

**Geriatric Medicine Fellowship Program**  
**Curriculum, Policy, and Procedure Manual**

Division of Geriatrics and Nutritional Science  
Washington University  
4950 Children's Place  
St. Louis, Missouri 63110  
Phone: 286-2700 Fax: 286-2701  
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# Washington University in St. Louis

## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

Mailing Address: 660 S. Euclid Ave, Campus Box 8303 St. Louis, MO 63110

Office Address: 4950 Children's Place, Wohl Clinic Building, Ste 300 St. Louis, MO 63110

Phone: (314) 286-2700

Fax: (314) 286-2701

Website: <https://gns.wustl.edu/>

Name	Office	Work	Cell	Email
Ellen Binder, MD Fellowship Director	286-2707	823-1200	313-8775	<a href="mailto:ebinder@wustl.edu">ebinder@wustl.edu</a>
David Carr, MD Clinical Director	286-2706	790-2790	704-0458	<a href="mailto:dcarr@wustl.edu">dcarr@wustl.edu</a>
Stephanie Paule Program Coordinator	286-2909		618-791-8753	<a href="mailto:paule@wustl.edu">paule@wustl.edu</a>
Barbra Guilford, RN Nurse Coordinator	747-8647		636-346-3306	<a href="mailto:bguilford@wustl.edu">bguilford@wustl.edu</a>
Lenise Cummings-Vaughn, MD Assistant Professor	286-2728	424-8662	574-0701	<a href="mailto:lenise@wustl.edu">lenise@wustl.edu</a>
Stanley Birge, MD Associate Professor	286-2708	424-6039	795-8873	<a href="mailto:birges@wustl.edu">birges@wustl.edu</a>
Khurram Mirza, MD Geriatrics Fellow	286-2971	574-7276		<a href="mailto:kmirza@wustl.edu">kmirza@wustl.edu</a>
Batool Eldos, MD Geriatrics Fellow	286-2937	226-5788	853-3083	<a href="mailto:batool@wustl.edu">batool@wustl.edu</a>

## Introduction

This manual is designed to orient fellows (PGY Level 4+) to our clinical, educational, and research activities in the Division of Geriatrics and Nutritional Science at Washington University. Please report at the designated time on the first day to our academic offices, located in the Wohl Clinic Building, 3<sup>rd</sup> floor, 4950 Children's Place, St. Louis, MO 63110.

## Educational Goals and Objectives

The fellowship in Geriatric Medicine is designed to expose the fellow to numerous aspects of clinical care, education, and research methodology for older adults. The trainee will participate in a variety of clinical experiences including outpatient geriatric assessments, inpatient geriatric consults, outpatient nursing home-based, and home-based primary care, acute geriatric rehabilitation, and inpatient palliative care. Fellows will also have the opportunity to learn about other disciplines and services, including geropsychiatry, movement disorders, wound care, uro-gynecology, hospice, dentistry, podiatry, and community outreach programs for Alzheimer's disease and related disorders. It is our hope that the fellowship experience will provide a framework and foundation for future career opportunities. The curriculum will ensure fellows the opportunity to achieve the knowledge, clinical skills, professional attitudes, and practical experience required of a physician who specializes in Geriatrics. Fellows will meet with the Program Director every three months for feedback. In addition, supervising attendings for the major rotations will provide immediate and direct feedback upon completion of each rotation.

The fellowship objectives for the competency of **Patient Care (PC)** will be for the trainee to effectively and consistently gather and synthesize data from history taking and physical examinations as related to geriatric patients, demonstrate the ability to make diagnostic and therapeutic decisions based on all information, which utilize clinical judgment and patient preferences, and demonstrate ability to appropriately modify care plans based on the patient's clinical course, patient preferences and cost effectiveness principles. By the end of the year, fellows should demonstrate exceptional **Medical Knowledge (MK)** pertinent to Geriatric Medicine through the ability to recognize common, multifactorial causes for geriatric syndromes, disease presentations that deviate from usual patterns, complex relationships between diseases, provide appropriate interpretation of common screening and diagnostic tests for geriatric patients, develop an understanding of end-of-life care issues and management strategies, and acquire knowledge of the varied mechanisms of disease in patient care. Fellows will gain experience in giving scholarly presentations at our weekly clinical and Topics in Aging conferences, and will complete a research, educational or patient safety project. The goals for **System Based Practice (SBP)** are to actively engage in interdisciplinary team care and be able to coordinate aspects of such care, recognize the potential for system errors and advocate for safe and optimal patient care systems, and to reflect and learn from clinical decisions that may lead to errors or patient harm. We also expect fellows to gain an awareness of cost issues relevant to geriatric care, and to incorporate this into clinical decision-making. Lastly, we expect fellows to gain skills in communicating across transitions in care, anticipating patient and caregiver needs, and to be proactive about communicating with other practitioners, team

members, patients, and family members to address such needs. **Practice-Based Learning Improvement** (PBLI) activities will be conducted to regularly provide feedback so that fellow may self-reflect upon practice and performance, as an opportunity for learning and self-improvement. Fellows will gain an understanding of the principles and techniques of quality improvement and apply this knowledge to a panel of patients. We expect fellows to search medical information resources on a regular basis to address questions relevant to their clinical activities, appraise clinical literature, and to eventually be able to translate new information needs into well-formed clinical questions. During the course of training, fellows are expected to maintain and/or develop a high degree of **Professionalism** (PROF) by demonstrating empathy, compassion, integrity, accountability, honesty, and to treat other patients and colleagues with the utmost respect. Although many trainees enter with these qualities, mentorship by our faculty should enhance these skills. Geriatricians often encounter ethical dilemmas in clinical practice, and our goal is for fellows to be able to identify and manage such challenges, and to provide leadership for managing clinical teams, as the need arises. Trainees are expected to willingly acknowledge errors, limitations or areas of weakness, and demonstrate efforts to improve in these areas. We expect all of our trainees to improve in this difficult area. In the area of **Interpersonal and Communication Skills** (ICS), we expect trainees to develop a highly effective and therapeutic relationship with patients and families from a variety of socioeconomic and cultural backgrounds, that includes narrative and nonverbal skills, along with counseling and the provision of education to our patients and families, and to other trainees/colleagues. We expect fellows to maintain health records that are organized, timely, accurate, comprehensive, and effectively communicate clinical reasoning, and demonstrate accurate interpretation of clinical findings.

## Major Clinical Rotations

### Outpatient Primary Care Clinic (48 Weeks)

This educational experience includes emphasis on management of common primary care geriatric medical problems, health prevention (such as outpatient screening), exposure to managed care, administrative aspects of practice, and interprofessional team work. There is emphasis on clinical assessment skills, including history taking, physical exam, primary and secondary data collection, prioritization, problem solving and decision-making skills, appropriate diagnostic testing, communication skills, and self-directed learning. The fellow will work with an assigned faculty member in an outpatient primary care practice setting and devote at least a 1/2 day a week continuously for 12 months.

### Outpatient Primary Care Practice Locations

#### Dr. Charles Crecelius

BJC Medical Group  
West County Medical Assoc.  
3009 N. Ballas Rd, Building C, Suite 383C  
Saint Louis, MO 63131  
Email: [charles.crecelius@bjc.org](mailto:charles.crecelius@bjc.org)  
Staff Contact: Sharon Parr,  
[sharon.parr@bjc.org](mailto:sharon.parr@bjc.org)  
(P) 314-996-4545  
(F) 314-996-4546

#### Dr. David Ban

BJC Medical Group  
Internal Medicine Specialists  
3009 N. Ballas Rd, Building C, Suite 387  
Saint Louis, MO 63131  
Email: [djb3651@bjc.org](mailto:djb3651@bjc.org)  
Staff Contact: Lynn Conway,  
[lynn.conway@bjc.org](mailto:lynn.conway@bjc.org)  
(P) 314-996-5905

### Educational Objectives and Competencies

The goal of the Outpatient Primary Care rotation is to provide experience in the practice of primary care geriatric medicine in an outpatient setting so that upon completion of the fellowship the trainee is well prepared for practice in this venue. Key to the training is an ongoing relationship with the attending for mentorship.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Outpatient Primary Care rotation:  
PC1 - 5, MK1, 2, SBP1 - 4, PBLI1 - 4, PROF1, 3, 4, ICS1, 3

### Patient Characteristics, Clinical Encounters, and Mix of Diseases

The clinical encounters include new patient examinations and follow-up visits. The mix of disease includes the typical outpatient internal medicine issues for older adults (addressing HTN, sensory deprivation, Diabetes, Hypercholesterolemia, etc.) and common geriatric syndromes.

### Procedures and Services

Fellow are expected to administer geriatric screens and assessments when appropriate. Laboratory services are available on site and radiological services are available locally.

### **Teaching and Evaluations Methods**

The designated primary care attending will observe the fellow regularly in order to provide ongoing teaching and feedback and opportunities for role modeling. Methods for teaching include oral presentations to the attending in clinic, review of pertinent physical exam findings by the attending, and review of the written history, physical exam, and care plans by the attending. Informal feedback from the supervising attending is expected throughout the rotation. Formal feedback from the supervising attending will be provided every three months. Evaluation methods will include the Direct Observation Feedback exam and the Multi-Source Evaluation, and completion of the Clinical Skills and Assessments Logs.

Fellows will provide an evaluation of the rotation and the attending at 6 and 12 months. Fellows will meet informally with Program Director on a monthly basis during the first 6 months of the fellowship to determine if there are any issues related to quality or quantity of the teaching experience.

### **VA Home-Based Primary Care Program (8 Weeks)**

The VA Home-Based Primary Care (HBPC) program provides interdisciplinary team-based care to homebound and/or otherwise frail and medically complex veterans in the St. Louis area who cannot easily travel to their Clinic appointments. The fellow will rotate for two months with the VA Home-Based Primary Care Program, during which he/she will be responsible for an assigned panel of patients and participation in weekly interdisciplinary team meetings. The fellow will work with an assigned VA HBPC faculty member and devote approximately 2 days a week continuously for 8 weeks.

### **VA-HBPC Practice Location**

Lakshmi Bandi, MD  
Medical Director, Home and Community-Based Care (H & CBC)  
Jefferson Barracks  
Building 53T, Room 115  
1 Jefferson Barracks Drive  
St. Louis, MO 63125  
(P) 314-845-5040  
(F) 314-894-5706  
[lakshmi.bandi@va.gov](mailto:lakshmi.bandi@va.gov)

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the practice of Home-Based Primary Care so that upon completion of the fellowship the trainee is well prepared for practice in this venue. The fellow will become familiar with interdisciplinary assessments of older



adults in the home setting and gain proficiency at collaborative, interdisciplinary team management of the frail elderly in the home setting.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Home-Based Primary Care rotation:  
PC1- 2, SBP1, 3, 4, PBLI1, 3, 4, PROF1 - 4, ICS1 - 3

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

The clinical encounters include new patient examinations and follow-up visits. In addition to typical outpatient internal medicine issues for older adults (addressing HTN, sensory deprivation, Diabetes, Hypercholesterolemia, etc.), and common geriatric syndromes, the VA HBPC program enrolls patients who are frail and/or have complex medical and psychosocial issues.

### **Procedures and Services**

Fellows are expected to administer geriatric screens and assessments when appropriate. Laboratory services are available on site and radiological services are available locally.

### **Teaching and Evaluations Methods**

The designated HBPC attending will supervise the fellow weekly to provide ongoing teaching and feedback and opportunities for role modeling. The attending will review the fellow’s oral and written history, physical exam, and care plans.

Informal feedback from the supervising attending is expected throughout the rotation. Formal feedback from the supervising attending will be provided at the end of the rotation, using the Multi-Source Evaluation. Fellows will provide an evaluation of the rotation and the attending at the end of the 8-week rotation. Fellows will meet informally with the Program Director on a monthly basis to determine if there are any issues related to quality or quantity of the teaching experience.

### **Outpatient Geriatric Consultation Clinic (48 Weeks)**

Older Adult Health Center  
Center for Advanced Medicine (CAM)  
Medicine Multispecialty Center (MMC)  
4921 Parkview Place 5th Floor, Suite C  
Dr. Ellen Binder: Mon PM  
Dr. Lenise Cummings-Vaughn: Wed PM  
Contact: Barbra Guilford, RN  
(P): 747-8647  
Email: [bguilford@wustl.edu](mailto:bguilford@wustl.edu)

Fellows will participate in one half-day session per week for 48 weeks and will work with two different faculty members, each for six months continuously. Our clinical team includes a physician faculty member, nurse specialist, and a PharmD. The clinic is also a training site for Internal Medicine residents and WUSM medical students. New patient evaluations usually take one hour to complete; follow-up visits are 30 minutes; family conferences are allotted 45 minutes. Since we work as a team, it is important for fellows to observe all staff during the first few weeks of clinic in order to understand their roles and responsibilities. By the third or fourth week, fellows are expected to perform the assessments with supervision by the attending. The goal is for fellows to be able to perform the physician assessment independently (with supervision), and also provide guidance to Internal Medicine residents and students as they learn components of geriatric assessment. The fellow is expected to manage incoming and outgoing telephone and fax request on behalf of their assigned Outpatient Geriatric Consultation Clinic attending. It is up to the fellow to determine if it is appropriate for them to sign for requests or if an attending signature is required.

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the Outpatient Geriatric Consultation Clinic so that upon completion of the fellowship the trainee is well prepared for practice in this venue. The fellow will provide outpatient Geriatric Medicine consultation services to other health care providers, assess (medically, socially, functionally, and psychologically) frail older adults and those with cognitive impairment in the outpatient setting, provide management of geriatric syndromes, and work in a multidisciplinary team; be proficient at leading a family/caregiver meeting; be able to discuss and document goals of care and advance care planning in the outpatient setting. Fellows will learn how to identify and manage geriatric syndromes, develop interview and communication skills with patients and families, understand the role of a geriatric consultant in the outpatient setting, work effectively in an interdisciplinary team to provide outpatient geriatric services, make appropriate referrals and network with community resources and other physician providers.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Outpatient Geriatric Consultation Clinic rotation:

PC1 - 5, MK1, 2, SBP1, 2, PBLI1, 3, 4, PROF1, 3, ICS1, 2, 3

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

Patients are typically brought to the Older Adult Assessment Clinic by a family member or caregiver. The clinical encounters include new patient consultations and follow-up visits. Common geriatric syndromes that are addressed and managed include; dementia, delirium, incontinence, falls, polypharmacy, depression, malnutrition, and failure to thrive.

### **Procedures and Services**

Fellows are expected to administer geriatric screens and assessments, as appropriate, become proficient in administering the psychometric test battery, and be able to administer the tests in the event the clinical nurse specialist is not available. Laboratory and radiology services are available on site. Pharm D services are available in the outpatient clinic.

### **Teaching and Evaluation Methods**

The faculty attending will directly supervise the fellow during each clinic, allowing for role modeling and ongoing informal feedback. The attending will directly observe the fellow's clinical interviews, physical exams, and conduct of family conferences; review progress notes in the electronic medical record and letters to referring physicians.

Methods for evaluation include the Direct Observation Feedback exam, Multi-Source Assessment, and completion of the Clinical Skills and Assessments Logs. Formal feedback from the attending will be provided at 3-month intervals, and a summary evaluation at 6 and 12 months. Fellows will formally evaluate the rotation and the attending at 6 and 12 months.

### **Long Term Care/Nursing Home (48 Weeks)**

Parc Provence  
605 Coeur De Ville Ct  
St. Louis, MO 63141  
Facility Phone: 314-542-2500  
Faculty: Lenise Cummings-Vaughn, MD  
Medical Director: David Carr, MD

Delmar Gardens West  
13550 South Outer 40 Road  
Chesterfield, MO 63107  
Facility Phone: 314-878-1330  
Faculty: Charles Crecelius, MD  
Medical Director: Charles Crecelius, MD

Fellows have two 6-month longitudinal clinical experiences, one at each of two nursing home sites, with an assigned panel of nursing home patients for whom they provide primary care, under the supervision of a faculty attending. Nursing home rounds are conducted during a one half-day session per week. At the Parc Provence nursing home site, fellows will typically supervise the Internal Medicine residents (usually two) and medical students on the Geriatrics rotation. The fellow is expected to manage incoming and outgoing telephone and fax request on behalf of their assigned Long Term Care/Nursing Home attending. It is up to the fellow to determine if it is appropriate for them to sign for requests or if an attending signature is required.

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the Long Term Care/Nursing Home setting so that upon completion of the fellowship the trainee is well prepared for practice in this venue. The fellow will obtain experience in management and treatment of common diseases and issues in the long term care setting (LTC); become proficient in discussing and documenting goals of care and advanced care planning; be able to manage end-of-life care

issues and understand the roles and responsibilities of hospice staff in the LTC setting; be proficient in managing dementia and related behavioral symptoms in the LTC setting. The goal is for fellows to take responsibility for physician assessments, and also to provide guidance to Internal Medical residents and medical students as they learn about primary care in the nursing home setting. The competencies for this rotation are as follows:

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Long Term Care/Nursing Home rotation: PC1 - 3, MK1, 2, SBP1, 2, 4, PBLI1 - 4, PROF1 - 4, ICS1 - 3

### **Educational Content**

Fellows will learn approaches to diagnosis and treatment of acutely and chronically ill/frail elderly in a less technologically sophisticated environment than the acute-care hospital, work within the limits of a decreased staff-patient ratio compared with acute-care hospitals, manage or co-manage psychiatric symptoms related to dementia and depression, manage communication related to end-of-life issues, and supervise end-of-life care in the LTC setting.

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

Nursing home patients have the typical geriatric syndromes, but also have a significant number of common internal medicine illnesses (CHF, COPD, DM, HTN). The clinical encounters include new patient evaluations and follow-up visits. Common geriatric syndromes that are addressed and managed include; dementia, delirium, incontinence, falls, polypharmacy, depression, malnutrition, and failure to thrive.

