GERIATRICS FELLOWSHIP

CURRICULUM

&

TRAINING OBJECTIVES

2005–2006

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Program Director
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OVERVIEW

Clinical Training

Depending on the fellowship track (one-year, 2-year combined Geriatrics and Public Health, 3-year Geriatrics and Health Services Research), clinical training will span one or more years. All fellows will receive training in the inpatient and outpatient sectors, the latter including care in the home as well as in the clinic. The fellow also will have formal training in the medical care of the nursing-home patient. Along the way, the fellow will have longitudinal rotations in non-medical specialties of particular relevance to geriatric medicine—e.g., geriatric psychiatry, physical medicine and rehabilitation, urology, uro-gynecology, neurology, and palliative care. Besides UC Davis Medical Center (UCDMC), required clinical experiences will make use of several institutions affiliated with UC Davis Health System, including the Mather Veterans Administration Medical Center (VAMC), the Martinez VAMC Center for Rehabilitation and Extended Care (CREC), and Eskaton-affiliated community nursing homes. Fellows also will be exposed to a variety of agencies involved in community-based long-term care, such as the UC Davis Multipurpose Senior Services Program and Linkages, UC Davis Home Health and Hospice, and local adult day health care programs. Most outpatient specialty experiences will be 1/2 to 1 day per week for a minimum of 3 months, with additional time based upon the fellow’s interest and the extent to which the rotation has met its training objectives. Inpatient geriatrics consultation and transitional care are done as 2-week block rotations, during which other subspecialty rotations are suspended.

All postdoctoral scholars in geriatrics will have a 1/2-day-per week longitudinal primary-care clinic with the UC Davis Internal Medicine Geriatrics Clinic and also will have a weekly geriatric evaluation and management (GEM) clinic at the Mather, VAMC. Fellows will follow their own panel of patients at the UC Davis Teaching Nursing Home (Greenhaven Country Place). The Mather VA Hospital Based Homecare Program will provide trainees with experience doing geriatric assessment and primary care in the patient’s own home. In order to learn about community-based (non-institutional) long-term care, fellows will make home visits with case managers to home-bound frail seniors. Fellows spend a minimum of two 2-week blocks doing inpatient geriatrics consultation with an attending geriatrician on the UC Davis General Medicine and Geriatrics Consultation Service and/or the inpatient medical/surgical unit at Mather VAMC. For two 2-week blocks, each fellow will learn interdisciplinary transitional care, including inpatient geriatric rehabilitation, at the Martinez VA CREC. This rotation also provides additional opportunities for geriatric consultation. Because the Martinez VA is located 60 miles from UCDMC, the fellow will receive room and board on the Martinez campus during the time spent at the Martinez VAMC. Most fellows will receive training in the role of the nursing home medical director and in federal and state regulations governing nursing homes during additional 1/2-day sessions with a faculty geriatrician/Medical Director at the Eskaton nursing homes.

Teaching

Because geriatricians, both in academia and community-based practice, are in short supply and must continuously educate colleagues and their parent healthcare organizations about the care of the frail elderly, the development of didactic skills is important. For this reason, fellows are expected to lead the pre-clinic seminar in the UCD Geriatrics Clinic, to teach residents on the consultation service about geriatric issues, to precept the occasional medical student in the clinic, and to deliver at least 2 prepared lectures in an approved venue. Fellows on the UCD inpatient consultation service are expected to attend internal medicine morning report, usually 8:30–9:30 M–W and Fridays. This affords them the opportunity to provide incidental teaching about geriatric issues pertaining to the patients being presented by the housestaff.

Didactics

A variety of formal and informal conferences and seminars are available to fellows. An informal seminar will precede most sessions of the UC Davis and VA-Mather geriatrics clinics. At UCD, the traditional housestaff noon conferences have been replaced by a didactic session occurring every Monday from 12 noon to 3 pm. The fellows will be excused from Geriatrics Clinic to attend geriatrically oriented lectures.

Fellows are expected to attend the General Medicine Case Conference (Thursdays, 10–11, PSSB-2400), the pre-clinic seminars, and the bioethics journal club, which is held roughly monthly (on a Thursday) from 12–1. Recommended conferences and journal clubs include: Medicine Grand Rounds (Thursdays, 8–9, PSSB Auditorium),
the Alzheimer Disease Center research seminar journal club (Thursdays, 9:30–11, Neurology Dept., ACC Building), the Health Services Research journal club (Thursdays, 9–10, PSSB 3rd-fl conference rm) and the Health Services Research weekly seminar series (Thursdays, 12–1, La Bou conference room). Unfortunately, the widespread decision to hold so many conferences on Thursdays means that fellows will have to pick and choose which of the “ elective” seminars to go to. Attendance at elective seminars and journal clubs is strongly encouraged! Fellows are considered junior faculty in the Division, and are expected to attend most Division meetings (usually every other week on a Thursday, 11–12) during which they gain experience with “continuous quality improvement” (CQI). Nursing–home CQI will be gleaned during the time with the nursing home medical director.

Research
Fellows in the one-year clinical track do not have time to do research, which requires a minimum of a 1/3-time commitment. However, those in this track who wish to pursue an academic career are strongly advised to plan on 1 or 2 years of an additional fellowship to obtain training in research methods. The Program Director will assist the fellow in identifying a topic, then will assign the fellow a suitable research mentor. With the help of the mentor, Program Director, and staff in the Center for Health Services Research in Primary Care, the fellow can apply for grant funding to support the additional research training. There are numerous grant programs for fellows, such as the Hartford/American Federation for Aging Research fellowship award and grant programs from major pharmaceutical companies. It should be emphasized that fellows in the clinical track who want to pursue research must secure extramural funding to support their salaries after the first year.

Fellows in the 2-year combined geriatrics and public health fellowship or the 3-year health-services-research fellowship are expected to complete a scholarly project as part of their fellowship.

A sine qua non for a successful research project is a mentor. Whether the proposed research is in health services or laboratory investigation, the Geriatrics Fellowship Program will make every effort to identify an appropriate mentor at UC Davis who will be responsible for guiding the fellow’s research, in much the same way a faculty advisor is identified for a graduate-degree thesis. All geriatrics fellows conducting research are required to write a full research proposal before starting their research, and to complete a project summary by the end of their fellowship. The acceptance of an abstract to a meeting of a scholarly society or the submission of a manuscript to a peer-reviewed journal will be accepted in place of a project summary.

All first-year postdoctoral scholars in the Dept. of Internal Medicine, including those in the 1-year clinical track, are required to take an intensive one-week course in research design, taught by epidemiologists from the Depts. of Medicine and Epidemiology and Preventive Medicine. You already have been signed up for this course, and will be excused from all clinical activities.

Evaluations
At the end of each rotation and clinical experience, or every 6 months (whichever comes first), the responsible preceptor(s) will complete a standardized evaluation of the trainee’s performance, which will be returned to the Program Director. In the case of specialty rotations, each preceptor is asked to review the evaluation with the trainee him- or herself. In turn, the trainee is asked to complete a standardized evaluation about each specialty rotation, which is returned to the Program Director.

All postdoctoral fellows will receive a written summary evaluation semi-annually, which will be reviewed with each fellow by the Program Director. These evaluations will reflect the composite evaluations of faculty, housestaff, medical students, research advisors, and other members of the geriatric health-care team who have formally interacted with the trainee. The trainee also will be given an opportunity to complete a written evaluation of the training program and its components. The latter evaluation constitutes valuable feedback to the Program Director and is used to modify and improve experiences that are considered suboptimal. As an incentive to the trainee to make candid statements about the fellowship experience, the trainee’s confidential evaluation may be submitted to the Division Chief of General Medicine instead of the Program Director, who will distill the criticisms and recommendations and present them to the core geriatrics faculty.

An informal discussion of the fellow’s evaluations and experiences will be held face-to-face between the Program Director and individual trainee at the end of the first and third quarters of the year. At any time during
the fellowship, serious concerns about the trainee’s performance will be documented in writing, as will as the plan of action for addressing these concerns. The trainee will receive a copy of this document, and will be required to sign it. Serious breeches of conduct will be brought before the Geriatrics Fellowship Committee for adjudication.

