GERIATRIC CERTIFICATE MODEL

This model is designed for Family Medicine Residents and can be modified for other residency programs focusing on primary care

Lesca Hadley, MD
lhadley@jpshealth.org

WE HAIL

Geriatric Certificate
Model for Family Medicine Residents

Contents

Background ... 2

Learner Objectives ... 3

Educational Strategies ... 4

Evaluation Measures ... 5

Summary of Educational Strategies Aligned with Objectives and Evaluation ... 6

Summary of Eligibility and Requirements for Geriatric Certificate ... 8

Appendices: ... 9

Appendix A: Community Based Learning Experiences ... 10

Appendix B: Quality Improvement Project Ideas ... 11

Appendix C: Implementation and Logistical Considerations ... 13

Appendix D: ACGME Milestones and Competencies ... 14

Appendix E: References ... 16

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28735. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Health Resources and Services Administration or the U.S. Department of Health and Human Services.

Background

Older adults are the fastest growing age group in the United States. A report by the American Hospital Association, states that by 2030 most people in this age group will need to manage more than one chronic medical condition. These vulnerable patients with their complex chronic medical conditions require a comprehensive longitudinal approach to their care.

Access to care for the elderly is a problem throughout the United States with a current need for over 13,000 Geriatricians across the nation. The Institute of Medicine recommends that immediate steps need to be taken across the United States to train a health care workforce to support the needs of this expanding population.

With a lack of Geriatricians, Family Physicians care for most of the elderly population across the United States so they must be well equipped to handle the complications of growing old. Family Medicine residents are required by the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee requirements to receive training in the care of the elderly during their residency. Numerous ACGME Family Medicine milestones address the care of the vulnerable elderly (Appendix C). Questions about the care of Geriatric patients are present on Family Medicine in-service and Board exams. However, the geriatric training residents receive is inconsistent and the comfort level of residents upon completion of residency with elderly patients varies.

Expertise in Geriatrics is needed by all Family Physicians. However, not all Family Physicians have the ability to complete a year of additional Geriatrics training in a Geriatrics Fellowship following residency. **The goal of this Geriatric Curriculum is to provide comprehensive training in the care of the elderly for Family Medicine residents.** Each Family Medicine resident will receive a standardized amount of Geriatrics training, but for those Family Medicine residents who are interested in additional Geriatric training, a Geriatrics Certificate for Family Medicine residents will be available. The certificate will indicate that the resident completed additional comprehensive Geriatric training.

Learner Objectives

Goal: The overall curriculum goal is to create Family physicians who provide exceptional comprehensive geriatrics care within a complex interprofessional team setting.

1. Effectively manage common geriatric syndromes in the chronically ill elderly to optimize health outcomes.
2. Demonstrate proper management of chronically ill patients in the home setting by performing home visits as part of an interprofessional team.
3. Demonstrate proper management of chronically ill patients in the long term care setting by providing physician visits in the long term setting as part of an interprofessional team
4. Develop appropriate interdisciplinary plans after completing a comprehensive geriatric assessment.
5. Create a personalized fall prevention plan for patients who are at risk for falls.
6. Effectively manage patients with Alzheimer's Disease and other related cognitive disorders.
7. Provide comprehensive end of life care for patients with terminal illnesses.
8. Prescribe appropriate medications in the elderly population as evidenced by chart review.
9. Document appropriate interdisciplinary referrals for a collaborative approach to address the effects of health literacy on chronic illness and medication compliance.

Educational Strategies

1. Didactics and Online Resources designed to cover important topics in geriatrics

2. Grand Rounds presentations and discussion by faculty and invited speakers in geriatrics

3. Continuity visits in long term care settings

4. Community-based learning experiences in partnership with the Area Agency on Aging and United Way agencies.
   - Residents go on home visits with Meals on Wheels and the Alzheimer's Association to visit older adult clients and caregivers of older adults.
   - Residents experience a dementia simulation and a mini session of a fall prevention program.
   - A detailed overview of community experiences is provided in *Appendix A*.

