INTRODUCTION

Age is a critical risk factor for one or more chronic condition. Chronic disease needs to be approached at the patient – specific and population levels. Fellows must understand how care of older adults becomes more complex when multiple chronic conditions exist, with or without cognitive impairment. Chronic disease models of healthcare help Geriatricians conceptual the goals of care. All chronic disease models of care emphasize patient self-management. For example, heart failure patients should monitor their weights daily and increase diuretic dosage when they gain 2 or more pounds of weight.

The Geriatrician approaches chronic disease from multiple angles, considering not only the disease and its progression but also functionality and psychosocial elements. Geriatricians need to understand how nutrition and exercise intersect with chronic disease, as well as be familiar with technology that helps manage chronic conditions. Additional knowledge is required to understand how poorly controlled conditions such as hypertension can lead to other chronic problems such as dementia (e.g., see SPRINT study on reduction of cognitive impairment by aggressive blood pressure management). All of these efforts are directed at increasing the quality of life while reducing costs of patients with chronic conditions.

OBJECTIVES BASED ON CORE COMPETENCIES

Medical knowledge

1. Report the components of a chronic disease model of healthcare
2. Determine whether randomized controlled trials include elderly or the oldest old as part of their clinical outcomes.

**Interpersonal and Communication Skills**

1. Apply motivational interviewing for helping patients improve self management of their conditions.
2. Improve team – communication through meetings, messaging, teleconferencing, and EMR documentation.
3. Follow-up test results with patients and PCPs

**Professionalism**

1. Timely follow-up of test results with patients and PCPs

**Patient-Based Learning and Improvement**

1. Identify an on – going or new quality improvement project that addresses a process or outcome measure in one or more chronic conditions.

**Systems-Based Practice**

1. Understand Medicare options, such as care coordination, in managing chronic conditions.
2. Understand the strengths and weaknesses of chronic disease models of health care.

**Patient Care**

1. Apply best practice guidelines in chronic disease management
2. Identify new RTCs that support changes in chronic disease management for older adults.

**DUTIES AND RESPONSIBILITIES**

During this block rotation fellows select two, two week rotations with a chronic disease clinic in either cardiology (heart failure), pulmonary medicine (COPD), rheumatology (OA), or endocrinology (diabetes). The fellow will see patients with one or more chronic conditions, perform a clinical assessment and opine a clinical management plan in collaboration with the chronic disease faculty and team members.
EVALUATIONS

Fellows are evaluated by one or more of the evaluation tools listed in the following table.

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>PATIENT CARE</th>
<th>MEDICAL KNOWLEDGE</th>
<th>PRACTICE BASED LEARNING</th>
<th>INTERPERSONAL COMMUNICATION SKILLS</th>
<th>PROFESSIONALISM</th>
<th>SYSTEMS BASED PRACTICE</th>
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*Milestones based quarterly evaluations *Evaluations performed semi-annually and annually

RESOURCES


GERIATRIC MILESTONES

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

ROTATION SPECIFIC MILESTONES

Medication Management
11 When a patient presents with a new symptom or geriatric syndrome, investigate whether a medication(s) is contributing
Diseases in older adults
17 Identify and manage medical disorders that occur in older adults
18 Know the different presentation, management, and underlying pathophysiology of common diseases in older adults (including but not limited to hypertension, coronary artery disease, osteoporosis, hypothyroidism, infections, and the acute abdomen; adjusting drug dosage for renal function)