A Prospective Controlled Trial of the Influence of a Geriatrics Home Visit Program on Medical Student Knowledge, Skills, and Attitudes Towards Care of the Elderly

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PURPOSE: To determine the impact of a geriatrics home visit program for third-year medical students on attitudes, skills, and knowledge.

METHODS: Using a mixed methods, prospective, controlled trial, volunteer control group students (n=17) at two sites and intervention group students (n=16) at two different sites within the same internal medicine clerkship were given Internet and CDROM-based geriatric self-study materials. Intervention group students identified a geriatrics patient from their clinical experience, performed one "home" visit (home, nursing home, or rehabilitation facility) to practice geriatric assessment skills, wrote a structured, reflective paper, and presented their findings in small-group teaching settings. Papers were qualitatively analyzed using the constant comparative method for themes. All students took a pre-test and post-test to measure changes in geriatrics knowledge and attitudes.

RESULTS: General attitudes towards caring for the elderly improved more in the intervention group than in the control group (9.8 vs 0.5%; p=0.04, effect size 0.78). Medical student attitudes towards their home care training in medical school (21.7 vs 3.2%; p=0.02, effect size 0.94) improved, as did attitudes towards time and reimbursement issues surrounding home visits (10.1 vs -0.2%; p=0.02, effect size 0.89). Knowledge of geriatrics improved in both groups (13.4 vs 15.2% improvement; p=0.73). Students described performing a mean of seven separate geriatric assessments (range 4–13) during the home visit. Themes that emerged from the qualitative analysis of the reflective papers added depth and understanding to the quantitative data and supported results concerning attitudinal change.

CONCLUSIONS: While all participants gained geriatrics knowledge during their internal medicine clerkship,

students who performed a home visit had improved attitudes towards the elderly and described performing geriatric assessment skills. Requiring little faculty time, a geriatrics home visit program like this one may be a useful clerkship addition to foster medical students' professional growth.

KEY WORDS: geriatrics; home visit; medical student; education; professionalism; narrative writing.

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BACKGROUND

Regardless of the chosen career path for graduating medical students, an overwhelming majority will have responsibilities that touch on the care of elderly patients. In 2006, 12.4% of the US population was over age 65,¹ and this group is growing. Despite this, medical schools struggle to implement geriatrics training in an already overloaded curriculum. The American Geriatrics Society has called for major revision of the educational approaches to geriatrics,² and the Association of American Medical Colleges (AAMC) and Hartford Foundation recently published a set of minimum geriatric competencies for graduating medical students.³

Home visits with geriatric patients improve attitudes towards caring for the elderly,^{4,5} and medical educators recommend home visits to develop well-rounded physicians.⁶ Geriatric home visits can enhance geriatric and palliative care curricular content.^{5,7} Similarly, narrative writing, where the learner reflects on the care provided or upon a critical incident, promotes reflection and may enhance professionalism.^{7–9}

At the Uniformed Services University, we developed a novel geriatrics home visit (GHV) program characterized by student-driven patient selection, goal setting, independent study, and a structured reflective writing experience. The purposes of the GHV program were to introduce skills for geriatric assessment, improve attitudes towards geriatric patients, and improve knowledge of geriatrics. This prospective, controlled study was designed as a pilot to gauge the feasibility and effectiveness of this program before implementation as a required exercise during our third-year internal medicine clerkship.

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METHODS

The Institutional Review Boards at the Uniformed Services University and at the four participating teaching hospitals approved this study. Participating medical students provided written informed consent.

Logistics of GHV Program. The third-year internal medicine clerkship at the Uniformed Services University consists of one 6-week ambulatory block and one 6-week inpatient block. Each block is performed at one of eight widely geographically separated sites across the continental United States and Hawaii. The GHV program occurred during one of these two blocks and was designed as an intentional process developed by each student based on a staged guideline. The program was student-driven and required a high level of student independence.

First, students identified a patient from their clinical experience, prepared goals for the home visit, and wrote the first section of their paper about these goals. Next, students completed self-directed internet and CDROM-based educational modules, including a required general geriatrics module and their choice of at least one module specific to their patient's situation and the student's goals for the visit. Modules supplied to the students were chosen by a group of educators and geriatricians based partially on guidance from the AAMC and Hartford Foundation recommendations³ and included the required overview, caregiver stress evaluation, dementia, depression, functional assessment, mobility/gait/falls, palliative care, polypharmacy, and urinary incontinence. Modules were either locally developed or augmented by freely available online resources.

