

UND GERIATRIC MEDICINE FELLOWSHIP CURRICULUM LONG TERM CARE

INTRODUCTION

Management of older people with multiple medical problems and geriatric conditions in the nursing home is exceptionally challenging. The quality of health care in this setting varies greatly and is dependent on staffing levels, competencies and family engagement. Like other health care settings, the SNF entails team based care. Thus, the fellows have an opportunity to collaborate with a physician extender, RN staff and other allied health professionals to develop and execute health care plans that are patient – centric and culturally appropriate. Many of the SNF encounters are linked to dementia care, so fellows need to understand the natural progression of dementia and use tools such as the FAST to identify points when patients transition to end – of – life care.

In addition to improving the quality of healthcare in the long term care setting, challenges in long term care include reduction of acute care use, improved safety, and effective transitions to other health care settings or home. Nearly half of patients admitted to skilled nursing units return home, so that transition is as important as the transition from hospital to the SNF.

Nursing homes are highly regulated, so fellows must become familiar with state surveys, Federal guidelines for healthcare and benefits, and well as the different resources available to residents according to their type of long term care insurance (public aid, Medicare, commercial insurances).

In general, application of Geriatrics Principles of care can greatly enhance the quality of medical care for NH residents. The goals of NH care often differ from those of medical care in other settings, and it is always important to regularly distinguish between restorative and curative care from comfort care.

LIST OF ACTIVITIES TO MEET OBJECTIVES OF THE LONGITUDINAL CLINICAL EXPERIENCE (BASED ON CORE COMPETENCIES):

1. **Patient Care:**
 - a. Demonstrate an appropriate initial evaluation and management of long term care patients using Geriatric assessment tools.
 - b. Obtain accurate and complete information through medical interviews, physical examination, and review of the electronic medical records and other sources of information.
 - c. Understand the special challenges of clinical assessment of the elderly including differential diagnosis of common geriatric syndromes such as visual and auditory disturbances, delirium, depression, dementia, weakness, falls, and transient losses of consciousness.
 - d. Manage high medical complexity.
 - e. Demonstrate sound clinical judgment; incorporating patient preferences and cultural consideration into the healthcare plan.
 - f. Continually review necessity of medications, especially anti – psychotics, and seek opportunities for de – escalation or de – prescribing medications.
2. **Medical Knowledge**
 - a. Understand high medical complexity in NH patients with and without cognitive changes
 - b. Report on the epidemiology and demographics of long term care
 - c. Strengthen knowledge about long term care regulation, quality improvement, and

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safety.

d. List the goals of Nursing home care

3. Practice-Based Learning and Teaching:

- a. Uses information sources effectively to support patient care decisions and to educate self, patients, and other physicians
- b. Develop skills necessary to balance knowledge of anticipated side-effects with quality of life.

4. Interpersonal and Communication Skills:

- a. Develop skills to manage patients with physician extenders and interdisciplinary teams.
- b. Develop communication skills, verbal and non – verbal, to effectively interact with cognitively impaired patients
- c. Implement effective communication with caregivers and family members of residents in long term care.

5. Professionalism

- a. Demonstrate good rapport with patients, family members, colleagues and staff.
- b. Work well with people from diverse backgrounds.
- c. Demonstrates respect, compassion and integrity in working with patients, families, colleagues and other health professionals regardless of their background
- d. Adhere to principles of confidentiality, scientific and academic integrity and informed consent
- e. Recognize and identify deficiencies in self and peer performance in a constructive, non–defensive manner.

6. Systems-Based Practice

- a. Identify the roles and responsibilities of inter – professional team members
Collaborate on a quality improvement project.
- b. Demonstrates appropriateness and cost-effectiveness of proposed diagnostic studies and therapeutic maneuvers.
- c. Summarize key ethical issues in NH care

CURRICULUM:

Both didactic and clinical experiences are part of the long term care curriculum. The didactic experience includes mini - lectures as well as self – directed study using the GRS and Chapter 20 of Hazzard's Geriatric Medicine and Gerontology. The following table lists activities to meet the objectives of the longitudinal, long term care clinical experience.

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| Activity | Objectives |
|-------------------------------|---|
| Engage in Quality improvement | Design a project with staff (Plan --> Do --> Study --> Act); attend monthly QI meetings |
| Educate staff | Improve application of Geriatric principles of healthcare |
| Family / team meetings | Modify and update health care plans |
| Educate residents | Assisted living presentations on nutrition, exercise, memory, etc. |
| Transitions of Care | Evaluate newly admitted Sanford Health residents |
| Geriatric consultations | Evaluate residents who have a change in function |
| Mental and cognitive health | Meet with psychiatry consultant |

DUTIES AND RESPONSIBILITIES:

The Geriatric Fellows share responsibility for patient coverage at two long term care facilities, Villa Maria and Bethany University. Their duties are to provide high quality health care for SNF and ALF residents. Each fellow is assigned a patient panel at one of the facilities for whom they will provide primary care. This care will be provided in collaboration with a Sanford – affiliated physician extender (PA or APN) as well as with SNF team members. Typically, the fellow will conduct patient rounds with a unit RN director. There will be routine and urgent patient evaluations as well as assessments of newly admitted patients to the Sanford LTC service. In addition to weekly rounds, Fellows will field phone call and inquiries during the work week from SNF staff, patients and family members, as well as provide “on call” coverage in rotation with other Sanford Health physicians. The on – call coverage will include other SNFs within the Sanford catchment. At all times, fellows have back up faculty coverage by the faculty member who is assigned to the long term care facility.

