Geriatric Medicine Fellowship Program

Curriculum, Policy, and Procedure Manual

Academic Year: 2019-2020

Division of Geriatrics and Nutritional Science
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Revised 7/1/19

1 See Appendix A for list of revisions
Table of Contents

Introduction ............................................................................................................................................. 6
Educational Goals and Objectives ............................................................................................................. 6
Major Clinical Rotations ............................................................................................................................. 8
  Outpatient Primary Care Clinic (48 Weeks) ............................................................................................. 8
  VA Home-Based Primary Care Program (8 Weeks) ................................................................................. 9
  Outpatient Geriatric Consultation Clinic (48 Weeks) ........................................................................... 11
  Long Term Care/Nursing Home (48 Weeks) ......................................................................................... 13
  Inpatient Consult Service (6, 1-Month Rotations) ................................................................................. 15
  Geriatric and Stroke Inpatient Rehabilitation (4 weeks) ............................................................ 17
  Inpatient Palliative Care (4 weeks) ....................................................................................................... 19
  Outpatient Geropsychiatry (6 Weeks) ................................................................................................. 22
Minor Clinical Rotations ............................................................................................................................ 23
  Memory and Aging Project (MAP) (2 sessions + CDR training) ............................................ 23
  Memory Diagnostic Center (MDC) Clinic (4 sessions) ................................................................. 24
  BJC Hospice and Evelyn’s House (4 sessions) ............................................................................. 21
  BJC Home Health Physical and Occupational Therapy (4 sessions) ........................................... 25
Subspecialty Clinics .................................................................................................................................. 25
  Bone Health Program (Division of Bone & Mineral Metabolism) (4 sessions) .................. 25
  Movement Disorders Clinic (Dept. of Neurology) (4 sessions) .................................................. 26
  Female Pelvic Medicine and Reconstructive Surgery (Uro-GYN) Clinic (4 sessions) .............. 26
  Wound Care Services and Podiatry (5 sessions) ........................................................................... 27
  Dentistry (online training module) ................................................................................................... 27
Clinical Screens, Assessments, and Consult Logs ................................................................................ 28
  Levels of Supervision ......................................................................................................................... 28
Schedule/Absences ................................................................................................................................ 30
Textbooks/Absences ............................................................................................................................... 30
Podcasts .................................................................................................................................................. 32
Expectations ........................................................................................................................................... 32
Conferences ............................................................................................................................................ 34
  Core Curriculum ................................................................................................................................. 34
  Clinical Case Conference .................................................................................................................. 36
  PSQI Conference ............................................................................................................................... 36
  Board Review Session ....................................................................................................................... 37
  ADRC Weekly Seminar .................................................................................................................... 37
  Geriatric and Nutritional Science Noon Research Seminar ...................................................... 38
  Medicine Grand Rounds .................................................................................................................. 38
  Hospice and Palliative Care Conferences ....................................................................................... 38
Patient Safety Quality Improvement (PSQI) Curriculum ................................................................. 39
Research and Teaching ........................................................................................................................... 44
  Institute of Clinical and Translational Sciences - ICTS ............................................................ 44
  Clinical & Translational Science Awards (CTSA) ........................................................................... 44
  Clinical Research Training Center .................................................................................................... 45

Page 2 of 96
Fellowship Program Policies

Clinical Competency Milestones in the Geriatric Context

Patient Care and Procedural Skills – PC
- PC1: Gathers and synthesizes essential and accurate information to define each patient’s clinical problem(s)
- PC2: Develops and achieves comprehensive management plan for each patient
- PC3: Manages patients with progressive responsibility and independence
- PC4b: Skill in performing and interpreting noninvasive procedures and/or testing
- PC5: Requests and provides consultative care

Medical knowledge – MK
- MK1: Clinical knowledge
- MK2: Knowledge of diagnostic testing and procedures
- MK3: Scholarship

System-Based Practices – SBP
- SBP1: Works effectively within an interprofessional team (e.g., peers, consultants, nursing, ancillary professionals and other support personnel)
- SBP2: Recognizes system error and advocates for system improvement
- SBP3: Identifies forces that impact the cost of health care, and advocates for and practices cost-effective care
- SBP4: Transitions patients effectively within and across health delivery systems

Practice-Based Learning and Improvement – PBLI
- PBLI1: Monitors practice with a goal for improvement
- PBLI2: Learns and improves via performance audit
- PBLI3: Learns and improves via feedback
- PBLI4: Learns and improves at the point of care

Professionalism – PROF
- 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)
- PROF2: Accepts responsibility and follows through on tasks
- PROF3: Responds to each patient’s unique characteristics and needs
- PROF4: Exhibits integrity and ethical behavior in professional conduct

Interpersonal Communication Skills – ICS
- ICS1: Communicates effectively with patients and caregivers
- ICS2: Communicates effectively in interprofessional teams (e.g., peers, consultants, nursing, ancillary professionals and other support personnel)
- ICS3: Appropriate utilization and completion of health records

Block Diagram and Evaluation Tools

Fellowship Program Policies

Policy on Selection
Policy on Education Stipend/Allowance........................................................................................................ 64
Policy on Effect of Leaves and Absence from Training.................................................................................... 65
Policy on Disciplinary Action, Suspension, Termination, and Grievances..................................................... 67
Policy on Promotion and Completion of Training.......................................................................................... 71
Policy on Evaluation of Geriatrics Fellows (CCC), Faculty, and Program (PEC).......................................... 73
Policy on The Learning and Working Environment....................................................................................... 77
Policy on Order Writing.................................................................................................................................. 81
Policy on Responsibilities, Communication, Supervision, and Attending Notification................................... 82
Requirements Portfolio...................................................................................................................................... 91
Helpful Resources ............................................................................................................................................ 95
BJH Connect Newsletter.................................................................................................................................. 95
Wayfinding.......................................................................................................................................................... 95
BJC Total Reward............................................................................................................................................ 95
Appendix A........................................................................................................................................................ 96
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Introduction

This manual is designed to orient fellows (PGY Level 4+) to the 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 the academic offices, located in the Wohl Clinic Building, 3rd 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. Fellows are expected to gain an awareness of cost issues relevant to geriatric care, and to incorporate this into clinical decision-making. Lastly, fellows are expected 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. Fellows are expected 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 and all trainees are expected to improve in this difficult area. In the area of Interpersonal and Communication Skills (ICS), trainees are expected 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. Fellows are expected 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 teamwork. 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
Staff Contact: Sharon Parr, sharon.parr@bjc.org
(P) 314-996-4545, (F) 314-996-4546
**Epic Dept:** BJCMG WCMA

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
Staff Contact: Lynn Conway, lynn.conway@bjc.org
(P) 314-996-5905
**Epic Dept:** BJCMG IMS IM

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, PBL1 - 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 Screens 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

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.

On-Boarding

All forms and instructions regarding WOC (Without Compensation) onboarding for the VA Graduate Medical Education (GME), is accessed via the website link below:
https://www.stlouis.va.gov/withoutcompensation-woc/without_compensation.asp

If you rotated at any VA in the past please let the coordinator know so that they can pull your record. The forms should be completed electronically when possible. Please cc the Program Coordinator when you submit your paperwork. All paperwork should be submitted electronically to:
STLTraineeOnboarding@va.gov

If you have questions or issues, please contact Jennifer Griffin, MHA, Office of Academic Affairs, GME Coordinator, Program Support Assistant, VA St. Louis Health Care System, (314) 652-4100 x55543.

Off-Boarding

The St Louis VA Medical Center will off-board any trainee (Student, Resident, Fellow) after they complete their Without Compensation (WOC) appointment and/or will no longer be rotating with them. This includes collecting PIV badges and terminating TMS and computer accounts.

