



GERIATRIC MEDICINE FELLOWSHIP

PROGRAM

2019-2020

ORIENTATION MANUAL

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INTRODUCTION

The geriatric medicine fellowship was initiated at the University of Texas Southwestern Medical Center (UTSWMC) in September 1999 in response to the growing need for academically trained geriatricians in the United States and in particular in Texas as we anticipate the growth in our elderly population. This fellowship is designed to exceed the training eligibility requirements for the Certificate of Added Qualifications in Geriatric Medicine offered by the American Board of Internal Medicine and the American Board of Family Practice. The program is conducted in conjunction with the accredited residency program in Internal Medicine at the University of Texas Southwestern Medical Center and Affiliated Hospitals.

Program Aims

- 1) Train geriatricians who understand the key principles of geriatric medicine and the health care system and are able to apply them to achieve a high level of quality of care and patient safety.
 - a. Fellows have clinical experiences in multiple health care systems including county, VA and University settings
 - b. Fellows design and implement a project as part of the Clinical Safety and Effectiveness course
 - c. Local and multi-site fellow conferences for board preparation and case presentations
- 2) Prepare geriatricians to manage older patients with diverse cultural and socioeconomic backgrounds across multiple healthcare settings.
 - a. Settings – inpatient (Acute Care of the Elderly unit), clinic (primary care, comprehensive geriatric assessment), home based primary care, skilled nursing facility/long term care, VA Community Living Center, hospice and perioperative care
 - b. Continuity of care across multiple settings
 - c. Understanding how to utilize team based care and community resources to care for specific sub-populations of older adults
- 3) Cultivate future leaders in academic and clinical geriatrics.
 - a. Participation in innovative models of care including post-acute care in the home., NICHE, UTSW POSH, ACE unit
 - b. Submission of poster for AGS
 - c. Opportunities for fellows to teach students and junior trainees (Colleges, Intern conferences)

2019-2020 Geriatric Medicine Fellows

Maria Arbelaez, M.D. - received her MD degree from the Universidad El Bosque, Escuela Medicina Colombiana, in 2001. She completed her residency at UT Health Science Center at San Antonio in 2019. Dr. Arbelaez is drawn to geriatrics because it allows her to spend time with her patients and work with the families to individualize care for each patient. Upon graduation from UT Health Science Center at San Antonio, Maria received the **Excellence in Clinical Geriatrics and Palliative Medicine** award. Her hobbies include reading, traveling and numismatics.

Geriatric Fellowship Training Program Administrative Responsibilities

University of Texas Southwestern Medical Center

Craig Rubin, M.D. – Director and Division Chief

- ◆ Supervises the fellows at the Geriatric Care Center in the Geriatric Assessment Program (GAP) Clinic

Vivienne Roche, M.D. – Director of the Geriatric Medicine Fellowship Program

- ◆ Coordinates all clinical activities, didactic sessions and schedules for the fellows
- ◆ Evaluates program content and coordinates electives for the fellows
- ◆ Supervises Coordinator for Educational Programs

Namirah Jamshed, M.D. – Assistant Program Director of the Geriatric Medicine Fellowship Program

- ◆ Coordinator of the Home Based Primary Care Rotation

Belinda Vicioso, M.D.

- ◆ Supervises fellows at Amelia Court
- ◆ Coordinates the delivery of care at PMH by the fellows
- ◆ Certified Medical Director of Long-term Care

Tara DuVal, M.D.

- ◆ Physician for the Mildred Wyatt and Ivor P. Wold Housecall Program
- ◆ She coordinates the fellows activities at the American Geriatrics Society annual meeting

Thomas Dalton, M.D.

- ◆ Coordinates the ACE Unit at Clements University Hospital
- ◆ Coordinator of the Eisenberg rotation

Sarah Wingfield, M.D.

- ◆ Coordinates the Fellow's participation in the Intern Lectures
- ◆ Coordinator of the Perioperative Optimization of Senior Health (POSH) Program

Abimbola Awodipe, M.D.

- ◆ Director of the Senior House Calls Program at PMH
- ◆ Supervises the fellows at PMH Clinic

Susan Murphy, M.D.

- ◆ Coordinates the Physical Medicine and Rehabilitation rotation

Padraig O’Suilleabhan, M.D.

- ◆ Coordinator and evaluator of the neurology rotation

Kyle Womack, M.D.

- ◆ Coordinator and evaluator of the geropsychiatry rotation

Elizabeth Paulk, M.D.

- ◆ Coordinator and evaluator of the palliative care rotation

Erica Bevilacqua – Administrative Associate

- ◆ Coordinates activities of, and provides administrative support to, Dr. Rubin, Director

Traci Child – Fellowship Coordinator

- ◆ Provides organizational support for the fellowship
- ◆ Coordinates activities of, and provides administrative support to Dr. Roche, Dr. Zuo, Dr. Voit and other division providers
- ◆ Supervises the online recruitment and application process
- ◆ Provides support for the fellowship regarding clinic schedules, maintenance of the geriatrics orientation manual, vacation time, and monthly rotation schedules.
- ◆ Assists the fellows with activities such as orientation, travel arrangements, arranging venues for educational activities, speakers for fellowship didactics, and scheduling.

Dallas VA Medical Center

David Hales, M.D. – Associate Chief of Staff of Geriatrics

- ◆ Responsible for the geriatrics program at the VAMC
- ◆ Ambulatory Clinic Director
- ◆ Community Living Center Director
- ◆ VA Nursing Home Care Unit Director

Patricia Larios, M.D. – Assistant Director of the Geriatric Medicine Fellowship program

- ◆ Coordinates all of the VA activities for the fellows
- ◆ Coordinates the long-term care rotation for the fellows and supervises the fellows’ longitudinal experience in long-term care

- ◆ Supervises the schedules for VA rotations
- ◆ Evaluates the fellows at the Veterans Administration Medical Center
- ◆ Supervises educational activities for the fellows

Geriatric Medicine Staff Physicians at the Veterans Administration Medical Center

Patricia Larios, M.D.

Barry O'Neal, M.D.

Tina Wald, M.D.

Elizabeth Polanco, M.D.

George Stephen, M.D.

Cody Wankowicz – Administrative Staff

- ◆ Provides administrative support to Chief, Geriatrics and the Geriatrics office
- ◆ Supervises the clerical staff

POLICIES AND PROCEDURES

UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER POLICIES AND PROCEDURES LINES OF RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION TRAINEES

All UT Southwestern Medical Center's Policies for Graduate Medical Education
Are found at:

<https://www.utsouthwestern.edu/education/graduate-medical-education/policies/>

A. POLICY

It is the policy of UT Southwestern to delineate clear lines of responsibility between geriatric medicine fellows and internal medicine residents in a manner consistent with the educational goals of the applicable residency program and proper patient care.

B. LINES OF RESPONSIBILITIES

Geriatric Medicine Fellows

1. The lines of responsibilities are identical at all teaching hospitals, namely Parkland Health and Hospital System (PHHS) and Veterans Affairs North Texas Health Care System (VANTHC).
2. Geriatric Medicine Fellows will be closely supervised by attending physicians during every clinical experience throughout the fellowship in a manner that is consistent with the ACGME program requirements. Supervision shall be structured to provide fellows with progressively increasing responsibility commensurate with their level of education, ability and experience. For each rotation, geriatric fellows will be given a clear means of identifying supervising physicians, including faculty, who share responsibility for patient care on each rotation. There must be a prompt means of accessing input and assistance from these physicians.
3. During rotations where there are no internal medicine interns or residents, the geriatric fellow will provide care to patients under direct supervision by faculty and will directly report to the supervising faculty.
4. During rotations where the geriatric fellow is present with internal medicine residents the following lines of responsibility apply. The internal medicine interns and senior residents will take care of assigned patients in commensurate with their degree of knowledge and level of training and will maintain their lines of responsibility as outlined by the Internal Medicine Program Director. The geriatric fellow will be a member of the team and will be assigned patients by the attending and will provide care for these patients in keeping with his level of training. The geriatric fellow will directly report to the attending on that rotation. The geriatric medicine fellow will not directly supervise the internal medicine interns or residents. The geriatric fellow will be a senior member of the team and may

provide additional guidance to the internal medicine residents. The geriatric fellow is responsible to and directed by the Attending Physician on that rotation. The faculty attending is responsible for all medical care and teaching on that rotation. The attending physician's decisions are final.

5. During rotations where the geriatric medicine fellow provides consults to medical resident teams, the geriatric fellow is supervised for the geriatric consult by the geriatric attending on that rotation.

Legal Responsibilities

The ultimate legal responsibility of the program is vested in a) Chair of Internal Medicine b) Program Director of the Internal Medicine Program and c) Geriatric Medicine Program Director.

**UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER
POLICIES AND PROCEDURES
PATIENT CARE RESPONSIBILITIES AND FELLOW SUPERVISION**

A. POLICY

It is the policy of UT Southwestern to delineate patient care responsibilities and fellow supervision in a manner consistent with the educational goals of the applicable residency program and proper patient care.

B. PATIENT CARE RESPONSIBILITIES

Geriatric Medicine Fellows

1. Patient care responsibilities are identical at all teaching hospitals, namely Parkland Health and Hospital System (PHHS) and Veterans Affairs North Texas Health Care System (VANTHC)
2. Patient care responsibilities include: data gathering, diagnostic test requisition, interpretation of data, therapy administration, patient management, and plan of care implementation. Integral to this process is the development of a therapeutic relationship with patients and their families. The geriatric fellow carries out his/her patient care responsibilities as a member of an interdisciplinary team.
3. When patients are admitted to an internal medicine team, the internal medicine team provides full care for that patient as per the Internal Medicine Program Director. This care is under the direct supervision of the attending.
4. During rotations where there are no internal medicine interns or residents, the geriatric fellow will provide care to patients in accordance with their level of education, ability and experience under direct supervision by faculty.
5. During rotations where the geriatric fellow is present with internal medicine residents the following patient care responsibilities apply. The internal medicine interns and senior residents will take care of assigned patients in commensurate with their degree of knowledge and level of training as outlined by the Internal Medicine Program Director. The geriatric fellow will be a member of the team and will be assigned patients by the attending and will provide care for these patients in keeping with his level of training. The faculty attending is responsible for all medical care and teaching on that rotation. The faculty attending supervises the Geriatric Medicine fellow. The Attending Physician's decisions are final.
6. During rotations where the geriatric medicine fellow provides consults to medical resident teams, the geriatric fellow is supervised by the geriatric attending on that rotation.

GRIEVANCE DUE PROCESS POLICY

**All UT Southwestern Medical Center's Policies for Graduate Medical Education
Are found at:**

<http://www.utsouthwestern.edu/utsw/cda/dept30273/files/571270.html>

**MOONLIGHTING POLICY OF THE INTERNAL MEDICINE PROGRAM
AT THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL**

**All UT Southwestern Medical Center's Policies for Graduate Medical Education
Are found at:**

<http://www.utsouthwestern.edu/utsw/cda/dept30273/files/571270.html>

Overall Educational Goals and Objectives

The overall goals and objectives for geriatric medicine fellows are to gain extensive experience in the diagnosis and ongoing management of elderly patients with multiple medical problems across a variety of health care settings.

Program Design

The Geriatric Medicine Fellowship program is a one-year clinical program. Goals and objectives have been established for the Geriatric Medicine fellows. These are primarily aimed at gaining experience in the daily management and provision of continuity care to elderly patients, paying particular attention to their functional status and cognitive ability. In general the expectations of fellows include demonstration of medical knowledge, comprehension of pathophysiology, development of differential diagnoses, formulation of management plans, and dissemination of plan of care by presentations in various clinical settings and at clinical conferences. The care and management of geriatric patients will be specifically addressed in inpatient, ambulatory, house call and long term care settings. The fellows are expected to review their practice, formulate a question, get appropriate IRB approval, if indicated, collect data, analyze the results and make recommendations. The fellows are also active members of interdisciplinary teams and teach internal medical residents and medical students.

1. Patient Care. Provide care that is compassionate, appropriate, and effective for the treatment of patients and the promotion of health within a variety of health care systems.

2. Medical Knowledge. Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavior knowledge needed by a geriatrician; demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

3. Interpersonal and Communication Skills: Demonstrate interpersonal and communications skills that result in meaningful and timely information exchange and partnering with patients, their families and professional associates.

4. Practice Based Learning and Improvement: Demonstrate knowledge, skills and attitudes needed for continuous self-assessment, using scientific methods and evidence to investigate, evaluate, and improve one's patient care practice.

5. Professionalism: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity within the cohort of patients fellows encounter during the fellowship.

6. Systems Based Practice: Understand how to practice high quality, safe, effective, health care and advocate for patients within the complexity and transitions across the health care system.