Additional Fellowship Policies

Call Schedule and Sleep Deprivation Policy: The fellowship strongly seeks to avoid sleep deprivation of its fellows by establishing a trainee-friendly call schedule. At UCD, the geriatrics fellows do not take overnight call in the hospital, and are not required to come to the hospital or nursing-home for patient-related issues at night. Fellows are expected to take beeper call for their patients during the week, and patients who contact a fellow with medical emergencies should be appropriately referred to an urgent-care clinic or emergency room, with appropriate advance briefing of the receiving physician. On weekends beeper call will alternate between the fellows. For vacations, beeper call will be taken over by the other fellow(s) or, by prior arrangement, with one of the senior primary-care residents.

Work Hours: The ACGME has a policy that residents and fellows cannot work more than 80 hours in a week, averaged over 4 weeks. Our fellowship conforms with this policy. Because there are no 24-hour call days, the geriatrics fellowship’s hours fall well under this maximum. Outside of work-related beeper calls, the fellowship’s activities are confined to a 5-day “professional” work-week, estimated to be about 50 hours long, except when the fellow is on the consultation service, when they may spend an additional 4 to 6 hours per week. The fellows will receive, and are required to complete, a weekly work-hours form, which should be returned to the Fellowship Coordinator. Note: Time spent in library research and medical reading is not included in the tallied work hours.

Medical Records: When fellows dictate a note (as an outpatient or inpatient consultation), they must check “e-sign” on a hospital computer regularly until the dictation is posted, and then must electronically sign it. Verbal orders must be signed electronically within 24 hours. If fellows do not electronically sign verbal orders in this time frame, the Division will be charged a daily $10 fine, and the fellow will receive a letter of warning from the Program Director. Dictated records that are not signed in a timely fashion will risk the fellow being placed on the 48-hour notice list. Those on this list have 48 hours to complete documentation or be suspended. Suspension could result in the interruption of the fellowship and commensurate extension of the fellowship year into the next academic year, withholding of salary, or termination of the fellowship.

Summary

The guiding principle of this fellowship is that fellows are here to learn and acquire clinical and research skills enabling them to become effective community- or university-based geriatricians and advocates for frail, older patients. At the conclusion of the fellowship, each fellow will be eligible for the examination for Advanced Qualification in Geriatrics. Fellows will have enough time to do outside reading, as there is no overnight in-house call during the fellowship, although fellows will be on pager call for their own primary-care patients during weekdays and (by rotation with the primary-care residents) some weekends.

GOALS OF THE GERIATRICS FELLOWSHIP

CLINICAL COMPETENCIES

Overview: For each clinical competency, a suggested reading list is appended. This reading list will be updated periodically as new “landmark” articles appear, or as new editions of textbooks and other reviews become available. Many of the articles listed below are provided in the accompanying syllabus, which is yours to keep. As with any textbook, the syllabus was up-to-date when assembled, but may not have the most recent pertinent articles. Consequently, the syllabus represents a work in continuous progress. Fellows should regularly consult

1 These goals satisfy the specific knowledge and skills required by the Accreditation Council on Graduate Medical Education for geriatric medicine.
the syllabus and the suggested readings below when they encounter a patient with a geriatric syndrome or start a specialty rotation. Fellows are expected to be familiar with Medline (available as PubMed via the UCD Clinical Resources Center web page – http://crcadmin.ucdmc.ucdavis.edu) and should conduct their own literature searches to supplement the syllabus. Important new articles found by the fellows and faculty will be added to the syllabus, while outdated articles will be removed.

We have requested an educational grant to provide each fellow with a core text (Hazzard WM, Blass JP, Ettinger WH, Halter JB, Ouslander JG. Principles of Geriatric Medicine and Gerontology, Fourth Edition, New York, McGraw–Hill, Inc., 1999), as well as a copy of the pocket–sized mini–reference, Geriatrics at Your Fingertips. The Program Director has additional textbooks in his office, which can be signed out with his permission.

1. Geriatric Evaluation and Management
   - Learn comprehensive geriatric evaluation and management (GEM).
     - Geriatric assessment (both cognitive and functional): the assessment of basic and instrumental activities of daily living; the appropriate use of history, physical, and mental examinations; appropriate, cost-effective use of diagnostic tests.
   - **References:**
     - Cf. Syllabus, § “Geriatric Assessment”
     - **Books**

2. Interdisciplinary Teamwork in Geriatrics
   - Learn to work effectively with different members of the geriatric health–care team.
   - Appropriate use of multiple professionals, especially nurses, social workers, and rehabilitation personnel (PT, OT, Speech Therapy), to assist in assessment and implementation of treatment.
   - **References:**
     - Cf. Syllabus, § “General Principles of Geriatric Medicine”
     - **Articles**

3. The long–term–care continuum
   - Acquire an understanding of the long–term–care continuum and the core regulations governing its components
     - Medicare–reimbursed home–health care, in–home supportive services, adult day health care, community–based resources such as meals on wheels, assisted living facilities/residential care, and
intermediate and skilled nursing care facilities; learn the role of the medical director in skilled nursing facilities.

- The Minimum Data Set and its use in SNF’s.
- The economic aspects of supportive services, including Title III of the Older Americans Act, Medicare, Medicaid (Medi-Cal in California)
- The role of transitional care for post-acute patient care: its relationship to shortened lengths of stay under HCFA DRG’s: principles of cost-effective home-health and nursing-home care.

References:
Cf. Syllabus, § “Long-term Care”

Textbooks

Articles
5. Community-Based Long-Term Care

- Acquire a working knowledge of the types of community-based resources for older patients, how they are financed, their eligibility requirements, and how to access them for your patients.
- Meals on Wheels, Adult Protective Services, Area Agencies on Aging, Legal Aid Services for the Elderly, in-home supportive services, adult day health care and respite-care services, senior centers, home health care, hospice

**References:**
Cf. Syllabus, § “Community-Based Long-Term Care”

**Textbooks**

**Articles**
- Hirsch CH. Epidemiology and demography of aging. Limited distribution: Syllabus to EPM 421, UC Davis School of Medicine, 1998.

6. The hospitalized older patient

- Develop proficiency in performing consultations on the hospitalized older patient; anticipating discharge needs of the older inpatient; and recognizing, preventing, and minimizing inpatient functional decline and other nosocomial complications.

**References:**
Cf. Syllabus, § “The Hospitalized Older Patient”

**Textbooks**
7. Pre- and peri-operative assessment and management
   • Develop expertise in preoperative assessment and perioperative medical management of the older surgical patient.
   • **References:**
     Cf. Syllabus, § “Peri-operative Assessment of the Older Patient”
   **Textbooks**
   • **Articles**

8. Principles of geriatric rehabilitation
   • Improve skills in performing a comprehensive musculoskeletal examination
   • Gait and balance evaluation/fall risk assessment
   • Assessment of strength and physical functioning
   • Knowledge of the application of physical treatment modalities – heat and cold, hydrotherapy, electrical stimulation, traction, exercise, and biofeedback
• Evaluation and management of pain (TENS, etc.)
• General approaches to strengthening and reconditioning the elderly – PT, group exercises
• Principles of stroke rehabilitation
• Non-operative management of the frozen shoulder/rotator cuff injuries
• Non-operative management of degenerative and other arthritides
• Prescription of walking aides and other assistive devices
• Ability to effectively collaborate with and direct rehabilitation specialists (PT, OT, Speech Therapists) in the acute-care, nursing-home, and home-care environments.

