How quickly Spring seems to turn into Fall. As I look out my window at the colorful leaves, I think about all we have accomplished since we last updated you on our grant progress. Our grant team has been moving full speed ahead finishing up our fourth year of funding. After our geriatric seminar at the Michigan Osteopathic Association (MOA) convention in May was so well received, we have posted the videos of our presentations on our website. If you didn’t see them in person, we hope you will tune in to one or all of them at:

http://com.msu.edu/FCM/Geriatrics.htm

We received the notification in early September that we have been funded for the final year of our geriatric medicine initiative. Anticipating that this would be the case, we held a strategic planning session in August to chart our course of action for the next year. Since then, we have been very busy with our grant activities and have been working on multiple projects.

We are adding additional physician consultants to help us modify and add geriatric medical content to the 3rd and 4th year medical school curriculum. We continue to modify geriatric content in the 1st and 2nd year curriculum.

Our progress on educational modules for students, residents, fellows and practicing health care providers has continued. These modules will be made available in several formats, including course outlines, content and materials, and video/audio presentations to use online, for distance learning, and for CME credit in the future. This will provide many options for use, and will be conveniently located on our website.

We are planning with the Michigan Osteopathic Association to present additional geriatric focused lectures at the MOA 117th Annual Spring Scientific Convention on Friday May 13, 2016. We will again record our presenters to add more presentations to our geriatric website for additional viewing.

We continue to seek your feedback on additional website content you would like to see included for your education in geriatric medicine. We will continue to expand our website to make it the destination for all information and education on caring for geriatric patients. Future plans for this site include the possibility of CME credits for viewing the presentations.

We continue discussions on an alternative pathway geriatric fellowship. This pathway would allow mid-career physicians to become fellows. Part-time

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Message from the Project Director (Continued from page 1)

employment and being in a geriatric fellowship on a part-time basis would be compatible. Overall requirements of this fellowship alternative would be the same, but would be spread over a period of two years. Completing the program would qualify the fellow to take the examination for a certificate of added qualification in Geriatric Medicine. We continue to move forward with our mission to increase Geriatric Medical Education in Michigan. We strive to involve all caregivers and patients in Michigan to Age Optimally with education from MSUCOM and SCS.

HELP US RECRUIT GERIATRICIANS FOR MICHIGAN!

Position Available for Geriatrician

The department plans to hire a geriatrician to work with faculty and students. If you are interested in applying for this position, you are encouraged to contact: Family & Community Medicine Chairperson, Dr. Amy Keenum at (517) 353-3100.

Geriatric Fellowships

Attention graduating residents or currently practicing physicians:

Our grant supports Geriatric Fellowships at the following sites: Lansing Sparrow, Grand Rapids Metro Health, and Detroit (FQHC) Federally Qualified Health Center.

If you (or someone you know) are interested in applying for a Geriatric Fellowship or want more information about grant activities and educational material development, please contact our grant office at:

Michigan State University
College of Osteopathic Medicine
Family & Community Medicine
Division of Geriatrics
(517) 432-2280 or TOMANL@MSU.EDU

Carol L. Monson, DO, MS

Geriatric Fellowship – Why would I want to see MORE old people?

Internal and Family Medicine residents spend much of their training caring mostly for older adults. For these residents it can sometimes seem unnecessary and unclear why to spend ANOTHER year learning to care for this population. As geriatrics is still a newer fellowship, many current attending physicians also do not understand the value of a geriatric fellowship so residents are rarely mentored in this direction. Yet for this upcoming millennium generation, a career in geriatrics is a perfect fit offering flexible hours, variety and often weekends off!

Geriatrics offers training in nursing home, home care, hospice patient care and medical directorship, as well as training in palliative care. Many hospitals are also looking for geriatricians to help with decreasing length of stay and improving patient care for older adults in the hospital. Medical schools are looking for geriatricians to supplement the education of our medical students. In addition, insurers and medical quality review companies are looking for geriatricians to review cases.

What does all this mean? Incredible job opportunities for full time, part-time and even just supplementing income. Nursing home, hospice, home care, administrative work and quality reviews all offer flexible hours and often work from home while still having the opportunity for office, hospital rounds and even seeing older adults in the ICU! National and international jobs are everywhere for geriatricians and salaries are often above traditional IM/FM positions. With the dramatic changes in healthcare today, spending one additional year to gain the experience and credentials of a geriatric fellowship will make young doctors today more successful in navigating the changes with added knowledge of the continuum of care. A geriatric fellowship is not just “seeing more old people”. It is learning to care for older adults in all settings so as to optimize their function, quality of life and when appropriate, their ability to spend their last days with dignity.

Visit the American Geriatrics Society website for more info on geriatric fellowship or contact MSU FCM/IM Division of Geriatrics.

(Note: Dr. Carron is the Director of Geriatrics and Palliative Care at Botsford Hospital)

Annette Carron, DO, CMD, FAAHPM, ACOI
Spotlight On...