Patient Care

Fellows are taught how to deliver high quality of care that is compassionate, appropriate and effective. As with many of the competencies there is significant overlap between competencies. Thus, this competency domain shares many of the tenets of several other competencies, such as professionalism, medical knowledge, interpersonal skills and systems-based practice.

Fellows are expected to provide

- Patient care proficiency for patients with common diagnoses and uncomplicated patients.
- Patient care in non-routine, complicated patients and under increasingly difficult circumstances.
- Thorough case presentations on new patient consults, during inpatient service, in outpatient clinics and at clinical conferences; documentation in the medical record that is detailed and appropriate along with pertinent diagnostic studies
- Expertise regarding utility of geriatric assessment tools such as MOCA, Mini Cog, GDS and gait assessment during their care of patients
- Patient care that is specific to the subspecialty of Geriatric Medicine as listed below under medical knowledge.

Medical Knowledge

Proficiency in this competency includes knowledge of biomedical, clinical, and epidemiological domains. Individual fellows will be taught and evaluated based on their ability to acquire and access new knowledge, interpretation of information and then how to apply this information to clinical settings specifically the individual patient.

- Knowledge of Geriatric Medicine, including but not limited to cognitive impairment, depression, falls, incontinence, osteoporosis, sensory impairment, pressure ulcers, sleep disorders, pain, elder abuse/neglect, malnutrition, polypharmacy, health maintenance, and functional impairment.
- Knowledge of diseases that are particularly prevalent in older patients and may have different clinical presentations including but not limited to neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic and infectious diseases.
- Knowledge of pharmacologic issues and aging, including polypharmacy, side effects, adverse drug events, drug interactions, adherence, costs, and changes in pharmacokinetics and pharmacodynamics in older patients
- Knowledge of geriatric principles of rehabilitation, the optimal use of physical occupational, and speech therapy, exercise, functional activities, assisted devices, environmental modification and various intensities of rehabilitation.
- Knowledge of perioperative assessment and management.
- Knowledge of the pivotal role of formal and informal caregivers and families and the formal community support systems available.
- Knowledge of long term care, including palliative care, knowledge of the administration, regulation and financing of long-term institutions and the continuum of safe and timely transitions across care settings.

- Knowledge of home care, including components of home visits, and appropriate community services
- Knowledge of hospice including pain management, symptom relief, comfort care and end-of-life decisions
- Knowledge of cultural aspects of aging, including demographics, health care status, diverse ethnicities, access to health care
- Knowledge of iatrogenic disorders and their prevention
- Knowledge of the economic aspects of supporting geriatric services including Title III of the Older Americans Act, Medicare, Medicaid, capitation and cost containment
- Knowledge of the ethical and legal aspects of elderly care, including limitation of treatment, competency, guardianship, right-to-refuse treatment, advanced directives, designation of a surrogate decision maker for health care, wills and Durable Power of Attorney for medical affairs.
- Knowledge of research methodologies including clinical epidemiology, decision analyses and critical literature review.

Interpersonal and Communication Skills

This competency domain contains two areas – communication skills, and interpersonal skills. Communication skills include effective verbal, nonverbal and written communication with patients, interdisciplinary team members and the public. It includes obtaining a history, obtaining informed consent, telephone triage, case presentation, writing consultation notes, informing patients of a diagnosis and implementing a plan of care. Interpersonal skills involve teamwork and relationship-building skills. Effective communication creates and sustains a professional and therapeutic relationship across a broad range of socioeconomic and cultural backgrounds.

Fellows are expected to

- Communicate effectively with patients, families and the public from diverse socio-economic and cultural backgrounds
- Communicate effectively with physicians, interdisciplinary team members and health related agencies
- Work effectively as a member or a leader of a health care team
- Act in a consultative role to other physicians and health professionals
- Maintain comprehensive, timely, and legible medical records

Practice-based Learning and Improvement

Life-long learning and quality improvement is at the core of this competency domain. Fellows are trained to engage in Plan-Do-Study-Act (PDSA) cycles for quality improvement in their individual practice. The skills and practice of Evidence-Based Medicine are incorporated into the fellowship.

Fellows are expected to

- Identify strengths, deficiencies, and limits of personal knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health concerns
- Use information technology to optimize learning
- Participate in the education of patients, families, students, residents and other health professionals.
- Meet with the attending of the month every 2 weeks, review monthly evaluations in a timely manner and meet with the Program Director every 6 months to review performance, and incorporate this feedback into a personal plan for professional development.
- Actively seek out and listen to constructive feedback from other members on the care team as well the patients and families and incorporate this feedback, when appropriate, into a plan for professional development.

Professionalism

Proficiency in this competency is integral to the other competencies. Fellows must demonstrate an adherence to ethical principles. They must make a commitment to their professional responsibilities and demonstrate sensitivity to their patients and the interdisciplinary team members.

Fellows are expected to:

- Consistently maintain compassion, integrity, and respect for others.
- Respond to patients needs that supersedes self-interest
- Demonstrate a commitment to excellence and ongoing professional development by being prepared, on-time, in appropriate attire and contributing to rounds, teaching conferences and didactic lectures.
- Respect patient privacy and autonomy
- Honestly assess one's contribution to errors that are made, accept responsibility for personal mistakes and implement plans to prevent one's self and others from making the mistake again
- Comply with institutional systems that have been developed to prevent errors
- Avoid using ambiguous or unacceptable abbreviations in the medical record, prescriptions and medical orders
- Remain accountable to patients, society and the profession of medicine

- Be sensitive to and respond to a diverse patient population, including but not limited to gender, age, culture, education, race, religion, disabilities, cognition, function and sexuality.

Evaluations of this competency are based primarily on commitment, adherence and sensitivity.

Commitment means respect, altruism, integrity, honesty, compassion, empathy and dependability; accountability to patients and society; and professional commitment to excellence.

Adherence means accepting responsibility for continuity of care; and practicing patient-centered care based on confidentiality, respect for privacy, patient autonomy and informed consent and shared-decision making.

Sensitivity means showing sensitivity to diverse cohorts of patients and appropriate recognition and response to physician impairment.

Systems Based Practice

This competency domain recognizes the multiple layers within the healthcare system. It includes the user – patient and families; the purchaser – employers, government; insurers – Medicare, Medicaid, commercial; delivery systems – hospitals, physician networks, drug and technology companies, community resources; work group – local entities providing care such as hospitalist service; and providers – physicians, nurses, and other health care professionals as individuals or groups/teams.

Fellows are expected to:

- Work effectively in various health care delivery settings and systems
- Coordinate patient care within the health care system
- Prioritize the various modes of diagnostic testing and select the most appropriate testing modality, with a goal toward preventing unnecessary laboratory or imaging tests
- Acknowledge medical errors in a forthright manner, and report observed medical errors (real or potential) to the appropriate member of the care team, then work with the team to develop a plan to prevent future errors
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and implementing potential systems solutions

Competencies

Patient Care	<p>Direct supervision at all clinical venues</p> <p>Monthly evaluations</p> <p>360° evaluation</p> <p>Semi-Annual Review</p>
Medical Knowledge	<p>Direct supervision at all clinical venues</p> <p>Didactics – July / August in-house schedule</p> <p>Monthly evaluations</p> <p>Semi-Annual Review</p> <p>Oral Exam</p> <p>Board Review Course</p> <p>Grand Rounds</p> <p>Fellowship Conferences</p> <p>Attendance at National Meetings</p> <p>Board Review pass rates</p> <p>Journal Clubs</p> <p>Geriatric Review Syllabus</p>
Interpersonal and Communication Skills	<p>Direct supervision at all clinical venues</p> <p>Monthly evaluations</p> <p>Chart reviews</p> <p>Consult service</p> <p>360° evaluations</p>
Practice-Based Learning	<p>Direct supervision at all clinical venues</p> <p>Direct observation of patient care</p> <p>Supervised observation of health professional, residents and medical student education</p> <p>Presentation at Geriatric Grand Rounds</p> <p>Review course packet, review literature, submit proposal, receive IRB approval, gather and analyze data, present findings to faculty to change current practices.</p>
Professionalism	<p>Direct supervision at all clinical venues</p> <p>Monthly evaluations.</p> <p>Ethics lectures</p> <p>360° evaluations</p> <p>Didactics.</p>
System-Based Practice	<p>Direct supervision at all clinical venues.</p> <p>Monthly evaluations.</p> <p>Supervision in a variety of settings: ambulatory care, house call program, hospice, assisted living, acute care, community living center.</p> <p>360° evaluations</p>

Overview of Clinical Activities and Responsibilities

The Geriatric Medicine curriculum has been specifically designed to ensure that each fellow has the opportunity to achieve the knowledge, professional attitudes, and practical experience required of a physician caring for the elderly patient. Each fellow will participate in and will be closely supervised by trained faculty in the clinical activities described below. Each portion of the fellowship has clearly defined expectations, objectives, and goals. Both the preceptor and the fellow are expected to complete timely written evaluations.

As peer interaction is essential for the fellows, each fellow will gain experience teaching nurses, allied health personnel, medical students and residents both in a structured and in an informal way. One of our strengths is the close association of this fellowship with Physical Medicine and Rehabilitation, Neurology and Geropsychiatry accredited training programs at The University of Texas Southwestern Medical Center at Dallas.

The fellowship is divided into two major sections:

- I. Longitudinal
- II. Block rotation

Longitudinal Rotations

Longitudinal clinical experience with patients is an integral part of this fellowship. Fellows will participate in these experiences throughout the 12-month program. During block rotations fellows will continue to serve their longitudinal patients and will be available to both the patients and their interdisciplinary team members. Fellows will attend three weekly outpatient clinics and provide continuity of care for their cohort of long-term care patients, hospice patients and homebound patients. Each of the block rotations have been designed with periods of open time so that fellows can honor these commitments.

1. Ambulatory Clinics

Primary Care Geriatric Clinic: Fellows will have two ambulatory clinics each week at two different sites: Parkland Memorial Hospital and at the Geriatric Care Center at the University of Texas Southwestern Medical Center. These different venues will provide fellows with diverse minority, ethnic and social experiences, and will provide 1-3 new patients per week and 4-8 follow-up visits each week, allowing the fellows to spend a minimum of a third of their time providing continuity of care.

2. Long-term Care

At the beginning of the year fellows will be assigned 6-8 long-term care patients at the Dallas VA Medical Center. Patients will be chosen from a diverse cadre of patients not only from a medical standpoint, but also with respect to ethnic and social diversity. The fellows will follow these patients longitudinally throughout the year. As their patient census changes, the long-term care coordinator will assign new patients. Fellows will have primary responsibility and management for these patients including on call duty.

3. Home Based Primary Care Program

The Home Based Primary Care Program is focused on providing comprehensive longitudinal care, to older people with multiple chronic conditions and functional impairment. Fellows will participate in providing care to a total of 4 HBPC patients from both community and assisted living. Fellows will be responsible for seeing their continuity patients once a month. They will also be assigned as the PCP for the patient, and therefore responsible for all care, including medication management related to their patients in between the visits. Fellows will be assigned two patients each, one for the Parkland Senior House Call Program, and the other from COVE (care of the vulnerable elderly) program at UT Southwestern Medical Center. The first visit for their patients should be made with the physician. Fellows are responsible for informing the house call coordinator, when they will be making the subsequent visits. Any changes should be communicated directly to the coordinator.

4. Hospice

The inpatient hospice program is located at the Dallas VA Medical Center and directed by Dr. Elizabeth Polanco. Each fellow will be the primary care doctor for one to two hospice patients at any given time. The hospice patients will be selected by diagnosis to provide a wide breath of experience to the fellows (e.g. patients with head and neck cancer status post radiation, patients with end stage COPD or end stage CHF). Selection will also favor diverse psychosocial issues. Each fellow will provide hospice care, which will include clinical evaluations, pain management, symptom relief, comfort care, and end-of-life issues under careful supervision. Fellows will work closely with the interdisciplinary team to facilitate patient and family/caregiver issues.

Block Rotations

During the year fellows will have specific block rotations that focus and concentrate on important areas of geriatric medicine including rehabilitation, neurology, geropsychiatry and palliative care. The rotations are monthly unless otherwise specified. Each rotation has an evaluation form to be completed at the end of service by both the geriatric medicine fellow and the faculty. These evaluations will be used as part of an ongoing quality assurance program implemented to improve, modify and update the program. Included in the block rotation schedule are two months of electives. Every fellow will choose an elective at least four months in advance so suitable arrangements can be made. Examples of topics selected by the fellows in the 2007-8 academic year included urinary incontinence and long-term care in the community.