### **Procedures and Services**

Fellows are expected to administer geriatric screens and assessments, as appropriate. Laboratory services and some radiological services, including portable x-rays and arterial/venous Doppler exams are available on site. When necessary, more sophisticated tests such as MRIs, CTs, DEXA exams are performed at a local hospital as directed by the family, although we prefer that a BJC-affiliated hospital be used for our patients because we can view test results using Clinical Desktop software.

### **Teaching and Evaluation Methods**

Rounds with the attending are conducted on a weekly basis on site at the LTC facility. The fellow is responsible for organizing rounds and managing a panel of approximately 25-30 patients at Parc Provence, and a smaller number of patients at Delmar Gardens. The attending will observe the fellow weekly, allowing for ongoing feedback and opportunities and for role modeling during rounds. Additional learning opportunities include didactic sessions with the attending, review of relevant journal articles, and review of written history, physicals, and progress notes by the attending.

Methods for evaluation include Direct Observation Feedback, Multi-Source Assessment, completion of the Clinical Screens and Assessments Logs, and the Quality Indicator Parameter Tracking form. Fellows are also required to attend 1 Quality Improvement Meeting at each location. Fellows will receive formal feedback from the attending at 3-month intervals and a summary evaluation at 6 months. Fellows will formally evaluate the rotation and the attending every six months.

### **Parc Provence Newsletter**

Parc Provence has a family newsletter that is produced quarterly. Fellows are required to write an article for the newsletter in lay language on a topic related to dementia or long-term care. Please refer to the list of topics that have been covered in the past. This aspect of the fellowship is intended to develop written communication skills, as directed to patients and families.

### **Inpatient Consult Service (6, 1-Month Rotations)**

The Inpatient Geriatric Consultation Service serves patients at Barnes-Jewish Hospital and The Rehabilitation Institute of St. Louis (TRISL). The geriatric fellow is responsible for managing the consultation team in collaboration with the attending faculty member. The team usually includes medical residents and students. Consultations are typically provided on the day of the request, although sometimes within 24-36 hours, depending upon the reason for the request and the schedule of the consult attending and/or fellow on a particular day. Each fellow will complete six one-month rotations on the consult service over the course of the 12-month fellowship period, with the goal of completing at least 25 consultations over the course of the fellowship.

### **Procedure**

#### **Consult Intake**

- The requesting team will either contact the Coordinator or page the fellow assigned to the consult service with a new consult.
- Gather the following information:
  - Date consult called
  - Requesting person, call back #, service
  - Patient's name, Date of birth, Hospital room number
  - Attending for the patient
  - Question/reason for consult
  - Expected Discharge
- There will be an IM resident assigned to consults everyday (unless otherwise noted). Based on availability and urgency, it will be the decision of the fellow/Coordinator as to who will see the consult. It is suggested that the fellow on service complete the first consult called each week to ensure they are meeting the requirement of 25 consults for the year.

- Use EMR to look-up the patient
- Fellows may need to, or instruct the resident to, contact the collateral source, family member or caregiver for the patient
- After information has been collected, go see the patient.
  - To help determine where a patient is located, the following should be used as a guide to which elevator to take (note: X = the floor #)
    - X-100: Queeny Tower
    - X-200, -300: Rand Johnson/West Pavilion
    - X-400: Central
    - X-500: East Pavilion
    - X-900: Schoenberg/CAM
- ALL psychometrics (SBT and Clock) and Short Physical Performance Battery (SPPB) (when appropriate) and the PHQ9 MUST be completed PRIOR to contacting the attending to staff
- Fellows will log inpatient consults through the Procedures, Patient Logs & Learning Assignments in [www.MyEvaluations.com](http://www.MyEvaluations.com) that they LEAD while on the consult service
- Fellows should use guidelines and journal articles to help guide their decision making.

### **Staffing**

- Fellows should feel free to contact the attending by email about cases,
  - Attendings do not mind answering questions about management.
- Once ALL testing (SBT, Clock, SPPB, PHQ9) are completed, the fellow or the resident will contact the attending and ALL OTHER CONSULT TEAM MEMBERS to staff (IM residents, medical students and attending)
- The fellow/resident completing the work-up on the patient will sign the note in COMPASS

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the Inpatient Consultation setting so that upon completion of the fellowship the trainee is well prepared for practice in this venue. The fellow will provide consultation services for older adults in the inpatient setting, provide comprehensive inpatient geriatric assessments, assist with management of geriatric syndromes, and provide guidance for appropriate level and location of care at discharge.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Inpatient Consult Service rotation:

PC1, 2, 5, MK1, 2, SBP2, 3, PBL11, 3, 4, PROF1 - 3, ICS1, 3

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

Common geriatric syndromes that are addressed and managed include; dementia, delirium, incontinence, falls, polypharmacy, depression, malnutrition, and failure to thrive.

### **Procedures and Services**

Fellows are expected to administer geriatric screens and assessments when appropriate. Laboratory services and radiological services are available on site. The full range of services is available, as expected for a tertiary referral center.

### **Teaching and Evaluation Methods**

Methods for learning include oral presentations to the attending and other trainees, review and discussion of consult and progress notes by the attending, didactic sessions with the attending, and the Direct Observation Feedback exam.

Faculty assigned to the Inpatient Consult Service will observe the fellow directly and provide ongoing feedback and opportunities for role modeling. The attending will formally assess fellows' performance and provide direct feedback at the end of each 1-month rotation. Fellows will also formally evaluate the rotation and the attending at the end of each 1-month rotation. The Program Director will meet with fellows periodically to determine if there are any issues related to quality or quantity of the teaching experience.

### **Geriatric and Stroke Inpatient Rehabilitation (4 weeks)**

The Rehabilitation Institute of St. Louis (TRISL)  
4455 Duncan Avenue  
St. Louis, MO 63110  
Facility Phone: 314-658-3800  
Faculty Contact: David Carr, M.D.

Fellows will participate in a four-week rotation at The Rehabilitation Institute of St. Louis (TRISL), which is an acute inpatient rehabilitation facility (IRF). The rotation can be completed as one 4-week block, or two 2-week blocks, though our preference is for a 4-week block because of enhanced continuity of care and learning. The experience at TRISL will be focused on inpatient primary care of the older adults with stroke, general deconditioning, or other neurological disease. Fellows will be assigned a panel of 4-5 older adult inpatients to manage under the supervision of a TRISL/Stroke Service attending. Fellows are expected to perform a limited or comprehensive examination (as appropriate), complete a problem list and care plan, and write admission and progress notes using an electronic medical record (EMR). Admission and discharge summaries are dictated. Participation in weekly interdisciplinary care rounds is expected.

TRISL is located on the WU Medical Center Campus.

Please contact Amanda Conway at [Amanda.Conway@healthsouth.com](mailto:Amanda.Conway@healthsouth.com) for an introduction to the electronic records system and passwords to access the system.

\*\*\*Fellows may need to reschedule some regular program activities during this block, so PLEASE notify the appropriate attending (Geriatric Assessment clinic, some Nursing Home, Primary Care sessions) if the need arises to attend activities on a different day during a particular week (except for the geriatric Assessment Clinic). Fellows are expected to attend required conferences during this block, so long as it does not disrupt Rehab duties.

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the Geriatric and Stroke Inpatient Rehabilitation setting so that upon completion of the fellowship the trainee is well prepared for practice in this venue. The fellow will be familiar with the Functional Independence Measure (FIM) including assessment and scoring methodology and utilization for patients treated in acute rehabilitation facilities (ARF); be able to evaluate the patient's psychosocial setting, cognitive function, affect, and communication ability, and to determine the effect these may have on rehabilitation and discharge potential; understand the expertise, and specific role of each member of the rehabilitation interdisciplinary team; be familiar with the process for the development, review, and revision of each patient's rehabilitation goals, including discharge planning, in consultation with other team members, the patient and family; be familiar with the principles therapeutic exercise, including indications and contraindications; understand the indication for, and appropriate use of equipment such as canes, walkers, wheelchairs, and adaptive devices; know the evidenced-based medicine regarding state-of-the-art treatment for neglect, spasticity, aphasia, and incontinence.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Geriatric and Stroke Inpatient Rehabilitation rotation:

PC1 - 5, MK1, 2, SBP1 - 4, PBLI1, 3, 4, PROF1 - 4, ICS1 - 3

### **Inpatient Palliative Care (4 weeks)**

Barnes Jewish Hospital South  
Mid-Campus Center (MCC), 6th Floor  
Service pager: 314-747-4462 (7-4GOC)  
Faculty: Maria Dans, MD, Medical Director



Office: 314-362-5800

Email: [mariadans@wustl.edu](mailto:mariadans@wustl.edu)

Staff Contact: Melissa Euler, 314-747-5361, [meuler@wustl.edu](mailto:meuler@wustl.edu)

The Palliative Care Service at Barnes-Jewish Hospital is an interdisciplinary professional team that addresses many facets of care for patients with life-limiting diagnoses. The team consists of physicians, nurse practitioners, social workers, and chaplains; they work together to support patients and their families by providing symptoms relief, including pain, and psycho-social or spiritual distress. Trainees participate on this rotation for one 4-week block, working as a member of the inpatient Palliative Care Consult Service. Fellows are expected to work as an active physician member of the inpatient Palliative Care Consult Team, perform comprehensive assessments as related to palliative care issues, make follow-up inpatient visits on assigned patients, attend daily rounds, family meetings, and interdisciplinary team meetings.

\*\*\*Fellows will be excused from some regular program activities during this block, so PLEASE notify the appropriate attending (Geriatric Assessment Clinic, some primary care and nursing home sessions). Fellows are expected to attend required conferences during this block, so long as it does not disrupt Palliative Care duties.

### **Educational Objectives and Competencies**

The goal of the rotation is to provide experience in the Inpatient Palliative Care setting so that upon completion of the fellowship, the trainee is well prepared for practice in this venue. The fellow will gain exposure to the following components of Palliative Care:

1. Pain and other symptoms
  - a. Assessment and management of pain syndromes
  - b. Assessment and management of common non-pain symptoms, including expected adverse effects of pain medications
  - c. Basic pharmacology of NSAIDs, opioids, and adjuvant analgesics
  - d. Concepts of tolerance, physical dependence, and addiction
  - e. Non-pharmacologic pain management techniques, including both behavioral and procedural options
  - f. Unique uses and routes of administration of medications for comfort
2. Psychological & Spiritual dimensions of care
  - a. Identification of psychological issues associated with life-limiting diagnoses
  - b. Identification of social and cultural issues associated with life-limiting diagnoses
  - c. Identification of spiritual and existential needs of patients and families dealing with chronic illness

- d. Differences & areas of overlap in each of the roles of Palliative Care team members
3. End of Life issues
  - a. Strategies for communicating effectively with patients and families about difficult subjects
  - b. Common symptom complexes during the last hours of life
  - c. Anticipatory grief and bereavement
  - d. Stress-reduction techniques for caregivers (including health care professionals)
  - e. Timely and appropriate use of consultation of other medical sub-specialties
  - f. Exploration of cultural, societal, and personal attitudes toward death and dying

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Inpatient Palliative Care rotation:  
PC1 - 3, MK1, SBP1, 3, PBLI3, 4, PROF1 - 4, ICS1 - 3

### **Principal Teaching Methods**

The Palliative Care attending will provide clinical teaching and role-modeling during daily rounds and team meetings. Trainees will also spend time working with members of each of the various disciplines represented on the Palliative Care team. The Palliative Care attending will provide prompt feedback on the trainees’ presentations, consult notes, and interactions with healthcare professionals, patients, and families. Trainees should review the literature on topics pertinent to the care of patients on the service in order to provide a short presentation to the Palliative Care team during rounds, as assigned by the attending.

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

Similar to other consultative services, new consults and follow-ups will be assigned; this service, however, will focus on participation in interdisciplinary care of patients, including family conferences and team meetings. Most patients have incurable and frequently life-limiting illness; for some, the condition is chronic; for others, it represents a new diagnosis.

### **Educational Materials**

Resources include journal articles provided by the attending physicians, residents, house officers, and medical students; palliative care journals, textbooks and the UNIPAC and EPEC materials (copies of all of these may be found in the Palliative Care Service office); as well as online resources, formal didactics, and conferences.

### **Evaluation Methods**

Fellows will receive feedback throughout the course of the rotation from the Palliative Care attending and members of the multidisciplinary team. Fellows will be evaluated by the Palliative Care attending at the end of the rotation, and will have the opportunity to provide

evaluation of the rotation through the Multi-Source Assessment. If fellows have comments or suggestions regarding the Palliative Medicine Rotation at any time, please contact the Palliative Care Medical Director.

### **Outpatient Geropsychiatry (8 Weeks)**

#### Clinic:

Barnes Jewish Hospital South  
West Pavilion, Suite 15340  
Tuesdays at 9:30am  
Faculty: Eric Lenze, MD  
Cell: 314-498-1919  
Email: [lenzee@wustl.edu](mailto:lenzee@wustl.edu)

#### Office (lectures):

The Institute for Public Health (aka Taylor Avenue Bldg/TAB)  
600 S. Taylor Avenue  
MEDEX/Healthy Mind Lab, Suite 121-124  
Mondays at 11:00am  
Staff Contact: Stephanie Brown, office #124P, 314-362-5154, [brownsj@wustl.edu](mailto:brownsj@wustl.edu)

This rotation includes six (6) ½ day clinical sessions, and four required didactic sessions and self-study modules. The goals are to prepare fellows to manage patients with common psychiatric disorders encountered in a typical Geropsychiatry outpatient practice, including depression, anxiety, and behavioral symptoms associated with dementia. Fellows will become familiar with how to manage older adults with psychiatric problems in the context of a general medical practice, and which patients require emergent and non-emergent referral to a gero-psychiatrist.

### **Educational Objectives and Competencies**

The fellow will be able to conduct an effective psychiatric interview in the evaluation of older adults with sensitivity to social and environmental issues that are common in this population; know important depression inventory questions and mental status examination; have an increase general knowledge in the recognition/identification of various dementias and other psychiatric illnesses in older adults; gain knowledge of evidence-based pharmacological approaches to treating psychiatric and behavioral disorders in older adults; learn psychosocial assessment of caregivers, and the myriad of community services/agencies available for the treatment of psychiatric illnesses in older adults; know the indications for Geropsychiatry and neuropsychological referral and for electroconvulsive therapy.

Refer to “**Clinical Competency Milestones in the Geriatric Context**” at the end of this document for competency specific objectives.

The following competencies are evaluated for the Outpatient Geropsychiatry rotation:

PC1 - 5, MK1, SBP1, PBL1, 3, 4, PROF1 - 4, ICS1 - 3

### **Patient Characteristics, Clinical Encounters, and Mix of Diseases**

Dr. Lenze and a collaborating Nurse Practitioner provides clinical supervision on this rotation. It is structured to provide the fellows with a clinical experience in outpatient geriatric psychiatry. Fellows will see a variety of diagnoses common in the geriatric population, including major depression and other affective disorders, anxiety disorders, Alzheimer's disease and other dementias.

### **Teaching Methods**

Fellows will learn by reading the core syllabus and didactic lectures, and read and review the literature on topics pertinent to their specific cases.

Fellows meet with Dr. Lenze weekly for one hour of 1:1 supervision devoted to the "adult learner" model (Mondays @ 11am unless otherwise noted on your schedule). Namely, from now on in your career, you will gain knowledge and skill mainly by reading articles and dealing with challenging cases. You will maximize your learning from these strategies:

This will cover several core principles of outpatient geriatric psychiatry, and is designed to complement both the readings and the cases. Dr. Lenze will also give you written feedback on your write-ups, and together will track your progress towards your goals.

**Solitary Practice:** Every week at supervision you will receive a handout of "difficult cases," (i.e., cases that are designed to enhance your skills) and important articles. Each case has questions attached. Each article has both a pre-article reflection and a post-article quiz. Read through this material and answer the reflections and questions. Prior to your 1:1 supervision with Dr. Lenze each week, arrive 15-30 minutes early to review your prior weeks' answers with Stephanie.

**Learning by Teaching:** We want your help in expanding this syllabus during the rotation by writing up new cases or finding new articles. Aim for 3-4 (cases or articles) during your rotation. For each, write a "test question" reflecting what was most difficult about that case, or most important about that article. Only two recommendations:

- If you write up a case, make your questions difficult, but not impossible
- If any doubts about the format of the question (or the answer), just do the best you can and get Dr. Lenze or another attending to help frame the question and then answer it

### **Evaluation Methods**

Fellows will be provided with formal direct feedback by Dr. Lenze at the end of the rotation. During the rotation he will review the trainee's clinic notes and provide informal feedback; a supervising NP will also provide point-of-care feedback about the trainee's

communication skills during clinical encounters with patients. Fellows are expected to complete an online attending evaluation at the end of the rotation.

## **Minor Clinical Rotations**

(These rotations involve primarily observation experiences and the fellow will **NOT** be evaluated on ACGME competencies).

### **Memory and Aging Project (MAP) (2 sessions + CDR training)**

Knight Alzheimer's Disease Research Center  
4488 Forest Park, Suite 101, 1<sup>st</sup> Floor (Basement)  
St. Louis, MO 63108  
Staff Contact: Maria Carroll, 314-286-0246, [carrollmariab@wustl.edu](mailto:carrollmariab@wustl.edu)

Most afternoons beginning at 1:30pm.

