CAMC/WVU CHARLESTON DIVISION

GERIATRICS FELLOWSHIP

FELLOWSHIP MANUAL/CURRICULUM/POLICIES

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Rev. 2013-4
GERIATRICS FELLOWSHIP: GENERAL GOALS & OBJECTIVES

This policy statement summarizes the general goals, and specific objectives and educational methods of the Geriatrics Fellowship sponsored by Charleston Area Medical Center and WVU Charleston Division.

The overall goal of the program is to train internists and family practitioners for careers in clinical practice, teaching, administration and research in geriatrics. The program is intended and structured to provide and/or facilitate the acquisition of the knowledge, clinical and interpersonal skills, professional attitudes, behaviors and experience required for a successful career in geriatric medicine, whether institutional/academic or clinical/private practice.

Teaching methods include learning "by example" and "by doing" in rounds, clinics, and research, formal lectures on rounds and at conferences (both live and electronic), fellows reading and preparing presentations on various topics and cases at rounds and conferences, attendance at all departmental meetings and inservices, and participation in quality assurance and administrative activities. Specific didactic and participatory conferences include Geriatrics Journal Club, Weekly Geriatrics Conference, Medical Grand Rounds and various meetings of the West Virginia Geriatrics Society and West Virginia Geriatrics Education Center and other organizations. In parallel with ongoing conferences, nursing home, home care and ambulatory care responsibilities; monthly rotations provide experience and teaching in general hospital-based primary care and consulting in geriatrics and related subspecialties. Attendance at local, regional and national geriatrics/gerontology meetings is encouraged. Fellows are evaluated monthly and semi-annually and additionally have the right and responsibility to evaluate the program, faculty and rotations regularly.

ACGME guidelines stress the general competency areas of patient care, medical knowledge, practice-based learning improvement, interpersonal and communication skills, professionalism, and system based learning.

Some additional general educational objectives for every component of the geriatrics program include:
- Developing skills of approach to patients, attitudes towards elderly and aging.
- Assessing and treating common clinical disorders in the aging population.
- Understanding and distinguishing aging vs. disease.
- Understanding the role of the geriatrician in long-term care, acute care, ambulatory care, home care settings: caring vs. curing, primary care vs. consulting role, medical, administrative/system/team issues important to each setting.
- Assessment of cognitive and physical functioning.
- Participating in an interdisciplinary/team approach to geriatric care; utilizing and interacting with other health professionals and community resources.
- Understanding the psychosocial, ethical, economic, regulatory, administrative issues in care of elderly & dying patients.

Some major specific content areas include:
- Physiology and diseases of aging.
- Common clinical problems in elderly: cancer, dementia, depression, diabetes, falls/gait disorders, dizziness/syncope, hypertension and heart disease, urinary incontinence, infectious diseases, nutrition, arthritis and osteoporosis, Parkinson's, pressure sores, sensory impairment, surgical interventions and evaluation...etc...
- Geriatric pharmacology.
- Geriatric psychiatry & neurology.
- Geriatric rehabilitation and long-term care
- Ethical/socioeconomic/legal/administrative/health care system issues.

For additional information see CAMC House Staff Manual and ACGME/RRC-IM Program Requirements for Internal Medicine Subspecialties and Geriatric Medicine (Appendix).

/T.G. Rev. 2013
OVERALL CURRICULUM, GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS FELLOWSHIP ROTATIONS:

The geriatrics fellowship curriculum is intended to cover the full range of experiences and knowledge related to geriatric care. The fellowship is divided into longitudinal experiences in ambulatory and long term care, didactic conferences, and the following monthly block rotations:

- Geriatrics Inpatient/Consult Service
- Geropsychiatry
- Geriatric Rehabilitation/PM&R
- Hospice/Palliative Care
- Rheumatology/Endocrine/Osteoporosis (“REO”)
- Electives (Research, Wound Care, Geriatric Cardiology, GI, Neurology, Renal, Oncology, Urology, etc.)

The program will stress, and fellows will be evaluated in all rotations/experiences, on the six core competencies established by the Accreditation Council on Graduate Medical Education (ACGME):

- Patient Care -- Fellows will provide competent care in a compassionate, appropriate and cost-effective manner.
- Medical Knowledge -- Fellows will demonstrate a command of the basic & clinical sciences.
- Practice-based learning and improvement -- Fellows will be able to analyze practice experiences, identify areas for improvement, demonstrate a willingness to learn from errors, and implement meaningful strategies to enhance knowledge, skills, attitudes, and processes of care.
- Interpersonal and Communication Skills -- Fellows will establish and sustain therapeutic and ethically sound relationships with patients, families and colleagues.
- Professionalism -- Fellows will demonstrate a commitment to ethical practice and a reasonable attitude toward families, patients and colleagues within the context of respect, compassion, integrity, sensitivity, accountability.
- Systems-based practice -- Fellows will demonstrate an understanding of the contexts and systems in which health care is provided. In geriatrics this particularly refers to and stresses not only inpatient and outpatient care but also long term care systems/regulations, assisted living, home care, hospice, Medicare & Medicaid, and community resources for the elderly.

General educational resources and recommended references on geriatrics:
(See also individual rotation descriptions and geriatrics bibliography distributed to residents & fellows).

General textbooks:

Journals and Organizations:
Journal of the American Medical Directors Association (www.jamda.com).

Rev. 2013
GENERAL GOALS/OBJECTIVES LINKED TO ACGME COMPETENCIES:
TOPICS CUTTING ACROSS ALL GERIATRICS SITES/ROTATIONS:

N.B. It is assumed and required by our program that Geriatrics fellows will have already met or exceeded all of the published competencies for geriatric care appropriate to the level of medical students and IM/FP residents. See Appendix 6 and if for whatever reason you have not met all the resident-level competencies before fellowship, this is your opportunity to make sure you catch up! All of these documents are available online at http://adgap.americangeriatrics.org/academic-resources/competencies/ and have been endorsed by the American Geriatrics Society (AGS) and ADGAP (Association of Directors of Geriatrics Academic Programs), of which we are members. IN ADDITION, geriatrics fellows should achieve all the goals/objectives/competencies/curricular milestones listed below and in conjunction with the various rotation descriptions which follow. These have been developed more specifically for the level of a geriatrics subspecialty fellowship and supersede earlier published lists of geriatric medicine competencies from POGO-E. Source/reference: Geriatrics Curricular Milestones, 2012-13 http://www.pogoe.org/fellowcompetencies

A fellowship trained geriatrician must be able to....:

Domain: Caring for the Elderly Patient (CEP)
CEP Communication
1. Practice culturally sensitive shared decision-making with patients and families/caregivers in the context of their health literacy, desired level of participation, preferences and goals of care.
2. Work effectively as a member or leader of an interprofessional health care team.
3. Use strategies to enhance clinician-patient oral and written communication in patients with hearing, vision, or cognitive impairment.
4. Skillfully discuss and document goals of care and advance care planning with elderly individuals and/or their families/caregivers across the spectrum of health and illness.
5. Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship.
6. Provide compassionate care while establishing personal and professional boundaries with patients and families/caregivers.
7. Effectively lead a family/caregiver meeting.
CEP Gerontology
8. Demonstrate current scientific knowledge of aging and longevity, including theories of aging and epidemiology of aging populations.
9. Describe the primary physiologic changes of aging of each organ system and their clinical implications, including how they may impact lab findings.
CEP – Medication Management
10. Demonstrate expertise in medication management by justifying medication regimen and duration based upon:
   a: age related changes in pharmacokinetics and pharmacodynamics.
   b: maximizing medication adherence.
   c: the common lists of medications that should be avoided or used with caution in older adults.
   d: a consideration of the reported benefits and known and unknown risks when prescribing a newly-released medication, realizing that older adults with multimorbidities are often underrepresented in clinical trials.
11. When a patient presents with a new symptom or geriatric syndrome, investigate whether a medication(s) is contributing.
12. Individualize pain control utilizing the most effective pharmacologic and nonpharmacological strategies based on the etiology and chronicity of the patient’s pain.
13. Prescribe pain medications with instructions and methods to prevent common complications including constipation, nausea, fatigue and opioid toxicity (myoclonus and hyperalgesia), using equianalgesic dosing conversion and opioid rotation when needed.
CEP – Complex or Chronic Illness (es) in Older Adults
21. Identify patients who are frail or otherwise at risk for death, dependency and/or institutionalization over the next few years.
22. Demonstrate the ability to manage the care of patients with multimorbidities by integrating the evidence,

23. Demonstrate the ability to manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement, and anxiety.

24. Assess and incorporate family/caregiver needs and limitations, including caregiver stress, into patients’ management plans.

25. Provide geriatric consultation in all settings with attention to multimorbidity, age-related changes in physiology, function, treatment efficacy and response, medication management and psychosocial issues.

26. Regularly re-assess goals of care to recognize patients likely to benefit from palliative and/or hospice care, including those with non-cancer diagnoses (e.g., Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Dementia).

Domain: Geriatric Syndromes (GS)

GS – Falls and Dizziness

52. Perform and interpret common gait and balance assessments, recognizing abnormal gaits associated with specific conditions.

53. Conduct an appropriate evaluation of patients who fall or are at risk for falling, implement strategies to reduce future falls, fear of falling, injuries, and fractures, and followup on referrals.

54. Evaluate, manage, and refer (when appropriate) patients with symptoms of dizziness or lightheadedness, differentiating among those with single or serious causes and those that are multifactorial.

GS – Pressure Ulcers

63. Recognize patient risk factors for pressure ulcers, and in high risk patients work with an interprofessional team to develop a prevention plan.

64. Stage pressure ulcers and demonstrate proficiency in describing their clinical characteristics (e.g., size, color, and exudate).

65. Develop a treatment plan for pressure ulcers with an interprofessional team, incorporating the indications for surgical and non-surgical treatments for ulcers (e.g., debridement, classes of wound care products and treatments, pressure relieving devices, etc.).

GS – Sleep Disorders

66. Provide initial evaluation and management of insomnia and other sleep disorders and, when indicated, refer to a sleep specialist.

GS – Hearing and Vision Disorders

67. Screen for hearing loss and recognize when referral is appropriate.

68. Recognize common ophthalmologic conditions associated with aging, including changes of normal aging, cataract, glaucoma, age-related macular degeneration, and refer when appropriate to ophthalmology, optometry and/or low vision services.

GS – Urinary Incontinence

69. Evaluate and treat the most common forms of both reversible and chronic urinary incontinence using nonpharmacological interventions where possible.

70. Refer when appropriate for urologic or gynecologic evaluation including urodynamic testing, pessary evaluations, pelvic floor muscle training.

71. Evaluate and manage urinary retention and incomplete bladder emptying including the appropriate use of intermittent catheterization or indwelling bladder catheters.

GS – Weight Loss and Nutritional Issues

72. Identify and appropriately evaluate and manage involuntary weight loss.

73. Discuss with patients and families/caregivers the risks and benefits of appetite stimulants, nutritional supplementation, enteral tube feeding, and parenteral nutrition, particularly in patients with advanced dementia or near end-of-life.

74. Identify swallowing disorders: in patients with involuntary weight loss or recurrent pneumonias, and work with an interprofessional team to evaluate, manage, and educate patient and caregiver(s) based on goals of care.

GS – Constipation and Fecal Incontinence

75. Evaluate and manage constipation and fecal impaction using nonpharmacological and pharmacological modalities.

76. Provide initial evaluation and management of fecal incontinence.
Geriatrics Inpatient/Consult Service Curriculum

Confirmation of review of this curriculum on New Innovations indicates that you have read and agree to the information below. If you have any questions about this curriculum, you should bring it to the attention of your attending or a program director.

Goals and Objectives

The fellow will gain experience and knowledge in all aspects of geriatrics in acute hospital settings. Fellows may have 3 different potential roles in the acute hospital:
1) Rounding/embedded with the general medical or hospitalist service and providing extra attention and teaching related to the geriatric patients on the service;
2) Following private geriatric clinic/fellows’ own patients when in hospital;
3) Providing geriatric consults on request to general medicine and other services (e.g. surgery, ortho, neuro, psych, and rehab).

Evaluation Methods

In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

Teaching Methods

Attendance and participation in geriatric/medicine team work and teaching rounds (Medical Knowledge, Patient Care, Communication, Professionalism, System Based Learning).
Learning while evaluating and discussing cases (Practice Based Learning).
Didactic discussions on relevant topics in conferences and on rounds (Medical Knowledge).
Self-study, reading, and review of online materials (Medical Knowledge, Practice Based Learning).