Fellows will need to turn in their PIV badges to the VA on their last day of service at Building 18.

If a fellow decides to extend their WOC appointment, they will need to:
• Complete a new WOC appointment letter.
• Complete their annual TMS training.
• Notify the GME office.

This will ensure their TMS account is not locked or removed. The VA Service will coordinate any needed updates to their PIV badge.

**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: Megan Herman  
(P): 314-747-8647  
Email: m.herman@wustl.edu  
**Epic Dept:** WU IM GER CAM 5C

Fellows participate in one ½ day session per week for 48 weeks and work with two different faculty members, each for six months continuously. The clinical team includes a physician faculty member and a case worker. The clinic is also a training site for Internal Medicine residents and WUSM medical students. New patient evaluations usually take one hour to complete; return visits and family conferences are 30 minutes. Since clinics are a team effort, 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, i.e. home health orders must be signed by the ordering physician.

**Required Trainings**

Psychometric Test Training  
MoCA  
- [https://www.youtube.com/watch?time_continue=11&v=XjrnsIXoSCg](https://www.youtube.com/watch?time_continue=11&v=XjrnsIXoSCg)  
- [https://www.youtube.com/watch?v=wO7n19KMveU](https://www.youtube.com/watch?v=wO7n19KMveU)

Logical Memory and Trails  
- [https://www.proprofs.com/training/course/?title=preview-diantu-cogcore-full-battery-training_5c0eeb237c27a](https://www.proprofs.com/training/course/?title=preview-diantu-cogcore-full-battery-training_5c0eeb237c27a)  
- Only Logical Memory and Trails under Section 7

Other tests (category fluency, digit symbol) are encouraged but optional.

CDR Training  
CDR Literature: [https://knightadrc.wustl.edu/CDR/CDR.htm](https://knightadrc.wustl.edu/CDR/CDR.htm)  
CDR Overview Video and 3 Sample Modules:  
[https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm](https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm)
Epic Templates (.phrases)
.GERIATRICSORDERSET: Routine order set
.GERIFAMVISIT: For Family Conference appointment
.GERIOV: For New appointments
.GEROV: For Return appointments

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. Fellows are expected to independently administer the full psychometric testing battery by the beginning of the second month (Aug) of the fellowship year. 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)**

<table>
<thead>
<tr>
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<td>Facility Phone: 314-542-2500</td>
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<td>Faculty: Lenise Cummings-Vaughn, MD</td>
<td>Faculty: Charles Crecelius, MD</td>
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<tr>
<td>Medical Director: David Carr, MD</td>
<td>Medical Director: Charles Crecelius, MD</td>
</tr>
<tr>
<td>AMD: Lenise Cummings-Vaughn, MD</td>
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</table>

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 one half-day 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.

Fellows are expected to attend QI meeting at each long-term care site. QI meetings at Parc Provence (QA/PAT Chats) are the 2nd Friday each month at 1:30pm. Fellows should coordinate with Dr. Crecelius regarding QI meetings at Delmar Gardens.

**Parc Provence EMR – PointClickCare**

Account login instructions:
Contact: Judith Ibidokun, BSN, RN, Director of Clinical Services, Phone (314) 453-7373, jibidokun@parcprovence.com

In an internet browser, go to https://login.pointclickcare.com/home/userLogin.xhtml

To login for the first time:
Username: gate.initial of first name and last name Ex. gate.jdoe for John Doe (provided by Judith)
Password: Welcome1

You will be prompted to change your password.
**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 to provide guidance to Internal Medical residents and medical students as they learn about primary care in the nursing 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 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 Epic.

**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 two articles for the newsletter in lay language on a topic related to dementia or long-term care while rotating at Parc Provence. Please refer to the list of topics in the WUSTL Box (Box\Geriatric Medicine Fellowship\Rotations\Long Term Care\Parc Provence\Parc Provence Newsletter) that have been covered in the past for examples and to be sure not to duplicate any topics. This aspect of the fellowship is intended to develop written communication skills, as directed to patients and families.

**Newsletter Due Dates:**
- **Fall** – Due late September for early October publication
- **Winter** – Due late December for early January publication
- **Spring** – Due late March for early April publication
- **Summer** – Due late June for early July publication

Newsletters should be sent to:
Brigid A. McGuire, MA, CRC
Assistant Director of Well Being
Direct Line: 314-453-7340
Fax: 314-453-7840
Email: bmcguire@parcprovence.com

Nicole Parris-Jacobs
Assistant Directors of Activities
njacobs@parcprovence.com

**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 geriatrics 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.

Please review the GME Standards for Inpatient Consultations here: [https://gme.wustl.edu/about/policies-procedures/standards-for-inpatient-consultations/](https://gme.wustl.edu/about/policies-procedures/standards-for-inpatient-consultations/)
Procedure
Consult Intake
- The consult fellow will monitor Epic for consult requests
  - Requesting services enter consults in Epic AND call the office to ensure the consult is received.
  - **Epic > Patient Lists > Barnes Jewish Hospital > New Consults – Physician > Gerontology**
- 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. The fellow on service will complete the first consult each week to ensure they are meeting the requirement of 25 consults for the year and educating residents/students on consult procedures.
- 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 and the chart has been reviewed, the trainee sees 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 (Queeny Tower is being demolished)
    - X-200, -300: Rand Johnson/West Pavilion
    - X-400: Central
    - X-500: East Pavilion
    - X-900: Schoenberg/CAM
- ALL psychometrics (Short Blessed Test (SBT) and Clock Construction) and PHQ9, Short Physical Performance Battery (SPPB) (when appropriate), 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, PHQ9) is completed, the fellow or the resident will contact the attending and ALL OTHER CONSULT TEAM MEMBERS to staff (IM residents, medical students and attending)

Documentation
- The fellow/resident completing the work-up on the patient will create the note in Epic and link their note to the order, also indicating the attending who will be the cosigner.
- See “WUSTL Box\Geriatric Medicine Fellowship\Epic” or “WUSTL Box\Geriatric Medicine Fellowship\Rotations\Inpatient Consults” for detailed instructions.
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, PBLI1, 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: Various
Fellows will participate in a four-week rotation at The Rehabilitation Institute of St. Louis (TRISL), an acute inpatient rehabilitation facility (IRF). The rotation is comprised of two 2-week blocks; one intensive and one less intensive. During the intensive 2-week block, the fellow spends M-F 8:30am-5:00pm with the rehab team 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). During the less intensive 2-week block, the fellow will attend their longitudinal rotations (outpatient geriatrics clinic, long-term care and primary care) and spend the remainder of their time at rehab on rounds, observing therapy, following the wound nurse, or other activities as the supervising attending sees fit. Participation in weekly interdisciplinary care rounds is expected.

REQUIRED Reading:
Fellows are to read the 7 sections of The Stroke Rehabilitation Clinician’s Handbook PRIOR to beginning the Stroke Rehabilitation Rotation, but are REQUIRED to read all sections within the first 2 days of the rotation.

Handbook sections are found in the WUSTL Box (Geriatric Medicine Fellowship\Rotations\Rehab), linked via the Geriatric Medicine Library Guide, or found here: http://www.ebrsr.com/clinician-handbook

TRISL is located on the WU Medical Center Campus.

To call long distance from TRISL, dial 9+1+area code, after the dial tone, enter the long distance code: 02025

Please contact Kari Cox at Kari.cox@encompasshealth.com for an introduction to the electronic records system (ACE-IT) and passwords to access the system. Fellows are able to access ACE-IT remotely via https://eawseh.encompasshealth.com/eawseh/default.aspx

Fellows are expected to attend required Geriatrics conferences during this block, so long as it does not disrupt Rehab duties.