Students arranged meeting times with patients and went alone to visit their patient—either in the patient's home, assisted living facility, or skilled nursing facility. After this, each student completed their paper, which replaced one of the required clerkship papers. Students integrated discussion of the experience into the usual teaching activities of the clerkship (teaching rounds, ward rounds, and ambulatory clinic discussions) such that there was no increased use of faculty time or resources. Teaching attendings gave feedback to the students about the papers.

Research Project Design. Students at two of our sites volunteered to participate in the GHV program (intervention group), and students at two other sites volunteered for the control group. Allocation to control and intervention group by site avoided cross-contamination occurring during discussion of the home visit experience. Both intervention and control group students took a 25-question multiple choice pretest within 5 days of starting the rotation and a different 25-question post-test during the last week of the rotation, designed to measure knowledge and attitudes towards geriatrics patients and home visits. Only intervention group students performed the home visit, wrote a paper, and discussed the experience.

The attitudinal portions of the pre-test and post-test were identical, validated questionnaires adapted with permission⁴ (see [Appendix](#)). Both intervention and control group students were supplied access to the educational materials, although only the intervention students received instruction to complete at least two modules. Students self-reported the time spent accessing the supplied materials via a question on the post-test.

Data Analysis. A prior study utilizing the attitudinal changes portion of the pre/post test⁴ guided sample size determination. In the same manner as the prior publication,⁴ Likert-scale responses within each domain ([Appendix](#)) were summed to a single score and standardized to a 100-point scale. Question 1 of the fourth domain was reformatted to establish between-question consistency in the direction of attitudinal change. Mann-Whitney U test was used to compare changes in attitudinal and knowledge domain scores between intervention and control groups.

We qualitatively analyzed the students' home visit papers, using the constant comparative method^{10,11} to identify themes in the following manner: Two authors (JLH and GD) independently read the first three papers, identified themes, conferred, and reached agreement. Subsequently, JLH coded the remaining papers, and GD independently coded one-third to ensure continued agreement. Disagreements were rare and resolved by consensus. A third author (JH) entered the data in HyperResearch version 2.8 software,¹² reviewed and agreed with all coding decisions. Finally, two authors (RR and JH) independently counted the geriatrics assessments described in each paper. They agreed 91% of the time as to whether a particular assessment was performed. Disagreements were adjudicated by a third author (GD).

RESULTS

Twenty-seven students volunteered for the intervention group; nine did not complete the home visit. One student did not complete the pre-test or post-test, but completed the home visit and wrote a paper. Thus, there were 17 intervention group students with complete data (63%) and one with only a paper available for qualitative analysis. Seventeen students volunteered for the control group; one did not complete the post-test, leaving 16 control group students (94%).

Baseline knowledge and attitudinal scores from the questionnaire (Table 1) did not differ between the two groups. Geriatrics knowledge improved similarly in both groups (13.4 vs 15.2% improvement; $p=0.46$). Student attitudes improved in the intervention group as compared to the control group in three of the four domains (Table 2). Compared to the control group, GHV participants reported improved attitudes towards: geriatric patients in general (9.8% vs 0.5%, $p=0.04$; Cohen's $d=0.78$); improved home care training (21.7% vs 3.2%, $p=0.02$; Cohen's $d=0.94$); and time and reimbursement for home visits (10.1% vs -0.02, $p=0.02$; Cohen's $d=0.89$).

Students performed a mean of 7 geriatric assessments in the home (range 4 to 13) (Table 3). Control and intervention group students reported similar amounts of time reviewing supplied educational materials (1.7 vs 2.7 h, $p=0.16$).

Qualitative analysis identified seven themes in three groups, described below.

