

TOPICS

In Geriatric Medicine and Medical Direction – Volume 32 Issue 6 – August 2011
A Peer Reviewed Journal of the Minnesota Medical Directors Association

Update in Geriatric Medicine Education Lawrence J. Kerzner, MD, FACP, AGSF

Introduction

This article reviews recent national initiatives in medical student and resident education in geriatric medicine. It also provides an overview of current and emerging concepts in assessing resident physician competence, the ultimate question for geriatric care being the degree to which our health care workforce is able to meet the health care needs of an aging population.

Overview

In 2008 the United States had 39 million people over age 65 comprising 13% of the population; this group collectively accounted for 44% of primary care office visits (excluding geriatrics providers), 56% of office specialist visits and 48% of hospital days.

Between 2000 and 2030 the number over 65 is expected to double from 35 to 72 million and will comprise 20% of population. Additionally, because some predict the death rate in those over 85 will decline more rapidly than official projections, an even larger growth in the frailest segment of the older population may be expected. Clearly the number of encounters with seniors in every medical specialty will grow tremendously. While the need to provide safe and effective care for the current older population already poses significant challenges, a future crisis is in the making.

To assist in defining direction and policy an expert panel convened by the Institute of Medicine (IOM) of the National Academy of Sciences published a 2008 report, *Retooling for an Aging America*;

Building the Healthcare Workforce.¹ Three broad approaches were advocated:

1. Enhance the geriatric competence of the entire workforce including formal and informal care providers.
2. Increase recruitment and retention of geriatric specialists and caregivers.
3. Improve the way care is delivered.

The IOM report specifically noted that “All licensure, certification and maintenance of certification for health care professionals should include demonstration of competence in the care of older adults”.

While the American Board of Internal Medicine (ABIM) and the American Board of Family Medicine (ABFM) have encouraged differentiation of internists and family physicians towards geriatric practice through fellowship training in Geriatric Medicine (GM), the numbers of fellowship trained geriatricians is currently inadequate and the numbers in the future will be even more inadequate.

A recent national survey conducted by the Association of Directors of Academic Geriatric Programs (ADGAP) identified an average of 3.8 geriatricians per 10,000 persons over age 75 (state to state range 1.1 to 6.9). In geriatric psychiatry the numbers were more dismal, 0.9 geriatric psychiatrists per 10,000 persons over age 75 (range 0.1-2.3).²

9,666 MD's graduated from FM and IM residencies in 2008, approximately 3% entered GM fellowships. In 2010, 148 IM and FP Geriatric Medicine fellowship programs offered 488

positions though there were only 273 first year fellows, a 56% fill rate. Only 23 fellows were beyond year 1. The smaller number of Geriatric Psychiatry fellowships had an even lower fill rate. 58 programs offered 130 positions though there were only 55 fellows, a 42% fill rate.

By 2010 only 8,756 of the 12,575 GM certificates awarded by ABIM and ABFM remained active. Of those initially certified during the 12 years 1988-2000 only 44 - 67% recertified in each of the subsequent recertification time intervals. Disturbingly, of the 763 FM and 1659 IM initially certified at the time of the first offering in geriatric medicine in 1988, only 271 (36%) and 265 (16%) in FM and IM remained recertified after the second recertification date.

By 2008 23% of medical schools required a clerkship in geriatric medicine and 56% had integrated geriatrics into a required clinical rotation. Considering the past poor exposure to education in geriatrics this seems somewhat encouraging though on retrospective review only 12% of students noted some exposure to a geriatrics curriculum.

While the John A Hartford Foundation, Donald W Reynolds Foundation, the Atlantic Philanthropies and others have supported medical schools in developing and disseminating curricula there remains great heterogeneity in implementation and in identification of geriatric related care competencies. Surveys of students and residents indicate they themselves feel overwhelmed by complex older patients and social situations. Other recent studies noted that only about 1/2 of graduating IM and FM residents felt "very prepared" for geriatric care and perceived training gaps such as recognizing and addressing complex multi-factorial illness, setting priorities and goals of work up and intervention, communication with families and patients with cognitive disorders, and assessment at hospital discharge.³

There currently are insufficient numbers of geriatrics specialists and given the declining numbers of those certified this gap will only increase. As emphasized by the IOM, increased geriatrics expertise is needed by all practitioners. In light of these observations increased energy has been directed towards developing tools for further strengthening curricular aspects in medical schools and in IM and FM residencies with the goal of enhancing and ultimately ensuring competency in high priority geriatric care concerns.

