SYLLABUS

GERIATRICS ROTATION
FOR RESIDENTS

2020-2021
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Geriatric Rotation Syllabus Purpose and Description

PURPOSE OF THE GERIATRIC ROTATION
The geriatric rotation affiliated with the University of North Texas Health Science Center/Texas College of Osteopathic Medicine serves to provide supervised, high quality opportunities for residents to apply and transform the medical knowledge and basic clinical skills that they have acquired into clinical competence in the care of older adults while functioning as learning members of interprofessional health care teams.

The geriatric rotation promotes and supports residents in developing clinical competence with emphasis on core competencies beyond medical knowledge. All participants are encouraged to seek opportunities to provide Health and Wellness Counseling, develop improved interpersonal and communication skills, professionalism, as well as practice-based learning and progressive improvement.

GERIATRIC ROTATION DESCRIPTION
The population of adults >65 years of age will continue to increase into the 21st Century. All physicians will be expected to be knowledgeable in geriatric care. The goal of this geriatric curriculum is to provide a foundation for competent and compassionate care of older patients. This includes attitudes, knowledge, and skills required to care for older adults. Education will occur in the ambulatory setting and via didactic activities.

During the 4-week rotation, trainees will be exposed to a variety of geriatric care experiences including ambulatory practice, home visits, Geriatric Psychiatry, and Long-term care settings. Knowledge will be gained through self-study, case reviews, didactic opportunities, and hands on experience in ambulatory, home, and long term care settings. At the clinical sites residents will examine their own attitudes toward aging, disability and death; they are encouraged to provide empathy towards older adults and their caregivers and to appreciate the need for functional status assessments of individual patients rather than focusing on diseases alone.

INTERPROFESSIONAL EDUCATION COMPETENCIES
Given that geriatric care requires teamwork and team approaches to care, rotation objectives integrate the Interprofessional Education Collaborative (IPEC) Core Competencies.

Core Competency Domains for Interprofessional Collaborative Practice

1. Values/Ethics for Interprofessional Service
   Trainees will place the interests of patients and populations at the center of Interprofessional health care delivery through creating a common mental model and understanding of the unique and shared needs of the geriatric population. Trainees will recognize the diverse and individual differences that characterize the geriatric population and the benefits of an Interprofessional team in the assessment of unique geriatric case study.

2. Roles/Responsibilities
   Trainees will recognize the need to engage diverse healthcare professionals to complement their own professional expertise, as well as, use the associated resources available to develop strategies to meet the needs of the geriatric patient.

3. Interprofessional Communication
   Trainees will recognize a common language and strategies to use in assessing and discussing the following content areas: medication reconciliation, physical and cognitive assessment, in working collaboratively with other health care professionals with care of the geriatric patient.
4. Teams and Teamwork
Trainees will recognize the need for multidisciplinary participation for improved quality of care and patient safety.


GERIATRIC COMPETENCIES
Residents must demonstrate competencies in these additional areas as required by the Accreditation Council for Graduate Medical Education (ACGME).

ACGME Competencies for Geriatric Medicine
1. Patient Care and Procedural Skills
   • Perform an efficient, focused outpatient visit with an older patient, including appropriate interview, taking of medical history, and physical examination.
   • Ability to write concise, accurate and informative history, physical examinations and progress notes.
   • Formulate a management plan.
   • Clearly document patient management in the medical record.
   • Appropriately prescribe medications in elderly patients.
   • Lead discussions of both general management and end-of-life issues with families.

2. Medical Knowledge
   • Recognize age-related changes in patient care.
   • Understand the concept of wellness and appreciate the importance of maintenance of function in elderly patients.
   • Testing for urgent and routine elder care.
   • Familiarity with special features of diagnosis, interpretation of tests and management of illnesses in a geriatric population.
   • Manage patients in outpatient setting.

3. Interpersonal Skills and Communication
   • Communicate effectively and compassionately with elderly patients and their families.
   • Recognize and deal effectively with the communication challenges resulting from cognitive impairment in elderly patients.
   • Effectively communicate elderly patient’s need to other providers (especially in transitions of care).
   • Facilitate the functioning of the multidisciplinary team.

4. Professionalism
   • Interact professionally towards patients, families, colleagues, and all members of the health care team.
   • Develop an appreciation of the social context of illness in the geriatric population.
   • Maintain patient confidentiality and HIPAA guidelines.

5. Practice Based Learning and Improvement
• Identify deficiencies in knowledge base and develop independent means to address them.
• Develop evidence-strategies for filling gaps in personal knowledge and skills in the care of elderly patients.
• Facilitate the learning of other health care team members.