Inpatient Therapy Services  Outpatient Therapy Services  Wound Care
Audra Sturmoski PT, NCS, CBIS  Mimi Kramper, LCSW  John Bishop
2nd Floor Therapy Manager  Outpatient Program Manager  John.bishop@healthsouth.com
Stroke Program Coordinator  314-658-3817
Ascom phone # is 2705  Marian.Kramper@healthsouth.com
Audra.Sturmoski@healthsouth.com
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, PBL11, 3, 4, PROF1 - 4, ICS1 - 3

Inpatient Palliative Care and Hospice (4 weeks)

Inpatient Palliative Care

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
Staff Contact: Melissa Euler, 314-747-5361, 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 intensive 2-week block as a member of the inpatient Palliative Care Consult Service and one less intensive 2-week block participating in home hospice visits (2 sessions) and working as a team member at Evelyn’s House (2 sessions). 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 are expected to attend required Geriatrics 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 provides 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 provides 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 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.

**BJC Hospice and Evelyn's House**

<table>
<thead>
<tr>
<th>BJC Hospice Program</th>
<th>Evelyn's House</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935 Belt Way Drive</td>
<td>1000 North Mason Road</td>
</tr>
<tr>
<td>St. Louis, MO 63114</td>
<td>Creve Coeur, MO 63141</td>
</tr>
<tr>
<td>Abosede Idowu “Bukie”</td>
<td>Jessica Mabb</td>
</tr>
<tr>
<td>Sr. Staffing Coordinator</td>
<td>Administrator</td>
</tr>
<tr>
<td>(P) 314-953-2080</td>
<td>(P) 314-953-1636</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:abosede.idowu@bjc.org">abosede.idowu@bjc.org</a></td>
<td>Email: <a href="mailto:jessica.mabb@bjc.org">jessica.mabb@bjc.org</a></td>
</tr>
</tbody>
</table>

Fellows will spend at least 2 sessions with the BJC Hospice program, accompanying an RN or NP on their rounds visiting hospice patients at home and at nursing home locations, and at least 2 sessions at Evelyn's House in conjunction with the Palliative Care rotation.

**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.
Outpatient Geropsychiatry (6 Weeks)

Barnes Jewish Hospital South
West Pavilion, Suite 15340
Tuesdays at 9:30am
Faculty: Eric Lenze, MD, 314-498-1919, lenzee@wustl.edu
Preceptor: Jacinda Berger, NP, jacindaberger@wustl.edu

This rotation includes six (6) ½ day clinical sessions that include 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 geropsychiatrist.

Lecture materials are found here: Box\Geriatric Medicine Fellowship\Rotations\Geropsychiatry

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, PBLI1, 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 reviewing the literature on topics pertinent to their specific cases. Fellows will gain knowledge and skill mainly by reading articles and dealing with challenging cases.
Learning is maximized through these strategies:

**Supervision:** 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 Brown.

**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 Online Certification and Training)**

Knight Alzheimer’s Disease Research Center  
4488 Forest Park, Suite 101, 1st Floor (Basement)  
St. Louis, MO 63108  
Staff Contacts:  
Maria Carroll, 314-286-0246, carrollmariab@wustl.edu, office hours: 3rd Weds, 2-3PM  
Connie Mayo, 314-286-2533, conniemayo@wustl.edu  
Nicole Elmore, 314-286-2683, helmore@wustl.edu, office hours: 1st Thu, 2-3PM

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 healthy 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 Online Certification Training. An ADRC staff member will assist with this process. Fellows are to complete the CDR training within the first month of fellowship, as the CDR is utilized for assessments in the Outpatient Geriatric Consultation Clinic.

**CDR Training**

CDR Literature: [https://knightadrc.wustl.edu/CDR/CDR.htm](https://knightadrc.wustl.edu/CDR/CDR.htm)
CDR Overview Video and 3 Sample Modules: [https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm](https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm)
CDR Online Certification Training: [https://knightadrc.wustl.edu/cdr/Application/Step1.htm](https://knightadrc.wustl.edu/cdr/Application/Step1.htm)

The Program Coordinator will connect fellows with ADRC staff for scheduling assessment observations and if assistance is needed with training. The Program Coordinator will schedule the 2 assessment observations and fellows 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_Us/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, 6th Floor, Suite C  
St. Louis, MO 63110  
Faculty Contact: Dr. David Carr  
Clinic Nurse: Dawn Ellington, dellington@wustl.edu  
Tuesdays at 1:00pm  
**Epic Dept:** WU NL MDC CAM 6C

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_Us/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.

**BJC Home Health Physical and Occupational Therapy (4 sessions)**

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<thead>
<tr>
<th>BJC Home Health Care</th>
<th>WU Program in Occupational Therapy</th>
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<tbody>
<tr>
<td>1935 Belt Way Dr.,</td>
<td>4444 Forest Park Ave.,</td>
</tr>
<tr>
<td>St. Louis, MO 63114</td>
<td>St. Louis, MO 63108</td>
</tr>
<tr>
<td>Jackie Rand, PT</td>
<td>Monica Perlmutter, OTD, OTR/L, SCLV, FAOTA</td>
</tr>
<tr>
<td><a href="mailto:jackie.rand@bjc.org">jackie.rand@bjc.org</a></td>
<td><a href="mailto:perlmutterm@wustl.edu">perlmutterm@wustl.edu</a></td>
</tr>
<tr>
<td>Tyson Bradley, PT</td>
<td>Stark, Susan, PhD, OTR/L, FAOTA</td>
</tr>
<tr>
<td><a href="mailto:tyson.bradley@bjc.org">tyson.bradley@bjc.org</a></td>
<td><a href="mailto:sstark@wustl.edu">sstark@wustl.edu</a></td>
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</table>

**Educational Objectives**

With BJC Home Health Care, fellows 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. Fellows will make home visits with a Physical/Occupational Therapist affiliated with the BJC Home Care program and/or WU Occupational Therapy. During this time, fellows will observe the HELA and I-HOPE. Information about these assessments can be found on the WU Program in Occupational Therapy website [https://www.ot.wustl.edu/about/resources/assessments-388](https://www.ot.wustl.edu/about/resources/assessments-388).

**Subspecialty Clinics**

Geriatrics fellows participate in the following subspecialty clinics: Bone Health Center (Osteoporosis), Movement Disorders clinic (Neurology), Urogynecology clinic (Gynecology), Wound Care service (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 through the Geriatric Medicine Library Guide via Becker Library.

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

Center for Advanced Medicine (CAM)
Medicine Multispecialty Center (MMC)
4921 Parkview Place 5th Floor, Suite C
St. Louis, MO 63110

**Epic Dept:** WU IM BONE CAM 5C

This clinic focuses on the comprehensive evaluation and management of metabolic bone disease, primarily osteoporosis. Geriatrics fellows participate in new patient assessments and follow-up visits, under the supervision of a faculty attending. Geriatric fellows attend 2 full-day or 4 half-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 DXA test results for osteoporosis screening and management.

Movement Disorders Clinic (Dept. of Neurology) (4 sessions)
Center for Advanced Medicine (CAM) McMillan Hall, Basement
4921 Parkview Place 6th Floor, Suite C Monday – All Day, Wednesday PM
St. Louis, MO 63110
Wednesday AM
Contact: Amy Bain
(P) 314-362-6908, baina@neuro.wustl.edu

Fellows participate in new patient and follow-up assessments, under the supervision of a faculty attending. Geriatric fellows attend 2 full-day or 4 half-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 Outpatient Health (COH)
Center for Women’s Wellness, Suite 450 4901 Forest Park Ave
Building D, 4th Floor 7th Floor
Monday AM, Thursday AM Monday PM, Wednesday PM
Dr. Chiara Ghetti Epic Dept: WU OB FPMRS MBMC 450D Epic Dept: WU OB FPMRS COH 7
Email: ghetti.c@wustl.edu
Contact: Karen Burns, Administrative Assistant
(P) 314-747-7688
Email: 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 prolapses (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 observe office procedures including urodynamic testing and cystoscopy.

