Teaching Geriatrics Competencies in Residency Training Programs

Hal H. Atkinson, MD, MS
Colleen Christmas, MD
Outline/Objectives of the Workshop

• Briefly review published competencies for residents in Internal Medicine and Family Medicine

• Share approaches to teaching competencies at Wake Forest and Johns Hopkins Bayview

• Reflect upon and share experiences in your own residency curricula –facilitators, barriers, good current models, future ideas

• Debrief and promote collaboration among programs
Background: Geriatrics Competencies

- 2008: Association of American Medical Colleges/ Hartford Foundation publishes minimum geriatrics competencies for medical students

- 2008: Institute of Medicine Report: “Retooling for an Aging America” published

- 2010: Publication of minimal competencies for Internal Medicine and Family Medicine Residents (Williams BC et al. J. Grad Med Ed)
Competency Domains in Geriatrics for IM and FM Residents

• Medication Management
• Cognitive, Affective and Behavioral Health
• Complex or Chronic Illnesses in Older Adults
• Palliative and End of Life Care
• Hospital Patient Safety
• Transitions of Care
• Ambulatory Care
Our approaches

- **Wake Forest**
  - Medication Management
  - Cognitive, Affective and Behavioral Health

- **Johns Hopkins Bayview**
  - Complex or Chronic Illnesses
  - Transitions of Care
Overall Curriculum for Geriatrics

PGY-1
- Intern Survival Manual
- SAFE App
- Intern Ambulatory Skills Seminar
- Ambulatory Geriatrics Experience/Palliative Care Rotation (4 weeks)

PGY-2
- Class QI project planning
- ACE Unit (4 weeks)
- Electives (Clinical geriatrics, research, systems)

PGY-3
- Class QI project implementation/completion
- Board Review
- Electives (Clinical geriatrics, research, systems)

Throughout training:
- Academic Half-Day, Clinic Minute, Morning Report cases, Physical Exam Friday, Grand Rounds
- Rotations with “gerontologized” generalists and subspecialists (GPS Program)
- 30 categorical and primary care residents per class, 9 preliminary, 5 neurology
### Medication Management (abridged version!)

1. **Prescribe** appropriate drugs and dosages considering multiple factors related to aging.

2. When prescribing drugs which present high risk for adverse events and interactions, **discuss and document** the rationale for their use, alternatives, and ways to decrease side effects.

3. **Periodically review** patient’s medications with the patient and/or caregiver to assess adherence, eliminate ineffective, duplicate and unnecessary medications, and assure that all medically indicated pharmacotherapy is prescribed.
Resources – Medication Management

Safe Admissions for Elders (SAFE) TOC

**Admission Assessment**
- Communication at admission
- Medicine reconciliation
- Functional assessment
- Cognitive assessment
- Advance directives

**Inpatient Care**
- Prevention of adverse events
- Delirium
- Pressure wounds
- Infection
- Functional decline, including falls
- Malnutrition
- Adverse drug events
- Symptom management
- Pain
- Insomnia
- Constipation

**Discharge Planning**
- Level of care determination
- Advance directives update (including MOST form)
- Palliative care consideration
- Patient education
- Medicine reconciliation
- Follow-up

“Getting granny through the night”
Academic Half Day: Medication Prescribing in Older Adults

- Cases and discussion (1/2 day for interns and upper-level residents)
- Medication review
- Identifying meds on differential diagnosis
- Identifying potentially inappropriate medications
- Review of Beers List/STOPP criteria
- PGY 2 and 3: Identifying missing medically indicated therapy (ex. anticoagulation)
Medication Management: Clinical Experience - Interns

- Ambulatory Geriatrics Experience (AGE) rotation
  - SmartPrescribe
- Clinical experiences
  - Consult clinic (high-yield for polypharmacy reduction)
  - Primary care
  - Housecalls
  - Long-term care
Case 1: Mr. F.

