## 2014 Reynolds Grantee Annual Meeting

Monday, October 6 – Wednesday, October 8, 2014
Red Rock Resort & Casino • Las Vegas, Nevada

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2014 Reynolds Grantee 12th Annual Meeting
Aligning Geriatrics Academic Healthcare Initiatives

Monday, October 6 – Wednesday, October 8, 2014
Red Rock Casino Resort • Las Vegas, NV

Follow us on Twitter for updates and share your thoughts throughout
the meeting using the hashtag #dwrf14.

DAY 1: Monday, October 6, 2014

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<tr>
<th>Time</th>
<th>Event Description</th>
<th>Room</th>
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<tr>
<td>7:00 – 8:00 am</td>
<td>Breakfast</td>
<td>Pavilion Ballroom Foyer</td>
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<td>FD~AGE Longitudinal Scholars Meet-and-Greet</td>
<td>Room: Ridges</td>
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<tr>
<td>8:00 – 8:30 am</td>
<td>Introductions and Overview</td>
<td>Pavilion Ballroom</td>
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<td>Rani Snyder, MPA, Donald W. Reynolds Foundation.</td>
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<td>Rosanne M. Leipzig, MD, PhD, Icahn School of Medicine at Mount Sinai.</td>
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<tr>
<td>8:30 – 8:45 am</td>
<td>Move Along Break</td>
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<td>8:45 – 10:00 am</td>
<td>Ice Breaker: Speed Dating</td>
<td>Pavilion Ballroom</td>
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<td>On your nametag you will find an assigned room name for this activity.</td>
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<td>Once in your assigned room, please take a chair either on the inner or the</td>
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<td>outer ring. You will have about 10 minutes to get to know and to ask the</td>
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<td>person sitting across from you about the projects and initiatives that are</td>
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<td>happening at their institution. The inner ring of each circle will move seats</td>
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<td>approximately 6 times. Please assign a timekeeper to make sure that you</td>
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<td>get to meet more than one person.</td>
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<td>Veranda Ballroom (A)</td>
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<td>Veranda Ballroom (B)</td>
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<td>Veranda F (outside terrace)</td>
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<td>Vistas</td>
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<th>10:00 – 10:15 am</th>
<th>Morning Break</th>
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<td>10:15 am – 12:00 pm</td>
<td>Keynote Address</td>
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<td>Pavilion Ballroom</td>
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<td>Geriatrics in the 21st Century: Obsolete or Mainstream?</td>
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<td>Mary Tinetti, MD, Gladys Phillips Crofoot Professor at Yale School of Medicine and Chief of Geriatrics.</td>
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<td>Over the past 30 years, the first generation of fellowship trained geriatricians have seen the discipline grow, develop a science and clinical base, and expand into other areas such as palliative care, all while struggling to survive. With the changing and uncertain health care delivery</td>
</tr>
</tbody>
</table>
and payment environment, geriatrics, more than ever before, teeters on the edge between becoming obsolete and mainstream. What are the opportunities and challenges that will define which our future is?

12:00 – 1:00 pm  
Lunch  
Room: T-Bones Restaurant  
FD~AGE Longitudinal Scholars Presentations  
Room: Ridges

1:00 – 1:15 pm  
Move Along Break

1:15 – 2:15 pm  
Faculty Development Workshop Sessions  
Grantees who have created materials that are appropriate for the session topic areas should bring 40 copies of materials for distribution. Please see last page of the agenda for session descriptions.

<table>
<thead>
<tr>
<th>ROOM</th>
<th>SESSION TITLE</th>
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| Veranda    | Writing for Publication in the Geriatric Literature  
Barry D Weiss, MD, University of Arizona; David Reuben, MD, University of California, Los Angeles; Deborah Simpson, PhD, Aurora Health Care & Medical College of Wisconsin |
| Trails     | Why I Love to Teach – Sometimes “Yes” and Sometimes “Not So Much”  
Deborah Simpson, PhD, Aurora UW Medical Group; Kathryn Denson, MD, Medical College of Wisconsin; Edmund Duthie Jr, MD, Medical College of Wisconsin; Michi Yukawa, MD, MPH, San Francisco VA Medical Center; Rainier Soriano, MD, Icahn School of Medicine; Mitchell T. Heflin, MD, MHS, Duke University; Sandro Pinheiro, PhD, MA, MRE, Duke University |
| Siena      | Cross Institutional Educational Research  
Kate Callahan MD, MS, Wake Forest University; Lindsay Wilson MD, MPH, University of North Carolina, Chapel Hill; Mitch Heflin MD, MHS, Duke University |
| Ridges     | Get your GACA On! Tips for 2015 GACA Applicants and Mentors  
Paul Tatum, MD, University of Missouri at Columbia; Talebreza Brandon, MD, University of Utah, Rosanne Leipzig, MD, PhD, Icahn School of Medicine at Mount Sinai; Stacie Levine, MD, University of Chicago; Eric Widera, MD, University of California at San Francisco, Timothy Farrell, MD, University of Utah, Michael Harper, University of California, San Francisco |
| Vistas     | Assessment Tools for Geriatric Fellows  
Helen Fernandez, MD, MPH, Icahn School of Medicine and Serena Chao, MD, MSc, Boston University |
| Suite 5104 | How to Develop a Business Plan  
Mike Malone, MD Aurora Health Care University of Wisconsin School of Medicine & Public Health; Kellie Flood, MD, University of Alabama; Kevin Foley, MD, Michigan State University |
| T-Bones Private Dining Room | Negotiation 301  
Lisa Walke, MD, Yale University and Cynthia Brown, MD, MSPH, University of Alabama at Birmingham |
|---|---|
| Hills | Getting to Associate: Practical Tips, Suggestions, and Insight into Navigating the Academic Promotion Process as a Clinician Educator  
Caroline Vitale, MD, University of Michigan; Kimberly Curseen, MD, University of Arkansas; Eric Widera, MD, University of California San Francisco |

2:15 – 2:30 pm  Move Along Break

2:30 – 4:00 pm  Plenary Session  
Room: Pavilion Ballroom  
The Interface between Geriatrics Education and Geriatrics Models of Care  
Sharon Brangman, MD, President-Elect, ADGAP, SUNY Upstate Medical University, Moderator.  
Mike Malone, MD Aurora Health Care University of Wisconsin School of Medicine & Public Health.  
Mike Malone will present ways to make the case for geriatrics models that bring value to the healthcare system, focusing on his experiences demonstrating the value of programs such as ACE and ACE Tracker. The presentation will explore what healthcare systems are looking for when they examine proposals for innovation. The talk will include ideas for making the business case for models of care that can gain institutional support for achieving bottom line financial &/ or quality goals, and some basic skills of business planning.

Interactive breakout sessions will discuss making the case for specific clinical models of care that achieve geriatric medical education and quality care goals. Facilitators will explore with participants how they might champion these programs at their home institutions.

Breakout sessions:
1. Orthopedic Co-management- Lynn McNicoll, MD, Brown University and Dan Mendelson, MD, University of Rochester.
2. Oncology Co-management- Bill Dale, MD, University of Chicago.
4. Hospital Elder Life Program- Mark Supiano, MD, University of Utah and Corey Romesser, MD, University of Rochester.
5. Geriatric Emergency Departments- Jan Busby-Whitehead, MD, University of North Carolina at Chapel Hill and Kevin Biese, MD, University of North Carolina at Chapel Hill.
6. Acute Care for Elders Units- Kellie Flood, MD, University of Alabama and Jeffrey D. Schlaudecker, MD, MEd, University of Cincinnati.
7. Accountable Care Organization- Audrey Chun, MD, Icahn School of Medicine and Laurie Jacobs, MD, Albert Einstein College of Medicine.
4:00 – 4:15 pm  Move Along Break

4:15 – 5:15 pm  Marketplace I  Room: Summerlin CD
(w/POGOe and AGS/ADGAP booths)
During this time, participants will showcase the educational materials that they have created. Use your worksheet (to be handed out at the marketplace) to take notes on your favorite products. Voting for Product of the Year will be held on Wednesday via www.PollEverywhere.com. Instructions on how to vote are available at the Registration desk.

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<td>University of Arizona</td>
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<td>Boston University</td>
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<td>University of California San Francisco</td>
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<td>Indiana University</td>
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<td>University of Iowa</td>
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<td>Medical College of Wisconsin</td>
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<td>University of Miami</td>
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<td>University of Missouri</td>
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<td>University of North Texas</td>
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<td>University of Oklahoma</td>
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<td>Vanderbilt University</td>
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<td>Yale University</td>
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[Refreshments will be available at the Marketplace.]

5:15 – 6:15 pm  Cocktails and Mingling  Room: Veranda
[Dinner on your own]
FD~AGE Schools: Evaluation Meeting  Room: Trails

6:15 – 8:15 pm  FD~AGE Schools: Meeting for the Reynolds Consortium for Faculty Development to Advance Geriatric Education (FD~AGE) Schools  Room: Trails

DAY 2: Tuesday, October 7, 2014

7:00 – 8:00 am  Breakfast  Room: Pavilion Ballroom Foyer

Teamwork and Its Assessment

8:00 – 9:00 am  Plenary Session  Room: Pavilion Ballroom
Assessment of Interprofessional Teamwork
Robyn Tamblyn, BScN, Msc, PhD, James McGill Chair, Departments of Medicine and Epidemiology and Biostatistics, McGill University.
Robyn Tamblyn will discuss assessment of interprofessional team work.
9:00 – 10:45 am  Plenary Session  Room: Pavilion Ballroom  
Multi-source Feedback: The Teamwork Effectiveness Assessment Module  

Benjamin Chesluk, PhD, Senior Researcher for Ethnographic Research.  
Benjamin Chesluk will present ABIM’s Teamwork Effectiveness Assessment Module (TEAM) tool to gather and interpret feedback from an interprofessional team.

Interactive breakout sessions will discuss ways to use the TEAM module and other tools that gather and provide multi-source feedback. Participants explore usefulness and limitations of various feedback approaches in geriatric care settings.

Focus for breakout sessions will be:
1. Ambulatory
2. Inpatient
3. Long term care
4. Home care
5. Hospice

10:45 – 11:00 am  Move Along Break

11:00 am – 12:00 pm Faculty Development Workshop Sessions
Grantees who have created materials that are appropriate for the session topic areas should bring 40 copies of materials for distribution. Please see last page of the agenda for session descriptions.

<table>
<thead>
<tr>
<th>ROOM</th>
<th>SESSION TITLE</th>
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| VERANDA | Geriatricizing EMR Workshop  
Audrey Chun, MD, Icahn School of Medicine; Heidi White, MD, Duke University; Franklin Watkins, MD, Wake Forest; Jessica Colburn, MD, Johns Hopkins University |
| TRAILS | Attaining Your Career Goals in Geriatrics: Applying Best Practices to the Critical Appraisal of Educational Scholarship  
Timothy Farrell, MD, University of Utah; Deborah Simpson, PhD, Aurora UW Medical Group; Edmund Duthie Jr, MD, Medical College of Wisconsin; Mark A. Supiano, MD, University of Utah; Cherie Brunker, MD, University of Utah; Manuel Eskildsen, MD, MPH, Emory University; Kathryn Denson, MD, Medical College of Wisconsin; Katherine Anderson, MD, University of Utah; Shaida Talebreza, MD University of Utah, Sharon Levine, MD, Boston University; Rainier Soriano, MD, Icahn School of Medicine |
| SIENA  | Combined Geriatric-Pal Care Fellowship  
Helen Fernandez, MD, MPH, Icahn School of Medicine and Lisa Walke, MD, Yale University |
12:00 – 1:00 pm  Meet the Professors Lunch (box lunches will be in Summerlin Foyer)
A listing of participants for the session will be provided at registration, based on the results of the survey completed by interested participants. The purpose of this session is to have informal discussions with a senior faculty member from another institution about their career, your career, and anything else you would like (within reason!).

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<td>Veranda</td>
<td>Deb Simpson, PhD</td>
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<tr>
<td>Summerlin A</td>
<td>Michael Harper, MD</td>
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<tr>
<td>Summerlin B</td>
<td>Mark Supiano, MD</td>
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<tr>
<td>Summerlin E</td>
<td>William Hall, MD</td>
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<td>Summerlin F</td>
<td>Annie Medina Walpole, MD</td>
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<tr>
<td>Hills</td>
<td>David Reuben, MD</td>
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<td>Siena</td>
<td>Sharon Brangman, MD</td>
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<tr>
<td>Trails</td>
<td>Sharon Levine, MD</td>
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1:00 – 3:00 pm  Plenary Session  Room: Pavilion Ballroom
Geriatrics Academic Programs: Small Group Problem-Solving
David Reuben, MD, UCLA.
This session is designed to help faculty solve current problems. Although problems that faculty face may appear to be unique, most have been encountered by other faculty who can provide insights and advice based on their own experiences with similar problems.
3:00 – 3:15 pm  Move Along Break

3:15 – 4:15 pm  Marketplace II  Room: Summerlin CD
(w/POGOe and AGS/ADGAP booths)
During this time, participants will showcase the educational materials that they have created. Use your worksheet (to be handed out at the marketplace) to take notes on your favorite products. Voting for Product of the Year will be held on Wednesday via www.PollEverywhere.com. Instructions on how to vote are available at the Registration desk.

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<td>University of Cincinnati</td>
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<td>Emory University</td>
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<td>University of Hawaii</td>
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<td>University of Michigan</td>
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<td>University of Nebraska</td>
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<td>University of North Carolina</td>
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<td>University of Rochester</td>
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<td>University of Texas Southwestern</td>
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<td>Virginia Commonwealth University</td>
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<td>Wake Forest</td>
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[Refreshments will be available at the Marketplace.]

6:00 – 7:00 pm  Reception  Room: Veranda F

7:00 – 9:00 pm  Dinner  Room: Pavilion Ballroom
DAY 3: Wednesday, October 8, 2014

7:00 – 7:30 am  Breakfast                Room: Pavilion Ballroom Foyer

Sustaining Reynolds initiatives through alignments with CLER and Patient Safety/QI

7:30 – 8:15 am  Plenary Session           Room: Pavilion Ballroom
Leveraging the NAS
Lynne Kirk, MD, University of Texas Southwestern Medical Center.
Lynne Kirk will present on the ACGME next accreditation system (NAS),
and how geriatrics might help your institution do well on the Clinical
Learning Environment Review (CLER), working with GME to develop
geriatricized ways to demonstrate “leadership in patient safety, quality
improvement, and reduction in health care disparities” and that the GME
learning environment can “deliver both high-quality physicians and higher
quality, safer, patient care.” She will also discuss specifics about how to
operationalize use of the NAS reporting milestones.

8:15 – 10:00 am  Plenary Session           Room: Pavilion Ballroom
Sustaining Education Initiatives after Reynolds
Kellie Flood, MD, University of Alabama and Sharon Levine, MD, Boston
University.
Presenters will describe Virtual ACE and CRIT.

Breakout sessions will explore ways to keep educational innovations
going. Participants will discuss practical ways to build sustainable
programs and engage non-geriatricians that advance both educational and
clinical goals, including patient safety and QI.

Focus for breakout sessions will be:
1. CRIT -Sharon Levine, MD, Boston University.
2. Hospitalists & CHAMP -Paula Podrazik, MD, University of
   Arkansas for Medical Sciences and Melissa Mattison, MD,
   Harvard Medical School/Beth Israel Deaconess.
3. Emergency Departments -Martine Sanon, MD, Icahn School of
   Medicine and Kevin Biese, MD, University of North Carolina at
   Chapel Hill.
4. Interprofessional Team Training -Janice Knebl, DO, MBA,
   University of North Texas Health Science Center and Craig
   Rubin, MD, University of Texas Medical Center.
5. Surgical Specialties -Mark Supiano, MD, University of Utah.
6. Senior Mentor Programs - Ellen Roberts, PhD, MPH, University of
   North Carolina at Chapel Hill.
7. CLER -Lynne Kirk, MD, University of Texas Southwestern
   Medical Center and Brijen Shah, MD, Icahn School of Medicine.
10:00 – 10:30 am  Wrap Up  
Room: Pavilion Ballroom  
Rosanne M. Leipzig, MD, PhD, Icahn School of Medicine.  
Steven Anderson, President, Donald W. Reynolds Foundation.  
Award ceremony – **one free** 2015 AGS registration to the 1st place winner of *Product of the Year* competition.

10:30 am  Box Lunch
<table>
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<th>FACULTY DEVELOPMENT SESSIONS DESCRIPTIONS</th>
<th>MONDAY</th>
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<tr>
<td><strong>Assessment Tools for Geriatric Fellows</strong>&lt;br&gt;<strong>Serena Chao, MD, MSc, Boston University and Helen Fernandez, MD, MPH, Icahn School of Medicine at Mount Sinai</strong></td>
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| **Getting to Associate: Practical Tips, Suggestions, and Insight into Navigating the Academic Promotion Process as a Clinician Educator**<br>**Caroline Vitale, MD, University of Michigan; Kimberly Curseen, MD, University of Arkansas for Medical Sciences; Eric Widera, MD, University of California San Francisco**
This session will provide an overview of academic promotions processes, utilizing the insight and experiences of three individuals recently promoted to the level of Associate Professor at three different institutions. The presenters will be able to compare and contrast aspects of their promotions process, finding common and important themes that participants can learn and take away from the workshop. A practical framework, tips, and tools to enable junior faculty to engage in planning for academic promotion within their home institutions will be provided. Participants in this workshop will each begin to develop a strategic plan, enabling them to return to their institutions with a guided approach to the academic promotions process. Through this workshop, participants will be able to develop peer connections, and will be able to share this material with others in their home institutions. |
| **Cross Institutional Educational Research**
**Kate Callahan MD, MS, Wake Forest School of Medicine; Lindsay Wilson MD, MPH, University of North Carolina, Chapel Hill – School of Medicine; Mitch Heflin MD, MHS, Duke University School of Medicine**
Most educational research is conducted at single sites, which can impact questions of generalizability and relevance at other sites. Publication may also be challenged by the local nature of the work. This workshop encourages participants to consider cross-institutional opportunities within the scope of their educational research work: how their work might complement that occurring at other sites, how to develop questions across multiple sites, and how to work effectively and collegially towards a fruitful collaboration. Group leaders will introduce three key tasks to consider when embarking upon cross institutional research:
- Developing questions across teaching areas/research areas of interest
- Working with Institutional Review Boards
- Negotiating roles (including authorship)
Workshop participants will practice identifying common ground with collaborators, naming potential strategies for multi-site IRBs, and identifying and negotiating roles. The workshop will close with orientation to practical tips and guidelines both in the literature and that the facilitators found when conducting multi-institutional projects. |
| **Get your GACA On! Tips for 2015 GACA Applicants and Mentors**
**Paul Tatum, MD, University of Missouri at Columbia; Shaida Talebreza Brandon, MD, University of Utah, Rosanne Leipzig, MD, PhD, Icahn School of Medicine; Stacie Levine, MD, University of Chicago; Eric Widera, MD, University of California at San Francisco, Timothy Farrell, MD, University of Utah, Michael Harper, University of California, San Francisco**
Once every 5 years, junior faculty members have the opportunity to apply for what is the "golden ticket" for clinician-educators in geriatrics: the Geriatrics Academic Career Award (GACA). Once announced, the timeline to submit an application is short, leaving many junior faculty... |
members feeling overwhelmed by the process. The goal of this workshop is to prepare future applicants and mentors for this process well ahead of the application due date. The workshop will include 1) an introduction to the GACA and why it is important for junior faculty members to have, 2) breakout groups for applicants and mentors to discuss key elements and timelines that go into a successful career development plan, as well as a discussion of common pitfalls to avoid when preparing for a GACA, 3) the development of an action plan for workshop participants.

**How to Develop a Business Plan**

*Mike Malone, MD* Aurora Health Care University of Wisconsin School of Medicine & Public Health; *Kellie Flood, MD, University of Alabama; Kevin Foley, MD, Michigan State University*

This interactive workshop will overview the basic principles of writing a business plan and build practical skills related to business plan development. The workshop will conclude with a debriefing of the skill building exercise and a summarization of the key elements necessary to ensure a successful business plan.

**Negotiation 201**

*Lisa M. Walke, MD, Yale University, and Cynthia J. Brown, MD, MSPH, University of Alabama at Birmingham*

This session will provide further insight on the art and science of negotiation. The facilitators will focus on the importance of both verbal and non-verbal communication during negotiations. Through the use of negotiation exercises, a brief review of bargaining styles, and peer-to-peer mentoring participants will better understand how to effectively utilize bargaining styles to advance their career.

**Why I Love to Teach – Sometimes “Yes” and Sometimes “Not So Much”**

*Deborah Simpson, PhD, Aurora UW Medical Group; Kathryn Denson, MD, Medical College of Wisconsin; Edmund Duthie Jr., MD, Medical College of Wisconsin; Michi Yukawa, MD, MPH, San Francisco VA Medical Center; Rainier P. Soriano, MD, Icahn School of Medicine at Mount Sinai; Mitchell T. Heflin, MD, MHS, Duke University School of Medicine; Sandro O. Pinheiro, PhD, MA, MRE, Duke University Medical Center*

Teaching can be extraordinarily rewarding yet sometimes it can be crushingly painful. On top of these highs and lows, clinical teachers are being pulled in multiple directions by the ever changing clinical and educational contexts in which they teach: from medical student curriculum transformations, new ACGME milestones and Clinical Learning Environment requirements to escalating expectations for clinical revenue production and technology utilization (clinicians and teachers). Understanding what motivates (and demotivates) us as teachers can help us chart a path through this maze to sustain our joys and minimize the disincentives in teaching. This session will apply precepts from Social Determination Theory and the study of expertise to identify geriatric clinical teachers’ intrinsic motivations and address de-motivators.

**Writing for Publication in the Geriatric Literature**

*Barry D Weiss, MD, University of Arizona Center on Aging; David B Reuben, MD, University of California, Los Angeles; Deborah Simpson, PhD, Aurora Health Care & Medical College of Wisconsin*

This writing for publication workshop is designed for aspiring and novice authors (though appropriate for authors at any level). This session will focus on (a) how to conceptualize and write a paper for a professional publication, (b) what happens in the peer review process, and (c) how to revise a manuscript in response to critique provided by peer reviewers using a combination of interactive presentations and audience discussions. The goal is to provide sufficient information and the opportunity dialogue with experienced journal authors/editors to enable aspiring authors to successfully write for publication.
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<td>Audrey Chun, MD, Icahn School of Medicine at Mount Sinai; Heidi White, MD, Duke University School of Medicine; Franklin Watkins, MD, Wake Forest School of Medicine; Jessica Colburn, MD, Johns Hopkins University School of Medicine</td>
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<td>This interactive workshop is designed to help participants identify key components to successfully incorporating geriatrics into the electronic medical record (EMR). Using the Epic EMR as a model, learn through the experiences of organizations at different stages of EMR maturity.</td>
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<td><strong>Objectives:</strong></td>
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<td>1. Describe how imbedding geriatrics into an EMR can enhance care for older adults and your health system.</td>
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<td>2. List key steps to incorporating geriatrics care into an EMR.</td>
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<td>3. Prioritize elements of the geriatric assessment and care to incorporate in the EMR in the setting of limited resources.</td>
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<td><strong>Attaining Your Career Goals in Geriatrics: Applying Best Practices to the Critical Appraisal of Educational Scholarship</strong></td>
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<td>Timothy Farrell, MD, University of Utah School of Medicine; Deborah Simpson, PhD, Aurora UW Medical Group; Edmund Duthie Jr, MD, Medical College of Wisconsin; Mark A. Supiano, MD, University of Utah School of Medicine; Cherie Brunker, MD, University of Utah School of Medicine; Manuel Eskildsen, MD, MPH, Emory University School of Medicine; Kathryn Denson, MD, Medical College of Wisconsin; Katherine Anderson, MD, University of Utah School of Medicine; Shaida Talebreza, MD University of Utah School of Medicine, Sharon Levine, MD, Boston University; Rainier Soriano, MD, Icahn School of Medicine</td>
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<td>This workshop is appropriate for faculty at all levels, ranging from junior faculty wishing to understand metrics for evaluating scholarship, to senior faculty on promotion committees seeking to apply rigorous consensus standards for the evaluation of educators and their “products.” Of note, this workshop is not intended to demonstrate educational products, but rather to demonstrate and apply a systematic framework for the evaluation of educational scholarship. It is expected that participants will be able to immediately apply the approach learned during this workshop to their home institutions in several contexts ranging from faculty preparing educator portfolios and/or specific educational products (e.g., an assessment tool using the “Toolbox” metrics) to mentors supporting their junior colleagues’ preparation for promotion and/or letters of support.</td>
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<td><strong>Combined Geriatric-Pal Care Fellowship</strong></td>
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<tr>
<td>Helen Fernandez, MD, MPH, Icahn School of Medicine at Mount Sinai and Lisa Walke, MD, Yale University</td>
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<td><strong>How to Negotiate: I Want a Raise!</strong></td>
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<tr>
<td>Laurie G. Jacobs, MD, Albert Einstein College of Medicine &amp; Montefiore Medical Center and Carla J. Herman, MD, MPH, Department of Internal Medicine UNM Center on Aging</td>
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<td>Have you ever walked into a negotiation feeling anxious and unprepared or walked out feeling unsuccessful? Have you ever asked your supervisor for a raise? This workshop will heighten your knowledge of how negotiation is conducted and your skills and confidence in negotiation.</td>
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### New Tools for Incorporating QI/Patient Safety into Residency Training

*Kate Callahan, MD, MS, Wake Forest School of Medicine and Brijen Shah, MD, Icahn School of Medicine at Mount Sinai*

This session uses a combination of mini-lectures and interactive group learning to illustrate and apply QI tools to teaching and assessing the ACGME competencies of SBP/PBLI and incorporating QI and Patient Safety into the learning environment. The session will focus on using teaching tools that allow 1) immediate application of knowledge in a clinically based format and 2) allow for formative assessment and summative assessment around the ACGME competencies of SBP/PBLI. The clinical issue of an inpatient fall with a hip fracture in an elderly patient will frame the discussion for the activities.

### Practice Redesign

*David B. Reuben, MD, UCLA*

The goal of this workshop is to introduce the concept of practice redesign to improve the care of older persons. In the workshop, we will review several existing conceptual practice models including the Donabedian “structure-process-outcome” categorization, the Chronic Care Model, the ACOVE-2 practice redesign model, co-management using the UCLA Alzheimer’s and Dementia Care program and the STRIDE study as examples, and emerging approaches (e.g., improve sidelines, huddles, Scribes/Physician Partners). During the session, participants will be given an opportunity to craft their own practice redesign initiatives and share these with other attendees.

### Taking Your Institution’s IPE to the Next Level: Using the IPEC Competencies to Develop and Improve Interprofessional Education

*Carla Dyer, MD, University of Missouri; Kevin Craig, MD, University of Missouri; Rochelle Parker, MD, University of Missouri School of Medicine; Lisa Royse, Med, University of Missouri School of Medicine; Kristen Deane, MD, University of Missouri School of Medicine*

This workshop will provide participants with an opportunity to learn briefly about a range of learning strategies designed to complement one another and provide students with opportunities to develop their interprofessional skills. Examples from a wide range of learning modalities including: small group discussions, simulation, team based activities, journal clubs, and more will be discussed briefly to provide audience with ideas to apply at their own institution.

### Fundraising

*Jeff Williamson, MD, Wake Forest*

Fundraising is a skill that takes time to hone. Participants will learn the art and science of fundraising and discuss strategies that have worked.
**2014 Reynolds Grantee 12th Annual Meeting At-A-Glance**
**Aligning Geriatrics Academic Healthcare Initiatives**
**Monday, October 6 – Wednesday, October 8, 2014**
**Red Rock Casino Resort• Las Vegas, NV**

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<th>TIME</th>
<th>DAY 1: MONDAY, OCTOBER 6</th>
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<th>DAY 3: WEDNESDAY, OCTOBER 8</th>
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<td>7:00 – 8:00 am</td>
<td>Breakfast</td>
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<td>7:00 – 7:30 am</td>
<td>Breakfast [Voting for Product of the Year]</td>
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<td>8:00 – 8:30 am</td>
<td>Introductions and Overview</td>
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<td>Teamwork and Its Assessment</td>
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<td>Rani Snyder, MPA, DWRF</td>
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<td></td>
<td>Rosanne M. Leipzig, MD, PhD, Icahn School of Medicine at Mount Sinai</td>
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<td>GUEST SPEAKER</td>
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<td>Assessment of Interprofessional Team Work</td>
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<td>Robyn Tamblyn, BScN, Msc, PhD, McGill University</td>
<td>7:30 – 10:00 am</td>
<td>Sustaining Reynolds Initiatives Through Alignments with CLER and Patient Safety/QI</td>
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<td>GUEST SPEAKER WITH BREAKOUT SESSIONS</td>
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<td>8:45 – 10:00 am</td>
<td>Ice Breaker: Speed Dating</td>
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<td>Multi-source Feedback: The Teamwork Effectiveness Assessment Module</td>
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<td>Benjamin Chesluk, PhD, Clinical Research Associate ABIM</td>
<td>7:30 – 8:15 am</td>
<td>Leveraging the NAS</td>
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<td>Lynne Kirk, MD, University of Texas Southwestern Medical Center</td>
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<td>10:00 – 10:15 am</td>
<td>Morning Break</td>
<td>10:45 – 11:00 am</td>
<td>Move Along Break</td>
<td>8:15 – 10:00 am</td>
<td>Sustaining Education Initiatives After Reynolds with Breakout Sessions</td>
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<td>10:15 – 12:00 pm</td>
<td>KEYNOTE ADDRESS</td>
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<td>Geriatrics in the 21st Century: Obsolete or Mainstream?</td>
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<td>Mary Tinetti, MD, Yale University School of Medicine</td>
<td>11:00 – 12:00 pm</td>
<td>Faculty Development Workshop Sessions</td>
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<td>12:00 – 1:00 pm</td>
<td>Lunch</td>
<td>12:00 – 1:00 pm</td>
<td>Meet the Professors Lunch (box lunch)</td>
<td>10:00 – 10:30 am</td>
<td>Wrap Up</td>
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<td>[Product of the Year Winner Announced]</td>
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<td>1:00 – 1:15 pm</td>
<td>Move Along Break</td>
<td>1:00 – 3:00 pm</td>
<td>Geriatrics Academic Programs: Small Group Problem-Solving</td>
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<td>David Reuben, MD, UCLA Medical Center</td>
<td>10:30 am</td>
<td>Box Lunch</td>
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<td>1:15 – 2:15 pm</td>
<td>Faculty Development Workshop Sessions</td>
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<td>Move Along Break</td>
<td>3:15 – 4:15 pm</td>
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<td>2:30 – 4:00 pm</td>
<td>GUEST SPEAKER WITH BREAKOUT SESSIONS</td>
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<td>The Interface between Geriatrics Medical Education and Models of Care</td>
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<td>Michael Malone, MD, Aurora Health Care and the University of Wisconsin School of Medicine and Public Health</td>
<td>6:00 – 7:00 pm</td>
<td>Reception</td>
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<td>4:00 – 4:15 pm</td>
<td>Move Along Break</td>
<td>7:00 – 9:00 pm</td>
<td>Dinner</td>
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<td>4:15 – 5:15 pm</td>
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<td>5:15 – 6:15 pm</td>
<td>Cocktails and Mingling</td>
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<td>6:15 – 8:15 pm</td>
<td>FD-AGE Schools Meeting</td>
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This project book contains the activity summaries of Cohorts I, II, III, and IV under the Reynolds grant.
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Medical College of Wisconsin

In May of 2001, the Medical College of Wisconsin (MCW) was awarded a grant by the Donald W. Reynolds Foundation. The project, “Comprehensive Program to Strengthen Physicians’ Training in Geriatrics” began on July 1, 2001 and continued through June of 2005. The program was a collaborative effort among several MCW departments, offices and centers including the Departments of Medicine, Family and Community Medicine (Center for Healthy Communities), and Psychiatry, the Division of Geriatrics and Gerontology and the Office of Educational Services.

Our Comprehensive Program to Strengthen Physicians’ Training in Geriatrics has achieved its original intent to support interest and training in geriatric medicine from the earliest years in medical school through the existing senior faculty. Student interest has been aroused and large numbers of preclinical students have been stimulated to anticipate geriatric curriculum and to look for geriatric issues in their courses, clerkships and patients. A complete set of virtual patient CDs has been completed and faculty have been engaged in the development process as well as the dissemination. These teaching CDs have been disseminated to medical educators nationally. Medical student assessment in required clerkship experiences now includes an emphasis on geriatrics. A unique medicine geriatric residency has been created, a curriculum developed, and resident trainees enrolled. Graduates are transitioning to practice and/or to additional subspecialty fellowships with 7 physicians currently enrolled (July 2014). The program continues after a decade and typically graduates 2 fellows per year. Four junior faculty scholars are continuing careers in academic geriatrics and making significant contributions as clinician educators.

The MCW Reynolds award has helped lever other important geriatric initiatives at MCW. These include the inception of a M1 Senior Mentor experience, a M3 option in internal medicine for M3 students to complete their medicine requirement in a geriatric setting (24/yr), participation by Reynolds faculty in the M4 “Preparing for Internship” class that is subscribed by 80+% of the graduating senior class, the funding and completion of a Hartford/SIGM award developing links between geriatric medicine and general internal medicine, an internal medicine resident community service project developing physician skills as patient educators, a web based curriculum in geriatrics for family medicine residents, the successful funding of 2 Geriatrics Academic Career Awards (GACA), the development of a set of Virtual Objective Structured Clinical Examinations (V-OSCEs). These projects were all separate from the original Reynolds Award, but reflect the synergy that developed through the MCW Reynolds Program. In some cases, extramural funds from foundations, both local and national, and public granting agencies were obtained to move these efforts forward.

In 2010 MCW received a “Next Steps” Reynolds Award. The focus was on hospital based specialist and subspecialist education. The first prong has been employed to achieve the goals of improving physician knowledge and practice in geriatrics. This prong has been forming Geriatric Education Teams (GETs). These teams consist of geriatricians, specialty/subspecialty faculty, subspecialty residents/fellows, medical students and a medical educator. Each GET performs a needs assessment and then develops a curricular intervention that will advance the care of elderly patients by the specialists/subspecialists. Curricular interventions are varied and have included gaming, team based learning, case based learning, and online learning. Other activities by the GETs have included activities such as OSCE development and use. The second prong has been the development of Geriatric Fast Facts (GFFs) http://www.mcw.edu/Geriatric-Fast-Facts.htm MCW began the successful End-of-Life / Palliative Education Resource Center (EPRC), Palliative Fast Facts. Using this template, the GET teams developed concise, easy-to-read contemporary summaries of geriatrics issues in medical care. All are formatted in the same way and are designed for point of service reference. With migration to smartphone use, the GFFs have been modified from their original format so that they can be accessed and read on a handheld device.

MCW remains committed to the goal of geriatric medical education. We believe that with aggressive efforts in “geriatricizing” medical education through strategic collaborations within the Medical School, will improve care for the geriatric patient.
The first Reynolds grant was successful in greatly expanding geriatrics curriculum at the medical student, residency, faculty and continuing medical education levels. In 2004, Geriatric Medicine officially received full Department Status within the medical school. With the Reynolds Next Steps grant, we continue to make great progress towards the long-term goal of infusing and sustaining principles of interdisciplinary team (IDT) geriatrics into every level of medical education, incorporating culturally competent IDT geriatrics principles into all four years of medical student training, every targeted residency program (IM, FM, OB-GYN, Psychiatry, General Surgery, Orthopedic Surgery and Pediatrics) and fellowship program (Geriatric Psychiatry, Addiction Psychiatry and Cardiology), and providing innovative IDT CME for practicing physicians.

Major Accomplishments in New Educational Techniques and Methodologies Developed:

- Fourth-year medical student 4-week required clerkship in Geriatric and Palliative medicine — students are presented with the importance of interdisciplinary collaboration for effective and safe geriatric care by streamlining and incorporating the Geriatric Interdisciplinary Care Summary (GICS) framework into all seminar sessions. This curriculum was presented at the Annual Reynolds Grantee Meeting in San Diego in October 2013. We have collaborated with geriatricians at the Rowan School of Osteopathic Medicine (formerly UMDNJ) who applied for and received Reynolds Next Steps funding to incorporate the GICS for training in IDT care.

- Two new SP-IDT cases were developed and implemented and provide a good tool to evaluate clinical skills related to IDT care. The second of these cases includes a Standardized Interdisciplinary Team Meeting (SIDTM). These cases have been validated, are posted on POGOe (ID#21248 and 21230), and have been published in JAGS.

- The WISH (Wellness Initiative for Seniors in Hawaii) Program is currently in its fourth year and is run by 3 to 5 motivated medical students. The program exposes students to IDT geriatrics early in their careers, creating a cadre of students in the school who show great potential for leadership and help to recruit other students for aging related activities.

- The Nursing Home Medical Directorship Curriculum provides training to geriatric medicine fellows on the basic roles and responsibilities of a nursing home medical director, as well as effective attitudes, skills and teamwork. Faculty were invited to present at an all-day pre-conference workshop at the Annual AMDA 2014 meeting in a session entitled “Teaching Medical and Interprofessional Learners in the Nursing Home: Overcoming Barriers and Changing Attitudes.” The curriculum is posted in POGOe (ID# 21255) and has had two publications in JAMDA.

- The Nursing Home On-Call Role Playing Curriculum has been disseminated via POGOe (ID# 20636) and has been requested over 40 times by various programs, and has also been published in JAGS.

- Training of Allied Health Professional Faculty at Kapiolani Community College continues to be viewed as an important resource to allied health faculty for geriatrics and IDT curriculum development. The 12-week course will continue through the spring of 2015 and include off-island faculty via distance learning modes.