References:
Cf. Syllabus, § “Geriatric Rehabilitation”

Textbooks

Articles

9. The financing of elder care in the United States
• Understand the coverage and limitations of Medicare Parts A and B for inpatient, outpatient, and long-term care: senior health maintenance organizations: Medi-Cal

References:

Booklets
• HCFA, “Medicare and You, 2002”

Articles

10. Cultural and ethnic factors in the care of older patients
• Understand the importance of assessing and addressing cultural biases, preferences, and attitudes regarding illness and medical care

References:
Cf. Syllabus, § “Cultural and Ethnic Factors in the care of the Elderly”

Articles
**11. Pain management in chronic disease and palliative care in the elderly**

- Understand the principles of pain management for acute and chronic conditions, as well as for terminal care

**References:**
Cf. Syllabus, § “Pain Management and Palliative Care”

**Textbooks**

**Articles**

**12. The demography and epidemiology of aging**

**References:**
Cf. Syllabus § “Demographics and Economics”

**Textbooks**

**Articles**
- Hirsch CH. Epidemiology and demography of aging. Limited distribution: Syllabus to EPM 421, UC Davis School of Medicine, 1998.

**13. The biology of aging**

- Current scientific knowledge of aging and longevity, including theories of aging, physiologic and pathologic changes of aging, the concept of frailty

**References:**

**Textbooks**

Articles

14. Preventive medicine for older persons
• Proper nutrition, exercise, screening and immunization: awareness of community resources to assist with these goals: avoidance of polypharmacy (see also #4, “Pharmacologic alterations with aging), restraint use, and other causes of iatrogenesis and nosocomial morbidity.
• References:
  Cf Syllabus, § “Prevention and Screening in the Elderly”

Textbooks

Articles
15. Pharmacologic alterations with aging
   - Changes in pharmacodynamics, pharmacokinetics, drug interactions, overmedication and polypharmacy, factors associated with compliance and non-compliance.
   - References:
     Cf. Syllabus, § Aging Pharmacology
     Textbooks
   - Articles

16. Psychosocial considerations in the care of older patients
   - The pivotal role of the family or caregiver for dependent elderly: respite care and in-home supportive services; elder abuse – recognition and prevention; bereavement and depression: care of the dying patient (from perspective of caregiver – see also “hospice” under #5 above); “successful” aging
   - References:
     Cf. Syllabus, § “Psychosocial Considerations in the Care of Older Patients”
     Textbooks
   - Articles

17. Geriatric psychiatry (excluding dementia)
   - Depression and anxiety, bereavement, bipolar disorder, personality disorders, psychosis, paranoia
   - References:
UC Davis Geriatric Fellowship Program

Cf. Syllabus, § “Psychiatric Issues in the Older Patient”

Textbooks

Articles

18. Geriatric neurology (excluding dementia)
- Parkinson’s disease and related movement disorders; Huntington’s chorea; other neurodegenerative conditions
- References:

Cf. Syllabus, § “Important Neurological Disorders in the Older Patient (Excluding Dementia)”

Textbooks

Articles
19. Ethical and legal issues
   - Incompetence, substitutive decision-making, advance health-care directive, conservatorship, informed
     consent, living wills.
   - **References:**
     Cf. Syllabus, § “Ethical and Legal Issues”
     **Textbooks**
     - Loewy, Erich H.. The ethics of terminal care: orchestrating the end of life /, Erich H. Loewy and 
     - Ahronheim, Judith C.. Ethics in clinical practice /, Judith C. Ahronheim, Jonathan D. Moreno, 
     - Barnes A. Legal issues in geriatric medicine and gerontology. In: Hazzard WM, Blass JP, 
       Ettinger WH, Halter JB, Ouslander JG (eds). Principles of Geriatric Medicine and Gerontology, 
     - Pearlman RA, Back AL. Ethical issues in geriatric care. In: Hazzard WM, Blass JP, Ettinger 
     - Kapp MB. Ethical and legal issues. In: Duthie EH, Katz PR (eds). Practice of Geriatrics, Third 
     **Articles**
     - Patient handout on California’s Advance Health Care Directive
     - California Probate code 4700–4701 for Advance Health Care Directive

20. Geriatric syndromes
   a. Dementia
      - Pathophysiology, screening, evaluation, and treatment (underlying disorder); psychosocial issues in 
        management; natural history of Alzheimer disease; behavioral complications in dementia.
      - **References:**
        Cf. Syllabus, § “Dementia”
        **Textbooks**
        - Reichman WE, Cummings JL. Dementia, In: Duthie EH, Katz PR (eds). Practice of Geriatrics, 
        **Articles**
          Feb;180:140–3.
          83.
        - Govoni S, Lanni C, Racchi M. Advances in understanding the pathogenetic mechanisms of 
          Feb;180:152–6.
        - Chui H. Dementia due to subcortical ischemic vascular disease. Clin Cornerstone 
        - Olin J, Schneider L. Galantamine for Alzheimer's disease (Cochrane Review). In: The Cochrane 

b. Delirium

• References:
  Cf. Syllabus, § “Delirium”

Textbooks

Articles

C. Falls

• Pathophysiology; risk factors; primary and secondary fall prevention.
• References:
  Cf. Syllabus, § “Falls”

Textbooks

Other books

Articles
d. Urinary incontinence

- Pathophysiology, evaluation, management.
- References:
  Cf. Syllabus, § “Incontinence”

Textbooks

Articles

e. Osteoporosis

- Cf. Syllabus, § “Osteoporosis”

Textbooks

Articles
f. Dysthermias
   - Epidemiology, pathophysiology, assessment, management, and prevention.
   - References:
     cf. Syllabus, § “Dysthermias”
     Textbooks
     Articles

g. Sensory impairment
   - Epidemiology, pathophysiology, assessment, and management.
   - References:
     Cf. Syllabus, § “Sensory Impairment”
     Textbooks
     Articles

h. Wounds
   - Pathophysiology, risk factors, prevention, and management of pressure ulcers, venous stasis ulcers, and ischemic ulcers
   - References:
     Cf. Syllabus, § “Wounds”
     Textbooks
     Articles
i. Nutritional Issues in the Elderly
   - References:
     Cf. Syllabus, § “Nutritional Issues”
   - Textbooks
   - Articles

j. Dizziness and syncope
   - References:
     Cf. Syllabus, § “Dizziness and Syncope”
   - Textbooks
     - Other books
   - Articles

k. Sleep disorders
   - References:
     Cf. Syllabus, § “Sleep Disorders”
   - Textbooks
   - Articles
     - Schneider DL. Insomnia. Safe and effective therapy for sleep problems in the older patient. Geriatrics 2002 May;57(5):24–6, 29, 32 passim.

Research and scholarly activity

1. Learn the principles of research design and clinical epidemiology.
   • Reference:
     Textbook

2. Become an effective teacher of geriatric medicine (via patient consultations, teaching of houseofficers, and didactic lectures).

3. Become familiar with the activities of organized geriatric medicine and gerontology by attending at least one national meeting of the American Geriatrics Society or the Gerontological Society of America.

5. Maintain currency with mainstream geriatrics literature: all fellows are expected to subscribe to and read the Journal of the American Geriatrics Society (JAGS), and are encouraged to at least peruse the Gerontologist and the Journal of Gerontology on a regular basis.

6. Become proficient in performing literature searches using PubMed or a similar database.

7. Develop (if not already acquired) basic proficiency with computer-based word-processing, spreadsheet use, and slide-making.

REQUIRED ROTATIONS AND CLINICAL EXPERIENCES

1. Geriatrics Clinics
   Location: Suite D, Cypress Bldg, UCDMC; Mather VAMC
   Duration: UCDMC: entire fellowship; VA-Mather: 6 months during Year 1
   Frequency: Each clinic: 1/2 day per week

Training objectives:
• Learn comprehensive geriatric assessment, utilizing common standardized assessment instruments for basic and instrumental activities of daily living, cognitive screening, depression screening, social resources, and nutrition screening.
• Learn appropriate health maintenance/disease prevention measures for older patients, following accepted clinical guidelines.
• Acquire a function–oriented, rather than primarily a disease–oriented, approach to the older patient.
• Acquire expertise in communicating with older patients and their families/caregivers.
• Learn to integrate caregiver concerns and caregiver support into your care of the dependent older patient: learn to treat the caregiver and patient as an integral unit.
• Acquire efficiency while retaining thoroughness in your primary care of the frail elderly.
• Acquire expertise in working with an interdisciplinary care team.
• Acquire familiarity and expertise dealing with home health agencies.
• Learn to perform geriatric consultation, particularly in the areas of pre-operative assessment and dementia assessment.
• Increase awareness and practice of cost–effective use of laboratory and imaging services as well as subspecialty consultations.
• Understand the provision of primary care by the Veterans Administration
• Understand health–care financing of primary care for older Americans: coverage and limitations, for Medicare parts A & B, major senior capitated health plans in the Sacramento area, Medi–Cal
• Understand the importance of, and obtain experience in, assessing and addressing cultural and ethnic biases, preferences, and attitudes towards health care for the older person
• Hone and expand primary-care internal medicine skills through a panel of primary-care, frail older patients followed for the entire duration of the fellowship.