Unfortunately there is no medical school accreditation requirement to incorporate these recommendations.

Assessing, measuring, and ensuring physician competence. What does it mean to be "competent"?

By introducing concepts of "structure, process and outcome" in quality management Arvis Donabedian set the stage for today's dominant paradigm in evaluating the quality of health care.⁴ The term "structure" relates to the inputs or resources applied towards a particular problem or care concern. "Process" relates to the ways in which care gets accomplished. Both "structure" and "process" are attributes that can be readily described and measured.

Applied to medical education, structure and process relate primarily to curricular content and how knowledge is transmitted to the learner, exposure to particular contents for specified periods of time.⁵ while at the completion of training, residency program directors certify trainees as having demonstrated sufficient competence to enter practice without direct supervision, the problem is in defining competence. In this sense "competence" is an outcome of the educational process, "outcome" being Donabedian's "holy grail".

We are most familiar with measures of knowledge, attitudes and skills though we also recognize that these learner attributes may only be indirectly linked to actual patient experiences and outcomes of care. While achieving a passing score on a Board Certification examination is one regularly accepted benchmark of competence, its multiple choice question framework is not completely applicable to assuring the multiple positive attributes society requires of today's and of tomorrow's doctors.

Outcome as a focus of Accreditation

The Accreditation Council for Graduate Medical Education (ACGME) currently frames outcomes of medical education related to individual learners as "must" attributes in six "Core Competency" areas which are further defined by multiple other descriptors (Table 1).

Each of the six core competency areas is required to be evaluated from multiple perspectives through multiple data driven measures that go beyond simple "global ratings".⁷ Successful

accomplishment in each core competency serves as a surrogate for overall resident competence.

The degree to which residency/fellowship programs conduct comprehensive evaluations within this framework is a major focus of accreditation. Less than fully robust evaluation systems may result in adverse training program accreditation decisions. Noteworthy is that the core competency framework is also increasingly applied to evaluation of physicians' practice by hospital medical staff credentialing bodies and others.

Despite much emphasis on measuring trainees' performance within these six areas, competence as defined by this framework may remain removed from the ability to successfully carry out some important patient care related responsibilities.

Competency Based Medical Education (CBME)

Developing benchmarks for competency has gained much momentum in recent years and while still an emerging concept, it is currently an international level priority among medical educators. Its main principles include focusing on outcomes, emphasizing abilities, de-emphasizing time based training, and promoting greater learner-centeredness.⁷

Competency at what level also needs to be considered, the "Dreyfus" model is frequently used as a benchmark.⁸ This framework identifies 6 levels of competence, novice, advanced beginner, competent, proficient, expert and master. Those completing residency training must be competent at the level of a new practitioner. Those in earlier phases of training may be competent at less developed levels.

Using CBME principles the ABIM is currently piloting a condensation of geriatric medicine with palliative care training, eliminating duplicative requirements thereby freeing up time for fellows to develop additional educational or research skills. A number of other specialty areas are involved with similar ABIM pilots including Internal Medicine – Medical Genetics, Gastroenterology-Transplant Hepatology, Internal Medicine-Cardiology, and Primary Care Internal Medicine.

Emerging Concepts

Milestones⁹ : Because almost 10 years of attention to ACGME core competencies have not resulted in full implementation of assessments and tools across training programs the ACGME, ABIM, American College of Physicians (ACP), Alliance for Academic Internal Medicine (AAIM), Society for General Internal Medicine (SGIM), Society for Hospital Medicine (SHM) and others have embarked on a process to further elaborate competencies within each of the 6 core competencies by describing a developmental process of observable behaviors. These further elaborations, "milestones", will provide more specific feedback and evaluation of residents to ensure they acquire the knowledge, attitudes and skills for completing the program and for entering the next phase of their career.