83-year-old man with hypertension, coronary artery disease, and systolic heart failure (ejection fraction 35%). He has been doing very well lately and only has significant dyspnea when he exerts himself for several flights of stairs.

His exam in the office reveals:

BP 118/62, HR 64, RR 14, Oxygen saturation 98% on room air

Heart: regular rate and rhythm, normal S1 and S2, no murmurs, rubs, or gallops

Lungs: Clear bilaterally

Extremities: No edema

Medications:
- aspirin 81 mg daily
- isosorbide mononitrate 60 mg daily
- ramipril 5 mg twice daily
- atenolol 25 mg at bedtime
- furosemide 20 mg daily
- spironolactone 25 mg daily
- simvastatin 20 mg daily
- calcium 500 mg three times daily
- vitamin D 400 IU daily
- multivitamin 1 daily
Medication Management: Clinical Experiences – PGY-2

• Acute Care for the Elderly Unit
  • Clinical pharmacist and pharmacy students round with team
    • Refresher on pharmacokinetics, pharmacodynamics, Beers/STOPTP
  • Prescribing directly observed by attending physicians
4. Administer and interpret at least one validated screening tool for each of the following: dementia, depression, delirium, and substance abuse.

5. Recognize delirium as a medical urgency, promptly evaluate and treat underlying problem.

6. Evaluate and formulate a differential diagnosis and workup for patients with changes in affect, cognition, and behavior.

7. In patients with dementia and/or depression, initiate treatment and/or refer as appropriate.
Resources/Didactic – Cognitive, Affective and Behavioral Health

- Intern Survival Manual, SAFE App
- Physical Exam Friday demonstration (Mini-Cog, PHQ-2, and CAM)
- SBIRT training on substance abuse
- Academic half day – delirium, dementia, depression
  - Interns – recognition and initial treatment
  - PGY-2-3 – advanced management
Clinical Experience: Cognitive, Affective and Behavioral Health

• AGE and ACE unit rotations provide experience in all these competencies (e.g. Memory Assessment Clinic)

• Tailored evaluation form on ACE Unit reinforces specifics ( "observable practice activities")
  • Example: Recognizes and incorporates key geriatrics concepts into assessment and management plans (e.g. delirium, dementia, depression, decision making capacity, falls, urinary incontinence and retention, potentially inappropriate medications and polypharmacy, atypical presentations of illness, physiologic changes of aging and hazards of hospitalization)

• Class QI projects and projects through Geriatrics Principles for Specialists (GPS) reinforce through EMR
Cognitive, Affective and Behavioral Health Geriatricized H&P

- **Delirium Risk Assessment (AWOL*) integrated into H&P template:**
  - Is the patient older than age 80? {YES/NO}
  - Can the patient spell the word “WORLD” backwards? {YES/NO}
  - Are they fully oriented to city, state, county, hospital, and floor (all must be named correctly)? {YES/NO}
  - Is the patient [moderately ill, severely ill, moribund]?  

- Final Score: [0-1=low risk, 2-3=moderate risk, 4=high risk]*

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Johns Hopkins Bayview IM

Colleen Christmas, MD
cchristm@jhmi.edu
Overview of Geriatrics Resident Education at Hopkins Bayview

• 9 Categorical residents and 7 Primary Care residents per year

• Big division with a lot of teaching
  – 24 full time faculty
    • 1/3rd of ward attendings
  – About 6 clinical fellows
    • Co-precept in GIM resident clinics

• Required rotations in geriatrics in PGY-2 or -3 ambulatory subspecialty rotations
  – Geriatrics Primary Care, PACE, Continence, Memory, Periop

• Primary care residents have a continuity panel in Elder House Call

• Worked into morning reports, noon conferences, ambulatory didactic curriculum
Complex or Chronic Illnesses

• 11. Consider adverse reactions to medication in the differential diagnosis of new symptoms or geriatric syndromes
• 13. Discuss and document advance care planning and goals of care with all patients with chronic or complex illness, and/or their surrogates.
• 14. Develop a treatment plan that incorporates the patient’s and family’s goals of care, preserves function, and relieves symptoms
Complex or Chronic Illnesses