The Washington University Memory and Aging Project (MAP) serves as the clinical research and neuropsychological evaluation unit for the Alzheimer's Disease Research Center (ADRC). Research participants are independently living volunteers who are recruited from the community for the longitudinal studies of health aging and dementia. Geriatrics fellows may attend Dr. Cummings-Vaughn's MAP Assessments on Thursday afternoons or one of the other MAP Clinicians' assessments if there is a schedule conflict. To attain sufficient training for certification in the administration of the Clinical Dementia Rating (CDR) assessment, fellows are also expected to complete the CDR training tapes. An ADRC staff member will assist with this process. It is strongly encouraged that fellows complete the CDR training within the first month of fellowship, as the CDR is utilized for assessments in the Outpatient Geriatric Consultation Clinic.

Fellows will need to make arrangements to meet with Maria Carroll prior to starting the training. Fellows can email Maria directly as the start time approaches to make arrangements. After the initial meeting, fellows can come and go as they please to get through the training videos. Fellows will need to communicate precise dates and times for the 2 observations and will need to complete an online observer form prior to coming found here: [http://alzheimer.wustl.edu/About Us/Forms/ObserverTrainee.asp](http://alzheimer.wustl.edu/About%20Us/Forms/ObserverTrainee.asp)

Also see "Knight ADRC Visitor Instructions" in the WUSTL Box → Rotations → Memory and Aging Project (MAP)

### **Memory Diagnostic Center (MDC) Clinic (4 sessions)**

Center for Advanced Medicine  
4921 Parkview Place, 6<sup>th</sup> Floor, Suite C  
St. Louis, MO 63110  
Faculty Contact: Dr. David Carr

Clinic Nurse: Dawn Ellington, [dellington@wustl.edu](mailto:dellington@wustl.edu)  
Tuesdays at 1:00pm

The Memory Diagnostic Center (MDC) provides clinical evaluations for patients with concerns about their memory and cognitive function. Geriatrics fellows attend Dr. Carr's MDC clinic ½ day a week, for four weeks.

Fellows will need to complete an Observer Trainee Form SEPARATE from MAP for MDC:  
[http://alzheimer.wustl.edu/About Us/Forms/ObserverTrainee.asp](http://alzheimer.wustl.edu/About%20Us/Forms/ObserverTrainee.asp)

Also see "Knight ADRC Visitor Instructions" in the WUSTL Box → Rotations → Memory Diagnostic Center (MDC)

### **Educational Objectives**

The fellow will understand interdisciplinary research assessments of cognitive impairment and dementia, and some of the research opportunities for older adults at the WU ADRC; learn the WU Clinical Dementia Rating (CDR) instrument, and to be able to apply it to assess standardized patients (videotapes) and clinic patients being evaluated for cognitive impairment; become familiar with the diagnosis, work-up, and management of Alzheimer's disease and other less common causes of dementia.

### **Hospice and Home Health Care (4 sessions)**

BJC Hospice Program  
1935 Belt Way Drive  
St. Louis, MO 63114  
Stephanie Fitzpatrick, BSN, RN  
Hospice Nurse Coordinator  
(P) 314-872-5050  
E-mail: [slf1075@bjc.org](mailto:slf1075@bjc.org)

Fellows will spend four (4) ½ days with the BJC Hospice program, and four half-days with a Physical Therapist affiliated with the BJC Home Care program.

BJC Hospice conducts interdisciplinary team (IDT) meetings weekly on Tuesday and Wednesday mornings at 8:30 a.m. Fellows are expected to attend at least one IDT meeting to gain an understanding of the format of the program and what is discussed. The remainder of the experience is spent accompanying a RN or NP on their rounds visiting hospice patients at home and at nursing home locations. In general, hospice rounds are Mondays-Thursdays, but schedules vary weekly.

### **Educational Objectives**

The fellow will understand the guidelines and criteria used for determining the eligibility for hospice care under the Medicare A hospice benefit, and the services provided and the medical and psychosocial management of patients enrolled in a hospice program.

### **BJC Home Health Physical Therapy (4 sessions)**

BJC Home Health Care  
Fridays at 8:30am

### **Educational Objectives**

The fellow will enhance their understanding of home health principles and practices; understand the role, responsibilities, and common practices of home-based physical therapists and understand the referring/supervising physician's role in managing patients who receive home care services.

### **Subspecialty Clinics**

Geriatrics fellows participate in the following subspecialty clinics: Bone Health Center (Osteoporosis), Movement Disorders clinic (Neurology), Uro-GYN clinic (Gynecology), Wound Care service (at TRISL or BJH/General Surgery). Some of these clinical experiences are more observational than others, but are an invaluable part of the fellowship experience. Articles on some of these topics are available in the WUSTLBox folder.

### **Bone Health Program (Division of Bone & Mineral Metabolism) (4 sessions)**

Center for Advanced Medicine (CAM)  
Medicine Multispecialty Center (MMC)  
4921 Parkview Place 5<sup>th</sup> Floor, Suite C  
St. Louis, MO 63110  
Faculty: Dr. Roberto Civitelli  
Email: [rcivitel@dom.wustl.edu](mailto:rcivitel@dom.wustl.edu)

2nd and 3rd Mondays of the month

This clinic focuses on the comprehensive evaluation and management of metabolic bone disease, primarily osteoporosis. Geriatrics fellows participate in new patients assessments and follow-up visits, under the supervision of a faculty attending. Geriatric fellows attend four (4) ½ day clinics.

### **Educational Objectives**

The fellow will understand screening and diagnostic guidelines for osteoporosis in women and men, pharmacological and non-pharmacological strategies to prevent and treat osteoporosis in the elderly and how to interpret DEXA test results for osteoporosis screening and management.

### **Movement Disorders Clinic (Dept. of Neurology) (4 sessions)**

Center for Advanced Medicine (CAM)  
4921 Parkview Place 6<sup>th</sup> Floor, Suite C  
St. Louis, MO 63110  
Wednesday AM  
Dr. Brenton Wright

McMillan Hall, Basement  
Monday – All Day, Wednesday PM

Contact: Amy Bain  
(P) 314-362-6908, [baina@neuro.wustl.edu](mailto:baina@neuro.wustl.edu)

Fellows participate in new patient and follow-up assessments, under the supervision of a faculty attending. Geriatric fellows attend four (4) ½ day clinics.

### **Educational Objectives**

The fellow will understand how to diagnose and manage common movement disorders in the elderly, especially Parkinson's disease, be able to detect subtle neurological impairment on physical examination, and understand the side effects of drugs that are used in the treatment of movement disorders, which drugs to avoid which may exacerbate movement disorders, and alternative management strategies.

### **Female Pelvic Medicine and Reconstructive Surgery (Uro-GYN) Clinic (4 sessions)**

Missouri Baptist Medical Center  
Center for Women's Wellness, Suite 450  
Building D, 4<sup>th</sup> Floor  
\*\*Preferred location for Geriatric Fellows

Center for Advanced Medicine (CAM)  
4921 Parkview Place  
13<sup>th</sup> floor, Suite C

Monday AM, Thursday AM

Monday PM, Wednesday PM

Dr. Chiara Ghetti  
Email: [ghetti.c@wustl.edu](mailto:ghetti.c@wustl.edu)

Contact: Karen Burns, Administrative Assistant  
(P) 314-747-7688  
Email: [burnsk@wustl.edu](mailto:burnsk@wustl.edu)

Board certified and fellowship trained female pelvic medicine and reconstructive surgery providers treat women with pelvic floor disorders including: urinary incontinence (including urgency, stress, and mixed and refractory urgency urinary incontinence), pelvic organ prolapse (including uterine, vaginal prolapse and post-hysterectomy vaginal vault prolapse), fecal incontinence, bladder/pelvic pain.



Fellows participate in new patient and follow-up assessments, under the supervision of a faculty attending. Fellows will also have the opportunity to observe office procedures including urodynamic testing and cystoscopy.

Geriatric fellows are to attend a lecture on Urinary Incontinence **(TBD)** and attend four (4) ½-day clinics.

### **Educational Objectives**

The fellow will understand the outpatient evaluation including obtaining a pertinent history in a patient with a suspected pelvic support defect, urinary incontinence, or fecal incontinence; become familiar with components of a focused physical examination in patients with urinary incontinence and prolapse, identify specific pelvic support defects and identify pelvic floor musculature; understand management options including non-surgical and surgical treatment options for urinary incontinence and pelvic floor support defects, and indications for referrals, the role of the female pelvic medicine and reconstructive surgeon (urogynecologist) as well as pelvic floor physical therapists in the management of pelvic floor disorders.

### **Wound Care Services and Podiatry (5 sessions)**

Center for Outpatient Health  
4901 Forest Park Ave, 1<sup>st</sup> Floor  
St. Louis, MO 63108  
Dr. John Kirby  
(P) 314-362-5298, [kirbyj@wudosis.wustl.edu](mailto:kirbyj@wudosis.wustl.edu)

Contact: Gay Sellers  
(P) 314-362-1272, [sellersg@wudosis.wustl.edu](mailto:sellersg@wudosis.wustl.edu)

### **Educational Objectives**

The fellow will become competent at diagnosis of etiologies of wounds; including pressure, PVD, venous stasis, diabetes; assessment tools used to determine those at-risk; how to properly describe and stage wounds, particularly pressure ulcer; techniques for wound prevention and management in the outpatient setting. They will also become familiar with management of common problems encountered by podiatrists, including bunions and other foot deformities.

Fellows participate in 5 clinic sessions at the WU Wound Care clinic, where they participate in new patient and follow-up assessments at the under the supervision of a faculty attending (General Surgery and Podiatry). Fellows also attend one didactic session with a certified wound care specialist for an overview of wound care services and management.

Fellows have the opportunity to participate in rounds on the in-patient Wound Service, although this is optional.

### **WU Ophthalmology Clinic (1 session)**

Washington University Eye Center  
Center for Advanced Medicine  
4921 Parkview Place, Suite C, 12th Floor  
St. Louis, MO 63110

Dr. Rithwick Rajagopal  
Email: [RajagopalR@vision.wustl.edu](mailto:RajagopalR@vision.wustl.edu)

Contact: Kelly Cuellar  
(P) 314-747-5848,  
[CuellarK@vision.wustl.edu](mailto:CuellarK@vision.wustl.edu)

Geriatric fellows attend one clinic with the attending, with a focus on retinal diseases.

### **Dentistry (online training module)**

Details will be provided by the Program Director and Coordinator.

## **Clinical Screens, Assessments, and Consult Logs**

To ensure trainees receive adequate exposure to a range of geriatric conditions and as a means to communicate practice habits, fellows are required to log their patient encounters relative to targeted geriatric syndromes and common age-related disorders. Logging of screens, assessments and inpatient consults are managed through [www.MyEvaluations.com](http://www.MyEvaluations.com). When logging in, select *Procedures, Patient Logs & Learning Assignments*, then under *Patient Logs* select *Submit New Patient Log* where information is entered regarding the patient encounter. In the “HIPAA Compliant Patient Data Log”, enter the patient name, DOB, gender, and date.

Fellows are expected to have graded and progressive responsibility according to the individual fellow’s clinical experience, knowledge, judgment, and technical skill. Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Fellows are responsible for asking for help from the supervising physician (or other appropriate licensed practitioner) for the specific clinical service or rotation, when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow is assigned by the Program Director and faculty members. Geriatric Medicine Fellows will be closely observed during the first three months of their PGY4 year, with direct supervision by all clinical attendings.

At the end of the 3-month evaluation period, the Program Director will determine the fellow's ability to practice at each clinical site with graduated levels of supervision, based on a review of all evaluations completed to date and the completion of at least  $\frac{1}{4}$  of the required Geriatric Screens and Assessments. At the time of the mid-fellowship evaluation (6 months), the Program Director, in collaboration with the Clinical Competency Committee (CCC), will determine the fellow's ability to practice with oversight, for specified clinical rotations, based on a review of all evaluations completed to date.

### **Levels of Supervision**

Appropriate supervision of fellows will be provided for all clinical encounters. Levels of supervision may vary depending on circumstances or the skill and experience of the fellow.

#### **Definitions of Levels of Supervision:**

1. *Direct Supervision* – The supervising physician is physically present with the fellow and patient.
2. *Indirect Supervision:*
  - a. *With direct supervision immediately available* – The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision
  - b. *With direct supervision available* – The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide Direct Supervision.
3. *Oversight* – The supervising physician is available to provide review of encounters with feedback provided after care is delivered.

In the table below, # *Milestone* is the number of encounters required to graduate by the end of the year and # *Competency* is the number of encounters required to graduate to indirect supervision.

<b>Encounter</b>	<b># Milestone</b>	<b># Competency</b>
Assessment - ADL/IADL Management	20	5
Assessment - Fall Management Plan	15	4
Assessment - Full Psychometric Battery	3	1
Assessment - Incontinence Management Plan	5	2
Assessment - Osteoporosis	15	4
Assessment - Pressure Ulcers	10	3
Inpatient Consult	25	6
Screen - AUA BPH and ED	5	2
Screen - Cognitive Impairment	20	5
Screen - Depression	20	5
Screen - Mobility	20	5
Screen - Osteoporosis	20	5
Screen - Sensory Deprivation	5	2
Screen - Sleep Apnea	5	2
Screen - Under-Nutrition	10	3

## Evaluation of Fellows, Faculty and Program

Evaluation of fellow performance with regards to ACGME Geriatric Medicine competencies will utilize the following tools: Multi-Source Assessments, the Direct Observation Feedback exam, patient/caregiver feedback surveys, a written examination (passing score is 70%), and a standardized oral examination.

Fellows will have the opportunity to confidentially evaluate all Geriatric Medicine faculty after each clinical rotation.

Fellows are expected to serve as a member of the Program Evaluation Committee (PEC), which meets once per academic year, typically in early June. The PEC committee meeting is an excellent venue to provide feedback regarding program quality. The Program Coordinator will provide fellows with a Program Quality Improvement Form to help organize and keep track of their thoughts throughout the year. Additionally, fellows are expected to complete all ACGME, Institutional and Division surveys/evaluations.

## Schedule/Absences

The Program Coordinator will update fellow's schedules monthly and maintain them in the Geriatric Medicine Fellowship WUSTL Box. This is intended as a framework to assist in organizing rotations, but allows flexibility for clinical or research experiences as each fellow's interests dictate. Please discuss any planned absences with the Director in advance, so that any potential schedule or coverage conflicts can be worked out. Fellows are expected to inform the Program Coordinator of approved absences so that adjustments can be made to call schedules, Division out of office calendar, etc. Unplanned absences should be communicated to the Program Coordinator, Program Director, and rotation/clinic attending as soon as possible.

Please refer to the GME Consortium Operating Principles ([http://gme.wustl.edu/About the GME Consortium/Policy/Pages/GME%20Consortium%20Operating%20Principles.aspx](http://gme.wustl.edu/About%20the%20GME%20Consortium/Policy/Pages/GME%20Consortium%20Operating%20Principles.aspx)), Appendix E – Leave Policy ([http://gme.wustl.edu/About the GME Consortium/Policy/Leave Benefits and Support/Documents/Leave%20Policy.pdf](http://gme.wustl.edu/About%20the%20GME%20Consortium/Policy/Leave%20Benefits%20and%20Support/Documents/Leave%20Policy.pdf)) for more information.

## Textbooks and Reading Materials

### **Required:**

**Kane, Robert L., 2013. Essentials of Clinical Geriatrics, 7e. McGraw-Hill.**  
ISBN: 9780071792189

- Available through Becker Medical Library:  
<http://accessmedicine.mhmedical.com/book.aspx?bookid=678>
- Available in the Geriatric Medicine Fellowship WUSTL Box folder
- Core topics from Essentials of Clinical Geriatrics will be covered during didactic sessions with the Program Director on **Mondays at 10:30am.**

- Be familiar with all sections of the book by the end of the year.

**Reuben, David B., 2016. Geriatrics at Your Fingertips. American Geriatrics Society.**

ISBN : 978-1-886775-40-4

- Available in print or the American Geriatrics Society:  
<https://geriatricscareonline.org/>
- Be familiar with all sections of the book by the end of the year.

### **Core Topic Articles**

- Available in the Geriatric Medicine Fellowship WUSTL Box folder
- Be familiar with all articles in the folder within the first couple months.

**The Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine, 9th Edition (GRS9). American Geriatrics Society.**

- Available in print or the American Geriatrics Society:  
<https://geriatricscareonline.org/>
- Multiple choice questions with answers and an extensive bibliography
- Board Review is on the **3<sup>rd</sup> Monday of the month at 11:30am.**

### **Portal of Online Geriatrics Education (POGOe) web-GEMs**

- Available online: <https://www.pogoe.org/webgems>
- Includes a comprehensive collection of educational materials.
- Geriatric Medicine faculty may request specific learning modules in POGOe be completed based on specific educational needs.

To access POGOe web-GEMs **(THIS WILL CHANGE)**:

1. **Register as a student**
  - a. <http://pogoe.org/user/register>
2. **Login**
3. From the POGOe Homepage, Click the **web-GEMs tab** at the top of the page
4. Scroll to the bottom of the page and click the button that says, "**Click Here to Sign-Up for web-GEMs Assignments**"
5. Click "**refine**" and search by instructor for: **Binder**
6. Select the assignment titled, "**Washington University/BJH Geriatrics Clinical Rotation**"
7. Scroll to the bottom of the page and where it says, "**Signup for this assignment: Enter a passcode if one was provided**" and enter **WashU** and click, "**Sign-Up**"
8. After registering, follow the link below and click "**Sign Up**" to begin the assignment.

[Washington University/BJH Geriatrics Clinical Rotation](#)

## **Additional Resources:**

### **Up to Date**

- Available through Becker Medical Library:  
<https://becker.wustl.edu/resources/databases/uptodate>
- Peer-reviewed text which provides specific, practical recommendations for diagnosis and treatment.

