Community LTC

By Bill Kubat, LNHA

Geriatric Med Ed Preps New Recruits for a Fast-Changing Future

Remember Bob Dylan's classic song, "The Times They Are A-Changin' "? That's true of many things, but it's certainly true of geriatric medical education. How and when geriatrics is introduced broadly into the medical school curriculum is one aspect of that evolution; postdoctoral geriatric fellowship program (GFP) curriculum is another.

Geriatric medical education in American medical schools has improved over the past 30 years, yet it is still facing many challenges. The familiar statistics tell the story: The number of Americans older than 65 will nearly double by 2025, making them the fastest growing age group in the country. As of 2014, there were fewer than 7,500 geriatricians in the United States. Only eight of the country's 145 academic medical centers have full geriatrics departments, while only 44% of the nation's 350 geriatric fellowship positions are filled.

The history of geriatric medicine and geriatric medical education is relatively recent. Geriatric medicine originated in the 1950s in the United Kingdom. In the United States, backed by significant financial support from Congress in the 1970s, the specialty of geriatrics slowly grew into more formalized academic programs. In 1988, geriatric board certification was initiated.

But despite the growth of the field and the looming number of practitioners that will be required to care for the nation's elders, it is difficult to attract and recruit family and internal medicine residents into geriatrics.

Continuing Education

Regarding community LTC, the question is this: As the health care environment changes, how is medical education changing to prepare physicians to be effective and successful in adapting new models and settings of care delivery? How are the postdoctoral fellowship programs changing? Are experiences in the nuances of facility-based care, ambulatory care, and home-based care adequately addressed?

There are promising indications that medical education is keeping up. One significant sign is recognizing that caring for elderly patients must include an understanding of the care setting. An article reported in the *Journal of the American Geriatrics Society* by Susan M. Parks, MD, and colleagues (*J Am Geriatr Soc* 2014;62:930-5) described the current thinking about "curricular milestones" for geriatric fellows, terminology used by the Accreditation Council for Graduate Medical Education to describe competency-based medical education.

The milestones fall into three domains:

- Caring for the elderly patient: This is made up of seven areas including gerontology, diseases in older adults, and functional impairment and rehab, among others.
- Geriatric syndromes: These syndromes comprise nine areas including cognitive, affective, and behavioral health.
- Care settings and systems-based care for the elderly patient: These areas include hospital care, ambulatory care, home care, long-term care, and nursing home care. Understanding the care setting is as important as the impact of polypharmacy.

Leaders in Geriatrics

I visited with two credible voices from the trenches of geriatrics practice, geriatric medical education, and geriatric fellowship programs: David Sandvik, MD, CMD, from the Sanford School of Medicine (SSOM), University of South Dakota, Vermillion, SD, and Laura Morton, MD, CMD, from the University of Louisville, Louisville, KY.

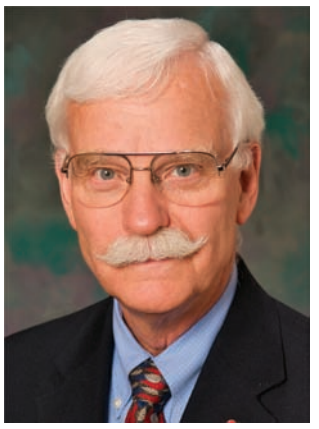
Dr. Sandvik began his practice in Rapid City in 1980 and is currently professor of internal and family medicine at SSOM. He also has served as program director for the SSOM geriatric fellowship program since its inception in 2010. Dr. Morton is an assistant professor in the department of family and geriatric medicine and is director of the geriatric medicine fellowship program at the University of Louisville School of Medicine.

I asked Dr. Sandvik and Dr. Morton about their own perspectives related to the changes they've seen in health care delivery and medical education.

In reflecting on more than 35 years of practice, Dr. Sandvik holds two convictions closely. First, he said the goal of geriatric health care has never changed, and that is "to get people home," regardless of where they are currently or where they consider to be their home. Second, "hospitals can be very dangerous places for older people," he said.

To that end, he and others pioneered the implementation of a comprehensive geriatric assessment process in Rapid City Regional Hospital years ago. In this process, an interdisciplinary team focuses on evaluation, care coordination, and rehabilitation. "If the admission was on Monday, the team met on Wednesday," Sandvik said. Few older patients can meet or tolerate the hospital rehab threshold of 3 hours of therapy daily, and so for many, "the ticket home is through the skilled nursing facility."

Dr. Sandvik also added that the increased emphasis on continuity and transitions of care is not completely new; this focus began with the introduction of diagnosis-related groups in the 1980s. Today, with accountable care organizations and bundled payments, the focus on care transitions has increased.



David Sandvik, MD, CMD, and Laura Morton, MD, CMD, agree that student exposure to the geriatrics field is growing, but there is still room for improvement.

Dr. Morton said that she "grew up in nursing homes" and worked as a certified nursing assistant in college. She admitted to a bias toward facility-based care because working with the interdisciplinary team is easier than in home-based or ambulatory care. Generally, in the nursing home, the team is right there and easier to convene. The team-based approach thrives as well in the clinic or in home-based care, but communication and subsequent delivery of care can be fragmented.

Both Dr. Sandvik and Dr. Morton referenced the Veteran's Affairs' Home Based Primary Care program as a model that both fellowships include in their rotations. The program's purpose is to better serve veterans' care needs and preferences by more effectively caring for complex patients at home. A key component of the model is that the interdisciplinary team meets once a week to review all clients. As Morton said, that is effective, but "hard to do elsewhere."

Although almost 30 years separate the medical school/residency experience for Dr. Sandvik and Dr. Morton, both agree that the exposure to geriatrics is better now than it used to be, but there is still room for improvement. Even given Dr. Morton's relatively recent experience in medical school, she still had to seek out ways for geriatrics to receive exposure. These are now built into the curricula — perhaps not as extensively or universally across all students, but there are more opportunities than before.

How do these two fellowships help prepare the next generation of LTC physician leaders?

In South Dakota, which has had a program since 2011, there have been seven fellows, and all but one have been mid-career practitioners as opposed to those directly out of residency. Last year, the fellowship also recruited part-time practicing physicians; for example, currently, the program has two hospitalists as part-time fellows. This has required creative thinking about how to "take the GFP to the fellow," not vice versa. Dr. Sandvik described the model as building toward a multi-campus experience with rotations across settings and communities. The rotations are key: nursing home, hospital, VA, home health, and a rural, remote telemedicine nursing home support system (*e*LTC) rotation. The fellows' CMD certification is also built into the fellowship year.

Recruitment Successes, Woes

The University of Louisville School of Medicine recently celebrated the 15th anniversary of its geriatric fellowship program. As with most programs, if not all, recruitment has been a challenge. There used to be three slots for fellows; this has been reduced to two. The strength of the Louisville program is its faculty, who serve as medical directors at five facilities, and the diversity of its practice settings, including the VA home-based primary care program, VA palliative care unit, the physical medicine, and rehabilitation rotation at the university hospital. An in-depth continuity nursing home experience that involves both a clinical and an administrative rotation, and a didactic component that prepares the fellow for leadership and active participation in preparing lectures on case review, serve as a strong foundation for geriatric education and practice.

The respective GFPs of Dr. Sandvik and Dr. Morton certainly align with what Dr. Parks described as "curriculum milestones" for graduating geriatric fellows — the inclusion of "systems-based care for the elderly patient" that accounts for the nuances of different care settings.

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