- Allied Health Professional Training in Nursing Homes (the Practice Improvement in Education PIE Project) was developed as a three part model of training for quality improvement projects in nursing homes. This PIE project focuses on depression. Part 1 involves educational inservices for frontline staff; Part 2 provides collaborative sessions for nursing home leadership; and Part 3 involves measuring patient outcomes.

Beyond Next Steps – Future Activities:

- In July 2013, we were awarded a new grant for the Chief Resident Immersion Training (CRIT) program, with the first CRIT held in May 2014. The second CRIT will be held in May 2015. The goals of CRIT are complementary to the Reynolds Next Steps grant and will provide more leveraging of resources within the John A. Burns School of Medicine, and allow the Department of Geriatric Medicine to continue in its efforts at providing relevant and sustainable training in geriatrics, while integrating geriatric training within all departments of the medical school. The DIO and Associate Dean for Medical Education have embraced
the CRIT, leading to the creation of a year-long “Chief Series,” for which the Department of Geriatric Medicine has been central.

- In response to national recommendations about the importance of IPE (inter-professional education), the University of Hawaii’s schools of medicine, pharmacy, and nursing have implemented collaborative learning experiences. In the past two years, this has involved 1st year students from the three schools in 3 day-long workshops (Inter-professional Communication, Patient Safety, and Clinical Ethics). This year, we are expanding this to third year-medical, advanced pharmacy and nursing students, and engaging them in simulation activities regarding discharge planning. Our Reynolds/geriatrics faculty are serving key administrative and practical roles in these IPE experiences, including case discussion modules and simulation activities.

**University of Iowa**

I. Medical Students:
   A. Development of a Student-led Geriatrics Interest Group: Activities focused on: 1) increasing student contact with geriatric faculty; 2) disseminating information to students about geriatric medicine careers, 3) organizing educational presentations by experts in geriatrics; and, 4) completing community service projects with long-term care facilities.
   B. Increase Geriatric Content in the Preclinical Curriculum: New lectures by geriatrics faculty encompassed the diversity of aging, biology of aging, physical examination of the elderly, medications in the elderly, utility of functional assessment, and rewards and challenges of caring for people with chronic disease.
   C. Inculcation of Geriatrics Content into a Rotation in Ambulatory Medicine for 3rd Year Students: This curriculum included 2 half-days of concentrated geriatrics content and was delivered through lectures, gaming (Geriatric Jeopardy), small group learning, computer-based instruction, and simulated patients. Activities expose students to effective role models, principles of geriatric care, interdisciplinary team work, geriatric syndromes (falls, depression, delirium, failure to thrive), and importance of community resources.

II. Primary Care Residents:
   A. 2-week Rotation for Internal Medicine Residents: This rotation integrates experiences in outpatient multidisciplinary evaluation and inpatient consultative geriatrics that teaches the challenges posed by the inpatient management of geriatric syndromes. The inpatient rotation also includes an evidence-based curriculum that encompasses such topics as polypharmacy, delirium, falls, use of restraints, nutrition (and malnutrition), constipation, and functional impairment.
   B. Long-term Care Workshop: The workshop, which was integrated into the Internal Medicine Ambulatory Block Curriculum involves a half-day session at a facility with both assisted living and skilled nursing unit and exposes residents to the spectrum of long term care, contrasts social and medical models of care, and reviews the role of physicians in long term care settings.
   C. Longitudinal Academic Nursing Home Rounds in Family Medicine: This experience encompasses the 3 years of training and combines precepting in nursing homes with weekly case discussions.

III. Subspecialty Residents
   Several pilot projects develop focused educational activities within individual residency training programs, including: a) Increasing Geriatric Expertise in Ophthalmology; b) Maximizing Educational Experiences in Geriatric Dermatology; c) Academic Detailing to Improve Narcotic Use in Postoperative Elders; d) Interactive Module for Improving Stroke Management in the Elderly in Neurology; e) Managing Geriatric Pain in Anesthesiology; and f) Curricula in Palliative Medicine and Hospice Care for Residents in Otolaryngology.

IV. Community Physicians
   A. Train-the-Trainer Program: This program trains community physicians who precept University of Iowa students and Family Medicine residents. The program 1) describes application of a brief functional evaluation framework for geriatric patients in a busy office practice; 2) provides strategies for incorporating brief focused geriatrics assessment education in the office; and, 3) identifies simple tools to assess patients and which can be easily conveyed to learners.
   B. Monthly Geriatric Lecture Series: This live tele-broadcast reaches physicians and nurse practitioners in over 40 hospitals throughout Iowa.

V. New Educational Techniques and Methodologies
A major success was the development of two computerized education products, which have been incorporated into several courses and rotations at the University of Iowa and which have been disseminated to other grantees. The first product (GeriaSims) is a set of 9 interactive, patient simulation modules on common geriatric syndromes that require learners to perform a virtual workup of a patient and make diagnostic and therapeutic decisions. Learners receive feedback about their workups and decisions, and can also get just-in-time instruction by asking questions to a simulated mentor. The second product (GeriaFlix) is a library of digitized lectures on 53 core topics that are delivered in a streaming audiovisual format with synchronized slides. Both products are available online through a University of Iowa website and on CD-ROM disks.

**University of Michigan**

The Medical School Curriculum Core’s specific goals for the entire project period were to:
1. Develop and implement a Geriatrics Portfolio encompassing the core competencies in geriatrics that every graduating medical student will be expected to have mastered.
2. Develop and establish innovative pre-clinical and clinical experiences to expand and enhance the existing curriculum and coordinate their implementation. The integrated four-year curriculum will provide opportunities to develop the proficiencies included in the Portfolio.
3. Work with the Evaluation Core to evaluate at specific intervals medical students’ attitudes, knowledge, and skills needed to care for older adults and to assess the learning environment and teaching methods developed within this curriculum.

The goal of the Faculty Development and House Officer Cores was to develop sustainable geriatrics teaching programs in residencies and fellowships that currently include little or no training in geriatrics. Targeted programs were all house officer programs in Surgical Specialties and Medical Subspecialties at the University of Michigan.

**Major Accomplishments and Impact—Medical Students**

**Goal 1. Develop and implement a Geriatrics Portfolio**

This goal was successfully accomplished largely by means of the web-based Geriatrics Portfolio. The published core competencies were indexed to specific activities in the curriculum as it existed at the beginning of the grant in 2001 and used to map attitude, knowledge and skill items to each of the four years. The portfolio was implemented with the M1 class that entered in August 2002. It evolved in parallel with this cohort with the subsequent year’s activities added as they advanced in their training. The Portfolio has been challenging to maintain and continuously update.

**Goal 2. Develop and establish innovative pre-clinical and clinical experiences**

In addition to the portfolio, the other major new pre-clinical experience was the Geriatric Functional Assessment (GFA) Standardized Patient Instructor (SPI) module for medical students. The GFA SPI experience was created as an educational exercise emphasizing functional status assessment and communication relevant to the care of older patients. In close collaboration with the House Officer Core and aided by the strong existing UM Standardized Patient program, we wrote the materials for the case, instructions for the Standardized Patient, a learner packet for the students and the evaluation instruments. The case was successfully pilot tested and subsequently all 170 M1 students completed the exercise in April 2003.

A modified GFA SPI was incorporated into the Comprehensive Clinical Assessment (CCA) that was administered to all beginning fourth year medical students in July 2004 (Class of 2005). This station requires that students demonstrate their competence using standardized assessment tools (ADL and IADL function, cognitive screen and gait evaluation) to determine whether the patient they are evaluating requires additional assistance in their home environment or if alternative placement arrangements need to be made. The results from the Class of 2005 were used to establish the minimum passing standard for the class of 2006 when a passing grade was required. As a consequence, a passing performance on the GFA station is required for graduation.

The new clinical experiences focused predominantly on the M3 year and in the Internal Medicine clerkship. The overall goal of the medical student clinical geriatrics curriculum is to provide the foundation of attitudes, knowledge, and skills for competent, compassionate care of older patients. These experiences offer hands-on opportunities to reinforce the basic elements of geriatric assessment the students learned in their SPI as M2 students. These activities include:

- Geriatrics Attending Chief Rounds occurs for all M3 students during their month-long inpatient experience at the VA Ann Arbor Healthcare System (three sessions per month).
Major Accomplishments and Impact-Faculty Development Core (Faculty Trainees)

Established Core Faculty to support Lead Faculty in surgical specialties and medical subspecialties. A cadre of nine geriatrics-trained faculty served multiple functions in supporting Lead Faculty, including clinical co-rounding, teaching, lecturing, and one-on-one counseling and lecture preparation. Disciplines included general geriatrics, social work, pharmacology, psychiatry, neurology, cardiology, gastroenterology, and nephrology.

Recruitment of Lead Faculty. A total of 21 faculty from 16 Departments or Divisions received training in geriatrics and implemented teaching reforms. Fifteen of these faculty from 12 Departments or Divisions participated fully in a 9-month series of weekly two-hour Faculty Development seminars that focused on clinical geriatrics, teaching, and curriculum development.

Faculty Development Seminars. In the seminars, Lead Faculty met weekly in stable small groups of 4-6. Content areas included clinical geriatrics, teaching skills, and curriculum development. Lead Faculty were also coached in completing a needs assessment that included a literature review, contacts with peer faculty at other institutions, and facilitating a focus group with their own learners. In addition, seminars were devoted to practice presentations with feedback by Lead Faculty, mutual problem solving among Lead Faculty, and special topics (e.g., Evidence Based Medicine). Core Faculty led in-depth discussions of key topics – dementia, delirium, depression, medication prescribing, and pre-operative assessment and hospital management of older patients.

Standardized Patient Instructor (SPI). An SPI focusing on functional assessment of older patients was developed under the Reynolds project, and implemented in eleven of the participating departments. Lead Faculty facilitated all aspects of the SPI implementation in their own department, including a pre-encounter lecture on assessment, arranging the (sometimes formidable) logistics of getting house officers to the Learning Resource Center, and debriefing house officers after the encounter.

Evaluation. Lead Faculty facilitated implementation of written evaluation of learners’ attitudes and clinical knowledge in the care of older patients. As far as possible, assessments were carried out before and after implementation of a new teaching in the care of older patients and the SPI encounter.

Major Accomplishments and Impact-the House Officer Core

Under the Reynolds Project a total of 474 house officers have experienced new educational experiences in the care of older patients, facilitated by Lead Faculty trained through our Faculty Development Program. This includes house officers from all years of training who were affected during the funding period. Going forward, an estimated 93 new house officers each year will be affected by some aspect of education in the care of older patients implemented under the project. An estimated 60 lectures on geriatrics topics were delivered by Lead Faculty to house officers from all years of training who were affected during the funding period. Clinical teaching focusing on the care of older adults, while impossible to quantify precisely, is occurring regularly in all participating departments and divisions.

Several new educational techniques and methodologies related to Graduate Medical Education were developed.

UM Geriatrics Clinical Decision Making Assessment Instrument A 20-item multiple choice assessment of geriatrics clinical knowledge developed over two years during the funding period. The instrument is now available without charge on POGOe (www.pogoe.org) and at www.med.umich.edu/geriatrics/educationalprograms/gme.htm.

UM Geriatrics Resources and Assessment Tools Website and Geriatrics Teaching Resources Warehouse Website The websites provide Lead Faculty and non-primary care clinicians at the University of Michigan with teaching resources and information on local clinical and social service resources relevant to the care of older patients, clinical assessment of older patients using appropriate screening tools, and links to additional sites.

Learning Packet on Geriatric Assessment and Pocket Card on Geriatric Pharmacology These two learning resources were distributed to all participating UM programs. In addition, they were accepted for inclusion on the Portal of Geriatrics Online Education (POGOe), and are available at www.pogoe.org

References:

University of Nebraska

This project focused on six target groups: medical students, primary care residents, surgery and anesthesia residents, practicing physicians and faculty in primary care, surgery, and anesthesia. The results of this project are summarized by citing major activities for each target audience.

1. MEDICAL STUDENTS:
   a. Aging Interest Group (AIG): Organized in 2001 as a student led organization, the AIG is a student chapter of the AGS. Activities include 4 large meetings/year; officer meetings 5 times/year; Images of Aging Photo Contest/year; end of the year party; students invited to grand rounds events; the Senior Companionship pairs a student with an older person to learn geriatrics beyond the classroom; outstanding student awards/year. In 2007 this became an interprofessional group engaging nursing, physical therapy, pharmacy, nursing, PAs in addition to medical students.
   b. Summer Externship: 32 students out of 72 applicants accepted in years 1-4. Activities include: Orientation by a geriatrician; shadowing on home visits, hospital rounds, nursing home rounds, outpatient continuity and assessment clinics. Other activities include visits to adult day care, adult protective service, and hospice house. A physician mentor is assigned to each student; all attend didactic lectures, and complete a living history project. Under the grant, students received stipends; without stipends, students elect this experience with one rotating every 3 weeks throughout the summer.
   c. M-1-M4: Aging and Integrative Medicine track: In 2009, the Division of Geriatrics participated in a new medical student initiative whereby specialty areas provide students the opportunity to participate in focused training by developing the Aging and Integrative Medicine Track. According to a recent issue of Academic Medicine (16). UNMC is only one of four medical schools in the US offering this kind of focused academic work in aging. Students are accepted in the second half of the first year and commit to study geriatrics throughout all four years and complete a capstone project by the fourth year. There are currently seven students enrolled in this program, we anticipate enrolling 3-4 students per year, so that when there are students enrolled in all four years there will be 12-16 students in this program. These are our student leaders.
   d. M-3: Geriatrics Selective. Geriatrics became a selective in the Internal Medicine Clerkship and we instruct approximately 14 students/year in this program.
   e. M-4: Senior Seminars. In December 2009, UNMC launched mandatory training for all fourth year medical students utilizing a seminar format. These seminars provide information and training on topics that students and faculty felt were needed before graduation. Geriatrician, Dr. Ed Vandenberg was selected to direct the newly required Senior Seminars for medical students. Some seminars are required (e.g. Palliative and end-of-life care) and others are elective (e.g. Rehabilitation and Nursing-home-care). All three of these seminars are taught by geriatricians in Internal Medicine and Family Medicine and two of the three include instructors from other disciplines.
   f. M-4: Geriatric Medicine Sub-internship for fourth year medical students was developed: 6 students participated in 2004-2005. Since 2006, 19 students have electing this experience. In the last 5 years faculty have made 10 presentations at national meetings related to medical student education.
   g. 2009-2010 Curriculum Review. The last year saw a curriculum review to align the M-1-M-4 experiences with the AAMC competencies. This resulted in planned and implemented updates to the curriculum in each of the years. Medication management was seen to be a deficit in the curriculum. As a result a
new didactic and small group session was developed and delivered for 2nd year students during the required core geriatric series. The M3 curriculum added a new geriatric case study to the internal medicine rotation on urinary catheters, pressure ulcers, and delirium. The fourth year curriculum added a required 2 ½ day senior seminar on “End of Life and Palliative Care” and a selective seminar on “Nursing Home Care and Rehabilitation”.

2. INTERNAL MEDICINE AND FAMILY PRACTICE RESIDENTS:
   a. Five of the 6 primary care programs in the State were targeted to increase the amount of geriatrics taught in the curriculum. Activities were tailored to meet individual program needs. A common activity was a Geriatrics orientation for incoming HOs, which included a lecture on delirium, introduction to Geriatrics at Your Fingertips and to our website. At UNMC-IM training includes: Geriatric Acute Care, a service for hospitalized elders whose primary providers are faculty within the Geriatric Section; Home care training: each resident makes at least one home visit on a discharged patient; longitudinal nursing home elective for UNMC-IM fourth residents started in July of 2006. For Clarkson FP activities: home care and nursing home rounds under the supervision of a Reynolds faculty development participant. Residents attend GAC clinics during their 3rd year and UNMC geriatrics faculty present a didactic series every 18 months. UNMC-FP: Rural Training Track residents, nursing home rounds educational materials, and end-of-life lectures or symposium. Geriatric mini-fellowship telecast to sites for residents and faculty. UNMC Family practice residents complete a required longitudinal and block rotation, and a number elect an additional block rotation with geriatrics internal medicine faculty. Creighton residents work with UNMC geriatrics faculty at the VA and some elect an additional rotation at UNMC. The Lincoln Family Medicine residents have longitudinal training in outpatient and inpatient care with a Reynold’s trained faculty member who also and in the last year those interested in geriatrics as a focus have come to Omaha for training on the inpatient geriatric service at UNMC. In the last 3 years, 5 of UNMC’s 6 geriatric medicine fellows have come from these affiliated programs and a 6th fellow from our programs was placed in a Texas fellowship program.

   b. The UNMC Residency Programs activities under Reynolds largely focused on IM and FP. This target group activity was expanded with a two-year funded Hartford-American Geriatrics Society program, Chief Resident Immersion Training (CRIT) for Chief Residents in Emergency Medicine, Neurology, Neurosurgery, Psychiatry, Orthopedics, ENT, General Surgery, and Urology. Beginning in 2010, CRIT training is being continued with support from the participating departments and UNMC.

3 & 4. SURGERY AND ANESTHESIA:
   a. Both departments were engaged in faculty and curriculum development. They held joint geriatric grand rounds and participated in a quality improvement project. Geriatric 6-hour surgery lecture series and anesthesia lectures are presented to residents every 18 months. Web-based surgery resident modules on Post Operative Pain Management and Delirium are posted on the geriatric website and Post Anesthesia Care Unit (PACU) Modules: Web-based interactive modules residents are required to complete all 5 during PACU rotation. M-3 modules on Delirium and Pain are used by 3rd year surgery students. M-4’s on anesthesia rotation complete preoperative evaluation, and care guidelines module, and attend a lecture on geriatric anesthesia.

   b. In 2006-2007, Emergency medicine and geriatrics completed a Hartford funded project (Geriatrics for Specialty Residents) which developed and implemented a curriculum for residents. 

   c. In 2008, UNMC obtained funding from the Hartford Foundation for a Chief Resident Immersion Training (CRIT) project. During the meeting on 6/6-6/8, 16 chief residents from surgery, anesthesia, otolaryngology, internal medicine, family practice, orthopaedics, neurology, emergency medicine and neurosurgery participated along with 6 geriatric medicine faculty and 5 program directors. Participant evaluations were positive, especially on the ability of CRIT training to increase appreciation of the value of interdisciplinary team care for older people (score=4.25, agree (4) to strongly agree (5)). Beginning in 2010, CRIT training is being continued with support from the participating departments and UNMC.

5. PRACTICING PHYSICIANS:
   a. 2001-2006: The EPEC curriculum was taught in collaboration with medical education departments at hospitals across Nebraska. In years 3 and 4, faculty also taught in the Nebraska End of Life
Conferences, regional VA and College conferences, and the Department of Neurology. A Palliative Care Consult Team was formed at the Omaha VA, which is used as a teaching site for residents, fellows and medical students. Just under 2000 individual contacts occurred during the 4 years of Reynold’s funding.

b. 2005-2010: Outreach to practicing providers continued under the HRSA funded Nebraska Geriatrics Education Center (NEBGEC). Since 2004, the NEBGEC has had 5,243 participants in its online, live and clinical training. Forty-nine individuals have completed the IP 80 hour minifellowship, and an additional 106 are currently enrolled. Disciplines in these programs include medicine, nursing, pharmacy, social work; physical, occupational and speech therapies; and psychology. Since 2007, the NEBGEC has reached 37 sites across the 500 mile length of the state with 184 hours of live programming and a total of 20,887 contact hours of education on critical aspects of elder care. In addition to live programming, 40 online modules are available at [www.unmc.edu/cce/gec_modules](http://www.unmc.edu/cce/gec_modules) and almost all have also been posted to POGOE. To date, 953 online modules have been completed by learners. Also since 2007, the NEBGEC has held six 2-hr evening conference events which have had 1,832 participants at 16 sites across the state of Nebraska. NEBGEC holds an annual conference in Omaha and transmits to several sites across the state. In 2009, 245 learners participated in a 2 day conference “Frail Elderly & Geriatric Syndromes.” In 2010 The NEBGEC runs a long-term-care telehealth mental health series that targets nursing home providers in rural Nebraska. Since 2008, we have conducted 18 live lectures with telehealth transmission to 20 distance sites of which 15 are located in Medically Underserved Areas or Health Professional Shortage Areas. There were 417 contact person-hours of education delivered in this format that also included tools to facilitate practice change. Since 2005, we have had 602 “program completers” 40+ hours of educational programming, 484 learners complete 80+ hours of educational programming including students. We have had 147 healthcare practitioners, faculty, and other professional learners complete 40+ hours of educational programming, 74 healthcare practitioners, faculty, and other professional learners completed 80+ hours of educational programming.

6. FACULTY DEVELOPMENT:
   a. 2001-2006: This activity was key to seeing that the programs were continued after grant funding. Faculty development activities were conducted with Surgery, Anesthesia and the primary care programs. This included quarterly faculty development workshops; mentorship in curriculum development; website resource development and update; Journal Club; site visits; purchase and distribution of resources e.g. GRS and GAYF; support of faculty for travel to intensive geriatric study courses. Activities continue through the HRSA sponsored NEBGEC for faculty development and mini-fellowship training.
   
   c. 2005-2010: Faculty development under Reynolds focused on anesthesia and surgery, this was expanded under CRIT funding to include UNMC faculty from: Neurology, Psychiatry, ENT, General Surgery, Family Medicine, Internal Medicine, and Urology. Also faculty training with NEBGEC funded geriatrics minifellowships have engaged six additional primary care and psychiatry faculty. In 2006, a Reynolds collaborator in Surgery, Jason Johanning, received a Hartford AGS Surgical and Related Specialty Jahnigen Career Development award.

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**University of Rochester**

I. Medical Student Education

**The Aging Theme**

The Aging Theme is sustained at the University of Rochester School of Medicine and Dentistry. Dr. Suzanne Gillespie and Dr. Kristen Thornton now co-direct the Aging Theme and continue to oversee the integration of aging into the curriculum. The active Aging Theme Initiatives we have created as part of the Reynolds Grants are summarized below:

**Initial Reynold’s Grant:**

- **Problem-Based Learning (PBL) Cases:** We reviewed and revised the PBL cases to highlight pertinent geriatric issues and syndromes and identify those where aging learning objectives could be emphasized. The students participate in a new problem-based learning case each week.
• **An Introduction to Fitness Assessment:** First year medical students participated in a four-hour interactive session with geriatricians and older adult fitness participants from the Center for Lifetime Wellness at Monroe Community Hospital during their Ambulatory Clerkship Experience in prevention. The session focuses on the well older adult and ways to maintain activity, mobility and health.

• **Functional Assessment in Long-Term Care:** This two-hour workshop for 1st year medical students occurs on site at Monroe Community Hospital. Students receive didactic sessions on long-term care and functional assessment and then interview and assess patients in the nursing home setting. Geriatric faculty and fellows assist in the supervision of the students and lead a debriefing/wrap-up session at the conclusion of the workshop.

• **Home Visits: “Mi Casa o Su Casa?” Assessing Function and Values in the Home:** As part of the Ambulatory Clerkship Experience, all 100 of the medical students in the second year class participate in a series of three home visits that combined elements of geriatric assessment and palliative care. Older adult and chronically ill homebound patients were chosen by their ambulatory clinic preceptor. Students report their visits to their clinic preceptors and have a graded written assignment describing several aspects of their home visit.

• **Case Seminar in Aging/Case Seminar Series:** This course for 2nd year medical students was designed and implemented during the first three years of the Reynold’s grant.

• **Clinical Geriatrics Elective:** This 2 week rotation incorporates a variety of clinical sites including Monroe Community Hospital, VA medical system, and Highland Hospital. This rotation provides exposure to older adults in multiple care settings and provides supervision and mentoring by clinical and academic geriatricians.

• **Emergency Department Management of the Geriatric Patient:** An Educational Model for Medical Students: As part of a required Emergency Medicine rotation, 3rd and 4th year medical students complete a functional assessment on several geriatric patients in the emergency department (ED). The assessment consists of a brief geriatric screen, which addresses activities of daily living, geriatric syndromes and review of systems, social supports, polypharmacy, elder abuse and vaccination history. Students then complete a follow-up phone questionnaire on discharged patients to assess medical and social issues relevant to the ED visit. This model has been published in manuscript form in the Journal of the American Geriatrics Society.

• **Adult Inpatient Medicine Clerkship:** Highland Hospital is home to Rochester’s ACE Unit. Medical students rotate through this unit, which demonstrates an interdisciplinary approach to hospitalized older patients. Geriatrics faculty provides supervision and teaching on this unit.

• **The Aging Interest Group – Student Chapter of AGS:** sponsors educational initiatives, patient care delivery forums and community outreach.

**Next Steps Grant:**

• **Initial Integration Conference:** Introduces Aging Theme and interviews an older adult highlighting geriatric syndromes, caregiving and the patient-physician relationship during 1st week of medical school.

• **Geri-Anatomy:** Based upon the model from other Reynold’s funded universities, Geriatricians and Hospitalists review PE findings on cadavers and link to prior functional status during an anatomy lab session.

• **Skills in Complete Patient Evaluation (SCOPE)** allows students to practice the complete history and physical examination on patients across the lifespan in a variety of care settings. This required course for first-year medical students includes patient interactions on inpatient hospital wards, rehabilitation units and in nursing homes. For the first time in URMC history, each medical student will spend four half-days in a community nursing home working with a Geriatrician preceptor. The course also teaches several new geriatric topics, and assures competency-based training in geriatrics for all students.

• **Elder Abuse Self-Study** for first year medical students
- **Functional Assessment and Quality of Care in Nursing Homes**: Case-based/ team based learning experience for first year students. Includes pre and post exam, mini-lectures on Quality of Care in Nursing Homes and Geriatric Assessment and team based evaluation of local nursing homes quality measures and five star ratings.

- **Issues in Mobility: Gait, Falls and the Musculoskeletal Exam**: Lectures on gait from a physical therapist and the Limping Adult from an orthopedic surgeon with case review and small group orthopedic faculty facilitated exam of hip and knee.

- **Approach to Memory Loss**: A geriatrician’s approach to memory loss conference for 2nd year medical students includes lecture and patient / caregiver interview.

- **Aging with a Chronic Disability**: Life history review presented to first year students by an older adult with cerebral palsy.

## II. Resident Education

- Interdisciplinary and Subspecialty Geriatrics Lecture Series

- **Hospital to Home Program**: In the Hospital to Home Program, first year internal medicine residents comprehensively assess an older person in the hospital immediately prior to discharge with an emphasis on functional status, medications and discharge planning. The session is videotaped by a Biopsychosocial Fellow and then shared during a noon teaching conference. This model of teaching discharge planning has been extremely successful, and our trigger tapes are disseminated and used nationally by other medical centers.

- **The Aging Interest Group – Resident Chapter of AGS**: This new chapter is attempting to span subspecialties and be inclusive of all GIMME retreat attendees and all GPS teams. The AGS Resident Chapter works conjointly with the AGS Student Chapter to sponsor educational initiatives, patient care delivery forums and community outreach.

- **Lecture series and case based education** has been developed for subspecialty residents in Orthopaedics, Physical Medicine & Rehabilitation, Emergency Medicine, Ophthalmology and Neurology.

## III. Hospitalist and Subspecialist Education – Next Steps Grant

We developed a comprehensive, evidence based educational program that integrates high quality geriatric care into the daily practice of the Hospitalist Group at Highland Hospital.

### Hospitalists

- **Case Based Education Sessions**: These are mandatory monthly conferences where Hospitalists present cases to geriatric syndromes and older adult care issues. Given that all of our Hospitalists are internal or family medicine trained, we track the competencies for internal and family medicine residents as training tools for the Hospitalists. The Hospitalists then teach these same core education principles to internal and family medicine residents and students on the wards and at teaching conferences at HH.

- **Hospital to Home Videotaping**: Building on the success of our Hospital to Home videotaping model, we initiated Hospitalist involvement in this program. The videotape and discharge follow-up is shared with the Hospitalist faculty at the noon conference and with residents at the monthly Hospital to Home conference.

- **Donald W. Reynolds Faculty Scholars**: A Donald W. Reynolds Faculty Scholar Award is presented to 1-2 faculty annually who develop high quality projects or show exemplary participation in the Reynold’s Grant activities.

- **Hospitalist Survey**: A survey of the hospitalists was developed and administered in Year 1 of the grant. This data was recently published in a manuscript entitled, “Geriatricizing” Hospitalists: Identifying Educational Opportunities” in Gerontology & Geriatrics Education..

### Subspecialist Education
We established Geriatrics Practice Partnerships with Subspecialists (GPS) as a collaborative team learning process targeting Orthopaedics, Physical Medicine & Rehabilitation, Emergency Medicine, Ophthalmology and Neurology.

- **Challenge Grants** have been awarded to each Subspecialty department, with funding included for the junior faculty member of each GPS team who is developing an educational initiative with support and oversight from the Geriatrician and senior faculty mentor. The challenge grant is designed to allow the junior faculty participant to develop expertise in a focused geriatric area that can serve as a venue for education and patient care delivery improvement. The junior faculty participant also provides mentorship to the chief residents and residents. The residents are responsible for developing a sustainable geriatric education project within their department for the other residents and medical students.

- **Examples of Challenge Grant Educational Products**
  - **Stroke Simulation Exercise:** A novel simulated patient program to improve acute stroke care and education was designed, pilot tested, and implemented for all neurology residents. The program begins with collection of background data and critical analysis to identify areas of focus. Exercises involve counseling of an acute stroke victim’s spouse on the nature of the diagnosis, expected outcome, and risks/benefits of acute stroke treatment. Following the exercise, residents undergo an extended debriefing component, during which residents are required to watch videos of their sessions and undergo a self-assessment to identify strengths, weaknesses, and areas of improvement.
  - **Home to Hospital Trigger Tapes:** Building on the success of our Hospital to Home model of teaching discharge planning to internal medicine residents, we created new trigger tapes for subspecialists entitled, Home to Hospital. Rather than participating in a videotaped home visit on a recently discharged acute hospital patient, we instead chronicled the hospital course of older adults admitted with hip fractures. The chronology begins in the emergency room with physician to physician interviews, and then continues to the operating room, acute hospital ward, and then to the skilled nursing facility or inpatient rehabilitation unit for rehabilitation. This hands-on experience showcases the challenges and potential adverse events that many older patients must overcome as they negotiate the healthcare system. This experience stimulates reflection and practice change for residents and practicing physicians as the videotapes are being used nationally and internationally.

**Cross-Discipline Experiences:** We created cross-discipline collaborative education experiences to link both groups of Hospitalist and Subspecialist learners.

- **Medical Student Preceptorships and Small Group Facilitation:** Subspecialty and Hospitalist participants are now serving as preceptors or small group facilitators during a new medical student course. Skills in Complete Patient Evaluation (SCOPE), includes student exposure to geriatricians in nursing homes, hospitalists on acute hospital wards and physiatrists on acute rehabilitation units. This course is a natural fit for the residents and faculty to precept students on rehabilitation units and in the acute hospital. Having Subspecialty and Hospitalist preceptors who are able to reinforce geriatric principles with medical students is a powerful tool in the wide dissemination of competency-based geriatric education as part of the Aging Theme impacting all 104 first year students.

- **AGS Resident Interest Chapter:** The URMC Division of Geriatrics & Aging recently established an AGS Resident Interest Chapter. This new chapter is attempting to span subspecialties and be inclusive of all GIMME retreat attendees and all GPS teams. The AGS Resident Chapter works conjointly with the AGS Student Chapter to sponsor educational initiatives, patient care delivery forums and community outreach.

- **Ger - E- News:** This email news blast is sent bimonthly to all Reynold’s Grant Subspecialty and Hospitalist participants at URMC. These newsletters focus on geriatric syndromes, clinical pearls and teaching tips. They expand and reinforce geriatric knowledge, and act as an additional point of connection with the Reynolds grant participants.
• **Geriatric Immersion Experience (GIMME):** Rochester was a participant in the highly regarded Chief Resident Immersion Training (CRIT) National Dissemination Project from 2007-09. We took the original CRIT program and incorporated aspects of University of Chicago's CHAMP program to develop the Geriatric Immersion Experience (GIMME) designed for hospitalists, medical and surgical subspecialists and their respective chief residents and residents. Core themes of frailty, palliative and end of life care and managing transitions of care are covered for this multispecialty audience over three evenings in the course of a year. Participants include residents, chief residents, hospitalists, fellows, subspecialists, students, geriatricians and nurse practitioners. Activities have included lectures, case reviews, mentor ‘speed dating’, geriatrics learning games, practice based learning improvement exercises and challenge grant/hospitalist progress reports/presentations.

**University of South Carolina**

**Faculty, Fellows and Resident Education**

A. **Dean's Faculty Scholars in Aging (DFSA):** The cadre of 32 clinical faculty served as a nucleus for expansion of geriatric capabilities beyond the core of faculty in the Division of Geriatrics and its related clinical components. The scope of the DFSA program went well beyond faculty development and raising awareness in non-geriatrics clinicians: the intent was to develop "geriatrics-oriented" clinicians in targeted clinical departments. The depth of scholar engagement varied: in several cases clinical faculty who began as scholars eventually entered and completed the geriatrics fellowship program. Many of the DFSA faculty went on to positions of authority within their specialty at the University of South Carolina and elsewhere. These relationships served as a foundation for the USC-Palmetto Health Next Steps Reynolds grant.

In most cases faculty members chose a focused series of projects both to increase their knowledge and skills in geriatrics relating to their specialty/clinical practice, and to extend these new capabilities into teaching at the undergraduate and graduate level.

B. **DFSA Evaluation:** During the final year of the original Reynolds grant the Division of Geriatrics engaged Dr. Sarah Laditka, Professor, Arnold School of Public Health to conduct an evaluation of the DFSA program. Dr. Laditka conducted extensive interviews with scholars and department chairs to consider the impact participation in the DFSA program had on scholars, their clinical teaching, and professional activities related to geriatrics. She found 36 new geriatric experiences have been developed, 29 of the 36 were implemented, and 11 of the 36 were evaluated. Experiences included an elective for residents in the care of older patients in the emergency room and a required hospice rotation in the psychiatry clerkship for third-year medical students. All scholars developed a personal geriatrics educational experience, and most implemented one.

C. **On-going Institutional Commitment to Faculty Development:** It seems safe to assume that a geriatrics focus will continue to be highlighted in faculty development for the School of Medicine, University of South Carolina. The Director of Faculty Development for the School of Medicine is a geriatrician who trained in the division's fellowship program early in the Reynolds grant period.

D. **Establishment of geriatrics core faculty at Greenville Hospital System:** A DFSA and a graduate of the division's fellowship program was in place at Greenville Hospital System to begin focusing upon geriatrics content for medical students from the USC School of Medicine and in the residency programs of Internal Medicine and Family Medicine. The Hospital system embraced the idea of developing an core geriatric expertise at GHS.

**Resident Training**

One of the major characteristics of graduate training is the development of a geriatrics "pipeline" of sorts: a high proportion of USC School of Medicine graduates, who have experienced a curriculum with extensive geriatrics content, enter the primary care and other residency programs at Palmetto Health Richland (PHR); in the PHR residency programs there is a relatively high proportion of geriatrics content as outlined in this report and the attached documents; and, a high proportion of the clinicians who enter the fellowship program of the Division of Geriatrics are clinicians who have either trained at Palmetto Health Richland or are teaching faculty in its clinical departments.
A. Six of the seven targeted clinical departments made substantial gains in the incorporation of geriatrics content – Emergency Medicine, Family Medicine, Internal Medicine, Psychiatry, Surgery, Gynecology. They continue to be closely aligned with the Division of Geriatrics in our Next Steps Reynolds grant.

B. Evaluation

Assessment and evaluation efforts were more prominent in PHR residency programs and in geriatrics education specifically. In June 2004 the Division of Geriatrics implemented its first Observed Skilled Clinical Evaluation (OSCE) in geriatrics education at the graduate level. This included two stations for incoming residents in the Emergency Medicine, Internal Medicine, Psychiatry and Surgery programs. Geriatric lecture series continues in the Internal Medicine residency program with frequent guest lectures in Family Medicine as well. As part of the Next Steps grant, a Delirium OSCE was developed and implemented for IM and FM residents in the PGY 1 and PGY 2 time frame.

C. Community Physician Education: The greatest headway in community physician education occurred with primary care physicians and surgeons. For twelve years the division has presented the Geriatrics Update for Primary Care Physicians and average attendance has been almost 270 physicians for the one to two day sessions. In this academic year, the program will change its name to “Late Life” conference and broadened the topics to a greater inter-professional audience. The impact of the Dept. of Surgery continues through the two major CME sessions offered by the Dept. of Surgery, the Sea Pines Surgical Update and the Annual South Carolina Surgery Update both have increasingly included geriatrics content and continue to the present day.

Undergraduate Medical Education

A. Vertical Curriculum: As a truly vertical curriculum geriatrics competencies and objectives have always been woven into and embedded in all of the pre-clinical courses and core clerkships of the School of Medicine, USC (with the exception of the pediatrics clerkship). This curriculum has been "mapped" and entered into a data base, entitled , which allows staff to monitor all aspects of that curriculum. At a minimum the AGS competencies were addressed in at least four lectures or small group discussions in each of the pre-clinical courses, but the course norm is closer to 12 sessions. The family medicine, internal medicine, Ob/Gyn, psychiatry and surgery clerkships include geriatrics modules with knowledge, skills and attitude objectives. With the addition of the AAMC minimum geriatric competencies and the interprofessional competencies, the curriculum has been re-mapped to these items. The geriatric elective present developed at the time of the original Reynolds funding has been joined by other opportunities. At present, we support an M3 one week elective, an M3 4 week required ACE unit elective, a 4 week M4 elective and a summer clerkship that is 8 weeks in the summer for rising M2 students.

