Training Physicians who will care for the Rural Old

Integrating Geriatric Education into a Rural Curriculum

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Assistant Dean, Rural Medical Education
Rural Geriatric Care

- Rural Population has large geriatric component
- Rural physicians- are engaged with long term and palliative care issues
  - Directors of rural extended care facilities
- Take care of the family caregivers as well as geriatric patient
  - Geriatric competencies are essential
Rural Scholars Curriculum (ROME)

- Selection is during admissions process
  - 16-20 spots out of class of 240

- Regular curriculum +
  - Approx 40 additional contact hours per semester

- Rural rotations during clinical years

- Continuity experience with one rural community
  - Over 4 years
  - Family Medicine
  - Community Health Research Project
## Rural Family Medicine Continuity Experience

<table>
<thead>
<tr>
<th>Description</th>
<th>Length</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rural Practice &amp; Lifestyle Practicum</td>
<td>4 days</td>
<td>Summer after Year 1</td>
</tr>
<tr>
<td>2. Rural Pre-Clinical Preceptorship</td>
<td>4 days</td>
<td>Year 2</td>
</tr>
<tr>
<td>3. Family Medicine Clerkship/OMM Clerkship</td>
<td>12 weeks</td>
<td>Year 3</td>
</tr>
<tr>
<td>4. Rural Primary Care Partnership</td>
<td>4 weeks</td>
<td>Year 4</td>
</tr>
<tr>
<td>5. Geriatrics</td>
<td>4 weeks</td>
<td>Year 4</td>
</tr>
</tbody>
</table>
Each student will complete a community project related to their assigned “family medicine continuity” community. The purpose of the community project is to provide the student experience in “community responsiveness” and leadership through the identification and development of a plan to address a relevant health concern in the community.
Curriculum Focus

- Emphasis is placed on special patient populations found in rural communities, cancer detection and prevention, and rural environmental health risks.
  - Understanding the needs of special patient populations in Rural Texas
  - Cultural Competency in the Practice of Rural Medicine
Addressing Barriers to Health Care for the Rural OLD

- Isolation
- Transportation
- Lack of family care givers
- Independent mind set
- Loss of CAH (the rural safety net)
- Broad scope of training for rural physicians
Outcomes

- Each student experiences a longitudinal relationship with a community and the rural doctor’s patients over all 4 years of medical school.
- Experiences first hand the necessity of expert clinical skills and adaptability of a rural physician.
- Specific geriatric competencies are addressed:
  - in part through SAGE.
Seniors Assisting in Geriatric Education
SAGE VISITS

Established Geriatric program at TCOM

- Completed in Urban environment
- Completed during years 1 and 2

Modification for ROME

- Completed in Rural environment
- Completed over 4 years
Sequence of Visits

**Regular Curriculum**
- Visit 1: Introduction to Senior Mentor/Client & Life Reminiscence
- Visit 2: Home Environment/Safety Assessment
- Visit 3: Medication/Pharmacology
- Visit 4: Medical History & Physiology of Aging
- Visit 5: Limited Physical and Structural Examination including OMM
- Visit 6: Community Resources and Functional Assessment
- Visit 7: Nutritional Assessment
- Visit 8: Advance Care Planning & Ending the Doctor/Patient Relationship

**Rural Scholars Curriculum**
- Visit 1: Introduction to Senior Mentor & Life Reminiscence
- Visit 2: Medical History & Physiology of Aging
- Visit 3: Limited Physical and Structural Examination including OMM and a functional assessment
- Visit 4: Medication/Pharmacology
- Visit 5: Home environment/Safety Assessment
- Visit 6: Nutritional Assessment
- Visit 7: Community Resources and Functional Assessment
- Visit 8: Advanced Care Planning & Ending the Doctor/Patient Relationship
ROME SAGE VISITS

• Rural Lifestyle Visit
  • Following Year 1
    • Visit 1: Introduction to Senior Mentor & Life Reminiscence
    • Visit 2: Medical History & Physiology of Aging

• Preclinical Clerkship
  • During Year 2
    • Visit 3: Limited Physical and Structural Examination including a functional assessment
ROME SAGE VISITS

- **Core Clerkship in Family Medicine & OMM**
  - **During Year 3 (3 months)**
    - Visit 4: Medication/ Pharmacology
    - Visit 5: Home environment/ Safety Assessment
    - Visit 6: Nutritional Assessment
ROME SAGE VISITS