1. Eisenberg Service

Fellows will spend one month on the Eisenberg Service where they will gain hands-on experience in the inpatient care of older adults. They will perform geriatric assessments on all patients over the age of 65. They will work with a team consisting of medical students, interns and residents, where they will teach on geriatric issues that arise while on service.

2. Palliative Care/ Ethics

Fellows will spend one month focusing on hospice and ethical issues. During this month they will do 2 weeks palliative care consults at Parkland Memorial Hospital as first on call for the palliative care consult service and 2 weeks at VA Inpatient Hospice. Currently there are 30-40 consults per month on this service. They will also attend the deliberations of the PMH ethics committee which review 3-5 ethics consults per month. In addition, the Education of Physicians on End-of life Care (EPEC) curriculum will be presented to the fellows during their palliative care month. This is a core curriculum developed by the AMA Institute of Medical Ethics with support from a grant from the Robert Wood Johnson Foundation specifically designed to train physicians in the provision of end-of-life care to patients and their families. Three UT Southwestern faculty members (two are geriatric medicine faculty) have been trained as trainers for the EPEC curriculum. Each fellow will have access to this material and interaction with faculty who are part of the EPEC project.

3. Neurology

Fellows will spend one month focusing primarily on neurology. During this month of intensive neurology training fellows will attend a series of comprehensive neurology didactics and participate in ambulatory clinics including general neurology, stroke, ALS and Parkinson's and movement disorder clinics. The neurology coordinator will oversee a radiology session including interpretation of MRIs and CT scans for geriatric diseases, such as Alzheimer's disease and vascular dementia.

4. Physical Medicine and Rehabilitation (PM&R)

One month will be devoted to PM&R and includes inpatient and outpatient PM&R experiences. One week of the four-week block rotation is located on the acute inpatient rehabilitation unit at Zale-Lipshy University Hospital and three weeks are located in PM&R general and specialty clinics at Parkland Memorial Hospital. Fellows will learn about different rehabilitation settings including acute rehabilitation, subacute rehabilitation, pulmonary and cardiac rehabilitation. During this month fellows will become knowledgeable in selecting and fitting the most appropriate type of assistive devices for individual patients. Fellows will learn the unique role of the physiotherapist, the occupational therapist and the speech therapist in the interdisciplinary team.

5. VA Community Living Center

Fellows will spend three months at the Community Living Center (CLC) at the Dallas VA Medical Center. The CLC receives consults from both the surgical and medical teams at the VA hospital. During their time on the CLC, the fellows will triage patients and decide who would benefit most by transfer to the Unit, as well as the continuum of care from acute to sub-acute care and then appropriate and timely disposition to permanent residence. Each successive month will see the fellow take on more responsibility and the third month will be directed by the fellow under faculty supervision.

6. Geropsychiatry

Fellows will spend one month focused on geropsychiatry at both Parkland Memorial Hospital and Dallas VA Medical Center. They will spend time at the Alzheimer's Disease Center and participate in neuropsychometric testing and interpretation. Recognition and treatment of common diseases in geropsychiatry, such as depression, anxiety and paranoia will be an important focus of this rotation. They will attend primary care psychiatry clinics and specialty psychiatry clinics. They will evaluate ECT, its benefits and complications and its long and short- term side effects. Fellows will have the opportunity to interact closely with Adult Protective Services.

7. House Calls

Fellows will spend one month rotating through HBPC experience at UTSW, the VA and Parkland House call programs. Fellows will be assigned patients that they are to see for follow up during that month. Each fellow is expected to see at least 2 patients per half day at the minimum. Fellows will coordinate to schedule these appointments with the coordinator themselves. Additionally, fellows will be available for "urgent visit" house calls on Fridays during the rotation. Fellows will also be required to do at least ONE hospital discharge follow up visit during their four-week rotation. Fellows will attend team meetings with UTSW and Parkland IDT as scheduled

Consultation Services

- Longitudinal outpatient consultation service as part of the yearly ambulatory experience.
- Palliative Care consults-as part of the palliative care rotation. Fellows will be first on call for all consults to the palliative care service at Parkland Memorial Hospital.
- Geriatric Care Clinic GAP patients.

EDUCATION

In addition to direct patient care responsibilities in a variety of clinical settings, the fellows will be provided with a variety of didactic lectures and learning experiences. Extensive library materials and services are available to the fellows at the UT Southwestern/ Parkland Hospital and Dallas VA Medical Center.

Core Lecture Series

There is a core lecture series of key topics presented during the first 2 months of the fellowship. Each week during July and August the fellows will receive 2-4 didactics. The July lectures will take place at the Dallas VAMC, and the August lectures will take place at the UT Southwestern Medical Center. These didactics are given by geriatric faculty, internal medicine faculty, basic science researchers and allied health care professionals. Topics are diverse and include normal aging, the physiology of aging, theories of aging and longevity, geriatric syndromes, health maintenance, instruments designed to measure cognitive function, dental care, methods to assess for depression and community resources.

Fellows Core Curriculum Conference

Beginning in September, the fellows will meet with geriatric faculty for a weekly curriculum meeting four times a month. For thirty minutes there will be a discussion on the GRS and for thirty minutes there will be a case presentation. The fellows will be pivotal in deciding the nature of these discussions and both faculty and fellows will present topics. The curriculum for these meetings is based on the Geriatric Review Syllabus published by the American Geriatrics Society.

Journal Club

The Geriatric Journal club takes place quarterly on the second Thursday of the month.

Geriatric Grand Rounds

There is a weekly UT Southwestern Geriatric Grand Rounds series that is mandatory for the fellows to attend. This Grand Rounds series is scheduled from September to May, meets the criteria for the Physician's Recognition Award of the American Medical Association and the 33 CME Credit hours have been endorsed by the American Geriatrics Society (AGS) and may be counted towards the AGS Geriatrics Recognition Award. The series delivered by UT Southwestern faculty and invited guest lecturers includes a wide range of topics that discuss both basic science and clinical perspectives pertinent to geriatric medicine. During the year of training, the fellows are expected to prepare a scholarly talk based on current scientific and clinical research for this venue.

Attendance at National Meetings

Educational leave is provided for the fellows so they can attend at least one national meeting (American Geriatric Society, Gerontologic Society of America OR American Medical Director Association meeting). Any prospective meeting plans must be discussed in detail with the program director in advance. The Internal Medicine Education Office allows each fellow \$1200 per year for educational activities, which includes attendance at national meetings.

Library Resources

Fellows have full access to libraries at UT Southwestern, the Dallas VA Medical Center, and the Geriatric Medicine faculty's own personal libraries.

The UT Southwestern library has 1,837 current journal subscriptions; 1,028 full-text electronic journals; 94,932 books; 257,782 volumes in all formats; and a full-time staff of 59. In addition the library maintains an extensive Internet site that enables users to do Ovid Medline searches as well as search the library's electronic journals, electronic books, and library catalog from any on-campus computer. Fellows will have a user I.D. that enables them to access the Internet library from off-campus as well. The library is open 101 hours weekly, seven days per week.

Upon the start of the fellowship, fellows take the library's hands-on class "Ovid: MEDLINE, Current Contents Search and More." The course covers finding elusive journal article references, setting up a personal update service, finding and viewing full-text articles on the computer screen, placing online document delivery orders for articles and using the web version of the library's Ovid system. The library has also developed two very good programs relating to information proficiency. One program is designed to teach fundamental literature searching and the second teaches evidence-based searching techniques.

The Dr. Eisenberg Medical Library at the Dallas VA Medical Center is dedicated to geriatrics and gerontology and includes up-to-date written materials and computer access.

Geriatric Medicine Fellowship

July Lecture Series @ VA

2019

Monday	Tuesday	Wednesday	Thursday	Friday
Unless schedule states otherwise , you will be at the VA all day for LTC rotation w/Dr. Patricia Larios.				
1	2	3	4	5
<p>8:30 – 12:30 EPIC Training at Parkland, Bass Bldg</p> <p>2-5 Ameila Ct. Orientation (you may park in the lot at Amelia Ct)</p>	<p>8:00 Arrive at CLC @ VA – go to the Geriatrics office to meet w/Cody Wankowicz.</p> <p>9-10 Orientation w/Dr. Patricia Larios in CLC Conference room.</p> <p>10-5 Long Term Care @ VA w/Dr. Patricia Larios</p>	<p>8-5 – Long Term Care @ VA</p>	<p>HOLIDAY</p>	<p>8-5 – Long Term Care @ VA</p> <p>Melanie Rue, PA 10-11am</p> <p>Managing CPRS Clinical Reminders</p>
8	9	10	11	12
<p>8-12 Open</p> <p>1-5 Amelia Ct</p>	<p>8-5 – Long Term Care (LTC) @ VA</p> <p>Julie Black, RD</p> <p>Nutrition, what a fellow needs to know</p>	<p>8-5 – Long Term Care (LTC) @ VA</p>	<p>Stacy Garland, RN 9-10 am</p> <p>Restorative care at CLC</p>	<p>8-5 – Long Term Care @ VA</p> <p>Dr. Hong 12-1pm</p> <p>Delirium</p>
15	16	17	18	19
<p>8-12 Fellow's Clinic POB II</p> <p>1-5 Amelia Ct</p>	<p>8-5 – Long Term Care @ VA</p>	<p>8-5 – Long Term Care @ VA</p> <p>Gloria Hendler, RN 9-10 am</p> <p>What is MDS!</p> <p>Noon – 1 Most Difficult Case conference call</p>	<p>UTSW All Day</p> <p>8:15 – 8:45 Photos w/Beni</p> <p>9-12 Orientation w/Dr. Roche</p> <p>1-3 Library Orientation</p> <p>3-4 Home Based Primary Care orientation w/Dr. Jamshed</p>	<p>8-5 – Long Term Care @ VA</p> <p>Dr. Hales 10-11 am</p> <p>Pathophysiology of aging</p> <p>Kalin Clifford PHD 11-12pm</p> <p>Pharmacy Pearls</p>
22	23	24	25	26
<p>8-12 Fellow's Clinic POB II</p> <p>1-5 Amelia Ct</p>	<p>8-5 – Long Term Care @ VA</p> <p>Elaine Parkhurst, PT 1-3 pm</p> <p>Subacute rehabilitation</p>	<p>8-5 – Long Term Care @ VA</p> <p>Dr. Wald 9-10am</p> <p>Evaluation of fever in the NH patient</p>	<p>8-5 – Long Term Care @ VA</p> <p>Natasha Edmondson, PhD 9-10 am</p> <p>Anticoagulation in the Geriatric patient</p>	<p>8-5 – Long Term Care @ VA</p> <p>Dr. Lamb 9-10 pm</p> <p>Decision Making capacity</p>
29	30	31		
<p>8-12 Fellow's POB II Clinic</p> <p>1-5 Amelia Ct</p>	<p>8-5 – Long Term Care @ VA</p> <p>Dr. Bakhtiani 3-4 pm</p> <p>Osteoporosis</p>			

All lectures will be held at the CLC conference room, except the lecture on Subacute Rehabilitation on 7/23/19, which will be held at the CLC PT gym.

August Lecture Series @ UTSW Geriatric Fellows

2019

Monday	Tuesday	Wednesday	Thursday	Friday
			1	2
5 8-12 POB II Clinic 1-5 Amelia Court	6	7 8-9 "Depression" Dr. Vicioso	8 8-9 "Billing & Coding" Dr. Jamshed, Location TBD?	9
12 8-12 POB II Clinic 1-5 Amelia Court	13 8-9 "Estimating Prognosis in Older Adults" – Dr. Wingfield	14 8-9 "Urinary Incontinence" – Dr. Rubin	15 8-9 – "Atypical Presentation of Disease" – Dr. Roche	16
19 8-12 POB II Clinic 1-5 Amelia Court	20 8-9 "Osteoporosis" – Dr. Rubin	21 8-9 "Elder Abuse" and "Functional Assessment" Dr. DuVal	22 8-9 "Frailty" – Dr. Wingfield	23 8-9 "Overview of Palliative Care" – Dr. Alexis Barina
26 8-12 POB II Clinic 1-5 Amelia Court	27 8-12 Polypharmacy w/Shelley Bingham, Pharm D	28 8-9 "Delirium" – Dr. Roche	29 8-9 "HHC" – Dr. Roche	30 8-9 "Dementia" – Dr. Vicioso

12 MONTH SCHEDULE
Geriatric Fellowship
2019-2020

	VA	VA	UT	PARKLAND	PARKLAND	PARKLAND	PARKLAND	PARKLAND	
	Long Term Care* (Larios) VA	CLC (Larios) VA	Eisenberg Service (Dalton) CUH	Neurology (O'Suilleabhain)	PM&R (Murphy)	Hospice/ Palliative Care* (Pauk)	Home Based Primary Care (Awodipe)	Geropsych* (Womack)	Electives PMH/VAMC*
July	MA					EB			
August		EB (1-9)					MA		
Sept.		MA							
Oct.				MA					
Nov.									MA
Dec.		MA							
Jan.			MA						
Feb.								MA	
Mar.					MA				
Apr.									MA
May		MA							
June						MA			

*Dallas VAMC

MA – Maria Arbeleaz, M.D.
EB – Emily Bowen, M.D.