B. Senior Mentor Program: Beyond the course and clerkship content USC medical students participate in a four year Senior Mentor Program (SMP) which matches students with a generally healthy older adult (age 75 or older) selected from the older population of the Columbia metropolitan area. The SMP allows the completion of additional geriatrics competencies and objectives as a parallel framework to courses and clerkships, (e.g. the completion of a home safety check for the mentors and a joint visit with mentors for a doctor's appointment). The USC SMP has received considerable local, regional and national recognition and press attention. The program won a South Carolina Hospital Association/SAGE Institute Geriatric Best Practices Award in 2004. The SMP is celebrating its 10th anniversary of the graduation of the first class of medical students that participated in all 4 years. Topics and assignments continue to be used and refined to stay relevant.

C. Evaluation: Earlier, four major components/approaches have been applied to evaluate program initiatives in undergraduate education: focus groups and debriefing interviews have been conducted with both students and mentors in the Senior Mentor Program; exit survey data from graduating medical students; analysis of student attitudes toward older adults using selected measures; vertical curriculum monitoring using the ©Tapestry curriculum mapping tool. At present, the Patient-Provider Orientation tool is used to monitor the SMP. Students take the survey before they begin the program, before they begin clinical courses and at the end of the program. Additionally, since the geriatric questions are not present on the AAMC graduation questionnaire, we have added a specific evaluation of the SMP and geriatrics into the pre-graduation activities for medical students.

Curriculum Continuity: The undergraduate curriculum’s considerable attention to geriatrics competencies and objectives continues following the Reynolds grant period. Two major administrators in undergraduate medical education maintain a strong commitment to geriatrics as DFSAs. The USC model was adopted by a "sister" school in South Carolina (MUSC) and the two schools participate in joint research and development in undergraduate medical education.
Virginia Commonwealth University

The Virginia Commonwealth University (VCU) program has four main elements: medical students, residents, community physicians, and medical informatics.

All VCU medical students (190 per year) experience a curriculum now enhanced with 30 hours of pre-clinical gerontological basic science material across a dozen courses, mandatory house calls and nursing home visits in the second year, an enhanced introductory program on evaluation of the older patient, and a required four-hour annual forum on aging for all M1 and M2 students. In the clinical years, students are exposed to geriatric concepts when rotating on non-medicine services supported by the geriatric inpatient consult team created through the Reynolds initiative. In all, medical students have about 50 hours of new geriatric curriculum. This is reflected in marked, progressive increases in the proportion of medical students that strongly endorsed geriatric items on the AAMC M-4 exit questionnaire comparing years 2001 through 2006.

The Internal Medicine (IM) residency now has a revamped geriatric education program that involves house calls and nursing home visits as R1’s and rotation as R2’s on an inpatient geriatric consult service created with the grant. The curriculum design is used as a model for other IM subspecialties and our co-management model with Orthopedics is being replicated with other surgical services. All Orthopedic and Ob-Gyn interns also rotate on geriatric medicine consults as of 2006. We have a similarly strong relationship with Geriatric Psychiatry. Of the many subspecialty areas reported for the 2006 in-service shelf exam, VCU Internal Medicine residents achieved their highest marks in Geriatrics.

The Reynolds Scholars program for community physicians brought 60 physicians to a 30-hour target for geriatric CME. We had very high satisfaction ratings both in terms of clinical practice value and impact on teaching. All learners are members of our community physician faculty and teach our medical students. This is one of the strongest community physician geriatric education efforts reported to date.

The website (VirginiaGeriatrics.org) which hosts our student and resident interactive modules, a library with over 130 lectures on a wide range of topics, and a self-help manual for inpatient care (Geriatric Quick Consult), receives about 1,700 requests per day from all over the country. There are six student modules that link key M1 and M2 topics across courses in staged cases, and resident modules for delirium, medication management, and discharge planning (still being finished). The site is hot-linked to the home page of our health system’s EMR server.

This comprehensive program touched the lives of at least 1,000 physicians and continues into the future with required, robust core components in the educational program of the medical school and several residencies. With Geriatric Education Center support, we also have continued the CME program for community physicians. We published more than 30 abstracts, with several manuscripts in process, had 5 pictorial write-ups in the local newspaper, and achieved high visibility in a broadly successful effort.

Weill Cornell Medical College

Our program focuses on 3 specific learners (medical students, medical residents, and practicing physicians (CME), and 3 specific content areas (fundamentals of geriatric medicine and the reality of living with chronic disease; enhanced geropsychiatry and psychosocial aspects of aging curriculum; and “environmental geriatrics.” Highlights of our accomplishments include:

- Successful integration of geriatrics into all four years of the medical student curriculum, including developing and implementing
  - 3 novel, 4-hour educational interventions in the first-year Medicine, Patient, and Society (MPS-I) course: *Introduction to the Geriatric Patient, Living with Chronic Illness,* and *Rehabilitation* (which includes students’ own navigation through the hospital in a wheelchair and performing assigned “tasks” to heighten their awareness of the challenges that disabled patients face everyday).
  - Unfolding, standardized patient and problem-based learning cases into the first 2 years of the medical school curriculum and geriatizing existing cases.
  - Provisions for every Primary Care Clerk each week to spend at least a full or half-day at a clinical geriatrics site and one half-day in a community-based geriatrics activity. Each also goes on home visits and then presents a creative project reflecting the student’s dominant impressions.
“Fast-Forward Rounds,” linking Primary Care Residents with third-year Medical Clerks to enhance both groups’ understanding of Geriatric aspects of chronic illness care, focusing primarily on discharge planning, utilization of community resources, working within a team, and health care financing.

- This year we will implement a module on elder abuse in the MPS-I course.
- Establishment of our ACE-Unit, a 17-bed inpatient geriatrics teaching service, on which all Medicine residents rotate.
- A 4-week geriatrics module created for Primary Care Residents with both didactic and experiential components; also, all medical residents now rotate on the ACE unit. Primary Care Residents also may do a longitudinal rotation at the Wright Center.
- Creation of CornellCARES.com (Creating Aging Resources and Educational Solutions) which includes:
  - A directory > 1,000 NYC Medicare mental health providers
  - Patient education handouts focusing on a wide-range of psychosocial topics
  - Ask Dr. Abrams column, in which health care providers can question our Director of Geriatric Psychiatry Services, on such topics as psychiatric disorder symptoms, current treatment strategies, and upcoming treatments.
- Development of the Psychosocial Screening Tool (PSST), designed to bring psychosocial problems to primary care providers’ attention at the earliest possible time in the medical encounter.
- Creation of an animated course on Environmental Design. Learners enter a web-based virtual home of patients with functional loss, viewing animated patients encountering remediable environmental hazards that increase fall and burn risk. Through sound, text, and moving images, learners witness virtual patients who have reduced visual, hearing, mobility, and memory skills struggling to accomplish tasks of daily living. Originally created to be a CME course, it is currently used in the Primary Care Clerkship.
- “This Caring Home” is an offshoot of the Environmental Design course. It provides tips and tools to enhance home safety for persons with Alzheimer’s and other types of dementias. Highlights include a virtual home, product guides, and videos and animations. See www.thiscaringhome.org

Yale University

Medical Students

1. **Cognitive Assessment of the Elderly**: A structured, small group exercise for all first year medical students where they interview long-term care residents who have subtle cognitive impairments using simple cognitive assessment tools. The students receive a pocket guide to dementia and delirium assessment at the completion of the exercise. Students are also asked to complete a reflection that describes whether or not the session changed their attitudes toward older adults.

2. **Functional Assessment of the Elderly**: A structured, small group exercise for all second year medical students in a Continuing Care Retirement Community. The students evaluate older residents who have physical limitations but are cognitively intact. At the completion of the exercise students receive a pocket guide to Geriatric ROS and functional assessment.

3. **“Across the Lifespan” course**: This course is being developed as part of the new Yale Medical School curriculum. The focus will be on life development from birth to puberty to the reproductive years to aging. This course, which will be the last major course taken by all second year medical students before they begin their clinical clerkships, is scheduled to be taught in 2016.

Residents

1. **Ambulatory education**: During their ambulatory block, every Internal Medicine intern spends six half days at several sites like long term care, sub-acute rehabilitation, continuing care retirement community and geriatric assessment center working with geriatricians. The residents learn cognitive and functional assessments and perform cognitive testing like MOCA and SLUMS.

2. **Geriatrics for Primary Care trainees**: As part of their ambulatory specialty care training, all primary care residents receive practical training on important geriatrics topics for primary care providers. A half-day session is held each year during their 3 year residency. Topics include cognitive assessment, falls assessment, medication review and an overview of the Medicare system.

3. **VA Consultation Team**: All primary care internal medicine residents rotate on the VA in-patient and out-patient consultation service. An interdisciplinary team provides inpatient consultations and routinely rounds with the general surgery team. Older general surgery patients are followed by the geriatric team from the pre-operative to post-operative period. Consultation is also provided to Orthopedic Surgery, Urology, Vascular Surgery, Medicine and Psychiatry patients. Due to the increased demand for outpatient geriatric
consultation services, the VA geriatric consult team operates outpatient clinic days three times a week. The team consists of a dedicated nurse practitioner and a pharmacy resident. Caregiver burden, social support and medications are reviewed comprehensively on all patients in addition to cognitive and functional testing. There is an electronic falls consult template which identifies predisposing and precipitating factors for falls. Electronic consults may be converted to direct patient consultation based on patient and team needs. Most recently, an online geriatric consultation template was also developed and is currently being piloted on new inpatient and outpatient consults.

**Interprofessional Geriatric Education**

**VA Center of Excellence in Primary Care Education:** This is an interprofessional team training program which includes medicine residents, nurse practitioner fellows, pharmacy residents, and health psychology trainees learning and working together in a patient-centered medical home model. Geriatric education includes a primary care geriatric curriculum taught in teams with geriatric allied health team members (geriatric pharmacists, physical therapists, social workers, etc.). Trainees also rotate with Home Based Primary Care and Palliative Care. A case-based curriculum is being developed to teach the value of interprofessional collaboration in the treatment of complex geriatric patients. In addition, trainees gain exposure to polypharmacy management through participation in the IMPROVE (Initiative to Minimize Pharmaceutical Risk in Older Veterans) Clinic, an innovative model of clinical care including a group visit and individual provider visit in which trainees learn to perform comprehensive medication reviews and decrease potentially inappropriate medication use through shared decision making. Medicine residents and nurse practitioner fellows perform the individual provider visits, pharmacy residents provide patient and trainee education and consultative support, and health psychology trainees assist with behavioral interventions which can minimize the need for medications (e.g., sleep hygiene strategies instead of sleep aids for the treatment of insomnia).

**Train-the-trainer**

1. **CRIT:** For six consecutive years we have conducted the CRIT program for all rising Chief Resident in adult medicine specialties. The Director of Graduate Medical Education and residents from the internal medicine, general surgery, neurosurgery, orthopedic, urology, neurology and psychiatry programs regularly attend the 2 day session.

2. **General Medicine faculty:** Based upon the areas with which General Medicine faculty stated they were least comfortable, we developed a geriatrics workshop. The topics include agitation in the elderly, medication management, goals of care discussions, falls prevention and mobility. The workshop is designed to facilitate an interactive discussion with the application of new teaching models such as a flipped curriculum and team based learning.

3. **Emergency Medicine providers:** As part of the development of our Senior-Friendly Emergency Department, we provide monthly mini-didactics on the topics ED providers state they are least comfortable managing. Initial topics have included management of the agitated patient, assessment of delirium and home safety assessment.

**COHORT II**

**Boston University**

**Student Core:** Our overall goal is to vertically and horizontally integrate geriatrics curriculum across disciplines in the medical school, hospital and community and to create more interest in geriatrics.

- A continuous curriculum across both Family Medicine (M3) and Geriatric Medicine (M4) Clerkships
  - **Family Medicine Clerkship (M3)**
    - 2-hour seminar on functional assessment
    - Virtual elderly patient for online curriculum
    - One required home visit to elderly patient
    - Students use geriatric assessment tools
    - Resulted in substantial increase in knowledge of core geriatric principles.
  - **Geriatric Medicine (M4) Clerkship**
    - Virtual elderly patient reappears in online curriculum
    - Interactive online learning modules developed for Delirium and Dementia
    - Students view online didactic PowerPoint slides and review the virtual patient case through video clips and chart information.
  - Student-Patient Encounter Logs allow us to monitor exposure to different geriatric diagnoses and assessment tools.
Objective Structured Clinical Examination in the Geriatrics M4 clerkship includes standardized patients for Dementia, Depression, Urinary Incontinence, Caregiver Stress, Falls, and Elder Mistreatment cases.

Provide faculty and patients for BUSM Student Interest Group/AGS Student Chapter. Additional exposure to geriatrics during pre-clinical and clinical years is available to Student Interest Group members.

Other medical student activities include: additional materials and cases for pre-clinical curriculum (Introduction to Clinical Medicine 1 and 2, Integrated Problems); and Internal Medicine M3 Clerkship cases.

Resident Core: Our overall goal is to integrate more geriatrics curriculum across disciplines in the residency programs.

Chief Resident Immersion Training Program (CRIT)
- Five annual retreats completed, with a total of 84 residents and 25 program directors (PDs) attending. Representing 14 medical and surgical disciplines.
- The programs included an unfolding interactive case, mini-lectures on topics in geriatrics and small group interactive exercises, and consultation on developing an action plan for a project. Seminars designed to enhance CR teaching and leadership skills were also included.
- Evaluation results have consistently demonstrated CRs improvements in objective testing and self-reported gains in knowledge related to geriatric content areas covered in the CRIT and an increase in confidence related to teaching others about areas covered. Evaluation also showed self-reported gains in CR teaching and leadership skills. CRs reported that it was a valuable opportunity to meet and network with CRs from other disciplines. PDs concurred that it was a valuable experience both for their CRs and for themselves.
- National Dissemination of the BU CRIT program is in its third year with support from the Hartford Foundation and collaboration with ADGAP. To date 9 institutions have replicated the BU CRIT program. 3 more institutions will replicate the program in 2010. Additionally, BU has partnered with two Reynolds funded institutions who will also replicate the program in 2010. Ongoing evaluation of the program remains positive. A 6-month follow-up report including the five sites that conducted their first programs in 2008 indicated that overall, chief residents’ (CRs) ratings as well as their narrative comments indicate that CRIT was an important experience in their training as residents and that it made a difference in the way they think about, deal with, and teach about older patients.

Family Medicine Nursing Home (NH) Rotation with 2-3 residents a week each seeing two patients and discussing all patients as a group at teaching rounds. Residents are assigned longitudinal patients that are seen once a month.
- A QI project is ongoing, including use of on-call phone logs: a description of the calls, the quality of care and communication between nursing home, covering residents and faculty; and nursing home team is being assessed. Lecture/discussion presented at annual STFM.
- 42 Family Medicine residents have participated in Stanford Geriatrics in Primary Care seminars. Resident evaluations from this program have been very positive.

Other resident activities include: Combined Inpatient Outpatient Morning Report and submissions to Inpatient Times, an online publication for residents.

Faculty Development Core: Our overall goal is to prepare faculty and practicing physicians across disciplines to care for older patients. Activities include: Three faculty attended Duke University EBM Training and a fourth attended the McMaster EBM Training; one family medicine faculty attended Stanford Faculty Development Program facilitator training for Geriatrics in Primary Care (GIPC); support for hospitalists, surgeons and related area physicians as faculty scholars for the year-long Center of Excellence in Geriatrics; BUMC Electronic Health Records have been enhanced with forms for Falls/Mobility assessment and ADL/IADLs.

Hospitalists Program implemented in 2008. Faculty development series consisting of 10 sessions addressing the medical care of hospitalized geriatric patients. The CHAMP (Care of the Hospitalized Aging Medical Patient) curriculum was used as a template. The focus of the series is medical care, teaching to teach and ongoing quality improvement. The participants are faculty members who supervise residents and students. They also provide direct patient care. Sessions have included: Transitions in Care, Breaking Bad News, and Assessing the Frail Elderly Patient. Each session is attended by 8-14 hospitalists.

Online Core Products
- Web-based Tutorial in Evidence-based Medicine helps our residents to 1) develop an answerable clinical question, 2) perform an effective and efficient search of Medline, 3) critique evidence, and 4) apply research evidence to the care of elderly patients with functional disability, cognitive impairment, and medical complexity.
- Geriatrics Information via Electronics (GIVE) has been converted to an archive of monthly EBM case conferences: www.bu.edu/geriatrics/give.
**Emory University**

**ELECTRONIC RESOURCES**
Website address: www.cha.emory.edu/reynoldsprogram

Twenty six Resource Modules completed with links to websites for web-based Assessment Tool(s), ACOVE Indicators, Practice Guideline(s), Key References (2-4), Case Presentation(s), Slide Presentation(s), other Web-based materials - Additional core resource modules are under development.

**Web-based Bibliographies on Geriatric Medicine, Long Term Care, & Palliative Care**– updated annually and loaded onto website

**Web-based Geriatric Assessment Tool with additional assessment instruments** – an Emory faculty member is currently funded as an ERP Faculty Scholar to develop the PDA algorithms for Microsoft and Palm-based PDA applications

<table>
<thead>
<tr>
<th>Medical Student Training</th>
<th>Major Accomplishments to date</th>
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<tbody>
<tr>
<td><strong>ALL</strong></td>
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<tr>
<td>Continue BiG 10 testing to all Medical Students controlling for “testing to the test” in M-2’s &amp; M-3’s</td>
<td>BiG 10 testing is integrated into Medical student Orientation each year. The testing provides an opportunity to introduce students to the Emory Reynolds Program and the BiG 10 Principles.</td>
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<tr>
<td>Continue administering 14-Item Attitude Survey &amp; reevaluate after data analysis</td>
<td>All M-1’s complete the 14-Item Attitude Survey during the Intro to Geriatrics session. The 14-Item Attitude Survey is administered again in their 4th year.</td>
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<tr>
<td>Continue introducing &amp; reinforcing the Emory BiG 10 Core Principles and related critical concepts</td>
<td>Introduces using pre-testing. Reinforced through the training sessions and distribution of laminated BiG (Basics in Geriatrics) 10 pocket cards</td>
</tr>
<tr>
<td>Meet regularly with Medical Student Advisory Group for feedback on curriculum and other Emory Reynolds Program training activities</td>
<td>A Medical Student Advisory Group has been formed. The group consists of previous AFAR Scholars and students who have indicated an interest in geriatrics.</td>
</tr>
</tbody>
</table>
| Continue to recruit students into the Geriatric Interest Group (GIG) | Annual Recruitment Pizza Lunch each Fall Activities include:  
  - Periodic Geriatric Journal Clubs  
  - Notification & invitation to participate in all Division of Geriatric Medicine didactic activities |
| Continue to solicit applications for Arts in Aging Contest | The first Arts in Aging contest was held in April, 2005 and repeated each year |
| Continue to solicit applications for AFAR Scholarships | Annual AFAR/MSTAR Recruitment Pizza Lunch each Fall. On average, 3-4 students receive AFAR Scholarships with a high of 8 students in 2005 |
| Continue to host Awards Ceremony to honor ERP Arts in Aging contest winners, AFAR Scholars & ERP Faculty Scholars | Publicizes ERP activities throughout Emory community |
| Review summary evaluations of all training activities and revise training activities as necessary | Evaluation data entry into SPSS database and analysis is ongoing. All training evaluation data is reviewed annually at Core Faculty meetings |
| **FIRST YEAR** |                               |
| Continue to review current curriculum in the M1 Pharmacology course to identify opportunities to integrate additional geriatric content | Key word searches of written Course Reports document geriatric content added |
| Continue to review current curriculum in the M1 Genetics course to identify opportunities to integrate additional geriatric content | Key word searches of written Course Reports document geriatric content added |
| Continue two-hour home visits to older adults integrated into the M-1 Patient/Doctor course | Assigned structured home visits to older adults living in congregate housing continue. Through this process, the majority of M-1’s are introduced to issues surrounding older adults’ medical care during the first month of training. |
| Currently developing a Geriatric Week for M-1’s to integrate into the New Curriculum for the 21st Century. Primarily small group sessions that will cover aging as the “Normal Human Experience”. | Primarily small group sessions that will cover aging as the “Normal Human Experience”. Meetings are taking place to determine what ERP content can be integrated into the Geriatric Week and what will need to be integrated into other M-1 sessions |
| Continue 1-hour BiG 10 lecture | Dr Ouslander will continue to provide a 1-hour Power Point lecture on BiG 10 Principles to all students during the Geriatric Week sessions. |
| Continue integration of the M-1 Geriatric Case into the new M1 Problem-based Learning curriculum | PBL faculty accepted the 3 session geriatric PBL case into the curriculum. Implemented February, 2005.  
  - Geriatric faculty & Faculty Scholars sit in on sessions whenever possible |
| Continue M1 “Introduction to Geriatrics” sessions. The challenge is to redesign and integrate this 4 hour session into the New Curriculum using larger groups | All M-1’s visit Wesley Woods in groups of 15/wk & are exposed to the facilities and services provided at Wesley Woods Geriatric Center and to older adults living independently.  
  - Geriatric Sensitivity Training provided to all M-1’s  
  - Senior Teaching Associates presentation on “What I need from my doctor & my health care system” (they develop curriculum annually)  
  - Students have dinner with older adult & participate in1-1 experiences |
<p>| <strong>SECOND YEAR</strong> |                               |
| Continue to review current curriculum in the M2 Pathophysiology course to identify opportunities to integrate additional geriatric content | Key word searches of written Course Reports document geriatric content added |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>Impact/Details</th>
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<tbody>
<tr>
<td>Continue integration of the Geriatric Assessment session for M2 Clinical Methods course</td>
<td>Incorporated into the Clinical Methods course in September 2004. Required for all M2 students. Sessions meet for 4 hours and include 15 students in each of the 7 sessions.</td>
</tr>
<tr>
<td>Review summary evaluations of all M-2 training activities and revise training activities as</td>
<td>Evaluation data is currently being entered into an SPSS database and analysis is ongoing.</td>
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<td>necessary</td>
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<tr>
<td>Continue integration of Geriatric Case into the M2 Problem-based Learning curriculum</td>
<td>PBL faculty accepted the 2session geriatric PBL case into the curriculum. Implemented February, 2005.</td>
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<tr>
<td><strong>THIRD AND/OR FOURTH YEAR</strong></td>
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<tr>
<td>Continue integration of case-based two-hour Geriatric Training Session for M3 Medicine</td>
<td>This training session was integrated into the M-3 Medicine Clerkship. The first session was offered on 8/21/04. This session emphasizes the BIG 10 and focuses on Core Curriculum topics, specifically Falls; Delirium</td>
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<tr>
<td>Clerkship students.</td>
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<tr>
<td>Continue to support the Medication Review exercise in the M-3 Family Med Clerkship</td>
<td>Integrated into the clinical experience July 2006.</td>
</tr>
<tr>
<td>Continue the Geriatric OSCE on Falls assessment for M3 students during the Medicine Clerkship</td>
<td>The first OSCE session was integrated mid August 2004 and continues 4 times/yr. Elderly standardized patients are utilized in this training experience.</td>
</tr>
<tr>
<td>Increase # of M-3 students participating in Geriatric electives</td>
<td>M-3 students are participating in geriatric electives monthly compared to 1/yr previously.</td>
</tr>
<tr>
<td>Continue integration of Geriatric Bedside Teaching Rounds into M3 &amp; M4 Ward Team Training</td>
<td>- Bedside Teaching Rounds have been implemented at Wesley Woods Hospital.</td>
</tr>
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<td></td>
<td>- Integrated at Grady Hospital as Professor Rounds.</td>
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<td></td>
<td>- A Case Presentation session that includes all ward teams is offered monthly at the VAMC</td>
</tr>
<tr>
<td>Increase # of M-3 students participating in Geriatric electives</td>
<td>M-3 students are participating in geriatric electives monthly compared to 1/yr previously.</td>
</tr>
<tr>
<td>Continue integration and participation in Interactive Case (in 3 modules) for M4 students</td>
<td>- Integrated into the M-4 Medicine subinternship.</td>
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<td></td>
<td>- The focus of this module is on transitions in care for elderly.</td>
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<td>- All students are required to participate.</td>
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<tr>
<td>Develop PDA algorithms to utilize BIG 10 Geriatric Short Screen assessment tool with</td>
<td>Expected Completion date delayed from 12/30/06 to 12/30/07 due to contracting problems.</td>
</tr>
<tr>
<td>additional assessment tools for both Palm &amp; Microsoft-based PDA's</td>
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<tr>
<td><strong>Resident Training</strong></td>
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<tr>
<td>Internal Medicine resident training has been revised due to demand for extended training</td>
<td>Revised IM Resident training implemented July 3, 2007 with 5 IM residents/month participating in one-month geriatric training rotations at several Atlanta sites: Wesley Woods Center, VAMC, Crawford Long &amp; Grady Memorial Hospitals</td>
</tr>
<tr>
<td>(from 2wks increased to 4 wks) of additional trainees from (1 to 5 residents/mo). Much of</td>
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<tr>
<td>the geriatric medicine curriculum will be integrated into the new rotations.</td>
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<tr>
<td>Continue to introduce and reinforce the Emory BIG 10 Core Principles and related</td>
<td>Introduced through Bedside Teaching Rounds and rotation training sessions. Laminated BIG 10 Pocket Cards distributed (a continuous process with each training activity).</td>
</tr>
<tr>
<td>critical concepts</td>
<td></td>
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<tr>
<td>Continue Integration of Geriatric Bedside Teaching Rounds for all residents</td>
<td>- Integrated at Wesley Woods as Bedside Teaching Rounds.</td>
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<td></td>
<td>- Integrated at Grady Hospital as part of Professor Rounds.</td>
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<td></td>
<td>- Integrated into the VAMC Noon lecture series as Geriatric Case Presentation Series for all ward teams</td>
</tr>
<tr>
<td>D/C four-hour Geriatric training session for all PGY1, 2, 3 Internal Medicine residents and</td>
<td>Use these teaching tools to enhance the new one-month rotation for all PGY2 Internal Medicine residents. All parties agreed on the curriculum.</td>
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<tr>
<td>integrate content into the new 4-week rotations</td>
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<tr>
<td>Continue to develop Computer-based Learning (CBL) modules to be used with the online</td>
<td>Nine CBL modules have been developed to date and incorporated in to a CBL Workbook that has been demonstrated and distributed at AGS and other meetings.</td>
</tr>
<tr>
<td>Geriatric Resource modules</td>
<td></td>
</tr>
<tr>
<td>Continue one-month Geriatric Rotation at the Atlanta VAMC for all PGY2 Family Medicine</td>
<td>Implemented in February 2004. Each PGY2 Family Medicine resident is exposed to clinical and didactic experiences in Geriatrics. This new Family Medicine rotation was conceived during the ERP’s development meetings.</td>
</tr>
<tr>
<td>residents</td>
<td></td>
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<tr>
<td>Continue to support the geriatric quality improvement projects integrated into the</td>
<td>All Family Medicine residents have complete QI projects in 2005, 2006 &amp; 2007. IM residents assigned to VAMC will be expected to complete QI projects, too.</td>
</tr>
<tr>
<td>Geriatric Rotation at the Atlanta VAMC for all PGY2 Family Medicine &amp; IM residents</td>
<td></td>
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<tr>
<td>Continue Monthly Longitudinal Long Term Care experience for all PGY2 and PGY3 Family</td>
<td>Implemented in August, 2004 at a LTC site closer to the Family Medicine training site.</td>
</tr>
<tr>
<td>Medicine residents</td>
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<tr>
<td>Incorporate Atlanta Medical Family Med residents into ERP geriatric training activities at</td>
<td>- Atlanta Medical requested one-month geriatric training rotations for all PGY2 Family Med residents/year.</td>
</tr>
<tr>
<td>Continue integration of Geriatric curriculum and related OSCE case for Emergency Medicine</td>
<td>Revised curriculum implemented in August, 2004 with lectures from Emergency Medicine and ERP Core Faculty members.</td>
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<tr>
<td>Dr Lisa Mack developed these cases for integrating into the Emergency Medicine curriculum</td>
<td></td>
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<tr>
<td>Continue the development of Social Admit cases for Emergency Medicine</td>
<td>She also provides a “Geriatric Tip of the month” email for all EM faculty &amp; trainees.</td>
</tr>
<tr>
<td>Integrate the “The Hospitalized Elderly modules” into the House Staff curriculum</td>
<td></td>
</tr>
<tr>
<td>Integrate “Unique Aspects of Gastroenterology in the Geriatric Population” into Grand</td>
<td>These modules developed by ERP Faculty Scholar, Jason Stein are completed and loaded on to the ERP website.</td>
</tr>
<tr>
<td>Rounds, the House Staff curriculum &amp; student GI experience</td>
<td>The Emory website of Gastrogerontology (<a href="http://medicine.emory.edu/qi/infra/index.cfm">http://medicine.emory.edu/qi/infra/index.cfm</a>) developed by ERP Faculty Scholar, John Affronti, is currently serving Faculty, Fellows, Housestaff &amp; students in the Division of Digestive Diseases. Links from the ERP website are in process.</td>
</tr>
</tbody>
</table>
Integrate the “Geriatric Dysphagia” teaching module into student, residency & faculty training

This module in 3 Sections, developed by ERP Faculty Scholar Michael Johns, is posted on the ERP website and is required for medical students and residents in Otolaryngology

Continue to solicit applications for Arts in Aging Contest

Twelve students submitted projects this year (4 winners were chosen)

Continue to review summary evaluations of all resident training activities and revise training activities as necessary

Evaluation data is currently being entered into an SPSS database and analysis is ongoing

Continue to meet quarterly with Resident Advisory Group to provide suggestions for innovative curriculum and feedback on Emory Reynolds Program training activities

The Resident Advisory Group is comprised of the IM Chief residents, Geriatric Medicine Fellows, and IM, FM & EM residents who have indicated an interest in geriatrics

Develop PDA algorithms to utilize BIG 10 Geriatric Short Screen assessment tool with additional assessment tools for both Palm & Microsoft-based PDA’s

Expected Completion date delayed from 12/30/06 to 12/30/07 due to contracting problems

Faculty Development

Faculty Survey – developed faculty survey, surveyed faculty to determine faculty development needs.

Indiana University

Medical Students

MS I and II

Council of Elders

• 2 hour session where medical students interact with a panel of well older adults
• The goal of the Older Adult Session was to foster positive attitudes in medical students toward older adults.
  • The Session included 90 minutes of interaction with a panel of well older adults “the Council of Elders” plus a reflective writing exercise

The Dean’s Office continues to support the Council of Elders activity. Our new Dean views the Council of Elders as a successful use of standardized patients for teaching purposes.

MS III

“Geripardy”

• Game format to teach inpatient content on dementia, delirium, drug prescribing, history taking

Students Making a Difference in the Lives of Elders (SMILE)

• Students can elect to participate during their required Family Medicine Clerkship
• By participating, students complete a screening QI Project on dementia, depression, falls or urinary incontinence while in an office practice with a family medicine physician for a month
• Students receive credit toward graduation by participating

A new curriculum on ACE and interdisciplinary team care was developed for 3rd year medical students. Students are invited to attend an ACE interdisciplinary team rounds and discuss their patient. After rounds, students complete a questionnaire that assesses their knowledge of the role of interdisciplinary team members and function limiting geriatric conditions.

MS IV

A geriatrics case has been inserted into the “Senior OSCE”. Passing the Senior OSCE is required for graduation. The case is a delirium case and assesses students' basic clinical skills around this topic as well as their professionalism and communication skills.

Residents

PGY1 Internal Medicine and Family Medicine Residents

“Caring for Elders” Retreats

• 4 hour retreats using a variety of educational methods
  • Mini Lectures
  • “Geripardy”
o Small group discussions
o Cased based interactions
o Development of geriatrics quality improvement project ideas for continuity clinic practice

PGY1 required Geriatrics Rotation

**Emergency Medicine Residents**
Developed and implemented a geriatrics curriculum across three years of training

**Fellows**
A geriatrics-oncology curriculum was developed and implemented.

**Practicing Physicians**
- “Train the Trainer” retreats on
  - Geriatrics
  - Quality Improvement
  - Relationship Centered Care
  - Teaching
- “Trainers” used to mentor practicing physicians statewide in quality improvement projects on dementia, depressions, falls or urinary incontinence
- Partnered with the IU Office of Continuing Medical Education to implement “electronic mentorship” of quality improvement projects for practicing physicians after funding
  - Incentives for practicing physicians to participate
    - Part IV ABFM credit for QI project for maintenance of certification
    - ABIM credit for QI project for maintenance of certification
    - 20 hours of CME credit
    - Practicing physicians can work with medical students who are participating in SMILE

**State University of New York at Buffalo**

**Undergraduate Students:**
- Longitudinal long-term care experience – independent study
- Standardized patient in year 1, 2, 3
- Theatre for change seminar
- Clinical didactics and home care in the 3rd year
- Polypharmacy community-based practice quality improvement in Family medicine
- Polypharmacy write-up in the 4th year.

**Post-graduate trainees:**

**Surgery**
- Fundamentals of aging
- Case book of geriatric clinical issues
- Post-op pain management
- The approach to abdominal disease among older adults

**Emergency medicine**
- Recognizing and managing delirium
- Palliative care
- Geriatric inpatient unit rotation
- Quality of care for older adults self-review
- Standardized patient

**Internal medicine**
- Polypharmacy conferences
- Morning report
- Outpatient geriatric clinic rotation
- Core topic seminars
- Faculty development
- Standardized patients in year 1, 2, & 3 with group feed-back
Family medicine
   a. polypharmacy
   b. core topics
   c. Patient safety

Continuing medical education (CME accredited)
   a. Internal medicine faculty as part of twice monthly conference
   b. Palliative care conference – internal medicine and family medicine
   c. Monthly ethics conference – internal medicine and family medicine
   d. Surgery didactics, chart review, and feedback (post-op pain)
Community practice quality-improvement to reduce polypharmacy – a student/preceptor collaborative

University of Chicago

CHAMP—the Faculty Development Program:
CHAMP is a multi-tiered educational project with a faculty development program (FDP) at its core. Hospitalists and
general internists who teach residents and students are the targeted audience.

Highlights of the FDP include:

Core geriatrics content:
Inpatient geriatric topics are organized around four themes: 1) Identify the frail or vulnerable aging patient;
2) Avoid hazards of hospitalization; 3) Palliate and address end-of-life issues; and 4) Improve Transitions of Care.
Materials have a “teaching trigger” to help recognize or create teaching opportunities on the busy inpatient wards
around the 5-10 minute teaching intervals available during the course of ward rounds.

Teaching the ACGME competencies on the inpatient wards and more:
An interactive mini-course within the CHAMP FDP entitled “Teaching on Today’s Wards” addresses the
issues of teaching in the site-specific arena of the busy inpatient wards and improving the process of teaching in
this setting. Also addressed in this section are teaching aspects of the newer ACGME competencies of systems-
based practice (SBP) and practice-based learning and improvement (PBLI) during inpatient teaching rounds.

OSTE: Observed Standardized Teaching Experience
An opportunity to practice new teaching content using new teaching skills, pertaining to delirium, pain,
transitions of care, and foley catheter use. Standardized learners are employed in a simulated “on the wards”
teaching experience.

Attention to Quality Improvement in Commitment to Change Contracts
Commitment to Change Contracts were expanded to include a small scale quality improvement project related
to the geriatric care in the hospital setting. Direction and feedback was given in the FDP and at the annual reunion.

Evaluation
CHAMP program evaluation measures professional development along all levels of learning: knowledge, attitudes, skills and behavior. Further, comparisons of geriatric teaching by CHAMP and nonCHAMP faculty participants are made possible by selfreports from these groups, and confirmed by residents’ and medical students’ surveys. Nontraditional methods of program evaluation include the Commitment to Change contracts. Observation on the wards rounds out the picture.
CHAMP teaching materials online

All CHAMP teaching materials including slide presentations with speaker’s notes, bedside teaching triggers, pocket teaching cards, references, user’s guides and all CHAMP evaluation instruments are available on the CHAMP website at http://champbsd.uchicago.edu.

Faculty and residents at the University of Chicago can also access CHAMP materials on CHALK Blackboard Learning Systems, a university-based course management website.

Annual reunion of Reynolds Scholars

Each spring, an annual reunion was convened to unite Reynolds Scholars and sustain their enthusiasm, interest and motivation teaching geriatrics on the wards. Commitment to Change Contracts were reviewed, teaching experiences were discussed, recognizing successes and barriers.

University of Cincinnati

Undergraduate Medical Students

The UC Physician Training project is built upon the existing required medical student geriatrics curriculum by establishing a four-year “Geriatric Medicine Student Scholars” Program (GMSS) for eight students per class. This enrichment program includes special clinical experiences, elective courses, extra-curricular seminars and other activities. Members of the geriatric medicine faculty are assigned to mentor one or two of the GMSS. Student reflective journals are used as both a learning activity and the primary method for evaluating the effectiveness of the GMSS program. The UC faculty have also implemented a senior-partner experience for all incoming first year medical students, Tell Me Your Story. Tell Me Your Story is a formal part of the college of medicine’s orientation week.

Residents

Primary care residency programs participating in the grant program include internal medicine (3 residency programs) and family practice. Sub-specialty residency programs participating in the grant program include gynecology, psychiatry, physical medicine, and emergency medicine. Each residency program is developing its curriculum to the unique needs of its respective trainees; a set of unifying guidelines has been established, to be addressed in each curriculum. In addition, all residents have a series of standardized encounters with simulated patients (see LEADS below). The UC faculty have also implemented a primary care block rotation for family medicine and internal medicine residents, GeRIE. GeRIE utilizes interactive small group sessions, community field trips, longitudinal experiences with faculty geriatricians, and resident presented projects.

