UND GERIATRIC MEDICINE FELLOWSHIP CURRICULUM
HOME AND COMMUNITY HEALTH

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Introduction

Home care includes a wide range of services and equipment to homebound elderly to restore or maintain their optimal level of comfort, function and health. Home care may involve Geriatricians at a distance (for example, reviewing and signing an initial health care plan from a Nursing agency) or directly (such as providing physician home visits). Home care is effective. In - home geriatric assessment leads to patients with less disability and lower transfers to nursing homes. Post – hospitalization visits to patient homes results in fewer acute readmissions (hospital and ED). Thus, home health is an important tool for improving quality while lowering costs of health care.

Community – based health care entails a variety of services. On example unique to North Dakota is the no - cost Social Work consultation provided by the ND Alzheimer's Association. Many other examples exist such as visiting paramedics, community faith nurses, day care centers, PACE programs, senior centers, and memory cafes. These community – based programs help the older adult address psychosocial and functional parameters. Geriatricians need to know these resources and interact with them as they create a triangular relationship between themselves, patients and community health workers.

During this block rotation, fellows are introduced to a variety of home care and community services. Fellows learn how to work with teams, how to conduct a home visit, and address care giver needs. Innovative aspects of the rotation include telehealth and intersecting with a quality improvement project on heart failure.

Objectives

This rotation addresses multiple competencies important to Geriatricians. In addition to the core competencies, fellows are expected to achieve several milestones and entrustable professional activities.

Patient Care:

1. Identify the needs of the patient and care giver
2. Demonstrate expertise in medication management by justifying medication regimen and duration based upon maximizing medication adherence and identifying medications that should be avoided or used with caution in older adults (CEP-10b, c)
3. Identify patients who are frail or otherwise at risk for death, dependency and/or institutionalization over the next few years. (CEP-21)

4. Demonstrate the ability to manage the care of patients with multimorbidities by integrating the evidence, patient's goals, life expectancy and functional trajectory. Document clinical reasoning when management differs from standard treatment recommendations. (CEP-22)
5. Demonstrate the ability to manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement, and anxiety. (CEP-23)
6. Assess and incorporate family/caregiver needs and limitations, including caregiver stress, into patients' management plans. (CEP-24).
7. Assess and develop team based plans of care (CEP-17, SBC-47)
8. Execute elements of geriatric assessment in community programs.

Medical Knowledge:

1. Know the indications and contraindications for referring patients to physical, occupational,
2. speech or other rehabilitative therapies, and refer if appropriate. (CEP 14)
3. Recognize and manage the care of patients at high risk for poor outcomes from common
4. conditions such as deconditioning, stroke, hip fracture, and dysphagia. (CEP-16)
5. Demonstrate knowledge of commonly accepted geriatric quality indicators. (SBC-32)
6. Describe patient criteria for admission to home health care
7. Know key elements of home care assessment and follow – up
8. Define community care resources for older adults

Practice Based Learning and Improvement:

1. Looks up information he/she does not know
2. Evaluate quality of care by monitoring and tracking key health outcomes such as acute care recidivism, symptom control (e.g., pain management), and safety (e.g., fall prevention or home safety checks).
3. Engage in on – going QI projects associated with home care.

Interpersonal Skills and Communication:

1. Practice culturally sensitive shared decision making with patient and families/caregivers in the context of their health literacy, desired level of participation, preferences and goals of care (CEP-1)
2. Use strategies to enhance clinician-patient oral and written communication in patients with hearing, vision, or cognitive impairment (CEP-3)
3. Know how to assess caregiver burnout
4. Effectively communicate with patients, caregivers, and team members in both oral and written forms.
5. Participate in home care / family conferences

Professionalism:

1. Provide compassionate care while establishing personal and professional boundaries with and families/caregivers (CEP-6)
2. Behaves in HIPAA-compliant manner regarding patient information
3. Demonstrate punctuality and timeliness

4. Readily accept feedback from patients, caregivers, and team members
5. Show clinical follow up with patients, team members, and consultants, including good documentation of these encounters.
6. Respond to urgent problems

Systems Based Practice:

1. Recognize health-care system issues that negatively impact the care of the geriatric patients, and identify improvement strategies. (SBC-39)
2. Demonstrate expertise in transitions of care by communicating the following to the receiving provider through discussion or timely discharge summary: medication reconciliation, an assessment of patient's cognition and function, pending medical results and follow-up needs. (SBC-30)
3. Identify patient and family/caregiver needs and refer to appropriate local community resources. (SBC-35)
4. Recognize and document signs of elder abuse and/or neglect and refer to community resources and adult protective services when appropriate. (SBC-36)
5. Recognize the complexity of geriatric care and demonstrate the ability to prioritize care, in a time-efficient manner, during encounters with geriatric patients (SBC-37)
6. Demonstrate the ability to teach patients, caregivers and others about aging-related healthcare issues. (SBC-40)
7. Refer patients to appropriate home health and support services to maximize ability to remain in their homes. (SBC-48)
8. Describe evidence – based outcomes of home care in quality and cost
9. Report funding of home care and community programs
10. Know how home care is assessed and accredited (e.g., OASIS)

Duties and Expectations

Fellows are expected to report to Sanford Home Health for patient assignments. These assignments will include co – visits with a RN, PT or social worker as well as physician home care. Fellows will communicate in advance with patient and family members to confirm the home visit. Documentation of the home visit will be recorded in EPIC EMR.

Fellows will contact representatives from community – based programs to arrange for visits, talks and other encounters with older adults in the community setting. These encounters will be documented in the Fellow's portfolio and an EMR progress note will be used if information needs to be transmitted to the patient's PCP (e.g., recent fall incident).

Resources

Geriatric Medicine: An evidence based approach, Chapter 12 Home Care

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Evaluations will be based on core competencies and completed by multiple entities. The objectives of this block rotation list the areas that will be evaluated (Likert 1 – 5 scale):

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

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

Geriatric Milestones

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

ROTATION SPECIFIC MILESTONES

Communication
2 Work effectively as a member or leader of an interprofessional healthcare team
Complex illness(es) and frailty in older adults
23 Demonstrate the ability to manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement, and anxiety
24 Assess and incorporate family/caregiver needs and limitations, including caregiver stress, into patients' management plans
25 Provide geriatric consultation in all settings with attention to multimorbidity, age-related changes in physiology, function, treatment efficacy and response, medication management, and psychosocial issues
Systems-Based Care for Elder Patients
General
32 Demonstrate knowledge of commonly accepted geriatric quality indicators
41 Describe models of care that have been shown to improve outcomes for older adults, e.g., ACE Units, PACE, multifactorial interventions to prevent falls, delirium prevention
Home care
47 Perform home visits, demonstrate modification of the physical exam for the home setting, and assess physical safety of the environment
48 Refer patients to appropriate home health and support services to maximize ability to remain in their homes