Evaluations: Semi-annually, from the core attendings, the geriatrics social worker, and clinic nursing personnel.

2. Teaching Nursing Home
Location: Greenhaven Country Place
Duration: Entire fellowship
Frequency: One-half day each month for formal rounds plus an average of 4 hours per month for admitting new patients/handling emergencies over the phone.

Method: The licensed fellow may carry up to 6 SNF patients at a time, both custodial and short-term. Patients will be assigned to the fellow and the senior primary-care residents on a rotating basis. Each resident or fellow should have no more than two admissions during any block month, and no more than one per week. Any exception must be approved by the Program Director. Rounds will be held in the teaching nursing home once every 4-wk block.

Once assigned a patient by the Division secretary, the resident or fellow must see that patient within 72 hours of admission to the SNF, as required by statute. The trainee often will be asked by the SNF to prepare or supplement holding orders until the patient can be seen. Each trainee is expected to contact the nursing-home attending, or whomever is acting in his/her stead, within 24 h of seeing the patient (48 h allowed if weekend or holiday) to review the case and management plans. Similarly, any major deterioration in the patient’s status, requiring that the patient be seen by a physician, sent to the ER or hospital, must be reviewed with the attending geriatrician within 24 h (48 h allowed if weekend or holiday). A planned discharge of the patient should, whenever possible, be reviewed with the attending prior to discharge.

The fellow will be on beeper call for his/her patients in the teaching nursing home on week-days. Weekend call will rotate with the primary-care residents and the other fellow(s). For geriatric issues, such as management of acute confusion and pressure sores, as well as for issues regarding medical management, the primary-care residents are encouraged to contact the fellow as the first-line consultant. In turn, the fellow should feel free to page/call the nursing-home attending any time during the day or night for assistance.

Training objectives:
• Familiarity with the use, strengths, and weaknesses of the skilled nursing facility for hospital aftercare/rehabilitation.
• Acquire skill in the medical care of custodial nursing-home patients.
• Knowledge of State and Federal regulations governing care of nursing home patients, particularly with regard to the obligations of the primary-care physician.
• Knowledge and utilization of the Minimum Data Set (MDS) and the associated Resident Assessment Profiles (RAP).
• Knowledge of the role of the Medical Director 2
• Familiarity with how to evaluate/triage patients over the phone with the help of the SNF licensed nurse.
• Knowledge of the limitations of the SNF with regard to acute medical care and the availability of diagnostic tests.

2An elective is available during which the trainee spends a minimum of 1/2 day per week assisting the Medical Director of Greenhaven Country Place on tasks related to his/her medical direction, attending meetings with the medical director, and working on a SNF-related CQI project. The duration of the rotation will depend on the hours spent per week; the minimum time spent in the rotation will be 32 hours.
• Knowledge and application of advance directives: experience discussing advance directives with the patient and his/her family.
• Knowledge of different payor sources for SNF care: Medicare, Medicaid (Medi-Cal), out-of-pocket fee-for-service, capitation, long-term-care insurance.

Evaluations: Semi-annually, with input from the SNF Nursing Director and the faculty geriatrician(s) for the Teaching Nursing Home. The nursing-home evaluation form is appended below. The traits listed under the “excellent” trainee should be viewed as performance objectives for the fellowship.

3. Home Visits

Location: Primary: Hospital-Based Home Care, VAMC-McClellan
Secondary: UC Davis Care Management, 3700 Business Drive, Sacramento

Duration: HBHC: 3 months (minimum)
           UCDCM: 1 month, plus occasional house calls for non-urgent medical assessment (average 1 per month)

Frequency: HBHC: 1 day per week
           UCDCM: 1/2 day per week

Method: The fellow will accompany the Hospital-Based Home Care (HBHC) attending physician or nurse practitioner on house calls to homebound veterans. House calls will consist of new patient evaluations, scheduled primary-care visits, and semi-urgent visits for acute problems. When the HBHC attending judges the fellow competent to make solo house calls (after supervising a minimum of 4 home visits), the fellow will be permitted to do so. All patient contacts seen without a preceptor must be reviewed with a faculty geriatrician, preferably that same day but definitely within 24h (48h in the special case of weekend or holiday HV’s).

Fellows are encouraged to make at least one home visit on homebound elders from their own roster of patients. In the context of their affiliation with UC Davis Care Management and Hospice, the fellow also may be asked to make occasional medical home visits on patients needing non-urgent assessment but who are physically unable to come to the clinic due to severe functional impairment (e.g., being bedbound).

At UCD Care Management, trainees will attend at least 2 case conferences and will accompany case managers on home visits to homebound older clients in order to acquire knowledge of community-based long-term-care resources and the role of case management.

Trainees will take beeper call on their primary-care HBHC patients during the week, with weekend call shared with HBHC faculty.

Training objectives:
• Ability to provide comprehensive geriatric assessment and primary care in the home.
• How to strategically use home visits as a means to prevent or minimize ER visits and hospital admission.
• Knowledge of the availability and use of high-tech therapy in the home (e.g., home peritoneal dialysis with automated cycling devices; home antibiotic therapy; home oxygen delivery systems; pressure-reducing and -relieving mattresses).
• Knowledge of adaptive equipment available for functionally dependent elderly and their cost/availability under Medicare and senior managed-care health plans.
• An appreciation of the importance of incorporating the patient’s psychosocial support systems, physical environment, cultural background, and value system into the treatment plan for his/her medical conditions.

Evaluations:
HBHC: At end of rotation, with input from the HBHC attending, nurse practitioner, home health staff, and the patients plus their caregivers.
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UCDCM: At end of rotation, with input from case managers.

4. The General Medicine and Geriatrics Consultation Service
   Location: UCDMC
   Duration: Two-week block rotation
   Frequency: A minimum of two blocks.

Method: The fellow will rotate on the service when there is a board-qualified geriatrician as the attending physician. The fellow will see and examine all consultation patients ≥ age 65, plus patients < age 65 who have “geriatric” problems (e.g., pressure sores or delirium). Although the fellow will be working with senior medical residents, he or she is expected to write at least one-third of the consultation notes for patients he or she evaluates. The fellow will attend internal-medicine morning report as a “geriatric expert” available to discuss geriatric issues. The fellow will join the consultation residents and medical students during “work” rounds in order to point out and teach them about the relevant geriatric issues with their patients. The fellow is expected to furnish the housestaff and students with relevant geriatric articles.

Although the houseofficer or medical student will present most of the cases on rounds, the effectiveness of the geriatric fellow will be measured by how accurately and thoroughly the student or house officer raises the geriatric issues, and if s/he fails to, whether the fellow brings them to the attention of the team. The fellow, as a board-eligible or board-certified internist, will be expected to function as the first-line consultant when the housestaff or students have internal-medicine questions.

In addition to rounding with the General Medicine and Geriatrics housestaff, the fellow will be available to provide formal and informal geriatric consultations on patients from the ward medicine service. These cases will be presented to the geriatrics attending on separate rounds. If a formal consultation is requested by the ward attending, the geriatrics attending and the fellow each will leave a consultation note; otherwise, no note will be left. Whether or not a formal consultation has been requested, following presentation to and discussion with the attending, the fellow will contact the house officer caring for the patient to relay suggestions for the assessment and management of the geriatric issues.