Geriatric fellows are to attend 4 half-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 (4 sessions)

Center for Outpatient Health
4901 Forest Park Ave, 1st Floor
St. Louis, MO 63108
Faculty: Dr. John Kirby, 314-362-5298, kirbyj@wudosis.wustl.edu
Contact: Gay Adams (Sellers), 314-362-1272, 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 ulcers; 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 4 clinic sessions at the WU Wound Care clinic, 2 sessions with an APP and 2 with a podiatrist, where they participate in new patient and follow-up assessments at the under the supervision of a faculty attending (General Surgery and Podiatry).

Fellows have the option to participate in rounds on the in-patient Wound Service.

Dentistry (online training module)

Fellows complete an online dentistry training module entitled, “An Interactive Geriatric Denture Case Study Approach Engaging Dental Students Designed to Link Oral Health, Nutrition and Patient Counseling in an Interprofessional Setting” provided by the AAMC through the MedEdPORTAL. The original publication is found here: https://www.mededportal.org/publication/10124/ and fellows access the module via the WUSTL Box.

The Rosa instructional module provides an interprofessional approach aiming to help trainees identify oral health risk factors associated with edentulous patients. Upon completion of the case, trainees are able to review medical, social, and dental histories and recognize systemic disease interventions related to oral health, in particular, that of geriatric patients. Trainees can then determine patients’ adequate nutritional needs, locate appropriate educational materials and handouts, and develop a tobacco-cessation strategy.
Clinical Screens, Assessments, and Consult Logs

To ensure trainees receive adequate exposure to a range of geriatric conditions and 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. 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. In addition to logging all screens and assessments, fellows are expected to retain copies (upload to your “Completed Screens and Assessments WUSTL Box folder) for the Program Director to review at quarterly feedback sessions.

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 their scope of authority and the circumstances under which they are permitted to act with conditional independence (see Policy on Responsibilities, Communication, Supervision, and Attending Notification). 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 ¼ of the required Geriatric Screens and Assessments, i.e. acquired competency. 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 and train others on the screen/assessment.

For a screen/assessment/consult to be counted towards the total required for the year, fellows must:

a. Complete the screen/assessment/consult form.
   
a. Forms found here: WUSTL Box\Geriatric Medicine Fellowship\Assessments and Screens.

b. Upload the completed form.
   
a. Upload here: WUSTL Box\Geriatric Medicine Fellowship\Fellows\[your folder]\Completed Screens and Assessments

c. Log them in through www.MyEvaluations.com

<table>
<thead>
<tr>
<th>Encounter</th>
<th># Milestone</th>
<th># Competency</th>
<th>Rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment - ADL/IADL Management</td>
<td>20</td>
<td>5</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Primary Care</td>
</tr>
<tr>
<td>Assessment - Fall Management Plan</td>
<td>15</td>
<td>4</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td>Assessment - Full Psychometric Battery</td>
<td>3</td>
<td>1</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td>Assessment - Incontinence Management Plan</td>
<td>5</td>
<td>2</td>
<td>Uro-GYN</td>
</tr>
<tr>
<td>Assessment - Osteoporosis</td>
<td>15</td>
<td>4</td>
<td>Bone Clinic</td>
</tr>
<tr>
<td>Assessment - Pressure Ulcers</td>
<td>10</td>
<td>3</td>
<td>Wound Clinic</td>
</tr>
<tr>
<td>Inpatient Consult</td>
<td>25</td>
<td>6</td>
<td>Consults</td>
</tr>
<tr>
<td>Screen - AUA BPH and ED</td>
<td>5</td>
<td>2</td>
<td>Uro-GYN</td>
</tr>
<tr>
<td>Screen - Cognitive Impairment</td>
<td>20</td>
<td>5</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consults</td>
</tr>
<tr>
<td>Screen - Depression</td>
<td>20</td>
<td>5</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consults</td>
</tr>
<tr>
<td>Screen - Mobility</td>
<td>20</td>
<td>5</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td>Screen - Osteoporosis</td>
<td>10</td>
<td>3</td>
<td>Bone Clinic</td>
</tr>
<tr>
<td>Screen - Sensory Deprivation</td>
<td>5</td>
<td>2</td>
<td>OP Geri Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Primary Care</td>
</tr>
<tr>
<td>Screen - Sleep Apnea</td>
<td>5</td>
<td>2</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Screen - Under-Nutrition</td>
<td>10</td>
<td>3</td>
<td>Primary Care</td>
</tr>
</tbody>
</table>
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 recommendation they have 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, out of office calendar, etc. All absences should be communicated to the Program Coordinator, Program Director, and rotation/clinic attending as soon as possible.


Textbooks, Reading Materials, Trainings

Textbooks


- Core topics from Essentials of Clinical Geriatrics will be covered during didactic sessions with the Program Director on Mondays at 10:30am.
- Print copy provided by program; electronic version available through the Becker Medical Library Geriatric Medicine Guide
- Be familiar with all sections of the book by the end of the year.
ISBN: 978-1-886775-40-4

- Print copy provided by program; electronic version available through the American Geriatrics Society: [https://geriatricscareonline.org/](https://geriatricscareonline.org/)
- Be familiar with all sections of the book by the end of the year.

doi:10.1017/CBO9780511576454

- Core topics from Essentials of Clinical Geriatrics will be covered through didactic sessions with a Program Faculty during Monday 11:30am conference.
- Print copy provided by program
- Be familiar with all sections of the book by the end of the year.

**Core Topic Articles**

Core Topic Articles are available through the Becker Medical Library [Geriatric Medicine Guide](https://geriatricscareonline.org/). Fellows are expected to read all articles by month 10 of the fellowship year. It is strongly suggested that fellows read articles related to major rotations within the first 3 months and those related to minor rotations prior to beginning the rotation.

**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/](https://geriatricscareonline.org/)
- Multiple choice questions with answers and an extensive bibliography
- Board Review questions are covered through didactic sessions with a Program Faculty during Monday 11:30am conference.

**Aquifer Online Learning Modules (web-GEMs)**

**MedU Account Set-Up:**
1. Go to: [https://www.meduapp.com](https://www.meduapp.com)
2. Click the blue "LOG IN" button in the top-right corner.
3. Click on the “Need Access OR Forgot your Password?” link
4. Type in your institutional email address into the Email box
5. Click “Send me instructions to set my password” button.
6. An email will be sent to you. Follow the instructions in the email to setup your account.

**Additional Resources**

**Up to Date**

- Available through the Becker Medical Library [Geriatric Medicine Guide](https://geriatricscareonline.org/)
- 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:

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.

**Trainings**

**Psychometric Training**

**MoCA**

1. Demonstration Video: [https://www.youtube.com/watch?time_continue=11&v=XjrnsIXoSCg](https://www.youtube.com/watch?time_continue=11&v=XjrnsIXoSCg)
2. Administration and Scoring: [https://www.youtube.com/watch?v=w07n19KMveU](https://www.youtube.com/watch?v=w07n19KMveU)

**Logical Memory and Trails**

1. Go to: [https://www.proprofs.com/training/course/?title=preview-diantu-cogcore-full-battery-training-5c0eeb237c27a](https://www.proprofs.com/training/course/?title=preview-diantu-cogcore-full-battery-training-5c0eeb237c27a)
2. Complete Logical Memory and Trails under Section 7
3. Other tests (category fluency, digit symbol) are encouraged but optional.