Practicing Physicians

The UC project team developed and implemented a comprehensive 4-year geriatric education program for primary care physician members of the Alliance Primary Care (APC) physician group (80 physicians in 15 offices). The program is approved for AMA Category I CME credit. The program is been designed to increase APC physicians’ clinical skills and assist them to implement new office/system strategies that can improve the quality of their care of older patients. Topics include: prescribing, falls, incontinence, and dementia.

Faculty Trainees

The UC Reynolds Center has identified fourteen clinical-educator faculty trainees without specialized training in geriatrics from the Departments of Internal Medicine, PM & R, Ob/Gyn, Family Practice, Emergency Medicine, and Psychiatry, who are participating as Geriatric Medicine Faculty Scholars (GMFS).

New Educational Techniques/Methodologies
Longitudinal Encounters with a Standardized Patient (LEADS) - A new curriculum addressing competency development and assessment in dementia and chronic disease management among interdisciplinary groups of residents. The curriculum’s centerpiece is an unfolding 3-part standardized patient (SP) case about a patient with Alzheimer’s disease (AD) and her daughter and soon-to-be caregiver.

Option Power: To enhance the teaching interaction for the community physician office training, the project faculty utilized a PowerPoint interactive polling program.

University of Miami

The Miami program “Development of Physician Competency in Geriatric Syndromes” is now several years post grant completion. We developed and implemented a competency-based UME curriculum that targets a core set of learning objectives for five geriatric syndromes: dementia, falls, delirium, pressure ulcers, and polypharmacy. This curriculum redesign has changed the educational focus from what is taught to what is learned. Students complete competency assessments at different time points throughout their four years of training and are required to meet specific performance standards. These performance standards are linked to specific learning objectives, and all students who do not meet the standards undergo remediation and reassessment.

The knowledge, skills, and attitude learning objectives for each of the geriatric syndromes are carefully aligned with teaching and assessment activities. We use a blended approach combining preceptor-led and computer-based teaching and assessment methodologies including: 1) focused debriefing of clinical encounters; 2) skills training and case-based exercises; 3) interactive lectures (both traditional and online); 4) standardized patients; 5) card-sorting and other game-based approaches; 6) assigned readings and structured case discussion; and 7) online interactive audiovisual modules for skills training instruction and assessment. We have documented learner satisfaction with these curricular components. More importantly, we have documented improvements in knowledge, skills and attitudes resulting from the curricular revisions. Moreover, preliminary evidence indicates that these improvements are sustained over time.

Most of our competency-based curricular components are exportable and can readily be implemented by other institutions. Many of our products have been published on MedEdPORTAL and POGOe. Some of our online interactive training modules and small group session materials have already been used successfully across the country for training health-care providers from various disciplines. We have also worked with other institutions in developing computer-based learning material. In collaboration with Emory University, Miami developed multimedia training and assessment modules primarily focused at the GME and CME learners. We have successfully introduced components of these modules into the UME curriculum.

At the GME level, we developed a 4-week geriatrics rotation for internal medicine interns that is now a well established component of the IM training program. To provide greater alignment between learners at various levels of training, and to enable those in teaching positions to reinforce medical student learning on important geriatric issues, some of the online interactive modules developed for students are also part of our GME curriculum. Interns rotate in clinical venues where students are present. This alignment in training between UME and GME opens the way for housestaff to reinforce geriatrics training for our medical students (UME) in clinical settings not overseen by geriatricians.

A subset of the online educational materials developed for students and residents have been converted into PDA format allowing learners and practitioners to access key information at the point of care. Additional instructional and assessment activities have been developed linked to the AAMC geriatric competencies for medical students. Building on our initial success with computer assisted training, some of our junior faculty and fellows have developed additional technology based instructional and assessment tools including virtual worlds and virtual patients and studying their impact in a broader range of learners.

We continue to use GeriU (www.geriu.org) as our online learning-management system to facilitate curriculum delivery and the related scheduling, communications, and tracking of attendance and performance (for instructors and learners). As we have provided more curricular activities online, we have noticed improved learning experiences in the ward and nursing home settings. Also, we have found that online modules help prepare students to master the competencies. We believe this observation reflects the efficiency (usability and utility) of computer-based learning. Although we scaled back on a few resource-intensive standardized patient components of our initial program, we have sustained the core of our instructional and assessment activities in each of the 4 years of training.
At this time, we have a core group of clinician educators and educators proficient in competency-based curriculum development, implementation, and evaluation. Our geriatrics faculty achievements have been recognized through collaboration with other DW Reynolds programs, peer-review publications, invitations to serve as peer reviewers and moderators to national medical educational meetings, and education awards.

**University of Missouri**

Our curriculum is guided by our Principles of Geriatric Care, which focuses on providing multidisciplinary, cost-effective care taking into consideration family caregivers and relationships, quality of life and function, patient advocacy, ethics, end-of-life care, evidence-based medicine and the right drugs for older adults. These principles are woven into the fabric of our curricular and training initiatives and serve to maintain and communicate our vision to learners and colleagues at all levels.

**Geriatrics Training Grant (2003-2007) at MU**

**Medical Students**
- Our principles are demonstrated during a DVD presentation and interview with a senior patient entitled, *MU Principles of Geriatric Care*. This video is intended for first- and second-year medical students who have little or no experience or skill interviewing senior patients.
- We have just completed new video for students: *Conversations about Health and Aging* which includes conversations with primary care physicians, geriatricians, and subspecialists about caring for older people. Older persons themselves comment on their experiences with aging and healthcare.
- We have also developed a “Think-aloud Strategy” for rewriting geriatric problem-based learning cases used in the first and second years of medical school. New geriatric medicine cases have been created for the curriculum.
- STEP, our senior mentor program, continues to thrive as an elective for first-year medical students. Each year more than half the class volunteers to be paired with a senior mentor.
- All M3s make home visits to elderly patients they cared for after soon after discharge from the hospital. Students contact the patient’s primary care physician and hospital team, sharing results of the home visit, and ensuring continuity during this important transition.
- New senior electives have been developed in geriatrics, ethics, and palliative care.
- Our geriatrics interest group sponsored the Reflections of Aging photo contest for five years. We are no longer running this contest.

**Resident Physicians**
- Family medicine residents are completing inpatient consults and outpatient geriatric assessments in the SAGE clinic in addition to a continuity nursing home and office practices. They are now spending a greater portion of their time gaining expertise in chronic care through the innovative P4 curriculum (Preparing the Personal Physician for Practice). The family med geriatrics rotation now will include inpatient palliative care consults.
- Residents and faculty from internal medicine, family medicine, and orthopaedic surgery, nurses and social workers continue to meet for a bimonthly interdisciplinary conference on hip fracture care.

**Fellows**
- We created a 2-year geriatric education/leadership track in the Geriatric Medicine Fellowship that includes 3 new medical education courses and associated practical teaching/administrative experiences in the pre-doctoral curriculum.
- We are working on an integrated resident/geriatric medicine fellow track.

**Faculty Development**
- Our successful hip-fracture pathway includes faculty, residents, and students in internal medicine, family medicine, anesthesia, orthopedic surgery, and emergency medicine and has led to the creation of a team developing a geriatric orthopaedic trauma pathway.
- Other multidisciplinary pathway projects address palliative care, pneumonia and delirium.

**Continuing Education**
- The *Caring for the Frail Elderly Conference* is held in Columbia each August. Average attendance is 250 registrants.
- Working with the Interdisciplinary Center on Aging, our electronic newsletter, *Chronicles in Aging*, is sent to over 1000 professionals in Missouri.
Evaluation

- An extensive summative evaluation was completed in 2007. Our evaluation team asked three questions:
  1. How does our work align with the stated goals and objectives of the grant? 2. In what ways can our activities be further enhanced? 3. What changes should be made?
- Data were collected and analyzed for congruence with stated goals and objectives, and the overall impact and changes that have occurred as a result of the project were examined. The evaluation team concluded that our work is in alignment with our stated goals and objectives.

Next Steps in Physicians’ Training in Geriatrics at MU (2011-2014)

With our Next Steps award, we have continued to enhance geriatric medicine education by offering new programs for medical students and resident physicians. Building on the curricular experiences created during the Geriatrics Training Grant, our program impacts all medical students in the first, second, and third years. It also offers targeted and continuous education for Geriatrics Program Scholars throughout the four years of the medical school curriculum and provides enhanced training for all residents in internal medicine and family medicine. We recognize the importance of developing attitudes, knowledge, and skills consistent with caring for older patients within interdisciplinary health care teams, therefore, our curriculum emphasizes the importance of interdisciplinary teams in promoting patient safety and health care quality improvement. Our program includes seven goals:

Goal 1: Use Problem Based Learning (PBL) cases to illustrate team-oriented aspects of the patient history and care provided.

Goal 2: Incorporate the interdisciplinary care of geriatric patients into an established interprofessional simulation.

Goal 3: Enhance patient safety in the hospital: Internal Medicine Clerkship.

Goal 4: Promote safe transitions from the hospital: Family Medicine Clerkship.

Goal 5: Start Geriatrics Program Scholars: Targeted Curriculum for years 1-4.

Goal 6: Train family medicine resident physicians to provide quality care of older adults in the patient-centered medical home.

Goal 7: Train internal medicine and family medicine resident physicians to provide quality care of hospitalized older adults, with particular focus on improving care transitions and teamwork.

The programs emphasize teamwork training and the patient-centered “medical home” model of care. The model involves close collaboration among multiple care providers, which is especially important to elderly patients with multiple chronic illnesses.

University of New Mexico

The UNM Geriatric Training Grant continues to work to meet the goal of improving and increasing the geriatric medicine training of medical students, residents, university faculty and community-based primary care physicians who are involved with the training of medical students and residents. We have implemented training programs that have been very successful in both undergraduate and graduate medical education and continue to provide geriatric education programs for practicing physicians throughout this very rural, multi-cultural state of New Mexico. In addition to the programs that were proposed in our original grant proposal we have implemented several additional programs for students and faculty. These have included our senior mentor program, practical immersion program (PIE) orientation training, and the implementation of additional clerkship and elective experiences for medical students. Working with an excellent group of evaluators at UNM, we have also been able to track our progress in meeting some of goals of changing attitudes and knowledge of older adults among medical students.
The following is a brief summary of some of the key areas:

### Undergraduate Medical Students

The first potential exposure that medical students have to geriatric medicine takes place during their first year orientation to medical school where we recruit first year students to our Senior Mentor program. This program was initiated in 2004 and includes about 1/3-1/2 of the first year class. In addition students can and do choose to continue for a second or third year with their mentors and receive elective credit as part of the School’s Perspectives in Medicine Program. We expect that the program size will continue to increase each year. Last year we also encouraged the participation of PA students. The Senior Mentor program continues to be well received by both medical students and our senior mentors.

The second program which has proved very successful is the 8-week Practical Immersion Experience (PIE) which is required of all medical students during the Summer between their 1st and 2nd year. The students are all required to perform two functional assessments and two cultural interviews. In addition they must complete a functional assessment module on Webct, an orientation to the MMSE (developed by the University of Miami), several required readings and evaluate their experiences. Each year the program this thoroughly evaluated and changes made.

The third major initiative has been the development and implementation of clinical clerkships. We have initiated a one-month geriatric ambulatory clerkship during the fourth year required ambulatory clerkship. About 10% of the class participates in this experience and evaluations are excellent. In addition we provide both palliative care and geriatric medicine clerkships which are well received, but under subscribed. Students use electronic resources such as the Geri-Sims at Iowa and the materials developed the University of Miami.

The fourth initiative is the addition of an introduction to a home visits that all 3rd year medical students will experience during their Internal Medicine rotation. Each involves a small group session with a faculty member, watching a video podcast, patient visits, as well as a pre- and post- test.

### Primary Care Residents

In New Mexico, nearly all residents train in Albuquerque, with the exception of small family medicine programs in Santa Fe, Roswell and Las Cruces. Currently we have one month geriatric rotations for all internal medicine PGYI and family medicine residents PGYII in Albuquerque. In addition we have quarterly geriatric and palliative care programs in Santa Fe and Roswell. We have focused on the community-based programs since over 85% of these residents remain in practice in New Mexico.

Geriatrics has now been assigned two half-day sessions a year to present Geriatric content to all Internal Medicine residents at the University of New Mexico.

### Other Programs

We have provided geriatric educational initiatives for the Indian Health Service. We currently run a monthly Elder Care Clinic in Jemez Pueblo. We are also developing monthly palliative care and geriatric telehealth clinics through Project ECHO (http://www.echo.unm.edu) Computer-based educational modules for medical students and residents focusing on demographics, functional assessment, health care decision making and preventive geriatrics have been completed. Support from the Reynolds Foundation has allowed us, as a small geriatric faculty, to develop significant geriatric medicine training initiatives in conjunction with other more extensive programs which are part of this Reynolds initiative.

1. Zwhalen D, Herman CJ, Kalishman S. Medical Students’ Longitudinal & Cross Sectional Attitudes Toward and Knowledge of Geriatrics at UNM SOM. JAGS. Accepted for publication 2010.

### University of North Carolina at Chapel Hill

The University of North Carolina School of Medicine at Chapel Hill continues to work to meet its goal of improving and increasing geriatric medicine training of medical students, residents, fellows, faculty, and community-based primary care physicians. The following is a brief summary of some of our key areas:

### Undergraduate Medical Students

Prior to the Reynolds grant, the Division of Geriatric Medicine taught 14 to 16 hours of required geriatrics content in the 4-year curriculum. Now 60 hours of required geriatrics content are taught by the Division. Our curriculum a selective is a unit which is required of all students, but students have a choice of topics/courses they can pursue
within a selective. There were no geriatric selectives prior to Reynolds. Post Reynolds, there are 3 geriatric selectives within the Ambulatory Practice Selective for 3rd- and 4th-year students: Senior Women’s Health; Geriatrics: Continuum of Care for the Older Patient; and End of Life & Palliative Care. In Medicine and Society for 2nd-year medical students there are two Humanities and Social Science required selectives with strong geriatric content/focus: “Old Age: In Health and Illness”, and “Myths of Aging.”

Curriculum Mapping
UNC has mapped all the AAMC/AGS Recommended Geriatric Competencies for Medical Students to their undergraduate curriculum. In addition, a survey instrument has been developed for evaluating UNC’s undergraduate medical curriculum for infusion and implementation of the AGS core competencies. UNC is working with AAMC and CurrMIT to develop implementation and reporting mechanisms on the geriatrics data once it has been entered into CurrMIT.

Best Assessment Tools
1. Carolina Opinions on the Care of Older Adults (COCOA) instrument is an attitude and belief survey. Learner groups assessed are medical students, residents, physicians, and nurses. It is used for formative and summative evaluation and is an attitude and belief instrument for assessing attitudes on caring for Geriatric patients.
2. Falls Risk Assessment Objective Structured Clinical Examination (OSCE) is a knowledge and skills assessment tool for falls risks. Learner groups assessed are medical students and residents. This OSCE is used for formative and summative evaluation and is administered in Outpatient MS3 Clerkship and with Physical Medicine and Rehabilitation residents.

Service Learning
In 2000, UNC’s medical students founded UNC Mobile Student Health Action Coalition, today known as Beyond Clinic Walls, as a means to extend the university’s existing free clinic services to isolated, elderly individuals in the community. Today, Beyond Clinic Walls is run by volunteer, interdisciplinary, health professional students and faculty and serves approximately 20 elderly patients each year.

Residents
- Geriatric educational modules focusing on prevention (hypertension and congestive heart failure) were designed with chart audit/CQI tools. These chart audit/CQI tools were implemented in the Family Medicine residents’ ambulatory practice. During the latter part of the second grant year a required longitudinal CQI curriculum for PGY3 residents was initiated. The focus was on exploring practice patterns and identifying practices to improve cardiovascular risk reduction in adults with a segment devoted to the geriatric population.
- In Year 3 all Family Medicine residents and faculty were participating in ongoing Continuous Quality Improvement (CQI) regarding chronic care management for cardiovascular risk reduction. This included a segment on hypertension control for geriatric patients. The 3rd-year Family Medicine residents spearheaded the CQI project, are auditing the charts, and providing feedback to the entire practice.
- Internal Medicine Resident Education Reynolds update:
  We have developed a website, www.med.unc.edu/aging/ace, for our Acute Care for the Elderly (ACE) inpatient unit. This website is accessible and user friendly for attendings, residents, and medical students who rotate on the internal medicine geriatric inpatient service/ACE unit. The site is well used, linked to the house staff webpage that is used by the medicine residents on a daily basis, and is the only site offered by an inpatient service at UNEducational resources contained on the site include:
  - Evidence-based presentations that can be used by attendings: a) syncope; b) hyponatremia; c) dementia; d) delirium; e) diabetes; f) CQI
  - Links to full text articles on important geriatric inpatient topics / CQI-based modules: a) delirium and reduction of antipsychotic use; b) osteoporosis – optimizing treatment for patients being discharged; c) elder mistreatment – screening; d) DVT/PE prophylaxis for older adults in the hospital setting.

Community-Based Primary Care Physicians
- “Lunch and Learn” is a program of 30-minute online learning modules designed for non-geriatrician physicians to be completed during a lunch break. This new tool for expanding knowledge and skills in the area of geriatrics focuses on a single, specific topic via a simple PowerPoint presentation. Presently, we have developed two modules: “Prescribing for Older Adults,” and “Elder Mistreatment”. The providers received 1 hour of Continuing Medical Education (CME) credit. The modules are presently on the UNC Center for Aging and Health website (www.med.unc.edu/aging).
Albert Einstein College of Medicine

SUMMARY: Albert Einstein College of Medicine and Montefiore Medical Center initiated the GeriEd Program - a comprehensive and innovative program for primary care physician training in geriatric medicine designed to strengthen practicing physicians' knowledge and skills, strengthen training for primary care residents, provide advanced fellowship training, support faculty recruitment and development, enhance medical school curriculum, and stimulate medical students' interest in geriatrics. It emphasizes the complex medical and neuropsychiatric geriatric syndromes of dementia, falls and delirium, as a paradigm for geriatric medicine. Targeted physicians are those who provide acute or chronic primary care for the elderly - hospitalists, emergency room physicians, internists, and family practitioners.

Activities:

A. Medical Students:
   1. Throughout the four year Curriculum:
      a. Geriatrics Club
      b. Geriatrics Mentorship Program
      c. Geriatrics and Aging Research Programs
   2. Preclinical Years
      a. Basic science courses – lectures, case-based learning and content in Neurophysiology, Pharmacology
      b. Introduction to Clinical Medicine
         i. First year – Workshops on elder abuse, ethics, health care systems, sexuality
         ii. First Year – Half day/wk Geriatrics Program – in history-taking course (18 students)
         iii. First Year – elective Successful Aging Module of home visiting
         iv. Second Year – core faculty in physical diagnosis course
         v. Second Year - Half day workshop with entire class on Geriatric Assessments
   3. Clinical Years – 2-week Geriatrics Clerkship (required)
      a. Workshops – elder abuse, transitions of care, nutrition, hospice; clinical rotation acute, long term, home and ambulatory care; seminars
   4. Geriatrics Research Elective

B. Residents
   1. Internal Medicine and Family Medicine – 2 weeks (IM), 4 weeks (FM) required rotation – 45 residents/year
      a. Clinical rotations: Acute, long term, ambulatory, home care
      b. Resident seminars: weekly skin rounds, monthly pain management, bimonthly geropsychiatry, bimonthly medication management rounds, monthly resident report (ambulatory geriatrics), monthly geriatric assessment, monthly geriatric pharmacology, monthly ethics, monthly transitions of care, monthly home care, monthly health care systems
      c. Assessments - health systems (several new to be implemented)
      d. Geriatrics conferences (research conf, grand rounds, journal club, fellows core curriculum)
   2. Co-Precepting in resident primary care clinics
   3. Subspecialty Rounds conferences
   4. Consultations for ED residents
   5. ED Core Curriculum lectures

C. Specialty Services
   1. Cardiology – case-based teaching conference program to teach clinical geriatrics and the principles of medical ethics regarding the care of older adults with heart disease, in order to improve care and decision-making with patients and their families
   2. Geriatrics Co-Management Service with orthopedics
   3. Geriatrics seminar series for OB/GYN

D. Attending Physicians
   1. Geriatrics Champions – physicians who pursue additional CME in geriatrics, develop a geriatrics QI project, participate in additional clinical roles in geriatrics
   2. Geriatric Co-Precepting – teaching preceptors as well as residents
   3. Geriatrics seminar and lecture series for the ambulatory network
   4. Geriatrics consultation
Comprehensive curriculum redesign and Reynolds support in 2006 facilitated integration of geriatrics content throughout the curriculum of the Warren Alpert Medical School of Brown University. Reynolds funds supported the planning, implementation and evaluation of an integrated, competency-based mandatory geriatrics curriculum for all medical students, and the creation of an elective and rigorous cross-disciplinary program called Scholarly Concentrations (SCs), in which Aging took the lead. Led by Dean Ed Wing, Brown has committed faculty, funds, and facilities to curriculum redesign, including aging-related content in clerkships and the development of clerkship “themes” across clerkships (end-of-life care is the first). Brown’s longstanding commitment to geriatrics provided a strong foundation for the Reynolds program. Our achievements to date include:

1. Development and integration of geriatrics content throughout the new medical school curriculum:
   a. Pre-Clerkship Curriculum: More than 80 new hours of aging-related content was integrated into courses through lectures and small group case discussions, including the new assisted living longitudinal experience in the Doctoring course, the aging-related findings (“treasure hunt”) in anatomy lab; new content for the brain sciences and scientific foundations of medicine courses, and “Themes of Aging” and “Physiological Changes of Aging” laminated cards.
   b. Clerkships: Minimum experiential clerkship goals were defined for all clerkships except pediatrics, and geriatrics cases were introduced to small group and clinical correlation sessions. Aging-related cases were developed for standardized patients and OSCEs, and the end-of-life care integrated clerkship theme was implemented, with core didactic content and required clinical experiences distributed among clerkships. Transitions across health settings was identified as the next integrated theme.
   c. The Geriatrics Virtual Curriculum (GVC) to complement the basic science portion of the new curriculum began to be deployed in 2007-2008.
   d. An elective cross-disciplinary Scholarly Concentration in Aging was launched, allowing students to pursue innovative geriatrics-related activities and complete a major independent project throughout medical school. Projects include research initiatives and curricular innovations. Students have won national awards, presented their work at national meetings, and published in prominent peer-reviewed journals.
   e. A pre-clerkship communications program, with support from the Schwartz Center, was initiated in the Doctoring course, using video, role play of small group cases, and panel discussion of major issues. Plans to expand the program into clerkships are underway.

2. New geriatrics content continues to be added to residency programs, and 8 geriatrics Simulation Center cases were deployed for EM resident training.

3. Faculty development initiatives include plenary CME presentations; a monthly column on geriatrics for the non-geriatrician practicing RI physician since 1/07; Doctoring faculty facilitator guides on communications and the Assisted Living Facility experience; award of a Hartford Foundation CoE; 3 GACA awards; and ongoing educator training for geriatrics physicians and nurse practitioners.

4. The Educational Resources in Aging (ERA) website contains and disseminates all geriatrics elements in the new curriculum; >100 curricular products include web-based products, and simulation, PBL and OSCE cases.

Innovative evaluation efforts of all activities include 1) the “journaling” project, which deploys volunteer students to respond to aging-related curriculum and clinical encounters with older patients, continues with qualitative analysis and manuscript preparation; 2) student “trackers” record the quality and amount of geriatrics content in pre-clerkship courses to calculate an increasingly accurate “dose” from baseline through implementation; and 3) focus groups have been held to elicit additional student evaluation of the impact of the curriculum on their training.

Our efforts focus on all medical students; IM, EM and OBG residents; and faculty teachers in clerkships and targeted residencies. Geriatrics education also includes a public health perspective, including themes of health of the population, the social context of care, effective health communication, cultural competency and quality of care improvement. This project uses web-based training elements for all levels of students.

The outcomes include: (1) more positive attitudes among students, residents and faculty toward the needs of older patients and more seamless integration of content; (2) students and residents are better equipped to care for older patients; (3) geriatrics is fully imbedded in the curriculum; and (4) more Brown medical graduates and residents are encouraged to pursue careers in geriatrics. Our plan to monitor initiatives and enhance the increasingly seamless integration includes annual visits with course leaders to maintain geriatrics content. Course leaders have accepted new content and seek more. Our initiatives strengthen geriatrics, develop new faculty as teachers, content experts,
and geriatrics advocates, and create new educational resources, providing an enduring platform for geriatrics training.

**Florida State University**

FSUCOM is uniquely positioned to respond to this call for proposals. Our legislated mission urges us to develop exemplary physicians who practice patient-centered health care and are responsive to community needs explicitly including the older population. FSUCOM has a Department of Geriatrics and we are located in the state with the highest percentage of older adults.

FSUCOM believes it is necessary for all physicians to have competence in basic geriatric care principles to initiate and/or provide appropriate care to this vulnerable population. We will assist non-geriatricians to care for the frail population that is not limited to older adults. We will start in the first two years of medical training with development of desired clinical behaviors and continue to expand abilities to act now while providing education for knowledge, skills and attitudes towards an understanding of why these behaviors are needed. Key behaviors relate to two areas: geriatric care principles (e.g. communication skills, functional assessment, therapeutic review) and geriatric syndrome management (e.g. delirium, falls, polypharmacy).

Geriatric care principles apply to all patients across the lifespan, especially those that are frail. Many physicians have negative attitudes towards concepts and patients labeled “geriatric”. Because of their specialty (e.g. pediatrics, obstetrics), many physicians dismiss geriatric-labeled content as not relevant to their practice. In order to impact all patients in all specialties of medicine, we will not focus educational efforts under a geriatric label.

“Stealth geriatrics” initiated at medical school entry will allow broad acceptance and application of behaviors with subsequent incorporation into all disciplines of medicine. Our students, via a unique distributive campus model that commonly connects students directly to over 700 practicing physicians (without residents), will impact the behaviors of practicing physicians and thus change patient care practice now, across the state of Florida.

Our proposal targets three audiences: students, residents and practicing physicians. Students will receive a 4-year longitudinal, “stealth geriatrics” curriculum that focuses from day one on development and habituation of desired clinical behaviors while over time providing the knowledge, skills and attitudes to appreciate the value of and need for these behaviors. There will also be substantial overt encounters with geriatrics labeled content allowing an opportunity to expound on why quality of care principles have even greater value when applied to the older, frail population. Finally to encourage the pursuit of additional geriatrics content, there will be optional efforts supported through a geriatrics interest group and geriatrician mentors program.

Our Tallahassee community-based family medicine (FM) residency is eager to “geriatricize” its program with meaningful, not just minimal, educational content. A new hire with significant geriatrics experience has been appointed the geriatrics education director. Together, with the FSUCOM department of geriatrics, we will completely update and innovate the FM residency’s geriatrics curriculum. Furthermore the teaching hospital with over 50% inpatient medical care provided by the FM residency, will implement a system-wide delirium prevention program and explore additional opportunities to geriatricize care throughout the inpatient environment.

Faculty development will occur at several levels. Basic scientists will understand the principles and desired clinical behaviors and provide opportunities for reinforcement in their courses. Clinical faculty will develop their own history taking and physical examination skills exemplifying desired behaviors and subsequently teach these to all students. College based faculty that also practice in the community will carry these behaviors directly to patient care that will be witnessed by the facilities’ faculty and staff as well as our students. Clinical preceptors will receive Practicing Physicians’ Education training. Family Medicine residency faculty will receive geriatrics resources and materials to incorporate into their everyday practice settings.

In summary our proposal will reach all FSUCOM students and all FM residents, their medical educators, and several hundred physicians per year and impact the care of patients across the state and across the lifespan.

**Harvard University**

Project Summary: Advancement of Geriatrics Education at Harvard Medical School

The AGE Project is administratively located at Beth Israel Deaconess Medical Center (BIDMC) within the BIDMC/HMS Interdisciplinary Center on Aging, which is responsible for uniting faculty and trainees across HMS for educational and research activities in the field of aging.
The aim of this initiative is to expand and improve the geriatrics education of Harvard medical students; residents in general surgery, emergency medicine and internal medicine at the BIDMC; and practicing physicians at BIDMC and across the country. This is an opportune time to implement the AGE project because: i) it coincides with an ambitious HMS curriculum reform that will embed geriatrics education into the medical school curriculum, ii) it has won the support and financial backing of the President (Paul Levy) and Chief of Medicine (Mark Zeidel) of BIDMC, and the Dean for Medical Education at HMS (Jules Dienstag), iii) it draws on a critical mass of clinician-educators who are experienced and knowledgeable in geriatric medicine, and iv) it builds upon the rich information technology (IT) resources of HMS and BIDMC to create curricular innovation. As part of our Project, curricular content and teaching methods developed at BIDMC will be disseminated to all Harvard-affiliated teaching hospitals.

Our proposal focuses specifically on 3 groups of learners: i) Students in all 4 years of medical school, ii) Residents in Internal Medicine (IM), General Surgery (GS), and Emergency Medicine (EM), and iii) Practicing physicians in the hospital and community. For the medical student component of the AGE project, we are enhancing the biology of aging/geriatrics content in the first and second-year pre-clinical courses. We have added geriatrics content to the required Pathophysiology course for first year students and the required Human Development Course for second-year students. We are using high-fidelity medical simulators to incorporate interactive geriatrics cases into the required Patient Doctor II course for second year students to teach them history-taking and physical examination skills in geriatric patients. We have also introduced a half-day session for all second year medical students at Hebrew Rehabilitation Center, a long-term care facility, where they practice history-taking and cognitive, gait, and functional assessments in geriatric patients under the supervision of a geriatrician. For third year students who are participating in a new yearlong, integrated clerkship at Cambridge Health Alliance and the BIDMC, called the “Principal Clinical Experience”, we are incorporating twice monthly conferences, medical simulation cases, and tutorial sessions on topics in geriatric medicine. We have developed a geriatric medicine simulator case for the required Fourth Year Comprehensive Objective Structured Clinical Exam. The HMS web platform, MyCourses, is being utilized for student and program evaluations and for the dissemination of teaching materials to other Harvard-affiliated teaching hospitals.

To enhance residency training, we are using a “train-the-trainer” approach, focusing primarily on academic hospitalists who do the bulk of inpatient teaching on the internal medicine services. We have developed an “AGE Scholarship” program for hospitalists in which they take a 2-day CME course in the acute care of geriatric patients, attend monthly seminars in geriatrics, and become certified as teachers of geriatric medicine for housestaff. Key faculty in geriatrics, IM, EM and GS are teaching geriatrics at the bedside, in ambulatory and long-term care settings, in didactic conferences, and through innovative web-based modules. The inpatient electronic health record (EHR) has been enhanced with automatic alerts for inappropriate medication orders and the outpatient EHR with automatic prompts for optimal geriatric health interventions and individualized feedback to residents.

To educate practicing physicians on the most important principles of clinical geriatrics, we have created, piloted, and disseminated 6 interactive, web-based geriatrics-teaching modules to physicians around the world via the Harvard CME Online web platform. These include case-based discussions by experts on the management of dementia, delirium, pain, blood pressure, ethical issues and wound care. The last two modules (Osteoporosis and Hypertension) are currently completing the last stages of programming and are anticipated to be available for open-access by September 2009.

These curricular innovations are being tracked, evaluated, assessed, and revised as needed. With support from the Donald W. Reynolds Foundation, geriatrics teaching is being woven into the fabric of medical education at HMS and will be sustained thereafter through HMS, hospital, CME, and endowment funds.

Next Steps in Geriatrics Training Grant II
The Beth Israel Deaconess Medical Center is one of Harvard’s teaching hospitals and headquarters for Harvard's Interdisciplinary Center on Aging. Together, Beth Israel and Harvard Medical School recognize that transitions that move patients from one facility to another, or to a new provider, are high-risk events for elderly individuals. Therefore, based on the University of New Mexico’s successful Extension for Community Healthcare Outcomes (ECHO) program, they have started a program called ECHO-Care Transitions. The program uses on-line video communication technology to educate practicing hospitalist physicians, medical residents, and medical students in best practices to care for medically complex older patients who have recently been discharged from the hospital. This initiative educates practicing physicians, residents and medical students on preparing, communicating and managing appropriate care transitions of elderly patients, thereby reducing health risks that too frequently occur during transfers.
To improve care for our multicultural and rural aging populations, the Reynolds Team of the TTUHSC School of Medicine (SOM) proposed Aging and the Quality of Life in the Southwest: A Comprehensive Competency-Based Program to Strengthen Physicians’ Training in Geriatrics. This Comprehensive Program has five major objectives:

Objective 1. Implement a 4-year Geriatrics Track in the undergraduate curriculum.

Objective 2. Strengthen programs to stimulate lifelong medical student interest in geriatrics.

Objective 3. Implement the Integrated Geriatrics Track for Primary Care Residents.

Objective 4. Implement the Geriatrics Training Program for Medical and Surgical Specialties.

Objective 5. Establish the Geriatrics Faculty Development Program for faculty and practicing physicians to improve geriatrics teaching and practice.

The Comprehensive Competency-Based Program to Strengthen Physicians’ Training in Geriatrics built training on three sets of competencies: Communication/Professionalism, Medical Knowledge/Evidence-based Medicine, and Patient Care/Health Systems. Based on American Geriatrics Society recommendations and the American Council of Graduate Medical Education (ACGME) required competencies, this far-reaching program seeks to institutionalize competencies in geriatrics at all levels of physician training at the TTUHSC School of Medicine, including its Lubbock, Amarillo, El Paso, and Permian Basin campuses.

The Reynolds Training Program features innovative models of teaching and patient care, comprehensive competency-based training that directly impacts delivery of geriatrics health care, and outcomes evaluation for both curriculum effectiveness and patient care. Innovations included: a unique Integrated Geriatrics Practice that combines students, residents, and faculty from Internal Medicine, Family Medicine, Neurology and Psychiatry; a Best Teachers Training Program to ensure student and resident exposure to our most talented geriatrics teachers; geriatrics portfolios to focus students and residents on acquisition of competencies in geriatrics; Texas Tech podcasts in geriatrics, including student-generated podcasts for Step Exam review; and new Geriatrics Training Programs for Medical and Surgical Specialties and for Faculty Development. The Reynolds Team is developing a new Geriatrics Assessment Registry for analysis and continuous improvement of training activities, scholarship, and strategies to strengthen care for aging West Texans.

Major activities in Year 4 of the Program include:

- Inauguration of a new Geriatric Fellowship program on the Lubbock campus, with two fellows currently in training
- Expanded the new Geriatrics Division in Internal Medicine and Family Medicine with addition of new geriatrician faculty on all four campuses.
- Continued the required two-week geriatric rotation at all campuses, with attention to comparability of curricular learning activities and evaluation across all sites.
- Expanded Geriatrics and Palliative Care elective rotations on all campuses
- Expanded the successful Geriatrics Podcasting Program for students and residents, including continuation of the Step 1 and Step 2CK podcast series created by MS1 and MS2 students. Texas Tech HSC SOM PodCast Program won the Educational Product Award at the September 2008 Annual Reynolds Grantee meeting in St. Louis.
- Added an integrated geriatrics rotation to the internal medicine residency in Lubbock, and Year 3 of Reynolds interdepartmental geriatrics conference series in Lubbock.
- Expanded geriatrics content in Years 1 and 2 medical student curriculum; continued the active student chapter of the American Geriatrics Society
- Continued the Geriatrics Scholars Program for SOM faculty and a new intercampus Geriatrics Grand Rounds program
- Revised and improved Integrated Geriatrics Practice (Internal Medicine, Family Medicine, Neurology, Psychiatry) in Lubbock
- Continued use of geriatrics knowledge and attitude assessments for Years 1-4 medical students.
Continued Reynolds Team expansion and implementation of geriatrics training in medical and geriatrics subspecialties.

Coordinated Reynolds Team Activities for 2009-2010, which occurred via the Principal Investigator (Dr. Dentino) meeting on all four campuses (during June-July 2009) with each faculty member on the grant, so as to review their individual 2008-2009 Reynolds Grant-related activities, and to plan their individual 2009-2010 Reynolds Grant goals.

Awarded funding for a Geriatrics Education Center from the Health Resources Services Administration

TTUHSC School of Medicine Dean's Educational Innovation Award in 2010

University of Arizona

The goals of The University of Arizona Reynolds Program of Applied Geriatrics are to improve medical student, resident, faculty and practicing physicians’ education and training in geriatrics by emphasizing practical, competency based, culturally competent, safe and quality care to improve health outcomes in older adults. Our target learners and major accomplishments of our past four years are summarized below:

Medical Students: We are integrating geriatrics into the new four-year ArizonaMed medical school curriculum in Tucson and the new Phoenix Campus. This includes required courses and extracurricular opportunities. Both campuses have geriatric interest groups. Key activities include:

- **2nd Annual Medical Students’ Aging for Specialists Conference (Tucson Campus).** This highly successful conference, co-sponsored with the student section of the AGS, brings together over 100 medical students (pre-clinical) and faculty together in a lunch-time symposium that confirms the importance of aging principles of care no matter what career path students may follow – especially surgical and related medical specialties. Following a brief lecture by a national Visiting Professor, our Reynolds Scholars (Department Heads and leaders in primary care, surgery and related specialties) lead informational and motivational discussions at breakout tables. This educational model includes a toolkit/guidebook/facilitator manual, including Fact Sheets on the application of geriatric principles.

- **LifeCycle Block.** We implemented and evaluated a geriatric curriculum during the LifeCycle Block, Year 2, utilizing case-based instruction (Falls), team learning (Medicare Part D exercise), and interactive lectures on core geriatric topics (Delirium, Depression, Dementia, Health Literacy, Elder Abuse and Neglect, Hazards of Hospitalization, Transitional Care, Pharmacology, and Physiology of Aging).