Entrustable Professional Activities (EPAs)¹⁰:

Emphasizing practitioner abilities, EPA's are critical activities that must be assessed and approved at some point during training, broad patient care responsibilities that may be fully entrusted to a trainee once she/he is competent. A future challenge for the geriatric teaching community will be to identify the EPA's required for geriatric care. Indeed a survey of geriatric fellowship program directors is currently being conducted by ADGAP to obtain consensus in this area.

Geriatrics Competencies

Two recent initiatives have advanced the field of defining recommended geriatric care competencies for students when they are at the point of graduating from medical schools and entering residency training, and for those completing residency training entering practice (competent at the level of a new resident, and competent at the level of a new practitioner respectively). "Keeping Granny Safe on July 1: A Consensus on Minimum Geriatrics Competencies for Graduating Medical Students" recommends performance benchmarks for medical school graduates because as first year residents they will care for geriatric patients.¹¹ These are areas the graduating student would "know about", not necessarily be competent in performing.

From a geriatrician's perspective it is interesting to note these do not include transient urinary incontinence (thought to be too

complicated), frailty (not sufficiently defined), theories of aging (not important), tools for assessing gait, mental state and function (no consensus on which tools to use).

“Medicine in the 21st Century: Recommended Essential Geriatrics Competencies for Internal Medicine and Family Medicine Residents” identifies 26 competencies in 7 domains that map to the medical student geriatric competencies and the 6 ACGME Core competencies (Table 2).¹²

From a geriatrician’s perspective it is noteworthy that these recommendations do not include peri-operative assessment and patient counseling skills (not specific to geriatrics), managing behavioral complications of dementia and prescribing psychotropic medications (too advanced), substance abuse, and nursing home care (not feasible in all training programs). It is interesting to reflect that while there are more long term care beds than hospital beds, neither nursing home care or home care is included as a recommended competency of graduating residents.

These are areas for focused post-graduate level education organized nationally through organizations such as the American Medical Directors Association, the American Geriatrics Society, and locally through their state affiliate chapters and other medical societies.

Conclusion

Across the globe aging of populations currently and increasingly will present major challenges to all forms of social structures. Medical care of aging populations must address the varying needs of those who are robust or healthy, those who may be considered frail, those who have illnesses affecting cognition, and those at the end of life. Evolving concepts of competence increasingly focus on the ability to actually provide certain kinds of care. Assuring that the health care work force in general and physicians in particular are properly prepared to meet the care needs of an aging population requires reorientation of training goals and specific competence in senior care.

About the Author

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Table 1: Core Competencies

1. Patient Care	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.
2. Medical Knowledge	Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.
3. Practice Based Learning and Improvement	Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
4. Interpersonal and Communication Skills	Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
5. Professionalism	Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
6. Systems Based Practice	Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Table 2 ACGME Core Competencies

1. Medication Management	<ul style="list-style-type: none"> a. Prescribe appropriate drugs and dosages b. Document rationale for prescribing drugs that present high risk for adverse events and interactions c. Periodically review medications
2. Cognitive, Affective, Behavioral Health	<ul style="list-style-type: none"> a. Administer and interpret screening tests for delirium, dementia, depression and substance abuse b. Recognize and treat delirium as a medical emergency c. Diagnose and treat changes in affect, cognition and behavior d. Treat and appropriately refer patients with dementia and/or depression
3. Complex Chronic Illness Management	<ul style="list-style-type: none"> a. Evaluate and demonstrate use of adaptive techniques in patients with hearing/sight impairment, speech difficulties, aphasia, limited literacy and cognitive deficits b. Assess capacity for providing an accurate medical history / medical decision making and participation in care planning c. Diagnose undifferentiated illnesses and “atypical” presentations of illness (acute coronary syndromes, acute abdomen, urinary tract infection, pneumonia) d. Recognize adverse medication reactions e. Recognize the impact of major age related changes in physical and laboratory findings in diagnosis and treatment f. Advanced care planning g. Develop treatment plans that incorporate patient and family goals, preserve function and relieve symptoms
4. Palliative/End of Life Care	<ul style="list-style-type: none"> a. Assess and treat pain and non pain symptoms based on goals of care b. Identify with patient, family and care team goals of care and transition to primarily comfort care
5. Hospital Patient Safety	<ul style="list-style-type: none"> a. Assess and document daily the presence or absence of delirium b. Evaluate and initiate corrective measures for falls risk, immobility, pressure ulcers, oral intake, pain, and incontinence, constipation, inappropriate medication prescribing on admission and regularly during hospitalization c. Indwelling bladder catheter management d. Physical /chemical restraint management
6. Transitions of Care	<ul style="list-style-type: none"> a. Team with other health care providers to recommend patient and family centered hospital discharge plans b. Ensure that inter institutional transfers are properly managed and documented
7. Ambulatory Care	<ul style="list-style-type: none"> a. Annually screen for and manage falls and fear of falling b. Diagnose and manage bladder and bladder dysfunction c. Recognize those at high safety risk including unsafe driving and abuse/neglect d. Health maintenance screening and prophylaxis based on life expectancy, functional state, patient preference and goals of care