**CDR Training**

1. CDR Literature: [https://knightadrc.wustl.edu/CDR/CDR.htm](https://knightadrc.wustl.edu/CDR/CDR.htm)
2. CDR Overview Video and 3 Sample Modules: [https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm](https://knightadrc.wustl.edu/cdrtraining/browsebtrp/default.htm)
3. CDR Online Certification Training: [https://knightadrc.wustl.edu/cdr/Application/Step1.htm](https://knightadrc.wustl.edu/cdr/Application/Step1.htm)

**Expectations**

1. Fellows are expected to take a leadership role in educating themselves and other trainees, including medical students and residents. To the extent possible, Fellows should lead attending/teaching
rounds, bring articles and other information to the team that are pertinent to the patients that are seen on rounds. Fellows are expected to prepare at least one teaching session 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 to provide training in our standardized screens for Geriatrics consults and clinic and should help them to complete their clinic/consult notes.

3. Fellows should serve as a liaison with outside physicians and consultants to ensure continuity of care is provided, including those 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
When: Mondays at 12:00pm
Where: Wohl Clinic Building Conference Room 338
Required: YES, please sign the attendance sheet

Schedule found here: WUSTL Box\Geriatric Medicine Fellowship\Division Schedules\Geri Conference Schedules

Friedman Center on Aging
When: 2nd Monday at 12:00pm (Sep-Nov, Jan-May)
Where: Medical Campus, Room TBD
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.

Schedule found here: https://publichealth.wustl.edu/series/issues-in-aging/

Presenter Instructions
Fellows are expected to present two Journal Clubs and two Clinical Reviews during the fellowship year; one of each in each half of the year.

Oral presentations for the Core Curriculum are scheduled on Mondays at 12:00pm. Fellows will select a topic in Geriatric Medicine to discuss 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 should focus on a brief clinical review of the specific content area. For the last 15-20 minutes of a 30-minute presentation, fellows should review a recent article on this area, preferably one that might change the management or treatment of this condition in older adults. Fellows are also expected to discuss the strengths and limitations of the described research study.

For Clinical Review sessions, fellows are expected 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. Details from important or landmark studies in the topic area should be presented and discussed.
The Core Topic List, log of previously presented articles/topics, generic disclosure slide and screenshots of the instructions below can be found in the Geriatric Medicine Fellowship WUSTL Box in the “Conferences” folder.

**By Thursday, [prior to presentation date]:**
1. Have your article approved by the Fellowship Director, Dr. Binder (cc the Program Coordinator, Stephanie Martino please)
2. Go to [https://cme.wustl.edu/](https://cme.wustl.edu/)
   a. Wash U faculty/staff – select “WUSTL KEY” and enter your username & password
   b. Edit/Complete your Profile information and SAVE
3. Click My Activity Center then click “My Assignments”
4. Update Disclosures and CME Standards. Click on each to complete the form, if needed, and submit
   a. Wash U faculty/staff – You will be directed to the RMS website to complete your disclosure
5. Scroll down to your Session date and click on Speaker Objectives and enter at least 1 objective and the title of your talk.
   a. Note – “to better understand the topic” is NOT an acceptable response. Objectives should be directly related to the objectives of the article and how they relate to geriatric practice.

**By Monday, [presentation date] at 11:00am:**

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 Conference 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, routine health screening, screening for geriatric syndromes
3. Geriatric assessment: cognitive, functional, medical, laboratory
4. Interdisciplinary coordination: care coordination
5. Geriatric Syndromes: falls, incontinence, osteoporosis, sensory impairment, pressure ulcers, sleep disorders, pain, elder abuse, self-neglect, malnutrition, functional impairment
6. Geriatric issues associated with sub-specialty areas: cardiovascular, neurologic, musculoskeletal, metabolic, infectious diseases, renal, rheumatology, hematology/oncology, orthopedics, etc.
7. Pharmacological issues associated with aging: polypharmacy, pharmacokinetics, inappropriate prescribing in the elderly, cholinergic burden.
8. Psychosocial aspects of aging and geriatric care; family interactions, living arrangements, adjustment disorders, depression, isolation, substance abuse.
10. Ethical and legal issues relevant to geriatrics: competency, guardianship, advanced care planning and directives
11. Geriatric rehabilitation
12. Long-term Care medical and financial issues: patient management, 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. Communication skills: patients, families, health professionals
16. Cultural aspects of aging: demographics, ethnicity, culture-specific beliefs and attitudes, role of the interpreter, education, urban vs. rural
17. Home care: resources, financing, components of the home visit
18. End of Life Care: Palliative care, Hospice care, pain management, withdrawal of care, communication issues

Clinical Case Conference

When: Mondays at 11:30am
Where: Wohl Clinic Building Conference Room 338
Required: YES, please sign the attendance sheet

Fellows are to choose cases to present from the following clinical sites: outpatient geriatric clinic, primary care clinic, consult service, Parc Provence and TRISL. The Program Coordinator will remind fellows 1 week in advance of their presentation date to provide a synopsis and any materials to be printed by sending the following reminder:

“Reminder to please send along a synopsis of your case, with the general topic, and any article(s) you plan to reference for next Monday. Examples of Case Conferences can be found here: Geriatric Medicine Fellowship\Conferences\Case Conference; and the core topics list can be found here: Geriatric Medicine Fellowship\Conferences.”

PSQI Conference

When: Mondays at 11:30am
Where: Wohl Clinic Building Conference Room 338
Required: YES, please sign the attendance sheet

There are 2 types of PSQI conferences:
1. Clinical Applications
   - Fellows present a review of their assigned The Washington Manual of Patient Safety and Quality Improvement (available from Becker through Ovid) clinical application topic and relate the topic to a clinical case.
2. PSQI Project Progress Reports
   - Designed to assist fellows with development and implementation of their project. Fellows are expected to present/discuss their PSQI proposal, implementation challenges, and results.
   - To allow sufficient time for initial data collection, data analyses, implementation of an intervention, and repeat data collection/analysis, fellows will submit to the PD their written
project proposal no later than the end of month 3 (September) of the fellowship year for presentation at the October conference per the conference outline below:

- Oct – Project Ideas
- Dec – Project Proposal
- Mar – Preliminary Findings
- Jun – Final Project Presentation

**Board Review Sessions**

When: Mondays at 11:30am  
Where: Wohl Clinic Building Conference Room 338  
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.

**Communications Sessions**

When: Mondays at 11:30am  
Where: Wohl Clinic Building Conference Room 338  
Required: **YES, please sign the attendance sheet**

Trainees and faculty discuss communication topics from *Mastering Communication with Seriously Ill Patients: Balancing Honesty with Empathy and Hope* (2009) by Back, A., Arnold, R. and Tulsky, J.

**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. Fellows are expected to attend at least 4 ADRC Weekly Seminars.

**Skeletal Health Foundational Lecture Series**

When: Friday, August 2, 9, 16, 23, 30, September 6, 2019 at 8:00am  
Where: BJC Institute of Health Building, 11th floor Conference Room AB  
Required: **YES –please sign the attendance sheet**

All of the lectures will be recorded and made available on the Bone and Mineral website for review for those fellows who may not be able to attend and for future reference.
Skeletal Health Case Conference Series
When: 3rd Friday of the month at 9:00am,
Where: BJC Institute of Health Building, 11th floor Conference Room AB
Required: YES, to present a case at least once per academic year; NO for monthly series

Geriatric Medicine Fellows are required to attend and present a case at least once per academic year, but are encouraged to attend as many case conferences as their schedule allows.

