UNTHSC Reynolds Geriatric Education and Training in Texas Program

Helping Physicians Effectively Treat An Aging Population.
Dr. Knebl’s Disclosures

– I am a “Baby Boomer” (one of 78 million)
– I love old people, old movies and antiques
– I don’t see anyone in my practice less than 65 years of age
– My favorite group are the “super seniors”
– My goal is to go from being a “DINK” to a “WOOF”
– I believe every day above ground is a great day!
– I believe “Geriatrics” is the field of the
The Demographics of the World are Changing

One of the largest areas of population growth worldwide is among those age sixty-five and above. Provision of health care to this age group is rapidly becoming a large proportion of clinical practice. Nationally there is a shortage of geriatricians and projections do not indicate relief in sight.
The UNTHSC Reynolds Geriatric Education and Training in Texas Program

Was Developed:

To help meet the growing need to train physicians in the care of the geriatric population
A four year program with four broad objectives targeting

Medical Students, Residents, Faculty, and Practicing Physicians

Funded by a four year grant from the Donald W. Reynolds Foundation
And UNTHSC matching funds
Donnaid W. Reynolds Foundation

- Foundation Established in 1954.

- Aging and Quality of Life Program Initiated in 1996

  Purpose: "Improving the quality of life of America’s growing elderly population through better training of physicians in geriatrics"

- Over $120 million in funding for Geriatrics Programs
Donald W. Reynolds Foundation

- 42 Universities Have Been Awarded Grants
- Two Departments of Geriatrics Established
- 2008 Two Schools of Osteopathic Medicine Were Selected to Join Cohort 4.

2008 Cohort 4

- Medical University of South Carolina
- University of Alabama
- University of California, Irvine
- University of Massachusetts
- University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine
- University of North Texas Health Science Center
- University of Pennsylvania
- University of Texas, Houston
- University of Texas, Southwestern Medical Center
- Wake Forest University
Reynolds Geriatric Education and Training In Texas (GET-IT)

Program Goal

To Develop and Implement an Innovative and Sustainable Program to Strengthen Physicians’ Training in Geriatrics
GET-IT Program Objectives

• 1. Implement an Integrated geriatrics Curriculum in all four years of **Undergraduate Medical Education**.

• 2. Implement an Integrated Geriatrics Curriculum during Osteopathic **Residency** Training.

• 3. Establish a Geriatrics **Faculty Development** Program for Osteopathic Residency Training.

• 4. Develop Geriatrics Continuing Medical Education Programs for **Practicing Physicians**.
How the GET-IT Program can help you

www.hsc.unt.edu/Sites/GETIT/
Minimum Geriatric Competencies
IM & FM Residents

• Developed by a working group comprised of members of:

  American Board of Family Medicine  Foundation
  American Geriatrics Society
  American Medical Association
  Society of General Internal Medicine
Minimum Geriatric Competencies
IM & FM Residents

Under the Area of Cognitive, Affective and Behavioral Health

Residents are expected to (demonstrate competency) administer & interpret results of at least one validated screening tool:

- Delirium,
- Dementia,
- Depression
- & Substance Abuse
Confusion Assessment Method

• High sensitivity (94%-100%)
• Negative predictive accuracy(90%-100%)
• High specificity (90-95%)
• 9 questions, less than 5 minutes
• Easy to use by all staff members with very little training
• Use the Diagnostic Algorithm

CAM

The diagnosis of delirium requires the presence of features 1 and 2 and either 3 or 4.

1. **Acute change in mental status and fluctuating course**
   - Evidence present of an acute change in cognition from baseline
   - Abnormal behavior fluctuates during the day

2. **Inattention**
   - Difficulty focusing attention, easily distracted or keeping track of what is said.

3. **Disorganized thinking**
   - Thinking is disorganized or incoherent, with rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

4. **Altered level of consciousness**
   - Mental status is anything besides alert, ie, vigilant (hyper alert), lethargic (drowsy, easily aroused), stuporous (difficult to arouse), or comatose (unarousable).
Mini-Cog Scoring Algorithm

- **Mini-Cog**
  - **Recall = 0**
    - Impaired
  - **Recall = 1-2**
    - Clock Abnormal: Impaired
    - Clock Normal: Not Impaired
  - **Recall = 3**
    - Not Impaired

Sensitivity 99% Specificity 93%  
Evaluation of AD

Mini-Mental State Examination

• Cognitive measurement

• Brief, structured mental status examination

• 10-15 minutes to administer

• Sensitivity and specificity vary by population

• Adjustments need to be made for age, gender, education and race

Scores Range From 0 to 30

28-30 = Normal
25-27 = Possible mild cognitive impairment
19-24 = Mild dementia
10-18 = Moderate dementia
0-9 = Severe dementia

Typical deterioration of 3 to 4 points per year

Montreal Cognitive Assessment (MOCA)
AD “Testing”