Training objectives:
- Acquire expertise performing inpatient consultations on geriatric patients.
- Hone and expand expertise communicating with the primary team requesting the consultation.
- Acquire expertise preparing concise yet thorough consultation notes.
- Enhance teaching skills by being responsible for teaching housestaff and medical students on the service about the geriatric issues raised during the consultations.
- Acquire clinical competence in the assessment, prevention, and management of common complications experienced by the hospitalized elderly:
  - Deconditioning and functional decline
  - Delirium
  - Pressure sores
- Acquire competence in helping to plan for discharge and the coordination of post–acute care
- Acquire expertise in the peri-operative management of hospitalized older patients.
- Acquire expertise working with bedside nurses and floor charge nurses to implement “non–medical” recommendations (e.g., nursing procedures to prevent and manage delirium).

Evaluations: From the attending geriatrician with input from the housestaff and students on the consultation service.

5. The Center for Rehabilitation and Extended Care (CREC)
   Location: Martinez VAMC, Martinez, CA
   Duration: Four weeks, as two 2-week blocks
   Frequency: Monday–Friday
Method: Because of the distance from UCDMC, the trainee will be provided with room and board on the Martinez VA campus. The trainee will work under the supervision of Dr. Ingrid Kwee.

Training objectives:
- The fellow will understand the role and limitations of step-down ("transitional care") units in the management of the patient no longer requiring hospitalization.
- The fellow will acquire expertise in the interdisciplinary assessment of veterans requiring rehabilitation and nursing care due to a variety of conditions, such as:
  - brain injury and stroke
  - spinal-cord injury
  - joint replacement
  - hip fracture
  - wound care
  - hospital-acquired deconditioning
- The fellow will learn the role of the geriatrician/primary-care physician in the ongoing interdisciplinary treatment of patients while in transitional care.
- The fellow will become familiar with the types of conditions appropriate for physical, occupational, and speech therapists: the content of their respective assessments; the techniques and equipment used to treat common conditions in their respective fields; common assistive devices and adaptive equipment; and community-based resources to help the patient and family after discharge.
- The fellow will gain experience participating in patient-based interdisciplinary team meetings involving physicians, nurses, therapists, and social workers.
- The fellow will gain expertise in performing geriatric/medical consultations on transitional-care patients with acute medical problems.
- The fellow will demonstrate knowledge of the pathophysiology, prevention, and management of pressure sores. (This objective compliments the elective Dermatology Rotation.)

Evaluations: At the end of each 2-week rotation, from the site director, with input from other attending physicians and members of the interdisciplinary staff.

6. The UC Davis Alzheimer’s Disease Center
Location: Neurology Clinic, Ambulatory Care Center, UCDMC
          The Alzheimer’s Disease Diagnostic and Treatment Center (ADDTC), ACC Building
Duration: 3 months (minimum)
Frequency: 1/2 day per week

Method: Under the preceptorship of a neurologist with expertise in dementia, the trainee will evaluate patients referred to the Neurology Clinic for evaluation of cognitive impairment. The fellow also will occasionally see patients in the ADDTC, a state-funded research clinic whose purpose is to develop a data bank of adjudicated dementia cases. In this clinic, all referred patients are evaluated under a standardized protocol by a neurologist, social worker, and clinical psychologist, with the latter performing standardized neuropsychological testing. At the conclusion of the diagnostic evaluation, each case is presented at a team meeting, where the final diagnosis is adjudicated. In a family conference, the team explains the diagnosis and recommendations to the patient and family members. A full consultative report is sent to the referring physician.

Training objectives:
- Expertise in the state-of-the-art evaluation of the cognitively-impaired patient, involving a comprehensive history and neurocognitive examination, plus the recommended laboratory work-up and diagnostic brain imaging.
- A knowledge of the differential diagnosis of dementia, the pathophysiology underlying the common dementing disorders, the respective natural history of these dementias, and the epidemiology of dementia, especially Alzheimer’s disease.
- Expertise in explaining the diagnosis to the patient and the patient’s family/caregiver.
• Knowledge of community–based resources for the caregivers of dementia patients, including the Alzheimer’s Association, adult day health care, and nursing homes with specialized dementia units.
• Knowledge of the spectrum of behavioral and functional disturbances that complicate dementing disorders, plus their pharmacological and non–pharmacological management.
• Expertise in counseling the families of dementia patients about the management of behavioral disturbances, substitutive decision–making, advance directives, and long–term–care options.

Evaluations: At the end of the rotation (or after the first 12 weeks), prepared by the site director with input from other attendings and members of the interdisciplinary team.

7. Geriatric Urology
Location: Urology Clinic, VA–Mather
Duration: 2 months (minimum)
Frequency: 1/2 day per week

Training objectives:
• Knowledge or the pathophysiology of obstructive uropathy in older men, as well as its diagnosis and treatment.
• Knowledge of the pathophysiology of urinary incontinence in men and women, as well as its diagnosis and management.
• Ability to perform a sensitive GU history in men and women, using, when appropriate, standardized assessment questionnaires such as the AUA symptom score for BPH.
• Knowledge of the epidemiology and treatment of prostatic cancer
• Ability to interpret urodynamic pressure tracings and GU diagnostic imaging studies for incontinence, as well as knowing when to order these studies.
• Ability to take a sensitive but thorough sexual history and assess and manage sexual dysfunction in the older man. (See # 8 for the same in women.)

Evaluations: At the end of the rotation, from the site director, with input from other attendings, if any.

8. Older Women’s Health and Urological Gynecology
Location: Women’s Health Clinic, VA–McCllellan
Urogynecology Clinic, UCDMC, Ambulatory Care Center
Duration: 3 months (minimum)
Frequency: 1/2 to 1 day per week

Method: The fellow usually will attend the Women’s Health Clinic and the Urogynecology Clinic during the same week, as these experiences are complimentary.

Training objectives:
• Skill in performing a sensitive, thorough pelvic examination in older women.
• Knowledge of the epidemiology and risk factors for cervical, uterine, and ovarian carcinoma.
• Understanding the pathophysiology and management of atrophic vaginitis and urethritis in older women.
• Ability to take a sensitive but thorough sexual history and assess and manage sexual dysfunction in the older woman.
• Ability to take a thorough history for the evaluation of urinary incontinence and how (by history and physical exam) to assess the different types of incontinence.
• A thorough knowledge of pelvic anatomy and the pathophysiology of prolapse, including urethral prolapse, cystoceols, and rectoceols.
• Knowledge of types of pessaries and the ability to select and fit pessaries in straightforward cases.
• Knowledge of the pathophysiology and state–of–the–art medical and/or surgical treatment options for the various types of urinary incontinence in women (stress, detrusor hyperactivity, detrusor disinhibition, stress, overflow, detrusor hyperactivity with incomplete contraction).
• Knowledge of the ancillary management of incontinence, including the various types of diapers; scheduled and prompted voiding; and the role of catheterization.
• Ability to interpret urodynamic pressure tracings and GU diagnostic imaging studies for incontinence, as well as knowing when to order these studies.

Evaluations: At end of the rotation, from each site director, with input from additional attendings, if any.

9. Physical Medicine and Rehabilitation
Location: Primary: PM&R Orthotics Clinic, VA-Mather; PM&R Stroke Rehab Clinic, VA-Mather
Secondary: Center for Rehabilitation and Extended Care, Martinez VA
Duration: 2 months (minimum)
Frequency: Each 1/2 day per week, usually done at the same time.

Method: Outpatient rehab will be learned in the PM&R clinics at Mather VAMC. Inpatient rehabilitation will be learned during the separate CREC rotation (see # 5 above).