- C-SIC curriculum
- Prescribing curriculum
- Immersions
Caring for the Seriously Ill Curriculum (C-SIC)

- 4-part conference series
  - Outcomes after ICU stay (didactic but including data about measured outcomes from our own ICUs),
  - Prognostication (case-based and interactive, using e-prognosis),
  - Palliative care (didactic),
  - Goals of care (role playing).
- Transitions after ICU Life (TRAIL) conference
  - Multidisciplinary
  - Patients and or family members come, or agree to be videotaped, describing what their course has been since they left our ICUs.
- Aliki ICU
  - Each new block in the ICUs we provide a brief “refresher” didactic on discussing and documenting goals of care and fostering shared decision making.
- Additional noon conferences decision making capacity, geriatric syndromes, and advanced directives.
<table>
<thead>
<tr>
<th>Pre-Meeting</th>
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<tbody>
<tr>
<td>Patient’s decision making</td>
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<tr>
<td>• Surrogate needed? Identified correctly?</td>
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<td>• Advance directives sought?</td>
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<tr>
<td>• Input from primary and other providers?</td>
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<tr>
<td>Prognosis</td>
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<tr>
<td>• Team members reach consensus on prognosis / anticipated outcomes with current and alternative treatment plans</td>
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<tr>
<td>Plan for meeting</td>
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<tr>
<td>• Listen more than speak</td>
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<tr>
<td>• Team’s goals for meeting, questions</td>
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<tr>
<td>• Primary facilitator identified</td>
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<table>
<thead>
<tr>
<th>Meeting</th>
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<tbody>
<tr>
<td>Introductions</td>
</tr>
<tr>
<td>• Names of patient’s family and friends</td>
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<td>• Team: names and roles</td>
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<tr>
<td>Shared agenda</td>
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<tr>
<td>• Ask patient/family what topics and goals they have for meeting</td>
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<tr>
<td>• Summarize team’s goals for meeting</td>
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<tr>
<td>Patient / family perspective</td>
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<tr>
<td>• What do you understand about ____’s medical condition?</td>
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<tr>
<td>• How much information would you like from us? (what to expect)</td>
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<tr>
<td>Who is the patient, and what is important to them?</td>
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<tr>
<td>• What’s important to patient</td>
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<tr>
<td>• Typical day recently</td>
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<tr>
<td>• Family’s preferred role, along spectrum of shared decision making</td>
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<tr>
<td>• What would patient say?</td>
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<tr>
<td>• How much willing to go through for possibility of more time?</td>
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<tr>
<td>Sharing information</td>
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<tr>
<td>• Benefits and risks of each treatment option</td>
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<tr>
<td>Empathy and support</td>
</tr>
<tr>
<td>• Acknowledge emotions</td>
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<td>• Listen</td>
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<td>• Support</td>
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<tr>
<td>o Reflect back (“It must be difficult...”)</td>
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<td>o Direct hope toward achievable goals</td>
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<tr>
<td>o Reassure: goal of comfort; support pt/family decisions</td>
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<tr>
<td>o If possible, do not rush family to make decisions.</td>
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<th>Post-Meeting</th>
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<tr>
<td>• Debrief with team</td>
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<tr>
<td>• Document in EMR (Family Meeting – Structured)</td>
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Prescribing curriculum

• 2-hours during ambulatory block in PGY -2 or -3
• Introduced to Beers List and STOPP Criteria using case-based approach
• Review own patient’s record and document plans to change meds
• Shown to impact those specific patients
  – Identified ave of 2.3 medications/patient to discontinue and increased documentation of “polypharmacy” as a problem
• Studying to see if impact more broadly
Immersion curriculum

– Home visit with faculty to meet one of their complex patients within the first 2 weeks
  • Attempt to understand their lives before focusing in on their (overwhelming) medical problems
  • Studying short and longer term impact

– Didactic on multimorbidity and care of the elderly

The home visit helped me get to know my patient better as a person

83%
17%

The home visit helped me provide better care for my patient.