5. The American Academy of Family Physician (AAFP) Self-Assessment Module (SAM) for Maintenance of Certification on the Care of the Vulnerable Elderly

6. Geriatric Faculty Mentorship by faculty champions of geriatrics

7. Quality Improvement Project in a setting where there is a predominantly geriatric patient population, such as a clinic or skilled nursing home.
   - Residents are oriented to use nationally recognized tools, such as the Institute of Healthcare Improvement (IHI), in order to complete their project within a six to nine month period.
   - Residents are encouraged to present a poster on their project, which may require going through review by the Institutional Review Board.
   - Examples of Project Topics are provided in *Appendix B*.

WE HAIL

Evaluation Measures

ACGME Competencies Addressed:

- Knowledge
- Patient Care
- Practice Improvement
- Systems Based Medical Practice Professionalism Communication

Evaluation Items:

- Inservice exam
- Board exam
- Rotation evaluation
- Observation by faculty
- Chart Review
- Observation

Summary of Evaluation and Feedback:

	Individual	Program
Formative Evaluation	Written evaluations	Written evaluation
	Informal verbal feedback	Informal verbal feedback
	Inservice exam	Annual review of Curriculum by Program Director
	Board Score	
Summative Evaluation	Inservice Exam score	Inservice Exam score
	Chart review	Board Score
	Geriatrics Certificate	Number of Residents who chose Geriatrics fellowship
		Number of Residents who chose to care for patients >65 as a component of their practice
		Number of Residents who viewed Geriatric modules Number of Residents who complete Geriatrics Certificate
		Number of Presentations by Residents and Faculty related to Curriculum

Summary of Educational Strategies Aligned with Objectives and Evaluation

Objective	Educational Methods	Evaluation of Learner	ACGME Competencies Addressed
Demonstrate proper management of chronically ill patients in the home setting by performing home visits as part of an interprofessional team.	Case scenarios	Inservice exam	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
	Home visit	Board exam	
	Continuity Long term care visits	Observation by faculty	
Demonstrate proper management of chronically ill patients in the long term care setting by providing physician visits in the long term setting as part of an interprofessional team	Continuity visits in long term care setting	Observation by faculty	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
		Inservice exam	
		Board exam	
Effectively manage common geriatric syndromes in the chronically ill elderly to optimize health outcomes	Didactics	Inservice exam	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care ✓ Communication
	Case scenarios	Board exam	
	Observation of Speech Pathologist Evaluation of a Patient	Rotation evaluation	
	AAFP SAM module		
Document appropriate interdisciplinary referrals for a collaborative approach to address the effects of health literacy on chronic illness and medication compliance.	Outpatient Geriatric Assessments	Chart Review	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
	Interdisciplinary Home Visits		
	Online didactics		
	Inpatient Geriatric Assessments		
Prescribe appropriate medications in the elderly population as evidenced by chart review	Case scenarios	Chart Review	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
	Didactics	Inservice exam	
		Board exam	

Provide comprehensive the end of life care for patients with terminal illness	Role play Case scenarios Outpatient Palliative Consults Palliative Care Inpatient Consults	Observation Chart Review	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
Create a personalized fall prevention plan for patients who are at risk for falls	Workshop Didactics	Chart Review	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Patient Care
Effectively manage patients with Alzheimer's Disease and other related cognitive disorders	Didactics Interdisciplinary Home Visits Workshop	Chart Review Observation Inservice Exam	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication
Develop appropriate interdisciplinary plans after completing a comprehensive geriatric assessment	Geriatric assessment clinic Inpatient Geriatric Consultations	Observation Rotation Evaluation Chart Review	✓ Medical Knowledge ✓ Practice Improvement ✓ Systems Based Medical Practice ✓ Professionalism ✓ Patient Care Communication

Summary of Eligibility and Requirements for Geriatric Certificate

<table>
<tr><th colspan="2">Summary of Eligibility and Requirements for Geriatric Certificate</th></tr>
<tr><td>Eligibility Requirements</td><td>Current Family Medicine Resident

Completes required clinical experiences in geriatrics

Evaluates the effectiveness of care for elderly patients by completing a Continuous Quality Improvement Project</td></tr>
<tr><td rowspan="3">Training</td><td>Minimum of 6 months of clinical experience in caring for the elderly over 3 years of training

