UND GERIATRIC MEDICINE FELLOWSHIP CURRICULUM
TRANSITIONS OF HEALTHCARE

LOCATION SITES:

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Sanfordhealth.org

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INTRODUCTION

Changes in health and function often lead to older adults traversing the continuum of care. These events may entail going from the hospital to a skilled nursing facility or aging in place but converting the home setting into a hospice. In most of these instances, patient care is transferred from one team to another, thus "hand –offs' are an essential concern, both for advancing or missing key elements of the health care plan. Transitions of care are widely known to be points of heighten vulnerability for older adults, resulting in lapses in safety, poor care coordination, duplication of services, and worsening disability.

In this block rotation, fellows must recognize how patient care "falls through the cracks" and attempts to prevent these problems. They need to understand the menu of post acute care services (e.g., SNF, home care, hospice, etc) that is appropriate for their patients. Ultimately, Geriatricians wish to optimize quality health outcomes for patients while avoiding acute care costs such as ED use and re – hospitalization.

Many times patients and their care givers are underprepared or overly confident in their ability to handle the next setting of care. Thus, check lists, care coordination, patient and caregiver education are all elements of competent transitions of care. Communication between provider teams additionally is an important component of care transitions. In this block rotation, fellows learn about high quality transitional care as compared to less optimal, usual health care. Fellows will understand different strengths and weaknesses of transitional models of care, as well as discern whether these models are generally applicable or unique to the health system in which they were studied.

OBJECTIVES BASED ON CORE COMPETENCIES

Patient Care

1. Improve patient safety y improving patient's preparedness for self-care after discharge.
2. Work with patients and care providers to determine any barriers in making follow up requirements of appointments, medications and other needs.

Medical knowledge

1. Describe different types of care transition commonly experienced by older adults
2. Understand the factors that contribute to poor quality care transitions.
3. Report on the epidemiology and outcomes of poor quality care transitions.
4. Describe effective translational care.

Interpersonal and Communication Skills

1. Demonstrate face to face, telephone or messaging evidence of transitional care activity with the PCP and PCMH team.
2. Work with the care coordinator and caregivers in elaborating a plan of care.

Professionalism

1. Provide timely transition of care notes and messages regarding the health care plan.

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TRANSITIONS OF HEALTHCARE

Practice-Based Learning and Improvement

1. Identify on – going projects to reduce hospital recidivism in HF and other patients with chronic conditions.

Systems-Based Practice

1. Understand the post-acute care continuum of services.

DUTIES AND RESPONSIBILITIES

Fellows collaborate with the subacute – ortho / rehab unit at Sanford University South. Fellows will provide initial and on – going assessment of patients and work with hospitalists and interdisciplinary team members in formulating a health care plan for older adults transitioning post – operatively to the community setting. Fellows will be responsible for H&Ps, progress notes and discharge notes, as well as coordination of care to the community setting. Thus, fellows may follow patients discharged from the TCU to their homes or clinics. Fellows are responsible for communicating the healthcare plan with the PCP and PCMH team.

Fellows will engage in quality improvement with ongoing or new projects such as fall reduction, antibiotic stewardship or delirium prevention.

EVALUATION

Fellows are evaluated both during and at the end of the block rotation by one or more of the methods listed in the following table.

COMPETENCIES / EVALUATOR	PATIENT CARE	MEDICAL KNOWLEDGE	PRACTICE BASED LEARNING	INTERPERSONAL COMMUNICATION SKILLS	PROFESSIONALISM	SYSTEMS BASED PRACTICE
ATTENDING	X	X	X	X	X	X
PEER	X			X	X	
PROGRAM DIRECTOR*						
SELF**						
PATIENT/FEMILY 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 Geronotology, chapter 15 Transitions in Care.

GRS 9th edition, Chapter 19, Transitions of Care

UND GERIATRIC MEDICINE FELLOWSHIP CURRICULUM
TRANSITIONS OF HEALTHCARE

Adaptations of the evidence-based Transitional Care Model in the U.S. Naylor MD, Hirschman KB, Toles MP, et al 2018 Jul 17;213:28-36. doi: 10.1016/j.socscimed.2018.07.023.

Inpatient placement: associations with mortality, cost, and length of stay. Handel DA, Su Z, Hendry N, Mauldin P. Am J Manag Care. 2018 Jul 1;24(7):e230-e233

Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences. Federman AD, Soones T, DeCherrie LV, Leff B, Siu AL. JAMA Intern Med. 2018 Jun 25. doi: 10.1001/jamainternmed.2018.2562. [Epub ahead of print]

Implementing a Standardized Transition Care Plan in Skilled Nursing Facilities. Toles M, Leeman J, Colón-Emeric C, Hanson LC. J Appl Gerontol. 2018 Jun 1:733464818783689. doi: 10.1177/0733464818783689. [Epub ahead of print]

Use of participatory visual narrative methods to explore older adults' experiences of managing multiple chronic conditions during care transitions.Backman C, Stacey D, Crick M, Cho-Young D, Marck PB.BMC Health Serv Res. 2018 Jun 20;18(1):482. doi: 10.1186/s12913-018-3292-6.

Effectiveness of a transition plan at discharge of patients hospitalized with heart failure: a before-and-after study. Garnier A, Rouiller N, Gachoud D, Nachar C, Voirol P, Griesser AC, Uhlmann M, Waeber G, Lamy ESC Heart Fail. 2018 May 14. doi: 10.1002/ehf2.12295

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

Systems-Based Care for Elder Patients

General

30 Demonstrate expertise in transitions of care by identifying, with the interprofessional team, the most appropriate care setting(s) for a patient, including independent living, assisted living, long-term care, acute rehabilitation, subacute rehabilitation, home care, primary care at home, adult day care, Program of All-Inclusive Care for the Elderly (PACE)-like program, and hospice based on the needs and preferences of the patient and families/caregivers, and the admission and payment requirements for each setting

31 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

32 Demonstrate knowledge of commonly accepted geriatric quality indicators