Training objectives:
• Improve skills in performing a comprehensive musculoskeletal examination
• Gait and balance evaluation/fall risk assessment
• Assessment of strength and physical functioning
• Knowledge of the application of physical treatment modalities – heat and cold, hydrotherapy, electrical stimulation, traction, exercise, and biofeedback
• Evaluation and management of musculoskeletal pain (TENS, etc.)
• General approaches to strengthening and reconditioning the elderly – PT, group exercises
• Principles of stroke rehabilitation
• Non-operative management of the frozen shoulder/rotator cuff injuries
• Non-operative management of degenerative and other arthritides
• Appropriate prescription of walking aides and other assistive devices
• Ability to prescribe appropriate orthotics and other assistive devices

Evaluations: At end of rotation, from respective site directors. (See # 5 for CREC evaluation.)

10. Geriatric Neurology
Location: Primary: Neurology Clinic, UCDMC
Secondary: Center for Rehabilitation and Extended Care, Martinez VAMC
Duration: (Neurology Clinic) 3 months (minimum)
Frequency: 1/2 day per week

Method: While this rotation is based primarily in the Neurology Clinic, many of the training objectives will be addressed during the CREC rotation.

Training objectives:
• The trainee will demonstrate the ability to perform a comprehensive, accurate neurological examination.
• The trainee will demonstrate a knowledge of neuroanatomy appropriate to understand and manage the conditions listed below.
• The trainee will demonstrate a basic knowledge of the neurological changes of normal aging (cortical atrophy, slowing of conduction velocity in peripheral nerves, age-related changes in gait and balance, etc.).
• Knowledge of autonomic changes seen in normal aging and in disease.
• How to assess and manage peripheral neuropathies.
• The evaluation and diagnosis of gait disturbances in the elderly, including the evaluation of falls. (This objective compliments #9-PM&R.)

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• Knowledge of the pathophysiology, evaluation, and treatment (pharmacologic and non-pharmacologic) of Parkinson’s disease and related disorders.
• The evaluation and management of “dizziness.”
• Current (“state-of-the-art”) opinions regarding evaluation and management of cerebrovascular disease, especially TIA’s.
• The ability to assess deficits and rehabilitation needs in the patients with acute stroke, and the prevention of stroke-related complications (e.g., seizure, contractures). (This objective compliments #5-CREC and #9-PM&R.)
• Evaluation and management of headaches in the older patient.

Evaluations: At the end of the rotation, from the site director, with input from other attendings and the geriatric nurse practitioner, if involved in precepting.

11. Geriatric Psychiatry
Location: Psychiatry Clinic, UCDMC
Duration: 3 months (minimum)
Frequency: 1/2 day per week

Training objectives:
• The fellow will be able to perform a sensitive but comprehensive psychiatric history and mental status evaluation.
• The fellow will be familiar with the diagnostic categories used in psychiatry (the “axes”) and with the DSM-IV.
• The fellow will know the epidemiology and presentation of depression and anxiety in the elderly.
• The fellow will be able to screen for and assess late-life depression and dysthymia, and will demonstrate familiarity with common screening tools, such as the Geriatric Depression Scale.
• The fellow will demonstrate knowledge about the pharmacology, selection, dosing, duration of treatment, and side-effects of medications for depression and anxiety in the elderly.
• The fellow will demonstrate knowledge about the pharmacology, selection, dosing, and side-effects of medications for paranoia and psychosis in the elderly.
• The fellow will demonstrate knowledge about pharmacologic and non-pharmacologic interventions for behavioral disturbances complicating dementia.
• The fellow will demonstrate knowledge about the diagnosis and treatment of bipolar disorder in the elderly.
• The fellow will know the role of ECT in the treatment of depression, its side-effects, efficacy, and for whom to recommend it.
• The fellow will demonstrate sensitivity to the needs and burden of the caregivers of older patients with psychiatric disorders.
• The fellow will have a knowledge of community resources to evaluate and assist older persons with mental disorders, including county mental-health clinics, psychiatric hospitals, assisted living facilities, nursing homes, state-run mental institutions, case management services, and Adult Protective Services.
• The fellow will demonstrate knowledge of the financing and accessibility of psychiatric services for the elderly in California.

Evaluations: At the end of the rotation (or after 12 half-days, if the rotation is longer than 3 months), from the site director, with input from other attending geropsychiatrists.

12. Palliative Care
Location: Primary: UC Davis Home Health and Hospice, 3630 Business Drive, Sacramento
Secondary: Hospital-Based Home Care, VA-McClellan
Duration: 2 months (minimum)
Frequency: 1 day per week
Method: The fellow will attend the weekly interdisciplinary hospice team meeting and will make home visits on selected hospice patients followed by UCD Hospice and/or HBHC. Home visits will be made with various members of the interdisciplinary team (nurse, social work, chaplain). When the fellow is deemed ready to make solo home visits by the hospice staff and medical director, the fellow will also acquire a panel of up to 10 primary-care hospice patients on whom visits will be made as needed, with a minimum of 2 visits per month per patient. At the end of the rotation, the patient will be transferred to the second fellow, or his or her primary care will revert to the hospice medical director. Fellows are encouraged to continue following their terminal hospice primary-care patients until their demise; provision for weekly house calls will be made in the fellow’s schedule.

In most cases, this rotation will be done in parallel with #13, Pain Clinic.

Training objectives:
• The fellow will demonstrate an understanding of the range of services, funding, and eligibility requirements for hospice.
• The fellow will demonstrate the ability to interact effectively and professionally with members of the hospice team.
• The fellow will develop skill in sensitively assessing and addressing the patient’s and family’s cultural and religious attitudes towards death and dying.
• The fellow will demonstrate sensitive, effective communication with the patient and family members concerning end-of-life care, and will demonstrate sensitive, effective counseling about care issues.
• The fellow will demonstrate a knowledge of advance directives and California’s laws that govern them.
• The fellow will be familiar with the physiologic processes common to imminent death.
• The fellow will acquire knowledge about pharmacologic and non-pharmacologic palliative interventions, including the use of narcotic and non-narcotic pain medications. (This objective is complimented by rotation #13, Pain Clinic.)

Evaluations: At the end of the rotation, from the hospice medical director, with input from the HBHC attending (if HBHC patients involved), the hospice staff, surviving patients, and family members.

13. Pain Clinic
Location: Ambulatory Care Center, UCDMC
Duration: 2 months (minimum)
Frequency: 1/2 day per week

Method: This rotation is usually taken concurrently with #12, Palliative Care, but may be extended by itself. A related elective is Musculoskeletal Disorders (see below).

Training objectives:
• The fellow will demonstrate knowledge of the physiologic and neuroanatomic correlates of pain.
• The fellow will demonstrate the ability to take a comprehensive pain history and to use standardized subjective pain scales, such as the McGill Pain Questionnaire.
• The fellow will demonstrate knowledge about the objective assessment of pain thresholds using thermal stimulators.
• The fellow will demonstrate the ability to perform a comprehensive physical examination pertinent to the patient’s pain, with commensurate demonstration of appropriate musculoskeletal and neurologic examination techniques.
• The fellow will demonstrate conversance with the pharmacologic principles underlying the use of narcotic and non-narcotic pain medications.
• The fellow will acquire knowledge about major treatment modalities and approaches for common pain syndromes, including the prescription of appropriate narcotic therapies (and their side-effects), transcutaneous electrical nerve stimulation (TENS), intra-articular injections, and nerve and spinal blocks.

The fellow is expected to review each home visit with the hospice medical director or another designated faculty attending – preferably within 24 hours. The fellow also is expected to communicate relevant findings to members of the team.
The fellow will acquire knowledge about the psychiatric and psycho-social correlates of chronic pain.

The fellow will acquire knowledge about community resources, such as support groups, for patients with various types of chronic pain.

Evaluations: At the end of the rotation, from the site director, with input from other attendings.

14. Geriatrics Specialty Clinic: Osteoporosis
Location: Cypress Building, Suite D, UCDMC
Duration: All year
Frequency: 1/2 day every other week

Method: The Osteoporosis Clinic is a subspecialty clinic within the Geriatrics Clinic, and currently meets on the 2nd and 4th Friday of the month. A related elective is Musculoskeletal Disorders (see below).