Theme Group A: Clinical Information about the Patient

- Student Preparation for the Visit

Most students reported their observations about the patient's needs from their time with them in the clinic or hospital, described areas they planned to assess, and then listed and briefly described the geriatric assessment tools they planned to use during the visit. Some students included self-reflection or

Table 1. Baseline Demographic Data and Geriatrics Attitudinal and Knowledge Pretest Scores by Group Assignment

	Control group (n=17)	Intervention group (n=16)	P value*
Demographics			
Age [years (SD)]	27.8 (4.2)	29.4 (4.0)	0.26
Race (% Caucasian)	62.5	87.5	0.10
Gender (% female)	41.2	25	0.34
Attitudinal scores** (see Appendix)			
General attitudes (SD; range)	84.6 (0.16; 38.0–100)	81.8 (0.16; 47.6–100)	0.54
Home-based therapies (SD, range)	69.3 (0.13; 39.3–85.7)	70.1 (0.13; 50.0–92.9)	0.91
Home care training (SD, range)	40.8 (0.19; 14.2–85.7)	33.0 (0.09; 14.3–50.0)	0.16
Time and reimbursement (SD, range)	70.3 (0.21; 19.0–100)	72.3 (0.18; 33.3–95.2)	0.70
Knowledge scores			
***Knowledge (SD, range)	49.6 (0.08; 34.8–69.6)	53.2 (0.11; 30.4–69.6)	0.20

Geriatrics home visit program, internal medicine clerkship, Uniformed Services University of the Health Sciences

*Comparisons via Mann-Whitney U test except for race and gender (chi square)

**Likert-scale variables normalized to a 100-point scale and expressed as percentage

***Knowledge scores based on responses to 25 single best answer questions

explicit statements about their goals for their own learning during the visit. For example,

“My goals for this visit are to not only fully understand the individual I have chosen for the home visit, but also try to generate a greater global understanding in terms of the geriatric population...I also hope...to uncover any other underlying medical or psychosocial problems that I can refer her to for help [sic]...I will evaluate these [geriatric assessment] issues mostly per the patient's perspective—as opposed to our time[s] on the ward, which are often spent investigating past outpatient visits...I believe that the point of this visit is to spend time outside of what we do on the ward and try to spend a few hours to take in and understand the patient holistically and in the environment in which they spend most of their time.”

• Medical Evaluation

Students sometimes recommended that a patient discuss a particular issue with their physician or noted that the student conveyed information about the patient to the physician. Several students included description of medical issues observed in the context of the patient's home life:

“The patient's foot was in good condition. I could not see any improvement in the foot since last I

met with him (last week). They kept it [his foot] covered in a sock, and [he] wore sandals...so 'his foot could breathe.' The patient states that he is compliant with a diabetic diet; however, I did have apple pie and ice cream during the visit.”

• Use of Specific Geriatric Tools

Students described the tools they used. For example:

“On this visit I first administered the Mini Mental Status Exam to get a baseline idea of her cognitive abilities. She scored a 29/30, which was very impressive for an 88 year old. I also administered the Geriatric Depression Scale long form with a result of 11/30 positive. A score of 10 or more indicates depression with a sensitivity of 84% and a specificity of 95%, so I feel that she likely is depressed, which is consistent with her own perceptions. At this discussion she was more receptive to the possibility of getting help in the form of an antidepressant medication so I advised her to bring this up with her primary care manager on Friday.”

Theme Group B: Contextual Information about the Patient

• Patient Support and Environment

Students addressed social support, i.e., the presence or absence of family, friends, and so forth, convenience of

Table 2. Change (Post-test Score Minus Pre-test Score) in Geriatrics Attitudinal and Knowledge Measures Following Home Visit Program

	Control group (n=17)	Intervention group (n=16)	p-value (Mann-Whitney)	Effect size (Cohen's D)
Changes in attitudinal scores* (see Appendix)				
General attitudes	0.5%	9.8%	0.04	0.78
Home-based therapies	6.6%	6.0%	0.97	n/a
Home care training	3.2%	21.7%	0.02	0.94
Time and reimbursement	−0.2%	10.1%	0.02	0.89
Knowledge measures**				
Change in percent correct	15.2%	13.4%	0.46	n/a
Student-reported number of hours spent on study material (SD)	1.66	2.67	0.16	n/a

Geriatrics home visit program, internal medicine clerkship, Uniformed Services University of the Health Sciences

*Likert-scale variables normalized to a 100-point scale and expressed as percentage. Scores <50 reflect negative attitudes, >50 reflect positive attitudes