Minimum of 135 hours of didactics (135-150 hours of instruction is number to receive Graduate Certificate from a University)</td></tr>
<tr><td>Instructional:
✓ Scheduled afternoon presentations and workshops: 18 hours
✓ Geriatrics Grand Rounds: 36 hours
✓ SAM Module Care of the Vulnerable Elderly: 12 hours</td></tr>
<tr><td>Clinical:
✓ 2nd year Geriatrics Rotation: 48 hours
✓ 3rd year Geriatrics Rotation: 24 hours
✓ 2 years of Continuity of Care of Patients in the Long Term Care Setting</td></tr>
</table>

Please note: eligibility and requirements are subject to interpretation and change based off the residency program and their requirements.

Appendices:

A. Community Based Learning Experiences
B. QI Project Ideas
C. Implementation and Logistical Considerations
D. ACGME Milestones and Competencies
E. References

WE HAIL

Appendix A: Community Based Learning Experiences

Virtual Dementia Tour:
The Virtual Dementia Tour® is a dementia simulation scientifically proven to build sensitivity and awareness in individuals who care for people with Alzheimer's disease and other forms of dementia. Participants are guided through a tour experience that includes completing common tasks while outfitted with devices designed to impair the senses, including goggles, headphones, gloves and shoe liners. This tour is available for individual and family use to identify with and understand a loved one's behaviors and needs. Tours are offered at James L. West Alzheimer's Center in Fort Worth, Texas, and developed by Second Wind Dreams,® a nonprofit organization.

Family Medicine residents participate in the virtual dementia tour in groups of 3-6 people and debrief with faculty over a one hour visit.

Meals On Wheels Home Visits:
Meals on Wheels of Tarrant County provides a variety of services for older adults in their homes to address isolation and hunger. Services include HomeMeds medication screenings and diabetes and nutrition counseling. HomeMeds computerized assessments are reviewed by a pharmacist to identify adverse drug effects and medication errors and duplications. The diabetes and nutrition counseling addresses self-directed behavior goals and improves the older adults' capacity for self-care and confidence in dealing with health issues.

Family Medicine residents go to client homes with Meals on Wheels registered dieticians and professional case managers, visiting two to three clients in a four-hour period.

A Matter of Balance Fall Prevention Mini-session:
A Matter of Balance is a nationally-recognized evidence-based program targeting adults over age 60 who are ambulatory, able to problem solve, and concerned about falling. The series of classes are designed to improve flexibility, balance, and strength, and to eliminate the fear of falling. The group classes are offered through Sixty & Better, formerly Senior Citizen's Services, a nonprofit organization in Fort Worth, Texas.

Family Medicine residents experience a one-hour mini-session of the full program led by Certified Master Trainers to learn chair exercises and fall prevention techniques, and to understand the teaching strategies employed by the program.

Alzheimer's Association Home Visits:
The Alzheimer's Association provides the Resources for Enhancing Alzheimer's Caregiver Health (REACH) Program, a multi-component psychosocial behavioral intervention designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients with Alzheimer's disease or related disorders. This 6 month long program is provided through the North Central Texas Alzheimer's Association.

Family Medicine residents go to client homes with Dementia Care Specialists, visiting two to three clients in a four hour period.

Appendix B: Quality Improvement Project Ideas

Content Area: Health Literacy

Potential Project: Identify patients in need of improved medical labeling – *will need pharmacy participation and buy-in.*

- Population segmentation
- Review and outline current process
- Design optimal process
- Implement process
- Refine process

Content Area: Advanced Care Planning

Potential Projects

- Implement physician billing process for advanced care planning conversation
- Define components of advance care planning at JPS (post-acute placement, will / estate planning, DNRs, Power of Attorney, medication planning)
- Define / Design proactive patient screening process for patients in need of advanced care planning
  - Inpatient
  - Outpatient
  - ED
- Implement process
  - Inpatient
  - Outpatient
  - ED
- Refine process
  - Inpatient
  - Outpatient
  - ED