Training objectives:
• The fellow will know the epidemiology and pathophysiology of osteoporosis in the elderly.
• The fellow will demonstrate the ability to perform a comprehensive geriatric evaluation of patients referred to the clinic, with emphasis on osteoporotic risk factors, prior osteoporotic fractures, fall risk and prior falls, gait and balance, and pain and other limitations imposed by the complications of osteoporotic fractures (e.g., low back pain, early satiety, and dyspnea due to severe kyphosis).
• The fellow will demonstrate knowledge of the current modalities to assess bone mineral density and their sensitivity and specificity, including DEXA, qCT, and ultrasound.
• The fellow will demonstrate a knowledge of the pharmacology, efficacy, and potential adverse effects of current drugs used for the treatment and prevention of osteoporosis.
• The fellow will demonstrate a knowledge of available adjunctive measures to reduce the risk of falls and osteoporotic fracture, including hip protectors, walking aids, and exercise programs.
• The fellow will demonstrate the ability to dictate concise yet thorough consultation reports to the referring physician.
• The fellow will demonstrate the ability to effectively counsel/educate patients and their families concerning osteoporosis evaluation and treatment, exercise programs, and fall prevention.

Evaluations: Every 6 months, from the clinic director, with input from other attendings and the geriatric nurse practitioner.

15. Geriatrics Specialty Clinic: Preoperative Evaluation
Location: Cypress Bldg, Suite B, UCDMC
Frequency: 1/2 day per month
Duration: 6 months

Method: In collaboration with the Anesthesia Preoperative Clinic, older patients referred for a preoperative medical evaluation will be seen in the Geriatrics Clinic instead of the Anesthesia Pre-Op Clinic in the Ambulatory Care Center.

Training Objectives:
• The fellow will be able to identify pertinent medical, functional, and psycho-social factors that may affect perioperative morbidity and mortality.
• The fellow will demonstrate the ability to make appropriate recommendations to prevent or reduce the likelihood of such morbidity.
• The fellow will learn to perform preoperative discharge planning – i.e., determining the likely short-term functional consequences of the planned surgery, assessing the patient’s actual and potential caregiver support and environment, and based on this evaluation, anticipating whether the patient will be able to be discharged home without special services, home with home care, or to a nursing home for transitional care.
• The fellow will demonstrate the ability to dictate a thorough but concise consultation report.
Evaluations: The evaluation for this rotation will be incorporated into the evaluation for the UCD Geriatrics Clinic.

Elective Rotations

1. Geriatric Dermatology
   Location: Primary: Dermatology Clinic, Mather VAMC
             Secondary: Vascular Clinic, UCDMC
   Duration: 2 months (Suggested)
   Frequency: 1/2 to 1 day per week

   Training objectives:
   • The fellow will be conversant with age-related changes to the skin, hair, and nails, and the resulting susceptibility to conditions such as xerosis, bruising, and pressure sores.
   • The fellow will learn the epidemiology and pathophysiology of common skin disorders in the elderly, as well as common skin cancers and pre-cancerous lesions (basal-cell and squamous-cell carcinomas, actinic keratoses).
   • The fellow will demonstrate the ability to perform a comprehensive skin examination and be able to recognize common age-related cutaneous disorders and malignancies.
   • The fellow will learn standard therapies for common skin disorders of the elderly, and will learn the staging and treatments for skin cancers.
   • The fellow will demonstrate the ability to perform a simple punch biopsy.
   • The fellow will demonstrate a knowledge of the pathophysiology and common classification of pressure ulcers, and the principles of pressure-sore prevention and management. (This objective compliments a similar objective for the CREC rotation.)
   • The fellow will become familiar with representative examples of the types of wound-care products commonly used in the treatment of pressure sores, and their indications, benefits, and limitations.
   • The fellow will demonstrate knowledge about the types of pressure-relieving mattresses and cushions, and their indications.
   • The fellow will learn about the efficacy of experimental wound-healing techniques, such as electrical stimulation and vacuum dressings.
   • The fellow will learn the management of venous stasis ulcers and the various types of compression dressings.
   • The fellow will learn the principles of managing ischemic ulcers.

   Evaluations: At the end of the rotation, from the site director, with input from other attendings, if any.

2. Musculoskeletal Disorders in the Elderly
   Location: Rheumatology Clinic, UCDMC
             Orthopedics Clinic (Arthroplasty), UCDMC
   Duration: 2 months
   Frequency: 1/2 to 1 day per week

   Method: This elective is split between the orthopedic joint-replacement clinic and the rheumatology clinic. While the latter does not specialize in joint diseases in the elderly, the fellow is encouraged to focus on patients with degenerative joint disease. To ensure adequate teaching cases, Geriatric Clinic patients with hard-to-manage DJD can be referred to the Rheumatology Clinic for evaluation by the trainee and the attending rheumatologist. The joint-replacement clinic compliments the rheumatology experience by exposing the trainee to advanced DJD of the hip and knee.

   Training objectives:
   • The fellow will learn the epidemiology, pathophysiology, and state-of-the-art management of major musculoskeletal conditions in the elderly:
     - Osteoarthritis, especially of the knee, hip, and spine
     - Late effects of rheumatoid arthritis
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- Polymyalgia and temporal arteritis
- Gouty arthritis
- Rotator cuff disorders

• The fellow will demonstrate the ability to perform thorough, targeted musculoskeletal examinations, with commensurate demonstration of a thorough knowledge of musculoskeletal anatomy.
• The fellow will learn the role of selected strengthening exercises and other physical and occupational therapies in the management of age-associated osteoarthritis and shoulder problems.
• Above and beyond the standard rheumatological and orthopedic evaluations of the patients, the trainee will apply the knowledge and techniques gleaned from the Pain Clinic rotation to assess the patient’s pain and propose appropriate multi-modal pain-control regimens.

Evaluations: At the end of the rotation, from the director of each clinic.
In evaluating the resident’s performance, use as your standard the level of knowledge, skills and attitudes expected from the clearly satisfactory fellow at this stage of training. Take into account the fellow’s previous training (internal medicine or family practice). For any component that needs attention or is rated a 4 or less, please provide specific comments and recommendations on the back of the form. Be as specific as possible, including reports of critical incidents and/or outstanding performance. Global adjectives or remarks, such as “good resident,” do not provide meaningful feedback to the trainee. If filling out electronically, please type inside the highlighted fields or select from the field menu.

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### 5. Professionalism
Lacks respect, compassion, integrity, honesty; disregards need for self-assessment; fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display responsible behavior

- Insufficient contact to judge

### 6. System-Based Learning
Unable to access/mobilize outside resources; actively resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care

- Insufficient contact to judge

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<th>Satisfactory</th>
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- Performance needs attention

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**Evaluator's Comments:**

If outpatient experience, approximately how many half-days of contact have you had with the trainee?

When did you give verbal feedback to the fellow during the rotation? Check all that apply:

- Beginning
- Midpoint
- End
- Never

Evaluator's Signature: ________________________________

Check if submitted electronically
Geriatric Fellow Evaluation Form
(Teaching Nursing Home Director of Nursing)

Trainee's name: 

Period of service at Greenhaven: 

Instructions: Based on your discussions with staff, please rate the physician-trainee by placing an "X" anywhere on the scale at a point that you feel best describes his or her overall performance. The descriptions of the categories below are meant as guides only, since many trainees will have qualities from more than one category. By placing an underline beneath those qualities from the various categories that best describe the trainee, you will help us establish a fuller assessment of his/her strengths and weaknesses in nursing-home care.

<table>
<thead>
<tr>
<th></th>
<th>UNACCEPTABLE</th>
<th>FAIR</th>
<th>GOOD</th>
<th>VERY GOOD</th>
<th>EXCELLENT</th>
</tr>
</thead>
</table>

Unacceptable
Very poor performance that has had a documented negative impact on the patient's care, such as a potentially avoidable illness or complication. When on call, frequently does not respond to phone calls from staff or frequently answers after unacceptable delay. Interaction with staff usually arrogant, brusque, or downright rude. Takes no apparent interest in patient's quality of life, or is rude or mean to patient. No contact with patient's family.
Remediation urgently needed.