6. Systems-Based Practice
• Mobilize resources to optimize elder health care delivery.
• Work as an equal member of a multidisciplinary team.
• Collaborate with other members of the health care team to assure comprehensive care for elderly patients.
• Use evidence-based, cost-conscious strategies in the care of elderly patients.

Reference: Accreditation Council of Graduate Medical Education. 2014. ACGME Program Requirements for Graduate Medical Education in Geriatric Medicine (Family Medicine or Internal Medicine).

OBJECTIVES FOR RESIDENTS RotATING ON GERIATRICS

What Matters
The resident will have confidence in counseling patients and families on advance directives and goals of care for end of life. The resident will demonstrate professionalism and a caring attitude in working with older adults and frail elderly.

The resident will identify when end of life care is appropriate and be able to describe when to utilize palliative and supportive care, make referrals, and propose pain management and hospice.

Tasks:
• Participate in an advance care planning discussions.
• Assist or observe the completion of one of the following documents: medical power of attorney, directive to physicians, out of hospital DNR, or Texas MOST Form.

Resources: INCEDO – Advance Care Planning Module

Medication
The resident will be able to conduct a medication review and evaluate appropriateness considering creatinine clearance, medication interactions and side effects.

Tasks:
• Interact with a clinical pharmacist.
• Review the Beer’s List.
• Conduct medication reconciliation during ambulatory visits and regulatory LTC visits.

Resources: INCEDO – Opioid Use in the Hospice Setting, NBOME – Medication Module

Mentation
The resident will be able to administer a brief cognitive assessment for screening purposes and identify when it is appropriate to refer for neuropsychological testing. The resident will be able to identify and recommend community resources available for older adults and their families to assist with care giving.

Tasks:
- Perform an MMSE, MOCA, or SLUMS.
- When possible, participate in a Dementia Care Conference.
- Interact with a clinical social worker regarding community resources.

Resources: INCEDO – Dementia Safety, NBOME – Elder Mistreatment

**Mobility**

The resident will be able to assess a patient’s basic activities of daily living, and perform a falls risk assessment.

Tasks:
- Complete a Timed up and Go for a patient.
- Interact with a physical therapist regarding mobility assistive devices for a patient case.

Resources: NBOME – Falls

**Core Entrustable Professional Activities (EPAs)**

The curriculum is based on the Geriatric Entrustable Professional Activities (EPAs) to include essential tasks that geriatricians can be trusted to perform effectively and safely in all care settings and with different older adult populations. Experiences and encounters throughout the rotation provide residents opportunities to practice these activities. By the end of their rotation, interns and residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health for older adults.

Geriatric Entrustable Professional Activities

- Provide patient centered care that optimizes function and/or well-being.
- Prioritize and manage the care of older patients by integrating the patient’s goals and values, co-morbidities and prognosis into the practice of evidence-based medicine.
- Assist patients and families in clarifying goals of care and making care decisions.
- Prevent, diagnose and manage geriatric syndromes.
- Provide comprehensive medication review to maximize benefit and minimize number of medications and adverse events.
- During ambulatory visits, coordinate healthcare and healthcare transitions for older adults after inpatient hospitalization or rehabilitation.
- Teach the principles of geriatric care and aging-related health care issues to professionals, patients and families.
Didactics and Evaluation Information

ONLINE DIDACTICS
The following modules are to be completed during your rotation

1. INCEDO Modules
   a. Advance Care Planning Module
   b. Opioid Use in the Hospice Setting
   c. Dementia Safety

2. NBOME Modules
   a. Medication Module
   b. Elder Mistreatment
   c. Falls

EVALUATION
Evaluations will be completed in New Innovations by the faculty with whom you are working.

Faculty and Staff

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Rotation Sites

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<tbody>
<tr>
<td>Ambulatory Geriatric Medicine Geropsychiatry Geriatric Neurology</td>
<td>UNTHSC GAPP Clinic Health Pavilion Fourth Floor</td>
<td>855 Montgomery Street, 4th Floor</td>
<td>817-735-2200</td>
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<td>Long Term Care: Add 7 facilities</td>
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General Responsibilities

Clinical conditions and geriatric syndromes encountered during daily clinical activities with the faculty will direct a significant portion of the educational experience. Individual learning goals will be based on knowledge deficits identified during patient interactions and reading literature during free time to advance knowledge.