Geriatrics 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, except during Palliative Care rotation
Patient Safety Quality Improvement (PSQI) Curriculum

The Division of Geriatrics and Nutritional Science has developed a PSQI Curriculum based on the Washington University Manual of Patient Safety and Quality Improvement. 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 4 components to the PSQI Requirement:
1. Participation in the Clinical Applications Conference outlined above.
2. Participation in the DOM Safety and Quality Improvement Seminar and completion of the “Basic Principles of Patient Safety Module” (assigned through MyEvaluations.com);
3. Participation in Division PSQI conferences
4. Completion of a Patient Safety or Quality Improvement project.

Fellows are encouraged to submit an abstract of their PSQI projects for presentation at the annual BJH Safety and Quality Symposium held in early March. Abstracts are due late December – early January. The Program Coordinator will provide detailed information to fellows as it becomes available.

The information below can be found at: https://gme.wustl.edu/resources/psqi/psqi-objectives/

WU/BJH/SLCH GME PSQI Objectives

At the completion of training, a graduate from our programs will attain the following objectives:

Patient Safety

1. Patient Safety System: The graduating house officer must define and apply system thinking (complex sets of interactions, relationships and linkages that make up today’s healthcare environment) to their day-to-day clinical practice.
   • Key topic area examples: Safety culture, high reliability, just culture, human error/at risk behavior/reckless behavior, stop the line, systems failures, personal role in system functioning, Swiss cheese analogy, basics of system evaluation (e.g. Donabedian Quality of Care framework), TeamSTEPPS, Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey, diagnostic error.
   • Program Level Assessment: AHRQ Culture of Safety Survey, Internal assessment
   • Individual Assessment: Internal assessment
   • Resources: The Washington Manual of Patient Safety and Quality Improvement (available from Becker through Ovid), IHI Open School
   • Teaching/Curriculum: DOM Safety and Quality Seminar

2. Patient Safety Goals: The graduate must state their institutional (hospital/departmental/divisional) and relevant national patient safety goals, priorities and strategies and how they interface with daily practice in their field.
   • Key topic area examples: National Patient Safety Foundation (NPSF) Goals, AHRQ PSI-90 quality indicator, Washington University/BJH/SLCH goals and priorities.
   • Program Level Assessment: Institutional Survey
   • Individual Assessment: Milestones
   • Resources: Departmental Patient Safety Officer and Coordinator, IHI/NSPF website, Pocket Guides (BJH GME), Patient Safety Resource Grid (available from the GME office)
3. Interprofessional activities: The graduate will lead and/or serve on interprofessional health care teams in a manner that maximizes safety and quality and appropriately support the role of other healthcare professionals on the team.
   - Key topic area examples: Stages of team development (forming, storming, norming, performing), characteristics of successful teams (common purpose, measurable goals, leadership, communication, respect), stop the line, TeamSTEPPS, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
   - Program Level Assessment: Participation in TeamSTEPPS, HCAHPS/PRC data
   - Individual Assessment: 360 evals
   - Resources: TeamSTEPPS, Partnering to heal
   - Teaching/Curriculum: Leadership and Teamwork PSEP (PSQI WUSTL Box Folder)

4. Error reporting and event analysis
   a. Reporting: The graduate will identify patient safety events or unsafe circumstances that must be reported. The graduate will take the professional responsibility to ensure that these events have been reported into the appropriate system. **Geriatric Medicine Fellows are expected to report at least 1 patient safety event through the WU reporting system during their fellowship year. Failure to do so will result in a System-Based Practices 2 (Recognizes system error and advocates for system improvement) milestone rating no higher than 2.**
      - Key topic area examples: Adverse events, errors, global/hospital/department/division specific triggers, near miss, sentinel event
      - Program Level Assessment: Triggers, # reports by department, % reports submitted by trainees
      - Individual Assessment: Semiannual PD meeting (have you put a report in)
      - Resources: Departmental Patient Safety Officers and Coordinators, Patient Safety Resource Grid (available from the GME office), IHI Open School
      - Teaching/Curriculum: DOM Safety and Quality Seminar, IHI Open School
   b. Analyzing: The graduate will analyze patient safety events, participate meaningfully in the event review process (including participation in the process of root cause analysis) and disseminate lessons learned to colleagues.
      - Key topic area examples: debrief, root cause analysis/cause mapping, Patient Safety Alerts (PSAs), fishbone diagram, fatigue and supervision as contributing factors.
      - Program Level Assessment: % housestaff invited to debrief/RCA who attended (monthly), fatigue and supervision assessment in M&M/case review
      - Individual Assessment: Led M&M/QI conference
      - Resources: IHI Open School
      - Teaching/Curriculum: IHI Open School; DOM Safety and Quality Seminar

5. Person-Centered Communication: The graduate will apply effective communication strategies to engage patients and care-givers in active participation with their care, promote safety and quality and describe (demonstrate) how to utilize common Centers for Medicare and Medicaid Services (CMS) assessments of person-centered communication.
   - Key topic area examples: Health literacy, cultural competency/humility, structured effective communication tools with patients (e.g. Acknowledge/Introduce/Duration/Explanation/Thank: AIDET), CMS HCAHPS/Clinician and Group (CG)-CAHPS/Outpatient and Ambulatory Surgery (OAS) CAHPS, Value-based purchasing.
   - Program Level Assessment: Participation in TeamSTEPPS, HCAHPS/PRC data
   - Individual Assessment: 360 evals, Participation in TeamSTEPPS
6. Disclosure of Adverse Events: The graduate will recognize events that require disclosure to patient and families. Through simulation or participation under direct attending/faculty supervision, the graduate will utilize the correct process and use person-centered communication in the disclosure of events to patients and families.
   - Key topic area examples: Frameworks for effective communication with patients (e.g. AIDET), who should disclose adverse events, apology, second victim.
   - Program Level Assessment: Institutional Survey (adding clinical vignette questions on if an event needs disclosure)
   - Individual Assessment: Pending
   - Resources: The Washington Manual of Patient Safety and Quality Improvement (available from Becker through Ovid), BJH Patient Safety Video on medical error
   - Teaching/Curriculum: Communicating Serious Adverse Events to Patients WUSM (PSQI WUSTL Box Folder)

7. Transitions of Care: The graduate will participate in safe, consistent transitions of patient care (change of shift, service, location-including discharge) utilizing a standard format and effective communication skills between providers, patients and care-givers.
   - Key topic area examples: IPASS, SBAR, Read-back, Contingency planning, service-line readmissions, social determinants of health, health literacy.
   - Program Level Assessment: Participation in Handoff seminar, questions answered on seminar prep document, readmission data, ED return rate data, Transitions of Care policy
   - Individual Assessment: Encourage specific evaluation and assessment of handoff, read back of critical information.
   - Resources: FPP Transitions of Care Summit
   - Teaching/Curriculum: Pending

Quality Improvement

8. Quality Data: The graduate will obtain and analyze specialty-specific data on quality metrics and benchmarks related to their patient populations.
   - Key topic area examples: Basic quality metrics (observed/expected mortality, readmissions), best in class scorecards, Quality and Accountability (Q&A, Vizient) Scorecard, department specific dashboards, patient satisfaction, CMS HCAHPS/G-C-CAHPS/OAS CAHPS, Medicare Access and CHIP Reauthorization Act (MACRA)/Merit-based Incentive Payment System (MIPS), cost, publicly reported metrics, national surgery quality improvement program (NSQIP), healthcare disparities, social determinants of health, community health needs assessment, implicit bias.
   - Program Level Assessment: LOS, Mortality, Readmissions, procedural complications, program designee attendance at BJH safety and quality council, program designee attendance at Housestaff safety and quality council.
   - Individual Assessment: QIKAT
   - Resources: DellMed Value-Based Care; IHI Open School
   - Teaching/Curriculum: DellMed Value-Based Care; IHI Open School; DOM Safety and Quality Seminar