Content Area: Chronic Disease Management

Potential Projects

Improving transitions of care in chronically ill geriatric patients from ER or hospital to home

- Population segmentation
- Review and outline current process
- Design optimal process
- Implement process
- Refine process

- Appropriate Diabetes or HTN management in the elderly
  - Population segmentation
  - Review and outline current process
  - Design optimal process
  - Implement process
  - Refine process

Content Area: Alzheimer's and Dementia Related Disease

Potential Projects

- Screening for Alzheimer's Disease for patients with suspected medication non-adherence

Content Area: Fall Risk and Assessment

Potential Projects

- Formalize automatic process for A Matter of Balance class referral
    - Population segmentation
    - Review and outline current process
    - Design optimal process
    - Implement process
    - Refine process

Appendix C: Implementation and Logistical Considerations

I. **Personnel Involved**
- Director of Family Medicine Residency Program
- Coordinator or Administrative Support for scheduling resident learning experiences
- Faculty Mentors

II. **Facilities/Equipment**
- Pre-reserved didactic conference rooms for lectures and discussions.
- Learning management system for additional resource materials and online videos.

III. **Schedule**
- Curriculum schedule to be completed and provided residents as a checklist of items to be completed.

IV. **Tools**
- IHI resources and tools
- Geriatric Certificate

V. **Presentations**
- Monthly Geriatric Grand Rounds

Appendix D: ACGME Milestones and Competencies

Review Committee Family Medicine Milestones

I. **Knowledge**
- Applies critical thinking skills in patient care
  - Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans
  - Collaborates with the participants necessary to address important health problems for both individuals and communities

II. **Patient Care:**
- Cares for patients with chronic conditions
  - Personalization of the care of complex patients with multiple chronic conditions and co-morbidities to help meet the patients' goals of care.
  - Continually uses experience with patients and evidence-based medicine in population management of chronic condition patients
- Partners with the patient, family, and community to improve health through disease prevention and health promotion
- Partners with the patient to address issues of ongoing signs, symptoms, or health concerns that remain over time without clear diagnosis despite evaluation and treatment, in a patient-centered, cost-effective manner
- Demonstrates comfort caring for patients with long-term undifferentiated signs, symptoms, or health concerns
- Investigates emerging science and uses multidisciplinary teams to care for patients with undifferentiated signs, symptoms, or health concerns

III. **Practice Based Improvement**
- Demonstrates self-directed learning
  - Role models continuous self-improvement and care delivery improvements using appropriate, current knowledge and best-practice standards

IV. **Systems Based Medical Practice**
- Coordinates team-based care
- Role-models active involvement in community education and policy change to improve the health of patients and communities
- Advocates for individual and community health Emphasizes patient safety

V. **Professionalism**
- Demonstrates humanism and cultural proficiency
- Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health

VI. **Communication**
- Develops meaningful, therapeutic relationships with patients and families
- Communicates effectively with patients, families, and the public

ACGME Program Requirements in Family Medicine

- IV.A.6. Curriculum Organization and Resident Experiences
- IV.A.6.a).(2) Experiences in the FMP must include acute care, chronic care, and wellness care for patients of all ages. (Core)
- IV.A.6.a).(3) Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. (Core)
- IV.A.6.a).(3).(a) Long-term care experiences must occur over a minimum of 24 months. (Detail)
- IV.A.6.a).(4) Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients. (Detail)
- IV.A.6.d) Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of the older patient. (Core)
- IV.A.6.d).(1) The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases. (Detail)
- IV.A.6.d).(2) The experience should incorporate care of older patients across a continuum of sites. (Detail)

Appendix E: References

1. John Peter Smith Health Network. Community Health Needs Assessment, 2013http://www.jpshealthnet.org/sites/default/files/updated_jps_chna_report.pdf.published2013
2. American Hospital Association: First Consulting Group. “When I’m 64: How boomers will change health care” Chicago: American Hospital Association, 2007.
3. http://www.americangeriatrics.org/files/documents/pdfs/Current_Geriatrician_Shortfall.pdf
4. “Retooling for Aging in America: Building the Healthcare Workforce” Institute of Medicine, 2008.