**Knowledge scores based on responses to 25 single best answer questions

Table 3. Geriatric Assessments Performed by Students in the Geriatrics Home Visit Program, Internal Medicine Clerkship, Uniformed Services University of the Health Sciences (n=16 students)

Assessment	Percent of students performing assessment
Polypharmacy assessment	89
Fall risk	83
ADL assessment	83
End of life discussion	78
IADL assessment	72
Gait evaluation	61
Mental status exam	56
Geriatric depression scale	44
Vision assessment	39
Nutritional status	39
Hearing assessment	22
Incontinence evaluation	22
Caregiver burden	22
Pain assessment	11
Functional reach	6

ADL, Activities of daily living

IADL, Instrumental activities of daily living

resources, sources of transportation, and help patients received from others with medications and with navigating the health-care system. They also provided detailed descriptions of physical environments, patient safety, and physical adaptations patients had or needed.

"Visiting their home also gave me insight into how patients' lives are affected after a major hospitalization. While talking with their daughter, I learned that [the daughter] was even rethinking the education plan for her 4-year-old son, starting him in kindergarten earlier because of her father's health problems. Mrs. B. usually picks up her grandson at preschool, but with the recent developments, they were unsure if she would have time between making trips for Mr. B.'s doctors' appointments or other possible hospital visits. The depth of the impact truly surprised me; I realized that their lives would be affected, but I never considered how it could drastically reshape the lives of [those] around them."

"There are two features in the home Mrs. J. was very excited to show me. The first are the double railings placed at the top of the stairs, because the last place you want to lose your balance is when you reach the top of the stairs! These railings are also placed at such a height that she can perform daily exercises while standing in the hallway...The second very useful feature is the 18" railing [installed] to aid with balance stepping over the lip of the shower floor...[This] was the ideal solution to independent bathing."

- Caregiver

Students described sources of caregiver stress, such as feeling overwhelmed by the demands of care, having limited time for oneself, or experiencing uncertainty or worry about the

patient. The students came to appreciate the importance of caregivers.

"The visit affected me professionally in my dealings with spouses of the terminally ill. I now recognize the difficulty and patience that is required...Furthermore, I recognize that the spouses of terminally ill patients, regardless of their health status, should have frequent evaluations by their own physicians. They should be counseled on stress management, finding personal time, depression, anxiety, and allowed an outlet to discuss their health concerns that are often eclipsed by the terminally ill loved one...The most valuable part of the visit was interacting with Mrs. J. and learning what it takes to care for a terminally ill patient. Her devotion was amazing."

Theme Group C: Personal Insight and Relationship with the Patient

- Getting to Know the Patient

Getting to know the patient as a person changed students' perspectives. For example, "I think that *a priori*, I expected to find significant impact of her cancer and her depression on her life. What I saw in clinic was a patient with numerous meds, a poor prognosis vis-à-vis her cancer, and a long list of chronic medical conditions. What I found was a woman in remarkably good health for her age, quite content with her situation despite her daughter's frustrations, and with a few signs of aging that to her were more minor frustrations than I might have expected in the clinic."

Students also described the patient's relationship to the health-care system. For example, a student noticed that a patient's husband helped her interact with the health-care system, and he was, "fairly proficient at using e-mail and Internet resources to provide some of her health-care needs. He regularly communicates with her PCM via e-mail and he searches for health information on the Internet...I was impressed by this, and it helped to break a stereotype that patients over the age of 65 are afraid of using or refuse to use electronic means for communication or information gathering."

The students also commented on the patients' reactions to the home visit, especially how much the patients appreciated someone taking an interest in them and taking time for a visit.

- Student Growth and Reflection

Students mentioned differences in their view of a patient at home, as compared to their view of the same patient in the hospital or clinic, and changes in their attitudes toward older people. They discussed changes in their clinical habits, describing skills they gained (including use of specific geriatric assessment tools) and intended to apply in their practice as physicians.

"I think that...we as physicians are determined to find something wrong during the HPI, and to appease us (and perhaps her daughter in this woman's case), they give us what we want—some medical symptoms. Then we can attack these with some other medication or consult and feel good

about making their lives better, when in fact, there was little wrong to begin with. Certainly in the future, I will always remember to ask the all important question, "What impact does this have on you?" or "How much does this bother you?" before I appoint myself 'House MD' in search of the solution to the next great medical mystery."