- **Medical Student Societies Program.** The Societies Program is a four-year structured program that emphasizes bedside and case-based teaching, and student mentoring in small groups. We initiated a geriatric training program for the physician mentors on the principles of aging, comprehensive geriatric assessment, the medical interview, and physical examination of the older adult. Core geriatric topics and associated competencies are incorporated into structured clinical labs linked to the block lecture content, including cognitive and functional assessment, polypharmacy, and falls.

- **Re-Structured 3rd and 4th Year Clerkships (started 2009 academic year).**
  - "Healthy Aging“ workshop: We incorporated geriatrics into a new course titled “Intersessions” which is comprised of four one-week blocks integrated between 3rd year clinical clerkships. A mandatory two-hour session on “Healthy Aging” was successfully implemented (repeated each block), allowing students to interact one-on-one with healthy older adults, while learning about health promotion and prevention, sexuality, physical activity, cognition, and social engagement. This learning session is described in a manuscript accepted for publication in JAGS (2010).
  - "Home Visits:" All 3rd year medical students make 2 home visits with HBPC medical staff as part of their ambulatory experience at the VA, in addition to 2 sessions in geriatric primary care clinics.

Residents: We have enhanced geriatric content for residents in both primary care and in surgery and related specialties. Specific activities include:

- **Mini-Chief Resident Immersion Training (CRIT) Program:** We implemented a successful mini-CRIT program at a local resort (one night, one and ½ day program vs. 2 night, 2 day program) with 23 residents and 4 program directors, nurses, and pharmacists to improve the care of older adults. Based upon the very successful BUMC program, this mini-CRIT received high marks at markedly reduced costs.

- **Enhancement of Primary Care Residencies.** Introduction of ACOVE web-based self-learning module, Environmental Geriatrics program (Cornell), CHAMP and USCF web-based modules, Health Literacy web module, and provider sheets on core geriatric topics in a mandatory one-month home-based geriatric rotation.

- **Integrative Medicine.** This innovative web-based case vignette was developed and implemented by Dr. Lebensohn, Reynolds Scholar, to illustrate preventive services in older adults- as part of a 250-hour web-based curriculum called
Integrative Medicine in Residency. [http://dime.arizona.edu/demos/lupecase/index.html](http://dime.arizona.edu/demos/lupecase/index.html) username and password is lupedemo

- **Surgery Residency.** Expanded core lectures/grand rounds on "Medical Considerations of the Older Surgical Patient" for medicine, ob-gyn, vascular surgery, general surgery, anesthesiology, and urology.
- **Emergency Medicine.** Led by Art Sanders, MD, nationally recognized for his work in geriatric emergency medicine, we developed and implemented 6 hours of case-based lectures for residents on core geriatric issues.

Faculty: We have implemented our Reynolds Scholars in Aging Program for Department Heads and leaders in primary care, surgery and related specialties, and our Associate Reynolds Scholar in Aging Program for junior faculty. Both programs provide a structured, mentored geriatric educational program to facilitate integration of aging-related issues into the training programs, clinical care, and scholarly activities.

- **CAPstone (Care of Aging Patients) Project: Reynolds Scholars and Associate Reynolds Scholars**
  - Our scholars developed and implemented several CAPstone projects, each of which comprised a comprehensive change project utilizing the practical application of geriatric principles to improve health care processes and outcomes in aging patients, and to serve as a training site in geriatric care for students, fellows, and faculty. Examples of projects implemented (or in process) include: Delirium Prevention and Management Program (implemented in ICU, in process on acute care wards); Developing a Gero-sensitive Emergency Room (in process); Developing an Acute Care of Elder unit/program (University Physicians Hospital, in process); Integration of Aging-Issues into the Societies Program; Geriatric-surgery collaborative care (Orthopedics and Vascular – in process; Integrating geriatrics into the medical school curriculum (ongoing).

- **Informationist: The New Health Professional.** Our informationist, Dr. Howe, is a board certified geriatrician with training in library sciences and informatics (MLS). She built the Arizona Geriatrics and Gerontology Health Topics” website on the main page of the Arizona Health Sciences Library (www.ahsl.arizona.edu) providing ready-access to evidence-based literature and other resources on core geriatric topics, including subspecialties of medicine, and surgery and related specialty areas. Comprehensive articles include key review articles, epidemiology, pathophysiology, practice guidelines, models of care, social and interdisciplinary issues for each key aging-related topic. "PubMed Alerts" -- pre-formulated and automatically updated searches on key aspects of these syndromes -- are provided. Dr. Howe also works closely with faculty, residents, and medical students to enhance their geriatric knowledge, and to provide evidence-based material in response to their ongoing clinical questions. This inquiry process has in turn been the basis for academic activities, such as case-based training, and journal articles.

Practicing Physicians: We are providing specific learning experiences that integrate geriatric education and training into community-based practices to improve care. Key activities include:

- **Arizona Geriatrics Society Journal.** A peer-reviewed, interdisciplinary journal published twice yearly, with sections on State of the Art, Clinical Practice, Research, Medical Humanities, Public Policy, and Perspectives. This journal provides a unique opportunity for medical students, residents, fellows and junior faculty from around the country to publish manuscripts on aging-related topics, and embark on an academic career.
- **Indian Health Service.** We continue to partner with Hopi Health Center and Whiteriver (Apache) Hospital and provide on-site consultation, lectures, radio broadcasts, and focused Elder Care Provider Sheets (see below) to meet their needs for practical information on common geriatric issues- with planned extension to other Indian Health Service and tribal units.
- **VA Learning Management System.** We identified the initial topics (delirium, falls), the implementation team, and VA leadership support to implement on-line geriatric learning clusters for VA physicians. The first module on delirium will begin beta testing in 1-2 months.

Educational Products:

- **Health Literacy for the Older Adult.** An interactive, web-based self-learning module for all target groups, developed by Barry Weiss, MD, a national leader in health literacy. This module received high praise in a JAGS review of educational products.
- **Cultural Competency and the Older Adult.** An interactive, web-based self-learning module for all target groups (beta-testing in process)
- **Elder Care Provider Sheets.** Initially developed for the Indian Health Service, provider sheets are one-page, practical, evidence-based and culturally competent hand-outs that synthesize key concepts in common geriatric syndromes and conditions. With screening and assessment tools and treatment gems, these sheets reinforce sound geriatric practice in an approachable format, and have been well received by medical students, residents, fellows and junior faculty. Over 25 fact sheets are available, based on ACOVE topics, and each sheet includes goals/objectives and questions/answers. Many are posted on POGOe, and can be branded by your institution for local use. Topics include:
Falls, Delirium, Dementia, Erectile Dysfunction, Elder Abuse, Health Literacy, Urinary Incontinence, Peripheral Vascular Disease, Depression, and others.


**University of California, San Francisco**

Project emphasis has been on two critical issues in geriatrics, transitions in care and care of hospitalized elders. Primary activities included:

**Medical Student Core**

**Activity 1:** *Every student will have a transitional care experience with an elder and an accompanying curriculum during their third year medicine clerkship.* In year 1, a curriculum was developed and implemented at 3 teaching sites, and the curriculum has become a permanent part of the third year medicine rotation.

**Activity 2:** *Every student will participate in a Geriatrics mini-CPX, CPX or both during their third year.* A geriatrics mini-CPX (Clinical Performance Exam) and a CPX case utilizing standardized patients have been developed. All eight medical schools in California have adopted the latter assessment.

**Activity 3:** *Every student will have a mentored home visit experience with a geriatrician preceptor in their third year Family and Community Medicine clerkship, with a companion geriatrics curriculum.* This was piloted in late 2006-early 2007, and fully implemented beginning in March 2007. Students spend one half day in an interactive didactic workshop that introduces core concepts in outpatient geriatric care followed by 4-6 half-day sessions seeing geriatric patients in their homes. This model was also adapted for use in pilot programs focused on integrated, longitudinal clerkships for third year medical students.

**Activity 4:** *The Student Geriatrics Interest Group (GIG) will be revitalized.* The student interest group, renamed the Aging and Palliative Care Interest Group, is the only interdisciplinary one at UCSF. In Year 1-2 the group hosted monthly conferences on clinical, policy and health services topics, with 30-50 attendees per conference. Several conferences have featured topics on underserved populations and were co-sponsored with other student interest groups on campus. In Years 3-4, the noon conferences were transformed into an innovative geriatrics and palliative care elective that combines lectures and experiential learning opportunities in a wide range of clinical settings. The elective is available to students in medicine, pharmacy, nursing, physical therapy and dentistry.

**Resident Core**

**Activity 1:** *Every medicine resident will receive a transitional care experience and a geriatrics inpatient experience with either the ACE unit at SF General Hospital, the "geri team" at the SF VAMC, or both in addition to the geriatrics training that they already receive.* The internal medicine residency didactic curriculum in geriatrics was standardized so that all residents receive more content aligned with the recently developed competencies for residents. The experience at the VA will transition to the new ACE unit this year. Residents in the primary care track also spend time with geriatricians in the outpatient Housecalls program.

**Activity 2:** *We will adapt our existing geriatrics curriculum for Urologists to reach Ophthalmologists in Year 1 of the grant, Anesthesiologists in Year 2, Orthopedists in Year 3, and Emergency Medicine physicians in Year 4.* In Year 1, an ophthalmology geriatrics Jeopardy game product was developed, as well as a presentation on diseases of the aging eye. During year 2, geriatrics sessions using the Jeopardy game format were held with Urology and Anesthesiology residents. In the third year, we implemented a three-hour interactive curriculum for orthopedic residents. In Year 4, a half-day session was developed and offered to emergency medicine residents. The session combined didactics, an expert discussion panel, and interactive, case-based learning stations.

**Hospitalist Core**

**Activity 1:** *We will recruit a Geriatrician to run an ACE Unit, provide house staff teaching, and faculty development at SF General Hospital.* The ACE unit opened in June 2007 and expanded in 2009 to include a cardiac ACE. It has become an important teaching site for geriatrics in both Internal and Family Medicine.

**Activity 2:** *We will recruit a Geriatrician-Hospitalist for UCSF Medical Center.* The three Reynolds Scholars of the Division of Hospital Medicine helped to sustain and advance efforts after the departure of the Geriatrician-Hospitalist.

**Activity 3:** *We will recruit one Hospitalist each year to be a Reynolds Hospitalist Scholar.* The three hospitalist scholars, who attended the UCLA geriatrics mini-fellowship and then developed a geriatrics curriculum project, have become geriatrics teaching champions and leaders within the Division of Hospital Medicine.
Activity 4: We will select and invite a Reynolds Visiting Professor annually. UCSF hosted Reynolds Visiting Professors for two-day visits in years 2-4 of the grant.

Activity 5: We will implement the Reynolds Hospitalist Training of Trainers Program. Sessions were developed and team-taught by hospitalist/geriatrician pairs to hospitalist faculty at UCSF. It is being implemented in 2009 at SF General Hospital.

Selected Products

1. The Transitional Care Curriculum for third year medical students;
2. Outpatient Geriatrics and Mentored Home Visit curriculum for third year medical students;
3. Hospitalist Faculty Development Program (based on CHAMP);
4. Incontinence bingo;
5. Geriatrics jeopardy;
6. Urology jeopardy;
7. Ophthalmology jeopardy and “Care of the Aging Eye”;
8. Geriatrics pocket card: Inpatient Care
9. Discharge planning pocket card for students and residents
10. Geriatrics comprehensive care case conferences for residents
11. Clinical Performance Exam (CPX) for students completing 3rd year (Doris Walker)
12. Approaching the End of Life booklet, for interns, residents, fellows, to use in difficult discussions with families and friends
13. Cross-Cover Challenges PowerPoint presentation for 4th year students preparing for internship/night call-highlights common geriatric challenges that are likely to be encountered

University of Kansas

The University of Kansas will create and maintain a comprehensive, highly innovative and long-lasting medical education program, the Kansas Reynolds Program in Aging for medical students, resident physicians, and medical school faculty. The Kansas Reynolds Program will emphasize training medical students, resident physicians, and medical school faculty to optimize the quality of health care for successfully aging and vulnerable older adults. All educational activities will be guided by the principle of providing the trainee an appropriate, broad-based foundation for managing the health care needs of older adult patients, with and without complex comorbid illness, across the continuum of care. Our approach to teaching the delivery of quality care to older adult patients will be to integrate selected quality indicators from the Assessing Care of Vulnerable Elders (ACOVE) project (1), along with the basic geriatric medicine content, into all of our educational materials and methods.

Based on the theme of quality improvement for the health care of older adults, the Kansas Reynolds Program will provide undergraduate medical student and post-graduate resident geriatric medical education, as well as faculty development, in the areas of improving functional independence, avoiding medical errors, appropriate pharmacotherapy, understanding system efficiency and transitions of care. Interwoven with these major grant focuses will be the primary educational objectives of teaching patient and family-centered care, interdisciplinary team management, evidenced-based practice, quality improvement, and informatics support for clinical decision-making.

Reynolds Activities:

Undergraduate Medical Education:

1. Incorporate geriatric content throughout Year 1 and 2 of the medical education curriculum.
2. Co-Direct a new module, “Medicine Across the Lifespan” in Year 2 of the undergraduate curriculum.
3. Revise Year 3 Clerkship lecture content.
4. Develop a geriatric component within the Year 4 Sub-internship in both Family Medicine and Internal Medicine.

Residency Education:
1. Collaborate with 12 subspecialty residency programs to incorporate geriatric clinical content into education conferences and professor rounds to increase awareness and care for older patients.

2. Provide a geriatric journal club in the Family Medicine residency program.

Faculty Development:
1. Develop a faculty development program for 10-12 junior and mid-level faculty in the subspecialties in geriatric clinical care, curriculum development and information mastery.

University of Utah – Next Steps

The objective of the University of Utah Reynolds Next Steps in Physicians’ Training in Geriatrics, “Quality, Safety and Value: What Utah GME trainees will learn from Geriatrics,” is to provide competency-based training in patient quality, safety, and care transitions grounded in principles of geriatric medicine for its graduate medical education (GME) trainees in medical and surgical specialties and Internal Medicine subspecialties. Two levels of training will be provided. An entry level for GME trainees across all of its ACGME-accredited programs – 27 residency and 41 fellowship programs – encompassing a total of approximately 740 physician trainees and an advanced level for six residency programs concurrently enrolled in our Chief Resident Immersion Training (CRIT) program and the ten fellowship programs representing Internal Medicine subspecialties.

This proposal builds on our successful experience in QI training programs and expands our target population to the geriatrics training needs of GME trainees from medical and surgical specialties and Internal Medicine subspecialties. Pursuit of the “triple aim” in health care is one of the drivers that supports the timeliness and feasibility of the proposed training activities. Beginning in July 2013, new ACGME requirements stipulate that all institutions offering GME training provide opportunities focused on patient safety, quality improvement and transitions in care. In addition, the ACGME Next Accreditation System will require that GME programs develop new approaches to assessing their trainees’ competency on a series of milestones by July 2013. For these reasons, the University of Utah Health Care clinical leadership, the School of Medicine Dean’s office, and GME Committee enthusiastically endorse this proposal and commit to almost $1 million in cost sharing matching funds and pledge to sustain its programs.

An experienced cadre of twelve geriatrician and hospitalist clinician educators will lead this training program. In addition, the proposed activities leverage the curricular products developed during the initial Reynolds award, the Chief Resident Immersion Training (CRIT) program, the successful delirium prevention Hospital Elder Life Program (HELP) and a new geriatric fragility fracture clinical pathway. Informed by results of a needs assessment survey completed by GME training program directors, the entry level training activities will include new requirements for all, approximately 250, entering GME trainees to: 1) complete two new quality and safety training modules based in part on Institute for Healthcare Improvement (IHI) Open School content, 2) submit at least one Patient Safety Net front line report, and 3) complete discharge summaries utilizing a new template at the time a patient is discharged to a skilled nursing facility. In addition to these requirements, 75 trainees from residency programs concurrently enrolled in CRIT and caring for patients in the geriatric fragility fracture pathway will obtain advanced training in geriatrics, quality, safety and care transitions. This training will encompass didactic training materials, case-based presentations, and supporting quality improvement projects. Additionally, in collaboration with all ten subspecialty Internal Medicine fellowship program directors, a CRIT-styled educational retreat will be developed and implemented annually for the 30 incoming fellows. The retreat will focus on geriatric competencies relevant to these subspecialties and principles of quality improvement that will facilitate their ability to conduct QI projects.

Using principles of participant evaluation, the evaluation plan will consist of formative metrics assessing the quality, intensity and effectiveness of the interventions as well as summative metrics that assess their impact on selected processes of care, especially care transitions and safety. These metrics will be woven into the program to support the concept of a “learning organization” which is key to improving care.

In summary, this innovative GME-focused training program will have an important and enduring impact in preparing approximately 250 physicians each year to provide high quality, safe care for the geriatric patients they will encounter throughout their careers.

Vanderbilt University

The Vanderbilt-Reynolds Geriatrics Education Center (VR-GEC) works to coordinate, enhance, and refine an innovative and comprehensive educational program in Geriatrics at Vanderbilt that strengthens training for medical
students, residents, faculty, and non-faculty practicing physicians. Through development of innovative curricula combined with novel use of informatics, we are enacting an educational redesign, providing learning at the point of care with decision support to enhance both educational and clinical outcomes.

**Undergraduate:** We are developing a competency-based medical school curriculum in geriatrics that builds on the educational experiences of all four years of the medical school curriculum (400 students). Vanderbilt-developed informatics tools, such as KnowledgeMap (a curriculum content management and concept-based search software) and KM/Portfolio (which tracks each learner’s exposure to content) are being utilized to evaluate the existing overall medical school curriculum and integrate geriatrics content. The system can also identify geriatric medicine exposure gaps for individual students and facilitate appropriate remediation. Innovative non-informatics accomplishments include:

- First-year and second-year medical student home visit experience with integrated classroom/didactic content, discussion groups, and preceptorship exposures. This focus of the program is on chronic illness care, effective communication and quality across the continuum of care. A video (simulation learning experience) was developed to introduce students to the home visit and to model effective patient-provider communication.
- First-year interdisciplinary clinic experience designed to provide students with a greater understanding of medical service delivery systems and interdisciplinary teams. This program also has a chronic illness focus.
- Multiple standardized patient exercises (MS I & III) addressing communication with regard to dementia patient and caregiver communication, end-of-life care, and geriatric syndromes (e.g., urinary incontinence, polypharmacy and elder abuse. Additional standardized patient exercises (MS II) focus on polypharmacy, gait assessment, falls risks and administration of the Mini Mental Status Exam.

**Residency:** A significant VR-GEC goal is to create an innovative curriculum of safety and quality in Geriatrics for Vanderbilt’s 800 residents. Informatics tools are being used in training of medicine and specialty residency programs alongside non-informatics methodologies. The goal of VR-GEC informatics work is to promote, coordinate, and extend geriatrics education for medical students, residents, and practicing physicians in a broad variety of settings. The overall VR-GEC informatics approach relies on learners using digital resources developed by the Eskind Biomedical Library, and point-of-care and point-of-learning informatics-based applications that deliver regularly updated, key educational content through the Vanderbilt-developed systems – KnowledgeMap (educational content indexed by concepts), WizOrder (care provider order entry -- CPOE), and the StarPanel Electronic Medical Record (EMR) system. The VR-GEC develops and disseminates information systems that can improve the geriatrics training of medical students, residents, and practicing clinicians. Informatics tools include clinical decision support linked to the electronic medical record, such as:

1. CPOE systems that provide guidance on prescription dosing safety, contraindications, Beers list medications to avoid, etc.; specialty appropriate simulator and standardized patient training; evidence-based medicine-focused lectures/case presentations by geriatrics specialty content experts.
2. Patient-specific, evidence-based clinical information delivered to clinicians at the bedside during encounters with patients through EMR-based tools as well as a Geriatrics Digital Library, containing links to online geriatric medicine reference material as well as Synthesized Information Packets on Geriatrics Topics, developed by the Vanderbilt Clinical Informatics Consultation Service (CICS). These include Warfarin dosing, activities of daily living assessment, falls risk reduction, PEG tubes in patients with dementia, peripheral arterial disease, aortic stenosis, mitral regurgitation, abdominal aortic aneurysm, and related topics.
3. Individual patient and patient-population monitoring through StarTracker, via a “geriatrics quality dashboard” embedded in the patient’s StarPanel EMR display whenever any student or physician (or other care provider) accesses the patient’s electronic chart. The content of the dashboard includes eight total quality measures: (a) renal function (represented by serum creatinine levels and Cockcroft-Gault estimates); (b) hematocrit levels (whether at acceptable levels, and whether trending downward in a problematic manner); (c) receipt of Influenza vaccine according to scheduled needs; (d) receipt of pneumococcal vaccine according to scheduled needs; (e) outpatient clinic visit-associated assessment of activities of daily living (ADLs), including related problems; (f) alert pops up if the patient is actively taking (or has been prescribed) any strongly contraindicated outpatient medication (based on modified Beers’ list of meds); (g) patient adherence to the recommended schedule for colorectal cancer screening; and, (h) patient adherence to the recommended schedule for breast cancer screening (mammography).
4. To improve evidence-based treatment of geriatric patients at Vanderbilt University Hospital, the VR-GEC is augmenting the geriatrics-related content of existing CPOE system order sets and, when appropriate, creating new order sets de novo. To improve geriatric care among all inpatient services, the VR-GEC informatics team has created a new, modular “geriatric pain management” order set that can be linked into each problematic order set, and which generically covers appropriate management of pain medications in the elderly. Another modular order set is being designed to address the issue in many services of inadequate or inappropriate discharge
planning for elderly patients (e.g., failure to suggest consultation of social services, physical and occupational therapy, etc.). Similar modular order sets are being developed for other issues in medical management of geriatric patients that are common to many or all services.

Major non-informatics VR-GEC accomplishments related to medicine and specialty residency curricular programming include:

- Design and implementation of a home safety program for first-year medicine residents, focusing on interdisciplinary team, continuity of care, falls prevention and home safety. Residents accompany Vanderbilt Home Care staff (RNs, PTs and OTs) on house calls with patients and perform a home safety assessment. Pre- and post-visit exercises and precepting sessions provide an opportunity to discuss observations and explore implications for future practice.
- Initiation of a geriatrics quality improvement program with Vanderbilt’s Cardiology Fellowship, with full integration of informatics resources to track and improve clinical care.
- Integration of electronic evidence-based medicine packets with traditional classroom case presentations/discussions. Packets are thoroughly researched by Masters-level clinical librarians and posted on the Vanderbilt Geriatrics Digital Library (link at www.mc.vanderbilt.edu/geriatrics).

Practicing Physicians: VR-GEC programming also enhances geriatrics knowledge and clinical care among faculty and community physicians affiliated with Vanderbilt (1,000 physicians). Major accomplishments in this area include:

- Establishment of a Geriatrics and Gerontology Advisory Service for faculty researchers in the Vanderbilt Center for Quality Aging.
- Extension of clinical informatics resources to nursing home settings to provide tailored geriatrics point-of-care education and clinical support.
- A well-received, twice-monthly interdisciplinary lecture series and regular journal club sessions providing geriatrics continuing education.
- Establishment and continued development of a VR-GEC web site (www.mc.vanderbilt.edu/geriatrics), containing links to continuing education opportunities sponsored by Vanderbilt and other organizations. The Web site also offers clinical support resources, including Vanderbilt Eskind Biomedical Library’s Geriatrics Digital Library.
- Vanderbilt’s annual Geriatric and Long-Term Care Medicine Conference provides high-quality continuing education opportunities for attendees from around the region.

POGOe: In June 2008 the VR-GEC informatics team launched a new, Vanderbilt-hosted version of POGOe that features the concept-based searching tool KnowledgeMap as its basis. The new POGOe includes fully searchable content by any word or concept within any text or PowerPoint document, an integrated Wiki, and archives of best products from Reynolds grant participants. In April 2008, the VR-GEC

Reynolds Trans-Institutional Education Group (R-TIEG): The VR-GEC coordinates a group of interested individuals from various Reynolds programs interested in evaluation of geriatrics educational programming and student assessment; this group is called the Reynolds Trans-Institutional Evaluation Group. The goal of R-TIEG is to serve as a “home” for evaluation within the Reynolds community, providing a forum for Reynolds program participants interested in the planning and implementation of program evaluation to discuss, learn and share. R-TIEG collaborations take place through conference call meetings, email, and POGOe and at the Reynolds Foundation Annual Meeting for Grantees, as well as informally at other conferences. R-TIEG meets its goals through multiple projects, including:

1. Develop and coordinate implementation of evaluation-related sessions at the annual Reynolds grantee meeting.
2. Co-coordinate with Harvard University, Mt. Sinai school of Medicine, the SGIM Geriatrics Taskforce and other collaborators the development and dissemination of the POGOe Evaluators’ Toolbox.
3. Develop, locate and disseminate program evaluation “self-assessment” tools that help schools identify evaluation needs and highlight areas of expertise to be shared with other programs.

The Vanderbilt Reynolds Program continues to collaborate with the Geriatric Education Centers and GRECC to deliver geriatrics education to health professionals and to evaluate the outcome of these programs at the point of patient care “tertiary evaluation.” To date there are 20 educational evaluation publications from the Vanderbilt Reynolds Education Center.
Aging Q3: Quality Education, Quality of Care, Quality of Life

The Medical University of South Carolina (MUSC) program, “Aging Q³”, has completed its first grant year. Our goals are to improve the quality of geriatric education for all learners, improve clinical care for elders while developing geriatrics as an academic and faculty development priority. Our focus is Internal Medicine residents on general Internal Medicine services, but we expect an impact on the medical students as they observe residents practicing new skills applicable to the geriatric population in University Internal Medicine clinic and inpatient General Internal Medicine services. The objectives of the Aging Q³ program are: to make Quality the geriatric focus, build broad-based knowledge and skills among GIMG faculty, create a training environment where internal medicine residents must learn and apply geriatric knowledge and skills, and to gerontologize MUSC.

The quality of care paradigm is based on the Assessing Care of Vulnerable Elders (ACOVE) program and educational and outcome measures are built around those concepts. Every three months we focus on a new ACOVE-derived geriatric quality of care issue, with materials and interventions developed by a rotating faculty working group. The working groups in Aging Q3 use a combination of faculty development, traditional didactics, academic detailing, and a variety of paper and electronic-medical record cues and reminders in developing curriculum and educational interventions in geriatric quality of care. To maintain consistency between each ACOVE issue, we have developed operational tools for the working groups to implement the sequence of interventions called, Knowledge to Performance, a Generic Template and a Structure-Process-Outcome logic model to translate interventions to measurable educational and quality of care outcomes. Measures include: pre-post test or resident knowledge, faculty and resident participation rates, faculty detailing performance, resident clinical behavior change through electronic medical record analysis and reported/observed resident behavior.

Lessons Learned:

With each ACOVE, we learn something different about what works and what doesn’t. We are able to build on our experiences and have had some major accomplishments. Four ACOVE areas have been completed: Vision, Falls, Dementia, and Continuity of Care. The 5th, Medication Use and Safety, is now in progress and we are gearing up to launch our 6th ACOVE (Screening and Prevention) mid September. We have created well developed organizational tools and data sources and have had a high participation rate among residents. We have been successful in establishing a decision-support vehicle through Practice Partner, and are becoming more efficient as we proceed. Residents are building knowledge and skills in each ACOVE. In Vision, the focus was teaching the residents how to recognize the most common diseases of the eye in the elderly and become familiar with the funduscopic exam. In falls, the residents learned about risk factors, taking a fall history, and how to evaluate a fall. They learned and demonstrated their ability to conduct a Timed Up and Go test on elderly patients seen in the ambulatory clinic. Differential diagnosis and recognition of the 3D’s was the focus of the dementia ACOVE. Residents learned how to complete a CAM (Confusion Assessment Method), PHQ-2 (Depression screen), and Mini-Cog with clock draw exam by administering the screens on patients with known or suspected dementia. In the Continuity of Care and Medication Use and Safety ACOVEs the residents are learning to perform a medication reconciliation and how to identify and decrease adverse drug events with elderly patients in both the hospital and clinic setting. To date, 6 manuscripts are in progress, ## presentations have been completed locally and regionally.

Educational resources:

Our Aging Q³ website, http://mcintranet.musc.edu/agingq3, is a helpful resource for faculty, residents, and other institutions to follow the progress of the ACOVEs. The resident lectures and detailing material as well as the reference articles used in each ACOVE are accessible on the website. We continue to explore ways to use the website as a teaching tool.

Future plans:

ACOVEs planned for the next year include, Hospitalization and Transitions, End of Life Care, Pain Management, and Osteoporosis.
The University of Alabama at Birmingham (UAB) proposes a Reynolds Program that will strengthen medical student, resident, faculty and community physician training in Care of the Complex Older Adult (COCOA). There is a critical need for this type of physician training and UAB is poised to play a key role in the design and implementation of the COCA Curriculum. Working with our Reynolds partners we will build a comprehensive geriatric education program that will provide over 875 UAB medical students, over 350 residents, and countless other faculty and community physicians with the tools to better navigate the increasing complexity experienced by their older patients.

Using Safford’s Complexity Model1 as a conceptual framework to guide the development of all program components, the proposed UAB Reynolds Program—Care of the Complex Older Adult—will improve training in the care of complex older adults by developing and implementing geriatric educational curriculum addressing five key Domains necessary for delivering high quality care to complex older adults:

- Advanced Illness and Multimorbidity
- Transitions in Care
- Family Systems and Self/Caregiver Management
- Cultural Aspects of Aging
- Health Literacy and Health Disparities

We will improve care of complex older adults using a variety of innovative educational techniques including standardized virtual patients and asynchronous distance learning. We will incorporate previously developed Reynolds resources and work with our Reynolds partners to develop needed web-based learning materials where we have identified gaps. This approach will succeed because we will build upon (1) strong existing programs and geriatric faculty at UAB, (2) support from UAB at all levels, and (3) a culture of collaboration.

- For medical students, we will integrate geriatrics into the new medical school curriculum throughout all four years by enhancing educational materials and creating required and elective courses as well as extracurricular opportunities. Using the acclaimed Computer-assisted Learning in Pediatrics Project (CLIPP) methodology, we will develop Web-based Geriatrics Education Modules (Web-GEMs), which will be continuously enhanced by programmatic review.
- For residents, we will enhance geriatric content for five residency programs and initiate a required 4-week geriatric rotation for all Internal Medicine interns. We will develop Web-based Physician Education and Remote Learning (Web-PEARLs) materials to teach COCA Domains.
- For faculty, we will offer training in virtual patient development, facilitate learning by participating in the creation of web-based geriatric curricula (e.g., Web-GEMs), and provide additional geriatric training to hospitalists and family medicine clerkship preceptors.
- For practicing physicians, in the Alabama and Mississippi Practice-Based Networks and in VA hospitals within our Network, we will provide learning opportunities that will effectively integrate concepts and strategies for managing complexity into their practices to improve geriatric care.
- For learners at all levels, computer-assisted instruction (CAI) will address the five COCA Domains while meeting key geriatrics competencies.

The COCA Program will have strong local support and far reaching national impact. It will be guided by an Internal Advisory Committee comprised of Deans, Department Chairs and other leaders who are committed to implementing a strong program. The strong institutional support will ensure sustainability, enduring educational products, and seamless integration in the curriculum for all levels of learners. The COCA Program will have a national impact because its emphasis on advanced illness, multimorbidity and the complex older adult fills important gaps in geriatric education. Additionally, the development of a standardized, collaborative authoring process for e-learning products, such as that proposed for Web-GEMS, builds on the unique partnership opportunities afforded by the Reynolds community and will add value to web-based geriatrics education nationwide.
**University of California, Irvine**

To improve medical care for all older adults touched by our graduates and others who utilize our materials, the University of California, Irvine (UCI) School of Medicine Reynolds Program focuses on a "Return to the Patient-Doctor Relationship (PDR)" and teaching AAMC basic geriatric competencies throughout the undergraduate and graduate programs.

Due to support from the Donald W. Reynolds Foundation grant, the Program in Geriatrics is developing the faculty, resources, and relationships needed to transform geriatric education at UC Irvine. The Program in Geriatrics is working side by side with the School of Medicine to integrate principles of patient doctor relationships into all levels of training. Our PDR goals include training physicians to provide compassionate, patient-centered care through a triad of subthemes: health literacy, communication skills, and shared decision making.

We developed two structures which have been instrumental in carrying out these goals. One is the Geriatric Education Undergraduate Committee (GEUG) and the other is the Geriatric Education Graduate Committee (GEG). The SOM Associate Dean who oversees residency and medical school education is a member of both committees.

This partnership has yielded many successes. This includes faculty development for core faculty teaching clinical skills for first and second year medical students. The first year focused on patient doctor relationship themes and the second year will focus on teaching AAMC geriatric competencies. Also, a summer rotation called "From Bench to Community," is now in its second year and offers introductions to all aspect of dementia care and research. Our first student developed a poster which was accepted to the 2010 AGS conference. A new Student Senior Partner Program has been piloted and will now extend to the entire first year class. The program includes clinical experiences and focuses on communication, health literacy and medical decision making. Medical students also have a new module and evaluation tool in Medical Interviewing and Communication.

Also, geriatric medicine is now an integral part of the ambulatory care internal medicine clerkship for the first time. A unique program titled Medical Reader’s Theater involving both students and volunteer seniors focuses on facets of communication through theater scripts. Significant changes in the Internal Medicine residency include a required geriatric rotation in the intern year. We have integrated pogoe curriculum into this two week rotation. In this way, learners are being introduced to geriatrics early in their careers. In addition, in collaboration with Vanderbilt University, Knowledge Map will become UC Irvine’s curriculum management system.

In addition, specific curricula for both undergraduate and graduate education has been developed and will be made available throughout the School of Medicine. Highlights include an Emergency Medicine web-based curriculum which includes five interactive teaching modules that emphasize clinical case studies and patient examples. Older patients and their family members from the community are the actors in these modules. Ophthalmology is developing interactive modules using geriatric eye conditions to illustrate elements of the patient doctor relationship relating to continuity of care and adherence.

A Transitions in Care project has resulted in a protocol for discharging patients from the hospital. Residents learn to facilitate improved continuity of care through a discharge protocol and evaluation. An inpatient curricula has been developed in Family Medicine focusing on care issues in older inpatients. Also, an ethnogeriatric curriculum focusing on the care of Latino and Vietnamese patients has been introduced to undergraduates prior to starting clinical medicine and in the Family Medicine and Internal Medicine residency programs. Anesthesiology has developed a resident rotation in Geriatric Anesthesiology and created a comprehensive manual that covers the current literature and controversies in perioperative care. Online presentations also include Geriatric Oncology, Geriatric Dermatology, Emergency Medicine, and Nursing Home care.

The many years of building relationships and working cooperatively with a multitude of departments have primed our colleagues to 'geriatricize' their programs. Through this grant, departments are continuing their commitment to the development and implementation of geriatrics into undergraduate and graduate education.

**University of Massachusetts**

The University of Massachusetts Medical School’s Reynolds/ AGE (Advancing Geriatrics Education) Project, facilitated by strong support from the University, the Dean, Department Chairs and faculty, continues its schedule of
planning and implementation of an integrated geriatric curriculum. The aim of the project is to create a suite of educational activities that will constitute a geriatrics education program across the medical education continuum. The institutional leadership working in tandem with the project co-principal investigators are fully committed to and actively engaged in the progress of the initiative, facilitating discussion and access to key individuals responsible for major educational development at the School. Following numerous Reynolds/AGE information dissemination meetings with various curriculum stakeholders, we achieved successful collaboration at all levels- undergraduate (UME) and graduate medical education (GME), and continuing professional education (CPE) - to orient key players and integrate new and enhanced geriatrics curriculum content across the continuum of medical education.

In the Undergraduate Medicine Education (UME) arena, we have seized the opportunity to work closely with an ongoing institution-wide Learner-centered Integrated Curriculum redesign (LinC) process to both strategize and seek advice on integrating curriculum, while offering the resources of the Reynolds/AGE to assist in that process. We have successfully implemented several elements of our 3 originally proposed UME components: (1) Integrated Geriatrics Curriculum (e.g. Integrated aging thread into Human Anatomy course: geriatrician led lecture and subsequent geriatrician faculty partnering with anatomy faculty and students in the anatomy lab); (2) Integrated Geriatrics Assessment (e.g. development, implementation and assessment of a geriatrics-based OSCE case focusing on presentation and differential dx of depression in older adults); and (3) Geriatrics Advocacy Program (e.g. establishment of the Elder Patient Navigator Program, a student driven initiative, implemented under geriatrician faculty guidance.

At the Graduate Medical Education (GME) level, we met our target milestones for our inaugural Chief Resident Immersion Training (CRIT) program April 30-May2, 2010. Thirteen chief residents representing 8 residency programs, and 4 residency directors and faculty participated in the CRIT. In addition, we have continued to work with 2 specialty residency programs, Orthopedics and Ob/Gyn to provide geriatrician led core lectures, work rounds, and jointly sponsored Grand Rounds with geriatric expert guest speakers. Also in the GME arena, we have delivered on-line geriatric curricular interventions promoting residents’ practice with older adults and we are in the process of implementing a practice improvement module (PIM) – type initiative for residents in the primary care practice setting.

At the CPE or Faculty Development level, we piloted our Faculty Immersion Training (FIT) program initiative which coincided with the CRIT training weekend in April 2010, with 3 non-geriatrician residency directors and 1 additional faculty member.