### **Podcasts**

Core curriculum requirements may also be met by downloading podcasts and reviewing key lectures provided by the Department of Medicine at Washington University. The podcast website has many excellent lectures that they provide to the internal medicine residency program that are up to date, concise, evidenced-based, and are pertinent to growth as a clinician in the field of geriatrics. These lectures are one hour in length and will count as part of the core curriculum lecture series. Although it is understood that many of these lectures were either provided during or part of previous training in internal medicine; we do require review if fellows have not had this specific lecture in previous training (e.g. recent graduate of the Barnes residency program).

To access Podcasts:

1. Visit the MedEd website: <http://meded.dom.wustl.edu/>
2. Click “Resident Login” in the upper right corner  
Username: resident  
Password: meded
3. Click “Webcasts” in the bottom left corner
4. Under “ARCHIVE WEBCAST”, click the “Click here to view past conference recordings.”

We ask that fellows keep a checklist of the lectures they have reviewed by the end of the fellowship year to be turned into the Program Coordinator as it is part of the requirement to complete the fellowship. Refer to the “Requirements Portfolio” for a complete list of Core Curriculum Topics.

### **Expectations**

1. Fellows are expected to lead in an educational role. Fellows should lead attending/teaching rounds, bringing articles and other information to the team based upon the patients that are seen. Fellows are expected to prepare several such teaching sessions each week, based upon the curriculum for the rotation established in conjunction with the attending on service.
2. Fellows should work specifically with residents and medical students, and should help them to complete their clinic/consult notes.

3. Fellows should serve as a liaison with outside physicians and consultants in order to ensure that continuity of care is provided during transitions to other settings of care.
4. If a fellow misses a required clinical experience or a conference presentation, it is the fellow's responsibility to reschedule the experience with the appropriate attending and/or notify the Coordinator that the experience needs to be rescheduled.

## **Conferences**

### **Core Curriculum**

#### **Journal Club, Clinical Review, Guest Speaker, Faculty Discussant**

When: 1<sup>st</sup>, 3<sup>rd</sup> and 4<sup>th</sup> Monday at 12:00pm

Where: 338 Wohl Clinic Building Conference Room

Required: YES, please sign the attendance sheet

#### **Friedman Center on Aging**

When: 2<sup>nd</sup> Monday at 12:00pm

Where: FL&TC, Rm 214A/B or Danforth Campus – DUC, Rm 276

Required: YES, please sign the attendance sheet

This experience will allow fellows to improve in their ability to rigorously review the medical literature and learn about research design and statistics.

## **Instructions**

Oral presentations for our Core Curriculum are scheduled on Mondays at 12:00pm. Fellows will select one topic in geriatric medicine to focus on for a 30 or 60 minute (depending upon how many trainees are presenting that day) oral presentation, using PowerPoint software.

For Journal Club, the first 10-15 minutes of the presentation will focus on a brief clinical review of the specific content area (e.g. sleep disorders in the elderly); epidemiology, important history, exam findings, differential diagnosis, and if there is time, interventions for common conditions. For the last 15-20 minutes of a 30-minute presentation we expect fellows to review a recent article on this area, preferably one that might change the management or treatment of this condition in older adults. We would ask that fellows also provide their opinion on the strengths and limitations of the article.

For Clinical Review sessions, we expect fellows to provide a more extensive review of a clinical topic, and present information from several relevant articles, although a review article can be utilized to assist in organizing the talk. Fellows are expected to e-mail the article of choice to Dr. Birge one week prior to the conference, and arrange a time to meet with him in advance of the Monday conference to discuss the article/topic.



**Please email the approved topic/article to the Program Coordinator by the preceding Wednesday at 12:00pm and any handouts that need to be copied by Friday.** The PowerPoint presentation should be emailed to the Program Coordinator by Monday at 8:00am. Please bring the presentation on a flash drive as back-up. The Program Coordinator sets up the laptop in the Division Conference Room by 11:50am.

**MANDATORY:** Because this is a CME activity, presenters must complete the annual financial disclosure and Course Faculty Agreement information on line. Go to <https://cme.wustl.edu> and click on "submit disclosures". Presenters should logon by using their email address and the first-time password is "disclose". If a presenter has previous submitted disclosures and do not remember login information, contact the CME office at 362-6891 or 362-6521 for a password reset. This should be done at least 48 hours prior to the presentation.

### **Core Curriculum Topics**

Below is a list of Core Curriculum topics to be referenced when deciding on a topic for Journal Club, Clinical Review or Case Conference. This list is neither inclusive nor exhaustive.

1. Science of aging: epidemiology, physiology, theories of aging
2. Preventive medicine: nutrition, oral health, exercise, screening
3. Geriatric assessment: cognitive, functional, medical, laboratory
4. Interdisciplinary coordination: care coordination
5. Geriatric Syndromes: depression, falls, incontinence, osteoporosis, sensory impairment, pressure ulcers sleep disorders, pain, elder abuse, malnutrition, functional impairment
6. Geriatric issues associated with common disease: neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, pharmacologic
7. Pharmacological issues associated with aging: polypharmacy, pharmacokinetics, inappropriate drugs in the elderly, cholinergic burden.
8. Psychosocial aspects of aging; family interactions, living arrangements, adjustment disorders
9. Economics of geriatric services: Medicare, Medicaid, Older Americans Act, cost containment.
10. Ethical and legal issue relevant to geriatrics: competency, guardianship, advanced directives, durable power of attorney
11. Geriatric rehabilitation: OT and PT for specific conditions
12. Long-term Care medical and financial issues: patient management, Hospice, Palliative care, regulations, financing.
13. Research methodology: epidemiology, statistics, critical review, level of evidence
14. Perioperative assessment: preoperative assessment, management of specific post-operative conditions, hip fracture
15. Iatrogenic disorders: prevention: cholinergic burden, inappropriate use of drugs
16. Communication skills: patients, families, health professionals

17. Support systems: family, community, organizations, AA
18. Cultural aspects of aging: demographics, ethnicity, culture-specific beliefs and attitudes, role of the interpreter, education, urban vs. rural
19. Home care: resources, financing, components of the home visit
20. Hospice care: pain management, end-of-life issues
21. Psychosocial aspects of geriatric care

### **Clinical Case Conference**

When: 1<sup>st</sup> and 4<sup>th</sup> Monday of each month at 11:30am

Where: 338 Wohl Clinic Building Conference Room

Required: YES, please sign the attendance sheet

Geriatrics fellows are assigned cases to present from the following clinical sites: Older Adult Health Center clinic, Primary Care Geriatrics clinic, Inpatient Geriatric Consult Service, Parc Provence nursing home, and TRISL Rehabilitation service.

### **Board Review Session**

When: 3<sup>rd</sup> Monday of each month at 11:30am

Where: 338 Wohl Clinic Building Conference Room

Required: YES, please sign the attendance sheet

Trainees and faculty discuss a set of approximately 10 board review questions from the current Geriatric Review Syllabus.

### **ADRC Weekly Seminar**

When: Tuesday at 12:00pm

Where: East Pavilion Conference Room

Required: YES, please sign the attendance sheet.

This conference focuses on the basic and clinical science of Alzheimer's disease and related disorders. The conference schedule is distributed in September and January. This is an important mandatory conference for all clinically-related topics.

### **Geriatric and Nutritional Science Noon Research Seminar**

When: Thursday at 12:00pm

Where: 213 West Building Conference Room

Required: YES for Research track if doing research with Dr. Klein or Metabolism faculty, please sign the attendance sheet; NO for 1-year clinical fellows.

**Medicine Grand Rounds**

When: Thursdays at 8:00am

Where: Clopton Auditorium

Required: NO, Optional

**Hospice and Palliative Care Conferences**

When: Wednesdays

Where: MCC 6th floor

Required: NO, Optional

## **Patient Safety Quality Improvement (PSQI) Curriculum**

The Division of Geriatrics and Nutritional Science have developed a PSQI Curriculum based on the WU/BJH/SLCH GME curriculum developed by the Patient Safety and Quality Improvement Working Group. Those objectives/milestones designated for proficiency at the “Resident” level are felt to be appropriate for all graduating Geriatric Medicine Fellows to achieve.

There are 2 components to the PSQI Requirement:

- 1) Participation in the DOM Safety and Quality Improvement and completion of the required quizzes (assigned through MyEvaluations.com); and
- 2) Participation in a project in either Patient Safety or Quality Improvement.

### **Curriculum**

We do not have a unified resource that encompasses all of the PSQI Competency areas. As such, Geriatrics Fellows are required to complete the flowing modules from the sources indicated below. All of the relevant materials can be found in the PSQI WUSTLBox.

#### **SECTION I. PATIENT SAFETY (MyEvaluations Quiz)**

##### **I.A. Patient safety fundamentals**

- Basic Principles of Patient Safety WUSM
- Gaps PSEP
- Patient Safety Fundamentals PSEP

##### **I.B. Human Factors**

- Human Factors WUSM
- Human Factors PSEP
- **MyEvaluations Quiz**

##### **I.C. Systems Thinking**

- Systems Thinking PSEP
- Next Steps PSEP

##### **I.D. Culture of Safety**

- Culture of Safety WUSM
- Organization and Culture PSEP

##### **I.E. Detecting, Reporting, and Learning from Errors**

- Reporting of Patient Safety Events WUSM

##### **I.F. Effective Teamwork and Interprofessional Communication**

- Leadership PSEP
- Teamwork PSEP

##### **I.G. Communicating with Patients**

- Communicating Serious Adverse Events to Patients WUSM
- Communicating with Patients PSEP
- Patients as Partners PSEP
- **MyEvaluations Quiz**

##### **I.H Health Information Technology**

- Technology PSEP

## SECTION II. QUALITY IMPROVEMENT

### II.A. Quality Improvement Fundamentals

- Quality of Health Care WUSM

### II.B. Evidence Based Medicine

- Evidence Based Practice PSEF

### II.C. Model for Improvement

- Model for Improvement PSEP
- Practice Improvement PSEP

### II.D. Measuring for Improvement

- Measuring for Improvement PSEP

## SECTION III. CLINICAL APPLICATION OF PSQI

### III.A Fatigue

- Lecture provided by Internal Medicine

### III.C Medication Safety

- Medication Safety PSEP

### III.D Preventing Falls/Injuries and use of Restraints/Seclusion

- Falls PSEP

### III.E Health Care Associated Infections

- Infection Control PSEP

### III.G Pressure Ulcers

- Pressure Ulcers PSEP

## **PSQI Project**

Each fellow will submit to the program director written documentation of their participation in a project in either Patient Safety or Quality Improvement to be included in the graduate's file. The project must be supervised/mentored by a faculty member and approved by the PD. This project should demonstrate application of the principles of the Institutional GME PSQI Curriculum. Written documentation should include:

**Name of project/activity:**

**Date of completion/participation:**

**Name of supervising faculty/faculty mentor:**

**Brief description of project/activity including which components of the PSQI curriculum were applied.**

**Date/place of presentation/submission for publication (if any):**

Examples of a Patient Safety or Quality Improvement project include:

1. Identification of a clinical problem (i.e., high readmission rates, long clinic wait times, etc.), description and analysis of causative/contributing factors, planned intervention, planned monitoring for effect and IF AVAILABLE, analysis of outcome of intervention. (Traditional PDSA cycle)

2. Review and analysis of patient outcomes (for resident's own patients seen in a residents' clinic or those inpatients/outpatients in whose care the trainee was involved over a period of time, or for larger group of patients such as all clinic patients or all patients undergoing a specific procedure in a given timeframe) and planned intervention to improve outcomes/compliance with standards, plan for monitoring and IF AVAILABLE, analysis of outcomes. Examples include: diabetic control of outpatients in continuity clinic, immunization rates, compliance rates with screening protocols, reduced "Door to Balloon" times, etc.)
3. Active participation in development/revision of clinical Care Paths or protocols. Should include review of evidence, plans for monitoring compliance and, IF AVAILABLE, analysis of outcomes post intervention.
4. Active participation on departmental or hospital PS or QI committee; should attend AT LEAST 3 consecutive meetings.
5. Presentation of analysis of medical error or near miss. May be at formal M&M but MUST include systems analysis of factors contributing to adverse outcome AND proposal of systems based changes to reduce recurrence.
6. Participation in a BJH LEAN project related to clinical care, including at least two meetings.

Ultimately, acceptability of a project/activity will be at the discretion of the PD.

Projects/activities may be done as a group project with approval of PD. Projects that are ongoing at the time of graduation should have an interim report documented and may be continued by a subsequent trainee.

It is intended that the GMEC will annually review the success of the above curriculum, assessing the need for revisions and or institutional resources to attain consistently excellent training for all graduates in Patient Safety and Quality Improvement.

Fellows are encouraged to attend PSQI training sessions organized by the WU GME office, and to visit the online WUSM Patient Safety Library (see below). To allow sufficient time for initial data collection, data analyses, implementation of an intervention, and repeat data collection/analysis, fellows are strongly advised to submit their proposal no later than the end of Month 3 (September) of the fellowship year. The Division PSQI Conference is designed to assist fellows with development and implementation of their project. For that conference, fellows are expected to present/discuss their PSQI proposal, implementation challenges, and results.

**Resources:** WUSM Patient Safety Library <http://patientsafety.wusm.wustl.edu>

Articles and a template are available in the WUSTLBox PSQI folder.

## **Research and Teaching**

There are numerous opportunities for research related to aging at Washington University. We are involved in several ongoing projects in clinical geriatrics, many of which could provide the basis for research studies. These include nutrition and obesity, drug studies on aging issues, the effect of exercise on aging and frailty, osteoporosis, long term care, medical conditions that affect driving, and case reports of unusual presentations of disease in the elderly. The annual scientific meeting of the American Geriatrics Society is held in May, and provides an excellent forum to present a paper or poster. However, the deadline for abstracts is December of the fellowship year, so fellows need to start working on a project early. The Geriatric Medicine faculty are delighted to provide guidance for this type of experience, and encourage fellow participation in a research project, but this aspect of the rotation is optional.

As fellows progress through training, they will have the opportunity to teach personnel such as nurses, allied health personnel, medical students, and residents. The fellowship director will ask fellows to participate in lectures/seminars in a variety of settings, when appropriate. The Becker Medical Library has training courses for database searches, Excel, and EndNote, among others. If fellows are interested in taking a class, please ask our Program Coordinator for assistance.

## **Institute of Clinical and Translational Sciences - ICTS**

To meet the intent of the national CTSA initiative, WU established the Institute of Clinical and Translational Sciences (ICTS). By funding some new resources, collaborating with a variety of existing resources and coordinating with the WU central administration to identify various ways to create more efficient processes, the ICTS umbrella covers resources required throughout the development cycle. The ICTS helps ensure that ICTS investigators have access to state-of-the-art research infrastructure, financial support, and education, facilitates translational research, assists in the creation and sustaining of interdisciplinary research collaborations, and helps move research findings from the initial discovery phase into new diagnostics, therapeutics, and prevention strategies to improve human health.

The ICTS leverages partnerships with other local and regional academic, healthcare, and community partners. These elements complement WU core expertise to form this transformational institute designed to help reinvent and reinvigorate clinical and translational research and clinical research training.

<http://icts.wustl.edu/>

## **Clinical & Translational Science Awards (CTSA)**

Accelerating Discoveries Toward Better Health -

With support of the National Institutes of Health (NIH), the Clinical and Translational Science Award (CTSA) program was launched in 2006 and has expanded to more than 60 academic medical institutions across the country. Part of the National Center for Advancing Translational Sciences (NCATS) Division of Clinical Innovation, the programs mission is to advance the pace of scientific discovery, disseminate and implement research results to improve human health, and educate the next generation of translational researchers. By working together as a consortium, we can help shape the future of healthcare.

<http://icts.wustl.edu/icts-researchers/about/national-ctsa>

## **Clinical Research Training Center**

The Clinical Research Training Center is part of the Washington University Institute of Clinical and Translational Sciences. The Center provides didactic curriculum and mentored training in clinical and translational research for students, house-staff, postdoctoral students, fellows and junior faculty. Senior faculty serve as mentors, role models and teachers to develop future leaders of clinical and translational research.

<https://crtc.wustl.edu/programs/>

## **Postdoctoral**

Postdoctoral Mentored Training Program in Clinical Investigation (MTPCI)

- <https://crtc.wustl.edu/programs/postdoctoral/mtpci/>

## **Masters Degrees**

Master of Science in Clinical Investigation (MSCI)

-<https://crtc.wustl.edu/programs/degrees/msci/>

## **Graduate Certificates**

Certificate in Clinical Investigation (CI)

-<https://crtc.wustl.edu/programs/certificates/ci/>

## **Job Opportunities**

The Program Director and Coordinator will forward information about career opportunities that are sent to their attention to the fellows. Career MD, <http://www.careermd.com/>, houses a vast database for opportunities with leading hospitals, healthcare systems, educational institutions, and government agencies.



## **Clinical Competency Milestones in the Geriatric Context**

### **Patient Care and Procedural Skills – PC**

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Fellows must demonstrate clinical competence in:

- assessing the functional status of geriatric patients;
- treating and managing geriatric patients in acute care, long-term care, community, and home care settings;
- assessing the cognitive status and affective states of geriatric patients;
- providing appropriate preventive care, and teaching patients and their caregivers regarding self-care;
- providing care that is based on the patient's preferences and overall health;
- assessing older persons for safety risk, and providing appropriate recommendations, and when appropriate, referral;
- peri-operative assessment and management; and,
- use of an interpreter in clinical care.

Fellows must be able to competently perform all medical and diagnostic procedures considered essential for the area of practice.

### **PC1: Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s).**

History taking.

- Accounts for patient's sensory, cognitive, physical impairments.
- Assesses whether patient is a reliable informant.
- Includes in ROS: function, cognition, new medications, home situation/psychosocial, nutrition, elder abuse, hearing, vision, involuntary weight loss, incontinence, swallowing problems, constipation.