METHODS OF EVALUATION.

Fellows will be evaluated by faculty quarterly via multiple methods (see table). Evaluations from patients, family members, nursing staff and allied health professionals will also be included in the formative assessment of fellows. Fellows will also have an opportunity for personal reflection and self – assessment.

The completion of this longitudinal rotation will include a presentation (or publication) of a quality improvement project.

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| 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 | | | | X | X | |
| ALIED HEALTH PROFESSIONAL | | | | X | X | X |
| PARTICIPATION IN DIDACTICS | | X | | | | |

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

RESOURCES

Hazzard's Geriatric Medicine and Gerontology, Chapter 20

Geriatric Review Syllabus, 9th Ed., Chapters 19 – 21

GERIATRIC MILESTONES

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

ROTATION SPECIFIC MILESTONES

Communication

- 1 Practice culturally sensitive shared decision-making with patients and families/caregivers in the context of their health literacy, desired level of participation, preferences, and goals of care
- 3 Use strategies to enhance clinician–patient oral and written communication in patients with hearing, vision, or cognitive impairment
- 4 Skillfully discuss and document goals of care and advance care planning with elderly individuals and/or their families/caregivers across the spectrum of health and illness
- 5 Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship
- 6 Provide compassionate care while establishing personal and professional boundaries with patients and families/caregivers
- 7 Effectively lead a family/caregiver meeting
- 11 When a patient presents with a new symptom or geriatric syndrome, investigate whether a medication(s) is contributing

Complex illness(es) and frailty in older adults

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- 21 Identify patients who are frail or otherwise at risk for death, dependency, and/or institutionalization over the next few years
- 22 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
- 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
- 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

- 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)
- 32 Demonstrate knowledge of commonly accepted geriatric quality indicators
- 33 Participate in quality improvement efforts to enhance the quality of care of older adults
- 35 Identify patient and family/caregiver needs and refer to appropriate local community resources
- 36 Recognize and document signs of elder abuse and/or neglect and refer to community resources and adult protective services when appropriate
- 37 Recognize the complexity of geriatric care and demonstrate the ability to prioritize care, in a time-efficient manner, during encounters with geriatric patients
- 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

Hospital care

- 43 Recognize common and subtle presentations of delirium and manage appropriately
- Ambulatory care
- 45 Perform and interpret an outpatient geriatric assessment, and develop a management plan that includes appropriate consultation with and referrals to other disciplines and community based resources
- 46 Recognize patients who are at risk for hazardous driving, identify strategies to reduce risk, and integrate state and local laws into the management plan

Long-term care and nursing home care

- 49 Individualize long-term care patient management considering prognosis, comorbidity, patient and caregiver goals, and available resources especially in the following situations: (a) consideration for transfer to the acute care hospital; (b) weight loss, dehydration, swallowing disorders; (c) agitation and problem behaviors
- 50 Describe the role of a long-term care medical director and demonstrate an understanding of nursing home and long-term care regulations and requirements, including the Minimum Data Set

- 51 Manage acute problems in long-term care via telephone call

Geriatric Syndromes

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Falls and dizziness

52 Perform and interpret common gait and balance assessments, recognizing abnormal gaits associated with specific conditions

53 Conduct an appropriate evaluation of patients who fall or are at risk for falling, implement strategies to reduce future falls, fear of falling, injuries, and fractures, and follow up on referrals

54 Evaluate, manage, and refer (when appropriate) patients with symptoms of dizziness or lightheadedness, differentiating among those with single or serious causes and those that are multifactorial

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.)

Sleep disorders

66 Provide initial evaluation and management of insomnia and other sleep disorders and, when indicated, refer to a sleep specialist

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

Weight loss and nutritional issues

72 Identify and appropriately evaluate and manage involuntary weight loss

73 Discuss with patients and families/caregivers the risks and benefits of appetite stimulants, nutritional supplementation, enteral tube feeding, and parenteral nutrition, particularly in patients with advanced dementia or near end of life

74 Identify swallowing disorders in patients with involuntary weight loss or recurrent pneumonias, and work with an interprofessional team to evaluate, manage, and educate patient and caregiver(s) based on goals of care

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