- PCP/Geriatrics
  - During Year 4 (8 weeks)
    - Visit 7: Community Resources and Functional Assessment
    - Visit 8: Advanced Care Planning & Ending the Doctor/Patient Relationship
ROME Geriatric Clerkship

- Same Didactic requirements as regular curriculum
- Completed in Rural continuity community
Anticipated Outcomes

• Appreciate the rural health care systems available for the elderly populations

• Understand the relationships that exist between the rural physician and their elderly patients

• Observe the adaptation needed by the rural physician

• Acquire competence in the total health care of the “Rural Old”
http://web.unthsc.edu/ruralmed

ROME@unthsc.edu
Questions
Community Based Geriatric Medicine Fellowships: Spreading Geriatrics into Communities
Training Physicians who will Care for the Rural Old

Kevin T. Foley, MD, FACP
Division Head, Geriatrics and Gerontology
• The U.S. faces unprecedented challenges in meeting the health needs of older adults. Critical shortages exist in the national workforce for geriatricians, especially in rural communities.

• To improve access to geriatricians, the Michigan State University (MSU) Department of Family Medicine initiated a network model of geriatric fellowship programs, aligned with our affiliated residency programs.

• The network model offers a promising approach to improving access to geriatricians and advancing geriatric education in community-based residency programs.
This project is supported by grant number D54HP10347 from the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration.

No other disclosures.
Number of Persons ≥ 65 Years, 1900-2030 (in millions)

www.aoa.gov/AoARoot/Aging_Statistics/Profile/2010/4.aspx
• March 2011- one certified geriatrician (6,756 allopathic and 406 osteopathic = 7,162) for every 2,620 adults ≥ age 75

• By 2030 - one geriatrician for every 3,798 older adults

AGS Geriatrics Workforce Policy Studies Center: www.adgapstudy.uc.edu/faq.cfm#q02
FELLOWSHIP TRAINING PROGRAMS

- 45 FM affiliated GM fellowships
- 107 IM affiliated GM fellowships
- 13 AOA accredited fellowships
- 273 of 489 allopathic geriatric medicine first-year fellowship training slots filled AY 2009-10, (56%)

AGS Geriatrics Workforce Policy Studies Center: www.adgapstudy.uc.edu/faq.cfm#q04
### GERIATRICIANS INVOLVED IN PATIENT CARE, BY RUCC

n (per 10,000 Older Adults)

<table>
<thead>
<tr>
<th>RUCC</th>
<th>Counties, n</th>
<th>2000</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>414</td>
<td>3,094 (1.18)</td>
<td>4,517 (1.48)</td>
</tr>
<tr>
<td>2</td>
<td>325</td>
<td>1,060 (1.15)</td>
<td>1,519 (1.40)</td>
</tr>
<tr>
<td>3</td>
<td>351</td>
<td>414 (0.99)</td>
<td>584 (1.20)</td>
</tr>
<tr>
<td>8</td>
<td>235</td>
<td>28 (0.72)</td>
<td>30 (0.67)</td>
</tr>
<tr>
<td>9</td>
<td>435</td>
<td>28 (0.53)</td>
<td>46 (0.80)</td>
</tr>
<tr>
<td>Total</td>
<td>3,141</td>
<td>5,157 (0.86)</td>
<td>7,412 (1.07)</td>
</tr>
</tbody>
</table>

Peterson et al. JAGS 2011;59:699-703
AGING IN NON-URBAN COMMUNITIES

• 19% of older persons live in non-metropolitan areas\(^1\)

• Non-metro residing older adults have more functional limitations, poorer self reported health status, and a greater need for health services compared to their urban counterparts\(^2\)

1. www.aoa.gov/AoARoot/Aging_Statistics/Profile/2010/8/aspx
THE GERIATRICS IMPERATIVE

• Geriatrician supply is not expected to meet demand

• Non-geriatrician providers will care for the majority of older adults using collaborative care delivery models

• Expansion of the geriatrician workforce is still necessary, especially in non-urban areas
CAQ GERIATRICIANS IN MICHIGAN