Other faculty highlights include the recruitment of 2 new geriatrician faculty, with dedicated time to serve on our AGE planning team and to directly support our teaching innovations. Supporting our expanded faculty and the overall work of the Reynolds AGE project, we have recruited two new outstanding educational professionals with complementary expertise in evaluation and education technology. Lastly, our robust Research and Evaluation resources have fueled the programmatic assessment of our project in its first year, with the development and implementation of several key evaluation components including: tracking of learner exposure (dosing) metrics and milestones for measuring program progress, and tools for assessing selected skills and attitudes. With the progress and achievements of our project to date, our model of shared leadership and institutional support at the highest level of leadership has yielded tangible results and assured the ongoing success of our project. Moving forward, we are well-positioned to continue this trajectory of success in meeting our stated goals and in planning for the sustainability of the Reynolds AGE innovations longer term.

**University of Medicine & Dentistry of New Jersey**

**Aims:** This proposal builds on the significant strengths within the UMDNJ-SOM New Jersey Institute for Successful Aging (NJISA); its longstanding reputation as a leader in geriatrics in the osteopathic profession; national ranking among the Top 20 graduate medical education programs in geriatrics; and nationally known senior faculty; The 3 major aims of the proposed program are to: 1) expand and enrich medical students’ education in the area of geriatrics over all 4 years of the curriculum; 2) enhance post-doctoral geriatric training in primary care, emergency medicine, and psychiatry; and 3) improve faculty skills in competency-based assessment and application of e-technology to enhance the delivery of content in geriatrics. Evaluation will be formative and summative, looking at process and measurable outcomes across all proposed project activities.

**Activities and Products:** The proposal focuses on the infusion of new geriatric content across all 4 years of the undergraduate curriculum and at the postgraduate level, targeting interns, internal medicine, emergency medicine, and psychiatry residents. Technical assistance from former Reynolds grantees (i.e., University of Hawaii, University
of Miami, and University of Arkansas) is designed to support faculty development in competency-based assessment and Objective Structured Clinical Examination (OSCEs); use of e-technologies and "virtual patients" to enrich our existing strengths in teaching geriatrics; and to adapt the CHAMP (Care of the Hospitalized Aging Medical Patient) curriculum for emergency medicine. Since the award was made, UMDNJ-SOM has expanded its medical student initiatives to include the development of osteopathic manipulative medicine (OMM) minimum competencies in geriatrics. Competency developers will use Delphi Survey techniques to survey Educational Council on Osteopathic Principles (an AACOM subcommittee) and geriatrics experts. The internal medicine residency initiative was likewise expanded to include the development of a formal curriculum on delirium and inappropriate drug prescribing (IP) for IM interns on a one-month, geriatrics-specific hospital rotation. The curriculum includes lectures, pocket cards, and assigned readings. Interns will be evaluated with pre- and post-knowledge tests, standardized bedside performance checklists, and chart review. Innovative aspects of the proposal include the development/evaluation of OMM competencies in aging and the development of an aging curriculum based on AAMC competencies, which builds upon basic science and aging concepts in Year 1; integration of basic science and clinical geriatrics in Year 2; and culminates in the application and competency-based assessment of patient care in clinical Years 3 and 4. Other innovations include the development of a core curriculum in geriatrics for emergency medicine residents including teaching trigger cards and virtual patient cases. Products produced for dissemination will include "teaching trigger cards" for geriatric emergency medicine faculty, curriculum modules, and virtual patient cases in geriatric emergency medicine and geriatric psychiatry.

Impact: The Reynolds grant will result in permanent, sustained resources and curriculum change in geriatrics at the medical student and resident level and, through faculty development, will have equipped faculty to integrate new, innovative strategies into their teaching. Over the 4 years of the project, the proposed geriatric infusion program will have provided new required geriatric content and a geriatric OSCE for over 460 osteopathic medical students; 256 new interns over 4 years will have had focused geriatric content at orientation; 62 interns, internal medicine residents and subspecialty fellows will have case-based presentations in geriatrics at Morning Report annually; 40 emergency medicine residents annually and 20 Emergency Medicine faculty will be impacted by the development of new geriatric didactic and case-based presentations, a virtual patient case, and geriatric teaching trigger cards. The emergency medicine component will also have national impact, with inclusion of geriatric questions into the American College of Osteopathic Emergency Physicians (ACOEP) Resident In-Service Examination (RISE) and dissemination of Emergency Medicine curriculum modules via POGOe. Over 20 faculty will have been trained in competency-based skills assessment (OSCEs) and utilization of e-technology in developing curriculum content as part of the faculty development initiative. Eight psychiatry residents will have had a new, structured geriatric rotation consistent with geriatric psychiatry competencies.

Match/Sustainability: A hard dollar match of $1,000,000 of new academic dollars and additional in-kind resources of $461,354 have been committed to achieve project goals and sustain project activities beyond the grant period.

**The University of North Texas Health Science Center (UNTHSC)**
**Texas College of Osteopathic Medicine (TCOM)**

Reynolds Interprofessional Geriatrics Education and Training in Texas (IGET-IT)

Interprofessional education (IPE) and Interprofessional Collaborative Practice (IPCP) will play a prominent role in the future of health professions’ education and healthcare delivery in the USA and internationally. In the Institute of Medicine report, "Retooling for an Aging America: Building the Health Care Workforce" the authors clearly state that nowhere will this interdisciplinary team based care be more important and prominent than in the complex care of older adults. The critical importance of building interdisciplinary health care teams was emphasized in six national health associations, and three private foundations recommended in the February 2011 conference proceedings report, "Team-Based Competencies-Building a Shared Foundation For Education and Clinical Practice," that health professions should establish team-based competencies for interprofessional education.

We will integrate interprofessional geriatrics education into the current UNTHSC Reynolds IGET IT program by first expanding the Interprofessional Seniors Assisting in Geriatrics Education (SAGE) Program for all health professional year one and two students, second, create Interprofessional Web-based Team Capstone (ITC) Geriatrics Experience for all senior year health professions students. The fourth year CORE GERIATRICS month long rotation will be the anchor for the implementation of this virtual online ITC experience. Finally, a web-based E-
learning continuing education program for residents and practicing physicians will be developed that will satisfy and
meet the residency competency domains and continuous certification and maintenance of licensure requirements
for practicing physicians. The proposed innovative Reynolds Interprofessional Geriatrics Education and Training in
Texas (IGET-IT) curriculum will impact hundreds of osteopathic medical students, health profession students and
practicing physicians and health care professionals.

Interprofessional Models of Geriatrics Education

Two interdisciplinary innovations will be integrated into the TCOM undergraduate osteopathic medical curriculum,
and, one interdisciplinary innovation for Texas OPTI residents in training and practicing osteopathic physicians on
geriatric care will be developed and implemented, details follow:

Innovation 1: Expanding the Interprofessional Seniors Assisting in Geriatrics Education (SAGE) Program for all
health professional year one and two students

Through the SAGE Program, UNTHSC/TCOM has created an opportunity to transform medical education by
enabling medical students and more recently other physician assistant, physical therapy and pharmacy students
partner on house calls to volunteer senior citizens from the Meals on Wheels Program Inc. of Tarrant County and
local community seniors during their first and second year of professional school education. Each one of the over
700 students who have been in the program have made 8 home visits where they apply their classroom
education in the context and care of an older patient. Students have the opportunity to practice and demonstrate
basic clinical skills, including taking histories, interviewing clients, conducting physical exams and cognitive
assessments, and advising clients on nutrition, home safety and discussing community resources available to
them and advanced care planning. This has provided a level of familiarity and comfort with interacting and
treating older adults and an insight into the complex medical issues that face older adults in order to maintain
their quality of life, their dignity and independence.

The creation of an expanded Interprofessional SAGE program will include the addition TCU nursing, social work
dietetics faculty and students to the already participating UNTHSC and TCOM faculty and students. The
TEAM Step program as developed by the Agency for Healthcare Research and Quality (AHRQ) Team
Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) will be utilized as the model.
Also the interprofessional in home program curriculum as developed by Thomas Jefferson University in
Philadelphia will be utilized as an important resource. By grant year two, the TCU nursing students will be added
to the program and then by grant year three, the social work and dietetics students included in a robust
interprofessional training experience that includes seven health care professions' students. The health
profession students will be placed into teams supported by the interprofessional faculty as mentors who
supervise the students virtually with an online learning system. Both the senior volunteer mentors and the faculty
mentors provide will provide feedback to the interprofessional students.

Innovation 2: Create Interprofessional Web-based Team Capstone (ITC) Geriatrics Experience for all
senior year health professions students

UNTHSC Reynolds IGET-IT will utilize the Interdisciplinary Senior Student Team Practicum Virtual Classroom
developed by the Virginia Commonwealth University (VCU) Donald W. Reynolds Interdisciplinary Partnership in
Geriatric Education. This model will be used for the development and implementation of the Interprofessional
Web-based Team Capstone (ITC) Geriatrics Experience for all of the senior UNTHSC osteopathic medical,
pharmacy, physical therapy, and physician assistant students, and, senior TCU nursing, social work and
dietician students. The ITC will occur during the TCOM mandatory fourth year CORE Geriatrics clerkship and
other health care professions' student "clinical learning" in order to create balanced teams. UNTHSC and TCU
faculty and students will have full access to the VCU ITC through a secured internet portal and will be provided
VCU technical support. Partnering with VCU to utilize their ITC platform rather than developing this type of
program ourselves will enable the timely implementation and utilization of a Reynolds Foundation funded
product rather than trying to "reinvent the wheel" and spending more for developing the program.

The additional health professions' students from the disciplines of physician assistant, physical therapy and
dietetics will need to be added as team participants. Preceptors will be the Reynolds IGET-IT faculty who will oversee the learner teams with an estimated one hour per week of preceptor support once implemented. The preceptor oversight will be performed asynchronously (or synchronously) over the internet. Prior to the initiation of the ITC Geriatrics Experience during grant year two, an initial in-person meeting for each team will occur where the AHRQ Team Steps model will be utilized to prepare the students prior to working on the unfolding geriatrics case exercise. As designed by VCU, at the start of each segment of the unfolding case, each discipline will receive information specific to the typical role of that discipline. Team members from other disciplines each receive different, discipline-specific information, thus mirroring real life. To succeed, team members must share their clinical information through the system’s electronic chart and then problem solve together, thus requiring team communication and interaction.

The virtual case will contain questions and choices designed to test content knowledge and decision-making around all of the 29 AAMC geriatric competencies as well as the competencies developed for fields other than medicine and the newest core competencies for Interprofessional Collaborative Practice. The "non-branching" nature of the case provides opportunity for feedback about the best approaches rather than a single absolute correct response. The case system also includes a numeric 360 degree evaluation of each team’s members by the other team members, performed at the end of each segment of the case. The case system provides a reference resource list with suggested reading and links to help with some of the questions, and an asynchronous chat room. All of this data will be captured, including individual participation, team interaction, and both individual and team numeric scores related to content knowledge and decision-making.

Innovation 3: Develop Interprofessional E-Learning Professional Development Modules for residents in training and practicing physicians

UNTHSC Interprofessional Geriatrics Education and Training in Texas Program (IGET-IT) will partner with the National Board of Osteopathic Medicine Examiners (NBOME) to develop and deliver performance improvement modules as an interdisciplinary formative assessment tool called Elder Safety Interprofessional Communication Improvement Module (ICIM). The original Reynolds GET-IT Program included both the Texas Osteopathic Postgraduate Training Institution (OPTI) Residents in Training and practicing physicians as target learners for the geriatric educational offerings.

This innovation includes these learner groups since they are currently training and practicing in a changing medical practice environment where team approaches to care, medical homes, and Accountable Care Organizations (ACOs) are being developed and implemented. There is also a national imperative to reduce medical errors and improve the quality of health care for older adults. One of the newest initiatives developed by the NBOME has a web-based Osteopathic Performance Assessment and Improvement Module (OPAIM™) to assist physicians to comply with the medical licensing and specialty board educational requirements. Each OPAIM is a comprehensive collection of learning components and formative assessments carefully designed to foster lifelong learning for osteopathic physicians. OPAIM™ programs combine pre-knowledge assessment, pre-practice assessment, educational material, self-reflection post-knowledge assessment and post-practice assessment. Because they are web-based, physicians can access an OPAIM™ at their convenience, anytime, anywhere they have Internet access. The NBOME’s goal is to assist organizations to develop OPAIM™ activities that are convenient, user-friendly, practical and applicable. Two OPAIM™ modules have been developed and are now available. The web-based modules are easily tailored to the needs of partnering organizations such as state medical boards, specialty boards or colleges and as proposed by UNTHSC the Reynolds (IGET-IT) Program.

Using the technologies and the procedures for developing the content for OPAIM™ programs, the NBOME in collaboration with the UNTHSC Reynolds (IGET-IT) Program is well suited for developing an interdisciplinary formative assessment tool for Elder Safety that could be utilized by residents in training and practicing physicians. The Elder Safety ICIM will include the following topics: Fall Risk Education and Assessment, Elder Maltreatment, Advanced Care Planning, Medication Reconciliation and Interdisciplinary Approach to Care of the Elderly Patient.

The Reynolds (IGET-IT) faculty will be the content experts and the NBOME staff will provide the development of the platform of the module that will include the text, video, formatting and assessment of exercises and tests.
The proposed product development timeline would include the creation of two didactic presentations annually during each year of the grant. The learning modules on Elder Safety ICIM will be pilot tested by the Texas Osteopathic Postgraduate Training Institution (OPTI) residents and TCOM primary care faculty, alumni and practicing osteopathic physicians who have attended the UNTHSC Professional and Continuing Education (PACE) programs. The E-Learning Elder Safety Module will be distributed via POGOe and available at no cost to users.

University of Pennsylvania

The Penn CARES (Community and Academic Resources for Education about Seniors) Program of the University of Pennsylvania School of Medicine will strengthen the capacity of physicians trained in the University of Pennsylvania Health System to care for elders and create new models of community based service learning. Penn CARES thereby incorporates the expertise and the institutional leadership required to create a substantive sustainable change in the current geriatrics education. Penn CARES targets three groups of trainees: 1) medical students; 2) residents in family medicine, internal medicine, orthopaedic surgery, physical medicine and rehabilitation, psychiatry, and urology; and 3) faculty preceptors of medical students and residents in the aforementioned residencies. Penn CARES will add a chief resident immersion training program, and innovative experiences in community based service learning of geriatrics for family medicine and internal medicine residents. A new “transitions of care” program for patients discharged from the Hospital of the University of Pennsylvania will anchor these educational programs.

The goals of Penn CARES are to:

- **Shape academic curricula and training** necessary to create a sustainable comprehensive geriatrics education program targeting students, residents, and faculty
- **Introduce new models of education in community based service learning for primary care residents**

At the conclusion of the four-year period, the school of Medicine will have established a comprehensive longitudinal curriculum for all medical students, substantially increased the expertise in geriatrics among key faculty teachers, and chief residents, and infused training in the fundamental domains of geriatrics for residents of the aforementioned specialties. When Penn CARES is fully implemented, geriatrics will be woven through undergraduate medical education and through graduate medical education for the specialties identified in this proposal. In this manner, we expect to influence the training of over 600 (100%) medical students, 16 (100%) family medicine residents; 208 (100%) internal medicine residents; 24 (100%) physical medicine and rehabilitation residents; 40 (100%) psychiatry residents; 32 (100%) orthopaedic residents, and 16 (100%) urology residents. Concomitantly we will provide expertise in geriatrics to 73 key faculty preceptors of medical students and residents. To the current portfolio of Reynolds materials and curricula, Penn CARES will add curricula in community based service learning including a clinical experience in transitions of care and community health education, and ethnogeriatrics cases.

Selected Accomplishments in Year One:

**A. Medical Students**

- inserted new content related to immunology into two of the courses.

- planned and delivered a house calls program that involved visitation of pairs of all first year medical students to a home accompanied by a geriatric faculty, fellow, or nurse practitioner. This Module 3 activity is the only structured home visit activity in the curriculum.

- added materials related to falls and gait assessment to the Introduction to Clinical Medicine course as part of Module 3.

- developed a cognitive assessment component for the Introduction to Clinical Medicine (Module 3) Course, in which students move across several stations in what is called a “Round Robin” Experience.

- led a healthy aging panel discussion for the entire first year class followed by a small group discussion (Module 3).
• developed new course content related to advance care planning and caregiver assessment.
• introduced an aging component to a new palliative care module for all medical students. This activity was not projected in our original proposal.

B. Primary Care Residents

Transitions of Care Training- Internal Medicine Residents
During their 4 week ambulatory (outpatient) block, all internal medicine interns received a didactic lecture on principles of Transitions of Care. Half of the interns were then paired with an Advance Practice Nurse from the Hospital of the University of Pennsylvania Transitions Team. The Transitions Team, modeled after the approach developed by Dr. Mary Naylor, is charged with improving transitions of care for patients admitted to HUP with congestive heart failure, coronary artery disease, or chronic obstructive pulmonary disease. Interns were given contact information and told to contact the nurse member of the Team on the Monday or Tuesday of the first week of this ambulatory care month; to schedule a patient visit in the hospital with the nurse; and to coordinate 1-2 home visits of recently discharged patients with the nurse. They also had the opportunity to accompany the patient/transitions nurse on a physician follow-up appointment.

Community Outreach and Education. From February 2010 to May 2010, 40 internal medicine residents visited four senior sites (two multipurpose senior centers and two senior housing buildings) in groups of 4. In collaboration with the seniors, falls and medications were topics selected for presentations. Residents will present to small groups of seniors with an emphasis on reducing falls and reducing medication problems. Prior to the presentation, residents are given background materials and a talk on falls and medications, including guidelines for communicating in plain language.

C. Surgical and Specialty Resident Training

• planned a four week Physical Medicine and Rehabilitation rotation that will begin
• incorporated a lecture series for orthopedic residents.
• The Department of Psychiatry initiated a GAP (Geriatric Ambulatory Psychiatry) Experience for its residents.
• Delivered our first Chief Resident Immersion Training to Physical Medicine and Rehabilitation, Psychiatry, Orthopedics, and Trauma, internal medicine, family medicine, and gynecology.

D. Faculty Development

created a 3-part workshop, 1.5 hours each, on Osteoporosis Management that was presented to faculty and fellows in geriatrics, rheumatology, and orthopedic surgery.

Delivered a 7 module Stanford Faculty Development Course to 8 Geriatric Medicine faculty.

University of Texas Medical School at Houston

In 2009, the UT Health School of Medicine was awarded a D.W. Reynolds educational grant. UT Health TEXAS Aging Excellence in Aging Studies (TEXAS) is making significant progress in achieving all stated objectives. Utilizing AAMC and ACGME competencies, TEXAS is providing state of the art geriatric education and skills acquisition for medical students, residents, faculty, and practicing physicians. Below, please find a brief review of some of our accomplishments.

Integration of Content into Medical School Curriculum:

In Year 01, we integrated important geriatric content into the medical school curriculum. Content included:

• Approach to the Geriatric Patient
• Dementia
Six hundred and forty five student learners participated in these lectures. Geriatric content is being further assimilated into the medical school curriculum with the integration of geriatric lectures in Reproductive Biology (Year MS Y 02) and Behavioral Science (Behavioral Science (Year MS Y 02).

TEXAS has developed and offered a variety of geriatric learning opportunities for students, residents, faculty and practicing physicians. This has been achieved through the geriatric integration of content into the medical school curriculum, the development of "Geriatric Gems and Palliative Pearls" (brief sound bytes provided to residents weekly); the Reynold's Visiting Professor Program, the MS 03 geriatric clerkship rotation, faculty and staff lectures at Grand Rounds and noon conferences, and our elder abuse seminars on elder abuse for community physicians.

In addition, TEXAS is capitalizing on its D.W. Reynolds award on many fronts. Not only have we made “geriatrics” the buzzword throughout the UTH Medical School, the Harris County Hospital District, and the Memorial Hermann Hospital System with our TEXAS size program we have, under Dr. Carmel Dyer's direction, received the support and blessing of the UT Health System to develop a system wide Consortium on Healthy Aging that includes all five schools within the UT Health System (Dental, Medicine, Nursing, Informatics, and Public Health).

**MS Year 03 Clerkship Experience:**

A mandatory clerkship in Geriatrics for Year 03 medical students has been established. The third year students are required to spend four days per week with a geriatric medicine or palliative medicine proctor. Students are assigned to a geriatric medicine or palliative medicine proctor and each student experiences a different aspect of geriatric or palliative medicine. Third year students attend house calls to homes of abused and neglected elders, work on the Acute Care of the Elderly unit, accompany the clinician who operates our Bridge Program (a house call program for palliative care patients), attend wound care clinic, round with the physicians and a variety of other experiences. The students are required to complete demographic, knowledge, and attitude surveys and attend Grand Rounds lectures in geriatrics and palliative medicine, and our Reynolds Visiting Professor presentations. In Year 01, 120 Year 03 students rotated through the clerkship. In Year 02, we are expanding the clerkship to include 5 days every two weeks, and are adding a problem solving case vignette to their experience. Our evaluation data reveals an increase in the self-reported confidence level of students to complete components of the Comprehensive Geriatric Assessment. We also developed sets of 25 laminated cards summarizing important geriatric topics for each student.

**Resident Interactive Spaced Education "Geriatric Gems and Palliative Pearls"**

Faculty developed very brief "soundbytes" of geriatric information to send via email to all Year 02 residents (42) in Internal Medicine and Neurology. The email contains a one or two line "hook" to entice the resident to click on a link that leads to geriatric and palliative content. The email also contains some element of humor, or compelling picture to draw the residents attention. This program was so popular it is now sent to all residents in internal medicine, neurology, emergency medicine, the chief residents, the Reynolds Champions, the Reynolds faculty and staff and various other UTH faculty and staff. We continue to measure impact in our Year 02 residents for evaluative purposes.

**Reynolds Visiting Professor Program**

Thus far, five Reynolds Distinguished Professors from across the country have spent two days in Houston providing Grand Rounds, Dinner Lectures and technical advice to Reynolds' staff, students, residents, faculty and others. Six hundred eighty three (683) attendees participated in these lectures in 2009.

Year 2009
Mindy Fain, MD (University of Arizona)
Dementia: A Clinical Approach
Death by Bedrest: The Perils of the Hospital

Laurie Jacobs, MD (Albert Einstein College of Medicine)
Teaching about Sexuality and Aging: A Workshop for Students and Residents
Oral Anticoagulants for Older Adults in 2009: Is this Warfarin's Last Stand

Sally Rigler, MD (University of Kansas)
Depression in the Elderly
Rational Drug Prescribing for Older Adults

Year 2010
Jeremy Walston, MD (Johns Hopkins)
The Development of Clinically Relevant, Interdisciplinary Translational Research Progress in Geriatrics: A Johns Hopkins Experience
Frailty: Etiology and Therapeutic Approaches

Timothy Quill, MD (University of Rochester)
Discussing Treatment Preferences with Patients who want "Everything"
Talking with Patients about End-of-Life Issues: Balancing Honesty, Compassion and Hope

Innovative Technology: Second Life (SL) Virtual World:

TEXAS has embarked on an ambitious, technically complex, and ground breaking initiative to develop a Second Life learning experience for all medical students. This interactive experience takes a "virtual" patient through the elderly lifespan - from healthy aging to palliative care and end-of-life issues. This experience provides students with the experience of treating a "geriatric patient" through the continuum of care. Year 01 students are introduced to "Mrs. Porter" as a healthy older person; Year 02 students see Mrs. Porter as having some medical problems and in Years 03 and Year 04 Mrs. Porter develops severe conditions that results in palliative and end of life issues. This exercise provides the student with experience in providing "continuity" of care as well as skill in treating a broad spectrum of geriatric conditions.

CHAMP Program

For each year of the grant, Dr. Paula Podrasik, from the University of Arkansas (formers from the University of Chicago) brings her colleagues to UTH to train non-geriatricians in bedside teaching using the Curriculum for the Hospitalized Aging Medical Patient (CHAMP). In Year 01, our CHAMP trainees included our Neurology Champion, our fellows and others who had an interest in the topic. For Year 02 we are including Champions from Internal Medicine, Neurology, Internal Medicine, our fellows and approximately 14 newly hired hospitalists.

Knowledge Map

TEXAS is working collaboratively with Vanderbilt University using KnowledgeMap, a system developed by Dr. Josh Denny and colleagues to electronically organize curriculum concepts. KnowledgeMap allows UTH School of Medicine to map geriatric curriculum content as well as provide a tool to evaluate the learner’s use of geriatric principals by reviewing electronic medical records.

Comprehensive Clinical Competency Examination (CCCE)

In Year 01, TEXAS developed a comprehensive clinical competency examination for Year 03 students. The CCCE topic is Geriatric Depression. The CCCE is to be initiated in Year 02 and will be administered to medical students between Year 03 and Year 04.

Elder Abuse Training for Practicing Physicians:

Elder mistreatment workshops have been developed, initiated and conducted for practicing physicians in community clinics. To date, two (2) workshops were conducted with 43 attendees. The program provides CME and
ethics credit as well as lunch and handouts. The attendees will be tracked at six months to determine self-reported practice changes.

**Evaluation:**

*TExAS* utilizes a comprehensive evaluation model to examine educational training materials, educational activities, and outcome measures of the various learners dependent on their stage of education as outlined in the Dreyfus Model of Skill Acquisition. In Year 01, we focused on formative evaluation measures that provide feedback to the faculty so that changes can be made as *TExAS* is implemented. In Year 02 and beyond we will employ new methods to include mapping changes in geriatric content offered in the curriculum (technology), evaluating performance and critical thinking skills when interacting with simulated patients (Second Life Virtual World and CCCE), reviewing assessment and treatment practices with geriatric patients in outpatient settings (electronic Learning Profiles based on the search engine used), review of geriatric issues in partner hospitals (after training of hospitalists and Champions), and follow-up of institutional practices related to elder abuse (following the initiative of the elder abuse training sessions).

**University of Texas Southwestern Medical School**

The University of Texas Southwestern Medical School (UT Southwestern) and its affiliated hospitals propose to implement a comprehensive program to increase geriatrics in undergraduate and graduate medical education through an innovative curriculum that emphasizes patient safety and patient-centered care for the vulnerable elder. This curriculum will impact every medical student and every internal medicine, family medicine, and psychiatry resident at UT Southwestern, along with many surgical specialty and subspecialty trainees. Highlights of this proposal, called the Reynolds-UT Southwestern Aging and Geriatrics Education (SAGE) Program include:

**Undergraduate Medical Education (UME):**

- Integrate geriatrics content into all 4 years of the medical school curriculum. All medical students (n=960) will attain all 26 AAMC/Hartford minimum geriatric competencies by graduation
- Ensure a strong foundation in geriatrics through implementation of a geriatricized Colleges curriculum (small group learning with mentors) and increased aging content in preclinical courses
- Weave geriatrics content into all third year required clinical clerkships and track competency-based objectives across the clerkships; have students complete a "SAGE passport" to track attainment of geriatrics knowledge and skills; and assess skills through required standardized patient examinations in all required clerkships
- Develop and implement an innovative, comprehensive transitions-of-care and patient safety/patient-centered care curriculum for the vulnerable geriatric patient for the required fourth year subinternship clerkship

**Graduate Medical Education (GME):**

- Implement an innovative, online patient safety/patient-centered care curriculum highlighting care of the vulnerable elderly patient for use by surgical subspecialty and internal medicine specialty GME trainees
- Implement a new geriatrics faculty-led inpatient service through which all internal medicine residents (n=145) will rotate at least once during their residency
- Improve the ability of trainees to care for hospitalized vulnerable older patients by adapting and teaching the University of Chicago's Curriculum for the Hospitalized Aged Medical Patient (CHAMP) Faculty Development Program to hospitalists (n=24), other general internal medicine faculty (n=40), family medicine faculty (n=7), and internal medicine subspecialty faculty who attend on inpatient services
- Implement a new month-long rotation in geriatrics for all psychiatry interns (n=12)
- Implement an enhanced geriatrics ambulatory experience for all internal medicine interns (n=56) including emphasis on transitions-of-care, and orientation to other sites of care such as visits to nursing homes, assisted living facilities, and patients’ homes
- Implement multi-faceted geriatrics training for all UT Southwestern affiliated family medicine residents including an online case-based curriculum, a new geriatric assessment teaching clinic, and lengthen the required geriatrics rotation from 4 to 6 weeks
- Increase the geriatrics knowledge of subspecialty trainees through the creation of a Reynolds-UT SAGE small grant program (SAGE Scholars) to provide funds for 3 faculty each year as they
develop geriatrics curricula for their trainees

A key component of the success of this grant will be mentoring from and collaborations with two prior Reynolds Comprehensive Programs to Strengthen Physicians’ Training in Geriatrics grantees—the University of Arizona and the University of Chicago.

This endeavor will succeed and endure due to strong institutional support provided by key institutional leaders who are on the SAGE Leadership Council. The council will meet monthly to implement the goals of the grant. Our institutional support has led to a 250% increase in geriatrics faculty since 2000, giving us sufficient faculty resources to accomplish the grant's objectives.

The proposed activities will be sustained beyond the grant period by emphasizing faculty development (Colleges, CHAMP, SAGE scholars) and integrating geriatrics content into the existing core curriculum. The impact of the Reynolds-UT SAGE program will extend beyond UT Southwestern as the new curricula are disseminated—including the comprehensive transitions-of-care curriculum and the GME-level patient safety/patient-centered care of the vulnerable elder curriculum.

Wake Forest University

Building upon a 20-year tradition of excellence in geriatric medicine and recent accomplishments, Wake Forest University School of Medicine (WFUSM) is in a position to benefit in unique ways from the support of Donald W. Reynolds Foundation. The WFUSM Donald W. Reynolds Geriatric Education Program will provide critically needed support for our efforts to integrate principles of geriatric care into key specialties that provide clinical education to all Wake Forest medical students, residents in Internal Medicine and Family Medicine, and to community physicians providing primary care for residents of Continuing Care Retirement Communities in our region. Since our 2006 application, through the leadership of Jeff Williamson, MD, MHS (Head, Section on Gerontology and Geriatric Medicine [SGGM]) and Stephen Kritchevsky, PhD (Director, Sticht Center on Aging), our program has several recent achievements that will provide the foundation for success:

- Designated a John A. Hartford Foundation Center of Excellence in Geriatrics Education and Training (2008-2010)
- Received renewal of our Claude Pepper Older Americans Independence Center (OAIC) (2008-2013, National Institute on Aging [NIA])
- Awarded the National Coordinating Center for the 11 current Pepper OAICs (2008-2013, NIA)

In addition, a Reynolds Geriatric Education Program will benefit from the following established resources:

- The $40 million J. Paul Sticht Center on Aging and Rehabilitation comprising Ambulatory Care, Acute Care for the Elderly Unit, Rehabilitation, Psychiatry, Palliative Care, and the Geriatrics Research Center (1997)
- The endowed Roena Kulynych Center for Memory and Cognition Research (2001)

These accomplishments are indicative of the high level of institutional support for WFUSM Geriatrics and, in combination with the leadership of Dean William B. Applegate and an outstanding cadre of geriatricians, provide a foundation of excellence in geriatrics education.

To achieve the goal of expanding and integrating high quality geriatrics education throughout the institution, we propose the following aims:

AIM 1: Developing geriatrics education leaders and teaching programs outside the SGGM by:

1. Implementing the Curriculum for the Hospitalized Aging Medical Patient Faculty Development Program (CHAMP-FDP) developed at the University of Chicago for 10 general internal medicine and hospitalist faculty;
2. Developing 5 new specialty-focused CHAMP-FDP programs in oncology, nephrology, pulmonary/critical care, cardiology, and emergency medicine which will train 30 faculty to integrate geriatrics into their specialty teaching programs for fellows, residents, and students;
3. Designating all faculty that complete CHAMP-FDP as Reynolds Faculty Geriatrics Teaching Scholars.

AIM 2: Strengthening current geriatrics education and expanding to ALL medical students, internal medicine and family medicine residents, and geriatric medicine fellows by:

1. Guaranteeing a clinical geriatrics experience to 100% of WFUSM medical students;
2. Adding geriatrics content to 10 Case Centered Learning modules in the medical student preclinical curriculum;
3. Adding ‘virtual patients’ emphasizing geriatrics into a standardized longitudinal curriculum for the student clinical clerkships;
4. Implementing “Care of the Vulnerable Elderly Practice Improvement Modules” into outpatient Internal Medicine and Family Medicine residency training;
5. Recruiting two faculty geriatricians to strengthen educational programs.

AIM 3: Developing new education programs to enhance recent Geriatrics initiatives by:

1. Using telemedicine technology to provide geriatrics education for trainees and consultations to physicians caring for older patients residing in Continuing Care Retirement Communities in the Western Carolinas;
2. Uniting healthy volunteer elders in our community Senior Services program with medical students, residents and geriatrics fellows in the Senior Mentor Independent Living Education (SMILE) Program

Funding from the Donald W. Reynolds Foundation is critically important to our goal of leveraging resources and expertise at WFUSM to “gerontologize” teaching for a cadre of 48 faculty educators throughout WFUSM; these educators will employ geriatrics teaching skills to train 480 medical students, 114 internal medicine and family medicine residents, 71 specialty trainees, and approximately 30 community physicians every year.
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<td>Laurie Jacobs, MD</td>
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<td>Mark Lachs, MD, MPH</td>
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<td>Jennifer Breznay, MD</td>
<td>Veronica LoFaso, MD (Evaluator)</td>
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<td>Claudene George, MD</td>
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<td>Debra Greenberg, MSW, PhD</td>
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<td>Wanda Horn, MD</td>
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<td>Hannah Lipman, MD</td>
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<td>Rubina Malik, MD</td>
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<td>Joe Verghese, MB BS</td>
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<td>Sharon A. Levine, MD (Key Contact)</td>
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<td>Erica Brownfield, MD</td>
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<td>Andrea Burridge, PhD (Evaluator)</td>
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<td>Manuel Eskildsen, MD</td>
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<td>Carol Hamilton (Evaluator)</td>
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<td>Laurie Dubois, BS</td>
<td>Susan Ratliff</td>
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<td>Laura Goldman, MD</td>
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<td><strong>Core Team Members</strong></td>
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<td>David Anthony, MD</td>
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<td>Lewis A. Lipsitz, MD (Key Contact)</td>
<td>William P. Moran, MD MS (Key Contact)</td>
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<td><strong>Program Manager:</strong></td>
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<td>Bruce R. Troen, MD (Key Contact)</td>
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<td>Edmund Duthie, Jr., MD</td>
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<td>Samina Ahsan, MD</td>
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- Richard Kasuya, MD MSEd, Associate Dean for Medical Education
- Michael Nagoshi, MD, Clinical Skills
- Damon Sakai, MD, Director, Office of Medical Education

**Project Staff**
- Katherine Kim, MPH (Project Coordinator)
- Keri Nitta
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<td>Marcia Mecca, MD</td>
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<td>Kharia Holmes, MD</td>
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Geriatrics Training Advisory Panel Members

John Burton, MD
Harvey Jay Cohen, MD
William J. Hall, MD
Rosanne Leipzig, MD, PhD
David B. Reuben, MD
Stephen C. Shannon, DO, MPH
Rani Snyder, MPA

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Gwendolen Buhr, MD, MHS, Med, CMD
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Harvey Cohen, MD
Mitchell Heflin, MD, MHS
Sandro Pinheiro, PhD
Quratulain Syed, MD
Heidi White, MD, MHS, CMD
Jean Suzin Whitten, MD

Johns Hopkins University
Kanwal Awan, MD
William Bynum, MD
Danelle Cayea, MD
Colleen Christmas, MD
Jessica Colburn, MD
Laura Gibson, C-TAGME
Deborah Villareal Smith, MD

Icahn School of Medicine at Mount Sinai
Shahla Baharlou, MD
Sara Bradley, MD
Christine Chang, MD
Audrey Chun, MD
Helen Fernandez, MD, MPA
Joyce Fogel, MD
Rosanne Leipzig, MD, PhD
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Maya Rao, MD
Veronica Rivera, MD
Martine Sanon, MD
Brijen Shah, MD
Halle Sobel, MD
Rainier Soriano, MD
Mathew Tharakan, MD
University of California at Los Angeles
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Jennifer Chen, MD, MPH
Lisa Gibbs, MD
Esther Ho, MD
Christy Ann Lau, MSSW
Kyaw Naing, MD, PhD
Danette Null, MD
Pamela Prescott, MD
David Reuben, MD
Sonia Sehgal, MD
Zaldy Tan, MD, MPH
Maili Velez-Dalla Tor, MD

University of Arkansas Department of Geriatrics Team Members
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Priya Mendiratta, MD
Paula Podrazik, MD
Jeanne Wei, MD

University of Oklahoma Department of Geriatrics Team Members
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Claire Dowers-Nichols, MHR
Laurence Rubenstein, MD
Kristen Sorocco, MD

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Meeting Attendee
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Karen Sauvigne, MA
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Deputy Executive Vice President & Chief Operating Officer

Erin Obrusniak
Manager, ADGAP & GSI

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2014 Reynolds Grantee Meeting Guests

Skotti Church, MD
University of Colorado

**Special Clinical or Teaching Interest(s):** Geriatrics, medical education, dementia memory loss

In her position as the Associate Fellowship Director, Dr. Church is a frequent preceptor for internal medicine resident of geriatrics, the attending for geriatric education and management service, and lectures for medical students and IM residents.

Kevin Foley, MD
Michigan State University

**Special Clinical or Teaching Interest(s):** Cognitive disorders, geropsychiatry, decisional capacity

Dr. Foley is the academic leader of geriatric medicine in the College of Human Medicine at MSU. He serves as the Program Director for an ACGME accredited geriatric medicine fellowship and network director for three MSU affiliated geriatrics fellowship programs in Michigan. He has lead roles in developing curricula for medical students, and residents in internal medicine and family medicine and devotes most of his student and resident teaching time to geriatrics instruction. He has teaching responsibilities for these learners at both MSU-CHM campuses (East Lansing and Grand Rapids).