President's Column By John Mielke, MD

I want to use this part of the Topics to encourage you to attend this year's fall conference: "Transitions in Geriatrics". The Thursday pre-conference day is focused on anti-psychotic medication reduction. Similar to last year's pre-conference, we hope the leadership triad at your home can attend together to design optimal care for the behaviorally challenged dementia resident.

One of the main challenges of geriatric care is the shortage of medical providers. We will hear from Dr. Pacala and Ratner about their efforts to introduce medical students to geriatrics and we will have a panel discussion on mid career transition to geriatric care moderated by Dr. Schoephoerster.

A transitional "hot topic" is rehospitalization reduction. We will have a session to discuss tools and resources available to develop a comprehensive system for reducing unnecessary hospital admissions.

An important transition is occurring in MMDA leadership at our Thursday evening dinner. Dr. Christine Duncan will be assuming the president's role at MMDA. Make plans to attend the annual business meeting, dinner and speaker on Thursday October 27th.

A final note: We are transitioning support for the conference to our nursing home organizations. We are committed to eliminating commercial bias at the MMDA conference. Please contact Rosemary Lobeck, our executive director, if you wish to help contact your nursing home organization for a contribution to our fall conference.

SENIOR CARE TRANSITIONS

Geriatric Medical Director Opportunity

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Transitions in Geriatrics Conference

**October 27-28, 2011
Minneapolis Marriott Southwest**

**Thursday October 27, 2011
2:00- 5:30 p.m.**

Preconference: Eliminating Antipsychotics use for Patients with Dementia and Behavioral Problems

6:30 p.m.

Fall Conference Kick-off Dinner and Annual Business Meeting

**Friday, October 28, 2011
8:00 a.m. -5:00 p.m.**

Topics Include:

- Medical Student Training in Long Term Care
- Attending Engagement Around Psychiatric Medication Reduction
- Transitioning to Geriatric Services
- Red Flags and Band Aids
- Improving Transitions in Resident Care
- Practical Ways to be a Better Medical Director and Attending MD
- Positive Pressure Ventilation – New Modalities and Indications
- Financial Elder Abuse
- Endocrinology Updates for Geriatrics Practice

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Vitamin D	Margaret Rice, MD

If you are interested in a previously published article, please contact Rosemary Lobeck @ rlobeck@mnmeddir.org and one will be emailed to you.



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Topics in Geriatric Medicine and Medical Direction is produced and Published bimonthly by the Minnesota Medical Directors Association.

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Save the Date:

MMDA Fall Conference:

October 27-28, 2011

Marriott Minnetonka Hotel, Minnetonka

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Manuscripts should be emailed to rlobeck@mnmeddir.org and cdwighttownes@hotmail.com. The first page should include the title and a 50 to 60 word abstract. Manuscripts should range around 1800 to 3000 words.

Review Policy: Manuscripts will be reviewed by at least two members of the review board whose evaluations will provide a basis for the publication decision. We are committed to a rapid review process.