Physical exam.

- Accounts for patient's sensory, cognitive, physical impairments.
- Includes assessment of frailty, gait & balance, cognition, and examination of skin for signs of pressure ulcers and elder abuse.

Primary and secondary data collection.

- Collects data from appropriate family, caregivers and other healthcare providers.

Synthesis and prioritization.

- Recognizes critical illnesses, particularly atypical presentations.
- Interprets geriatric history and physical accurately to optimize diagnostic testing.

## **PC2: Develops and achieves comprehensive management plan for each patient.**

Individualization of care plan.

- Identifies decision-maker regarding care plan.
- Prioritizes based on prognosis, goals of care, patient preferences, benefit/risk of diagnostic/therapeutic interventions.
- Takes into consideration: psychosocial issues, caregiver stress, function, appropriateness of level of care, costs of care.
- Refers to community or institutional resources.

Recognizes and reacts to 'sick' patients.

- Recognizes delirium, atypical presentations (e.g. acute abdomen, elder abuse or neglect).

Asks for guidance (knows limits).

- Seeks guidance from interprofessional team.
- Knows when to refer for neuropsychologic testing, physiatry, psychiatry, neurology, urology, audiology, ophthalmology, sleep specialist, gynecology, speech therapy (dysphagia), palliative care and ethics.
- Recognizes conflict and boundary issues and asks for help.

Recognizes and manages complex diseases.

- Recognizes atypical presentations.
- Manages multiple chronic conditions and geriatric syndromes by prioritizing care based on prognosis, goals of care, patient preferences, benefit/risk of dx/tx interventions.

## **PC3: Manages patients with progressive responsibility and independence.**

Provides quality, safe care.

- Develops care plans aligned with patient goals of care, and that provide benefits that outweigh risks given the patient's illness trajectory.
- Considers geriatric syndromes or medications as part of all differential diagnoses.
- Appropriately chooses medication regimens using principles of geriatric pharmacology.

Manages high acuity patients.

- Considers goals of care and patient prognosis when managing high acuity patients.
- Manages delirium with minimal use of restraints and psychotropic medication.
- Prevents hazards of hospitalization.
- Manages pain crises.

Manages patients with progressive responsibility and independence.

- Prioritizes care of complex patient, including incorporating patient/ caregiver goals of care and recognizing when patients are at high risk for poor outcomes.

- Uses prognosis to distinguish between futility and nihilism.
- Accepts ownership of patient's care, collaborating with IPT members and other specialists, and framing consultant recommendations within the context of the patient's goals of care.

**PC4b: Skill in performing and interpreting noninvasive procedures and/or testing.**

Geriatric non-invasive procedures:

- Comprehensive Geriatric Assessment.
- Cognitive and mood assessment.
- Gait and balance assessment.
- Capacity assessment.
- Family meeting.

- (1) Appropriate utilization.
- (2) Technical skill including interpretation.
- (3) Obtaining informed consent.
- (4) Attention to patient comfort and safety during procedure.

**PC5: Requests and provides consultative care.**

Effectively provides consultation

- Consults in all settings with attention to multiple chronic conditions and function.
- Expertly manages medication.
- Expertly prevents and manages delirium.
- Provides pain management and palliative care expertise for older patients.
- Assesses patient capacity and identifies decision-maker.
- Provides tailored comprehensive geriatric assessment.

Effectively requests and uses consultation

- Seeks guidance from interprofessional team.
- Knows when to refer for neuropsychologic testing, physiatry, psychiatry, neurology, urology, audiology, ophthalmology, sleep specialist, gynecology, speech therapy (dysphagia), palliative care, and ethics.

**Medical knowledge – MK**

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Fellows must demonstrate knowledge in the following content areas:

- the current science of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged;

- aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization, and chemoprophylaxis against disease;
- geriatric assessment, including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); medication review and appropriate use of the history; physical and mental examination; and interpretation of laboratory results;
- the general principles of geriatric rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, pulmonary, and neurologic impairments;
  - These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, and, environmental modification, patient and family education, and psychosocial and recreational counseling.
- management of patients in long-term care settings, including palliative care, administration, regulation, and financing of long-term institutions, and the continuum from short- to long-term care;
- the pivotal role of the family in caring for the elderly, and the community resources (formal support systems) required to support both the patient and the family;
- home care, including the components of a home visit, and accessing appropriate community resources to provide care in the home setting;
- hospice care, including pain management, symptom relief, comfort care, and end-of-life issues;
- behavioral sciences, including psychology and social work;
- topics of special interest to geriatric medicine, including cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment;
- diseases that are especially prominent in the elderly or that may have atypical characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders;
- pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, and adherence;
- psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety;
- patient and family education, and psychosocial and recreational counseling for patients requiring rehabilitation care;
- the economic aspects of supporting geriatric services, such as Title III of the Older Americans Act, Medicare, Medicaid, Affordable Care Act capitation, and cost containment;
- the ethical and legal issues pertinent to geriatric medicine, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs;

- research methodologies related to geriatric medicine, including clinical epidemiology and decision analysis;
- iatrogenic disorders and their prevention;
- cultural aspects of aging, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care, issues of ethnicity in long-term care, and special issues relating to urban and rural older persons of various ethnic backgrounds;
- behavioral aspects of illness, socioeconomic factors, and health literacy issues; and,
- basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

### **MK1: Clinical knowledge**

Scientific and behavioral health knowledge.

- Physiology, pharmacology, epidemiology of aging.
- Atypical presentations in elders.
- Geriatric syndromes.
- Bioethics and palliative care.
- Principles of rehabilitation and functional trajectories.
- Geriatric psychiatry.
- Prognostication.
- Applicability of evidence from studies with younger adults to older adults

Socioeconomic and systems knowledge.

- Models of care.
- Financing of health care.
- Medical Directorship (LTC, PACE, home health, hospice).
- Community resources.
- Geriatric quality indicators.
- Geriatric health disparities.

### **MK2: Knowledge of diagnostic testing and procedures**

Appropriate utilization.

- Considers performance characteristics when ordering tests and procedures in geriatric patients.
- Adjusts recommendations for diagnostic work-up based on patient's and caregiver's goals of care, patient's multiple chronic conditions, risks of testing, patient's overall prognosis.

Appropriate test interpretation.

- Uses knowledge of test performance characteristics when interpreting results in geriatric patients.

- Knows the strengths and limitations of cognitive and functional assessments and how to interpret assessment results (i.e. geriatric screens).

### **MK3: Scholarship**

#### Foundation

- Independently formulates novel and important ideas worthy of scholarly investigation

#### Investigation

- Obtains independent research funding and leads a scholarly project advancing clinical practice, quality improvement, patient safety, education, or research

#### Analysis

- Critiques specialized scientific literature at a level consistent with participation in peer review
- Employs optimal statistical techniques
- Teaches analytic methods in chosen field to peers and others

#### Dissemination

- Effectively presents scholarly work at national and international meetings
- Publishes peer-reviewed manuscript(s) containing scholarly work (clinical practice, quality improvement, patient safety, education, or research)

### **System-Based Practices - SBP**

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

#### **SBP1: Works effectively within an interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and other support personnel)**

Appropriately involves other team members.

- Involves IPT in family meetings, and development and implementation of care plans and in transitions and management of geriatric syndromes.

Participates as a team member and a team leader.

#### **SBP2: Recognizes system error and advocates for system improvement**

Anticipates and attempts to prevent medical errors.

- Recognizes health-care system processes that may lead to errors in the care of older patients (e.g., high risk medications in order sets; overuse of bedrest; medication reconciliation; care transitions).

Engages in system improvement activities.

**SBP3: Identifies forces that impact the cost of health care, and advocates for and practices cost-effective care**

Recognizes forces that impact cost of health care.

- Considers over-utilization based on: time-to-benefit, payor.
- Uses newer drugs, tests, and procedures with caution until data are available about applicability to older adults.

Practices cost-awareness.

- Knows patients' financial contribution for all parts of Medicare including hospitalization, hospice, observational care, durable medical equipment, etc.

**SBP4: Transitions patients effectively within and across health delivery systems**

Communicates with previous and future care providers.

- Provides receiving caregivers with necessary and critical information.
- Includes patients and families/caregivers in planning transitions between sites of care.
- Considers patient and family goals of care when deciding whether to transfer/admit patients to acute care hospital.

Provides complete written and verbal care plans.

- At time of transfer/ handoffs, provides information about patients' cognitive and functional status and advance directives.

Negotiates and coordinates available resources for safe, efficient care transitions.

- Identifies patient and family/caregiver needs and refers to appropriate local community resources (e.g., utilizes home visits; refers to home health care and other support services; orders DME).
- Develops consensus among interprofessional health care teams, patients and their families/caregivers as to appropriate level and site of care.

**Practice-Based Learning and Improvement – PBLI**

Fellows are expected to develop skills and habits to be able to meet the following goals:

- systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

**PBLI1: Monitors practice with a goal for improvement**

Performance improvement based on self-evaluation.

Performance improvement based on the principles of life-long learning

**PBLI2: Learns and improves via performance audit**

Performance improvement based on performance audit.  
Participation in performance improvement activities.  
Skills in quality improvement.

**PBLI3: Learns and improves via feedback**

Solicits feedback.  
Accepts feedback.

**PBLI4: Learns and improves at the point of care**

Knows when to reconsider approach to a clinical problem.

- Reconsiders diagnostic accuracy and/ or treatment efficacy based on geriatric principles.
- Reconsiders goals of care and prioritization.
- Reconsiders medications as contributors to illness.

Frames appropriate clinical questions.

- Addresses patients with multiple chronic conditions.
- Addresses functional outcomes.

Critically appraises the literature.

- Uses scientific knowledge of aging in appraisal.
- Considers how clinical trials and guidelines are applicable to older adults in general and to a specific patient in particular.

Utilizes information technology (e.g, IT, decision support, tools and guidelines).

- Knows best sources for geriatric guidelines and decision- support tools.

**Professionalism - PROF**

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

- Fellows must demonstrate high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest.

**PROF1: Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel)**

Empathic and respectful interactions.



- Treats patient as a mature adult in all circumstances, regardless of cognitive or other impairment.
- Engages patient during interactions when other family members and caregivers are present.
- Respects all members of IPT.

Responsive to needs of patients, caregivers and IPT members.

- Anticipates needs for information and guidance on chronic diseases, palliative care, dementia trajectories, community referrals.
- Advocates for patients/families across settings of care.
- Supports members of the IPT in care of the patient.

Respects privacy and autonomy.

- Addresses patient, asks permission to speak to others, and spends time alone with patient, when seeing patients with family/caregivers present.
- Provides compassionate care while establishing and maintaining personal and professional boundaries.

Recognizes and responds to dysfunctional self, peer and team member behaviors, and reinforces healthy behaviors.

### **PROF2: Accepts responsibility and follows through on tasks**

Reliability

- prioritizing many competing demands in order to complete tasks and responsibilities in a timely and effective manner.

Accountability

- Completes assigned professional responsibilities without questioning or the need for reminders.
- Willingly assumes professional responsibility regardless of the situation

### **PROF3: Responds to each patient's unique characteristics and needs**

Interactions acknowledge patient uniqueness.

- Accommodates patient's sensory, cognitive, and/or physical impairments.
- Recognizes that patient decision-making capacity varies according to the decision.
- Recognizes heterogeneity of older adults.
- Solicits family/caregiver needs.

Care plan tailored to patient's uniqueness.

- Adjusts evaluation and priorities to account for medical complexity of patients, patients' goals of care, preferences, life-expectancy.

### **PROF4: Exhibits integrity and ethical behavior in professional conduct**

#### Honesty

- Demonstrates integrity, honesty, and accountability to patients, society, and the profession.
- Assists others in adhering to ethical principles and behaviors, including integrity, honesty, and professional responsibility.

#### Personal accountability

- Demonstrates accountability for the care of patients
- Regularly reflects on personal professional conduct

#### Ethical behavior

- Adheres to ethical principles for documentation, follows formal policies and procedures, acknowledges and limits conflicts of interest and upholds ethical expectations of research and scholarly activity.

#### Manages conflicts of interest

- Identifies and manages conflicts of interest

### **Interpersonal Communication Skills – ICS**

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

- Fellows must demonstrate effective communication skills with patients, families, professional colleagues, and community groups.

#### **ICS1: Communicates effectively with patients and caregivers**

Elicits patient preferences.

- Regarding goals of care and advance care planning.
- Regarding site of care.

Practices shared decision making.

- Convenes family/caregiver meetings, as appropriate.
- Considers patient and family needs and limitations in suggesting options.

Establishes therapeutic relationships.

- Modifies communication with hearing, vision or cog impaired patients.
- Provides compassionate care while establishing personal and professional boundaries.

#### **ICS2: Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel)**

Collaborative communication with team: Oral, written, behavioral

- During transitions of care.
- When making referrals to interprofessional care providers (e.g, PT/OT/ST/ skilled nursing/wound care/SNF-level rehab).

### **ICS3: Appropriate utilization and completion of health records**

Timely, accurate and complete records

- Completes authorizations and related forms in a timely and efficient manner.
- Patient specific health records are organized, timely, accurate, comprehensive, and effectively communicate clinical information and reasoning.

Documentation of results, interpretation and follow-up

- Medical information and test results/interpretations are effectively and promptly provided to physicians and/or other health care provider, and patients.

## Block Diagram and Evaluation Tools

Block	1	2	3	4	5	6	7	8	9	10	11
<b>Rotation</b>	<b>Primary Care</b>	<b>VA- HB Primary Care</b>	<b>OP Assessment Clinic</b>	<b>LTC/ Nursing Home</b>	<b>IP Consults</b>	<b>Rehab</b>	<b>Palliative Care</b>	<b>Geropsych</b>	<b>Subspecialty Clinics<sup>4</sup></b>	<b>Research/ Lectures</b>	<b>Vacation/ Conference</b>
<b>Location</b>	MOBAP	Jefferson Barracks	BJH	Parc Provence	BJH	TRISL	BJH	Private Practice	Various		
				Delmar Gardens	TRISL						
<b>% Outpatient</b>	100	0	100	0	0	0	0	100	100	0	0
<b>% Research</b>	0	0	0	0	0	0	0	0	0	100	0
<b>Type</b>	OP	HB	OP Ambulatory Hospital	LTC Facility	IP	Rehab Facility	IP	OP	Observation		
<b>Duration</b>	6 Weeks	4 Weeks	6 Weeks	6 Weeks	4 Weeks	4 Weeks	4 Weeks	4 Weeks	8 Week	2 Weeks	3 Weeks/ 1 Week
<b>PC</b>	1-5	1, 2	1-5	1-3	1, 2, 5	1-5	1-3	1-5			
<b>MK</b>	1, 2		1, 2	1, 2	1, 2	1, 2	1	1			
<b>SPB</b>	1-4	1, 3, 4	1, 2	1, 2, 4	2, 3	1-4	1, 3	1			
<b>PBLI</b>	1-4	1, 3, 4	1, 3, 4	1-4	1, 3, 4	1, 3, 4	3, 4	1, 3, 4			
<b>PROF</b>	1, 3, 4	1-4	1, 3	1-4	1-3	1-4	1-4	1-4			
<b>ICS</b>	1, 3	1, 3	1-3	1-3	1, 3	1-3	1-3	1-3			
<b>Evaluation Tools</b>	DOF <sup>1</sup> MSA <sup>2</sup> Written/Oral Exam	MSA <sup>2</sup> Written/Oral Exam	DOF <sup>1</sup> MSA <sup>2</sup> Written/Oral Exam	DOF <sup>1</sup> MSA <sup>2</sup> QIPT <sup>3</sup> Written/Oral Exam	DOF <sup>1</sup> MSA <sup>2</sup> Written Exam	MSA <sup>2</sup> Written Exam	MSA <sup>2</sup>	MSA <sup>2</sup>			
<sup>1</sup> Direct Observation Feedback; <sup>2</sup> Multi-Source Assessment; <sup>3</sup> Quality Indicator Parameter Tracking; <sup>4</sup> Subspecialty Clinics: Memory Diagnostic Center, Memory and Aging Project, Bone Health, Hospice, Home Health Physical Therapy, Wound Care, Movement Disorders, Urogynecology, Ophthalmology, Dentistry  <b>OP = Outpatient</b> <b>IP = Inpatient</b> <b>HB = Home Based</b> <b>LTC = Long-Term Care</b>											

## **Fellowship Program Policies**

The policies and procedures established in this document are intended to provide a governance structure for overseeing the Geriatric Medicine Fellowship Program by the Division of Geriatrics and Nutritional Science at Washington University School of Medicine in St. Louis. The policies outlined in this document do not supersede those established by the WUSM/BJH/SLCH GME Consortium.

The GME Consortium Operating Principles can be found here: <https://gme.wustl.edu/about/policies-procedures/gme-consortium-operating-principles/>

The Memorandum of Appointment can be found here: <https://gme.wustl.edu/about/policies-procedures/memoranda-of-appointment/>

Links to GME Policies will be provided below as they relate to the Geriatric Medicine Fellowship Program Policies.

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Selection**

#### **Purpose**

Washington University School of Medicine and participating institutions strive to provide excellence in graduate medical education. Many factors contribute to the realization of this goal. Our Geriatric Fellowship Program has traditionally attracted very strong applicants and is committed to the practice of carefully screening and selecting those applicants who are best qualified to participate and succeed in the program based on their academic achievements and personal and professional characteristics.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

#### **Policy**

The process utilized by the Geriatric Fellowship Program at Washington University School of Medicine is as follows:

#### **All applicants must provide the following:**

- Completed application
- 3 Letters of recommendation; one from the residency program director
- Academic credential scores from USMLE I and II, documentation of participation in any other graduate medical education experiences, or clinical work as a physician.