Sarah Hallen, MD
Maine Medical Center

**Special Clinical or Teaching Interest(s):** Interprofessional education/practice and the evolving role of the physician on interdisciplinary teams; shared care and prognostication and communication at the end of life
Dr. Hallen is most interested in engaging with senior geriatric educators to explore mentorship and collaboration opportunities at the 2014 Reynolds Meeting. She also hopes to connect with educators interested in interprofessional education. She is also interested in learning more about evaluation and how to use medical education research methods to judge the effectiveness of the my curricula.

Kamal Kejriwal, MD, CMD, AGSF
Southern California Permanente Medical Group

**Special Clinical or Teaching Interest(s):** Dementia, Delirium, polypharmacy, System issues

Dr. Kejriwal is the Program Director of the Geriatric Fellowship at Kaiser Permanente, Fontana, the Associate Director of Citrus Nursing Facility, and Co-Chair Bioethics Committee Fontana. Dr. Kejriwal hopes to engage in team building and leadership activities, as well as, discuss ideas to develop interest and promote geriatric practice in the US.

Jesus Mateos del Nozal, MD
Hospital Ramon y Cajal

**Special Clinical or Teaching Interest(s):** Geriatric teaching evaluation, surveys, competencies, new programs

Dr. Nozal is receiving his PhD in geriatrics training at the undergraduate level. He has published two reviews about the topic. He is a member of the recently created European Specific Interest group on education and is the European Geriatrics Trainee representative.

Brooke Salzman, MD
Thomas Jefferson University

**Special Clinical or Teaching Interest(s):** Geriatrics, multimorbidity, interprofessional education

Dr. Salzman is the geriatric fellowship program director and course director for 3rd year clerkship in geriatrics. She is interested in attending the Reynolds Meeting to hear about developing and sharing innovative educational curriculum in geriatrics, utilizing strategies to measure the effectiveness of teaching geriatrics, networking/collaborating with other geriatric educators, and fulfilling the program requirements of the new accreditation system.

Amit Shah, MD
Mayo Clinic Arizona

**Special Clinical or Teaching Interest(s):** Medical Education

Dr. Shah recently moved from University of Texas Southwestern medical school to the Mayo Clinic in Arizona. At the Mayo Clinic, Dr. Shah will be precipitating residence as a rotate through geriatrics (1 per month). The Mayo Clinic in Arizona will also be opening up medical school in 2017, and I will be participating in the planning and details for this to occur. In addition, I currently serve as the editor-in-chief for the Portal of Online Geriatrics Education’s (POGOe) web-based geriatrics education modules (webGEMs), a national geriatrics education project.
2014 Annual Reynolds Grantee Meeting
Speakers, Session Leaders, and Moderators

Katherine Anderson, MD
University of Utah

Kevin Biese, MD
University of North Carolina, Chapel Hill

Sharon Brangman, MD
SUNY Upstate Medical University

Cynthia Brown, MD, MSPH
University of Alabama at Birmingham

Cherie Brunker, MD
University of Utah

Jan Busby-Whitehead, MD
University of North Carolina, Chapel Hill

Kate Callahan, MD, MS
Wake Forest University

Serena Chao, MD, MSc
Boston University

Audrey Chun, MD
Icahn School of Medicine at Mount Sinai

Jessica Colburn, MD
Johns Hopkins University

Kevin Craig, MD
University of Missouri

Kimberly Curseen, MD
University of Arkansas

Bill Dale, MD
University of Chicago

Kristen Deane, MD
University of Missouri

Kathryn Denson, MD
Medical College of Wisconsin

Edmund Duthie, Jr. MD
Medical College of Wisconsin

Carla Dyer, MD
University of Missouri

Manuel Eskildsen, MD, MPH
Emory University

Mindy Fain, MD
University of Arizona

Timothy Farrell, MD
University of Utah

Helen Fernandez, MD, MPH
Icahn School of Medicine at Mount Sinai

Kellie Flood, MD
University of Alabama

Kevin Foley, MD
Michigan State University

William Hall, MD
University of Rochester

Michael Harper, MD
University of California, San Francisco

Mitchell Heflin, MD, MHS
Duke University

Carla Herman, MD, MPH
University of New Mexico

Laurie Jacobs, MD
Albert Einstein College of Medicine
2014 Annual Reynolds Grantee Meeting
Speakers, Session Leaders, and Moderators

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University of North Texas Health Science Center

Rosanne Leipzig, MD, PhD
Icahn School of Medicine at Mount Sinai

Stacie Levine, MD
University of Chicago

Melissa Mattison, MD
Harvard Medical School

Lynn McNicoll, MD
Brown University

Annie Medina Walpole, MD
University of Rochester

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University of Rochester

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University of Missouri at Columbia

Caroline Vitale, MD
University of Michigan

Lisa Walke, MD
Yale University

Franklin Watkins, MD
Wake Forest University

Barry Weiss, MD
University of Arizona
2014 Annual Reynolds Grantee Meeting
Speakers, Session Leaders, and Moderators

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Duke University

Eric Widera, MD
University of California, San Francisco

Jeff Williamson, MD
Wake Forest University

Lindsay Wilson, MD, MPH
University of North Carolina, Chapel Hill

Michi Yukawa, MD, MPH
San Francisco VA Medical Center
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Alphabetical Listing of 2014 Meeting Attendees
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<td>Kimberly Curseen, MD</td>
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<td>William Dale, MD, PhD</td>
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<td>Thomas Dalton, MD</td>
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<td>Kristen Deane, MD</td>
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<td>Andrew Dentino, MD</td>
<td>Professor and Vice Chair</td>
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<td>Maureen Dever-Bumba, FNP-C, DrPhC</td>
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<td>Claire Dowers-Nichols, MHR</td>
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<td>Margaret Drickamer, MD</td>
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# Alphabetical Listing of 2014 Meeting Attendees

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Alphabetical Listing of 2014 Meeting Attendees

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<th>Name</th>
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Directory Correction Page

This page can be used to change the following information:
Grantee Project Team List, Main Contact Assignment, Your Contact Details, Participating Faculty Members

Name of Person Completing this form: _______________________________________________________

Grantee School: _________________________________________________________________________

Correction #1:

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Please return this form to Erin Obrusniak at the meeting or by email/fax: eobrusniak@americangeriatrics.org or 212-832-8646
Speakers Bios

Benjamin Chesluk, PhD

Benjamin Chesluk holds a PhD in Cultural Anthropology from the University of California at Santa Cruz. He currently works at the American Board of Internal Medicine, where he has managed and carried out a wide range of qualitative and mixed-methods r&d projects, all aimed at helping physicians improve both the quality of their work and the systems within which they practice. This work includes the development and launch of the TEAM (Teamwork Effectiveness Assessment Module), a new online tool for physicians to gather feedback from their interprofessional teammates in order to improve work more effectively as part of a patient-care team. Before coming to the ABIM, he spent several years at Design Science, a design research firm, where he led numerous ethnographic research projects aimed at improving and innovating medical devices and health care delivery, from surgical devices to patient monitors and EMR systems; these projects took him into operating rooms, ICUs and clinics around the world. Benjamin Chesluk is also the author of Money Jungle (2007), an anthropological study of the redevelopment of New York City’s Times Square, published by Rutgers University Press.

Kellie Flood, MD

Kellie Flood, MD received a Bachelor of Science degree in physics from Baylor University and her MD from the University of Texas Southwestern Medical Center in Dallas. She completed her residency training in Internal Medicine and a fellowship in Geriatrics at Washington University School of Medicine in St. Louis, MO. She then remained as faculty in the Division of Geriatrics and Nutritional Science at Washington University and served as Medical Director for the nation’s first Oncology-Acute Care for Elders Unit.

Dr. Flood joined the UAB faculty in the Division of Gerontology, Geriatrics, and Palliative Care in August 2006 and was the founding Medical Director for the UAB Acute Care for Elders Unit. She now leads the development and implementation of all UAB inpatient geriatric clinical, educational, quality, and outcomes research programs and serves as UAB Hospital’s first Geriatric Quality Officer. She is also the Director of the Geriatric Section within the UAB Division of Gerontology, Geriatrics, and Palliative Care. Dr. Flood’s research focus is outcomes in hospitalized older adults and interdisciplinary team models of care. This work was recognized by the American Geriatrics Society in 2011 with an Outstanding Excellence in Geriatric Research award and in 2013 when the UAB Acute Care for Elders study demonstrating reduced patient-care costs and readmissions was recognized as one of the eight most impactful geriatric publications of the year.

Lynne Kirk, MD, MACP

Dr. Kirk is the Toni and Timothy P. Hartman Distinguished Teaching Professor in Internal Medicine at the University of Texas Southwestern Medical Center in Dallas. She is a general internist and geriatrician. Dr. Kirk was President of the American College of Physicians (ACP), the national specialty organization for internists in 2006-2007. She has served on several committees relating to the U.S. Medical Licensing Examination (USMLE) and has served on the council of the Society of General Internal Medicine (SGIM).
She has published on medical professionalism, faculty development, clinical guidelines, and patient education. She is on the Council on Medical Education of the American Medical Association and the Board of Directors of the ACGME. She served for six years on the internal medicine residency review committee of the ACGME. She is an Associate Program Director in the internal medicine residency training program at UT Southwestern and had previously served as the Associate Dean for GME and DIO at that institution.

Sharon Levine, MD

Dr. Levine is a board certified internist and geriatrician and Professor of Medicine at Boston University School of Medicine, where she served as the Associate Dean for Academic Affairs. She is currently the Director of Geriatric Educational Innovations in the Geriatrics Section.

Dr. Levine has also been the Director of Education and the program director for the geriatric medicine, oncology and dentistry fellowships and PI on the HRSA-funded Geriatrics Training Program for Physicians, Dentists, and Behavioral and Mental Health Professionals. Additionally, she provides clinical care for homebound elders and teaches students and fellows as part of the Boston University Geriatrics Services Home Care Program.

Among her many significant contributions to geriatrics education, Dr. Levine created Boston University's Chief Resident Immersion Training (CRIT) in the Care of Older Adults. The program focuses on providing chief residents with knowledge and confidence to practice and teach geriatrics and to develop leadership and teaching skills needed in their chief resident roles. The program has been offered at 19 other institutions nationwide, through national dissemination projects supported by the John A. Hartford Foundation, the Hearst Foundations and the Donald W. Reynolds Foundation, which will bring the model to 40 institutions by 2015.

A member of the American Board of Internal Medicine's Council, Dr. Levine is Chair of the ABIM Subspecialty Board on Geriatric Medicine. She is also a fellow of the American Geriatrics Society (AGS). She was awarded the AGS’s Dennis W. Jahnigen Memorial Award in 2011 for her outstanding leadership in advancing geriatrics education in health professions schools. She is also the winner of Boston University's prestigious Metcalf Cup and Prize, the Society of General Internal Medicine's New England Educator of the Year award, and the Boston University Department of Medicine’s Robert Dawson Evans Special Recognition Teaching Award. Dr. Levine has served on numerous national education committees and has supported and inspired trainees at all levels. She has authored peer-reviewed publications that focus on the dissemination of innovative teaching models and faculty development programs in geriatrics.

She received her medical degree from Albert Einstein College of Medicine and completed her residency in Internal Medicine at Yale-New Haven Hospital, where she taught before coming to Boston.
Michael Malone, MD

Dr. Michael Malone is the Medical Director of Aurora Health Care- Senior Services and the Aurora Visiting Nurse Association of Wisconsin. He is a Clinical Adjunct Professor of Medicine at the University of Wisconsin School of Medicine and Public Health. He also serves as the Director of the Geriatrics Fellowship Program at Aurora Health Care. Dr. Malone received his undergraduate and medical degrees from Texas Tech University in Lubbock, Texas; he completed his internal medicine residency and geriatric fellowship training at Mt. Sinai Medical Center in Milwaukee. His Aurora Health Care practice is to home bound older persons in inner city Milwaukee.

Dr. Malone is the Chairman of the Public Policy Committee for the American Geriatrics Society and the Section Editor-Models of Geriatric Care, Quality Improvement and Program Dissemination for the “Journal of the American Geriatrics Society”. He led the development of the first Acute Care for Elders (ACE) unit in Wisconsin. He and his colleagues have developed innovative strategies to disseminate geriatrics models of care including the ACE Tracker software to identify vulnerable hospitalized elders, and the e-Geriatrician telemedicine program to bring geriatrics expertise to rural hospitals with no geriatrician on staff. Dr. Malone has developed innovative teaching tools including: ACE pocket cards, and the Geriatrics Fellows’ Most Difficult Case conference. He has joined his colleagues at the Medical College of Wisconsin to implement “Geriatrics Fast Facts” on mobile devices and tablets. In August, 2014, he released a book with Elizabeth Capezuti and Robert Palmer, MD, entitled: “Acute Care for Elders – A Model for Interdisciplinary Care”, Springer Business and Science.

David Reuben, MD

Dr. Reuben is Director, Multicampus Program in Geriatrics Medicine and Gerontology and Chief, Division of Geriatrics at the University of California, Los Angeles (UCLA) Center for Health Sciences. He is the Archstone Foundation Chair and Professor at the David Geffen School of Medicine at UCLA and Director of the UCLA Claude D. Pepper Older Americans Independence Center and the UCLA Alzheimer’s and Dementia Care program.

He sustains professional interests in clinical care, education, research and administrative aspects of geriatrics, maintaining a clinical primary care practice of frail older persons and attending on inpatient and geriatric psychiatry units at UCLA. He has won 7 awards for excellence in teaching. Dr. Reuben’s current research interests include redesigning the office visit to improve health care quality and and co-management with nurse practitioners to improve health care quality. His bibliography includes more than 190 peer-reviewed publications in medical journals, 33 books and numerous chapters. He is lead author of the widely distributed book, Geriatrics at Your Fingertips.

In 2000, Dr. Reuben received the Dennis H. Jahnigen Memorial Award for outstanding contributions to education in the field of geriatrics and, in 2008, he received the Joseph T. Freeman Award from the Gerontological Society of America. He was part of the team that received the 2008 John M. Eisenberg Patient Safety and Quality Award for Research – Joint Commission and National Quality Forum, for Assessing Care of the Vulnerable Elderly. In 2012, he received the Henderson award from the American Geriatrics Society.
Dr. Reuben is a past President of the American Geriatrics Society and the Association of Directors of Geriatric Academic Programs. He served for 11 years on the Geriatrics Test Writing Committee for the American Board of Internal Medicine (ABIM) and for 8 years on the ABIM’s Board of Directors, including as Chair from 2010-2011.

In 2012, Dr. Reuben received one of the first CMMI Innovations Challenge awards to develop a model program to provide comprehensive, coordinated care for patients with Alzheimer’s Disease and other dementias. In 2014, he was one of three principal investigators to be awarded a multicenter clinical trial (STRIDE) by the Patient-Centered Outcomes Research Institute (PCORI) and the National Institute on Aging (NIA) to reduce serious falls related injuries; it is the largest grant that PCORI has awarded. In addition to his leadership in geriatrics, Dr. Reuben continues to provide primary care for frail older persons, including making house calls. In his spare time, Dr. Reuben has written four plays and lyrics for more than 20 songs with composer Sidney Sharp. A compilation of the first 10 has been recorded.

Robyn Tamblyn, BScN, MSc, PhD

Dr. Robyn Tamblyn is a Professor in the Department of Medicine and the Department of Epidemiology and Biostatistics at McGill University. She is a James McGill Chair, a Medical Scientist at the McGill University Health Center Research Institute, and the Scientific Director of the Clinical and Health Informatics Research Group at McGill University. Dr Tamblyn’s ground-breaking research on educational outcomes has elucidated important relationships between health professional training, licensure and practice that have subsequently guided credentialing policies. Her work on prescription drug use, its determinants, and computerized interventions to improve drug safety (MOXXI) have been recognized internationally. She leads a CIHR-funded team to investigate the use of e-health technologies to support integrated care for chronic disease, and co-leads a Canadian Foundation for Innovation Informatics Innovation Laboratory to create advanced technologies to monitor adverse events in populations and create new tools to improve the safety and effectiveness of health care. Her work is published in the Journal of the American Medical Association, the Annals of Internal Medicine, the British Medical Journal, Medical Care, and Health Services Research, among others. She has been awarded the CHSRF KT award for her research in improving the use of medication, the ACFAS Bombardier award for innovation in the development of a computerized drug management system and the John P. Hubbard Award by the NBME for her contribution to the assessment of professional competency and educational program development in medical education and delivery of healthcare. In January 2011, she became the Scientific Director of the Institute of Health Services and Policy Research at the Canadian Institutes of Health Research.

Mary Tinetti, MD

Dr. Mary Tinetti is the Gladys Phillips Crofoot Professor at Yale School of Medicine and Chief of Geriatrics. In her earlier research, she investigated the epidemiology and prevention of falls in older adults. She is working to translate these findings into practice. Her current research focus is on clinical decision-making for older adults in the face of multiple health conditions, particularly trade-offs among health conditions, the harms and benefits of commonly recommended treatments, and the use of
universal outcomes to assess the benefits and harms of treatments. She has over 175 original publications and is a Viewpoint writer for JAMA. Dr. Tinetti received her undergraduate and medical degrees from the University of Michigan; she completed an internal medicine residency at the University of Minnesota and a geriatric fellowship at the University of Rochester. Dr. Tinetti provides care to older adults at Yale New Haven Hospital.

Dr. Tinetti has been a member of the board of directors of the American Geriatrics Society (AGS) and served on several national advisory committees including the Advisory Council of the NIA, the Beeson Faculty Scholars, the RWJ Generalist Physician Faculty Award, the Brookdale Fellowship and the Nonprescription Drug Advisory Committee of the FDA. She has participated in advisory panels for NQF, NCQA and other national organizations focused on improving the quality of health care. She is a member of the Methodology Committee of the Patient-reported Outcome Institute. Awards include the Outstanding Investigator Award and the Henderson Award from the AGS; Joseph T. Freeman, Powell Lawton, and Maxwell Pollack Awards from the GSA; the Irving Wright Award from AFAR; the John Eisenberg Award from SGIM; the Greppi Prize from the Italian Gerontological and Geriatric Society. She is a member of the Institute of Medicine and a MacArthur Foundation Fellow. She recently was an Atlantic Philanthropies Health and Aging Policy fellow at CMS.
Voting for Product of the Year Instructions

EXAMPLE

How to vote via texting:
Send a text message to 22333 with a voting code indicated on the Marketplace handout.

How to vote via web page:
Go to www.pollev.com/DWRFmeeting and click on the products you wish to vote for.

How to vote via Twitter:
Log into your Twitter account and tweet a message @poll followed by a code indicated on the Marketplace handout. Since @poll is the first word, your followers will not receive this tweet.

Please NOTE:
1. You can cast 3 votes for any of the products (if you wish all 3 can go to one product).
2. Capitalization does not matter, but please do not use any spaces and make sure you enter the code as it appears on the Marketplace handout.
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The interface between geriatrics medical education and models of care

Michael L. Malone, MD
Aurora Health Care
University of Wisconsin School of Medicine and Public Health
October 6, 2014
Learning Objectives:

• Describe how to perform a needs assessment for a geriatrics model of care.

• Describe how to develop the business plan & gain support for a clinical program.

• Describe effective methods to educate our workforce within clinical models of care.

• Describe some simple lessons learned in developing, disseminating, and sustaining geriatrics models.
John Powell as a young man:

• Son of a minister.
• Grew up in Janesville, Wisconsin.
• Saw American Indian communities near his family farm.
• Enjoyed learning about native Americans, civilizations, and history.
• Walked across Wisconsin in 1855.
• Rowed down the Mississippi River, the Ohio River, etc...
• Hired by Illinois Wesleyan University museum.
• Captain in the Union Army during the Civil War.
• Lost his right arm, when struck by a minie ball, at the Battle of Shiloh.
• Returned to the museum and proposed to explore the Colorado river.
John Powell’s first trip down the Colorado River:

- 11 men set out in 1869 from Green River Station, Wyoming.
- Multiple struggles exploring the “Fretful River”.
- Powell got caught on side of the 600 foot (Echo Rock) canyon.
- GY Bradley used his “long drawers” to pull Powell to the ledge above.
- After three months, four men abandoned the expedition.
Best Practices in the Care of Older Adults who have Complex Needs:

- Enable seniors to remain at home.
- Prevent functional disability.
- Preserve patient quality of life.
- Respect patient values, preferences, and goals.
- Consider patient safety.
- Address needs of caregivers.
- Appreciate psychosocial needs.

With permission from Robert M. Palmer ME November, 2010.
Needs assessment

Describe how to perform a needs assessment for a geriatrics model of care.
Needs Assessment:

• Define the problem that is most important to your patients and their caregivers.
• Quantify the frequency of the problem at your practice site.
• Compare your outcomes to the reports in the literature.
• Compare your outcomes with other practice sites.
• “Who is doing better and what are they doing?”
• Describe the context of the problem.
Context is Key:

- You and your environment.
- The culture / mission of your organization.
- The values of the individuals.
- “The politics” that you and your organization are facing.
- Competing priorities.
- The local economics of your organization.
- Fee for Service vs. Value-based purchasing.
- The workforce you have on your team.
- The support of your bosses and of your team.
- Philanthropic resources.
- “The meaning” or “the shared purpose” of this work.

The case vignette can bring focus.

Context drives how you and your team choose your interventions.

A Needs Assessment is the Platform for Improvement:

Observation of the problem.

Describe of the problem.

Measure the problem.

Measure outcomes.

Disseminate to multiple sites.

 Compare your practice to other sites and to the literature.

Get buy in from leadership.

Develop an interdisciplinary team to address the challenge.

Measure the fidelity of your interventions & repeat pro forma.

Use your interdisciplinary advisory team to replicate model.

Develop pilot intervention at local site.

Deploy a geriatrics model of care.

• Measure /communicate your outcomes.
• Note lessons learned.

• Do a pro forma

Thomas H Lee, MD

How do we resolve the tension between the imperative to do all we can to help patients and the needs of societies with constrained resources?
Care Redesign- A Path Forward for Providers

• Define your overarching goal.
• Understand the outcomes that matter most to patients and families.
• Use teams (working together) to own the work of defining, measuring, & improving value.

• Begin measuring outcomes and costs.
• Figure out how to meet those needs systematically.
• Use report cards as a framework for learning and improving.
Care Redesign- A Path Forward for Providers

- Identify pause points at which important interventions should be reliably delivered.
- Use checklists & modified those checklists over time.
- Take responsibility for improving value for specific population segments.
- Learn from other organizations.
- Develop a relentless desire to improve.
- Charge teams with driving improvement.

Care Redesign- A Path Forward for Providers,
Business plan

Describe how to develop the business plan & gain support for a clinical program.
Powell’s business plan:

• Nine men.
  – 3 hunters.
  – 1 cook.
  – 1 cartographer- map maker.
  – 1 expedition chronicler.

• Food for ten months.

• Pots, utensils.

• 3 boats, 6 tarps, 6 shovels, ropes, guns, sextons, broad rim hats.

• Journal.
Key components of the business case for a geriatrics model of care:

1. Define the challenge / patient group.
2. Describe the program in a clear and concise manner.
3. Include an executive summary of the project.
4. Outline the current services and costs associated with it.
5. Outline the key components of your proposed service.
6. Define how the service will be evaluated- outcomes measures.
7. Describe the roles and responsibilities of your team & how the program will be integrated into current programs.
8. Prepare a communication plan.
9. Outline an implementation schedule.
10. Define the financial plan.
Eight Steps to Transform Your Organization:

1. Establish a sense of urgency.
2. Assemble a group with enough power to lead the change effort.
3. Create a vision to help direct the change effort / develop strategies to achieve that vision.
4. Communicate the vision.
5. Empower others to act on the vision.
7. Consolidate improvements and produce still more change.
8. Anchor the new behaviors in culture.

Without a business plan:

• Team members provide the service with good intentions.
• The work is added on to their current job.
• The hospital does not have an idea of the program goals and value.
• The providers are under-paid for their services and likely to get frustrated/burn out.
• Program closure will occur:
  – During the next economic downturn.
  – During organization leadership change.
  – When a new initiative or someone else’s model comes around.
An unsuccessful proposal for the replication of HELP at a second Aurora hospital:

• The geriatrician leaders at the site made the presentation.
• Six page detailed business plan sent two weeks prior to the presentation.
• Asked for $75,000 for an Elder Life Specialist.
• 15 slides provided detail of program outcomes.
• Relationship of the leaders to the nurse executive +/-.
• The leadership team was about to launch another project.
• Result:
  – “Not this year.”
A successful proposal for dissemination of HELP from 4 to 12 units at Aurora St Luke’s:

• The presentation was a collaborative: local hospital geriatrics leader and system leader, attended by all geriatrics system leadership.
• The leaders had a long-standing professional relationships.
• The presentation was edited- succinct/
• Presentation used an SBAR format.
• Major understanding of the value of the geriatrics programs.
• 11 slides/ 7 minutes asking for $150,000.
• Nursing attestation from recent Magnet outside reviewers.
• Momentum of recent recognition of the program.
• Result: “Prepare the pro forma for expansion.”
Features of a Successful Proposal to Gain Support for Geriatrics Model:

<table>
<thead>
<tr>
<th>Features:</th>
<th>Unsuccessful Proposal:</th>
<th>Successful Proposal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context:</td>
<td>Start a new HELP program at outlying hospital.</td>
<td>Disseminate a HELP program from 4 to 12 units.</td>
</tr>
<tr>
<td>Complexity of the presentation:</td>
<td>++</td>
<td>--</td>
</tr>
<tr>
<td>Simple message for the administration:</td>
<td>--</td>
<td>++</td>
</tr>
<tr>
<td>Buy in from the nursing leadership:</td>
<td>--</td>
<td>++</td>
</tr>
<tr>
<td>Long-standing relationships with leaders:</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Competing priorities:</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>
Geriatrics models implementation strategies:

New geriatrics model:

Powell’s Initial two trips:

- Funded by Illinois museum and congress.
- Small team with photographer added during second trip.
- Asked for $12,000 and got $10,000.
- 3 boats and 10 men.
- Leader was stuck on the side of a cliff.
- Leader had a chair high up on the boat.
- Four men abandoned journey/ left the team.
- Leader kept a journal of the discoveries and made measurements.
- Reports provided to museum and congress.
- Has potential for water use in the West.
Geriatrics models implementation strategies:

New geriatrics model:

- Address challenges of patients.
- Use resources of philanthropy and grants.
- Refer to efficacy from the literature.
- Assess current workflow; culture; attitudes.
- Uses a new approach.
- Measure model fidelity & outcomes.
- Launched at a site with best relationships and resources.
- Requires champions.
- Project is the job expectation of the leader.
- Assess costs for small cohorts.
- Use a planning committee.
- Use quality improvement strategies.
- Teach the healthcare team.

Powell’s Initial two trips:
Geriatrics model dissemination strategies:

Dissemination of the model:  The US Geological Service:

- Funded by congress.
- Multiple surveyors mapping the West.
- Standard topographic assessment of the land and resources of the entire region.
- Leader got an office.
- Leader made regular reports to congress.
- Service became part of the national budget.
- Defined the use of water for populations in multiple states.
Geriatrics model dissemination strategies:

**Dissemination of the model:**
- Resources are provided by budgets.
- Address challenges of populations of patients.
- Approach becomes the standard of care.
- Measure model fidelity and outcomes.
- Spread to sites where others control resources.
- Requires champions & leadership facetime at the site.
- Requires communication plan.
- Model becomes job performance of all at dissemination sites.
- Assess costs for the organization.
- Use an advisory committee.
- Use public health and patient safety strategies.
- Improve the competencies of the workforce.

**The US Geological Service:**
Educate the workforce

Describe effective methods to educate our workforce within clinical models of care.
Geriatrics Practice Models to Educate the Workforce-
1) Acute Care for Elders:

- Teach during the interdisciplinary team rounds.
- Help professional staff to do their job.
- Use pocket cards to provide a succinct message.
- Ask the professions to tell you “their greatest challenges”.
- Use ACE as a training site:
  - medical students, house staff, nurses, and pharmacists.
- Support the physicians in practice: ACE consultations, grand rounds, CME.
- Use an advisory team to identify outcomes and challenges.
- Develop clinical champions.
2) Use Multiple Strategies to Educate the Workforce:

- Grand rounds.
- ACE interdisciplinary team rounds.
- ACE cards on topics which can help the nurses.
- www.Geriatricfastfacts.com
- NICHE.
- Integrating geriatrics concepts into the electronic health record.
- ACE Tracker to guide the discussion.
- Yearly conference to review the key challenges.
ACE Cards®
Check List to Improve the Hospital Care of the Elderly

Acute Care for the Elderly (ACE) Program
Aurora Sinai Medical Center/UW Medical School

Prevent Problems: Critically review the necessity of all tests/procedures.

Pressure Ulcers: Ambulate; avoid “bed rest” order. Correct nutrition restrictions. Turn q 2 hrs. if bedridden.


Immobility/Falls: Prescribe assist device; physical therapy. Order acute rehab therapy consult. Walk with assist. (Else, consider DVT prophylaxis.)

Functional Decline: Define baseline ADLs. Increase activity level. Avoid restraint and catheters.

Constipation: Provide prune juice/power pudding. Provide stool softener.

Undernutrition: Review serum albumin. Consider nutrition consult; supplement. Could medications contribute to anorexia?

Depersonalization: Music, pictures, food from home. Encourage visitors, stuffed animals. Chaplain visit (hospice care).


Data Collection: Review vital signs, intake/output, daily weight, diet intake, bowel movement. Review the medication cardex; How does it compare to Rx prior to admit? Could problems be caused by the Rx? Should any Rx be stopped? Add multiple vitamin. Review therapy notes (PT/OT/speech). Review social service note (living situation/support). Review dietitian notes; lab data changes.

Communicate: Talk with the nurse to assess status; discuss goals and anticipated discharge. Update family of anticipated discharge plans or change in status.

Michael Malone, MD & Ellen Danto-Nocton, MD - 03/03
X22187e (02/04) ©AHC
Geriatrics Fast Facts

• Mobile enabled device.
• Available on all smartphones and tablets.
• [www.Geriatricfastfacts.com](http://www.Geriatricfastfacts.com)
• Funded by the Reynolds Foundation.

• Collaborative between Medical College of Wisconsin & Aurora Health Care & the Wisconsin Geriatrics Education Center.
ACE Tracker as an Educational Tool:

- Simple, brief, and to the point.
- Information comes from daily nursing assessment/interaction with the patient.
- Information is pulled from the EHR (Cerner/ Epic).
- Short enough to fit on a single page.
- A step by step checklist for common conditions.
- Allows clinicians to assess multiple fields, which are too complex for them to carry out reliably from memory alone.

ACE Tracker software to identify vulnerable elders:

3) - Geriatrics Practice Models to Educate the Workforce- HELP program:

- Teach about delirium prevention.
- Teach about management of older persons with delirium.
- Use multiple teaching forums to describe best practice in delirium care- HELP.
Describe lessons learned in developing, disseminating, and sustaining geriatrics models.
The Hedgehog Concept in Social Sectors:

- What you are deeply passionate about...
- What you can be best in the world at.
- What drives your resource engine.

You as a Geriatrics Leader-

“Good to Great and the Social Sectors, A monograph to accompany Good to Great”, Jim Collins, 2005.
How do we promote the dissemination of those models of care for older adults that have been shown to be effective and efficient?

Simplified Care for the Patient

- Simple & easy to use
- Smooth transitions coordinated care
- Complex, fragmented episodic care experience

Implementation of high quality, simple care

Best practices partially applied
- Rapid adopter of best practices / services
- Leading edge health care
- Best care everywhere
- Rapid implementation of different care delivery models
- Care designed around patient needs

All patients, same care, same way
- Different services for different needs/groups

Rapid Adopter

Best care everywhere
- Leading edge health care
- Rapid implementation of different care delivery models

Designed for You

Best practices partially applied
- Rapid adopter of best practices / services
- Leading edge health care
- Best care everywhere
- Rapid implementation of different care delivery models

Designing different care delivery models facilitates simplified care based on patient needs and characteristics
What can you do?

1. Use systems- approaches to the pursuit of your patients’ greatest challenges.
2. Measure / follow / record your outcomes.
3. Use the electronic health record to disseminate geriatrics principles.
4. Establish geriatrics models as the site of your training of the health care workforce.
5. Use educational forums to speak to the community needs for high-quality health care for older individuals.
Writing for Publication in the Geriatric Literature

Workshop Presentation by
- David B Reuben, MD
  David Geffen School of Medicine at UCLA
- Deborah Simpson PhD
  Aurora Health Care
- Barry D Weiss, MD
  University of Arizona Center on Aging

2014 Reynolds Grantee Meeting – Las Vegas, NV

Part 1: Writing Your Manuscript

David B Reuben, MD
Archstone Professor
Chief, Division of Geriatrics
David Geffen School of Medicine at UCLA

What We Will Cover
- What to publish
- Where to publish
- Preparing to write
- Getting started
- Moving forward
- Getting unstuck
- Using tables and figures
- Getting to the finish line

What to Publish
- Case reports
- Review articles
- Descriptions of practice or education models
- Research
  - Case series
  - Observational studies
  - Controlled studies
- Opinion pieces

Where to Publish
- Peer reviewed journals
  - General (e.g., NEJM, JAMA) versus specialty (e.g., AIM, JAGS, JGIM) journals
  - Which tier (1st, 2nd, 3rd)
- Non-peer reviewed journals
- On-line publications (e.g., POGOe)

Preparing to Write: Mental Preparation
- What are you writing?
- Who is the audience?
- Where do you plan to publish it?
- What format and length do they want?
- What is the intended consequence?
- Who are your co-authors?
- What is the authorship order?
Preparing to Write: More Mental Preparation

- What is the timeline for drafts and submission?
- Where am I going to write?
- When am I going to write?
- How do I write best?
- How early can I start?

Getting Started: Planning the Attack

- What is your take home message?
- How to build the case?
  - Mock up tables and figures
- What have you already done?
- Where is the easiest place to start?
- What’s in a title?

Getting Started: At The Keyboard

- Write a simple declarative sentence
- Write another
- Repeat until you cannot write any more
  - Run out of time
  - Fried brain
- Take a break

Moving Forward: Write Well

- Short simple sentences
- Let every word tell
- Use active verbs and voice
- Short simple words
- Avoid jargon
- Eschew clichés
- Link sentences and paragraphs
- Short paragraphs

Moving Forward: General Tips

- Use the beginnings and endings for the important points
- Avoid name dropping
- Be judicious when citing statistical facts
- Round numbers to nearest percentages
- Avoid broad ranges (eg, 30-70%)
- Use terms like “essential”, “important”, “critical” sparingly

Moving Forward: The Introduction

- Three paragraphs
  - General problem and significance
  - Specific problem and gaps
  - What will follow
- Strong opening sentence
- Keep this section short and crisp
Moving Forward: The Belly

Methods
- Follow the journal’s guidelines
- If none, go to JAMA
- CONSORT guidelines if clinical trial
- STROBE if observational study
- Provide a short overview
- Use subheadings
- Keep language consistent (same names for the same things)

Results
- Keep short and refer to tables and figs
- State only the key findings
- Primary findings first
- Tell it as a story
- No references
- No weaving in other studies
- No parenthetical comments

Moving Forward: The Discussion

- Restate the primary findings
- Don’t introduce new data
- How does this build upon and extend previous work?
- What are the limitations and cautions?
- What are the implications for the future?
- Finish with the take home message

Getting Unstuck

- Take a long break
- Resume with a different section
- Read it aloud to your dog
- Share it with a colleague

Tables and Figures

- Convey larger amounts of info
- Tables convey more information than histograms but perhaps not as clearly
- Keep tables as brief as possible
  - More rows is better than more columns
- Tables should be able to stand alone
- Abbreviations, explanations in footnotes

- Figures always need legends
- Figures must be able to stand alone
- For best effect use figures sparingly
Getting to the Finish Line

- Get internal and external feedback
- Different drafts to different reviewers
- General and content-specific
- Establish due date but give ample time
- Don’t ask for more than one read
- Decide on written versus oral feedback
- Don’t be defensive
- Allow time to elapse

Getting to the Finish Line

- How to improve your writing skills
  - Write often
  - Try new approaches
  - Rewrite often
  - Have your spouse/child read your writing
  - Critique others’ writings
  - Critique your own writing
  - Read books about writing

Great Books About Writing

- Strunk and White: The Elements of Style
- William Zinsser: On Writing Well
- George M Hall: How to Write a Paper
- Stephen King: On Writing: a Memoir of the Craft

PART 2: WHAT HAPPENS AFTER YOU SUBMIT
FROM “SCREENING” TO PEER REVIEW AND EDITOR DECISION

Deborah Simpson, PhD
Deputy Editor – Journal Graduate Medical Education
Medical Education Programs Director, Aurora Health Care
Professor, Family & Community Medicine – MCW & UWSMPH

Summary: WHAT HAPPENS AFTER YOU SUBMIT

MANUSCRIPT

- Flow Process Decisions!
  - Screen, Editor, Reviewers
- How you can Help!
  - Comply with all journal submission guidelines
  - Scope, Length, # Figures, Author info, References
  - Suggest reviewers (key papers you’ve cited)
  - Select categories carefully (used to search for reviewers)

REVIEWERS

- Decide Quickly Accept/Decline
- Submit within time period (or ask for extension)
- Constructively Critical
  - Overall Value
  - Specific feedback (page/line number)
  - Recommendation – be honest (reject, major revision)
  - Be Respectful (all tracked)

Be Respectful (all tracked)
Part 3: Responding to Reviewer Comments

Barry D Weiss, MD
University of Arizona
Center on Aging

Responding to Comments

- Don’t take it personally
  - Comments are about your paper.
  - They are not about you.

- If asked for a revision....
  - Be encouraged!
  - Editors don’t ask for revisions of papers they plan to reject.
  - Even the very best papers get critical comments.