Specific Topics

Topics to be covered include:
All medical, neuropsychiatric, socioeconomic and ethical issues concerning hospitalized elderly patients. E.G.: dementia/delirium, falls, incontinence, pressure sores, placement, ethical issues in care of chronically or terminally ill patients. (Medical Knowledge)
Primary care versus consultant and teaching roles (Professionalism, System/Practiced Based Learning).
Hospital regulations & discharge planning (System).

Additional Competencies for Hospital Care/Inpatient Service:

The graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
1. Implement strategies for preventing the most common potential hazards of hospitalization among elders (including immobility, falls, delirium, pressure ulcers, malnutrition, procedures, indwelling catheters, nosocomial infections). ACGME Competencies: Practice-based learning, Patient care
2. Implement strategies to minimize indwelling urinary catheter use, and identify the indications for indwelling catheter use. ACGME Competencies: Practice-based learning, Patient care
3. Formulate safe discharge plans, including working with other team members to choose the most appropriate discharge setting and services for the patient. ACGME Competencies: Systems-based practice, Patient care, Interpersonal communication.
4. Perform pre-operative assessments for older patients and make specific recommendations based on type of surgery and patient characteristics. ACGME Competencies: Patient care.
5. Recognize the risks of, and indications for, restraint use, and implement strategies to minimize restraint use. **ACGME Competencies: Patient care, Practice-based learning.**

6. Implement strategies to reduce common post operative complications in older adults (including delirium, pain, deconditioning, and urinary tract infection). **ACGME Competencies: Patient care, Practice-based learning.**

**References/Suggested Readings**

- *Hazzard's Geriatric Medicine & Gerontology* textbook
- American Geriatrics Society *Geriatrics Review Syllabus & Geriatrics at Your Fingertips* handbook
  
  *(Note: Copies of above books provided to each fellow)*


“Ten Rules for Rounding on Hospitalized Elders” (Lecture given at ACP Internal Medicine 2011, Available on CD/online)

Geriatric Fellowship Learning Objectives Linked to ACGME Competencies. Portal of Online Geriatric Education, [http://www.pogoe.org/fellowship_objectives](http://www.pogoe.org/fellowship_objectives)

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**Additional competencies/curricular milestones related to hospital and other sites of care (ADGAP 2013):**

**Domain: Systems-Based Care for Elder Patients (SBC)**

**SBC General**

29. Reduce **iatrogenic events** among elders in all settings through implementation of patient-specific and system-wide strategies to prevent falls*, immobility, delirium*, pressure ulcers*, incontinence*, malnutrition*, indwelling catheter use, nosocomial infections, deep vein thrombi, restraints, depression*, functional decline*. *(NB: asterisk indicates additional competencies in syndromes or functional impairment section.)*

30. **Demonstrate expertise in transitions of care by** identifying, with the interprofessional team, the most appropriate care setting(s) for a patient, including independent living, assisted living, long-term care, acute rehabilitation, subacute rehabilitation, home care, primary care at home, adult day care, Program of All-Inclusive Care for the Elderly (PACE)-like program, and hospice based on the needs and preferences of the patient and families/caregivers, and the admission and payment requirements for each setting.

31. **Demonstrate expertise in transitions of care by communicating** the following to the receiving provider through discussion or timely discharge summary: medication reconciliation, an assessment of patient’s cognition and function, pending medical results and follow-up needs.

32. Demonstrate knowledge of commonly accepted geriatric **quality indicators.**

33. Participate in **quality improvement** efforts to enhance the quality of care of older adults.

34. Describe the services provided by **Medicare** Parts A, B and D, the Hospice Benefit, and by Medicare and Medicaid for patients who are “dual eligible,” including the basics of the patient’s fiscal responsibility for each.

35. Identify patient and family/caregiver **needs** and refer to appropriate local **community resources.**

36. Recognize and document signs of **elder abuse** and/or neglect and refer to community resources and adult protective services when appropriate.

37. Recognize the complexity of geriatric care and demonstrate the ability to **prioritize care**, in a time-efficient manner, during encounters with geriatric patients.

38. Serve as an **advocate** for older adults and caregivers within various healthcare systems and settings.

39. Recognize health-care **system issues** that negatively impact the care of the geriatric patients, and identify improvement strategies.

40. Demonstrate the ability to **teach** patients, caregivers and others about aging-related healthcare issues.
41. Describe models of care that have been shown to improve outcomes for older adults, e.g., ACE Units, PACE, multifactorial interventions to prevent falls, delirium prevention.

**SBC Hospital Care**

42. Reduce iatrogenic events (see SBC General #29)
43. Recognize common and subtle presentations of delirium and manage appropriately.
44. Perform pre-operative assessments for older patients and document specific peri-operative management recommendations to improve patient care and safety based on type of surgery and patient characteristics.

**SBC – Ambulatory Care**

45. Perform and interpret an outpatient geriatric assessment, and develop a management plan that includes appropriate consultation with and referrals to other disciplines and community based resources.
46. Recognize patients who are at risk for hazardous driving, identify strategies to reduce risk, and integrate state and local laws into the management plan.

**SBC – Home Care**

47. Perform home visits, demonstrate modification of the physical exam for the home setting, and assess physical safety of the environment.
48. Refer patients to appropriate home health and support services to maximize ability to remain in their homes.

**SBC – Long Term Care and Nursing Home Care**

49. Individualize LTC patient management considering prognosis, comorbidity, patient and caregiver goals, and available resources especially in the following situations: (a) consideration for transfer to the acute care hospital; (b) weight loss, dehydration, swallowing disorders; (c) agitation and problem behaviors.
50. Describe the role of a long-term care medical director and demonstrate an understanding of nursing home and long-term care regulations and requirements, including the minimum data set.
51. Manage acute problems in long-term care via telephone call.

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GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS FELLOWSHIP ROTATIONS:

GERIATRIC PSYCHIATRY ROTATION

(1-2 months)

Overall Goals: The geriatric medicine fellow will learn about the role of mental health professionals in geriatric care and about the diagnosis and treatment of major geropsychiatric syndromes. The fellow will interact with other professionals (psychologists, social workers, psychiatric nurses) in the context of a multidisciplinary team. Rotation includes inpatient and outpatient Geropsych primary care and consults.

Specific topics to be covered include dementia, delirium, depression, behavioral problems in acute hospital psych unit, outpatient and long-term care facilities. Pharmacologic and psychotherapeutic management, inpatient milieu therapy, ECT. (Medical Knowledge) Primary care versus consultant role (Professionalism, system/practice based learning).

Teaching methods: Attendance and participation in Geropsychiatry ward work and teaching rounds (Medical Knowledge, Patient Care, System Based Practice, Communication). Performance of geropsych consults in outpatient, hospital and long-term care settings under supervision of attending geropsychiatrist (Patient Care, Communication, Professionalism, Patient Care). Learning while evaluating and discussing cases (Practice Based Learning). Didactic discussions on relevant topics (Medical Knowledge).

Evaluation methods: In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

References:
AMDA Clinical Practice Guidelines: Dementia (Rev. 2009), Depression (2003), Delirium (Rev. 2008).


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ADDITIONAL SPECIFIC GOALS AND OBJECTIVES FOR GERIATRIC PSYCHIATRY ROTATION

Fellows rotating on the geriatric psychiatry rotation will gain experience managing elderly patients with psychiatric disorders. 1-2 months of geriatric psychiatry are required for all geriatric fellows, who will gain experience in a variety of settings including inpatient, outpatient, consultative, and emergency settings.

Goals:
1) Become able to perform a complete geriatric psychiatric evaluation including mini mental status exam with appropriate diagnostic conclusions and plan of care.
2) Learn appropriate use of diagnostic techniques (i.e., MRI, labs, EEG, neuro-psych testing, etc.) in the context of geriatric psychiatry.
3) Learn judicious use of appropriate psychopharmacologic agents and ECT in the management of geriatric psychiatric patients.
4) Learn fundamentals of psychotherapy with geriatric patients.
5) Learn to utilize/refer to community agencies supportive of geriatric psychiatry patients.
6) Become familiar with medico-legal issues that are germane to geriatric psychiatry (i.e. capacity, POA, advance directives, etc.)

Objectives:
1) Residents and fellows as assigned by attending will care for all patients over age 60 admitted to the inpatient service including:
   1) History and Physicals
   2) Daily Rounds with Appropriate Documentation
   3) Physician Orders
   4) Discharge Planning/Assessment
2) Residents and fellows as assigned by and in consultation with attending will complete assigned geriatric psychiatry consultations in the hospital.
3) fellows will attend weekly geriatric psychiatry clinics.
4) fellows will complete assigned readings.
5) resident will attend weekly department journal club.

Competencies:
1) Medical Knowledge
   • Learn components of proper geriatric psychiatry examination/report
   • Learn presentation of major psychiatric disorders in the elderly and their management including:
     A) Cognitive Disorders
     B) Mood Disorders
     C) Anxiety Disorders
     D) Thought Disorders
     E) Substance Abuse Disorders
     F) Personality Disorders
   • Management techniques to be learned include:
     1) Psychopharmacologic Treatment of Elderly Patients
     2) Psychotherapies in the Elderly
     3) Electroconvulsive Therapy in the Elderly
     4) Use of Family Support System
     5) Utilization of Community Resources

2) Patient Care
   • Perform complete geriatric psychiatric assessments including the following:
     A) Complete History of Presenting Illness
     B) Social History with Emphasis on Safety Issues, Support System, Living Arrangements, and Phase of Life Issues
     C) Relevant Medical/Neurologic Issues
     D) Complete Physical and Neurologic Examination
     E) Appropriate Use of Ancillary Testing
     F) Complete Mental Status Examination and appropriate ongoing re-examinations
G) Appropriate Documentation
   1) Develop ability to communicate effectively and build rapport with elderly patients with appropriate accommodation for sensory limitations and socio-cultural factors
   2) Prescribe appropriate medication to geriatric patients with proper dosing and consideration of medical co-morbidities and monitoring for adverse reactions

3) Interpersonal Skills/Communication
   - Fellow will demonstrate effective communication with elderly psychiatric patients and members of their support system.
   - Fellow will be able to verbally present cases and updates to peers and supervisors in a concise and organized manner.

4) Practice Based Learning
   - Fellow will develop receptiveness to feedback with willingness to learn and improve in all areas of geropsychiatric practice.
   - Fellow will participate in quality improvement when assigned.

5) Professionalism
   - Fellow will demonstrate qualities of timeliness in completion of duties, completion of medical records, and response to emergencies.
   - Professionalism in interaction with peers, colleagues, patients, supervisors, consultants, and other medical disciplines, including ethical and medical legal issues.
   - Appropriate professional attire and appearance.

6) System Based Practice
   - This competency is particularly critical in the area of geriatric psychiatry. Geriatric patients often require particularly careful assistance navigating the health care, legal and social systems.
   - Fellows will demonstrate the ability to assist patients by working within the system of care in the hospital and utilizing ancillary services such as:
     - Social Services
     - Occupational/Physical Therapy
     - Nutrition Services
     - Other Medical Consultants

Additional Geriatric Psychiatry Goals/Objectives/Curricular Milestones (ADGAP, 2013)

GS – Cognitive, Affective, and Behavioral Health
55. Distinguish the clinical presentation and prognosis of changes in cognition and/or affect among people with normal aging, mild cognitive impairment, dementia, delirium, and depression.
56. Perform, interpret, and articulate the strengths and limitations of the commonly used cognitive and mood assessment tools.
57. Identify clinical situations where a psychiatric referral, psychological counseling, or neuropsychological assessment is indicated and integrate the findings into the patient’s plan of care.
58. Diagnose and manage the potentially reversible/treatable causes of cognitive and affective changes in older adults.
59. Identify and manage depression.
60. Diagnose and manage the causes of dementia, including Alzheimer’s disease, vascular dementia, Lewy body dementia, dementia of Parkinson’s Disease, alcoholic dementia, frontotemporal dementia, Creutzfeldt–Jakob Disease and Normal Pressure Hydrocephalus as well as other rare causes. Recognize and appropriately refer ambiguous cases for further evaluation.
61. Care appropriately for patients at each stage of dementia (mild, moderate or severe) and provide anticipatory guidance based on prognosis and their goals of care.
62. Assess and manage cognitive, functional, and disruptive behavioral manifestations of dementia, both behaviorally and pharmacologically.
CURRICULUM FOR CAMC GERIATRICS FELLOWSHIP ROTATIONS:

PHYSICAL MEDICINE & REHABILITATION ROTATION (MEDICAL REHAB CAMC GENERAL)
(1 month)

General Goals: The geriatric medicine fellow will learn to apply the principles of PM&R to the special functional needs of the geriatric population. Fellow will participate in Med Rehab/PM&R inpatient services at CAMC General and participate in corresponding inpatient consults and outpatient clinics. Fellow will learn what services are provided by Med Rehab team, when to refer, and how to prescribe therapies and assistive devices.