#### **Residency Requirements**

- evidence of completing an internal medicine or family practice residency and;
- have board certification and/or potential board eligibility or
- documentation of credentials similar to board certification or board eligibility in another country, but only if the position is non-ACGME-accredited.

#### **Previous Medical School Training**

- Graduates of medical school in US or Canada accredited by the LCME.
- Graduates of medical school in the US or Canada accredited by the AOA or AAMC.
- Graduates of medical schools outside the US who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
  - A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions:
    - 1) have completed in an accredited college or university in the US undergraduate

- premedical education of the quality acceptable for matriculation in an accredited US medical school;
- 2) have studied at a medical school outside the US and Canada but listed in the WHO Directory of Medical Schools;
  - 3) have completed all of the formal requirements of the foreign medical school except internship and/or social service;
  - 4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and
  - 5) have passed the FMGE in the Medical Sciences; Parts I and II of the examination of the NBME, or Steps 1 and 2 of the USMLE.
- Graduates of medical schools outside the US and Canada who either:
    - have received a currently valid certificate from the ECFMG;
    - or possess a full and unrestricted license to practice medicine in a US licensing jurisdiction.
  - U.S. citizen graduates from medical schools outside the US who have successfully completed the licensure examination in a US jurisdiction in which the laws and regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of graduate medical education.
  - Graduates of medical schools in the US and its territories not accredited by the LCME, but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in 4 above.
    - From time to time, graduates of non-U.S. medical schools which do not have LCME accreditation may be entertained as candidates for admission to residency or fellowship programs at Washington University School of Medicine and participating institutions. In addition to the criteria referenced in Section A, the academic qualifications of such applicants may be assessed by reference to the school from which their degree has been granted.
      - Criteria for evaluation of such schools will be established on a program by program basis within the School of Medicine and participating institutions and may include some or all of the following criteria:
        - the performance of recent graduates of that particular school at the USMLE examination;
        - the participation of the medical school in a detailed accreditation process recognized by the relevant statutory authority of a duly elected government;
        - experience of the training program with recent graduates of the same medical school.

### Citizenship

- Candidates who are not citizens of the U.S.A., including Canadian medical school graduates, must meet the requirements of the INS for training in this country.

### The selection process involves the following:

- Applicants are selected for interviews, further screening and/or final ranking on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs do not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.
  - These policies notwithstanding, it is recognized that relative emphasis on aspects of these criteria may differ within our program on a year-to-year basis depending upon size of total applicant pool, content, and configuration of the training program.
  - From among the applications of eligible candidates who are considered, a limited number of applicants will be selected by our program based upon our specific needs, for interviews

- by faculty members, trainees, and interdisciplinary staff.
- The Program Director, after consultation with faculty members and staff who have interviewed the applicants, reviews the qualifications of each applicant, will rank them in order of preference. We do not enter into the matching program.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/selections-review-promotion-policies/>

Effective 4/6/05

Updated 6/2/09, 12/26/09, Reviewed and Approved 01/04/10

Updated 4/2/15, Reviewed and Approved 6/30/15



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## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Education Stipend/Allowance**

#### **Purpose**

The goals of this policy are to describe the requirements and procedures for provision of an educational stipend to fellowship trainees.

#### **Policy**

Each Geriatric Medicine fellow is allowed up to \$1500 for reimbursement of education-related expenses as follows:

- professional society membership fees in Geriatrics/ Gerontology, Internal Medicine or Family Medicine;
- training materials, including books, Geriatric Review Syllabus, educational CDs;
- registration fees and travel expenses to attend a scientific meeting in Geriatrics/Gerontology or a field related to the Fellow's research to give a scientific presentation;
- reimbursement of up to \$500 towards the registration fee for the ABIM/ABFM Geriatrics Subspecialty board exam, **if** the fellow registers for the exam by June 1<sup>st</sup> of their graduating year to take the exam in November of the same year.

The fellow must request and receive approval for reimbursement from the Program Director in advance.

Original receipts and appropriate reimbursement forms must be completed by the fellow, in accordance with policies of the Division, and submitted to the Program Coordinator for processing.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/stipends/>

Approved 6/2/14

Reviewed and Approved 6/9/16

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Effect of Leaves and Absence from Training**

#### **Purpose**

The Leave Policy is intended to provide Clinical Fellows, Trainees and House Staff with specified paid time off, as well as unpaid leave should the need arise. This leave policy also ensures that Clinical Fellows, Trainees and House Staff have the opportunity to rest and provides financial security in the case of illness.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the GME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

#### **Policy**

Clinical Fellows have a total of 30 paid workdays off. For purposes of this policy, a workday is defined as Monday through Friday.

- **Vacation:** Fifteen of those days are designated as vacation. Vacation days should be scheduled in advance and may be taken at any time during the year with the approval of the Program Director. There are no recognized holidays. Duties are assigned by each Program Director.
- **Illness:** Clinical Fellows may be paid for up to 15 days in the case of their own illness. This leave may also be used for their own medical conditions related to pregnancy and childbirth. In the case of an extended illness or disability, Clinical Fellows must use their available vacation days after they have exhausted their 15 days of paid time off.

Paid time off does not carry over from year to year nor is there a payment for any days that are not used for purposes of this policy, the year begins on July 1. Time off will be prorated for Clinical Fellows who join any of the affiliated institutions throughout the year.

Additional unpaid leave may be available, in certain circumstances, with the approval of the Program Director. Additional leave may require extension of the training program depending on the guidelines established by the ACGME or the certifying Board for that particular program. Leave must be requested in advance of the actual leave. Additional documentation may be required by the awarding training program to suspend the award and/or the accrual of service for calculating the time away from the training program. To obtain further information regarding how leave relates to Board requirements, contact the Program Director.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/leave-benefits-support/>

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Updated 06/11/12, Reviewed and Approved 06/11/12

Updated 06/30/15, Reviewed and Approved 06/30/15

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## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Disciplinary Action, Suspension, Termination, and Grievances**

#### **Purpose**

In the case of poor performance, this policy outlines the steps toward disciplinary action, suspension, termination, and grievance.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

Both the School of Medicine and the Hospitals recognize that the primary responsibility for academic and disciplinary decisions relating to clinical fellows and fellowship programs resides within the departments and the individual fellowship programs. Academic and performance standards and methods of clinical fellows training and evaluation are to be determined by the departments and programs and may differ among them.

The interests of the clinical fellows, the Medical School, and the Hospitals are best served when problems are resolved as part of the regular communication between the clinical fellows and departmental officials in charge of the training program. Thus clinical fellows are encouraged to make every effort to resolve disagreements or disputes over academic or disciplinary decisions, or evaluations by discussing the matter with the Program Director, Division Chief and Department Chair, as appropriate. The Office of the Associate Dean for Medical Education (Graduate Medical Education) is available to provide confidential guidance in this effort.

#### **Policy**

##### **Informal Procedures**

Our program will use informal efforts to resolve minor instances of poor performance or misconduct. In any case in which a pattern of deficient performance has emerged, informal efforts by the Program Director shall include notification of the clinical fellow in writing of the nature of the pattern of deficient performance and remediation steps, if appropriate, to be taken by the fellow to address it. If these informal efforts are unsuccessful or where performance or misconduct is of a serious nature, the Department Chair or Program Director may impose formal disciplinary action.

##### **Formal Adverse Disciplinary Action**

Formal adverse disciplinary action may be taken for due cause, including but not limited to any of the following:

- Failure to satisfy the academic or clinical requirements of the training program
- Professional incompetence, misconduct, or conduct that might be inconsistent with or harmful to patient care or safety

- Conduct that is detrimental to the professional reputation of the Hospital or School of Medicine
- Conduct that calls into question the professional qualifications, ethics, or judgment of the resident/clinical fellow, or that could prove detrimental to the Hospital's or School of Medicine's patients, employees, staff, volunteers, or operations
- Violation of the bylaws, rules, regulations, policies, or procedures of the Consortium, School of Medicine, Hospital, Department, Division, or training program, including violation of the Responsibilities of Residents and Clinical Fellows set forth above
- Scientific misconduct

Type of Discipline/Formal disciplinary action includes:

- suspension, termination, or non-reappointment;
- reduction, limitation, or restriction of the resident/clinical fellow's clinical responsibilities;
- extension of the residency or fellowship program or denial of academic credit that has the effect of extending the residency or fellowship;
- denial of certification of satisfactory completion of the residency or fellowship program.

Method of Communication

- The Department Chair or Program Director shall notify the clinical fellow in writing of the action taken and the reasons.
- A copy of the notification shall be furnished to the Hospital's GME Office (in the case of residents) and the Associate Dean for Medical Education (Graduate Medical Education).
- The notification will advise the clinical fellow of his or her right to request a review of the action in accordance with the Procedure for Review of Academic and Disciplinary Decisions Relating to Resident's and Clinical Fellow's set forth below.
- In the case of a suspension, the written notification should precede the effective date of the suspension unless the Department Chair or Program Director determines in good faith that the continued appointment of the clinical fellow places safety or health of Hospital or School of Medicine patients or personnel in jeopardy or immediate suspension is required by law or necessary in order to prevent imminent or further disruption of Hospital or School of Medicine activities, in which case the notice shall be provided at the time of suspension.
- If the President of the Hospital or his or her designee has a complaint about performance or conduct of the clinical fellow, the matter should first be brought to the attention of the Department Chair or Program Director. If the Hospital's complaint is not resolved at the departmental level, then the Hospital shall have the right to request a review of the complaint under the Procedure for Review of Academic and disciplinary Decisions Relating to Resident's and Clinical Fellow's set forth below.

Reporting Requirement

- Section 383.133 of the Missouri Revised Statutes requires the chief executive officer of any hospital or ambulatory surgical center to report to the State Board of Healing Arts any final disciplinary action against a physician licensed in Missouri for activities which are also grounds for disciplinary action by the State Board or the voluntary resignation or any physician licensed in Missouri against whom any complaints or reports have been made which might have led to such disciplinary action.

Procedure for Review of Academic and Disciplinary Decisions for Clinical Fellows  
Associate Dean (Graduate Medical Education)

- The clinical fellow shall make the request for a formal review in writing within 30 calendar days after the departmental decision to the Associate Dean for Medical Education (Graduate Medical Education), describing the matter in dispute and all previous attempts at resolution.
- The Associate Dean shall forward a copy of the request to the Program Director, who shall have the opportunity to respond in writing within 10 calendar days, a copy of which shall be furnished to the clinical fellow. (Copies of all correspondence relating to the review shall be furnished by the Associate Dean's office on a confidential basis to the President of the Hospital in the case of a clinical fellow.
- The Associate Dean shall discuss the dispute with the fellow and the Program Director (and the Hospital, if appropriate) in an effort to resolve the matter. If the matter is not resolved within 30 calendar days from the date of receipt of the request for review, the Associate Dean shall notify the clinical fellow in writing that the matter has not been resolved and that the clinical fellow has a right to request a hearing. If the matter is resolved, the Associate Dean shall summarize the resolution in a letter to the clinical fellow, Program Director, and President of the Hospital in the case of a clinical fellow.
- Periodically, the Associate Dean shall report to the GMEC on the nature of matters brought to his or her attention under this procedure and the nature of the resolution, if any.

#### Hearing Panel

The clinical fellow may make a request for a hearing in writing to the Chair of the GMEC within 7 calendar days after the date of the notice from the Associate Dean that the matter has not been resolved. The Chair of the GMEC shall appoint a five-member hearing panel, three members to come from the GMEC membership, one program director, who shall act as chair of the hearing panel, one senior resident or clinical fellow, and one Hospital representative, and two members to come from the elected representatives of the clinical departments to the Executive Committee of the Faculty Council or the Faculty Rights Committee of the School of Medicine. No member of these bodies who has been involved in the dispute in any way shall serve on the hearing panel.

A hearing date shall be set by the chair of the hearing panel within 30 calendar days of the receipt of the resident/clinical fellow's request for a hearing. At least 7 calendar days before the hearing, the Program Director shall furnish the chair of the hearing panel and the resident/clinical fellow with a statement of reasons for the action taken, along with any supporting documentation. The resident/clinical fellow shall have the opportunity to respond in writing at least two calendar days before the hearing, copies to be furnished to the chair of the hearing panel and the Program Director.

At the hearing, both the clinical fellow and the Program Director may present evidence and witnesses, subject to limitations set by the chair based on relevancy or time, and may examine the evidence and witnesses presented by the other. The members of the hearing panel may also ask questions and request the presence of additional witnesses, if deemed necessary. A stenographic record of the hearing will be made. The clinical fellow may be accompanied by one advisor, identified by name and title at least 6 days before the hearing, who may advise the clinical fellow but not otherwise participate in the hearing. The hearing shall not be construed as a formal legal proceeding, and formal rules of law or evidence shall not apply.

Subsequent to the conclusion of the hearing, the hearing panel shall deliberate in private and reach a decision as to its recommendation by majority vote. It shall make a written report and recommendation to the Dean of the Medical School and President of the Hospital within 15 calendar days after the conclusion of the hearing, copies of which shall be sent to the clinical fellow, the Program Director and the Associate Dean. The recommendation of the hearing panel shall be accepted, rejected or modified by the Dean and President, or their designees, in writing, within 15 calendar days after the date of the

recommendation and report. Copies shall be sent to the chair of the hearing panel, the resident/clinical fellow, the Program Director, and the Associate Dean. The decision of the Dean and President, or their designees, shall be final.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/disciplinary-action-suspension-or-termination/>

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Reviewed and Approved 6/11/12

Reviewed and Approved 6/30/15

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## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Promotion and Completion of Training**

#### **Purpose**

This policy outlines the criteria to achieve satisfactory completion of the fellowship program.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

#### **Policy**

##### Promotion

Promotion of the clinical geriatrics fellow to the next level of the Program depends upon the clinical fellow's performance and qualifications. Decisions about promotion or entering into subsequent years of fellowship are communicated to the clinical fellow as soon as reasonably practicable under the circumstances and will occur at least four months prior to the end of the academic year. Communication between the Program Director and the hospital GME office will occur at least four months in advance of a new appointment year.

The criteria for promotion include:

- passing all clinical rotations with scores of at least a four rating on all categories of the evaluation forms in the six major competencies,
- passing the assigned DOF exams (two per year in a variety of settings),
- passing the written examination and oral examinations,
- completing all clinical rotations that are not specifically evaluated but assigned in the manual, and
- completing the checklist of objectives

##### Completion of Training

Each clinical fellow must, at a minimum, fulfill the following criteria to achieve satisfactory completion of the fellowship program:

- Demonstrate a level of clinical and procedural competence to the satisfaction of the Department.
- Fulfill the requirements of the applicable American Board for completion of approved training in geriatrics.
- Demonstrate attitude, demeanor and behavior appropriate to our specialty and as the fellow relates to patients, other health care professionals and colleagues.
- Complete all documentation in patient medical records.
- Certificates are issued by BJH GME upon satisfactory completion of the above.

In addition, any financial obligations owed the Hospitals or School of Medicine are paid or terms established for payment, that all Hospital or School of Medicine property issued solely for use during an



academic year, including identification badges and beepers, must be returned or paid for, and that a forwarding mailing address be provided to the Program.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/selections-review-promotion-policies/>

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Updated 6/11/12, Reviewed and Approved 6/11/12

Reviewed and Approved 6/30/15

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## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Evaluation of Geriatrics Fellows (CCC), Faculty, and Program (PEC)**

#### **Purpose**

As specified by the ACGME, the Geriatric Fellowship Program provides evaluation and feedback of the Fellows' performance to determine their competence in the various areas outlined below.

#### **Scope**

The following procedures will be used for evaluation of Geriatric Fellows, Faculty and the Program. The information obtained through these procedures will be reviewed by the Clinical Competency Committee (CCC) and the Program Evaluation Committee (PEC).

#### **Policy**

##### Evaluation of Geriatric Medicine Fellows

##### Clinical Competency Committee (CCC)

- The CCC will:
  - prepare and assure the reporting of Milestone evaluations of each fellow semi-annually to ACGME.
  - make recommendations to the Program Director regarding Fellow progress, including promotion, remediation and dismissal. Final decisions will be made by the Program Director.
- Composition:
  - Program Director and
  - at least two other faculty members from within the Division of Geriatrics, selected by the Program Director.
  - Appointments will be made on an annual basis.
  - The program coordinator will attend all meetings as an observer and record meeting minutes.
- CCC Meeting Logistics
  - All fellows will be reviewed at each CCC meeting.
  - Each fellow will be presented by a committee member to the full committee for discussion.
  - All members will have access to the fellow's educational performance.
  - After each CCC session, approved documents from the meeting will be shared with fellows and form the basis for their Semi-annual performance evaluations.

##### Evaluation Methods

- Multi-Source Assessment from attendings, program staff, patients, and peers.
- Completion of Direct Observation Feedback exams.
- Written exam at the start and upon completion of the program.
- Oral exam at the end of the program year.

- Completion of logs to document performance of specified screening tools, assessment tools and inpatient consults.
- Completion of Core Curriculum Topics Review
- Completion of scholarly activities and PSQI Project

### Formative Evaluation

Evaluation of each Fellow and related feedback will occur at the completion of each clinical rotation, or at six months if the rotation is longer (e.g., nursing home, primary care clinics).

Fellow performance is evaluated formally by multiple evaluators (faculty, program staff, patients, peers). The Program Director will meet with the Fellow to discuss a written summary of the evaluations at six-month intervals, and to communicate the recommendations of the CCC.