Revised 10/17/19

PROGRAM EVALUATION

Monthly evaluations

At the beginning of each rotation, each fellow will sit down with the attending of the month and review the goals and objectives for each month. Fellows will evaluate and be evaluated both in oral and written format monthly.

Mentor evaluations

Each fellow will be assigned a designated faculty mentor, who will meet with the fellow on an informal but regular basis (at least every three months). This will benefit the fellow by providing a venue for problem solving and career development.

Clinic evaluations

Fellows will evaluate and be evaluated every 6 months as part of their ambulatory care experience. In addition the fellows will evaluate each other in the chart review evaluation format as part of the peer evaluation for timely, concise, accurate and comprehensive medical charting.

360 Evaluations

Fellows will be evaluated by the interdisciplinary team members and by the patients on a semiannual basis. Forms are enclosed.

Oral Exam

In the second quarter of the fellowship each fellow will participate in an oral exam attended by three or more faculty where fellows will be given written cases to review and will be asked to respond to a series of questions. There will be four cases and fellows are given one hour to complete the examination. Cases will include a house call patient, a nursing home resident, an ambulatory care patient and a hospice patient. The cases are provided in written format to provide uniformity so that fellows can be evaluated in an objective setting.

Semiannual evaluations

Fellows will meet with the program director twice a year for a complete review of the preceding interval. In addition to reviewing the fellows' progress, achievements and future goals, they will review all of the evaluations, determine current progress, and identify areas of strengths and areas that may be improved. Each fellow is encouraged to continuously review the monthly rotation evaluations so that they are aware of areas of strengths and weaknesses in a timely fashion.

Annual Review

At the end of the fellowship the Program Director will review the overall performance of each fellow prior to completion of the fellowship and provide a summary of the fellow's performance based on all evaluations submitted for review.

End of the year evaluation

At the end of the year, fellows are asked to evaluate the program. They are asked to note its strengths and weaknesses and any additional comments after they have completed the program so that we can continuously improve the program.

Examples of the evaluation forms are available for review.

Fellow/Advisor Worksheet

FELLOW _____ ADVISOR _____

DATE OF MEETING _____

The purpose of this form is to document both the fellow and the advisor's perceptions of his/her own progress.

I. **FELLOW'S PROGRESS** (Take into consideration the following: Attitudes - The geriatric fellow is developing appropriate attitudes and behaviors. Progress - The geriatric fellow is learning geriatrics - that is, developing knowledge and skills appropriate for this stage of the fellowship.)

II. **FELLOW'S EVALUATION OF PROGRAM** (Fellow's perception of his/her strengths and weaknesses as a fellow/physician.)

III. **TRAINING** (Is the training meeting the fellow's personal educational goals and expectations?)

IV. **ADDITIONAL COMMENTS ON THE FELLOWSHIP PROGRAM**
(Feedback on rotations, teaching conferences, discussion of research plans, etc.)

Faculty Advisor Signature _____ Date: _____

Fellow Signature _____ Date: _____

CLINICAL ROTATIONS

Long-Term Care

Nursing Home

Coordinator: Dr. Patricia Larios

One of the most important continuity-of-care experiences for the fellows is long-term care. Geriatric fellows will spend the first month of their fellowship participating in a nursing home rotation at the Dallas VA Community Living Center (CLC). The CLC is a 120-bed unit that is attached to the main VA Hospital.

During this rotation, the fellows will be exposed to the tenets of nursing home care. This rotation will include both clinical and teaching experiences.

Clinical Experiences:

During the nursing home rotation, fellows will be exposed to geriatric rehabilitation, wound care, palliative care/hospice and respite care. Fellows will be assigned 3-4 patients at the start of the nursing home rotation, and will then admit 1-2 patients per week during the remainder of the month. Each fellow will be assigned patients with a view to optimal case mix such as patients with stroke, congestive heart failure, chronic pulmonary conditions, pressure ulcers and patients with dementia with behavioral problems. Fellows are expected to follow their patients throughout the remainder of the fellowship year or until the patient is discharged. Time will be arranged during non-VA rotations to allow the fellows to provide continuity of care for these patients.

Fellows will complete H and P's on all new patients they admit, and write regular progress notes. H and P's should contain all the elements of a complete geriatric assessment. After seeing each patient, the assessment and plan is discussed with the attending and all notes (H and P's and progress notes) are forwarded to the attending for co-signature. When patients require admission to the acute care hospital, the fellow communicates with emergency room and admitting physician to coordinate the patient's care and transition to and from the facility.

Fellows attend weekly interdisciplinary team (IDT) meetings on their patients. A schedule of which patients are to be discussed at the IDT meeting each week is available from the department secretary. During the IDT meeting the fellows provide a brief medical summary of the patients' medical status, interact with the interdisciplinary team, and contribute to the care plan. Throughout this rotation, fellows are expected to interact with other health professionals such as social worker, Physical Medicine and Rehabilitation attendings, PT/OT, chaplain, pharmacy, nursing and psychology, to coordinate their patient's care and if indicated, discharge.

Teaching Experiences:

During this rotation, fellows will attend a series of didactic lectures given by VA faculty that provide an introduction to various aspects of geriatric care. They will receive introduction to the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPS). They will be scheduled to receive an introduction to geriatric rehabilitation with the Physical Medicine & Rehabilitation Attending, as well as an introduction to the basics of rehabilitation, given by OT and PT. They will also attend rounds with the CLC Wound Care nurse.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older nursing home patients with common diagnoses
- Ability to report and manage data, including reviewing the patient's medical record
- Proficiency in caring for complicated patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re: optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, rounds, direct observation.

Evaluation tools include rounds, monthly evaluation, 360 evaluation, skill cards sign off.

Medical Knowledge

- Knowledge and management of key concepts in Geriatric Medicine, including cognitive impairment, depression, falls, incontinence, polypharmacy, health maintenance, functional status, pressure ulcers, sleep disorders, delirium, pain management, malnutrition and sensory impairment.
- Knowledge of pharmacologic issues within the nursing home setting.
- Knowledge of geriatric principals of rehabilitation.
- Knowledge of the unique aspects of long-term care including institutional outbreaks of disease, infection control issues, and the epidemiology, prevention and treatment of these diseases.
- Knowledge of the administration of long-term care, including respite care, palliative care, accreditation requirements, regulation and financing of long term care at the local, state and federal levels.
- Knowledge of the regulations for credentialing medical, nursing and ancillary staff at long-term care facilities.
- Knowledge of the process of becoming a medical director and his/her role.
- Knowledge of the demographics of long-term care in the US.
- Knowledge of and critical review of the literature on long-term care.
- Knowledge of the different staffing ratios in long-term care and the range of services available on site versus distant acute care facilities.
- Review and understand the Minimum Data Set process.
- Knowledge of the ethical and legal aspects of patient care, including limitation of treatment, competency, guardianship, right to refuse treatment, advanced directives, designation of a surrogate decision maker, and durable power of attorney for health care.

Teaching methods include: didactics, Geriatric Review Syllabus, rounds, direct observation.

Evaluation tools include rounds, monthly evaluation skill cards sign off.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds
- Ability to communicate effectively with other physicians and interdisciplinary team members
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records

Teaching methods include: rounds, team meetings, and direct observation.

Evaluation tools include rounds, case presentations, all notes written by fellows are reviewed and signed by the attending and monthly evaluation.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population
- Understand that long- term care is the patient's permanent place of residence, i.e., his/her home and not a temporary acute care facility

Teaching methods include: rounds, team meetings, direct observation, and individual mentors.

Evaluation tools include rounds, case presentations, all written notes are reviewed and signed by the attending, monthly evaluation, Morbidity and Mortality conference.

Practice-based Learning

At the end of the month fellows are expected to have demonstrated the following:

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health status
- Use information technology to optimize learning
- Participate in the education of patients, families, students, residents and other health professionals.

Teaching methods include: rounds, case presentations, direct observation, and individual mentors.

Evaluation tools include rounds, all written notes are reviewed and signed by the attending, monthly evaluation, Morbidity and Mortality conference.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Work effectively in this health care delivery setting and system
- Coordinate patient care within the health care system
- Understand and incorporate considerations of cost awareness and risk-benefit analysis in this cohort of patients
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and implementing potential systems solutions

Teaching methods include: rounds, interdisciplinary team meetings, case presentations, direct observation, and individual mentors.

Evaluation tools include rounds, all written notes are reviewed and signed by the attending, monthly evaluation.

On-call Schedule

During this rotation the fellow will master the following:

- Understanding how to take a telephone call from home, resulting in competent telephone assessments and triage.

Fellows will take on-call service at the VA nursing home throughout the year, beginning in August. The current call schedule involves the fellow being first on-call for long-term care patients at the VA Medical Center for approximately one 24 hour period per month. There is 24 hour faculty backup for the fellow on call. The fellows will learn how to triage problems over the telephone. Many problems will be able to be managed by telephone. For those residents who are more ill and need to be examined, the fellow will discuss the care and coordinate care over the telephone with the emergency room staff.

Responsibilities of Nursing Home Medical Directors

Certified Medical Director: Dr. Belinda Vicioso

Although fellows will follow long-term care patients throughout the year at the Veteran's Administration Center at Dallas, the role of the medical director in community nursing homes needs to be addressed during the fellowship. For this reason, fellows will spend a portion of the long-term care month understanding the practical issues facing medical directors. Dr. Vicioso, a certified medical director, has overseen the development of this aspect of the curriculum specifically addressing the challenges and expectations of the medical director in community nursing homes. She will meet with the fellows at the beginning of the month allocated to long-term care and ensure that the fellows have practical experience and access to the current body of literature on the medical director's job description in community nursing homes. The goals of this rotation and expectations are as follows:

- To organize comprehensive medical services;
- To understand that primary and consultant physicians and other health professionals are expected to fulfill their obligations to the resident, the families, and the facility;
- To collaborate with administrators and other department heads in developing and implementing appropriate policies and procedures;
- To monitor and continually improve the quality of medical services;
- To act as spokesperson for the facility to health care agencies and the community;
- To understand how to implement and oversee an employee health program;
- To assist in the development, organization and presentation of educational activities for the staff, residents and families;
- To discuss issues of consent and competency in this at-risk cohort of patients;

During didactic sessions we will emphasize the pivotal role of the medical director in determining the nursing home's quality of medical care. We will explain how the specific role, responsibility and authority of the medical director vary depending on a number of factors including facility ownership, location, size and administrative structure and staffing.

The diversity and complexity of medical conditions among nursing home residents predicate that a wide variety of services are available. It is the fundamental responsibility of the nursing home director to ensure that the NH can provide or arrange for these types of services. Fellows will be introduced to the heterogeneity and range of these services and instructed in translating traditional medicine into the skilled nursing environment. They will also be taught staffing options, oversight of credentials and strategies to ensure nursing home regulation compliance by providers.

Long-term care educational materials

Core long-term care reading materials are collated in a comprehensive long-term care syllabus and the AM.D.A Comprehensive Guidelines and Policies and should be reviewed prior to the end of the rotation. Copies are available at both the VAMC and UT Southwestern geriatric offices.

Rehabilitation Medicine

Coordinator: Dr. Susan Murphy

This rotation, coordinated by Dr. Susan Murphy, is a four-week rotation, one week inpatient service (located at Zale Lipshy University Hospital) and three weeks outpatient clinic (located at Parkland Memorial Hospital on 6 North).

Before the rotation begins, fellows will meet with Dr. Murphy to outline goals and objectives for the month. If there is some experience, for example, working with spinal cord injury patients in addition to those outlined above that you are interested in, please discuss this at the beginning of the rotation. At the end of the month Dr. Murphy will meet with each fellow and provide informal feedback on the fellow's performance; they will discuss the merits and limitations of this rotation. At this time the fellow and Dr. Murphy will complete written evaluations of the rotation, which will be used as needed to change and improve subsequent rotations. This should ensure continuous quality improvement.

Dr Murphy is available by pager (214/786-8976).

Patient Care

- Proficiency in evaluating and managing older patients who require inpatient or outpatient rehabilitation
- Ability to report and manage data
- Proficiency in caring for complicated older patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation

Evaluation tools include daily rounds, monthly evaluation, 360 evaluation, skill cards sign off.