Mobility Assessment of Older Adults -
Assessing Fall Risk
Francis A. Komara, D.O.

One of the key components of geriatric care is the concept of functional assessment. Americans are living longer, but there are multiple dangers to living effectively and independently. Over 25% of those over the age of 65 report living with a physical disability and about 10% with a self-care disability. Approximately half of those over the age of 85 report a mobility or self-care limitation or both. Functional assessment addresses the domains of physical function, psychosocial/spiritual function and cognitive function and how the individual interacts with their environment. Many times this assessment may lead to a new diagnosis or understanding of an existing diagnosis.

Medical treatment is diagnosis driven. Yes, this may be important to the medical system, but I wish to introduce a novel concept that may be more important is to assess how the individual functions and how their mobility affects their ability to live independently. The focus on the curative model of care becomes less important. Indeed, an article by Rubenstein suggests that many primary care providers do not adequately assess problems, such as falls, when a patient is seen in the office. Ultimately, it is the focus on function and mobility that become more important to the older adult wishing to live independently and whether a patient has a diagnosis of hypertension, osteoarthritis or hyperlipidemia may become secondary in importance. As the patient ages beyond 65 years of age, the chances are greater that they will have multiple diseases and medical conditions. Considering the concept of “optimal aging” proposed by Baltes and Baltes, and cited in the article by Brummel-Smith, may allow us to assist our patients in optimizing their capabilities and satisfaction regardless of their health status. Optimal aging refers to the capacity to function to one’s own satisfaction across many domains of physical, functional, cognitive, emotional, social, and spiritual, with the existence of medical conditions. This is in contrast to successful aging which assumes the absence of disease and disability, a state contrary to many over the age of 65 and especially for those over age 85 who have many chronic diseases and limitations to function.

MOBILITY HISTORY

Are there conditions that affect the patient’s mobility such as pain, spasticity or lack of assistive devices that may contribute to limits in mobility? If the patient has an assistive device, is it fitted properly and is the patient using it correctly?

IDENTIFY RISK FACTORS

- Have there been prior falls?
- Is the patient taking 3 or more medications?
- Does the patient exercise regularly?
- Check BP sitting and standing. Is there orthostatic change?
- Is gait normal or abnormal? 10 ft. walk with turn. Broad-based, deviant path?
- Balance: Timed Up & Go Test. Resistance to nudge?
- Quad strength: Can patient rise from a chair without using arms?
- Hip and knee range of motion?

INTERVENTION

Respond to your screens. Improve muscle weakness with regular exercise. Our patients are inactive and a personal trainer or regular visit to the YMCA may be the best recommendation that we can offer.
Zest for Life—My Geriatric Fellowship Experience

She looked into my eyes and said, “Oh man, either you have oxygen or you don’t”. I felt such a rush of relief and awe at the same time. This was the most coherent conversation that I had ever had with Mrs. W. in the six months that I had taken care of her. In that moment, two months from graduation I gained an unwavering sense of confidence. It was the right choice, and I was able to take care of patients with the geriatric approach. There is no algorithm that can fully account for all of the changes in the end stages of life, and there you are as investigator, advocate, and compassionate observer. Each patient is different in physiology, interplay of multiple medical comorbidities, and their goals of care, which makes this field fun as well as challenging for my life work.

My choice to pursue geriatrics stated more innocently, simply enjoying my interactions with my geriatric outpatients. There was such as sense of fulfillment after every interaction, the patients were so gracious, that it resulted in my pursuit of geriatric medicine during residency. I wanted to know that I did everything that I could to be the best physician for my patients. As I began attending the conferences for geriatrics, it became abundantly clear; I would need to eventually seek a fellowship to be trained in the principles of care. The principles were subtle, easily passed over, but would result in boundless differences. Mrs. W. apparently had been having fits of anxiety, and now had been receiving anxiolytics from the on call teams. My nurses and medical assistants reported that Mrs. W. would wake up from naps (which she was napping frequently) panicked, asking for help, and increasingly confused. Everyone was convinced that she had now developed some sort of anxiety disorder. This struck me odd, as I had found her to be a very sweet calm lady, and did not recall any history of anxiety related disorders in the past. Sitting with Mrs. W. (who was “having a better day”), differentials began to run through my mind. I was convinced that this was not anxiety at all, this had to be obstructive sleep apnea. My team trusted my plan, they said they would work with her and monitor her oxygen SATS for the next week. Sure enough, she had been in the low 80’s when she would fall asleep, they added supplemental oxygen the same night. Within two days, she stopped having anxiety attacks, did not need any PRN anxiolytics, left her room for the first time in days, attended groups for the first time in months, and she remembered the names of her care takers for the first time.

Looking into her eyes, I could see that she remembered me. I felt that I found her, somewhere from the abyss, she had in ways returned. My heart was full, I knew her daughter would have meaningful interactions with her mother, and my patient was interacting with the residents, making jokes, and most importantly living.

Karendeep Gill, M.D.