Fair
Performance marginally acceptable. Patient care has not been compromised, but physician's behavior makes this a possibility. When on call, sometimes does not respond to phone calls from staff or sometimes answers after unacceptable delay. Interaction with staff sometimes arrogant, haughty, or impatient. Takes little interest in patient's quality of life, or curt or condescending. No contact with patient's family. "Does the minimum to get by."

Good
Performance acceptable; patient care adequate. When on call, usually responds to phone calls from staff with an acceptable delay. Interaction with staff usually professional, although does not go out of way to solicit information from staff. Behaves professionally with patients. Does not go out of way to inquire about nursing home regulations or how to improve patient's overall status. Focused on medical care, not the "whole picture." Unrealistic expectations of the nursing home – thinks facility is a small-scale hospital that can do the same things.

Very good
Physician performance above average. Patients under his/her care receive competent medical care. When on call, responds promptly and courteously to phone calls from staff. Collegial relationship with staff. Treats patients with dignity and respect. Shows evidence of learning and applying knowledge of nursing-home regulations, and of the potentials and limitations of nursing-home care.

Excellent
Physician's performance outstanding. Respects patient's dignity and displays compassion and warmth toward the patients – is an ardent patient advocate. Interacts extremely well with staff. Makes a point of discussing patient with all involved personnel – aides, LVN's, RN's, rehab. personnel, social worker. When on call, responds promptly and courteously to phone calls from staff, and goes out of way to explore problems. Takes an interest in, and has contact with, patients' families. Renders excellent medical care and displays outstanding medical judgment. Graciously accepts advice of staff and displays eagerness to learn and comply with nursing-home regulations. Understands potentials and limitations of nursing-home care.

Rev. 6-02

36
Geriatric Fellow Evaluation Form
(Patient or Family Member)

Trainee's name: ___________________________ Period of contact: ___________ to ___________ Role: □ Patient □ Family Member □ Other caregiver

Date of this evaluation: _____________________ Evaluator: _______________________

THIS EVALUATION IS STRICTLY CONFIDENTIAL AND WILL BE USED BY THE GERIATRIC FELLOWSHIP COMMITTEE TO EVALUATE THE PROGRESS OF GERIATRIC FELLOWS. WE WILL NOT REVEAL YOUR IDENTITY TO THE FELLOW. THIS EVALUATION WILL IN NO WAY AFFECT THE CARE YOU RECEIVE FROM UC DAVIS MEDICAL CENTER OR FROM ANY OF ITS AFFILIATED PHYSICIANS OR ALLIED HEALTH-CARE PROFESSIONALS.

Instructions: In each row, place a checkmark in the box next to those qualities that best describe the fellow’s performance in your opinion. Please check only one box in each row.

<table>
<thead>
<tr>
<th>MEDICAL CARE</th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th>VERY GOOD</th>
<th>OUTSTANDING</th>
<th>NOT ENOUGH INFORMATION TO DECIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is never thorough; often seems superficial or misses important problems.</td>
<td>☐ Often not thorough, sometimes seems superficial or misses important problems.</td>
<td>☐ Usually thorough, almost always pays attention to important problems</td>
<td>☐ Very thorough, always pays attention to important problems</td>
<td>☐ Exceptionally thorough, pays attention to important and also minor problems.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seems to have a poor knowledge of medicine. The doctor seems incompetent.</td>
<td>☐ Seems to have just a fair knowledge of medicine. The doctor generally seems to know what to do.</td>
<td>☐ Seems to have a good knowledge of medicine. The doctor seems to know what to do.</td>
<td>☐ Seems to have a very good knowledge of medicine. The doctor seems very competent.</td>
<td>☐ Seems to have an exceptional knowledge of medicine. The doctor seems exceptionally competent.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Takes no interest in how hard it might be for the family to take care of the patient.</td>
<td>☐ Shows some but not much interest in how hard it might be for the family to take care of the patient.</td>
<td>☐ Shows a moderate amount of interest in how hard it might be for the family to take care of the patient.</td>
<td>☐ Shows a lot of interest in how hard it might be for the family to take care of the patient.</td>
<td>☐ Shows an exceptional amount of interest in how hard it might be for the family to take care of the patient.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

| CARING & COMPASSION                     | ☐ Usually arrogant, impatient, or impolite. Seems cold and caring. | ☐ Sometimes arrogant, impatient, or impolite. At times may seem cold or uncaring. | ☐ Usually polite, shows a generally caring manner, but not very warm as a person, | ☐ Always polite, warm, caring and friendly. | ☐ Exceptionally polite, warm, caring, and friendly. Shows exceptional patience and kindness. | ☐                                                                  |
| ☐ Takes no interest in how hard it might be for the family to take care of the patient. | ☐ Shows some but not much interest in how hard it might be for the family to take care of the patient. | ☐ Shows a moderate amount of interest in how hard it might be for the family to take care of the patient. | ☐ Shows a lot of interest in how hard it might be for the family to take care of the patient. | ☐ Shows an exceptional amount of interest in how hard it might be for the family to take care of the patient. | ☐                                                                  | ☐                                                                   |
### COMMUNICATION

<table>
<thead>
<tr>
<th>POOR</th>
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<th>VERY GOOD</th>
<th>OUTSTANDING</th>
<th>NOT ENOUGH INFORMATION TO DECIDE</th>
</tr>
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<tbody>
<tr>
<td>□ Answers and explanations are usually unsatisfactory, or always difficult to understand.</td>
<td>□ Answers and explanations are sometimes unsatisfactory, or sometimes difficult to understand.</td>
<td>□ Answers and explanations are usually satisfactory and usually easy to understand.</td>
<td>□ Answers and explanations are almost always satisfactory and almost always easy to understand.</td>
<td>□ Answers and explanations are always excellent, very helpful, and very clear – makes complicated topics easy to understand.</td>
<td>□</td>
</tr>
<tr>
<td>□ Never involves patient or family in decisions about health care – just tells them what is going to be done.</td>
<td>□ Sometimes involves patient or family in decisions about health care – but doesn’t like it if anyone disagrees.</td>
<td>□ Usually involves patient or family in decisions about health care AND usually willing to discuss plans if anyone disagrees.</td>
<td>□ Always involves patient or family in decisions about health care AND always willing to discuss plans if anyone disagrees.</td>
<td>□ Always involves patient or family in decisions about health care AND always willing to discuss other options and leaves everyone feeling good about the final decisions.</td>
<td>□</td>
</tr>
</tbody>
</table>

### PROFESSIONALISM

<table>
<thead>
<tr>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th>VERY GOOD</th>
<th>OUTSTANDING</th>
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<tbody>
<tr>
<td>□ Frequently acts or looks professional Does not inspire confidence or trust.</td>
<td>□ Sometimes does not act or look as professional as he or she should. Often does not inspire confidence.</td>
<td>□ Appearance and behavior always professional. Inspires some confidence or trust.</td>
<td>□ Appearance and behavior always professional. Inspires a fair amount of both confidence and trust.</td>
<td>□ Outstandingly professional – inspires an exceptional amount of confidence and trust.</td>
<td>□</td>
</tr>
</tbody>
</table>

### OVERALL RATING

Place an "X" anywhere on the scale at a point that you feel best describes the fellow’s overall performance as a doctor.

[ ] UNACCEPTABLE  [ ] FAIR  [ ] GOOD  [ ] VERY GOOD  [ ] EXCELLENT

### COMMENTS:

THANK YOU FOR COMPLETING THIS EVALUATION! PLEASE RETURN THE FORM TO DR. CALVIN HIRSCH OR DR. MICHAEL McCLOUD IN THE CLINIC, OR MAIL THE FORM IN THE ENCLOSED POSTAGE-PAID ENVELOPE TO: MS. TONYA LANGE, GERIATRIC FELLOWSHIP COORDINATOR. DIVISION OF GENERAL MEDICINE, UC DAVIS MEDICAL CENTER, 4150 V STREET -- PSSB-2400, SACRAMENTO, CA 95817