Medical Knowledge

- To know the components of geriatric rehabilitation.
- To know how to perform gait assessment, evaluation of functional ability; perform both a focused and comprehensive musculoskeletal examination and ADLs assessment.
- To know the range of services and assistive devices provided by speech therapy, occupational therapy and physical therapy.
- To know which types of patients would benefit from rehabilitation.
- To know what specific type, duration and intensity of inpatient rehabilitation should be offered to individual patients, specifically but not limited to, patients with orthopedic, rheumatologic, cardiac and neurologic impairments. This includes patient selection for acute rehabilitation, subacute rehabilitation, pulmonary rehabilitation, cardiac rehabilitation and rehabilitation in the nursing home setting.

- To know what specific type, duration and intensity of outpatient physiotherapy and occupational therapy would benefit individual patients.
- To know how to treat common rehabilitation conditions like rotator cuff injuries and osteoarthritis.
- To know wound care management, specifically venous stasis ulcers, diabetic ulcers and pressure ulcers.
- To know the role of debridement, hydrotherapy, dressings, and surgery in the management of these wounds.
- To know the different types of mattresses, beds, wheelchair cushions and other devices that are available, their indication and costs.
- To know the types of exercises that can be prescribed to geriatric patients in the ambulatory setting as part of their health maintenance.
- To know the Medicare system and other reimbursement systems regulations regarding durable medical equipment, home and other types of services.
- To know how to write instructions and prescriptions for physiotherapists and occupational therapists regarding exercise regimens, assistive devices and related equipment.
- To know how to perform injection of joints under PM&R attending supervision, including but not limited to knee, shoulder and trigger points sites
- To know the different types of assistive devices, when they are indicated and the cost of these devices
- Attend a session of hydrotherapy

Teaching methods include: didactics, Geriatric Review Syllabus, one-on-one teaching by attendings, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds
- Ability to communicate effectively with interdisciplinary team members
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records

Teaching methods include: one-on-one supervision by attendings, GRS syllabus, didactics, interdisciplinary team meetings, and direct observation.

Evaluation tools include monthly evaluations.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population

Teaching methods include: daily rounds, team meetings, direct observation, and individual mentors.

Evaluation tools include daily rounds, case presentations, monthly evaluations.

Practice-based Learning

At the end of the month fellows are expected to have demonstrated the following:

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to rehabilitation
- Use information technology to optimize learning
- Participate in the education of patients, families, and other health professionals.

Teaching methods include: daily rounds, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Work effectively in this health care delivery setting
- Understand and incorporate considerations of cost awareness and risk-benefit analysis in this cohort of patients
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and implementing potential systems solutions

Teaching methods include: daily rounds, interdisciplinary team meetings, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Eisenberg Service

Dr. Thomas Dalton

Fellows will spend one month on the Eisenberg Service where they will gain hands-on experience in the inpatient care of older adults. They will perform geriatric assessments on all patients over the age of 65. They will work with a team consisting of a medical student, interns and residents, where they will teach on geriatric issues that arise while on service.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older patients in the acute care setting
- Ability to report and manage data, including performing a comprehensive geriatric inpatient consult
- Proficiency in caring for complicated patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation

Evaluation tools include daily rounds, monthly evaluation, skill cards sign off.

Medical Knowledge

- To know the components of a geriatric inpatient consult.
- To understand the special issues relating to urban older persons of various ethnic backgrounds, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to healthcare, and cross-cultural assessment.
- To understand specific inpatient geriatrics issues and their prevention/treatment including, but not limited to, delirium, pressure ulcers, functional status, nutrition, restraint use, health maintenance, depression, advanced directives, sleep hygiene, vaccinations and polypharmacy.
- To understand the pivotal role of the family or principal caregiver in caring for many elderly patients.
- To know the components of perioperative assessment
- To understand the wide spectrum of available community resources (formal support systems) needed to help both the patient and the patient's family.
- To review the managed care approach and Medicare regulations regarding inpatient care.
- To review the geriatrics literature on acute geriatric inpatient care including, but not limited to, ACE Units.
- To review the literature on preoperative assessment.

Teaching methods include: didactics, Geriatric Review Syllabus, one-on-one teaching by the attending, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds including working effectively with translators. This population includes Native American, African American, Mexican, Korean, Vietnamese, Chinese Caucasian and Indian patients
- Ability to communicate effectively with interdisciplinary team members and professional colleagues. Work with each member of the interdisciplinary team and participate in the weekly interdisciplinary team meetings. Fellows will direct the last team meeting of the month.
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records
- Provide an in-service re acute care topic for the nurses and LPNs after discussion with the Senior Nursing Unit Manager

Teaching methods include: one-on-one supervision by the attending, GRS syllabus, didactics, interdisciplinary team meetings, and direct observation.

Evaluation tools include, monthly evaluations, Clinical Evaluation Tools sign off.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population

Teaching methods include: daily rounds, team meetings, direct observation.

Evaluation tools include daily rounds, case presentations, monthly evaluations.

Practice-based Learning

At the end of the month fellows are expected to have demonstrated the following:

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities such as liaison with and educating the medical team caring for the patient.
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to acute inpatient care including research on ACE Units and delirium
- Use information technology to optimize learning
- Participate in the education of patients, families, residents, and other health professionals.

Teaching methods include: daily rounds, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Work effectively in this health care delivery setting and recognize its pivotal role in the transition of care
- Recognize the range of dispositions from acute care that are possible for an elderly patient such as geriatrics clinic, senior house calls program, acute rehabilitation, subacute rehabilitation, hospice, palliative care, home health services (Visiting Nurse Association) and specialty clinics like the problem foot clinic at PMH. Special emphasis will be placed on the cost and risk-benefit analysis of these services for this mainly frail, indigent and culturally diverse group of patients.
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and implementing potential systems solutions

Teaching methods include: daily rounds, interdisciplinary team meetings, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Geriatrics consult template

A geriatrics consult template sheet is available for the fellow to complete after assessing a patient and is included in the appendix.

Preoperative assessment

Attend the preoperative assessment clinic at the (8th floor) on two of the four Wednesday mornings. Choose the best times to see the most patients as this clinic has variable attendance.

Wound Care

Fellows will review all patients with pressure ulcers admitted to the Unit and address dressing changes, correct bedding such as mattresses and overlays, protective footwear, diabetic foot care and optimal use of hydrotherapy. Diagnoses of osteomyelitis and indications for surgical intervention such as debridement or amputation will also be reviewed.

For two sessions during the month, fellows will have the opportunity to work with the Parkland Memorial Hospital wound care nurse, who supervises wound care throughout the hospital. This will include hands-on experience with different types of dressings and treatments and visiting patients in specialty units, for example ICU, to review care plans.

Geriatric Psychiatry

Dr. Kyle Womack

At the beginning of the month the fellow will meet with Dr. Womack who is the coordinator of this rotation to discuss goals and objectives for the month. After two weeks Dr. Womack will meet with the fellow to discuss progress. After completion of the month they will evaluate the month and discuss any improvements or changes that need to be implemented to continuously improve the rotation.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older patients with psychiatric diagnoses
- Ability to report and manage data
- Proficiency in caring for complicated older patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation

Evaluation tools include daily rounds, monthly evaluation, skill cards sign off.

Medical Knowledge

- To know the normal biology and physiological changes associated with aging, and understand the impact of these changes on an individual's psychological development.
- To be familiar with the influence of social, educational, and cultural factors on normal aging.
- To understand the diverse components of geriatric psychiatry and the role of the psychiatrist and associated professionals in the management of geriatric patients.
- To know how to evaluate and treat older people for alcohol and drug abuse.
- To know the etiology, differential diagnoses, evaluation and management of common psychiatric conditions like depression, paranoia, delirium, delayed grief reactions, anxiety and hallucinations.
- To become familiar with common psychiatric medications, their indications and side effects.
- To become familiar with common clinical psychiatric methods of assessment, for example, the Geriatric Depression Scale and neuropsychometric testing. Address which patients benefit from these specialized tests, how to correctly complete and interpret these tests and understand their scope and limitations.
- To appropriately prescribe, adjust taper off and withdraw geropsychiatry medications.
- To diagnose and manage common psychiatric conditions in the inpatient and outpatient setting.

- To know about pertinent geropsychiatry issues in the long-term care setting, including behavioral management of patients with dementia, restraint use, psychotropic drugs and common geropsychiatry diseases in this setting.
- To know when and how to perform a competency evaluation.
- To know how to triage patients for electroconvulsive therapy, the indications, risks, benefits and side effects, from both the short and long-term perspective.
- To understand elder abuse and the role of Adult Protective Services, its usefulness and limitations.

Teaching methods include: didactics, Geriatric Review Syllabus, one-on-one teaching by attendings, direct observation.

Evaluation tools include daily presentations, monthly evaluation.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds.
- Ability to communicate effectively with interdisciplinary team members and professional colleagues.
- Be an effective member of the health care team

Teaching methods include: direct observation and supervision by the attending, GRS syllabus, didactics, and interdisciplinary team meetings.

Evaluation tools include, monthly evaluations, Clinical Evaluation Tools sign off.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population

Teaching methods include: team meetings, direct observation.

Evaluation tools include monthly evaluations.

Practice-based Learning

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities such as evaluation of patients with depression
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to psychiatric disorders
- Use information technology to optimize learning
- Participate in the education of patients, families, residents, and other health professionals.

Teaching methods include: daily rounds, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Systems-based Practice

- At the end of the month fellows are expected to have met, if not exceeded, the following goals:
- Work effectively with this cohort of patients
- Recognize the cost and risk-benefit analysis of these services for older, often frail, indigent and culturally diverse group of patients.
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality

Teaching methods include: outpatient clinics, interdisciplinary team meetings, case presentations, direct observation.

Evaluation tools include monthly evaluation and Clinical Evaluation Tools sign off.

Home Based Primary Care

Dr. Abimbola Awodipe/Dr Namirah Jamshed

The Home Based Primary Care (HBPC) experience is based on an innovative delivery model of care that focuses on care of the vulnerable elderly. Our vision is to train physicians who are not only experts in medical knowledge required to take care of the vulnerable elderly, but also to understand their special needs. You will be exposed to a wide spectrum of pathology in the elderly, in addition to understanding psychosocial needs, chronic disease management, post-acute care and end of life care. This experience will provide you with a basic understanding in the care of the vulnerable elderly. Weekly team meetings will allow you to learn from experts in allied health professions including Certified Geriatric Nurse Practitioners, Nurses and social worker. At the center of all this care will be the patient and their caregivers who are the drivers of their own care. Following these patients at their residence over the year will focus on longitudinal experience that is well suited to teach the necessary attitudes, knowledge and skills to deliver successful home care (Council on Scientific Affairs, American Medical Association. Educating Physicians in Home Health Care. JAMA 1991; 365:769-771)

Parkland Health and Hospitals Systems

The program was initiated in 1998 and has a census of 100-120 patients. PHHS patients who are 65 years and above, are homebound, reside in Dallas County and require help with 2 or more Activities of Daily Living or have significant cognitive impairment are enrollees. The PHHS home care team includes the medical director, nurse practitioner, social worker, dietician and pharmacist. Fellows are introduced to 3 of these patients at the beginning of the year and follow them throughout the year with regular house call visits and provide continuity of care for these 3 patients. During the month rotation they receive education regarding the overview and implementation of a housecall program.

Mildred Wyatt and Ivor P Care of the Vulnerable Elderly (COVE) Program

The COVE Program is focused on providing care in the Dallas Metroplex Area to frail vulnerable elderly. Patients are seen at home and at Assisted Living Facilities. The program focuses on Medicare Fee For Service and Dual eligible patients. The team includes physicians, nurse practitioners, a nurse, social worker and a clinical coordinator. There is significant emphasis on continuity of care. Maximum effort is made to see urgent visits within one business day and all discharge follow ups within two business days. Fellows will be introduced to three patients at the Belmont Senior Living Assisted Living facility. They will provide continuity of care for these patients throughout the year, including urgent and post-acute visits when available.