• ACOVE Guidelines:
  – Memory:
    • REMOTE: What happened to President Kennedy? Where? Who shot him? (or other appropriate question)
    • RECENT: What happened 9/11/01? Buildings/cities affected/ Who was responsible?
  – Executive Function:
    • Bread is 75 cents/loaf. Buy 2 loaves with $2. Change?
    • Fish is $8/lb. Buy ½ pound with $5. Change?
  – Language:
    • Name animals in zoo/jungle/farm (Normal ≥10/min)
  – Visual/spatial:
    • Clock Drawing

Hachinski Score

- Abrupt onset: 2
- Stepwise deterioration: 1
- Fluctuating course: 2
- Nocturnal confusion: 1
- Relative preservation of personality: 1

Scoring:
< 4 – suggestive degenerative dementia
> 7 – indicative of VaD

- Depression: 1
- Somatic Complaints: 1
- Emotional Incontinence: 1
- Hypertension: 1
- Hx Strokes: 2
- Atherosclerosis: 1
- Focal Symptoms: 2
- Focal Signs: 2
Instrumental Activities of Daily Living (IADLs)

- Ability to use telephone
- Shopping
- Food Preparation
- Housekeeping
- Laundry
- Mode of transportation
- Responsibility for own medications
- Ability to handle finances

IADL Score: ____/8

Lawnton MP, JAGS 1971; Gerontologist 1969
Basic Activities of Daily Living (ADLs)

Physical Self-Maintenance Scale

Bathing
Dressing
Toileting
Transfers
Continence
Feeding

ADL Score:__/6

Lowenthal MF, 1964
Katz, JAMA, 185:914, 1963
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you basically satisfied with your life?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Have you dropped many of your activities and interests?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you feel that your life is empty?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Do you often get bored?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Are you in good spirits most of the time?</td>
<td>Yes/NO</td>
</tr>
<tr>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you feel happy most of the time?</td>
<td>Yes/NO</td>
</tr>
<tr>
<td>Do you often feel helpless?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you feel you have more problems with memory than most people?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you think it is wonderful to be alive?</td>
<td>Yes/NO</td>
</tr>
<tr>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you feel full of energy?</td>
<td>Yes/NO</td>
</tr>
<tr>
<td>Do you feel that your situation is hopeless?</td>
<td>YES/No</td>
</tr>
<tr>
<td>Do you think that most people are better off than you are?</td>
<td>YES/No</td>
</tr>
</tbody>
</table>

Total Score (bolded)
Center for Epidemiological Studies – Depression Scale (CES-D)

- During the past week
- 1. I was bothered by things that usually don’t bother me. (S)
- 2. I did not feel like eating; my appetite was poor. (S)
- 3. I felt that I could not shake off the blues even with help from my family or friends. (D)
- 4. I felt that I was just as good as other people. (P)
- 5. I had trouble keeping my mind on what I was doing. (S)
- 6. I felt depressed. (D)
- 7. I felt that everything I did was an effort. (S)
- 8. I felt hopeful about the future. (P)
- 9. I thought my life had been a failure.
- 10. I felt fearful.
- 11. My sleep was restless. (S)
- 12. I was happy. (P)
- 13. I talked less than usual.
- 14. I felt lonely. (D)
- 15. People were unfriendly. (I)
- 16. I enjoyed life. (P)
- 17. I had crying spells. (D)
- 18. I felt sad. (D)
- 19. I felt that people disliked me. (I)
- 20. I could not get “going.” (S)
Alcohol Intake

— Older adults are particularly prone to toxic effects due to physiologic changes and comorbid illnesses.

• Daily drinking ranges from 10% to 22% in samples of older patients. (7 drinks per week)
  — Hazardous effects of excessive alcohol intake
    • Impaired driving skills
    • Increased rate of injuries like falls and fractures
    • Cognitive Impairment
    • Interactions with medications (Ramadan and Massoodi)

• Screen for At Risk drinking
  — Michigan Alcoholism Screening Test (MAST)
  — CAGE
# CAGE Questionnaire For Alcoholism

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever felt the need to cut down on your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever felt annoyed by criticism of your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever felt guilty about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever take a morning drink (eye-opener)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Two affirmative answers may be suggestive of alcoholism**

Ewing, JAMA 252:1905-1907, 1984
Physician Workforce Recommendations
(IOM 2008)

- Training of residents in all settings where older adults receive care, including LTC facilities, ALF’s and patients’ homes.

- All licensure, certification and maintenance of certification for physicians should include demonstration of competence in the care of older adults.

- Public and private payers should provide financial incentives to increase the number of geriatric specialists.
All payers should include a specific enhancement of reimbursement for clinical services delivered to older adults by practitioners with a certification of special expertise in geriatrics.

Congress should authorize and fund an enhancement of the GACA program to support junior geriatrics faculty.

States and federal government should institute programs for loan forgiveness, scholarships and direct financial incentives for professional who become geriatric specialists (National Geriatric Service Corps).