The evaluations will provide objective assessments of the following areas of competence, based on specialty-specific Milestones:

- Patient Care and Procedural Skills
- Medical Knowledge
- System-Based Practices
- Practice-Based Learning and Improvement
- Professionalism
- Interpersonal Communication Skills

### Summative Evaluation

The Program Director will provide a summative evaluation for each fellow upon completion of the program. This evaluation will document the Fellow's performance during the clinical fellowship and verify that the Fellow has demonstrated sufficient competence to enter practice without direct supervision. This evaluation will become part of the Fellow's permanent record, and will be accessible for review by the Fellow.

If the Fellow is enrolled in the Program for more for more than one year, then the Program Director will prepare a written summative evaluation of the Fellow's clinical competence annually.

### Access and Record of Evaluations

An evaluation record shall be maintained by the Program Director for each clinical fellow and treated as confidential. The file may be reviewed by the clinical fellow and by departmental faculty and staff with legitimate educational and administrative purposes. The record of evaluation shall document that Fellows were evaluated in writing, and that their performance was reviewed with them on completion of each rotation period, and that their performance in continuity clinics was reviewed with them verbally on at least a semi-annual basis.

### Evaluation of Geriatric Medicine Faculty

Confidential written faculty evaluations are to be completed via [www.MyEvaluations.com](http://www.MyEvaluations.com) by the Fellows at the end of each clinical rotation. Fellow evaluations will include feedback about Faculty members' effectiveness as teachers, and the effectiveness of the rotation in achieving the goals identified in the curriculum for that rotation.

In order to maintain confidentiality, due to the small number of Fellows in Geriatric Fellowship Program, the Program Coordinator will aggregate evaluations from the current fellows, with faculty evaluations from past fellows so that there are at least 5 respondents for each faculty member. The evaluations will be reviewed by the Program Director annually and feedback will be provided to all faculty members. If

specific concerns arise before the aggregate feedback is compiled annually, and Program Director will meet with the faculty member informally to communicate the information.

Faculty evaluations are based on the following elements:

- Attendance and Availability
- Clinical knowledge and its application to patient care
- Personal and Professional Development
- Professionalism
- Responsibility
- Teaching Skills

#### Evaluation of Geriatric Medicine Fellowship Program

The following describes the composition, role and responsibilities of the ACGME mandated Program Evaluation Committee (PEC) and the procedures for program evaluation and improvement.

- The PEC is tasked with reviewing various aspects of the training program including, but not limited to:
  - planning, developing, implementing and evaluating educational activities of the program;
  - reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
  - addressing areas of non-compliance with ACGME standards;
  - reviewing the program annually using evaluations of faculty, fellows, and others;
  - rendering a written Annual Program Evaluation (APE);
  - monitor and track each of the following areas;
    - fellow performance;
    - faculty development;
    - evaluations of conferences and clinical rotations;
    - review program goals and objectives and the effectiveness with which they are achieved;
    - progress on the previous year's action plan;
    - graduate performance of program graduates on certification examinations;
    - Prepare a written plan of action to document initiatives to improve performance as outlined in Section f above, and delineate how they will be measured and monitored.
- Composition
  - Program Director,
  - at least two other members of the core faculty, and
  - all Fellows currently being trained in the fellowship.
  - The Division Chief or his/her designee attends as a standing guest.
  - The program coordinator will record meeting minutes and provide input.
  - The Program Director will service as Committee Chair.
- PEC Meeting Logistics
  - The PEC committee will meet at least annually, but may meet more frequently if there is business to be conducted.
  - After each PEC session, approved documents from the meeting will be shared with the Division Chief and the GME Office.
  - The Chair will provide a report to the Geriatric Medicine Services faculty annually, outlining the PECs actions.

Find GME Policy Here:

<https://gme.wustl.edu/about/policies-procedures/selections-review-promotion-policies/>

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Combined Evaluation of Fellows, CCC, Faculty and Program 5/9/17, Reviewed and Approved 6/13/17

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

## **Policy on The Learning and Working Environment**

### **Purpose**

It is the policy of the Geriatric Fellowship Program to follow guidelines established by the ACGME regarding clinical experience and education for fellows in accredited training programs. Clinical and educational work hours are defined as all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

### **Policy**

#### **Maximum Hours of Clinical and Educational Work per Week**

- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
  - Required work hours are Monday – Friday, 8:00 A.M. to 5:30 P.M., however longer hours might be necessary to ensure proper patient care.
  - The Program will monitor Fellow duty hours and adjust assignments as needed to maintain compliance.

#### **Maximum Clinical Work and Education Period Length**

- Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments.
- Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

#### **Mandatory Time Free of Clinical Work and Education**

- Fellows should have eight hours off between scheduled clinical work and education periods.
- If a circumstance arises when the Fellow does not have eight hours free of duty between scheduled duty periods because of a clinical circumstance and/or humanistic attention to the needs of a patient or family, the Fellow is instructed to notify the Program Director of the circumstance, so that the Fellow can be relieved of clinical duties for a period of rest and alternative arrangements can be made for coverage. The Program Director will monitor such circumstances and instances.

#### **Clinical and Educational Work Hour Exceptions**

- In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
  - to continue to provide care to a single severely ill or unstable patient;
  - humanistic attention to the needs of a patient or family; or,
  - to attend unique educational events.
- These additional hours of care or education will be counted toward the 80-hour weekly limit.

#### At-Home Call

- Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
- At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

#### Fatigued House Officer

Fellows are provided with didactic lectures regarding the signs and impact of fatigue and sleep deprivation, educated about alertness management and strategies to mitigate fatigue, encouraged to monitor themselves for signs of fatigue or sleep deprivation, and to adopt strategies to reduce fatigue and manage the potential negative effects of fatigue on patient care and learning, such as work breaks, naps, etc. Fellows are instructed to contact their supervising Attending and the Program Director when they are fatigued or unable to meet the ACGME duty-hour requirements.

Attendings are instructed on how to recognize signs of fatigue and sleep deprivation, and about fatigue mitigation processes and are instructed to closely observe the Fellows for signs of undue stress and/or fatigue such as daytime sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue and/or excessive stress, and report any concerns to the Program Director.

Fellows are monitored quarterly to ensure compliance with ACGME Clinical and Educational Work Hour requirements.

#### Moonlighting

The Department of Medicine and the Program Director in the Division of Geriatrics and Nutritional Science permit, in a limited capacity, geriatrics fellows to practice outside of the required clinical activities which are official components to the teaching program. Such practice (moonlighting) is considered a privilege for those geriatric fellows that are performing well and without deficiencies.

However, the geriatrics fellows must limit such employment to:

- preserve sufficient study time,
- minimize fatigue so as not to impede maximal educational benefit and clinical activities, and
- not interfere with the daily and/or scheduled on-call hours of the fellowship program.

In addition to the guidelines listed above, geriatrics fellows must also conform to the guidelines from Barnes-Jewish Hospital and the Graduate Medical Education (GME) Consortium at Washington University.

Guidelines:

- The written permission of the program director must be obtained for those fellows who moonlight.

- Moonlighting may be performed only after successful completion of three years of internal medicine residency.
- Moonlighting is restricted to geriatric fellows who are in good academic standing. Good academic standing is defined as:
  - attendance at 80% of all required conferences each month, and
  - no unsatisfactory evaluations by faculty within the past six months.
  - Fellows on probation will not be permitted to moonlight.
- In special circumstances, requirements may be waived at the discretion of the program director.
- While on call for the weekend, moonlighting is not permitted.
- Moonlighting activities must be limited to no more than four shifts or 48 hours per month.
- Moonlighting shifts must be separated in time by at least 48 hours.
- Time sheets will be reviewed by the program director to ensure compliance.
- Moonlighting activities must not place the resident's total work hours in excess of the 80 hour weekly limit established by the ACGME and must be included in duty hour reporting.
- A geriatrics fellow's moonlighting privileges may be suspended at the discretion of the program director.
- Those failing to adhere to the moonlighting policy will be subject to disciplinary action, which may include probationary status and dismissal from the fellowship program.
- If such authorization is granted, the fellow must obtain permanent licensure, personal DEA registration, and personal BNDD registration.

#### Program Requirement Provisions:

- Fellows are responsible for accurately reporting their duty hours, including all time spent in internal and external Moonlighting, per program requirements.
- Program Directors are responsible for monitoring and enforcing compliance with duty hour guidelines.
- The Clinical and Educational Work hours for Geriatrics Fellows ordinarily do not come close to the upper limit specified by the ACGME. Fellows are instructed to notify the Program Director if their duty hours may exceed the ACGME limit so that they can be sent home in a safe manner, and arrangements for alternative coverage can be made.

Concerns regarding duty hours may be reported to the Office of the Associate Dean for GME or through the following options:

- Contacting the House Staff representatives on the Graduate Medical Education Committee (GMEC) via the E-mail address: [GMEConnect@wustl.edu](mailto:GMEConnect@wustl.edu)
- Complaints can be submitted to the Office of the Associate Dean for GME at 314-747-4479, or by email at [draket@wusm.wustl.edu](mailto:draket@wusm.wustl.edu).
- Concerns may be reported anonymously via the Institutional Anonymous Fellow Survey conducted by the Office of the Associate Dean for GME annually.

#### Specific Method of Assessment

- Fellows are required to log their Duty Hours in [www.New-Innov.com](http://www.New-Innov.com) and complete a Moonlighting, Stress, and Sleep Deprivation Questionnaire on a quarterly basis. The information will be regularly reviewed by the program director. Any deviations from the Duty Hour requirements will be addressed immediately by the program director and fellow.
- The data collected will be made available to the internal review team and external site visitors (upon their request) during future internal and external reviews. Faculty and housestaff are to be educated on the correct use of the method chosen to assure consistent, reliable data collection.



- **Attest to Compliance:** The Office for the Associate Dean for GME requires the Geriatric Program Director to attest, on a quarterly basis, to the program's compliance. This attestation is based on the raw data collected by the program. Programs found out of compliance may undergo an immediate internal review and/or follow-up action by the Internal Review Subcommittee.

Find GME Policy here:

<https://gme.wustl.edu/about/policies-procedures/duty-hours/>

Effective 4/6/05

Updated 6/2/09, 12/26/09, Reviewed and Approved 01/04/10

Updated 6/11/12, Reviewed and Approved 6/11/12

Updated 6/10/13, Reviewed and Approved 6/10/13

Updated 6/30/15, Reviewed and Approved 6/30/15

Updated 5/9/17, Reviewed and Approved 6/14/17

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## SCHOOL OF MEDICINE

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Order Writing**

#### **Purpose**

To specify the responsibilities of the Geriatric Fellows for the writing of patient orders.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in geriatric medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

#### **Policy**

- Fellows must write all orders for all primary care and consulting patients with appropriate supervision by the attending physician. Orders must be signed and dated and in compliance.
- Fellows may allow other fellows or residents under their direct supervision to write orders.
- Medical student orders must be counter-signed by the supervising fellow.
- Attendings may write orders for patients being covered by a fellow that has days off or for urgent situations.
- Physician extenders may write orders for patients if the fellows have the day off or for urgent situations.
- Consulting clinicians may write orders for patients if the fellows have the day off or for urgent orders.
- It is recognized in circumstances where attendings or physician extenders have written orders on a fellow's patient (i.e. DNR/DNI, pain medicine, etc.) that the attending or physician extender must communicate his/her action to the fellow in a timely manner.
- Barnes-Jewish Hospital has an order-writing policy for all physician trainees that will be provided to the fellow during orientation during the first week of the fellowship.

Effective 3/15/03

Reviewed and Approved 6/15/09

Updated 6/10/13, Reviewed and Approved 6/10/13

John T. Milliken Department of Medicine  
Division of Geriatrics and Nutritional Science

### **Policy on Responsibilities, Communication, Supervision, and Attending Notification**

#### **Purpose**

This policy will establish the responsibilities of the Program Director, Attending Physicians and Fellows for supervision and attending notification at all teaching sites for the Geriatric Fellowship Program and its teaching affiliates. Each of our teaching sites, as well as training programs, might have additional requirements that each trainee will follow.

#### **Scope**

The Geriatric Fellowship Program in the Department of Medicine complies with the ACGME program requirements for fellowship training in Geriatric Medicine. This policy applies to all fellows during their rotations at any of our training sites including the outpatient clinic, hospital, the rehabilitation center, and the nursing home.

#### **Policy**

##### Program Director Responsibilities

Ensure that the teaching staff at all participating institutions and clinical sites provide appropriate supervision of fellows that is consistent with proper patient care and the educational needs of the fellow.

Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner) who is ultimately responsible for that patient's care at all clinical sites utilized for the education of fellows.

This information should be available to fellows, faculty members and patients

Fellows and faculty members should inform patients of their respective roles in each patient's care

Faculty attending and call schedules must be structured to provide fellows with continuous supervision and consultation.

Fellows and other health care personnel must be provided with rapid, reliable systems for communicating with supervising faculty.

Defining the levels of responsibilities through written descriptions of the types of clinical activities fellows may perform and/or teach. (See E. Clinical Service Lines below)

The level of responsibility granted to a fellow is graded and progressive, determined by the program director and/or supervising teaching faculty, and is based on documented evaluation of the fellow's clinical experience, judgment, knowledge, technical skill and the needs of the patient.

It is recognized that fellows in the Geriatric Medicine program have completed residency training and, although they require supervision as they learn the skills needed to care for older patients as a geriatrician, also need a certain level of autonomy.

#### Definitions of Levels of Supervision:

- Direct Supervision
  - The supervising physician is physically present with the fellow and patient.
- Indirect supervision with direct supervision immediately available
  - The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide direct supervision
- Indirect supervision with direct supervision available
  - The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide direct supervision.
- Oversight
  - The supervising physician is available to provide review of encounters with feedback provided after care is delivered.

#### Graduated Level of Supervision:

- For the first 3 months of training or once  $\frac{1}{4}$  of the required Screens and Assessments are signed off on (whichever comes first), all patients in the long term care setting and in the clinic setting must be seen by the attending physician.
- After this, all patients seen by a fellow must be discussed with the attending physician who is available on site, but the attending physician may make the decision that the patient does not need to be seen.

#### Attending Responsibilities

The attending physician of record for each patient is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by individual program policy.

The availability of the attending to the fellow is expected to be greater with less experienced fellows and with increased acuity of the patient's illness.

The attending must notify all fellows on his or her team of when he or she should be called regarding a patient's status. In addition to situations the individual attending would like to be notified of, the attending should include in his or her notification to fellows all situations that require attending notification per program or hospital policy.

The attending may specifically delegate portions of care to fellows based on the needs of the patient and the skills of the fellows and in accordance with hospital and/or departmental policies.

The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care.

Fellows and attendings should inform patients of their respective roles in each patient's care.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

### Fellow Responsibilities

In participating in educational activities and providing services in the clinical fellowship program, the clinical fellow agrees to do the following:

- Obey and adhere to the applicable policies, procedures, rules, bylaws, and regulations of the Consortium, School of Medicine and Hospitals to which he or she rotates.
- Obey and adhere to all applicable state, federal, and local laws, as well as the standards required to maintain accreditation by the ACGME, RRC, JCAHO, HIPAA and any other relevant accrediting, certifying, or licensing organizations.
- Participate fully in the educational and scholarly activities of the Program, including the performance of scholarly and research activities as assigned by the Program Director, attend all required educational conferences, assume responsibility for teaching and supervising other residents/clinical fellows and students, and participate in assigned Hospital and University committee activities.
- Fulfill the educational requirements of the program.
- Use his or her best efforts to provide safe, effective, and compassionate patient care and present at all times a courteous and respectful attitude toward all patients, colleagues, employees and visitors at the School of Medicine, Hospitals and other facilities and rotation sites to which the clinical fellow is assigned.
- Provide clinical services:
  - Commensurate with his/her level of advancement and responsibilities
  - Under appropriate supervision
  - At sites specifically approved by the Program
  - Under circumstances and at locations covered by the professional liability insurance maintained for the resident/clinical fellow by the Hospital or School of Medicine as appropriate
- Develop and follow a personal program of self-study and professional growth under guidance of the Program's teaching faculty
- Fully cooperate with the Program, School of Medicine and Hospital in coordinating and completing documentation required by the RRC, ACGME, Hospital, School of Medicine, Department and/or Program, including but not limited to the legible and timely completion of patient medical records, charts, reports, time cards, operative and procedure logs, and faculty and Program evaluations.
- Perform a complete history and physical examination on all assigned patients. Outpatient clinic experiences will be performed on that day. Nursing home admissions need to be performed within 72 hours; inpatient consultations within 24 hours.
- The elements of a complete evaluation include chief complaints, history of present illness, past medical history, review of systems, family history and social history, physical examination, and assessment and management plan.
- When appropriate, write daily progress notes on all patients on the inpatient consult service, weekly nursing home notes on sub-acute unit, bi-monthly notes for chronic long term care patients, daily notes while on the Rehab Service and outpatient visit notes for the Geriatric Assessment Clinic.
- A countersigned resident's progress note and the history portion of the medical student's notes may substitute for a geriatric fellow note. If a medical students or residents note is countersigned, the contents of that note must be reviewed for accuracy and completeness and revised as needed.

- Notify the supervisory attending physician of any serious event involving the fellows' patient (for example, change in patient status requiring admission/transfer to the hospital or nursing home; impending death; etc. See Attending Notification below).
- Discuss transfer of patients to other services or to special units with the supervisory Attending before the transfer, or if urgent in a timely manner.
- Maintain an accurate pager status.
- Discuss all discharges from institutions with Attendings

### Transitions of Care

Clinical rotations for the Fellows will be made for periods of time that will facilitate continuity of care, as follows: nursing home practice (6- or 12-month block); outpatient geriatric clinic (6-month block), in-patient Geriatrics Consult service (6, 1-month blocks).

To monitor the quality of communication by attending of the fellow's handoff, it will be required to provide written and verbal feedback to fellows about the timeliness and thoroughness of their communication regarding clinical handoffs.