57%
40%
3%

Based on this experience I am more likely to do a home visit on another patient.

Strongly Agree
Agree
Disagree
Strongly Disagree

22
8
1
Transitions of Care

• 21. In planning hospital discharge, work in conjunction with other health care providers to recommend appropriate services based on: the clinical needs, personal values and social and financial resources of the patients and their families; and the patient’s eligibility for community-based services.

• 22. In transfers between the hospital and skilled nursing or extended care facilities, ensure that: for transfers to the hospital: the caretaking team has correct information on the acute events necessitating transfer, goals of transfer, medical history, medications, allergies, baseline cognitive and functional status, advance care plan and responsible PCP; and for transfers from the hospital: a written summary of hospital course be completed and transmitted to the patient and or family caregivers as well as the receiving health care providers that accurately and concisely communicates evaluation and management, clinical status, discharge medication, current cognitive and functional status, advance directive, plan of care, scheduled or needed follow-up, and hospital physician contact information.
Transitions of Care

• Aliki Initiative
• Transitions rotation
Aliki Initiative

• One of 4 ward teams
• Contact outpatient providers at admission
• All patients get a follow up phone call 1-3 days after discharge and team reviews
• Select patients have home visits

• Faculty cohort
Patients rated their physicians on Aliki Initiative more highly than on other teams.

Residents addressed problems with medication adherence, communicated with patients about leaving the hospital, and knew their patients as individuals better than on other teams.
• Reduced readmission to the hospital for heart failure within 30 days by 70%
What Geriatricians Have Always Known!

"The Aliki Initiative is the most important innovation in graduate medical education of the past generation. Its strength derives from its reaffirmation of basic educational principles: that residents learn best when they study their patients thoroughly and get to know them as people. Such principles are easily overlooked in today's market-driven health care environment."

- Dr. Kenneth Ludmerer, May 2008
Transitions Rotation

• 1-month intern rotation
• Shadowing in rehab and VNA, etc,
• Interviewing staff and patients in rehab about the transition of care
• Reviewing discharge summaries of newly transitioned patients
### Ratings Criteria

<table>
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<tr>
<th>Ratings</th>
<th>Problems were listed separately for complicated patients.</th>
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<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>All procedures during hospitalization were recorded (e.g., “status post retroperitoneal lymph node biopsy on 9/21/06” — this helps troubleshoot if complications arise).</td>
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<tr>
<td>1 2 3 4 5</td>
<td>Pertinent new mile markers for major conditions were included (e.g., “dry weight is 135#” or “neurologic exam on discharge was ...”</td>
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Discharge medications were recorded accurately:
- Names, doses, and frequencies and matched discharge instruction sheet EXACTLY
- Stop dates when appropriate (e.g., “ciprofloxacin 500mg twice daily – last dose 8/1/07”)
- Medications changes and reason (e.g., “stopped ACE inhibitor due to cough”)
- Pending information was noted accurately (e.g., “hepatitis B serology”)

Follow-up:
- Provided algorithm and rationale for follow-up (e.g., “repeat chest CT with contrast to evaluate for progression”)
- Provides recommendations for anticipated problems (e.g., “If pulse increases during rehabilitation therapy, would increase Dilatazem to 60 mg four times daily.”)
- Notes warning signals for need to return for evaluation.

Overall
- Concise
- Timely (within 48 hr)
- Paired with phone call to “receiving provider” to convey urgent information, when appropriate, or at least faxed to next provider

Ratings: 1 = suboptimal  3 = acceptable  5 = outstanding
Set up for Small Groups (45 min)

• Choose 1 of 7 EPAs to focus on
• Reflect on what you are already doing and what works well within that domain
• Identify the gap: what would be the ideal approach to that domain
• What are the barriers and facilitators to bridging that gap
• Share ideas in group
• Share group’s favorite idea with large group at the end