Specific topics to be covered include stroke, hip and other fractures/injuries, arthritis, Parkinsons, amputation, deconditioning. Rehabilitative management, compensatory/assistive devices and functioning. Course and processes of inpatient versus outpatient rehabilitation; insurance and Medicare coverage in various settings. Role of physiatrist, assistive devices, therapies in comprehensive geriatric acute and long-term care. Inpatient vs outpatient/subacute rehab settings. (Medical Knowledge, System Based Learning)

Teaching methods: Attendance and participation in PM&R team meetings, consults, teaching rounds and conferences (Medical Knowledge, Professionalism, Communication). Learning while evaluating and discussing cases (Practice based learning, Patient Care). Didactic discussions on relevant topics (Medical Knowledge).

Evaluation methods: In all rotations fellows are directly observed and formally evaluated by the attending assigned to the respective service. Attendings and/or program director review each evaluation with fellow in detail, and summative evaluations semi-annually. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

Additional specific objectives regarding Geriatric Rehabilitation from AGAP Curricular Milestones, 2013

CEP – Functional Impairment and Rehabilitation
14. Know the indications and contraindications for referring patients to physical, occupational, speech or other rehabilitative therapies, and refer if appropriate.
15. Know indications for durable medical equipment, prescribe and evaluate for appropriate use.
16. Recognize and manage the care of patients at high risk for poor outcomes from common conditions such as deconditioning, stroke, hip fracture, and dysphagia.

References:
Dobkin BH. Rehabilitation after stroke. NEJM 2005;352:1677-84.

T.Goldberg/K. Wright Rev. 2013
GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS ROTATIONS:

HOME VISIT PROGRAM

(Longitudinal ½ d per week x 12 months)

**General Goals & Objectives:** The geriatric fellow will learn about the role of geriatrician in home care (Professionalism), relevant medical topics (Medical Knowledge) and logistics of how to care for home bound elderly patients in conjunction with other available professionals and services (System Based Learning). Dealing with community resources, dealing with insurance, arranging tests and ordering/utilizing assistive devices (System Based). Facilitating safe and appropriate transitions of care between home and other settings (hospital, LTC); ensuring proper medication reconciliation and appropriate patient follow-up after discharge from hospital to home setting (Patient Care, Communication, Systems Based Practice).

**Teaching methods:** Attending will supervise and discuss cases in the home care site and/or at conferences at geriatric division. Learning while evaluating and discussing cases (Patient Care, Communication, Practice based learning). Didactic discussions on relevant topics (Medical Knowledge, Communication). Trainee will progress with experience from observation of attending to independent home visits (Professionalism).

**Evaluation methods:** In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

**References:**
Clinics in Geriatric Medicine March 2009 – Home Care.
Goldberg T, DeLaGarza V. “Home Care” & “Sites of Care” modules from AGES program.

**Additional Home Care Objectives/Competencies from POGO-E:**

The graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
2. Execute a home care visit, including modifying the physical exam for the home care setting, and performing a home safety assessment. Rotation Sites: Home visit. ACGME Competencies: Patient care.
4. Utilize the home health and support services available to help frail elders maintain independence. Rotation Sites: Home visit. ACGME Competencies: Systems-based practice, Interpersonal communication, Professionalism

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GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS FELLOWSHIP NURSING HOME ROTATION:

NURSING HOME/LTC CLINICAL EXPERIENCE

Fellow will work with attendings longitudinally as physician for a panel of patients at nursing homes affiliated with CAMC and WVU Physicians of Charleston.

Goals/objectives include learning topics, issues & methods in care of chronically ill/ institutionalized nursing home patients. A key specific objective is to “implement effective transitions of care for geriatric patients between hospital and nursing home settings” (Medical Knowledge, Patient Care, Practice & System Based Learning)

Relevant topics further include: Federal and state LTC regulations, interdisciplinary teams, dementia, incontinence, decubitus ulcers, depression, etc. Nursing home vs inpatient vs subacute care. (Medical Knowledge, System Based Learning). Role of medical director in LTC (Systems, Professionalism).

Teaching methods: Attending will supervise and discuss cases in the LTC site and/or at conferences at geriatric division (Patient Care, Communication). Learning while evaluating and discussing cases (Medical Knowledge, Communication, Practice Based Learning). Didactic discussions on relevant topics, including seminar series based on AMDA medical director training modules (Medical Knowledge, Practice & System Based Learning). Trainees will progress with experience from observation of attending to semi-independent practice (Communication, Professionalism).

Evaluation methods: In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

EDUCATIONAL OBJECTIVES FOR ADMINISTRATIVE MEDICINE IN NURSING HOME

Fellow will participate in medical direction and administration of nursing homes affiliated with CAMC. Based on this experience during the program as well as subsequent Medical Director experience, fellowship graduate should be qualified for Certified Medical Director program of the American Medical Directors Association. (Professionalism, System Based Learning)

Issues to be covered include:
Understanding relevant federal and state regulations.
Infection control.
Long-term care ethics.
Quality management/improvement, Risk management.
Dealing with medical staff as medical director.
Nursing home committees and personnel.
Financial issues in nursing home care.
Employee health and safety in nursing homes.

References:
Additional specific objectives/competencies relating to Long Term Care and Nursing Home Care from the Portal of Geriatrics Online Education, (POGO-E) website (http://www.pogoe.org/content/3088):

The graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:


2. Prioritize appropriate long term care settings for the patient, including independent living, assisted living, nursing home, skilled nursing home care, subacute care, adult day care, and rehabilitation unit. Rotation Sites: Long term care. ACGME Competencies: Systems-based practice.


6. Describe the most common payment sources for different long term care venues. Rotation Sites: Long term care. ACGME Competencies: Systems-based practice.

7. Summarize important nursing home regulations, the minimum data set, the physician's role in nursing homes, and requirements under OBRA. Rotation Sites: Long term care. ACGME Competencies: Systems-based practice, Practice-based learning.

Relating to the above objectives, the geriatric fellow will read/review AMDA’s Synopsis of Federal Regulations in the Nursing Facility, as well as a PowerPoint or recorded version of AMDA’s annual programs on “Primer for the New Medical Director” from CD/tape sets available in the program director’s library.

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GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS FELLOWSHIP ROTATIONS:

GERIATRIC RHEUMATOLOGY/OSTEOPOROSIS/ENDOCRINE ROTATION (“REO”)

**Goals & Objectives:** The trainee (fellows/residents) will learn about diagnosis and treatment of arthritis, osteoporosis, diabetes, thyroid disease, and related endocrine/rheumatologic conditions in elderly patients.

**Specific topics/concepts to be covered** include:
Arthritis, osteoporosis, other musculoskeletal disorders, pain management, radiology, rheumatologic lab testing, appropriate use of medications, therapies, and large joint injections. Endocrine issues of importance to geriatrics including menopause, andropause, Vitamin D, diabetes, thyroid disease (Medical Knowledge, Practice Based Learning, Patient Care). When to consult rheumatologist or endocrinologist, communication between specialists and primary care (Professionalism, Systems Based Practice).

**Teaching methods:** Attendance and participation in endocrine and rheumatology rounds and clinics at WVUPC/CAMC and associated clinics and geriatric facilities (Medical Knowledge, Practice Based Learning, Patient Care). Learning while evaluating and discussing cases (Medical Knowledge, Practice Based Learning). Didactic discussions on relevant topics (Medical Knowledge, Communication, Professionalism). Lectures for geriatrics and medical staff on site and off site and online.

**Evaluation methods:** In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

Additional relevant competencies from POGO-E:

Rheumatologic/Musculoskeletal Diseases and Disorders:
Diagnose and manage the most common rheumatologic/musculoskeletal disorders of elders and identify instances in which those diseases might present or be managed differently than in younger individuals.
Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care

Endocrinologic Diseases and Disorders:
Diagnose and manage the most common endocrine diseases of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

References:

T.G. Rev. 2010
CAMC GERIATRICS FELLOWSHIP: HOSPICE/PALLIATIVE CARE ROTATION

Goals & Objectives:  The geriatric fellow will gain appreciation of logistical and medical issues in caring for both hospitalized, homebound and institutionalized dying elderly patients.  1 month clinical rotation in hospital, home and hospice settings (System Based Learning, Patient care)

Specific topics/concepts to be covered include:
Hospice care for dementia, cancer, and other hospice diagnoses.  Medicare hospice coverage/regulations.  Working with interdisciplinary team.  Relationship of palliative care and hospice.  Comfort care and death and dying issues.  (Medical Knowledge, System Based Learning, Professionalism, Communication)

Teaching methods:  Attendance and participation in CAMC Palliative Care team rounds and conferences, Kanawha Hospice team meetings, and home visits with hospice physician and nurses (Patient Care, System Based Learning, Communication, Professionalism).  Learning while evaluating and discussing cases (Patient Care, Practice Based Learning, Communication).  Didactic discussions on relevant topics. (Medical knowledge, communication).  During this month the fellow should attend each of the following activities at least once or twice: Palliative care rounds at CAMC, CAMC Ethics Committee, Kanawha Hospice Team Meeting, Hubbard Hospice House Team Meeting, Patient rounds at Hubbard Hospice House, Home Visits with Hospice Physician, and Home Visits with Hospice Nurse.

Evaluation methods:  In all rotations fellows are formally evaluated monthly by attending and semi-annually by program director.  Attendings and/or program director review each evaluation with fellow in detail.  Fellows likewise evaluate program and rotations formally monthly and semi-annually.  Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings.

References:

Additional specific geriatric fellowship competencies/curricular milestones related to palliative and end of life care (ADGAP, 2013)

CEP Palliative and End of Life Care
26. Regularly re-assess goals of care to recognize patients likely to benefit from palliative and/or hospice care, including those with non-cancer diagnoses (e.g, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Dementia).
27. Counsel patients and families/caregivers about the range of options for palliative and end of life care.
28. Assess, manage, and provide anticipatory guidance for patients and families/caregivers for common non pain symptoms during severe chronic illness or at the end of life.

T. Goldberg/S. Warren/M. Covelli, Rev. 2010
## Geriatrics Fellowship Curriculum: AMBULATORY CARE: GERIATRICS OUTPATIENT (65-PLUS) CLINIC

### Description of Rotation or Educational Experience:
Fellow will participate in longitudinal and consultative outpatient geriatric care in hospital clinics and satellite ambulatory care centers. As of 2010, specific Geriatric Clinic sites include: CAMC Outpatient Care Center; and WVU Physicians of Charleston Geriatrics Office at Edgewood Summit (Longitudinal, 1/2 day per week at each site for each fellow).

### Goals and Objectives:

#### Overall Goals:
Fellows must be able to provide outpatient care that is compassionate, appropriate, and effective for the treatment of health problems and the preservation of patient function. Fellows should be able to diagnose and treat common geriatric patient clinical problems; logistically manage outpatient care; appropriately use ancillary resources; orchestrate consultation and collaboration with other professionals and specialists.

(Medical knowledge, patient care, systems based practice, communication, professionalism).

#### Specific Objectives:
The graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
1. Perform an efficient outpatient geriatric assessment, and implement a management plan based on the findings, working with other team members as appropriate and available.
2. Demonstrate the ability to manage multiple comorbidities, utilizing evidence, patient’s goals, and estimated life expectancy.
3. Demonstrate the ability to manage time efficiently in the outpatient setting, and receive satisfactory to excellent ratings on 360 evaluations by both patients and clinic staff. (Professionalism, SBP, Communication).

#### Systems Based Practice

**Goals, Competencies & Objectives:**
Fellows 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.

The graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:

- Work effectively in outpatient care systems relevant to geriatrics
- Coordinate patient care within the health care system relevant to geriatrics
- Incorporate considerations of cost awareness and risk-benefit analysis in patient care
- Advocate for quality patient care and optimal patient care systems
- Work in interprofessional teams to enhance patient safety and improve patient care quality. In geriatrics clinic, IDT members present typically include nurses, consulting pharmacist, pharmacy residents and students, NP students, and social worker on request. Staff all meets together at geriatric team meetings weekly and “collaborative practice” meetings monthly.
- Participate in identifying systems errors and in implementing potential systems solutions
- Choose appropriate billing codes for outpatient visits.
- Utilize consultants and other team members appropriately for ambulatory elderly patients.

### Interpersonal and Communication Skills

**Goals, Competencies and Objectives:**
Geriatric fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

Fellows are specifically expected to:

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with elderly people with sensory impairments and/or dementia, and their families and caregivers.
- Communicate effectively with physicians, other health professionals, and health related agencies
- Work effectively as a member of leader of a health care team or other professional group
- Act in a consultative role to other physicians and health professionals
- Maintain comprehensive, timely, and legible medical records
- Communicate with emergency rooms and hospital staff members when patients go to the hospital or are discharged from hospital to outpatient follow-up.