9. QI Project (see below for additional details): The graduate will apply fundamental aspects of quality improvement to the care of their patients and will participate in quality improvement activities in their program or their clinical learning environment.
- Key topic area examples: Lean, Six sigma, IHI Model for Improvement, Plan-Do-Study-Act cycle, system of profound knowledge, run chart, control chart, implementation science.
- Program Level Assessment: % Trainees participating in a QI project (asked on Institutional program survey)
- Individual Assessment: Participation in a QI project, QIKAT
- Resources: DellMed Value-Based Care; IHI Open School; The Washington Manual of Patient Safety and Quality Improvement (available from Becker through Ovid)
- Teaching/Curriculum: DellMed Value-Based Care; IHI Open School; DOM Safety and Quality Seminar

**Clinical Applications**

10. Preventable harm: The graduate will recognize risk and apply risk mitigation strategies in their clinical learning environment at all times to prevent patient safety events.
   - Key topic area examples: Human error/at risk behavior/reckless behavior, universal protocol, wrong site/patient/procedure events, retained foreign objects, positive patient identification, specimen identification, HIPAA/patient confidentiality, hospital acquired infections, falls with serious injury, pressure ulcers, VTE prophylaxis, and medication errors.
   - Program Level Assessment: Hand-washing compliance (service line/floor), universal protocol compliance (Service line/floor), hospital/health system preventable harms data.
   - Individual Assessment: Pending
   - Resources: Just culture training; Partnering to heal; The Washington Manual of Patient Safety and Quality Improvement (available from Becker through Ovid)
   - Teaching/Curriculum: DOM Safety and Quality Seminar
     a. Fatigue (PSQI WUSTL Box Folder)
     b. Medication Safety (PSQI WUSTL Box Folder)
        * Medication Safety PSEP
     c. Preventing Falls/Injuries and use of Restraints/Seclusion (PSQI WUSTL Box Folder)
        * Falls PSEP
     d. Pressure Ulcers (PSQI WUSTL Box Folder)
        * 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, 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 a 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.

Articles, a template and past projects are available in the WUSTL Box PSQI folder.
Research and Teaching

There are numerous opportunities for research related to aging at Washington University. Faculty 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 program 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 program's 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.
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.

Postdoctoral

Postdoctoral Mentored Training Program in Clinical Investigation (MTPCI)
https://crtc.wustl.edu/programs/postdoctoral/mtpci/

Master's 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/

National/International Conferences

American Geriatrics Society Annual Scientific Meeting
Abstract submissions will be open from mid-September until the deadline December 1st.
http://meeting.americangeriatrics.org/

The Gerontological Society of America Annual Meeting
Abstract submission open mid-December.
https://www.geosociety.org/GSA/Events/Annual_Meeting/GSA/Events/Annual_Meeting.aspx

International Nursing Home Conference
http://www.nursing-home-research.com/

Core Curriculum on Medical Direction

Offered by the American Board of Post-Acute and Long-Term Medicine
It's easiest to do this with or right after fellowship.
Complete online core curriculum and then attending the Core Synthesis.

Clinical Educator
CME Course: Advancing your confidence as an Educator in Gerontology and Geriatrics: A Webinar Series

You can find out more and register by contacting Jessica.strong2@va.gov

Annual Harvard Macy Institute Programs
View this year’s flyer in the WUSTL Box – National/International Conferences.

Scholarly Activity Opportunities
AGS
IAGG
BJH Safety and Quality Symposium
(https://bjc.confex.com/bjc/psqs18/registration/index.cgi?username=7299&password=257619)
AAMC Integrating Quality Meeting

Health Systems Innovation Lab (HSIL)
The Health Systems Innovation Lab (HSIL) is a joint collaborative between BJC HealthCare and Washington University School of Medicine. Its purpose is to identify and evaluate innovations in data, analytics, technology, and care delivery. Our strategic areas of focus include personalized health data and analytics, virtual care technologies, community data interventions to promote community health, and technology-enabled patient engagement strategies.

As part of our work, we design and evaluate care delivery innovations, and seek to involve trainees in our work. If you encounter trainees with interest in health care technology and innovation, health services research, outcomes research, and/or implementation research, we would welcome connection to them to see if collaboration is possible. In addition, as you are recruiting new classes of trainees, you may wish to alert those with relevant interests to HSIL’s presence as an enticement for them to join us here at WUSM.

https://www.bjc.org/For-Health-Care-Professionals/Center-for-Clinical-Excellence/Health-Systems-Innovation-Lab

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.
Wellness

BJH Connect Newsletter link: http://barnesjewishhospital.us.newsweaver.com/test/b5ygimrymza7sqn4i8pd6h?email=true

Division of Geriatrics and Nutritional Science Website: https://gns.wustl.edu/about/wellness/

In the current health care environment, trainees, faculty, and staff are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

The Division of Geriatrics and Nutritional Science, in partnership with the Internal Medicine Core, BJH and WUSM, take on the responsibility of:

- enhancing the meaning that each physician trainee finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;
- attending to scheduling, work intensity, and work compression that impacts well-being;
- evaluating workplace safety data and addressing the safety of trainee, staff and faculty members;
- establishing policies and programs that encourage optimal trainee, staff and faculty member well-being; and providing the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours;
- monitoring trainee, staff and faculty member burnout, depression, and substance abuse and of educating trainee, staff and faculty members in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions and to also recognize those symptoms in themselves and how to seek appropriate care.
- providing access to appropriate tools for self-screening and to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

Trainees, staff and faculty members are encouraged to alert the program director or other designated personnel or programs when they are concerned that another trainee, staff or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
ACGME Wellness Initiatives and Partnerships

The ACGME has created this page to share with programs, institutions, residents, and fellows resources that promote a culture of well-being and provide support for burnout, depression, or suicide. The ACGME has partnered with the National Academy of Medicine (NAM) to launch a new Action Collaborative on Clinician Well-Being and Resilience, co-chaired by ACGME CEO Thomas J. Nasca, MD, MACP, NAM President Victor J. Dzau, MD, and Association of American Medical Colleges (AAMC) President Darrell G. Kirch, MD.

The ACGME has also partnered with Mayo Clinic and the American Foundation for Suicide Prevention (AFSP) in the initiative, “Physician and Medical Student Depression and Suicide Prevention” and have developed a toolkit, fact page, a compilation of resources for physicians, and a Prevention Programs source list.

Back to Bedside is an ACGME initiative designed to empower residents and fellows to develop transformative projects that combat burnout by fostering meaning in their learning environments; engaging on a deeper level with what is at the heart of medicine: their patients.

WU/BJH/SLCH Graduate Medical Education Consortium Initiatives

BJC WellAware Fitness Center
Child care on campus
WU Medical Center Noon-Time Aerobics Class Flyer and Facebook Page
Wellness Connection
Wellness Resource Listing on the Department of Surgery Website
Emergency Medicine’s Events of the Week
WUMCHA (Washington University Medical Center Housestaff Auxiliary)
BJC Employee Assistance Program
WU Employee Assistance Program

Department of Medicine Initiatives

The Department of Medicine has taken great strides in the area of Resident Wellness. They provide resources on topics such as Personal Finance, Personal Wellness, Fatigue Management, Mental Health and Support, Parenting and Personal Development.
**Geriatrics and Nutritional Science Initiatives**

The Division of Geriatrics and Nutritional Sciences hosts peer/social events at least quarterly to build personal relationships. These events range from Cookouts and Potlucks to employee recognition events such as retirement, dedication, welcome and farewell parties. These events are meant to promote healthy lifestyle habits by providing healthy foods, social interactions, and trainee/mentor interactions in an informal environment.
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.
• 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.
PBL1: Monitors practice with a goal for improvement

- Performance improvement based on self-evaluation.
- Performance improvement based on the principles of life-long learning

PBL2: Learns and improves via performance audit

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

PBL3: Learns and improves via feedback

- Solicits feedback.
- Accepts feedback.

