the appropriate use of intermittent catheterization or indwelling bladder catheters

Constipation and fecal incontinence

75 Identify, evaluate, and manage constipation and fecal impaction using nonpharmacological and pharmacological modalities

76 Identify and provide initial evaluation and management of fecal incontinence