The assignment schedule for the Inpatient Consult service that includes detailed contact information for all Faculty and Fellows will be distributed at the beginning of the academic year and updated/distributed as needed. The assignment schedule for After-hours/Weekend call that includes contact information for all Faculty and Fellows will be distributed in July and January of each academic year, and updated/distributed as needed in response to Faculty/Fellow requests. In addition, the Program Coordinator will distribute a weekly e-mail to Faculty and Fellows to describe back-up phone coverage for days when Faculty or Fellows are unavailable due to travel.

Fellows will be provided with didactic and case-based training about effective communication with other team members in the hand-over process.

Fellows will be responsible for communicating pertinent information in a timely manner about acute issues on the patients they are following in the nursing home, outpatient clinic or consult service to the on-call attending. The information should be communicated either in person, by phone, or e-mail, so that the covering physician can effectively manage acute issues or transitions in care such as readmission to the nursing home, or transfer to an acute care facility.

If a faculty physician has a concern that a Fellow did not effectively communicate about a transition in patient care, this should be brought to the attention of the Program Director.

Special mention is made of communicating patient care issues when checking out to on-call physicians on week nights and/or weekends. The majority of our clinical coverage is in the outpatient and/or long term care setting. Thus, the best method for fellows to communicate patient information is by email to on-call physicians in our group.

The adequacy of communication will be monitored by the fellowship director by:

- discussing the consistency of the "electronic handoff" at faculty meetings and the routine scheduled meetings with the fellows,
- reviewing the adequacy and content of the communication by the fellows to the fellowship director when he is on call, and
- discussing our methods of communication at the annual educational meeting.
- Quality of this communication will be addressed by email or direct conversation with the fellow, if concerns are raised by faculty members or trainees.

### Teaching Responsibilities

Members of the fellowship team play a critical role in the education of junior and senior medical students and residents assigned to the geriatric medicine rotations/clerkships. Students consistently report that they value highly the clinical teaching by housestaff. It is expected that the geriatric fellows will incorporate students into patient care activities and participate fully in their teaching.

Students respect the geriatric fellows and the students should be equally respected by the fellows. The juniors and seniors should be encouraged to feel that they are an active, important part of the team.

Fellows must maintain the image of professionalism at all times to provide the best possible role models for the students and residents. Teaching, however, goes beyond role modeling and must include an environment conducive to and promoting questions by the students/residents, a sincere effort to incorporate teaching into daily patient care responsibilities, and when possible, planned lectures/presentations to or by the students/residents on topics agreed upon by the teacher (housestaff) and trainees.

Fellows will be required to assist in the evaluation of the students/residents on their team. Feedback should be provided to the student/resident not only at the end of the rotation but also frequently during the rotation. The evaluation process is important, and the fellow's perception will have equal weight to that of the faculty members. In turn, geriatric fellow performance as teachers is evaluated formally both by faculty and medical students/residents and the evaluation record is kept in the program directors personal file. Fellows may review this file upon request to the program director.

When any physician trainee has performed in a deficient manner, the fellow must notify both the program director and the teaching attending. The fellow should counsel the student about the matter as soon as the deficient performance is noted.

### Clinical Service Lines

Geriatric Medicine Fellows are part of a team of providers caring for patients that are dedicated to providing excellent patient care. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students. The clinical responsibilities for each fellow are based on patient safety, education, severity and complexity of patient illness/condition and available support services and may vary with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team.

The following is a guide to the specific patient care responsibilities of clinical training. Fellows must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

All fellows will be supervised by a faculty member on site (either a member of the Division of Geriatrics or an attending with Board or a Certificate of Added Qualifications in Geriatric Medicine) during all of their clinical, geriatric focused activities (Geriatric subspecialty clinic, long term care, inpatient geriatric service, home visits). In these situations direct supervision of the fellow occurs, fellows are advised and notes are co-signed by the attending (either electronically in Allscripts, in the paper record, or later with communication letters to referring physicians).

Exceptions where the geriatric fellow has indirect supervision:

- The Review Committees allow fellows to complete home care visits without on-site faculty supervision. On-site supervision may be provided by a physician extender or nurse operating

under physician-directed care protocols or orders. An attending faculty physician must always be available by phone. This is the only exception to on-site outpatient supervision rule and does not extend to other settings or other fellowships.

- **Unscheduled (urgent) visits by fellows to their continuity patients in long-term care settings:** Many programs are affiliated with community nursing homes that are not located on the campus of the program's sponsoring institution, and it is the standard of practice in most nursing homes that physicians be on-site only when attending to patient care. Because fellows are expected to be the primary care providers for patients in this setting, they are encouraged to make visits to the nursing home for these patients for unscheduled urgent visits. These may occur at times when attending faculty members are not on-site. In this situation, the attending faculty member is not required to supervise the fellow on-site, but must be available by phone. Furthermore, the fellow must discuss the care of the patient by phone with that attending faculty member at the time the patient is being seen by the fellow in the long-term care facility. This exception DOES NOT APPLY to routinely-scheduled rounds on fellows' continuity patients in long-term care. For these visits, attending faculty members are expected to be on-site and available to examine patients jointly with the fellows.
- Inpatient geriatric consults on the weekend that does not need to be staffed urgently by an attending.

In the situation where communication needs to be made urgently, contact with the attending will occur by cell phone/pager. The attending on call will provide back-up for the fellow. If the attending cannot be reached, the fellowship director will serve as final back-up.

#### Attending Notification

At a minimum, the fellow must notify the supervising attending physician/licensed provider of any significant changes in the patient's condition, including but not limited to:

- Admission to the hospital
- Transfer from the nursing home to the hospital
- Transfer to a higher level of care, including the ICU, or change in level of care (or Code) status
- Development of hemodynamic instability
- Development of significant neurological changes
- Development of major wound complications
- Medication errors requiring clinical intervention
- Any clinical problem that requires an invasive procedure or surgery
- Any condition which requires the response of a consulting team
- Death
- Any other clinical concern whereby the fellow feels uncertain of the appropriate clinical plan
- Decisions regarding end-of-life treatments and/or hospice enrollment must be discussed with the Attending physician prior to initiation of the actual treatment or referral to hospice.

#### Fellows may:

- Provide care in the inpatient, outpatient, home and long-term care settings.
- Serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services.
- Obtain the medical history, perform physical examinations and other evaluations required as part of the clinical service provided (i.e. cognitive and fall screening procedures).
- Develop a differential diagnosis and problem list.



- Using information from the clinical assessment, develop a plan of care or a set of recommendations in conjunction with the attending.
- Document the provision of patient care as required by hospital/clinic policy.
- Write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations.
- Interpret the results of laboratory and other diagnostic testing.
- Request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services.
- Initiate and coordinate hospital admission and discharge planning.
- Discuss the patient's status and plan of care with the attending and the team.
- Assist the attending with the education and clinical supervision, of post-graduate residents and medical students.

#### Inpatient Consult Service Responsibilities

- Round on all patients being actively followed by the consult service as well as new patients.
- Remain available to receive consultations each weekday on the rotation up until 5:00 p.m. and to stay later to complete them, except when overridden by hour requirements.
- All new consults should be staffed within 24 hours of the initial consult. Some consultations for urgent problems require immediate staffing. The urgency of the consultation should be established by the requester of the consult and not by the provider of the consult.
- Consult rotations are an opportunity for the fellow to learn extensively about geriatric medicine or related issues. As a resource for the primary teams and for his/her own educational benefit, each consulting fellow should take time to learn (read, talk to the attendings) about the problems that arise from each consult patient.

#### Inpatient/Nursing Home/Outpatient Services Responsibilities

- During regular work hours, for all clinical service lines, patient care is delivered by a team consisting of a faculty attending and the geriatric fellow. There may be residents and/or students assigned to the team.
- The geriatric fellow is primarily responsible for the care of the patients. The fellows are expected to provide most of the detailed day-to-day care of their patients and to receive first calls from nurses and other ancillary personnel regarding patient care. Residents and students can write patient orders if supervised by the geriatric fellow and may be responsible for writing additional progress notes to supplement the fellows' evaluations.
- The geriatric fellow must be available in-house to provide advice and guidance to the resident or medical student on the geriatric inpatient rotations unless under the direct supervision of the faculty attending.
- The geriatric fellow is expected to provide oversight and counsel to some of the weekly activities of the resident or medical student. Geriatric fellows must countersign all orders written by medical students.
- The faculty attending is available to both the fellow and other physician trainees and oversees the patient care activities of the entire team.
- A faculty attending is available for all clinical service lines and is on site in the outpatient clinic at all times.
- The method of immediate contact will be by pager or cell phone. All fellows are provided with BJH issued iPhones.

- Their iPhone numbers and on-call schedules are maintained by the Program Coordinator, disseminated to all faculty and staff, the Medical Exchange, and the Telecommunications department at Barnes-Jewish Hospital.
- During the day it is expected there will be frequent contact between the fellows and faculty for any emergent or urgent issues that cannot be handled during the next scheduled rounds with the attending.
- E-mail addresses and computers are also provided to the fellows along with voicemail and are additional methods of communication for non-urgent matters.
- A faculty member is available 24 hours a day seven days a week by telephone or pager and within 30 minute drive from the hospital and serve as consultants and backup for the fellows for all clinical service lines and emergency issues.

#### After-Hour Call Coverage

- The fellows will participate in the after-hour and weekend call schedule, to provide medical coverage starting on Monday at 4:30pm and ending the following Monday at 8:00am. In the case of a holiday falling on a Monday, after-hour call coverage will end the following Tuesday at 8:00am.
- The fellows will be assigned a week of coverage every five to eight weeks, depending upon how many faculty and fellows are rotating on the schedule in a given academic year.
- After-hour call coverage is generally provided by telephone, to cover urgent and some non-urgent medical issues for nursing home and Geriatric clinic patients.
- On-call physicians will occasionally be required to round on hospital inpatients at Barnes-Jewish hospital or TRISL that are being followed by the Geriatric consult service.
- The necessity for weekend coverage of consult patients will be determined by the attending on the Geriatric Consult Service.
- On-call physicians will also occasionally be required to see a new inpatient consult at Barnes-Jewish hospital or TRISL.
- The need for an urgent inpatient consult over the weekend will be determined by the fellow, only after discussion with the physician requesting the consult and the Geriatrics attending on the consult service, or his/her designee.
- If the Geriatric Consult attending is not available then the fellow should confer with the Program Director.
- The initial call for the specific clinical service line (nursing home, hospital consults, outpatient clinic) will be placed to the attending of record during working hours or his/her designee if out of town, and/or to the geriatrics fellow on the service.
- In the event this attending could not be reached, the fellows are instructed to page the attending on-call for the week.
- If the attending on call could not be reached, the Program Director will then be contacted.
- If the Program Director could not be reached, the Clinical Director will then be contacted.
- If the Clinical Director could not be reached, fellow can reach any other attending by utilizing the contact list that is distributed with the call schedule or simply have the Program Coordinator find appropriate back-up.
- The geriatric fellows do not have in-house overnight responsibilities.

#### Cross-Coverage

In the event one fellow has a disability/illness and cannot perform their clinical duties, their faculty mentors will cover the duties at their respective clinical sites (e.g. outpatient clinic, nursing home).

In regards to the consult service, the other fellow(s) will cover the consult service and/or the medicine residents on the geriatric rotation until the fellow returns from leave.

Failure of the Clinical Fellow to comply with any of the Responsibilities set forth above shall constitute grounds for disciplinary action, up to and including suspension or termination from the Program.

Effective 3/15/03

Reviewed and Approved 6/30/11

Updated 5/9/17, Reviewed and Approved 6/13/17

# Requirements Portfolio

## Geriatric Medicine Fellowship

**SKILLS** (tracked via MyEvaluations.com, Procedures, Patient Logs)

Demonstrate how to screen for:

- cognitive impairment (20)
- AUA BPH/Erectile dysfunction (5)
- depression (20)
- osteoporosis (20)
- mobility (20)
- under-nutrition (10)
- sleep apnea (5)
- sensory deprivation (5)

**KNOWLEDGE** (tracked via MyEvaluations.com, Procedures, Patient Logs)

Demonstrate the diagnosis, evaluation, and management of the following geriatric syndromes, emphasizing their multiple etiologies and multiple causes, which may occur in a single person.

- Full Psychometric Battery (3)
- osteoporosis (15)
- pressure ulcers (10)
- Incontinence Management Plan (5)
- ADLs/IADLs (20)
- Fall Management Plan (15)
- Direct Observation Feedback (6)
- Written Exam
- Oral Exam

**SCHOLARLY ACTIVITIES/PSQI**

- Case Conference (6); Dates: (1) \_\_\_\_\_, (2) \_\_\_\_\_, (3) \_\_\_\_\_, (4) \_\_\_\_\_, (5) \_\_\_\_\_, (6) \_\_\_\_\_
- PSQI Conference (3); Dates: (1) \_\_\_\_\_, (2) \_\_\_\_\_, (3) \_\_\_\_\_
- Journal Club Dates: (1) \_\_\_\_\_, (2) \_\_\_\_\_; Clinical Review Dates: (1) \_\_\_\_\_, (2) \_\_\_\_\_
- PSQI Modules and Quiz
- PSQI Project
- Other (conference abstracts/presentations, publications, etc.)  
Specify: \_\_\_\_\_
- Parc Provence Newsletter

Name of project/activity: \_\_\_\_\_

Date of completion/participation: \_\_\_\_\_

Name of supervising faculty/faculty mentor: \_\_\_\_\_

Date/place of presentation/submission for publication (if any): \_\_\_\_\_

Brief description of project/activity including which components of the PSQI curriculum were applied.

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## **CORE CURRICULUM TOPICS**

Below is a list of Geriatric Core Curriculum Topics that you are expected to review during your fellowship year. Review of these topics can be accomplished in a number of ways, including, but not limited to, Noon Conference lectures, Case Conferences, Essentials of Clinical Geriatrics Core Topic Discussions, Geriatrics at Your Fingertips, Core Topic Articles, The Geriatrics Review Syllabus, Pathy's Principles and Practice of Geriatric Medicine, Up to Date, Portal of Online Geriatrics Education, and Podcasts. When you have completed your review of a topic, check it off and provide the resource(s) you used in your review.

**Resource**     **Science of aging:**  
 \_\_\_\_\_ epidemiology  
 \_\_\_\_\_ physiology  
 \_\_\_\_\_ theories of aging

**Geriatric assessment:**  
 \_\_\_\_\_ cognitive  
 \_\_\_\_\_ functional  
 \_\_\_\_\_ medical  
 \_\_\_\_\_ laboratory

**LTC medical and financial issues:**  
 \_\_\_\_\_ patient management  
 \_\_\_\_\_ Hospice  
 \_\_\_\_\_ Palliative care  
 \_\_\_\_\_ regulations

**Economics of geriatric services:**  
 \_\_\_\_\_ Medicare, Medicaid  
 \_\_\_\_\_ Older Americans Act  
 \_\_\_\_\_ cost containment

**Communication skills:**  
 \_\_\_\_\_ patients  
 \_\_\_\_\_ families  
 \_\_\_\_\_ health professionals

**Ethical and legal issues:**  
 \_\_\_\_\_ competency  
 \_\_\_\_\_ guardianship  
 \_\_\_\_\_ advanced directives  
 \_\_\_\_\_ durable power of attorney

**Resource**     **Psychosocial aspects of aging:**  
 \_\_\_\_\_ family interactions  
 \_\_\_\_\_ living arrangements  
 \_\_\_\_\_ adjustment disorders

**Preventive medicine:**  
 \_\_\_\_\_ nutrition  
 \_\_\_\_\_ oral health  
 \_\_\_\_\_ exercise  
 \_\_\_\_\_ screening

**Pharmacological issues and aging:**  
 \_\_\_\_\_ polypharmacy  
 \_\_\_\_\_ pharmacokinetics  
 \_\_\_\_\_ inappropriate drugs in the elderly  
 \_\_\_\_\_ cholinergic burden

**Perioperative assessment:**  
 \_\_\_\_\_ preoperative assessment  
 \_\_\_\_\_ management of specific post-operative conditions  
 \_\_\_\_\_ hip fracture

**Home care:**  
 \_\_\_\_\_ resources  
 \_\_\_\_\_ financing  
 \_\_\_\_\_ components of the home visit

**Research methodology:**  
 \_\_\_\_\_ epidemiology  
 \_\_\_\_\_ statistics  
 \_\_\_\_\_ critical review  
 \_\_\_\_\_ level of evidence

**Resource**      **Cultural aspects of aging:**  
\_\_\_\_\_ demographics  
\_\_\_\_\_ ethnicity  
\_\_\_\_\_ culture-specific beliefs and attitudes  
\_\_\_\_\_ role of the interpreter  
\_\_\_\_\_ education  
\_\_\_\_\_ urban vs. rural

\_\_\_\_\_ **Iatrogenic disorders prevention:**  
\_\_\_\_\_ cholinergic burden  
\_\_\_\_\_ inappropriate use of drugs

\_\_\_\_\_ **Interdisciplinary coordination:**  
\_\_\_\_\_ care coordination

\_\_\_\_\_ **Support systems:**  
\_\_\_\_\_ family  
\_\_\_\_\_ community  
\_\_\_\_\_ organizations

**Resource**      **Geriatric issues and common disease:**  
\_\_\_\_\_ neoplastic  
\_\_\_\_\_ cardiovascular  
\_\_\_\_\_ neurologic  
\_\_\_\_\_ musculoskeletal  
\_\_\_\_\_ metabolic  
\_\_\_\_\_ pharmacologic

\_\_\_\_\_ **Hospice care:**  
\_\_\_\_\_ pain management  
\_\_\_\_\_ end-of-life issues

\_\_\_\_\_ **Geriatric rehabilitation:**  
\_\_\_\_\_ OT and PT specific conditions