**Teaching Methods**

Attendance and participation in clinics at CAMC, Edgewood Summit, WVUPC. Learning while evaluating and discussing cases with attendings and other team members. Trainee to progress with experience from observation to semi-independent practice (with appropriate attending supervision and billing practices). Didactic and team discussions on relevant topics. Attendance at collaborative practice staff meetings.

**Assessment Methods**

Direct observation by attendings, periodic global rotation evaluations, 360/multi-source evaluations (patients, nursing staff, peers), continuous feedback. Rather than monthly, longitudinal rotations are evaluated periodically, e.g. quarterly. In all rotations fellows receive formative and summative evaluations at least semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally (in this case quarterly and semi-annually).

**Assessment Method (Program Evaluation)**

Fellow schedules and performance discussed regularly at Geriatrics Division faculty meetings. Fellows and faculty evaluate each rotation and program as a whole. Performance of geriatrics staff and practices discussed at dept./staff meetings and performance improvement meetings.

**Supervision**

In outpatient settings, direct faculty supervision is continuously available on-site within the outpatient care center or WVUPC office, however fellows are allowed progressive autonomy in patient management over time based on experience and performance. (See supervision policy).

**Educational Resources**

See “General educational resources and recommended references on geriatrics” elsewhere in this curriculum handbook.
GOALS & OBJECTIVES, EDUCATIONAL & EVALUATION METHODS FOR CAMC GERIATRICS FELLOWSHIP ROTATIONS:

CONFERENCES/LECTURES

(Longitudinal year round)

**Goals & Objectives:** Fellows to be exposed to and taught entire range of geriatric knowledge, attitudes and topics over 1 year fellowship cycle, via live and online conferences/lectures, teaching rounds and readings.

**Specific topics/concepts to be covered** include: All geriatric topics as required by RRC. *(Medical Knowledge)*

**Teaching methods:** Attendance and participation in conferences, rounds and lectures including geriatrics teaching rounds, Medical Grand Rounds, Journal Clubs, Geriatrics Conference, Resident Lectures, Lunch & Learn, WVGEC Programs, WVGS Programs, AGES, and other local and national meetings. Self study via readings and computer/audiovisual materials. Each fellow prepares and presents several talks on geriatric topics each year. *(Medical Knowledge, Communication, Professionalism)*.

**Evaluation methods:** When giving talks/lectures, immediate feedback is provided by faculty and other participants. In all rotations and experiences fellows are formally evaluated monthly by attendings and semi-annually by program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluate program and rotations formally monthly and semi-annually. Fellow schedules, clinical performance and conference participation discussed regularly at Geriatrics Division faculty meetings and reviewed with Program Director and with fellows.

T.G. Rev. 2010
GOALS AND OBJECTIVES FOR GERIATRICS FELLOWSHIP

ELECTIVE ROTATIONS

Geriatric Cardiology Clinic Elective w/Dr. W. Carter (CAMC Outpatient Care Center)

General Goals: The fellow shall glean, throughout the rotation, the competent workup and evaluation of commonly encountered cardiovascular maladies with institution of current standards of treatment and when to refer to specialists/higher levels of intervention for optimal patient care (Medical Knowledge, Systems Based Learning, Patient Care, Interpersonal Communication).

Specific topics/concepts to be covered include: Medical and surgical management of atherosclerosis and ischemic heart disease, atrial fibrillation, cardiomyopathies, congestive heart failure, dysrhythmias, hyperlipidemia, hypertension, peripheral vascular disease, syncope. Recognition and modification of cardiovascular risk factors. (Medical Knowledge, Patient care).

Teaching methods: Didactic conferences/lectures and hands-on patient care and discussion with cardiology attending supplemented by individual reading. Fellow will optionally attend CAMC/WVU’s Annual January “Snowshoe Cardiovascular Symposium” (Patient Care, Medical Knowledge, IPC).

Evaluation methods: In all rotations fellows are formally evaluated monthly by the attending and semi-annually by the program director. Attendings and/or program director review each evaluation with fellow in detail. Fellows likewise evaluation the program, attendings and rotations formally monthly and annually. Fellow schedules and performance discussed regularly at geriatrics faculty/division meetings.

Additional specific geriatric fellowship goals/objectives competencies from POGO-E:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:

1. Diagnose and manage the most common CV diseases of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All/multiple. ACGME Competencies: Medical knowledge, Patient care.
2. Discuss the pathophysiology, diagnosis, sequelae, and management of systolic hypertension in elders. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
3. Discuss diagnosis and management of atrial fibrillation in elders, including strategies for determining risks and benefits of warfarin use in individual cases. Rotation Sites: Ambulatory Care. ACGME Competencies: Medical knowledge, Patient care.
4. Identify elders for whom hypertension should be managed more or less aggressively based on age, functional status, and co morbidities. Rotation Sites: Ambulatory/Home/ LTC/Acute Care, ACGME Competencies: Medical knowledge, Patient care.


End of Month Comments: __________________________________________________________
GOALS AND OBJECTIVES FOR GERIATRICS FELLOWSHIP

ELECTIVE ROTATIONS

Renal/Nephrology Elective w/ Dr. Rahman & Haddy (CAMC-Affiliated Private Office):

Geriatric fellowship goals/objectives competencies from POGO-E related to kidney diseases and electrolyte disorders:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:

Diagnose and manage the most common kidney/electrolyte disorders of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

Geriatric Neurology Elective w/ Dr. K. John (CAMC-Affiliated Private Office):

Key topics to be covered: diagnosis and treatment of common geriatric neurologic disorders such as peripheral neuropathies, Parkinson’s, headaches.

General objectives/competencies related to Neurologic Diseases and Disorders from POGO-E:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:

Diagnose and manage the most common neurologic disorders of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
Geriatric GI Elective

POGO-E Objectives/Competencies Relating to Gastrointestinal Diseases and Disorders:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
Diagnose and manage the most common gastrointestinal diseases of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

Hematology/Oncology Elective with Heme/Onc Drs at CAMC Cancer Center:

Heme-Onc related objectives and competencies from POGO-E:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
Diagnose and manage the most common oncologic disorders of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
Diagnose and manage the most common hematologic diseases of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

Wound Care Elective (CAMC Wound Care Center)

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to diagnose and treat various kinds of wounds including vascular and Pressure ulcers:
1. Describe the complications (medical and economic) of skin ulcers. Rotation Sites: All or multiple sites. ACGME Competencies: Patient care, Medical knowledge.
2. Describe the risk factors (intrinsic and extrinsic) and perform/interpret a risk assessment tool (ex: Braden scale). Rotation Sites: All or multiple sites. ACGME Competencies: Patient care, Medical knowledge.
3. Work with medical teams to implement strategies to prevent and reduce pressure ulcers in older patients. Rotation Sites: All or multiple sites. ACGME Competencies: Patient care, Interpersonal and Communication skills, Systems-based practice, Professionalism.
4. Demonstrate proficiency in the indications for and applications of non-surgical and surgical treatments for ulcers. Rotation Sites: All or multiple sites. ACGME Competencies: Patient care, Medical knowledge.

Urology Elective w/Dr. Tierney et al. (CAMC Outpatient Clinic and Affiliated Private Office)

Elective consists of Urology clinic and possibly some inpatient urology rounds. Key topics: urinary incontinence in the elderly, urologic malignancies (prostate, renal, bladder).

Objectives and competencies related to Geriatric Genitourinary Diseases and Disorders from POGO-E:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:
Diagnose and manage the most common genitourinary diseases of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
Specific objectives and competencies related to Incontinence:
1. Identify and treat potentially reversible causes of incontinence. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
2. Diagnose and treat urge incontinence and mixed incontinence with non-pharmacological and pharmacological techniques. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.
3. Diagnose and treat stress incontinence, including non-pharmacological and pharmacological techniques. Rotation Sites: All/multiple. ACGME Competencies: Medical knowledge, Patient care.
5. Manage incontinence non-pharmacologically in patients with cognitive and/or functional impairment. Rotation Sites: Multiple. ACGME Competencies: Patient care, Medical knowledge.
6. Identify when long-term indwelling bladder catheters are necessary and manage them appropriately. Rotation Sites: Multiple/long term care. Competencies: Patient Care.

Dermatology Elective w/CAMC Medical Staff Dermatologists (Dr. Endicott et al.): Hospital and Office

Topics to be covered include diagnosis and treatment of pressure sores and wounds (or: wound care rotation), common dermatoses in the elderly, skin cancer, herpes zoster (Medical knowledge, patient care).

Geriatric Dermatology – Related Competencies from POGO-E:

After completing this rotation, the graduating geriatric fellow, in the context of a specific older adult patient scenario (real or simulated), must be able to:

Diagnose and manage the most common dermatologic diseases of elders. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

Pulmonary/Sleep Disorders Elective w/WVU-CAMC Pulmonologists (Haden, Takubo, Zaldivar)

Pulmonary Diseases and Disorders Competencies from POGO-E:
Diagnose and manage the most common pulmonary disorders of elders and identify instances in which those diseases might present or be managed differently than in younger individuals. Rotation Sites: All or multiple sites. ACGME Competencies: Medical knowledge, Patient care.

OTHER AVAILABLE/POSSIBLE ELECTIVES:

Allergy/Immunology
Radiology
Vascular Medicine/Surgery
PACE (away)
Additional block time at any other LTC or non-hospital site.
APPENDIX 1: *CORE READINGS IN GERIATRIC MEDICINE*

**General/interdisciplinary topics:**

Goldberg TH. The literature of geriatric medicine: an annotated bibliography. (Available from Dr. G or online).

Buff DD. What you should know before going into geriatrics. Med Econ 1994(9 May):81-82.

**Key geriatric syndromes and diseases in the elderly:**

Friedland RP. 'Normal'-pressure hydrocephalus & the saga of the treatable dementias. JAMA 1989;252:2577-8.
Tinetti ME. Preventing falls in elderly persons. NEJM 2003;348:42-49.

T.G. Rev. 2010
Appendix 2: Regional and National Organizations and Meetings in Geriatrics

Geriatric fellows should be aware of the following major geriatric organizations and their meetings and publications. Involvement in AGS/WVGS is mandatory. Involvement in GSA and AMDA is recommended but optional.


WV AGS Affiliate: West Virginia Geriatrics Society (WVGS), Annual Meeting Fall 2014, Charleston, WV. West Virginia Geriatrics Society, 3501 MacCorkle Avenue, SE, Box 207, Charleston, WV 25304 WVGS Phone: 304-556-3828 Fax: 304-556-3824 Email wvgas@hsc.wvu.edu.


/T. Goldberg MD, Geriatrics Program Director WVU/CAMC, Rev. 03/14
CAMC/WVU GERIATRICS FELLOWSHIP MOONLIGHTING AND DUTY HOURS POLICIES

Our program is committed to and responsible for promoting safe and high quality care and training in a supportive educational environment. Accordingly, geriatric fellows are not encouraged to moonlight and if they do it must not interfere with the fellows’ duties and studies.

The moonlighting policy contained in the CAMC housestaff manual is followed by the Geriatrics Fellowship as well as the Internal Medicine residency (see appendix). Accordingly, moonlighting for geriatric fellows is permitted only under certain circumstances, for fellows in good standing (as defined by satisfactory performance in ALL rotations and clinical and academic sites/duties). Approval/permission for all moonlighting must be specifically requested from the program director, and monthly duty hour attestations must be filled out and must include moonlighting hours, if any. The program director will meet regularly with each fellow to review fellow schedules, performance, and compliance with duty hour limits, and will withdraw permission to moonlight if limits are exceeded or performance is adversely impacted.

The duty hours policy contained in the CAMC housestaff handbook is likewise also followed by the geriatrics fellowship (see appendix). Under no circumstances can fellows exceed ACGME prescribed limits on duty hours which require that no housestaff can work more than 80 hours per week, averaged over 4 weeks.

Signed and approved by:

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Todd Goldberg MD, CAMC Geriatrics Program Director

______________________________
Jack DePriest MD, CAMC Internal Medicine Program Director

Rev. Aug. 2010
APPENDIX 4: MOONLIGHTING AND DUTY HOURS POLICIES FROM CAMC HOUSESTAFF HANDBOOK:

G. MOONLIGHTING

1. Residents must not be required to engage in moonlighting and moonlighting is not encouraged. Residents who engage in moonlighting must not allow such activity to interfere with the ability of the resident to achieve the goals and objectives of their GME program. The program director is responsible for monitoring resident performance and for determining the potential impact of moonlighting practices on the clinical or educational performance of resident or patient safety. The program director shall monitor the number of hours and the nature of the workload of residents engaging in the moonlighting experience. All residents and fellows must obtain written permission from the program director prior to engaging in moonlighting.