As patient conditions, diseases, and syndromes encountered are unpredictable, a list of references of common geriatric conditions and syndromes are provided as per AGS slides. It is the learner’s responsibility to address each of these topics during self-study. The topics identified by the learner will be discussed with the faculty. These daily interactions with the faculty will not be lecture-based, but learner-centered, with the needs of the individual learner directing the interaction.

As with most clinical experiences, trainees will be responsible for the initial evaluation of patients by performing a careful interview and physical examination, reviewing pertinent laboratory and radiological studies, and formulating a preliminary diagnosis and plan for further diagnostic study and therapeutic intervention. In the ambulatory clinic, a more abbreviated, focused approach is appropriate with the depth of interview and examination directed by the attending physician prior to patient contact. The patient case will then be presented in concise fashion to the attending physician, relaying pertinent parameters, diagnostic assessment, differential diagnostic possibilities and pathophysiologic justification for the diagnosis and proposed course of action.

Discussions will follow, with clarification and reinforcement of important geriatrics concepts. This should allow the individual learner to identify areas requiring further study in order to enhance understanding of the problems or diseases under consideration.
It is anticipated that there may be significant gaps in the geriatric content knowledge with limited clinical experience in the specialty of geriatrics. The purpose of probing questions by the faculty is to identify prior knowledge and direct the student to important areas of misunderstanding or new data that should be acquired to enhance the learner’s conceptual knowledge of geriatric medicine.

After patient assessment and discussion, it is the responsibility of the resident to carefully document their findings and impressions in the progress notes. An initial assessment requires an in-depth progress note. All written and/or electronic notes will be reviewed and cosigned by the on-service faculty.

Frequent feedback will be provided, striving to help advance understanding as much as possible during the rotation. Any concerns, difficulties or problems should be discussed with the attending or the course director to find solutions that enhance the quality of learning and enjoyment of what the faculty hopes is an enjoyable as well as challenging experience.

General Guidelines

ATTENDANCE POLICY

The Center for Geriatrics expects 100% attendance at all required clinics, rounds, meetings and assigned functions. Residents are required to adhere to the standard attendance policies described in their respective performance handbooks.

An absence of more than 5 days during the 4-week rotation will result in an INCOMPLETE grade and remediation of time absent from the rotation will be required. Faculty must be informed of any absences.

Any Paid Time Off (PTO) arranged prior to the rotation must be provided to the residency rotation coordinator two weeks prior to rotation start date in order to complete scheduling.

Failure to notify the rotation supervisor of any absence will be considered neglect of duty and may impact evaluation. If you are ill, or otherwise cannot be in the clinic, you must notify your preceptor at the earliest possible time. You may also call the geriatric rotation coordinator.

PROFESSIONALISM AND ETHICS

The trainee is expected to act professionally and adhere to medical ethical principles and respect patient confidentiality. Appropriate badges identifying trainees as physicians should always be worn when seeing patients. The physician should appear well groomed, neatly dressed, and provide a professional image. Adherence to infection control procedures at the clinical site must be followed. The maintenance of the highest standard of professionalism and ethical behavior is always expected. This includes your relationship with the clinic staff, attending providers, and the interdisciplinary team.
AVAILABILITY
You will always be expected to be available during clinic hours. If for any reason you need to leave the clinic, you must notify both the supervising attending physician and the geriatric rotation coordinator. Your contact phone number must be provided to the geriatric rotation coordinator.

EQUIPMENT
During the rotation, all interns and residents are required to bring their stethoscope to the clinical site. Personal protective equipment for infection control measures will be provided as needed.

ROTATION SITES
Ambulatory Geriatrics (UNTHSC GAPP CLINIC SITE)
Goals
The resident should understand:

1. Geriatric assessment and its components
2. Normal aging including cardiopulmonary, GU, GI, musculoskeletal system, ophthalmologic, auditory, etc.
3. Geriatric syndromes.
4. Application of Osteopathic principles and practice to the geriatric patients
5. Appropriate placement of patients to long term care facilities (assisted living, independent living, skilled nursing, and nursing centers.)
6. Functional Assessments of the older adults.
8. Considerations of culture in relation to health care.
9. When to move from aggressive treatment to palliative treatment while maintaining dignity.

Objectives

Attitudes – The resident will develop sensitivity for the following:
1. Growing older is a part of the life continuum.
2. Forgetfulness is not part of normal aging.
3. Physical weakness does not equal decreased mental capacity.
4. Death of a patient is not a failure by the physician.
5. Treating the whole person including physical, mental, emotional and spiritual.