TYPES OF EXPERIENCES:

LONGITUDINAL: You will be responsible for total of 6 HBPC continuity patients residing at Assisted Living Facilities and in the community. It is expected that you will **(23,24,25, 26)**

1. See them every month
2. Document progress notes that incorporate cognitive, functional and psychosocial assessment during the year
3. Address their acute needs by responding to their messages in My chart, calling them back if clinical staff identifies urgent need
4. Arrange urgent visit by yourself or Nurse practitioner (if you are not available)
5. Triage to the ED if indicated after discussion with faculty

6. Follow them within 7-14 days if discharged from SNF, Hospital for Post-Acute visit
7. Completion of all notes within 24 hours of seeing patients
8. Responding to inbox messages from caregiver, home health agencies or hospice (as indicated)

EPISODIC: One-month rotation that incorporates different aspects of Home Based Primary Care. During this month:

1. You will make the first visits with your assigned continuity patients
2. See patients at the Belmont Senior Living Assisted Living Facility
3. See patients that have urgent needs
4. See one patient per session AM/PM in the community
5. Attend interdisciplinary team meetings at Parkland Geriatric Center
6. Spend time at the Dallas office of Aging to understand community resources available to the seniors in the community

At the end of the month fellows are expected to have the following attitudes, knowledge and skills to be able to practice effective and safe care:

CARE FOR THE COMPLEX OR CHRONIC ILLNESS(ES) IN OLDER ADULTS AT HOME (8,9,10,11,12,13,14)

- Diagnose and manage patients with common and advancing chronic conditions and multi-morbidity, such as heart disease, diabetes, lung disease, and arthritis
- Diagnose and manage patients with common geriatric syndromes and conditions, including falls, wound care, sleep disturbance, urinary incontinence, chronic pain, weight loss, constipation, frailty, and self-care deficits.
- Competently and appropriately use diagnostic and therapeutic technology in the home. Know available ancillary services in the community and refer appropriately.
- Apply concepts of prognostication to inform patients and families about estimated life expectancy and provide quality end-of-life care
- Develop, document and oversee patient-centered plans of care with patients related to their health and condition(s) and expected or realistic trajectory with emphasis on personal health goals, such as prolonging life, function, and achieving rehabilitative and/or palliative aims.
- Develop plans of care collaboratively with the patient, family, caregivers, and other health and community professionals involved in the patient's care that include all aspects that effect the patient's overall well-being: medical management including medication management, behavioral health, family health and relationships, functional impairments and environmental adaptations, financial problems including housing and nutrition; and steps in each area, and responsible person.

MEDICATION MANAGEMENT (1,2,3)

- Accurately review a patient's pharmacotherapy (including those prescribed by other physicians and clinicians, over-the-counter medications and preparations, expired medications, and complementary and supplemental nutritional preparations) and prepare a comprehensive reconciled medication list for the patient.

- Use evidence-based practices to maximize medication adherence, identify undesired medication effects and adverse drug reactions, eliminate medications that are no longer effective, duplicative, carry a greater burden than benefit, and/or no longer have an indication, and to offer all medically-indicated, appropriate medications

FUNCTIONAL IMPAIRMENT AND REHABILITATION

- Describe the indications and contraindications for referring patients to physical, occupational, speech, or other rehabilitative therapies, and refer if appropriate
- Appropriately evaluate for, document the medical necessity, and prescribe durable medical equipment
- Recognize and manage the care of functionally impaired patients at high risk for poor outcomes, including those with falls, deconditioning, skin breakdown, hip fracture, stroke, frailty, and dementia.

COGNITIVE, AFFECTIVE AND BEHAVIORAL HEALTH (4,5,6,7)

- Describe key issues in the management of patients with dementia in the home setting, including patient and family safety, quality of life, behavior management, driving, firearms, caregiver stress, and medical comorbidities
- Describe key issues in the management of patients with depression in the home setting, including medication management and safety

CAREGIVER ASSESSMENT AND SUPPORT

- Assess and incorporate family/caregiver needs and limitations, including caregiver stress into management plans.
- Describe community resources available to provide support for caregivers

PATIENT AND STAFF SAFETY

- Assess specific risks and barriers to patient home safety, including the general environment, falls, fire hazards, elder mistreatment and other risks in the home (e.g., heating/air conditioning), be able to use home safety checklists and describe interventions to maximize safety.
- Recognize mistreatment (abuse/neglect) for patients of all ages, and develop a plan of care to maximize patient safety and quality of life, including knowledge of the reporting responsibilities of staff/clinicians of suspected abuse/neglect
- Describe approaches to personal safety of the clinician and other staff while traveling and during home visits

ACUTE/EMERGENT CARE

- Be able to accurately and effectively triage patients with acute issues to appropriate timing and setting of face-to-face assessment and provide guidance to patients and caregivers for reporting changes in condition in a timely manner.

- Recognize, diagnose and manage common acute conditions such as fever, delirium, falls, acute pain, and shortness of breath both in person and by reports from formal and informal caregivers by phone.
- Develop and implement urgent/emergent management strategies to provide support for patients and families and reduce unnecessary ED visits and hospitalizations, in alignment with patient/family goals, values and preferences

PALLIATIVE AND END OF LIFE CARE (15,16)

- Effectively manage pain and other physical and psychosocial symptoms in the home for patients with advancing chronic conditions and those near the end of life.
- Sensitively communicate prognosis and guide planning for future medical care by leading conversations regarding Advance Directives, resuscitation guidelines, surrogate decision-makers, location of care, and limitation of additional therapies with patient and family.
- Employ palliative and hospice care principles when making a treatment plan; engage relevant community resources as appropriate

INTERPROFESSIONAL CARE

- Work effectively with patients, informal caregivers and interprofessional health care team professionals across care settings when making treatment plans.
- Describe the roles and responsibilities of commonly encountered team members in home care, including OT, PT, and Social Work.

COMMUNICATION AND PROFESSIONALISM

- Demonstrate the ability to teach patients, caregivers and others about their health conditions.
- Act professionally in all settings
- Recognize and manage ethical issues that arise in the home setting, such as who should make decisions, when to change living arrangements (autonomy vs. safety), how to handle conflicts and how to maintain boundaries.
- Practice culturally sensitive shared decision making with patients and families/caregivers in the context of their health literacy, desired level of participation, and goals of care.

COMMUNITY AND SYSTEMS BASED RESOURCES AND SUPPORTIVE CARE AND SERVICES (21,22)

- Identify the need for, refer to and collaborate with community service providers, such as support groups and those that aid with housing, personal care services, home oxygen and other durable medical equipment, meals, and transportation.

- Describe, navigate and use the different sites of care that can best manage specific patient needs, refer patients to appropriate home health and community support services to maximize ability to remain in their homes, and advocate for patients' needs when appropriate.
- Demonstrate expertise in effective transitions of care by communicating verbally or with a timely discharge summary the following: medication reconciliation, patient's cognition and function, pending medical results, advance care plans, and follow-up needs including home services.
- Describe tele-health and other e-technologies that may enable remote monitoring and assessment of patients in the home setting

PRACTICE MANAGEMENT

- Specify how home care medicine is financed, including the roles of fee-for-service payments, managed care, Veterans Health Administration and Medicare/Medicaid, where applicable.
- Appropriately document and bill for visits, care plan oversight, care management, certifications, and procedures.
- Detail important elements of a house call program business plan including the role of a mission/ vision statement, the product(s)/services delivered (e.g. urgent, chronic, transitional, or concierge care), regulatory requirements, market analysis, management team/staffing and finances. 4. Describe models of care and ongoing demonstration projects exploring the organization of home care services to improve outcomes, including those in the Department of Veterans Affairs, Accountable Care Organizations, and private insurers. 5. Demonstrate knowledge of commonly accepted quality measures and explain the importance of reporting. 6. Describe the elements of a corporate compliance program.

Geriatric Medicine Milestones that will be addressed during this HBPC experience:

1. Develops and achieves comprehensive management plan for each patient.
2. Manages patients with progressive responsibility and independence.
3. Works effectively within an interprofessional team (e.g., with peers, consultants, nursing, ancillary professionals, and other support personnel).
4. Identifies forces that impact the cost of health care, and advocates for and practices cost-effective care.
5. Transitions patients effectively within and across health delivery systems.
6. Has professional and respectful interactions with patients, caregivers, and members of the interprofessional team (e.g., peers, consultants, nursing, ancillary professionals, and support personnel).
7. Accepts responsibility and follows through on tasks.
8. Responds to each patient's unique characteristics and needs.
9. Communicates effectively with patients and caregivers.
10. Communicates effectively in interprofessional teams (e.g., with peers, consultants, nursing, ancillary professionals, and other support personnel).
11. Appropriate utilization and completion of health records.

Contact information:

Dr. Namirah Jamshed: cell: 202-596-0902

Dr. Tara Duval: cell: 718-737-6956

Dr. Amy Johnson: cell: 214-801-0030

Dr. Abimbola Awodipe: cell: 972-748-4000
Dr. Ramos: email: Edid.Ramos-Rivas@utsouthwestern.edu

Belmont Senior Living ALF
3535 North Hall Street, Dallas TX

Parkland House Call Program with Dr Awodipe:
4811 Harry Hines Blvd
Support building C
intersection of HHB and Medical district drive, opposite the Ambulatory Surgery Center. Parking
is free in the AMELIA COURT lot.

Reading Material:

Desai, Abhilash K., and George T. Grossberg. "Recognition and management of behavioral disturbances in dementia." *Primary care companion to the Journal of clinical psychiatry* 3.3 (2001): 93.

Rabow, Michael W., Joshua M. Hauser, and Jocelia Adams. "Supporting family caregivers at the end of life: They don't know what they don't know." *Jama* 291.4 (2004): 483-491.

Murray, Scott A., et al. "Illness trajectories and palliative care." *BMJ: British Medical Journal* 330.7498 (2005): 1007.

VEMUR, SATHYA R. "Depression in later life: a diagnostic and therapeutic challenge." *American family physician* (2004): 2375-2382.

Conroy, Simon, and Gertrude Chikura. "Emergency care for frail older people—urgent AND important—but what works?." (2015): 724-725.

Unwin, Brian K., and Paul E. Tatum III. "House calls." *American family physician* 83.8 (2011).

Haider Warraich. *Modern Death: How Medicine Changed the End of Life.* (2017)

Neurology

Director: Dr. Padraig O'Suilleabhain

Four one-week rotations in outpatient setting (Aston Clinic)

Duration: 4 weeks

Course Objectives:

- To review clinical neurology with particular emphasis on conditions commonly found in elderly patients and common conditions that present with different characteristics in elderly patients;
- To provide training in ambulatory care management of these conditions;
- To increase familiarity with recent research developments in etiology and treatment of neurodegenerative diseases;
- To be familiar with procedures in neurology, for example, performance of EMG and botulinum toxin injections;
- To be aware of pharmacological treatments of neurologic conditions, the signs of over and under medication, appropriate prescribing, side effects and cost of medications.

Course Components:

Dr. Nations (ALS and peripheral/neuromuscular diseases)

Dr. Johnson (Stroke)

Dr. O'Suilleabhain (Parkinson's disease and other Movement Disorders)

Dr. Quiceno Behavioral neurology)

Dr. Agostini (Epilepsy)

Dr Khemani (Parkland)

[PO1]Neurology Grand Rounds (Wednesday noon)

Neurology Journal Review and M&M conferences (Friday noon)

Neurology Evaluations:

The Director of the Neurology rotation will meet with each fellow prior to the rotation and discuss the course, expectations and evaluations. At the end of the rotation the two will discuss recommendations for improvement and deficiencies/limitations of the fellow or of the course. A summative evaluation of the fellow's effort and knowledge will be provided.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older patients with neurological diseases
- Ability to report and manage data
- Proficiency in caring for complicated older patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, direct observation

Evaluation tools include daily clinic sessions, monthly evaluation.

Medical Knowledge

- To know the normal biology and physiological changes in the neurological system associated with aging, and understand the impact of these changes on an individual's psychological development.
- To understand the diverse components of geriatric neurology and the role of the neurologist and associated professionals in the management of geriatric patients.
- To know how to evaluate and treat older people with dementia.
- To know the etiology, differential diagnoses, evaluation and management of common neurological conditions like stroke, Parkinsonism and movement disorders, and seizures post CVA.
- To become familiar with common neurologic medications, their indications, adjustments, costs and side effects.
- To become familiar with common clinical neurological methods of assessment, for example, neuropsychometric testing. Address which patients benefit from these specialized tests, how to correctly complete and interpret these tests and understand their scope and limitations.
- To diagnose and manage common neurologic conditions in the outpatient setting.
- To know about pertinent neurologic conditions in the long-term care setting, including long term effects of CVAs, management of patients with Parkinsonism.
- To know the usefulness and limitations of neurologic procedures such as lumbar puncture, EEG, EMG studies or botulinum toxin treatments.

Teaching methods include: didactics, Geriatric Review Syllabus, one-on-one teaching by attendings, direct observation.

Evaluation tools include daily presentations, monthly evaluation.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds.
- Ability to communicate effectively with interdisciplinary team members and professional colleagues.

Teaching methods include: direct observation and supervision by the attending, GRS syllabus, didactics, and interdisciplinary team meetings.

Evaluation tools include, monthly evaluations, Clinical Evaluation Tools sign off

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals

- Demonstrate sensitivity to a diverse frail population

Teaching methods include: direct observation, didactics, Geriatric Review Syllabus

Evaluation tools include monthly evaluations.