Individual residency programs must adhere to the RRC requirements specific to the accredited residency program and the Institutional requirements as specified by the ACGME. Residency programs must adhere to policies imposed by other accrediting or regulatory agencies.

CAMC as the sponsoring institution is not responsible for any action or problem arising from professional activities which are initiated by the resident and do not involve any agreement between the sponsoring institution and an external employer.

Professional liability insurance coverage is not provided for moonlighting activities. Residents are responsible for securing confirmation of malpractice coverage outside the scope of the residency training assignment.

All residents engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. The program director shall not approve moonlighting for any unlicensed resident.

Residents must obtain a separate DEA certificate for use in prescribing medications as part of any moonlighting activity.

The Graduate Medical Education Committee or Charleston Area Medical Center may choose to monitor policy compliance at any time.

2. RESIDENT REQUIREMENTS: The primary responsibility of the resident is to the service or activity to which the resident is assigned. Moonlighting MUST NOT interfere with clinical and educational performance. The resident must obtain permission for moonlighting and adhere to criteria for moonlighting that is set forth in this policy or by the residency program director. The residency program director has authority to restrict moonlighting at any time and may establish more stringent reporting requirements than outlined by this policy. Permission will be based on individual academic, clinical and professional performance; an adverse effect on performance may lead to withdrawal of permission. The following guidelines will be applied:

Residents must have satisfactorily completed requirements for the first post-graduate year in the residency program. Interns are not permitted to engage in moonlighting activities.

“Sunlighting” (working for income during hours when an individual has duties and responsibilities to the service on which he/she is training) is not permitted at any time.

Residents must be in good academic standing within their residency training program demonstrating overall satisfactory performance.

Effective with exam dates after January 1, 2003 residents must demonstrate in-training exam scores at the national median or 50th percentile for residents in training at the comparable training level in order to be granted
permission to moonlight. Program directors are responsible for scheduling the residents off at least 8 hours prior to and during the exam for ideal conditions conducive to enhancing the resident’s performance on the exam.

3. PROCESS FOR REQUESTING PERMISSION TO MOONLIGHT: All residents desiring to engage in moonlighting must complete a Request for Permission to Moonlight Form (“the Form”) prior to engaging in any moonlighting activity. It is the responsibility of the individual resident to complete the form and to provide reporting as required.

Permission to moonlight will be granted for a maximum 6-month time period at which time a new request form must be submitted. Interim reporting may be required by the program director or coordinator.

A Form is required for each employer of a moonlighting resident. Multiple sites staffed by the same employer may be listed on one form and may be updated at any time prior to the resident performing services at a new location.

A copy of the resident’s license, DEA certificate in his/her name and confirmation of malpractice insurance at the moonlighting institution must be submitted with the Form.

Upon completion of the Form, one copy will be placed in the resident’s institutional file; originals will be placed in the resident’s permanent program file.

4. REPORTING REQUIREMENTS: The program director is required to monitor hours and location throughout the academic year. Permission to moonlight is based on a maximum number of hours per week and is specified by location. Any change that results in additional moonlighting hours or changes in locations will require an updated written permission from the program director. The GMEC, the Director of Medical Education or the DIO may require summary reports from programs at any time.

5. RESPONSIBLE PARTIES: Resident programs are responsible for communication of moonlighting policies or changes in policy during the academic year.

Program directors are responsible for enforcement of the policy.

Residents are responsible for meeting requirements set forth in the policy.

The President of the CAMC Health Education and Research Institute has ultimate authority to permit, restrict or withdraw permission to moonlight.

Moonlighting is defined by the ACGME/AOA as “professional and patient care activities that are external to the educational program.” The ACGME/AOA prohibits any requirement of resident/interns to perform moonlighting services.

H. HOURS OF DUTY

Duty hours are different in each training program. Night schedules, weekend duty schedules, and holiday schedules are the responsibility of the Program Director. Resident/intern will not go off duty if service to the patient requires that he/she remains to meet demands of care. Before going off duty, resident/intern must make certain that his/her relief is present, as well as to report to him/her all seriously ill and critical patients. The resident/intern on-call will remain at CAMC according to departmental policy. At no time may a medical student cover a service. All resident/interns must adhere to institutional and program policies regarding duty hours.
In accordance with ACGME/AOA program requirements duty hours are defined as all clinical and academic activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Resident/interns must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of all call time. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call. The objective of on-call activities is to provide resident/interns with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when resident/interns are required to be immediately available in the assigned institution. In-house call must occur no more frequently than every third night, averaged over a four-week period. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Resident/interns may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements).

At-home call (pager call) is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident/intern. Resident/interns taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When resident/interns are called into the hospital from home, the hours resident/interns spend in-house are counted toward the 80-hour limit. The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. Moonlighting must be counted toward the 80-hour weekly limit on duty hours as defined by institutional policy and ACGME institutional requirements.

Residents are responsible for adhering to duty hour requirements and for reporting areas of non-compliance to program and administrative officials in a timely fashion. Residents must also provide accurate and truthful documentation, attestation or other reports required by the program or institution for the purpose of moonlighting practices or duty hour requirements.
Our program is committed to safe and high quality geriatric care and training in a supportive educational environment. Accordingly the chain of command and supervision policy for the geriatrics fellowship is as follows.

Geriatrics fellows in training are at all times supervised by an assigned attending physician in all settings, e.g. clinic attending, hospital attending, nursing home attending, etc. All such assignments are arranged, scheduled and overseen by the program director. Depending on the site and circumstances, supervision may be direct or indirect. As per RRC-IM rules, in inpatient settings, direct supervision need not be continuous/on site and may occur at specified times such as teaching rounds, but with immediate availability at all other times. In outpatient settings, supervision will continuously be available on site. An attending physician will be present either in the same suite or directly in the exam room with the fellow when a fellow is seeing outpatients; the fellow must present the case to the physician faculty prior to the patient leaving clinic. In long-term care settings (i.e. SNF), supervision can occur at the end of the session but faculty will always be present on site for assistance and reporting as required. The RRC-IM permits geriatrics fellows to complete home care visits and urgent unscheduled nursing home visits without direct faculty supervision onsite, but at all times and in all sites a designated supervising attending physician must be immediately available by telephone/beeper for assistance if needed and must review all patient visits, documentation and bills with the fellow in a suitable time frame to meet the requirements of patient care as well as billing. Fellows will be given progressively increasing responsibility and autonomy as appropriate to their experience and performance, but also must at all times be clear on the scope and limits of their authority, responsibility, and capabilities, and should freely ask for assistance when needed/appropriate. Fellows should always be cognizant of exactly who is their direct supervisor/preceptor in any activity or setting. It is possible at times for more than one attending physician to be supervising a fellow at the same time, e.g. if multiple geriatricians are present in the same clinic or conference, in which case supervisory responsibility may be shared, with the ultimate authority still resting with the program director. In some sites (clinics, nursing homes, hospitals) there also may be a site medical director, administrator, or other site official who should also be consulted as appropriate.

The preceptor/attending, as assigned by the program director, is responsible for all academic and clinical supervision and billing in each clinical or academic site, and should be approached regarding any concerns not resolved by the fellow, or any concerns about the fellow or fellowship. The next level of reporting is to the program director, who will meet regularly with all faculty/preceptors and fellows. All concerns or complaints about the fellow or attending preceptor that cannot be resolved directly with them should be brought to the attention of the program director. Concerns about or over the head of the program director should be brought to the Chairman of Medicine, Dean of WVU School of Medicine, and/or DIO. The GME office of CHERI/CAMC also officially employs and is also responsible for all issues relating to housestaff in all levels and departments.

This policy is intended to supplement/reinforce and not supersede or contradict anything in individual contracts or the CAMC housestaff handbook, which provides that residents will follow policies as defined by said handbook, other institutional policies, and ACGME program requirements.

Todd Goldberg MD, CAMC Geriatrics Program Director / Jack DePriest MD, Internal Medicine Program Director

Rev. Aug. 2010

CAMC/WVU GERIATRIC MEDICINE FELLOWSHIP

POLICY ON NON-TEACHING PATIENTS

Rev. 9/10

CAMC and associated WVU Physicians of Charleston sites and practices have no official category or service of “non-teaching patients.” Though some inpatients are covered by hospitalists or other private attending physicians who may not customarily work directly with housestaff or students, all patients are eligible to be seen by any trainees, e.g. in subspecialty consults and ancillary services, as appropriate to clinical circumstances. Specifically, while consults are only done on request, there are no older adult patients whom the geriatric fellows are not allowed to see in CAMC, depending on the service they are working with, and subject to appropriate clinical privileges and the permission of the patient and attending physician. It should be noted that any patient has the right to refuse any service or provider at any time, within legal limits. If or when numbers of patients followed by housestaff on any service become excessive, caps may be implemented.
Charleston Area Medical Center Graduate Medical Education Supervision Policy

(Adopted by GMEC, 4/12/2011)

Purpose:
The purpose of this Supervision Policy is to initiate institution-wide, general standards regarding resident supervision in post-graduate medical education programs at Charleston Area Medical Center (CAMC) and to outline essential guidelines for program-specific supervision policies to meet. Basic principles of supervision among all CAMC residency programs are patient safety, education, quality patient care, communication and documentation. Ultimate supervision is provided by licensed independent practitioners including full-time and part-time clinical attending physicians or off-site approved attending physicians of the program. Each program will develop and maintain program-specific policies consistent with the principles set forth in this policy and according to guidelines established by their respective Residency Review Committee or residency accreditation standards.

Accountability:
It is the responsibility of program directors, attending physicians, supervising independent practitioners, and senior residents involved in the supervision and education of residents at CAMC and other training sites to act in accordance with this policy.

Responsibility:
Responsibilities of Institution/GMEC
Charleston Area Medical Center GMEC is responsible for resident supervision in the following capacities (As outlined in ACGME Institutional Requirements, III.B.4.):

- Monitor programs’ supervision of residents and ensure that supervision is consistent with:
  - Provision of safe and effective patient care
  - Educational needs of residents
  - Progressive responsibility appropriate to residents’ level of education, competence, and experience
  - Other applicable Common and Specialty/subspecialty-specific Program Requirements

Responsibilities of Residency Program
The graduate training programs of CAMC will afford each resident appropriate and sufficient supervision for all activities involved in patient care in order to help ensure patient safety as a priority. The following guidelines describe standards and responsibilities for residency training programs in supervision of their residents:

1. Each program must share their policy with residents and attending physician on an annual basis.

2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

3. Each program will ensure that residents will perform under the supervision of attending physicians or licensed independent practitioners who hold appropriate appointments and have been credentialed at the specific training site.

4. Each program is responsible for setting guidelines for circumstances and events where residents must communicate with appropriate licensed independent practitioner/senior resident.

5. A supervision plan must include actions to be taken in the event the supervising physician or independent practitioner is unavailable or cannot be reached.

6. The program’s policy should include procedures for providing feedback and notification in the event a supervising physician/licensed independent practitioner or resident identifies issues with supervision.
7. Each program will establish methods for monitoring compliance with its supervision policies. Examples of processes used to monitor this include duty hour log reports, procedure logs, resident and attending physician feedback, evaluation questions regarding adequacy of supervision and quality improvement reports.

Responsibilities of Residents/Supervisees
Clinical activities and procedures are conducted only by residents with the necessary knowledge, skill, and judgment, and only under proper supervision. Residents are responsible for performing their duties to the best of their abilities under the guidance and instruction of their supervisors and for promoting behaviors that lead to patient safety.
The following standards summarize the roles and responsibilities of residents regarding supervision in their training program.

1. Residents will ask for supervision from an attending physician or licensed independent practitioner if the resident has insufficient experience with the procedure and/or skill.

2. The resident will inform each patient under his/her care of their trainee status and the name of the licensed independent practitioner physician who is supervising him/her.

3. The resident will notify their supervisor if for any reason he/she is not able to carry out any assigned duties. The resident will also immediately report any concerns or issues he/she has regarding adequacy of supervision.

4. Residents should aim to develop understanding and awareness of their limitations and areas of improvement and to request assistance when appropriate.

Responsibilities of Supervisors
When residents are involved in the care of patients, the ultimate responsibility for these patients lies with the supervising resident or fellow, attending physician, or licensed independent practitioner.
The following are general responsibilities and expectations of attending physicians and licensed independent practitioners:

1. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending physician or licensed independent practitioner who is ultimately responsible for the patient’s care. The supervising physician or licensed independent practitioner will maintain the appropriate level of privileges at each clinical site.