Cognitive Knowledge – The resident will describe and utilize tools to improve and maintain older adults functional status using:
1. Folstein Mini Mental State Exam/Mini Cog/MOCA
2. Geriatric Depression Scale
3. Up and Go Test
4. Functional status evaluation of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).
Skills – The resident will demonstrate the following:

1. History and Physical exam of the older adult
2. Electrocardiogram (EKG) interpretation

EMR TIPS

1. Template driven system therefore use the templates when possible
2. Verify correct doctor, date, patient, encounter, clinic
3. Finish notes daily
4. Complete notes include HPI, ROS as necessary, PE, assessment and plan
5. Annual Wellness Visits Review and Updates
6. Medication review and update done each encounter
7. Document encounters in the adult office visit template as this allows for your electronic signature to be affixed to the note and then sent to the attending for review and sign off.

GAPP House Calls

Goals

The residents should understand:

1. Assessment and treatment of patients that require house calls.
2. Methods to communicate with patients, family, social services and home health about home care.
3. Components of a home safety evaluation.
4. Cultural issues that impact home care.
5. Importance of in-home care.

Objectives

Attitudes – The resident will become sensitive to the following:

1. House calls are an essential part of the continuum of health care.
2. Many elderly patients need access to house call and this trend will increase.
3. Preventative maintenance of patient’s health and safety can be accomplished with a home safety evaluation
4. The most effective approach is via the ”whole patient” interdisciplinary team.
5. End of life care is often a component of house calls.
6. House calls can reduce hospitalizations.
7. Medicare reimburses for house calls.

Cognitive Knowledge – The resident will be able to:

1. Understand the structure of a house call program.
2. Recognize the types of syndromes and diseases that afflict home-bound older adults.
3. Common medical equipment used in home care (Hoyer lifts, hospital beds, oxygen, wheelchairs, walkers, etc.)
4. Home safety issues related to geriatric patients.
5. Develop an understanding of the need for and types of community-based resources for patients and caregivers.
6. Develop an understanding of appropriate levels of care relative to diagnoses and treatment that is possible in the home setting
7. Develop an understanding of the appropriate protocol for referral to other health care providers for diagnoses and treatment that is not appropriate in the home setting.
8. Learn to differentiate between practice approaches of a House Call Program and how they differ from those in ambulatory or long term care.
9. Recognize that caregiver stress in the home is an integral component to the management of care in the home.
10. Learn to recognize when the patient requires a living arrangement other than independent living at home.
11. Understand conditions in the home that may warrant an APS referral.

Skills – The residents will perform and be included in the following:
1. Home visits with the interprofessional team
2. Interdisciplinary Group (IDG) meetings

Post-acute and Long-term Care

Goals
The residents should understand:

1. The Long-Term Care continuum including sites of service, financing and the physician’s role (attending vs facility medical director).
2. Types of nursing facility residents (short stay/skilled, residential, those with dementia and functional impairments).
3. The chronic conditions of the nursing facility and assisted living residents.
4. The functioning of the Interdisciplinary Team in Long-Term Care.
5. The role of family and caregivers within Long-Term Care setting.
6. Pertinent regulatory requirement for the medical care of residents in the skilled nursing setting.
7. The components and purpose of a care plan meeting or care conference with the skilled nursing facility interdisciplinary team

Objectives

Attitudes – The resident will become sensitive to the following:
1. Focus on Quality of Life for Long-Term Care residents
2. Focus on highest practicable functioning for the Long-Term Care resident
3. Dementia specific care with an emphasis on dignity
4. Respect for the Interdisciplinary Care Team within Long-Term Care.
5. Physician communication with the residents, consultants, members of the care team and family members.

Cognitive Knowledge – The resident will be able to:
1. Cognitive, functional and behavioral assessment tools for Long-Term Care residents
2. Overview of Long-Term Care continuum including nursing facilities and assisted living facilities
3. Dementia specific models of care
4. Dementia specific behavioral management (environmental, behavioral [validation] and pharmacologic).
5. Role of Palliative and End-of-Life Care within Long-Term Care including Advanced Directives, Withholding/Withdrawing Treatment and Do Not Hospitalize.
6. Chronic illness management within the Long-Term Care environment.

Skills – The residents will perform and be included in the following:

1. Cognitive, functional behavioral assessments (see Cognitive Knowledge)
2. Documentation within medical record (paper or electronic) in Long-Term Care setting.

Resources
Unless otherwise noted, information is provided by Internet link via the Lewis Library Home Page on the Course Reserves Page: http://library.hsc.unt.edu/content/services-resources-medical-residents.

Recommended Reading:

Tools

Administrative

Other