PBL4: 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.

- 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

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¹Direct Observation Feedback (optional); ²Multi-Source Assessment; ³Quality Indicator Parameter Tracking; ⁴Subspecialty Clinics: Memory Diagnostic Center, Memory and Aging Project, Bone Health, Hospice, Home Health Physical Therapy, Wound Care, Movement Disorders, Urogynecology, Ophthalmology, Dentistry

OP = Outpatient  
IP = Inpatient  
HB = Home Based  
LTC = Long-Term Care

Page 59 of 96
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.
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
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;

Additional reimbursement of up to $500 towards the registration fee for the ABIM/ABFM Geriatrics Subspecialty board exam may be granted if the fellow attends a scientific meeting AND registers for the exam by June 1st 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 5/31/19
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.

- **Personal Days:** Twenty (20) of those days are defined as personal time off. Personal time off may consist of vacation days, paternity leave, maternity leave beyond what is covered by sick time, bonding time, and other personal needs. Personal time off 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. If personal time off extends beyond 15 consecutive days, the Clinical Fellow must apply for leave.

- **Illness:** Clinical Fellows may be paid for up to 10 sick days in case of illness. Sick days may be used for your personal illness or medical condition (including medical conditions related to pregnancy and childbirth) or for illness of a family member. In the case of any extended illness or disability, House Officers must use available personal time off days after they have exhausted their 10 paid sick days.

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 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 Barnes-Jewish Hospital Memorandum of Appointment to House Staff here:

Reviewed and Approved 01/04/10
Updated 06/11/12, Reviewed and Approved 06/11/12
Updated 06/30/15, Reviewed and Approved 06/30/15
Updated 6/25/18, Reviewed and Approved 6/30/18
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.

After 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/

Effective 3/15/03  
Reviewed and Approved 6/15/09  
Reviewed and Approved 6/11/12  
Reviewed and Approved 6/30/15
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 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/

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  
Reviewed and Approved 6/30/15
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:
  o prepare and assure the reporting of Milestone evaluations of each fellow semi-annually to ACGME.
  o make recommendations to the Program Director regarding Fellow progress, including promotion, remediation and dismissal. Final decisions will be made by the Program Director.
• Composition:
  o Program Director and
  o at least two other faculty members from within the Division of Geriatrics, selected by the Program Director.
  o Appointments will be made on an annual basis.
  o The program coordinator will attend all meetings as an observer and record meeting minutes.
• CCC Meeting Logistics
  o All fellows will be reviewed at each CCC meeting.
  o Each fellow will be presented by a committee member to the full committee for discussion.
  o All members will have access to the fellow’s educational performance.
  o 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 (optional).
• 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). 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 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 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.

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 4 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 serve 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 service’s 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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Updated 6/11/2012, Reviewed and Approved 6/11/12
Updated 02/25/2014, Reviewed and Approved 6/02/14
Updated 02/25/2014, Reviewed and Approved 6/30/15
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:
  o attendance at 80% of all required conferences each month, and
  o no unsatisfactory evaluations by faculty within the past six months.
  o 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
• 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.
• 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 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/

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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
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
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 “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, they 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 fellowship training, all patients in all settings are seen with direct supervision, except the VA-HBPC setting where clinical encounters are conducted under indirect supervision with direct supervision available.

- After this, or when specified by the Program Director in consultation with fellowship faculty, fellows will be allowed to have some occasional indirect supervision with direct supervision available, although in most instances attendings will provide direct supervision of fellows. For all encounters, the fellow must discuss each patient encounter with the attending.

Clinical Service Lines

Geriatric Medicine Fellows are part of a team of providers caring for patients that provide 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 the 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 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 Epic, 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 always.

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 a 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).

Regarding 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.

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), inpatient 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 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 always 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.

Effective 3/15/03
Reviewed and Approved 6/30/11
Updated 5/9/17, Reviewed and Approved 6/13/17
Updated, Reviewed and Approved 6/30/18
Requirements Portfolio
Geriatric Medicine Fellowship

SKILLS (tracked via MyEvaluations.com, Procedures, Patient Logs)
Demonstrate how to screen for:
___ AUA BPH/Erectile dysfunction (5)
___ cognitive impairment (20)
___ depression (20)
___ mobility (20)
___ osteoporosis (10)
___ sensory deprivation (5)
___ sleep apnea (5)
___ under-nutrition (10)

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.
___ ADLs/IADLs (20)
___ Fall Management Plan (15)
___ Full Psychometric Battery (3)
___ Incontinence Management Plan (5)
___ osteoporosis (15)
___ pressure ulcers (10)
___ inpatient consults (25)
___ Written Exam
___ Oral Exam

SCHOLARLY ACTIVITIES/PSQI
___ Case Conference (12)
___ PSQI Project Conferences (3)
___ PSQI Clinical Applications Conferences (2)
___ Journal Club (2)
___ Clinical Review (2)
___ PSQI Modules and Quiz
___ PSQI Project
___ Other (conference abstracts/presentations, publications, etc.)
  Specify: __________________________________________
___ Parc Provence Newsletter (2)

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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Page 91 of 96
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.
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Helpful Resources

**BIH Connect Newsletter**
http://barnesjewishhospital.us.newsweaver.com/test/1jtzuf46t6g7sqn4i8pd6h?email=true

**Wayfinding**
https://www.bjc.org/On-the-Move/Wayfinding/Patient-Communication

**BJC Total Reward**
https://www.bjctotalrewards.org/
## Appendix A

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>6/30/18</td>
<td>PSQI Curriculum, Core Curriculum Topics, Research and Teaching, Wellness, Dentistry Module, Rehab rotation, Palliative Care rotation</td>
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<tr>
<td>9/6/18</td>
<td>Rehab less intensive block: Contact info for I/O patient therapy services</td>
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<tr>
<td>9/24/18</td>
<td>Update to VA on-boarding – link, process, contact info</td>
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<td>Update to VA off-boarding – turning in badges, deactivating account</td>
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<tr>
<td>10/2/18</td>
<td>Added Health Systems Innovation Lab (HSIL) information</td>
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<td>10/9/18</td>
<td>Updated rotations with Epic Dept names and .phrases</td>
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<tr>
<td>11/20/18</td>
<td>Added long distance dialing info for TRISL</td>
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<tr>
<td>12/3/18</td>
<td>Added Building 18 where VA badges are to be turned in</td>
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<tr>
<td>5/28/19</td>
<td>Added Skeletal Health Lectures</td>
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<tr>
<td>6/7/19</td>
<td>Added Psychometric Training requirements to Outpatient Geriatric Assessment Clinic</td>
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<td>Fellows are required to attend all QA/PAT Chats while rotating at Parc Provence</td>
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<td>Updated MAP requirements to include online training</td>
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<td>BJC Home Care: Removed Laurie, added Tyson</td>
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<tr>
<td>6/14/19</td>
<td>Added required reading to Rehab rotation: 7 sections of The Stroke Rehabilitation Clinician’s Handbook</td>
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<tr>
<td>6/24/19</td>
<td>Added PointClickCare login instructions for Parc Provence</td>
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