2. The supervisor should make every effort to recognize signs of fatigue and sleep deprivation, and aid residents in avoiding and counteracting the negative effects of these.

3. Each supervising physician or licensed independent practitioner supervisor will comply with the requirements of CAMC for supervision and documentation of activities. Licensed independent practitioner supervisors will be knowledgeable of CAMC policies.

4. At the outset of each rotation, the supervisor should set expectations for circumstances and events in which residents must communicate with appropriate supervisors, such as the transfer of a patient to an intensive care unit or end of life decisions.

5. The supervisor should recognize when a resident is not fit for duty and when the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

6. The supervisor will inform patients of their role in the patient’s care.

Graduated Levels of Responsibility:
As residents advance in their training program, they will be given progressive responsibility for care of patients. Residents are supervised by attending physicians and licensed independent practitioners in order for residents to assume progressively increasing levels of authority and responsibility, conditional independence, and the role of supervisor in patient care consistent with their level of education, ability, and experience.
1. Each program should be organized in a way that promotes and allows residents to assume increasing levels of responsibility consistent with their individual progress in their training program.

2. Each program director will delineate the levels of progressive responsibility for each year of residency training. The amount of supervision will vary with the clinical circumstances and the training level of the resident. Objective criteria used to assess a resident’s aptitude to function independently in particular skill areas will be created and clearly described in the program’s policy. When appropriate, the program will set specific expectations for non-supervised clinical activity. The program will communicate the defined levels of responsibility to each resident.

3. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the resident.

4. Senior residents or fellows will serve in a supervisory role of junior residents in recognition of their progress toward independence.

5. Each resident must know the limits of his/her scope of authority and circumstances under which he/she is permitted to act with conditional independence.

Direct and Indirect Supervision:

Unless specified further by the Program’s specific RRC or respective residency accreditation requirements, PGY1 residents must have either Direct Supervision or Indirect Supervision in which the supervisor is immediately available and within the confines of the site of patient care. Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.

Direct Supervision
When the resident receives direct supervision, the supervising physician or licensed independent practitioner supervisor must be physically present with the resident and patient.

Indirect Supervision
When the resident receives indirect supervision, the licensed independent practitioner supervisor must be immediately available to the resident either in person or via telephone or pager. With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. The supervisor must also be capable of being physically present within a sufficient amount of time (within 30 minutes of being contacted by the resident), if necessary.

If supervision is being provided via oversight, the supervisor is available to provide review of procedures/encounters with feedback provided after care is delivered.

Documentation of Supervision:
Documentation is a crucial element of the exchange of information between resident and supervising attending physician. Supervision of resident activities must be documented appropriately and accurately in the patient record at all times. This guideline includes, but is not limited to, documentation of consultations, admitting notes, procedural activity, continuing care and progress notes, and discharge summaries for patient encounters.

The medical record must clearly indicate the involvement of the supervising physician in resident care of the patient. The supervising attending physician’s documentation must comply with standards mandated by CAMC and The Joint Commission.
### MINIMUM GERIATRIC COMPETENCIES for IM-FM RESIDENTS

http://adgap.americangeriatrics.org/academic-resources/competencies/


The graduating IM or FM resident, in the context of a specific older patient scenario (real or simulated), must be able to:

(Note: Fellows should have mastered these prerequisites during residency; if not they should certainly catch up and be able to demonstrate and teach all of these competencies to others by the end of fellowship! For medical student-level geriatrics competencies, which should also be achieved before or during residency, see: http://adgap.americangeriatrics.org/academic-resources/competencies/)

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<td>1</td>
<td>Prescribe appropriate drugs and dosages considering: age-related changes in renal and hepatic function, body composition, and CNS sensitivity; common side effects in light of patient’s comorbidities, functional status, and other medications; and drug-drug interactions.</td>
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<td>2</td>
<td>When prescribing drugs which present high risk for adverse events and interactions (these medications include, but are not limited to, coumadin, NSAID’s, opioids, digoxin, insulin, strongly anticholinergic drugs, and psychotropic drugs), discuss and document the rationale for their use, alternatives, and ways to decrease side effects.</td>
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<td>3</td>
<td>Periodically review patients’ medications (including meds prescribed by other physicians, OTC and CAM) with the patient and/or caregiver to assess adherence, eliminate ineffective, duplicate and unnecessary medications, and assure that all medically indicated pharmacotherapy is prescribed.</td>
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#### MEDICATION MANAGEMENT

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<td>4</td>
<td>Appropriately administer and interpret the results of at least one validated screening tool for each of the following: delirium, dementia, depression, and substance abuse.</td>
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<td>5</td>
<td>Recognize delirium as a medical urgency, promptly evaluate and treat underlying problem.</td>
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<td>6</td>
<td>Evaluate and formulate a differential diagnosis and workup for patients with changes in affect, cognition, and behavior (agitation, psychosis, anxiety, and apathy).</td>
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<td>7</td>
<td>In patients with dementia and/or depression, initiate treatment and/or refer as appropriate.</td>
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#### COGNITIVE, AFFECTIVE, AND BEHAVIORAL HEALTH

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<td>8</td>
<td>Identify and assess barriers to communication such as hearing and/or sight impairments, speech difficulties, aphasia, limited health literacy, and cognitive disorders. When present, demonstrate ability to use adaptive equipment and alternative methods to communicate (e.g., with the aid of family/friend, caregiver).</td>
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<td>9</td>
<td>Determine whether an older patient has sufficient capacity to give an accurate history, make decisions and participate in developing the plan of care.</td>
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<td>10</td>
<td>In evaluating adults with undifferentiated illness, generate differential diagnoses that include diseases that often present atypically in older adults (e.g., acute coronary syndromes, the acute abdomen, urinary tract infection, and pneumonia).</td>
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<td>11</td>
<td>Consider adverse reactions to medication in the differential diagnosis of new symptoms or geriatric syndromes (e.g., cognitive impairment, constipation, falls, and incontinence).</td>
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<td>12</td>
<td>Demonstrate understanding of the major age-related changes in physical and laboratory findings during diagnostic reasoning (e.g., S4 does not reflect CHF, pulse increase less common with orthostasis, pO2 declines with age, abdominal pain may be less severe).</td>
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<td>13</td>
<td>Discuss and document advance care planning and goals of care with all patients with chronic or complex illness, and/or their surrogates.</td>
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<td>14</td>
<td>Develop a treatment plan that incorporates the patient’s and family’s goals of care, preserves function, and relieves symptoms.</td>
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<td>15</td>
<td>In patients with life limiting or severe chronic illness, assess pain and distressing non-pain symptoms (dyspnea, nausea, vomiting, and fatigue) at regular intervals and institute appropriate treatment based on their goals of care.</td>
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#### COMPLEX OR CHRONIC ILLNESS(ES) IN OLDER ADULTS

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<td>16</td>
<td>In patients with life limiting or severe chronic illness, identify with the patient, family and care team when goals of care and management should transition to primarily comfort care.</td>
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<td>17</td>
<td>As part of the daily physical exam of all hospitalized older patients, assess and document whether delirium is present.</td>
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#### PALLIATIVE AND END OF LIFE CARE

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#### HOSPITAL PATIENT SAFETY

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<td>18</td>
<td>In hospitalized medical and surgical patients, evaluate on admission and on a regular basis for fall risk, immobility, pressure ulcers, adequacy of oral intake, pain, new urinary incontinence, constipation, and inappropriate medication prescribing, and institute appropriate corrective measures.</td>
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<td>19</td>
<td>In hospitalized patients with an indwelling bladder catheter, discontinue or document indication for use.</td>
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<td>20</td>
<td>Before using or renewing physical or chemical restraints on geriatric patients, assess for and treat reversible causes of agitation (e.g., use of irritating tethers [including monitor leads, blood pressure cuff, pulse oximeter, intravenous lines and in-dwelling bladder catheters], untreated pain, alcohol withdrawal, delirium, ambient noise). Consider alternatives to restraints such as additional staffing, environmental modifications, and presence of family members.</td>
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**TRANSITIONS OF CARE**

| 21 | In planning hospital discharge, work in conjunction with other health care providers (e.g., social work, case management, nursing, physical therapy) to recommend appropriate services based on: the clinical needs, personal values and social and financial resources of the patients and their families (e.g., symptom and functional goals in the context of prognosis, care directives, home circumstances and financial resources); and the patient's eligibility for community-based services (e.g., home health care, day care, assisted living, nursing home, rehabilitation, or hospice). |
| 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 medications, current cognitive and functional status, advance directives, plan of care, scheduled or needed follow-up, and hospital physician contact information. |

**AMBULATORY CARE**

| 23 | Yearly screen all ambulatory elders for falls or fear of falling. If positive, assess gait and balance instability, evaluate for potentially precipitating causes (medications, neuromuscular conditions, and medical illness), and implement interventions to decrease risk of falling. |
| 24 | Detect, evaluate and initiate management of bowel and bladder dysfunction in community dwelling older adults. |
| 25 | Identify older persons at high safety risk, including unsafe driving or elder abuse/neglect, and develop a plan for assessment or referral. |
| 26 | Individualize standard recommendations for screening tests and chemoprophylaxis in older patients based on life expectancy, functional status, patient preference and goals of care. |
SUMMARY OF NEW AND IMPORTANT RESIDENCY/FELLOWSHIP COMMON PROGRAM REQUIREMENTS 2011


Duty Hours
- Duty hours must be limited to 80 hrs per week, averaged over 4 weeks, inclusive of all in-house call activities and all moonlighting.
- Residents/fellows must have 10 hrs off between shifts and at least 1 day totally free of duty every week (averaged over 4 weeks).
- Maximum duty period length: 16 hours for PGY-1, 24(+4) hours for PGY 2 and above. All geriatric fellows are PGY4.
- 10 hrs off required between scheduled shifts. Must have 14 hours free of duty after 24 hrs in-house duty.
- On call and night float: No more than 6 consecutive night floats, no more than every 3rd night on call.
- At home call (~1 week per month for geriatrics fellows) must not be so frequent or taxing as to preclude reasonable rest and personal time. Hours spent coming in to the hospital or nursing home, if any, must count towards the 80 hour weekly maximum.
- Backup/relief: If for any reason residents/fellows experience excessive workloads, hours, fatigue or any condition rendering them unable to safely perform their duties, such must be reported to the attending physician and program director, relief must be provided, and schedules must be adjusted.

Supervision and Evaluation of Residents/Fellows:
- For all training sites/experiences, faculty/preceptors must complete evaluations on the residents/fellows in a timely fashion, and vice versa. Additionally each resident/fellow will be provided with both ongoing feedback and a semi-annual performance evaluation, and each program must also evaluate all faculty and the program as a whole annually.
- Supervision may, depending on the circumstances, be direct or indirect, and trainees should be given appropriate autonomy based on their level of training. However all trainee supervision and patient care is ultimately the responsibility of assigned and appropriately credentialed faculty/preceptors. Trainees should always identify themselves as such and note/be aware of their faculty/supervisors at all times.
- Transitions and handoffs in patient care must be conducted as safely as possible.

Curriculum and faculty development:
- Competency-based goals and objectives exist for each rotation/curricular assignment, at each educational level, which the program distributes to trainees and faculty at least annually and are always available on the program web site. These should be reviewed by the resident/fellow and faculty/preceptor at beginning of each rotation.
- Curriculum and evaluations must be based on the following 6 ACGME core competencies: Patient care, medical knowledge, practice-based learning and improvement, interpersonal/communication skills, professionalism, and systems-based practice. Further details on these competencies as well as all other institutional and program requirements may be found on the ACGME and program web sites.

/T. G. 3/11
Appendix 8:

Program Requirements for Fellowship Education in Internal Medicine-Geriatric Medicine (www.acgme.org) (2006 version; being revised 2013).

For sections I. through VII, see Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine.

VIII. Educational Program

A. An educational program in geriatric medicine must be organized to provide a well-supervised experience at a level sufficient for the fellow to acquire the competence of a physician with added qualifications in the field.

B. The training program must be 12 months in duration, all of which must include clinical experience.

C. The program must provide the opportunity for fellows to maintain their basic primary skills during the course of this training. The program must have at least 1/2 day per week averaged over each month in a continuity of care setting caring for patients of all ages and both genders. The program must also arrange for contact with a mentor from the primary specialty for each fellow.

IX. Faculty

A. The director must have demonstrated experience in geriatric medicine, must have demonstrated experience in education and scholarly activity, and must have a career commitment to academic geriatric medicine.

B. In addition to the program director, each program must have at least one additional key clinical faculty member with similar qualifications who devote(s) a substantial portion of professional time to the training program.