DISCUSSION

This geriatrics home visit program was associated with improved medical student attitudes towards caring for the elderly and provided opportunities to practice geriatric assessment skills. Knowledge of geriatrics improved in both intervention and control groups. Even though the intervention group students were required to complete geriatric learning modules and control group students were not, the time students reported spending on the modules did not differ significantly. The lack of difference in knowledge acquisition, which was not the primary outcome for which this study was powered, may reflect small sample sizes, the small number of questions on the tests, or the influence of other educational opportunities during the internal medicine clerkship.

While these results are consistent with prior published reports, ours is the first study of a home visit program to use a prospective design with a control group. The University of Rochester reported enhancement of the geriatric curricular content of undergraduate medical education via a three-visit home experience and positive changes in student attitudes towards the chronically ill and homebound.⁷ Another study of five medical schools with a home care program found positive affects on medical students' attitudes towards home care. According to the authors, successful programs had a greater number of visits, physician precepting of home visits, and an involved physician-program director.⁴ A recent qualitative report found positive effects on empathy and attitudes towards caring for the chronically ill based on interviews with medical students and recent graduates regarding a mandatory geriatric home visit experience.⁵

This study has limitations. It is a single institution study. Medical students went alone to visit patients during this project, which may have limited the positive effects, as prior publications have stated that faculty accompaniment was important for a successful program.⁴ While our students safely conducted solo home visits, we subsequently required students to conduct home visits in pairs when we implemented this as a clerkship requirement and believe this is most prudent. Medical students in this project were volunteers; mandating a home visit may not result in the same changes in attitude as a voluntary activity. Further, we could not evaluate the accuracy of the geriatric assessments done in the home, although student descriptions suggested appropriate use of the tools.

Nine of 27 volunteer students in the intervention arm did not complete the study, and most stated that they were unable to identify an appropriate patient for a home visit. We can only speculate what this means, as the average patient age in the primary care clinics at participating hospitals is over 65 years. Perhaps students felt time pressures with other clerkship responsibilities, or did not understand which

patients might benefit from a home visit. However, in the first 6 months after implementation as a mandatory clerkship exercise, every student (approximately 83) has completed the GHV.

CONCLUSIONS

A single geriatrics home visit with reflective writing improved student attitudes towards the elderly, provided an opportunity to practice geriatric assessment skills, and built an understanding of the context of geriatric patients' lives. This home visit program required no additional faculty time or resources. A geriatrics home visit is a feasible, useful clerkship addition.

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APPENDIX

Pre-test and Post-test Attitudinal Survey, adapted with permission from Flaherty et al⁴

General Attitudes

1. Geriatrics patients are (unwelcome/welcome) in my training:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Unwelcome *Welcome*

2. Caring for geriatric patients is (not valuable/valuable):

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not valuable *Valuable*

3. It is (unrewarding/rewarding) to care for geriatric patients:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Unrewarding *Rewarding*

Home-based therapies

1. An (inadequate/adequate) physical exam can be performed in the home:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Inadequate *Adequate*

2. Use of EKG's, oximeters, and X-ray in the home setting is (unrealistic/realistic):

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Unrealistic *Realistic*

3. It is (difficult/easy) to control pain in the home setting:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Difficult *Easy*

4. I can do (nothing/a lot) for the home care patient who refuses to come to the clinic or hospital:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Nothing *A lot*

Home care training

1. My exposure to home care during medical school has been (minimal/extensive):

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Minimal *Extensive*

2. In my medical education, I have learned (not enough/enough) about home care to feel capable of doing home visits:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not enough *Enough*

3. In my medical school training, I have learned (not enough/enough) about what home care team members do to be able to write or sign home care orders:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not enough *Enough*

4. I (do not know/know) which patients need or do not need home care services.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Do Not Know *Know*

Time and reimbursement

1. Adequate financial compensation will matter (not at all/a lot) in my decision to do home visits:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all *A lot*

2. The geriatric patient lives (too short/long enough) to be worth my investment of time:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Too short *Long enough*

3. House calls by physicians are an (ineffective/effective) use of my time:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Ineffective *Effective*