Data from American Board of Medical Specialties website, accessed October 2011
• 2010 Michigan population = 9,883,640
• 2009 Michiganians > 65 = 13.4%
• 5 SE county population = 3,974,494 (40%)
• CAQ geriatricians in Michigan = 206
• Geriatricians in 5 SE counties = 132 (64%)
• 3/5 SE counties were below the national average for population age 65+ in 2009

Population data from: U.S. Census Bureau: Census 2010 and Administration on Aging: Aging Statistics
MI COUNTY POPULATION ESTIMATES

- > 13% 65+: 69
- > 20% 65+: 82
- > 2% 85+: 43
- > 2.5% 85+: 20

U.S. 65+ = 12.8%
U.S. 85+ = 1.9%

Total Counties
Aged Counties

Network Description

- A collaborative of 9 family medicine residency programs and the MSU Department of Family Medicine; established in 1992.
- Utilizes a nodal system, rather than hub-and-spoke.
- Engages 34 faculty in East Lansing; over 70 community affiliate residency faculty in 9 affiliated residency programs; nearly 700 volunteer clinical faculty.

FM Residency Network Vision

By working together, we hope to serve each program more fully in accomplishing their goals and improve the quality of family medicine education in Michigan.
MSU GERIATRIC FELLOWSHIP NETWORK
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GM FELLOWSHIP BENEFITS TO SITES

- Increases local supply of practicing geriatricians
- Improves quality of care for elderly patients
- Enhances teaching and role modeling of geriatrics to residents and medical students, and other health professions
- Elevates institutional status
- Strengthens accountable care organizations
BENEFITS OF THE NETWORK MODEL

- Administrative assistance with fulfilling ACGME requirements, business plan advice, and program director mentorship
- Improved recruitment of new fellows from affiliated residencies across the network
- Option to use a network training curriculum
- Sharing of resources and training opportunities (didactics, journal clubs, research)
- Group assessment of clinical skills and competencies
Representatives from throughout the residency network gave input into the curriculum design.
Four-Phase Development Model:
Initial draft of curriculum by faculty, draft revision and validity/feasibility check by development team, pilot test of curricular units
• Provides faculty development
• Builds a team of community-based faculty
• Distilled consensus on key curricular elements

Curriculum
• Instructionally sound, meets ACGME core competencies
• Based on behavioral objectives
• Adaptable to different training sites
• Fellows can rotate to resource intensive sites
• Training in person or via video-conferencing
GERIATRICS CURRICULUM DOMAINS

• Gerontology
• Hospital Care
• Diseases in the Elderly
• Ambulatory Geriatrics
• Geriatric Psychiatry
• Home Care
• Gero-pharmacology
• Long Term Care and Nursing Home Care
• Geriatric Syndromes

• Palliative Care
• Economic Aspects of Care
• Functional Assessment and Rehabilitation
• Preventive Medicine
• Caring for the Elderly Patient
• Caregiver, Family, and Community Concerns
• Research / QI

www.pogoe.org
<table>
<thead>
<tr>
<th>Objective 8-1</th>
<th>Instructional Objectives</th>
<th>Resources</th>
<th>Evaluation Strategies</th>
<th>ACGME Core Competencies</th>
<th>Performance Site(s)</th>
</tr>
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<tr>
<td>The fellow will complete all modules of the Stanford Ethnogeriatrics curriculum, to the satisfaction of the attending physician.</td>
<td>• Curriculum in Ethnogeriatrics, Second edition. <a href="http://www.stanford.edu/group/ethnoger/">http://www.stanford.edu/group/ethnoger/</a> • Sign an Attestation form • Discussion with attending physician</td>
<td>Complete all modules of the Stanford Ethnogeriatrics curriculum, to the satisfaction of the attending physician</td>
<td>• Medical Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 8-2</td>
<td>During an OSCE with a simulated geriatric patient, the fellow will identify the patient’s ethnic or religious background by chart review or by asking the patient, according to the resources.</td>
<td>• Doorway Thoughts, AGS, 2004 • Curriculum in Ethnogeriatrics, Second edition. <a href="http://www.stanford.edu/group/ethnoger/">http://www.stanford.edu/group/ethnoger/</a> • Discussion with attending physician</td>
<td>During an OSCE with a simulated geriatric patient, identify the patient’s ethnic or religious background by chart review or by asking the patient, according to the resources.</td>
<td>• Patient Care • Practice-Based Learning &amp; Improvement • Interpersonal &amp; Communication Skills • Professionalism • Systems-Based Practice</td>
<td>OSCE</td>
</tr>
<tr>
<td>Objective 8-3</td>
<td>During an OSCE with a simulated geriatric patient, the fellow will treat the patient while demonstrating sensitivity to aging and ethnicity/religion, according to the resources and to the satisfaction of the patient, family and attending physician.</td>
<td>• Doorway Thoughts, AGS, 2004 • Curriculum in Ethnogeriatrics, Second edition. <a href="http://www.stanford.edu/group/ethnoger/">http://www.stanford.edu/group/ethnoger/</a> • Discussion with attending physician</td>
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<td>• Patient Care • Medical Knowledge • Practice-Based Learning &amp; Improvement • Interpersonal &amp; Communication Skills • Professionalism • Systems-Based Practice</td>
<td>OSCE</td>
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• Half day semi-annual fellow evaluations
• “Real world” simulated patient cases using OSCE format
• Six complex cases developed by network faculty assessing core ACGME and geriatrics competencies simultaneously (elements of comprehensive assessment, falls, dementia, end-of life care, malnutrition, discussion of advance directives, team meetings) with varying degrees of difficulty
• Participation by all network program directors and fellows plus interested faculty
Sustainability