C. For programs with more than 2 fellows, a ratio of 1 faculty to 1.5 fellows must be maintained.

D. The program must ensure that interdisciplinary relationships occur between the geriatric fellows and faculty in the following specialties: physical medicine and rehabilitation, neurology, and psychiatry.

E. Appropriate relationships should be maintained between the geriatric fellows and faculty in general surgery, orthopedics, ophthalmology, otolaryngology, podiatry, urology, gynecology, emergency medicine, dentistry, pharmacy, audiology, physical and occupational therapy, speech therapy, and nursing and social services.

F. Additionally, a team or collaborative care of geriatric patients with physician assistants or with nurse practitioners is recommended.

X. Facilities and Resources

The program must include the following:

A. The acute-care hospital central to the geriatric medicine program must be an integral component of a teaching center. It must have the full range of services usually ascribed to an acute-care general hospital, including intensive care units, emergency medicine, operating rooms, diagnostic laboratory and imaging services, and a pathology department.

B. Long-term Care Institution

1. One or more long-term care institutions, such as a skilled nursing facility or chronic care hospital, must be affiliated with the geriatric medicine program.
2. There must be a formal affiliation agreement between each long-term care facility included in the program and the sponsoring institution, in which each institution must acknowledge its responsibility to provide high-quality care, adequate resources, and administrative support for the educational mission.

3. There must be a letter of agreement between each long-term care facility and the office of the director of the geriatric medicine program that guarantees the director appropriate authority at the long-term care institution to carry out the training program.

4. Fellows must have exposure to subacute care and rehabilitation in the long-term care setting.

5. The total number of beds available must be sufficient to permit a comprehensive educational experience.

6. The long-term care institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each must be consistent with those promulgated by the Joint Commission on Accreditation of Healthcare Organizations.

C. Long-term Non-institutional Care

1. Non-institutional care service, for example, home care, day care, residential care, or assisted living, must be included in the geriatric medicine program to permit fellows to learn to provide care for patients who are homebound but not institutionalized.

2. It is recommended that the program provide opportunities for experience in day-care or day-hospital centers, life care communities, and residential care facilities.

D. Geriatric Care Team

The fellow must have experience with physician-directed interdisciplinary geriatric teams.

1. Essential members include a geriatrician, a nurse, and a social worker/case manager.

2. Additional members may be included in the team as appropriate, including representatives from disciplines such as neurology, psychiatry, physical medicine and rehabilitation, physical therapy, occupational therapy and speech therapy, dentistry, pharmacy, psychology, and pastoral care.

3. Regular team conferences must be held as dictated by the needs of the individual patient.

4. Fellows must have interdisciplinary geriatric team experience in more than one setting, which may include:
   a) an acute care hospital;
   b) a nursing home that includes subacute and long-term care;
   c) a home care setting;
   d) a family medicine center, internal medicine center, or other outpatient settings.

E. Other Facilities, Resources, or Support Services

1. Peer interaction is essential for fellows. An accredited training program in at least one relevant specialty other than internal medicine or family medicine must be present at the primary training site.

2. Involvement in other health care and community agencies is suggested.
F. Patient Population

1. The program must provide a patient population adequate to meet the needs of the training program in the facilities in which the educational experiences take place.

2. Elderly patients of both sexes (at least 25% of each gender, cumulative across settings) with a variety of chronic illnesses, at least some of whom have potential for rehabilitation, must be available.

3. At all facilities used by the program the fellow must be given opportunities to assume meaningful patient responsibility.

XI. Specific Program Content

A. Fellows must develop clinical competence in the field of geriatrics, including:

1. the physiology of aging;
2. the pathophysiology that commonly occurs in older persons;
3. atypical presentations of illnesses;
4. functional assessment;
5. concepts of treatment and management in acute care, long-term care, community, and home-care settings; and
6. assessment of cognitive status and affective states.

B. Clinical experience in the management of elderly patients must include:

1. direct care for patients in ambulatory, community, and long-term care settings, and consultative and/or direct care in acute inpatient care settings in order to understand the interaction of natural aging and disease as well as the techniques of assessment, therapy, and management;
2. care for persons who are generally healthy and require primarily preventive health-care measures;
3. understanding of the behavioral aspects of illness, socioeconomic factors, health literacy issues and ethical and legal considerations that may impinge on medical management.
4. care for elderly patients as a consultant providing expert assessments and recommendations in the unique care needs of elderly patients.

C. Curriculum

1. All major dimensions of the curriculum must be structured educational experiences for which written goals and objectives, a specific methodology for teaching, and a method of evaluation exist.
2. A written curriculum that comprehensively describes the program, including sites, educational objectives for each component, and topics to be covered in didactic sessions, must be available to fellows and faculty.
3. The curriculum must ensure the opportunity for fellows to achieve the cognitive knowledge, physical examination skills, interpersonal skills, professional attitudes, and practical experience required of a physician who specializes in the care of the aged.

D. Pathology

1. All deaths of patients who receive primary care by fellows should be reviewed and autopsies performed whenever possible.
2. Fellows must receive autopsy reports after autopsies are completed on their patients.

E. Teaching Opportunities

As the fellows progress through their training, they should have the opportunity to teach other health professionals and trainees, such as nurses, allied health personnel, medical students, and residents.
F. Clinical Experiences

The following components must be provided in the training program:

1. Geriatric Medicine Consultation Program
   This program must be formally available in the ambulatory setting, the inpatient service, and/or emergency medicine in the acute-care hospital or at an ambulatory setting administered by the primary teaching institution.

2. Ambulatory Care Program
   a) The ambulatory care program must comprise a minimum of 33% of the fellow’s time, and may include home care, adult day health care, home hospice care, and outpatient geriatric rehabilitation.
   b) Fellows should be responsible for at least five patients each week, and no more than the number for whom adequate teaching can be provided. This must include at least 1/2 day per week spent in a continuity of care experience. This experience must be designed to provide care in a geriatric clinic or internal medicine center to elderly patients who may require the services of multiple medical disciplines (including but not limited to neurology, gynecology, urology, psychiatry, podiatry, orthopedics, physical medicine and rehabilitation, dentistry, audiology, otolaryngology and ophthalmology, as well as nursing, social work, and nutrition, among other disciplines.)
   c) The fellows must have the opportunity to provide continuing care and to coordinate the implementation of recommendations from medical specialties and other disciplines in their continuity clinic.
   d) In addition, experiences in relevant ambulatory specialty and subspecialty clinics (e.g., geriatric psychiatry and neurology) and those that focus on the assessment and management of geriatric syndromes (e.g., falls, incontinence, and osteoporosis) are strongly recommended.

3. Long-term Care Experience

   Fellows must have 12 months of continuing longitudinal clinical experience in the long-term care setting and manage an assigned panel of patients for whom the fellow is the primary provider.
   a) Emphasis during the longitudinal experience should be focus on:
      (1) the approaches to diagnosis and treatment of the acutely and chronically ill, frail elderly in a less technologically sophisticated environment than the acute-care hospital; (2) working within the limits of a decreased staff-patient ratio compared with acute care hospitals; (3) a much greater awareness of and familiarity with subacute care physical medicine and rehabilitation; (4) the challenge of the clinical and ethical dilemmas produced by the illness of the very old; (5) geriatric pharmacology; (6) administrative aspects of long-term care; (7) the role of physicians as interdisciplinary team members in the care of the long-term care patient; (8) the importance of interaction and communication with the family/caregiver; and (9) the role of palliative care and hospice in the terminally ill.
   b) The program must provide experience with home visits and hospice care.
      (1) Fellows must be exposed to the organizational and administrative aspects of home health care.
      (2) The program must include experience with continuity of care for home or hospice care patients.
   c) Additional block time to provide long-term care experience is recommended.

4. Geriatric Psychiatry

   Identifiable structured didactic and clinical experiences in geriatric psychiatry must be included in the program of each fellow.

G. Formal Instruction

   The curriculum of the program must exhibit, as a minimum, the following content and skills areas:
   1. Current scientific knowledge of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged;
   2. Aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization and chemoprophylaxis against disease. Instruction about and experience with community resources dedicated to these
activities should be included;
3. Geriatric assessment, including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); medication review, the appropriate use of the history; physical and mental examination; and laboratory;
4. Appropriate interdisciplinary coordination of the actions of multiple health professionals, including physicians, nurses, social workers, dieticians, and rehabilitation experts, in the assessment and implementation of treatment;
5. Topics of special interest to geriatric medicine, including but not limited to cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment;
6. Diseases that are especially prominent in the elderly or that have different characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders;
7. Pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, mover-medication, appropriate prescribing, and adherence;
8. Psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety;
9. The economic aspects of supporting geriatric services, including Title III of the Older Americans Act, Medicare, Medicaid, capitation, and cost containment;
10. Ethical and legal issues especially pertinent to geriatric medicine, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs;
11. General principles of geriatric rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, pulmonary, and neurologic impairments. These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, environmental modification, patient and family education, and psychosocial and recreational counseling;
12. Management of patients in long-term care settings, including palliative care, knowledge of the administration, regulation, and financing of long-term institutions, and the continuum from short- to long-term care;
13. Research methodologies related to geriatric medicine, including clinical epidemiology, decision analysis, and critical literature review;
14. Perioperative assessment and involvement in management;
15. Iatrogenic disorders and their prevention;
16. Communication skills with patients, families, professional colleagues, and community groups, including presenting case reports, literature searches, and research papers, when appropriate, to peers and lectures to lay audiences;
17. The pivotal role of the family in caring for many elderly and the community resources (formal support systems) required to support both patient and family;
18. Cultural aspects of aging, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care, and use of an interpreter in clinical care. Also, issues of ethnicity in long-term care, patient education, and special issues relating to urban and rural older persons of various ethnic backgrounds;
19. Home care, including the components of a home visit, accessing appropriate community resources to provide care in the home setting;
20. Hospice care, including pain management, symptom relief, comfort care, and end-of-life issues;
21. Behavioral sciences such as psychology/social work.

ACGME Approved: September 13, 2005 Effective Date: July 1, 2006
Appendix 9: AGS/ADGAP Geriatric Fellowship Curricular Milestones, 2012-13

http://adgap.americangeriatrics.org/academic-resources/competencies/

The Geriatric Fellowship Curriculum Milestones build on the geriatrics competencies developed for medical students and residents and will serve as a foundation for our ongoing work. They were created by a working group of geriatricians (see table below), reviewed and commented on by over 400 geriatricians, revised and then approved by the Boards of the American Geriatrics Society (AGS) and the Association of Directors of Geriatric Academic Programs (ADGAP). These “curricular milestones” supersede/replace earlier competency lists and will be published in a national journal soon. Additional forthcoming “reporting milestones” will also serve as the basis for fellow evaluation under the NAS.

Domain: Caring for the Elderly Patient

**CEP Communication**

1. Practice culturally sensitive shared decision making with patients and families/caregivers in the context of their health literacy, desired level of participation, preferences and goals of care.
2. Work effectively as a member or leader of an interprofessional health care team.
3. Use strategies to enhance clinician-patient oral and written communication in patients with hearing, vision, or cognitive impairment.
4. Skillfully discuss and document goals of care and advance care planning with elderly individuals and/or their families/caregivers across the spectrum of health and illness.
5. Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship.
6. Provide compassionate care while establishing personal and professional boundaries with patients and families/caregivers.
7. Effectively lead a family/caregiver meeting.

**CEP Gerontology**

8. Demonstrate current scientific knowledge of aging and longevity, including theories of aging and epidemiology of aging populations.
9. Describe the primary physiologic changes of aging of each organ system and their cliniciimplications, including how they may impact lab findings.

**CEP - Medication Management**

10. Demonstrate expertise in medication management by justifying medication regimen and duration based upon:
   a. age related changes in pharmacokinetics and pharmacodynamics.
   b. maximizing medication adherence.
   c. the common lists of medications that should be avoided or used with caution in older adults.
   d. a consideration of the reported benefits and known and unknown risks when prescribing a newly-released medication, realizing that older adults with multimorbidities are often underrepresented in clinical trials.
11. When a patient presents with a new symptom or geriatric syndrome, investigate whether a medication(s) is contributing.
12. Individualize pain control utilizing the most effective pharmacologic and nonpharmacologic strategies based on the etiology and chronicity of the patient’s pain.
13. Prescribe pain medications with instructions and methods to prevent common complications including constipation, nausea, fatigue and opioid toxicity (myoclonus and hyperalgesia), using equianalgesic dosing conversion and opioid rotation when needed.

**CEP - Functional Impairment and Rehabilitation**

14. Know the indications and contraindications for referring patients to physical, occupational, speech or other rehabilitative therapies, and refer if appropriate.
15. Know indications for durable medical equipment, prescribe and evaluate for appropriate use.
16. Recognize and manage the care of patients at high risk for poor outcomes from common conditions such as deconditioning, stroke, hip fracture, and dysphagia.