Practice-based Learning

- Identify individual strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities such as evaluation of patients with depression
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to psychiatric disorders
- Use information technology to optimize learning
- Participate in the education of patients, families, residents, and other health professionals.

Teaching methods include: daily rounds, case presentations, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Work effectively with this cohort of patients
- Recognize the cost and risk-benefit analysis of these services for older, often frail, indigent and culturally diverse group of patients.
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality

Teaching methods include: outpatient clinics, case presentations, direct observation.

Evaluation tools include monthly evaluation and Clinical Evaluation Tools sign off.

A written evaluation of the rotation and the fellows' performance will be completed at the

VA Community Living Center (CLC)
Coordinator Dr. Patricia Larios

Fellows will spend three months at the CLC at the Dallas VA Medical Center. The first month will be spent understanding the concept, role and management of the CLC. The second and third month will see the fellow assume a leadership role in the CLC under the careful supervision of the attending. The purpose of this rotation is to consolidate the skills learned in the nursing-home rotation. Each fellow will meet with the CLC attending at the beginning of the month to outline expectations, review the fellow's schedule, and obtain input from the fellow about their preferences for patient care and teaching experiences.

During these months, the fellows will admit approximately 1-2 new patients per week, and continue to follow their existing CLC patients. Fellows will admit geriatric rehabilitation, wound care, and palliative care/hospice patients.

Fellows will do monthly assessments on their CLC patients throughout the year and address acute and other issues such as change in functional status, pressure ulcers, immunizations, psychosocial needs, nutritional status, oral status, hearing and vision impairment, mobility, falls, medications, and behavioral problems.

Fellows are expected to attend weekly interdisciplinary team (IDT) meetings on their patients. A schedule of patients to be discussed at the IDT meeting each week is available from the department secretary. During the IDT meeting the fellow will provide a brief medical summary of their patient's medical status, interact with the interdisciplinary team, and contribute to the care plan. Throughout this rotation the fellows are expected to interact with other disciplines (social worker, PM&R, PT, OT, chaplain, pharmacy, nursing and psychology) to coordinate their patients care. If the fellow is scheduled at the VA at the time of their patient's discharge, then the fellow should dictate the discharge summary.

Daily clinical duties and responsibilities

The fellow assigned to the CLC will round on his/her CLC patients daily. Each patient will be examined and assessed for symptom control, response to treatment and new issues. The fellow will review all interim notes in the electronic medical record. Daily interaction with the CLC nurse staff, other CLC team members, and liaison with consultants on a day-to-day basis is essential to coordinate optimal care of these patients.

The fellow will be responsible for writing progress notes on their patients. This should be done at least monthly and as often as needed to address acute problems. Progress notes should be forwarded to the attending for co-signature.

Discharge Summaries

The fellow is responsible for dictating a CLC discharge summary on each patient discharged from the CLC. This summary should include: a complete problem list, how each problem was addressed, depression screen results if performed, functional status, cognitive status, and other members of the interdisciplinary team who were involved with the patient's care during admission. Any issues which need to be addressed or followed up as an outpatient should be included in the CLC discharge summaries.

Finally, starting in August, fellows will take telephone call for the CLC approximately once a month, for approximately a 48 hour period, from home. They will triage patients based on nursing assessment of the patient, and either provide telephone management of the patient's problem or coordinate transfer to the ER if indicated. If the patient is transferred to the ER, the fellow is expected to speak with the ER provider to coordinate the patient's care. There is a backup attending assigned for each fellow on call.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older patients with common diagnoses
- Understand the CLC Unit and its unique place in the continuum of care of elderly patients
- Present each patient to the CLC attending or CLC nurse coordinator
- Coordinate the transfer of the patient to the CLC with the referring team
- Perform comprehensive patient assessment
- Design a treatment plan for all new patients transferred to the CLC
- Develop a comprehensive problem list and management plan
- Enter the current interdisciplinary plan of care into the electronic medical record
- Ability to report and manage data, including reviewing the patients electronic medical record.
- Proficiency in caring for complicated patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re: optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, rounds, direct observation. Evaluation tools include rounds, monthly evaluation, 360 evaluation, skill cards sign off.

Medical Knowledge

- Knowledge and management of key concepts in Geriatric Medicine, including cognitive impairment, depression, falls, incontinence, polypharmacy, health maintenance, functional status, pressure ulcers, sleep disorders, delirium, pain management, malnutrition and sensory impairment.
- Knowledge of pharmacologic issues within the nursing home setting
- Knowledge of geriatric principals of rehabilitation
- Knowledge of the unique aspects of long-term care including institutional outbreaks of disease, infection control issues, and the epidemiology, prevention and treatment of these diseases.
- Knowledge of the administration of long-term care, including respite care, palliative care, accreditation requirements, regulation and financing of long term care at the local, state and federal levels.
- Knowledge of the regulations for credentialing medical, nursing and ancillary staff at long-term care facilities.
- Knowledge of the process to become a medical director and his/her role.
- Knowledge of the demographics of long-term care in the US.

- Knowledge of and critical review of the literature on long-term care.
- Knowledge of the different staffing ratios in long-term care and the range of services available on site versus distant acute care facilities.
- Review and understand the Minimum Data Set process.
- Knowledge of the ethical and legal aspects of patient care, including limitation of treatment, competency, guardianship, right to refuse treatment, advanced directives, designation of a surrogate decision maker, and durable power of attorney for health care.
- Address the psychosocial and recreational aspects of care

Teaching methods include: didactics, Geriatric Review Syllabus, rounds, direct observation.

Evaluation tools include rounds, monthly evaluation, skill cards sign off.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients and their families from diverse socioeconomic and cultural backgrounds
- Ability to communicate effectively with other physicians, and interdisciplinary team members
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records

Teaching methods include: rounds, team meetings, and direct observation.

Evaluation tools include rounds, case presentations, all notes written by fellows are reviewed and signed by the attending, monthly evaluation.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population
- Understand that long- term care is the patient's permanent place of residence, i.e., his/her home and not a temporary acute care facility

Teaching methods include: rounds, team meetings, direct observation, and individual mentors.

Evaluation tools include rounds, case presentations, all written notes are reviewed by and signed by the attending, monthly evaluation, Morbidity and Mortality conference.

Practice-based Learning

At the end of the month fellows are expected to have demonstrated the following:

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health status

- Use information technology to optimize learning
- Participate in the education of patients, families, students, residents and other health professionals.

Teaching methods include: rounds, case presentations, direct observation, and individual mentors.

Evaluation tools include rounds, all written notes are reviewed and signed by the attending, monthly evaluation, Morbidity and Mortality conference.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Participate effectively in the assessment and triage of patients referred to the CLC.
- Work in and coordinate effectively in this health care setting and across the variety of health care delivery systems throughout the VA.
- Understand and incorporate considerations of cost awareness and risk-benefit analysis in this cohort of patients
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care
- Participate in identifying system errors and implementing potential systems solutions
- Teaching methods include: rounds, interdisciplinary team meetings, case presentations, direct observation.

Evaluation tools include rounds, all written notes are reviewed and signed by the attending, monthly evaluation.

Palliative Care / Ethics

Dr. Elizabeth Paulk

Fellows will spend one month focusing on palliative care. Dr. Paulk is the coordinator for this program. Dr. Paulk is the director of the Palliative Care Program at Parkland Health and Hospital Systems. This service currently receives between 40-50 inpatient consults per month and there are two outpatient clinics per week at Parkland Memorial Hospital.

Before the rotation Dr. Paulk will meet with the fellow and discuss goals and objectives of patient care.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing older patients receiving palliative care for common diagnoses
- Review the criteria for admission to the palliative care service
- Perform comprehensive assessment of the patient
- Ability to report and manage data
- Proficiency in caring for complicated patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to address fears of being a burden, loss of control, indignity, future pain and suicidal ideation.
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Be aware of the impact of cultural differences in patient decision-making
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation, EPEC manual.

Evaluation tools include daily rounds, monthly evaluation, 360 evaluation, skill cards sign off.

Medical Knowledge

- Knowledge of the components of palliative care assessment
- Knowledge of pharmacologic issues for this cohort of patients
- Knowledge of the administration of palliative care and hospice for funded and non-funded patients, accreditation requirements, and its regulation and financing at the local, state and federal levels.
- Knowledge of symptom management of terminally ill patients.
- Ability to assess and treat common symptoms such as delirium, depression and anxiety in terminally ill patients.
- Ability to integrate a patient's cultural background and social and economic status into the palliative care management plan for the individual patient.

- Knowledge of the demographics of hospice and palliative care in the US.
- Knowledge of and critical review of the literature on palliative care.
- Knowledge of the services available at home versus inpatient hospice
- Knowledge of the ethical and legal aspects of palliative care, including limitation of treatment, competency, guardianship, right to refuse treatment, guardianship, advanced directives, designation of a surrogate decision maker, durable power of attorney for health care, and end of life care.
- Understand the importance of functional status for the individual patient.
- Knowledge of the legal debate regarding euthanasia, and physician-assisted suicide
- Review of the Education for Physicians on End-of-life Care (EPEC) manual (see below).

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, EPEC manual, direct observation.

Evaluation tools include daily rounds, monthly evaluation Skill cards sign off.

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds
- Ability to communicate effectively with other physicians, and interdisciplinary team members
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records

Teaching methods include: daily rounds, team meetings, and direct observation.

Evaluation tools include daily rounds, case presentations, monthly evaluation.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population

Teaching methods include: daily rounds, team meetings, direct observation, and individual mentors.

Evaluation tools include daily rounds, case presentations, all written notes are reviewed by the attending, monthly evaluation, Morbidity and Mortality conference.

Practice-based Learning

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health status

- Use information technology to optimize learning
- Participate in the education of patients, families, students, residents and other health professionals.

Teaching methods include: daily rounds, case presentations, direct observation, and individual mentors.

Evaluation tools include daily rounds, all written notes are reviewed by the attending, monthly evaluation.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Participate effectively in the assessment and triage of patients to the palliative care program.
- Understand palliative care and its unique place in the continuum of care of elderly patients
- Work in and coordinate effectively in this health care setting and across the variety of health care delivery systems.
- Understand and incorporate considerations of cost awareness and risk-benefit analysis in this cohort of patients
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Understand the accessibility and availability of appropriate community resources to provide optimal care, participate in the Parkland Memorial Hospital Ethics Committee during the rotation.
- Participate in the Parkland Health and Hospital Systems Ethics Committee during the rotation.
- Participate in identifying system errors and implementing potential systems solutions

Teaching methods include: daily rounds, interdisciplinary team meetings, case presentations, direct observation, Mortality Conferences.

Evaluation tools include daily rounds, all written notes are reviewed by the attending, monthly evaluation.

Education for Physicians on End-of-life Care (EPEC)

This program has been specifically designed to train physicians in the provision of end-of-life care to patients and their families. It is a national Robert Wood Johnson Foundation Project. There are three faculty members who have trained with this EPEC Project, Dr. Rubin, Dr, Vicioso and Dr. Paulk. A complete copy of the Participant's Handbook is available from Dr. Roche's program coordinator for the fellow to use throughout the month. There are a series of questions accompanying this module and Dr. Paulk will review this material with the fellow during the month.

This is one example of the goals and objective for an elective:

Electives

Rehabilitation Medicine – Elective

This rotation is a four-week rotation - Dr.

Before the rotation, fellow(s) should contact Dr. to discuss goals and objectives for the month. After two weeks, Dr. will discuss the positive and negative aspects of the rotation, if the goals and objectives are being met and any changes that need to be implemented. At this time the fellow and Dr. will complete online evaluations of this rotation which will be used to develop and change subsequent rotations as needed.

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

Patient Care

- Proficiency in evaluating and managing common foot problems and rehabilitation for older for common diagnoses
- Perform comprehensive rehabilitation assessment of the patient
- Ability to report and manage data
- Proficiency in caring for complicated patients under increasingly difficult circumstances such as multiple medical problems, behavioral issues, challenging social circumstances, and increasing frailty
- Ability to prioritize tasks and time
- Provide education to patients, their families, and staff re optimal care management
- Demonstrate empathy, compassion, and respect, for patients and their families

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation.

Evaluation tools include daily rounds, monthly evaluation.