- Institutional support (protected time and funding)
- Faculty recruitment
- Fellow recruitment
- Scheduling of synchronous distance learning sessions and group assessments
MSU GERIATRIC FELLOWSHIP NETWORK
 Flint Hurley Program

**Fellow #1 Post Fellowship (7/10-6/11)**
- Joined the fellowship teaching faculty

**Fellow #2 During Fellowship (7/11-6/12)**
- Submitted an abstract to annual AGS meeting

**Fellow #2 Post Fellowship**
- Completed HPC fellowship then joined faculty at FIU

**Fellow #3 (7/12-6/13) During Fellowship**
- Submitted an abstract to the annual AGS meeting and won award for resident poster presentation

**Fellow #3 Post Fellowship**
- Practicing in Saginaw, Michigan
Grand Rapids Program

Fellow #1 During Fellowship (7/10-6/11)

- Presented poster at local research day conference
- Won competitive MSU research award (Aldrich Endowment) $3525

Post Fellowship

- Joined MSU Division of Geriatrics
- 3 peer reviewed publications, 1 manuscript submitted

Fellow #2 During Fellowship (7/12-6/13)

- Presented poster at local research day conference, won 2nd place

Post Fellowship

- Joined Grand Rapids geriatrics faculty
SCHOLARLY ACHIEVEMENTS

East Lansing Program

Fellow #1 During Fellowship (7/09-6/10)
- Presented poster at local research day conference
- 1 letter to the editor (JAGS)

Post Fellowship
- Lectures on Dementia at Montana State University College of Nursing

Fellow #2 During/Post Fellowship (7/10-6/11)
- Presented a poster at May 2012 Annual AGS meeting
- Practicing in rural Minnesota

Fellow #3 During Fellowship (7/10-6/11)
- Two peer reviewed publications
East Lansing Program

Fellow #3 Post Fellowship

- Joined MSU Division of Geriatrics
- Two peer reviewed manuscripts submitted
- Presented two posters at May 2012 Annual AGS meeting (Presidential Poster Session Awardee)
- Blue Cross Blue Shield of Michigan Foundation Grant Awardee ($10,000)
- MSU-Sparrow Center for Innovation & Research Grant Awardee ($75,000)

Fellows #4 and #5 in training

#5 presented a poster at 2012 GSA meeting and intends to join the COM Geriatrics Division
FELLOWSHIP NETWORKS – A NEW MODEL

• Formation of regional networks involving non-aligned residency programs
• Facilitation of development of new geriatric fellowship training programs in less population dense areas
• Resource sharing to decrease unintended fellowship program closures
• Assessment of health care outcomes and costs related to fellowship networks

• Evaluation of the financial implications of fellowship networks to health care facilities

• Assessment of the impact of fellowship networks on training slot fill rates and rural distribution of geriatricians
IN CONCLUSION

This model has facilitated the accreditation of two new fellowship programs, enhanced closer collaboration between four programs, developed viable business plans, enhanced recruitment of fellows, produced a network training curriculum meeting ACGME requirements, and stimulated greater interest in geriatrics among family medicine residents.