**CEP - Diseases in Older Adults**
17. Identify and manage medical disorders that occur in older adults.
18. Know the different presentation, management and underlying pathophysiology of common diseases in older adults (including but not limited to: hypertension, coronary artery disease, osteoporosis, hypothyroidism, infections, and the acute abdomen; adjusting drug dosage for renal function).
19. Know the national guidelines for preventive care; adjust as appropriate for clinical circumstances or patient preferences, and document reasons if these guidelines are not followed.
20. Recognize the limitations of the evidence base and critically review the medical literature for studies that are valid and applicable to the care of older adults.

CEP - Complex Illness (es) and Frailty in Older Adults
21. Identify patients who are frail or otherwise at risk for death, dependency and/or institutionalization over the next few years.
22. Demonstrate the ability to manage the care of patients with multimorbidities by integrating the evidence, patient’s goals, life expectancy and functional trajectory. Document clinical reasoning when management differs from standard treatment recommendations.
23. Demonstrate the ability to manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement, and anxiety.
24. Assess and incorporate family/caregiver needs and limitations, including caregiver stress, into patients’ management plans.
25. Provide geriatric consultation in all settings with attention to multimorbidity, age-related changes in physiology, function, treatment efficacy and response, medication management and psychosocial issues.
26. Regularly re-assess goals of care to recognize patients likely to benefit from palliative and/or hospice care, including those with non-cancer diagnoses (e.g., Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Dementia).

CEP Palliative and End of Life Care
27. Counsel patients and families/caregivers about the range of options for palliative and end of life care.
28. Assess, manage, and provide anticipatory guidance for patients and families/caregivers for common non pain symptoms during severe chronic illness or at the end of life.

Domain: Systems-Based Care for Elder Patients

SBC General
29. Reduce iatrogenic events among elders in all settings through implementation of patient-specific and system-wide strategies to prevent falls*, immobility, delirium*, pressure ulcers*, incontinence*, malnutrition*, indwelling catheter use, nosocomial infections, deep vein thrombi, restraints, depression*, functional decline*.
30. Demonstrate expertise in transitions of care by identifying, with the interprofessional team, the most appropriate care setting(s) for a patient, including independent living, assisted living, long- term care, acute rehabilitation, subacute rehabilitation, home care, primary care at home, adult day care, Program of All-Inclusive Care for the Elderly (PACE)-like program, and hospice based on the needs and preferences of the patient and families/caregivers, and the admission and payment requirements for each setting.
31. Demonstrate expertise in transitions of care by communicating the following to the receiving provider through discussion or timely discharge summary: medication reconciliation, an assessment of patient’s cognition and function, pending medical results and follow-up needs.
32. Demonstrate knowledge of commonly accepted geriatric quality indicators.
33. Participate in quality improvement efforts to enhance the quality of care of older adults.
34. Describe the services provided by Medicare Parts A, B and D, the Hospice Benefit, and by Medicare and Medicaid for patients who are "dual eligible," including the basics of the patient’s fiscal responsibility for each.
35. Identify patient and family/caregiver needs and refer to appropriate local community resources.
36. Recognize and document signs of elder abuse and/or neglect and refer to community resources and adult protective services when appropriate.
37. Recognize the complexity of geriatric care and demonstrate the ability to prioritize care, in a time- efficient manner, during encounters with geriatric patients.
38. Serve as an advocate for older adults and caregivers within various healthcare systems and settings.
39. Recognize health-care **system issues** that negatively impact the care of the geriatric patients, and identify improvement strategies.
40. Demonstrate the ability to **teach** patients, caregivers and others about aging-related healthcare issues.
41. Describe **models of care** that have been shown to improve outcomes for older adults, e.g., ACE Units, PACE, multifactorial interventions to prevent falls, delirium prevention.

**SBC Hospital Care**
42. Reduce **iatrogenic** events (see SBC General #29)
43. Recognize common and subtle presentations of **delirium** and manage appropriately.
44. Perform pre-operative assessments for older patients and document specific **peri-operative** management recommendations to improve patient care and safety based on type of surgery and patient characteristics.

**SBC – Ambulatory Care**
45. Perform and interpret an outpatient **geriatric assessment**, and develop a management plan that includes appropriate consultation with and referrals to other disciplines and community based resources.
46. Recognize patients who are at risk for **hazardous driving**, identify strategies to reduce risk, and integrate state and local laws into the management plan.

**SBC – Home Care**
47. Perform **home visits**, demonstrate modification of the physical exam for the home setting, and assess physical safety of the environment.
48. Refer patients to appropriate **home health and support services** to maximize ability to remain in their homes.

**SBC – Long Term Care and Nursing Home Care**
49. Individualize **LTC patient management** considering prognosis, comorbidity, patient and caregiver goals, and available resources especially in the following situations: (a) consideration for transfer to the acute care hospital; (b) weight loss, dehydration, swallowing disorders; (c) agitation and problem behaviors.
50. Describe the role of a **long-term care medical director** and demonstrate an understanding of nursing home and long-term care regulations and requirements, including the minimum data set.
51. Manage **acute problems in long-term care via telephone** call.

**Domain: Geriatric Syndromes**

**GS - Falls and Dizziness**
52. Perform and interpret common **gait and balance** assessments, recognizing abnormal gaits associated with specific conditions.
53. Conduct an appropriate evaluation of **patients who fall** or are at risk for falling, implement strategies to reduce future falls, fear of falling, injuries, and fractures, and followup on referrals.
54. Evaluate, manage, and refer (when appropriate) patients with symptoms of **dizziness or lightheadedness**, differentiating among those with single or serious causes and those that are multifactorial.

**GS - Cognitive, Affective, and Behavioral Health**
55. Distinguish the clinical presentation and prognosis of **changes in cognition** and/or **affect** among people with normal aging, mild cognitive impairment, dementia, delirium, and depression.
56. Perform, interpret, and articulate the strengths and limitations of the commonly used cognitive and mood **assessment tools**.
57. Identify clinical situations where a **psychiatric referral**, psychological counseling, or neuropsychological assessment is indicated and integrate the findings into the patient’s plan of care.
58. Diagnose and manage the potentially **reversible/treatable causes of cognitive and affective changes** in older adults.
59. Identify and manage depression.
60. Diagnose and manage the causes of **dementia**, including Alzheimer’s disease, vascular dementia, Lewy body dementia, dementia of Parkinson’s disease, alcoholic dementia, frontotemporal dementia, Creutzfeldt–Jakob Disease and Normal Pressure Hydrocephalus as well as other rare causes. Recognize and appropriately refer ambiguous cases for further evaluation.
61. Care appropriately for patients at each **stage of dementia** (mild, moderate or severe) and provide anticipatory
guidance based on prognosis and their goals of care.

62. Assess and manage cognitive, functional, and disruptive behavioral manifestations of dementia, both behaviorally and pharmacologically.

**GS - Pressure Ulcers**

63. Recognize patient risk factors for pressure ulcers, and in high risk patients work with an interprofessional team to develop a prevention plan.

64. Stage pressure ulcers and demonstrate proficiency in describing their clinical characteristics (e.g., size, color, exudate).

65. Develop a treatment plan for pressure ulcers with an interprofessional team, incorporating the indications for surgical and non-surgical treatments for ulcers (e.g., debridement, classes of wound care products and treatments, pressure relieving devices, etc.).

**GS – Sleep Disorders**

66. Provide initial evaluation and management of insomnia and other sleep disorders and, when indicated, refer to a sleep specialist.

**GS - Hearing and Vision Disorders**

67. Screen for hearing loss and recognize when referral is appropriate.

68. Recognize common ophthalmologic conditions associated with aging, including changes of normal aging, cataract, glaucoma, age-related macular degeneration, and refer when appropriate to ophthalmology, optometry and/or low vision services.

**GS - Urinary Incontinence**

69. Evaluate and treat the most common forms of both reversible and chronic urinary incontinence using nonpharmacological interventions where possible.

70. Refer when appropriate for urologic or gynecologic evaluation including urodynamic testing, pessary evaluations, pelvic floor muscle training.

71. Evaluate and manage urinary retention and incomplete bladder emptying including the appropriate use of intermittent catheterization or indwelling bladder catheters.

**GS – Weight Loss and Nutritional Issues**

72. Identify and appropriately evaluate and manage involuntary weight loss.

73. Discuss with patients and families/caregivers the risks and benefits of appetite stimulants, nutritional supplementation, enteral tube feeding, and parenteral nutrition, particularly in patients with advanced dementia or near end-of-life.

74. Identify swallowing disorders in patients with involuntary weight loss or recurrent pneumonias, and work with an interprofessional team to evaluate, manage, and educate patient and caregiver(s) based on goals of care.

**GS - Constipation and Fecal Incontinence**

75. Evaluate and manage constipation and fecal impaction using nonpharmacological and pharmacological modalities.

76. Provide initial evaluation and management of fecal incontinence.
Geriatricians entering into unsupervised practice, in and across all care settings are able to:

1. Provide patient centered care that optimizes function and/or wellbeing.
2. Prioritize and manage the care of older patients by integrating the patient’s goals and values, comorbidities and prognosis into the practice of evidence based medicine.
3. Assist patients and families in clarifying goals of care and making care decisions.
4. Prevent, diagnose and manage geriatric syndromes.
5. Provide comprehensive medication review to maximize benefit and minimize number of medications and adverse events.
6. Provide palliative and end of life care for older adults.
7. Coordinate healthcare and healthcare transitions for older adults with multimorbidity and multiple providers.
8. Provide geriatric consultation and co-management.
9. Skillfully facilitate a family meeting.
10. Collaborate and work effectively as a leader or member of an interprofessional health care team.
11. Teach the principles of geriatric care and aging related health care issues to professionals, patients, families, health care providers and others in the community.
12. Collaborate and work effectively in quality improvement and other systems based initiatives to assure patient safety and improve outcomes for older adults.
Appendix 11:

CURRICULAR BLOCK DIAGRAM FOR CAMC/WVU GERIATRIC MEDICINE FELLOWSHIP

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<th>Month</th>
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<td>GERI IP</td>
<td>GERI IP</td>
<td>GERI IP</td>
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<td>PSYCH</td>
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<td>X2</td>
<td>NH</td>
<td>HV</td>
<td>CONFS</td>
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Details: Geriatrics Inpatient (IP) service includes consults and primary coverage of geriatric/NH/hospice patients in CAMC. 3-4 months.

Hospice includes Hubbard Hospice House (Dr. Boggess et al) & CAMC Inpatient Palliative Care Consult Service (Dr. Cotes) (1 month, approx. 50% or 2 weeks each). Multiple lectures on hospice, palliative care, death & dying and pain management are also provided.

“REO” Rheum/Osteo/Endocrinology includes Osteoporosis/Arthritis Clinics w/Dr. Pfister, Endocrine w/Dr. Grubb & Artz, inpt & outpt consults.

Geri Psych (1-2 months) includes Outpatient GeriPsych Clinic, Inpt GeriPsych consults, Inpatient service w/Dr. Griffith & associates. Includes lectures/demonstrations on neuro/psychological testing.

PM&R (1 month) – Medical Rehabilitation Unit with Dr. Wright at CAMC General, Outpatient, Consults & Exposure to PT/OT/Speech/Assistive Devices. Weekly rehab team meetings and multiple lectures by rehab staff also included.

~3-4 months electives. Can include any other subspecialty of interest (e.g. urology, neurology, wound care, GI), additional block time in LTC, etc.

Research/QI project encouraged to be completed and presented/submitted by end of year. May be ongoing/intermittent through the year on in combination with a clinical rotation/elective (e.g. could do an osteoporosis project during the Rheum/osteoporosis/endocrine rotation).

Ongoing longitudinal outpt/NH/home visits – 2 clinics (usually 1 CAMC, 1 Edgewood), 1 NH (Heartland), 1 Home Visit (incl. Edgewood).

Ongoing conferences 52 wks/yr = 10 confs/month, 2 hrs/week (4 core curric, 4 clinical, 1 journal club, 1 research). Plus frequent extra conferences provided by CAMC/WVGEC (research & geriatrics lunch & learn, WVGS annual meeting, WVGEC literacy program, AGES, AGS national meeting, etc.)

LTC/Clinics/Home Visits (40%) and conferences (10%) take up ~50% of time so hospital/specialty rotations are another 50% of time. Time out of CAMC is ½ month at Hubbard Hospice House and ½ day per week at Nursing Homes, plus possible/variable electives with private specialists in Charleston – all on clinical/teaching staff and seeing inpatients at CAMC but outpatient services may be provided at their own private offices nearby.