Medical Knowledge

- Knowledge of the components of foot care
- Ability to perform a lower extremity vascular examination
- Ability to perform a lower limb musculoskeletal examination
- Ability to perform a lower extremity neurological examination
- Knowledge of the common causes and treatment of heel pain
- Knowledge of the arterial tests available for the lower limb, their indications and interpretation
- Knowledge of the identification and treatment of plantar fasciitis
- Knowledge of the identification and treatment of Morton's neuroma

- Knowledge of the diagnosis and treatment of osteomyelitis
- Knowledge of the causes and treatment of peripheral edema
- Knowledge of venous disease
- Knowledge of the evaluation and current management of foot wound care
- Knowledge of the diseases and issues specifically related to the diabetic foot, including infection, wound care, neuropathy and osteomyelitis
- Knowledge of the different types of diabetic footwear and insoles available and specifically which patients benefit from these devices
- Knowledge of the indications for different types of lower limb surgery including transtarsectomy, above and below knee amputation, tendon lengthening surgery
- Understanding the management and rehabilitation issues with all of the above types of surgery
- Knowledge of the different types of seating arrangements available for wheelchairs and their indication and cost
- Knowledge of the different types of stomas and their management
- Recognition of the common complications of stomas and the treatment of these conditions

Teaching methods include: didactics, Geriatric Review Syllabus, daily rounds, direct observation

Evaluation tools include daily rounds, monthly evaluation

Interpersonal and Communication Skills

- Ability to communicate effectively with patients, and their families from diverse socioeconomic and cultural backgrounds
- Ability to communicate effectively with other physicians, and interdisciplinary team members
- Be an effective member of the health care team
- Maintain comprehensive, timely, and legible medical records

Teaching methods include: daily rounds, team meetings, and direct observation.

Evaluation tools include daily rounds, case presentations, monthly evaluation.

Professionalism

- Demonstrate a commitment to carry out professional responsibilities
- Adherence to ethical principals
- Demonstrate sensitivity to a diverse frail population

Teaching methods include: daily rounds, team meetings, and direct observation

Evaluation tools include daily rounds, case presentations, and monthly evaluation

Practice-based Learning

- Identify their personal strengths, deficiencies, and limits of knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health status
- Use information technology to optimize learning
- Participate in the education of patients, families, students, residents and other health professionals.

Teaching methods include: daily rounds, case presentations, and direct observation

Evaluation tools include daily rounds, and monthly evaluation.

Systems-based Practice

At the end of the month fellows are expected to have met, if not exceeded, the following goals:

- Participate effectively in the assessment and triage of patients for rehabilitations
- Understand rehabilitation and its unique place in the continuum of care of elderly patients
- Work in and coordinate effectively in this health care setting and across the variety of health care delivery systems.
- Understand and incorporate considerations of cost awareness and risk-benefit analysis in this cohort of patients
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to enhance patient safety and improve patient care quality
- Understand the accessibility and availability of appropriate community resources to provide rehabilitation.
- Participate in identifying system errors and implementing potential systems solutions

Teaching methods include: daily rounds, interdisciplinary team meetings, case presentations, direct observation.

Evaluation tools include daily rounds, and monthly evaluation.

Continuity Clinics – Competency Based Goals and Objectives

Overall description

Each fellow is assigned 2 continuity clinics during the fellowship year, Amelia Court, and the Geriatric Care Center. The Geriatric Care Center is on Monday mornings and Amelia Court Clinic is on Monday afternoons. On Wednesday afternoons for 6 months, the fellows attend the Geriatric Assessment Program (GAP) clinic. Every block rotation has assigned time for fellows to attend these clinics. The 2 clinics have been chosen by the fellows as they provide a variety of experiences in continuity care, Amelia Court is a predominantly African- American, Hispanic population of indigent frail patients and the Geriatric Care Center is primarily community based care for elderly, funded patients. Working alongside full-time geriatric faculty members, nurse practitioners, outpatient nurses, and other health care personnel of the interdisciplinary team the fellow will manage their primary care patients with presumed and established geriatric diagnoses under close supervision by the faculty.

For every fellow the minimum level of achievement expected is:

Progression to competency to practice independently

Specific Competencies

Fellows develop the skills over time to be independent in their management of patients. Each fellow must have achieved this level of competency by the end of their fellowship. The fellow will gain experience in management of patients with but not limited to the following problems:

- a. diagnostic evaluations of new patients and determining treatment plans for new patients
- b. indications for admission for patients
- c. administration of geriatric assessment tools such as MMSE, and GDS
- d. monitoring and management of nutritional status and functional status
- e. providing end of life care for terminally ill patients
- f. management of frail elderly patients with multiple co-morbidities
- g. Providing health maintenance
- h. Specifically providing care to patients with geriatric syndromes such as falls, polypharmacy, pressure ulcers, dementia, urinary and fecal incontinence, and sensory impairment

Objectives

- 1.1. Demonstrate **thorough presentations** of patients seen; the ability to report a detailed and appropriate history and physical examination along with pertinent diagnostic studies.
- 1.2. Develop and provide rationale for the management plans of older patients
- 1.3. Recognize the indications for and the risks of the following therapies in the out-patient setting and develop appropriate management plans for common conditions:
 - 1.3.1. dementia
 - 1.3.2. falls

- 1.3.3. pressure ulcers
- 1.3.4. incontinence
- 1.3.5. delirium
- 1.3.6. dizziness
- 1.3.7. pain management
- 1.3.8. polypharmacy
- 1.3.9. osteoporosis
- 1.3.10. Sensory impairment

- 1.4. When requesting consultation services, demonstrate the ability to formulate an appropriate question and rationale justified by pertinent points of the history, physical examination and laboratory data.
- 1.5. Discriminate between patients who may be appropriately treated in the out-patient clinic, and those who require admission to the acute care setting.

2. GOAL: Medical Knowledge. Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavior knowledge needed by a geriatrician; demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

The fellow will gain clinical experience in out-patient management of patients with the following diagnoses

- Knowledge of Geriatric Medicine, including but not limited to cognitive impairment, depression, falls, incontinence, osteoporosis, sensory impairment, pressure ulcers, sleep disorders, pain, elder abuse/neglect, malnutrition, polypharmacy, health maintenance, and functional impairment.
- Knowledge of diseases that are particularly prevalent in older patients and may have different clinical presentations including but not limited to neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, infectious diseases.
- Knowledge of pharmacologic issues and aging, including polypharmacy, side effects, drug interactions, adherence, costs, and changes in pharmacokinetics and pharmacodynamics in older patients
- Knowledge of geriatric principles of rehabilitation, the optimal use of physical occupational, and speech therapy, exercise, functional activities, assisted devices, environmental modification and various intensities of rehabilitation.
- Knowledge of the pivotal role of formal and informal caregivers, families and the formal community support systems available.
- Knowledge of the continuum of safe and timely transitions across care settings.
- Knowledge of home care, including components of home visits, and appropriate community services

- Knowledge of hospice including pain management, symptoms, relief, comfort care and end-of-life decisions
- Knowledge of cultural aspects of aging, including demographics, health care status, diverse ethnicities, access to health care
- Knowledge of iatrogenic disorders and their prevention
- Knowledge of the economic aspects of supporting geriatric services including Title III of the Older Americans Act, Medicare, Medicaid, capitation and cost containment
- Knowledge of the ethical and legal aspects of elderly care, including limitation of treatment, competency, guardianship, right-to-refuse treatment, advanced directives, designation of a surrogate decision maker for health care, wills and durable power of attorney for medical affairs.
- Knowledge of research methodologies including clinical epidemiology, decision analyses and critical literature review.

3. Interpersonal and Communication Skills: Demonstrate interpersonal and communications skills that result in information exchange and partnering with patients, their families and professional associates.

Competencies

The fellow will gain experience in the following:

- Effective communication with patients, their families and/or caregivers across a broad range of socioeconomic and cultural backgrounds
- Effective communication with physicians and other health professionals and health related agencies
- Maintain comprehensive, timely and legible medical records

Objectives

- 3.1. Communicate effectively with patients and families to create and sustain a professional and therapeutic relationship across a broad range of socioeconomic and cultural backgrounds
- 3.2. Effectively communicate changes in patient status to attending physicians
 - 3.2.1. Maintain comprehensive, timely and legible medical records on primary continuity patients. .

4. Practice Based Learning and Improvement: Demonstrate knowledge, skills and attitudes needed for continuous self-assessment, using scientific methods and evidence to investigate, evaluate, and improve one's patient care practice.

Competencies

- a. Incorporate feedback into daily practice
- b. Participate in the education of families, students, residents and other health professionals

Objectives

- 4.1. Actively seek out and listen to constructive feedback from other members on the care team as well as patients and families and incorporate this feedback, when appropriate, into a plan for professional development.
- 4.2. Review written educational materials for family and professional education

5. Professionalism: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity

Competencies

- a. compassion, integrity and respect for others
- b. responsiveness to patient needs that supersedes self-interest
- c. respect for patients privacy and autonomy
- d. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation

Objectives

- 5.1. Consistently maintain respect, compassion, integrity, honesty and responsiveness to the needs of patients and the health care team in a way that supersedes self-interest
- 5.2. Continually demonstrate accountability to all patients (even if other physicians are primarily responsible for their care) and the health care team
- 5.3. Demonstrate a commitment to excellence and ongoing professional development by being prepared, on-time, in appropriate attire and contributing in teaching conferences and didactic lectures
- 5.4. Exercise sensitivity to the needs of the patient and their families by applying cultural awareness, negotiation, compromise and mutual respect in the daily care of outpatients
- 5.5. Recognize and demonstrate an understanding of ethical, cultural, religious or spiritual values of import to patients and families during communications and care decisions
- 5.6. Demonstrate a commitment to confidentiality, privacy, and respect for patients and families
- 5.7. Demonstrate empathy towards the patient and family in negotiating and designing goals of treatment, including relevant medical, legal and psychological issues
- 5.8. Demonstrate advocacy for patients and their families

- 5.9. Honestly assess one's contribution to errors that are made, accept responsibility for personal mistakes and implement plans to prevent one's self and others from making the mistake again.

6. Systems Based Practice: Understand how to practice high quality health care and advocate for patients within the context of the health care system

Competencies

- a. coordinate patient care within the health care system
- b. work in interdisciplinary teams to enhance patient safety and improve patient care quality
- c. incorporate considerations of cost awareness and risk-benefit analysis in patient care
- d. Participate in identifying systems errors and in implementing potential systems solutions

Objectives

- 6.1. Prioritize the various modes of diagnostic testing and select the most appropriate testing modality, with a goal toward preventing unnecessary laboratory or imaging tests.
- 6.2. Demonstrate the ability to work effectively with other members of the health care team, including, but not limited to, other physicians, nurses, pharmacists, dietitians, social workers and chaplains.
- 6.3. Comply with institutional systems that have been developed to prevent errors in the system
- 6.4. Avoid use of ambiguous or unacceptable abbreviations in the medical record, prescriptions and medical orders.

Teaching methods:

1. Continuous interaction with geriatric faculty in case presentation and decision making
2. In-formal teaching during clinic encounters
3. Weekly Geriatric Medicine Grand Rounds
4. Formal orientation / teaching conferences during first 2 months of fellowship
5. Weekly fellow curriculum conference

Assessment method (fellows):

1. Global evaluation completed by the senior clinic attending every 6 months; this is shared with the fellow and reviewed with the fellow during a bi-annual meeting with the program director.
2. Twice yearly 360-degree evaluations by members of the interdisciplinary team and patients

Assessment method (program):

1. Fellows complete an evaluation of the program and all the rotations once per year using an anonymous evaluation tool.
2. Monthly faculty meetings review the progress of each fellow and the program in general
3. Yearly meeting for the faculty and fellows to review the program in general

Level of supervision:

1. Continuously under the supervision of a geriatric faculty member for all patient care decisions

Educational Resources:

1. Geriatric Review Syllabus
2. Geriatric Grand Rounds
3. Journal Club
4. Evidence Based Medicine Course
5. Internet and Library resources
6. Clinical Safety & Effectiveness Course

MORTALITY CONFERENCES

A bi-annual mortality conference where fellows present every death during their fellowship and have the opportunity to discuss the ethical, legal and cultural issues and the involvement of the interdisciplinary teams with at least two geriatricians-one from each site . Form is included for review.

UT Southwestern Geriatrics Mortality Case Report

Patient Name : _____ Date: _____ MR#: _____ Age: _____

Fellow: _____ Attending: _____

Geriatrics Service: Home-Care In-Pt LTC Ambulatory Care

Place of Death: _____

AD in chart: Yes No DNR: Yes No Death Anticipated: Yes No

Geriatrics contact with Pt (describe): _____

Follow-up with family, Circle: Phone Call Card Funeral Attendance Other

Autopsy requested: Yes No Autopsy Performed: Yes No

Reason autopsy denied: _____

Brief Clinical Outline

This should include: Underlying medical comorbidities and functional status. Medical interventions patient received in final days: intubations, central lines, etc.

Ethical, Cultural, Legal Issues: _____

Interdisciplinary Team Involvement: _____

Unanswered questions: _____

Issues for providers: _____