- If rejected....
  - Keep in mind that
  - Many papers are rejected on first submission
  - But most papers ultimately get accepted somewhere.

- If rejected....
  - Don’t ignore the comments
  - Address them to improve the paper before submission to another journal.

Responding to Comments

- If asked for a revision....
  - Respond to every comment
  - Respond politely
  - Show where/how you responded
  - It’s OK to disagree. Just have a good reason and explain.
INCONTINENCE SUPPORT GROUPS

BACKGROUND

More than half of adults over 65 experience urinary incontinence to some degree. These individuals often experience psychological distress and unsatisfactory quality of life from the time incontinence develops and throughout treatment. We report on development of a support group developed to assist patients in dealing with their incontinence.

METHODS

We developed a support group with assistance from local hospitals and urology organizations. The support group provided opportunities for patients to meet and discuss incontinence with each other and with urologists. We measured the patient’s satisfaction with the support groups and whether they thought they were worthwhile.

RESULTS

27 patients attended the groups. They reported that the most important part of the retreat was the opportunity to meet with other incontinence patients and being able to ask questions. 80% of the patients would recommend the support groups to other patients diagnosed with incontinence.

CONCLUSIONS

Support groups are helpful to patients dealing with a new diagnosis of urinary incontinence.
USE OF SOCIAL MEDIA TO INCREASE KNOWLEDGE OF NEW RESEARCH IN GERIATRICS AMONG GERIATRIC FELLOWS

Setting and Problem

New developments and science in Geriatrics is ever changing and it is difficult for the geriatric fellows to keep up during their busy schedule. There are resources like NEJM’s Journal Watch Aging/Geriatrics and others but they require computer access and internet. Social Media like Facebook and Twitter is becoming increasingly popular among younger generation students and the convenience of accessing them on smartphones have made them very popular among residents and fellows.

Intervention

We opened a twitter account for the geriatric fellowship at (name of institution) and have started using the account for “twitting” links to important new developments and research published in peer reviewed journals. All fellows have been instructed in use of twitter and private accounts have been setup for all fellows. The program director currently maintains and updates the account but in future may be helped by the chief fellows. No private use of the account is allowed for non- academic purposes. Plans are there for twitting interesting images from POGOe to assure HIPPA compliance in the future.

Outcomes to date

The new system of dispersing information have been well received by the fellows and almost all fellows are following the account. We have set up quizzes on the material posted on the twitter account and fellow’s scores are used for assessing their clinical competence as per new NAS guidelines. The fellows have done well in the quizzes with >60% achieving a perfect score in the quiz.
THE INCONTINENCE BAG

BACKGROUND

Many patients with urinary incontinence are given medications for treatment, and medications often result in side effects. We developed a new device for managing incontinence that offers the possibility of effective treatment without adverse drug effects.

METHODS

Through a small tube, we inserted a soft pliable bag containing ferromagnetic particles into patients’ bladders. A small magnetic pad inserted into the patient’s underpants then pulls the bag towards, and blocks, the bladder outlet.

RESULTS

We used the bag in 10 patients. It was effective and no side effects were reported.

CONCLUSIONS

The incontinence bag offers a new approach to managing urinary incontinence.
Why I Love to Teach – Sometimes “Yes” & Sometimes “No”

Deb Simpson, PhD, Katie Denson, MD, Ed Duthie, MD, Michi Yukawa, MD, MPH, Rainier Soriano, MD, Mitch Heflin, MD, MHS, Sandro Pinheiro, PhD

WORKSHOP CAST RECOGNIZED AS TEACHERS!
WHY EXPLORE TEACHING DURING TIME OF “TRANSFORMATION”? 

• Education is “Transforming”
  – Mobile Technologies
    • MOOCS & Big Data → Learning Analytics
  – Competency Based
    • NAS, Milestones, EPAs, CLER → MOC & PI

• Our Workplaces & “Expertise” is Transforming
  – Health Care Systems & Delivery
    • “Value-based” & Teamwork
  – Sciences of Medicine
    • Basic → Translational (CTSAs) + Improvement Sciences
    • Patient & Population (Disease Registries)
    • Metrics based performance
OBJECTIVES – THE WHY!

1. Articulate the joys of teaching geriatrics
2. Analyze the joys (and challenges) of teaching
   • Lense Social Determination Theory (SDT)
   • 3 psych needs [competence, autonomy, relatedness]
3. Utilize SDT to generate strategies to turn a “pain” into joys
4. Celebrate our roles as teachers; recognize that DWRF participation = supported our SDT needs as geriatric educators
ACTION PLAN

☑ Overview

➔ Joys of Teaching – Small Group

• Overview SDT & 3 Ψ Needs
  – Application Exercises – Small Group
    • Reframe “Joys” SDT 3 Ψ Needs
    • Reframe Painful Teaching Experience - to ↑ Joy

• Debrief
  – Explanatory power of SDT?
  – Consider DWR participation via SDT 3 Ψ Needs
MOTIVATION: SELF-DETERMINATION THEORY

3 BASIC PSYCHOLOGICAL NEEDS MUST BE FULFILLED TO STIMULATE & SUSTAIN INTRINSIC MOTIVATION \(^{6,7,8,9,10,15,16}\) TO ACHIEVE PURPOSE

**MOTIVE: “ALTRUISM”**
Self-Determination

- **Competence**
  - Perception - Feeling effective!
  - Capable of achieving goal
  - Competent as
    - Geriatrician
    - Educator/Teacher
  - Continue to learn

- **Relatedness**
  - Desire feel connected
  - Feeling valued & accepted
  - Feeling of belonging to group/community
  - Peers, Patients, “Dean”, Students...

- **Autonomy**
  - Direct own behavior
  - Perception of having a choice
  - Opportunity for Self Direction
  - Volition/Control
**Review Lit: Joy Teacher via SDT**

**I teach because... engage in teaching because**

- **Feel Capable/Competence**
  - Teaching about my own specialty\(^1,3,18\)
  - Opportunities for **own** learning\(^2,3,4,16,17,18,19\)
    - I teach to be challenged in my established views\(^1\)
    - Keeping up to date: Good way to clarify my level of understanding. Hard to tech something you don’t really understand yourself\(^4,19\)
  - Professional growth (teaching career)\(^2,3\)
  - Respect from patients\(^4\)
  - Like the challenge of teaching... as effectively as possible\(^1,17\)
  - Feedback on my teaching performance\(^3,16,17,18\)
**LITERATURE – JOY**

[I TEACH BECAUSE... ENGAGE IN TEACHING BECAUSE]

- **Self Determination - Autonomy**
  - Freedom to determine what I teach // Autonomy in decision making
  - Set priorities for what is taught in my discipline
  - Shared responsibility for teaching & learning

- **Relatedness-Connectedness**
  - Collegiality with students
  - Support from colleagues/co-workers & superiors
  - Opportunity to be part of innovative program
What about those “not so much” times?

Competent
- SME - Geriatrics
  - Growth - Learning
- Teacher
  - Teach in my Area
  - Feedback on Teach

Autonomy
- What
- How
- With Whom
- When

Engage
- Relationship
  - Student
  - Teacher
- Valued
  - Peers / Chair
  - SoM
LITERATURE I DON’T TEACH…DISENGAGED

• (Dys) Competence
  – Not my area of “expertise”\textsuperscript{17}
  – Not how I teach (sage on stage)\textsuperscript{17}

• (Dis)Involvement
  – …no strong involvement in course design\textsuperscript{1}

• (Dis) Incentives/Rewards
  – Clinical load/efficiency/research targets\textsuperscript{1,4,17, 19}
  – … institution devalues teaching\textsuperscript{1,4, 19}
    • I am always surprised & disappointed by how much the universities feel we should teach & how little they are prepared to support us practically
    • Negatively impact my career \textsuperscript{17}
SDT Value to you a Geriatric Teacher? Educator?

- Way to “understand” motivations to teach?
- Generate strategies to address “pain”?

Organize? Explain?
USE SDT to Enhance Joy?

SDT Guide?

- Competence
  - What Teach:
    - Make Visible my “Expertise”
    - Promote: My Growth as Expert
  - How Teach = What I’m good at?
    - Positive Feedback
    - Students? Peers? Admin?
  - My Expertise as Teacher?

- Autonomy

- Engage
USE SDT TO ENHANCE JOY & IDENTITY?

SDT Guide?

Competence
- Shared Values about WHY?
- “Win-Win” Changes?

Autonomy
- Some Say @ My Teaching?
  - What Teach?
  - How?
  - With Whom?
  - When

Engage
USE SDT TO ENHANCE JOY & IDENTITY?

SDT Guide?

- Competence
- Autonomy
- Engage

• Promote Relationships
  - Take Risks > “Expertise”
  - LT Students?
  - Colleagues as Teachers?

• TRULY Valued?
  - Protected Time
  - FD, Prepare
  - Teach
  - Peers / Chair
  - Travel Profess Societies
  - SOMPH – Academy?
OBJECTIVES – JOY OF TEACHING

TIME OF INTERNAL AND EXTERNAL TRANSFORMATION IN MEDICAL EDUCATION

1. Articulate the joys of teaching geriatrics

2. Analyze the joys (pain) of teaching
   • Lense Social Determination Theory (SDT)
   • 3 psych needs [competence, autonomy, relatedness]

3. Utilize SDT to generate strategies to turn a “pain” into joys

4. Celebrate our roles as teachers;
   • Recognize DWRF participation = supported our SDT needs as geriatric educators?
DONALD W. REYNOLDS SUPPORTS

3 BASIC PSYCHOLOGICAL NEEDS STIMULATE & SUSTAIN MOTIVATION TO IMPROVE
CARE FOR GERIATRIC PATIENTS THROUGH MEDICAL EDUCATION

Competence

DWR FOUNDATION

Relatedness

Autonomy

PERCEPTION - FEELING EFFECTIVE!

• Make Geriatric SME & Edu Expertise visible
  o Opps to present
  o Marketplace
• Continue to learn “safely”

DIRECT OWN BEHAVIOR

• DWR Awards
  o Pick Project
  o Protected time
• POGOe materials available to select

• DESIRE FEEL CONNECTED
  • “Site visits” guidance
  • DWR Annual meeting
    o Valued
    o Feeling of belonging to DWR community
  • Post Funding “invited”
  • POGOe Award
  • Partner with others
    o AGS “visible”

Celebrate & Share the Joy of Geriatric Education!
REFERENCES


REFERENCES


Practical Tips, Suggestions, and Insight into Navigating the Academic Promotion Process as a Clinician Educator Workshop

Annual Reynolds Grantee Meeting
October 6, 2014
Kimberly Curseen, MD
Eric Widera, MD
Caroline Vitale, MD, AGSF

Promotion Overview:

1. Name the academic track you are currently on for promotion at your institution:

2. Name your academic mentor(s):

3. List the basic requirements for academic promotion on your current track:

4. Describe the time frame for promotion at your institution and what happens if you fall out of this time frame:

5. Describe your strategic plan for obtaining promotion at your institution:

6. When was the last time you had or plan to have a conversation with your mentor/chair/ or direct supervisor concerning for plan for promotion?
Practical Tips, Suggestions, and Insight into Navigating the Academic Promotion Process as a Clinician Educator Workshop

Annual Reynolds Grantee Meeting
October 6, 2014
Kimberly Curseen, MD
Eric Widera, MD
Caroline Vitale, MD, AGSF

Personal Promotion Needs Assessment:

1. Describe how you are keeping track of the educational offerings and the curriculum you are creating:

2. Describe how you are keeping track of what you are teaching, and who you are teaching:

3. Teaching evaluations:
   a. Have you reviewed your teaching evaluations?

   b. Do you know how your evaluations compare to your peers internally?

   c. Do you know how to obtain this information?

4. What is the average number of peer reviewed publications expected for promotion to associate professor per year at your institution?

5. Describe the impact of your educational/clinical contributions on a local, regional, and/or national level?

6. What does your institution value? What is your unique value to your institution?
The Teamwork Effectiveness Assessment Module (TEAM): helping healthcare providers to assess and improve their interprofessional teamwork

Benjamin Chesluk, PhD
2014 Reynolds Grantee Annual Meeting
Las Vegas NV, 10/7/2014
Learning objectives

Distinguish an **organizational** view of teamwork from an **individual** view of teamwork

Understand ABIM's strategy for researching and developing an assessment of physicians’ competency in interprofessional teamwork

Evaluate the strengths and limitations of multi-source feedback for assessing physicians’ teamwork competency in different practice settings
Background of ABIM

Founded in 1936

Mission:
To enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for excellent patient care.

“Of the profession... for the patient”

Includes 19 subspecialty areas, 1 focused practice area (hospital medicine)

More than 200,000 physicians certified

Growing focus on assessment of all 6 ACGME competencies, in practice
Research-and-development process

1. Examine the field (theory, research, assessments)
   • Definitions of teamwork & theoretical frameworks
   • Approaches to training and assessment

2. Convene expert panel
   • Medicine, nursing, aviation, team training, patient advocacy

3. Explore existing contexts and practices (ethnography)
   • 3 primary-care practices; 8 hospitalists in 5 hospitals

4. Create draft assessment; test with “cognitive lab”
   • 11 non-physicians, 6 physicians

5. Pilot test (feasibility)
   • 25 hospitalists

6. Module launch (October 2012)
Findings: examining the field (1)

Many other initiatives related to teamwork, e.g.:

- Training and assessing healthcare teams (TeamSTEPPS, in-situ simulation, etc.)
- Interprofessional competencies (CanMEDs, WHO, QSEN, IPEC, IPPC)
- Promoting team care (ABIMF, SHM, etc.)

Focus of most is team, not individuals (understandably)

- Teamwork = emergent / collective (Lingard 2012)
  - Healthcare outcomes produced by teams (i.e., groups) in context
  - Competent individuals ≠ competent teams
  - Group competence: develops through practice, in context
  - Need to integrate individualist / collectivist perspectives to understand teamwork competency
    - What does the team do?
    - How do individuals affect what the team does?
Findings: examining the field (2)

Key theoretical frameworks:

Relational coordination (Gittell et al 2008)
  • Degree of mutual knowledge & trust between roles

Defining attributes of teamwork (Xyrichis and Ream 2007)
  • Exercising concerted effort
  • Employing interdependent collaboration
  • Utilizing shared decision-making

Core KSAs of physician teamwork (Baker et al 2005)
  • Team leadership
  • Mutual performance monitoring
  • Backup behavior
  • Adaptability
  • Team/collective orientation
  • Shared mental models
Findings: examining the field (3)

Teamwork quality is linked to:
- Quality of care
- Patient safety and experience
- Provider experience

Largely studied in contexts unlike internal medicine
- i.e., ORs, EDs, etc.
- Well-defined teams, with clear individual tasks/roles
- Activities bounded in space & time (e.g., ED admission, surgery)
- Passive patient

By contrast, internal medicine teams often have:
- Unclear members/roles
  - Instead, networks / “knots”
- Lack of defined space/time boundaries
  - Need to coordinate across settings & over time
- Engaged patient/family
Findings: expert panel

Focus on interprofessional teamwork
  • Not just physician-physician
  • Physician isn’t always (or even usually) the “leader”

Aim should be formative assessment for improvement in context

4-fold “individual competency”:
  • Communication (sharing information)
  • Collaboration (sharing decisions)
  • Empowering the entire team (“boundary spanning”)
  • Assessing the team environment (context, resources)
Findings: ethnography (primary care)

Ethnography = close observation in context

• Patterns of behavior ⇒ underlying knowledge/beliefs
  ◦ Culture (what people do, and why it makes sense to them)

3 practices (solo MD; independent PCMH leader; university-owned)

Findings: complex team dynamics; role divisions

• Focus on maximizing 1-on-1 physician-patient sessions limits possibilities for teamwork
• Physicians isolated in “frantic bubble” (always behind schedule)
  ◦ May not be aware of what others in practice do
• Lots of fluid collaboration within practice team
  ◦ Only indirectly involving physicians
Findings: ethnography (hospitals)

8 hospitalists in 5 hospitals (community / academic; teaching / non-teaching; urban / suburban)

Findings: lots of variation (hospital / unit / indiv.)
- Some units: substantial, well-structured teamwork
- Others: highly dependent on individuals’ teamwork “KSAs”
  - ↓ coordination between professions
  - ↓ communication or social familiarity (= ↑ resentment)
  - ↑ potential (or actual) safety / timeliness issues
    - Missing information, forgotten tasks, conflicts, etc.
    - No clear way to identify or resolve issues when they occur
  - “Homemade” solutions, e.g.:
    - Daily faxes to nurses re: how MDs have assigned patients
    - Note cards to deal with “stacked” interruptions
Findings: cognitive interviews

Cognitive interviews: structured review of survey items with potential respondents

- Physicians, nurses, therapists, case managers, etc.
- Evaluate items – Do they make sense? Are they appropriate?
- Probe into respondents’ experiences of teamwork

Reiterated need to focus on process/relationships

Physicians often need help to define their “team”

- Bouncing between multiple teams (esp. in hospital)
- “We don’t have teams here”

Focus on respectful, effective collaboration

- “Does this physician... know what you can do for patients?”
- “… give you the info. you need to do your job?”
TEAM: Teamwork Effectiveness Assessment Module

Formative 360° assessment (not summative)

For inpatient physicians and their teams

4-part process:

1. Guided process to identify interprofessional team
2. In-depth qualitative + quantitative feedback
3. Guided reflection with “trusted peer(s)”
Feasibility pilot test in 2010

Pilot testers:
• n=25 hospitalists
• Broad range of practice models, hospital types

Results:
• 20 hospitalists completed assessment process
• Very promising, even in challenging contexts, e.g.:
  ◦ Scattered teams
  ◦ Physicians working in multiple hospitals
• Physicians: feedback was valuable and actionable
• Took “guided debrief” with peer(s) seriously; added value
• Raters: liked being asked for feedback
  ◦ Wanted to be able to rate other physicians (esp. surgeons)
Module launch to hospitalists

Launched to participants in ABIM’s Focused Practice in Hospital Medicine (FPHM) program in October 2012

Results so far (as of September 17, 2014):

- 204 ordered; 113 completed
- Feedback from physicians – consistent with pilot:
  - Ratings and comments from team are concrete and helpful
  - Provides information they couldn’t get any other way
  - Improvement plans mostly focus on communication & feedback
- Feedback from raters – also positive:
  - Most feel comfortable assessing physician
  - Assessment covers “what is important” about how they work with the physician being assessed
  - Feel confidentiality adequately protected
Welcome Lisa!

You have successfully registered for the TEAM: Teamwork Effectiveness Assessment Module. This is your welcome page, which will be your guide throughout this module. Check the Next Step box (on your right) to see where you should go each time you return to TEAM.

Letter to Department Chair (Optional)

You may present this letter to your Department Chair to alert him or her of your participation in the TEAM module. The letter can be used “as is” by filling in the name of the Chair, the hospital or health system where you work, and your name. Additionally, you may make any revisions to the letter that are appropriate for your situation.
TEAM sample screen 2 (survey status)

Survey Status

16 Team members were invited to participate (minimum of 15 required)
10 Team members completed surveys (minimum of 10 required)
0 Team members declined participation
7 Team member invitations have expired. To renew them, return to your Sent Invites.
1 Invitation emails have been identified as undeliverable.

You will receive weekly emails of your survey status until you move on to the Feedback Report section.

Common Questions
10 Team Members have submitted their assessments; the data has been aggregated into this report.

### Detailed Report (ratings and comments)

**VIEW SUMMARY REPORT**

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>TEAM MEMBER COMMENTS</th>
<th>TEAM MEMBER RESPONSES</th>
<th>YOUR RESPONSE</th>
<th>YOUR COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gives me all the information I need from him/her to provide patient care.</td>
<td>Comment 1:comment</td>
<td>Never</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comment 2:comment one</td>
<td>Rarely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives me all the information I need from him/her to assure a safe transition when a patient is transferred from another unit/facility to my unit.</td>
<td>Comment 1:comment 2</td>
<td>Never</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comment 2:comment two</td>
<td>Usually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives me all the information I need from him/her to assure a safe transition during a patient's discharge.</td>
<td>Comment 1:comment 3</td>
<td>Never</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comment 2:comment three</td>
<td>Sometimes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

View this report in PDF format
Next steps (underway)

1. Improve module based on findings from pilot launch
   - Clearer framing of module for raters
   - More & better guidance for “trusted peers”
   - More focused guidance for reflecting on feedback

2. Make available to more users
   - All inpatient ABIM physicians
   - Pediatrics and Family Medicine diplomates

3. Proof-of-concept test of TEAM for primary care
   - In conjunction with ABFM and ABP
   - Initial results promising... more work is needed
Next steps (in planning)

1. Explore use in training contexts (i.e., for residents)
   • SFVAMC pilot with PACT training teams (residents and nursing trainees)

2. Explore use in other settings, e.g.:
   • Long-term care
   • Dialysis care

3. Other new possibilities:
   • Use by teams / departments (not just individuals)?
   • New versions for other health professions (e.g., nursing)?
   • More resources for module users and their teams, e.g.:
     ◦ Models for teamwork
     ◦ “Best practices” for improvement plans
     ◦ Link to TeamSTEPPS
References


Chesluk, B. and E. Holmboe (2010). “How teams work (or don’t) in primary care: a field study on internal medicine practices.” Health Affairs 29(5), 2010


Contact information

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Philadelphia PA 19106
bchesluk@abim.org
(215) 399-4009
Practice setting where you work / teach:__________________________________

The teamwork competencies included in ABIM’s TEAM are:

1. Communication
2. Collaboration
3. Boundary spanning
4. Assessing the team environment

How these teamwork competencies apply in your setting? Are there important nuances within these general categories? What’s most important? What’s missing?

What are the most important ways that providers demonstrate teamwork in your setting? What are the behaviors that demonstrate individual competence in teamwork? Are there behaviors that show that an individual lacks competence in teamwork?
**Assessment types:**
- Multi-source feedback
- Observation in context
- Simulation

**Assessment focus:**
- Individual
- Group/team

What kind(s) of teamwork assessment would be most feasible in your setting?

What kind(s) of teamwork assessment would be most helpful to improve teamwork and patient care in your setting?

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Group/team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MSF</strong></td>
<td>(ABIM TEAM)</td>
<td>(Relational Coordination)</td>
</tr>
<tr>
<td><strong>Observation</strong></td>
<td>(TENTS) (Interprofessional professionalism)</td>
<td>(TeamSTEPPS Team Performance Observation Tool)</td>
</tr>
<tr>
<td><strong>Simulation</strong></td>
<td>(Standardized patients in role playing)</td>
<td>(in situ simulation events)</td>
</tr>
</tbody>
</table>
# Interprofessional Collaborator Assessment Rubric

Instructions: For each of the statements below, circle the number which corresponds to the performance of the learner.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Below Expected</td>
<td>Below Expected</td>
<td>Expected</td>
<td>Above Expected</td>
<td>Well Above Expected</td>
<td>Not Observable</td>
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</tbody>
</table>

## Communication: Ability to communicate effectively in a respectful and responsive manner with others (“others” includes team members, patient/client, and health providers outside the team).

<table>
<thead>
<tr>
<th>Resident...</th>
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<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates with others in a confident, assertive, and respectful manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
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</tr>
<tr>
<td>Communicates opinion and pertinent views on patient care with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</tr>
<tr>
<td>Uses communication strategies (verbal &amp; non-verbal) appropriately in a variety of situations.</td>
<td>1</td>
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<td>9</td>
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</tr>
<tr>
<td>Communicates in a logical and structured manner</td>
<td>1</td>
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<td>6</td>
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</tbody>
</table>

## Collaboration: Ability to establish/maintain collaborative working relationships with other providers, patients/clients and families.

<table>
<thead>
<tr>
<th>Resident...</th>
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<th></th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes collaborative relationships with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Integrates information and perspectives from others in planning and providing patient/client care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Shares information with other providers that is useful for the delivery of patient/client care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

## Roles and Responsibility: Ability to explain one’s own roles and responsibilities related to patient/ client and family care (e.g. scope of practice, legal and ethical responsibilities); and to demonstrate an understanding of the roles, responsibilities and relationships of others within the team.

<table>
<thead>
<tr>
<th>Resident...</th>
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<th></th>
<th></th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes one’s own roles and responsibilities in a clear manner with the team/patient/family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>7</td>
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<td>9</td>
<td></td>
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<tr>
<td>Demonstrates professional judgement when assuming or delegating tasks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<td>9</td>
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</tr>
<tr>
<td>Shares evidence-based or best practice discipline-specific knowledge with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
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</tbody>
</table>
**Collaborative Patient/Client-Family Centred Approach:** Ability to apply patient/client-centred principles through interprofessional collaboration.

<table>
<thead>
<tr>
<th>Resident...</th>
<th>1</th>
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<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks input from patient/client and family.</td>
<td></td>
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<tr>
<td>Shares options and health care information with patients/clients and families.</td>
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</table>

**Team Functioning:** Ability to contribute to effective team functioning to improve collaboration and quality of care.

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<tr>
<th>Resident...</th>
<th>1</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates recognition of the relationship between team functioning and quality of care.</td>
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<tr>
<td>Contributes to interprofessional team discussions.</td>
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</tbody>
</table>

**Conflict Management/Resolution:** Ability to effectively manage and resolve conflict between and with other providers, patients/clients and families.

<table>
<thead>
<tr>
<th>Resident...</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>N/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks the perspectives and opinions of others.</td>
<td></td>
<td></td>
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<tr>
<td>Seeks clarification in a respectful manner when misunderstandings arise.</td>
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</tr>
<tr>
<td>Uses appropriate conflict resolution strategies to manage and/or resolve conflict.</td>
<td></td>
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</tr>
</tbody>
</table>

**With respect to collaboration ability,** compared to other residents you have previously interacted with, this resident was:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Below Average</td>
<td>Below Average</td>
<td>Average</td>
<td>Above Average</td>
<td>Well Above Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments regarding the resident’s collaboration ability:
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________

Comments regarding the study or ICAR:
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________

202
INTERPROFESSIONAL PROFESSIONALISM ASSESSMENT

Developed by the Interprofessional Professionalism Collaborative
September 20, 2011 (final draft)
INTERPROFESSIONAL PROFESSIONALISM ASSESSMENT

Purpose:
The purpose of the Interprofessional Professionalism Assessment (IPA) is to evaluate an entry-level health professional’s demonstration of professionalism when interacting with members of other health professionals.

Application:
The Interprofessional Professionalism Assessment can be used by health professionals to evaluate themselves or others including learners, peers, supervisors, or subordinates.

Definition:
Interprofessional professionalism: “Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism and caring, excellence, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities.”


Directions:
Use the rating scale provided below, please rate each of the items based on your overall impressions and observations of the individual’s behavior throughout the practice experience. Complete your final assessment of the individual at the conclusion of the practice experience. Definitions are provided as a context for each of the categories provided.

Rating Scale:
SD = Strongly disagree; D = Disagree; A = Agree; SA = Strongly agree; N/O = No opportunity to observe in this environment

Communication
Communication: Impart or interchange of thoughts, opinions or information by speech, writing, or signs; “the means through which professional behavior is enacted.” (Arnold and Stern in Stern 2006)

1. Works with members of other health professions to coordinate communication with patients/clients and family members.
2. Demonstrates active listening with members of other health professions.
3. Communicates respectfully with members of other health professions.
4. Communicates with members of other health professions in a way they can understand, without using profession-specific jargon.
5. Responds to questions posed by members of other health professions in a manner that meets the needs of the requester.

Provide comments related to the behaviors associated with Communication, including those that are positive and those needing improvement.
INTERPROFESSIONAL PROFESSIONALISM ASSESSMENT

Respect

*Respect:* “Demonstrate regard for another person with esteem, deference and dignity . . . personal commitment to honor other peoples' choices and rights regarding themselves . . . includes a sensitivity and responsiveness to a person's culture, gender, age and disabilities . . . the essence of humanism . . . signals the recognition of the worth of the individual human being and his or her belief and value system.” (Arnold and Stern in Stern, 2006)

6. Demonstrates confidence, without arrogance, while working with members of other health professions.
7. Recognizes that other health professions may have their distinct cultures and values, and shows respect for these.
8. Respects the contributions and expertise of members of other health professions.
9. Seeks to understand the roles and responsibilities of members of other health professions as related to care.
10. Determines patient care roles and responsibilities in a respectful manner with members of other health professions.

Provide comments related to the behaviors associated with Respect, including those that are positive and those needing improvement.

Altruism and Caring

*Altruism and Caring:* Overt behavior that reflects concern, empathy, and consideration for the needs, values, welfare, and well-being of others and assumes the responsibility of placing the needs of the patients or client ahead of the professional interest.

11. Offers to help members of other health professions when caring for patients.
12. Demonstrates empathy for members of other health professions.
13. Models for other health professionals compassion towards patients/clients, families and caregivers.
14. Places patient/client needs above own needs and those of other health professionals.

Provide comments related to the behaviors associated with Altruism and Caring, including those that are positive and those needing improvement.
INTERPROFESSIONAL PROFESSIONALISM ASSESSMENT

Excellence

*Excellence:* Adherence to, exceeds, or adapts best practices to provide the highest quality care.

15. Coordinates with other health professions and the patient/client, family and caregivers to produce an optimal plan of care.

16. Reviews all relevant documentation from other health care professions prior to making recommendations to plan of care.

17. Contributes to decisions about patient care regardless of hierarchy/profession-based boundaries.

18. Works with members of other health professions to assure continuity of care for patients.

Provide comments related to the behaviors associated with Excellence, including those that are positive and those needing improvement.

Ethics

*Ethics:* Consideration of a social, religious, or civil code of behavior in the moral fitness of a decision of course of action, especially those of a particular group, profession, or individual, as these apply to every day delivery of care.

19. Interacts with members of other health professions in an honest and trustworthy manner.

20. Works collaboratively with members of other health professions to resolve conflicts that arise in the context of caring for patients/clients.

21. Discusses with members of other health professions any ethical implications of healthcare decisions.

22. Reports or addresses unprofessional and unethical behaviors when working with members of other health professions.

Provide comments related to the behaviors associated with Ethics, including those that are positive and those needing improvement.
INTERPROFESSIONAL PROFESSIONALISM ASSESSMENT

Accountability

Accountability: Accept the responsibility for the diverse roles, obligations, and actions, including self-regulations and other behaviors that positively influence patient and client outcomes, the profession, and the health needs of society.

23. Engages with members of other health professions in quality assurance/improvement activities.

24. Seeks clarification from members of other health professions about unclear information.

25. Accepts consequences for his or her actions without redirecting blame to members of other health professions.

26. Works with members of other health professions to identify and address errors and potential errors in the delivery of care.

Provide comments related to the behaviors associated with Accountability including those that are positive and those needing improvement.

Overall Strengths related to Interprofessional Professionalism

Areas for Improvement related to Interprofessional Professionalism
## Relational Coordination Survey

<table>
<thead>
<tr>
<th>1. Frequent Communication</th>
<th>How frequently do people in each of these groups communicate with you about [insert focal work process/client population]?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Timely Communication</td>
<td>Do they communicate with you in a timely way about [insert focal work process/client population]?</td>
</tr>
<tr>
<td>3. Accurate Communication</td>
<td>Do they communicate with you accurately about [insert focal work process/client population]?</td>
</tr>
<tr>
<td>4. Problem Solving</td>
<td>When there is a problem with [insert focal work process/client population], do people in each of these groups blame others or work with you to solve the problem?</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>5. Shared Goals</td>
<td>Do people in each of these groups share your goals for [insert focal work process/client population]?</td>
</tr>
<tr>
<td>6. Shared Knowledge</td>
<td>Do people in each of these groups know about the work you do with [insert focal work process/client population]?</td>
</tr>
</tbody>
</table>
| 7. Mutual Respect        | Do people in each of these groups respect the work you do with [insert focal work process/client population]?

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WHAT IS RELATIONAL COORDINATION?

Relational Coordination is a mutually reinforcing process of communicating and relating for the purpose of task integration.

Relational Coordination:
• Drives quality and efficiency,
• Is enabled by effective management practices,
• Matters most for work that is complex, uncertain and time constrained.

WHAT IS THE RELATIONAL COORDINATION SURVEY 2.0?

The Relational Coordination Survey 2.0 is an actionable diagnostic that provides a comprehensive view of how teams communicate and relate in the course of their daily work. The survey measures the quality of communication and relationship behaviors integral to building cultures of teamwork that enable the creation of healthy, learning organizations. Each survey is customized to focus on a specific work process or client population, tailored to align with the needs of the organization.

WHAT DOES THE RELATIONAL COORDINATION SURVEY 2.0 DO?

• Diagnoses critical communication and relationship patterns that underlie team performance.
• Captures the quality of team performance from the perspective of key stakeholders—patients, caregivers, care teams and leaders.
• Structures working relationships that enable process improvement.
• Monitors team progress and performance over time and between units.

ABOUT RELATIONAL COORDINATION ANALYTICS

Relational Coordination Analytics collaborates with organizations to transform their work processes, organizational culture and performance through positive relationships. Our diagnostic tool identifies concrete, actionable opportunities to improve and strengthen how teams work together in the context of their daily work. For more information, email us at info@rcanalytic.com or call 617-892-8653.

Relational Coordination Analytics • One Broadway, 11th Floor • Cambridge, MA 02142 • www.rcanalytic.com
### Interprofessional Teamwork Behavior

Please give us some information on how you work with others in the hospital. Remember, in these questions, “team” refers to the other health-care professionals, primarily non-physicians, with who you work to care for patients.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I check with the other health-care professionals, including non-physicians, involved in caring for my patients to make sure they have all the information they need from me to provide patient care.</td>
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<tr>
<td>I give my team all the information they need from me to assure a safe transition when a patient is transferred from another unit/facility to my unit.</td>
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<tr>
<td>I give my team all the information they need from me to assure a safe transition during a patient’s discharge from the hospital.</td>
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<tr>
<td>I respond to other care providers’ requests (for example, for information, new orders, etc.) without their having to remind me to do so.</td>
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<tr>
<td>I communicate respectfully with others on my team.</td>
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<tr>
<td>I communicate with my team about patients in a way that they can understand.</td>
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<tr>
<td>I address others on my team by name.</td>
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<tr>
<td>I make an effort to know others on my team as people.</td>
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<tr>
<td>I am sensitive to cultural differences within my team.</td>
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<tr>
<td>I make sure my team knows when there are urgent changes to a patient’s plan of care.</td>
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<tr>
<td>I make sure my team knows the reason for any changes to a patient’s plan of care.</td>
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<tr>
<td>I make sure my team knows who to contact and how and when to contact them, if problems arise in a specific patient care situation.</td>
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<tr>
<td>I remain professional when dealing with difficult situations (for example, unexpected changes in a patient’s status, unusual requests from a patient’s family members, etc.)</td>
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<tr>
<td>I know the roles of the other health-care professionals on my team in providing patient care.</td>
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<tr>
<td>I ask for input about patient care from all the professionals (for example, nurses, therapists, social workers, etc.) involved with caring for that patient.</td>
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<tr>
<td>I only ask my teammates to do things that are within their scope of practice or professional expertise.</td>
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<tr>
<td>I acknowledge what others on my team contribute to caring for patients.</td>
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<tr>
<td>I encourage my teammates to use their expertise in the care of their patients.</td>
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<tr>
<td>I encourage my team to express any concerns they may have about a patient’s care.</td>
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<tr>
<td>I listen to the other members of my team when they have suggestions about a patient’s care.</td>
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<tr>
<td>I respect unit and hospital rules and protocols around patient care.</td>
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</tr>
<tr>
<td>I ask for help from other health-care professionals (nurses, therapists, social workers, etc.) when needed.</td>
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<tr>
<td>I give others on my team feedback about what they do well.</td>
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</tr>
<tr>
<td>I give others on my team feedback about what they do that needs improvement.</td>
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<tr>
<td>I admit mistakes when I make them.</td>
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<tr>
<td>I ask for feedback from others on my team about my performance.</td>
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</tr>
<tr>
<td>I accept feedback from others on my team about my performance.</td>
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</tr>
</tbody>
</table>
Team Events Non-Technical Skills (TENTS)
Hohenhaus-Powell-Haskins

Date: ___________ Time : ___________ Process: _________
Location/Unit: _____________ Observer: ________________

<table>
<thead>
<tr>
<th>Element</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Communication</td>
<td>Sends and receives appropriate information</td>
</tr>
<tr>
<td>1b</td>
<td>Asks questions</td>
</tr>
<tr>
<td>1c</td>
<td>Utilizes feedback between team members</td>
</tr>
<tr>
<td>1d</td>
<td>Sends and receives information to/from patient/family</td>
</tr>
<tr>
<td>1e</td>
<td>Uses appropriate critical language</td>
</tr>
<tr>
<td>1f</td>
<td>Utilizes teamwork tools</td>
</tr>
<tr>
<td>1g</td>
<td>Debrief completed</td>
</tr>
<tr>
<td>2a Leadership</td>
<td>Establishes event leader</td>
</tr>
<tr>
<td>2b</td>
<td>Verbalizes plan: States intentions, recommendations and timeframes</td>
</tr>
<tr>
<td>2c</td>
<td>Delegates as appropriate</td>
</tr>
<tr>
<td>2d</td>
<td>Instructs as appropriate</td>
</tr>
<tr>
<td>3a Situation Monitoring</td>
<td>Visually scans environment</td>
</tr>
<tr>
<td>3b</td>
<td>Cross monitors activities; Uses back-up behavior</td>
</tr>
<tr>
<td>3c</td>
<td>Verbalizes adjustments in plan as changes occur</td>
</tr>
<tr>
<td>4a Mutual Support/ Assertion</td>
<td>Secures additional resources</td>
</tr>
<tr>
<td>4b</td>
<td>Supports others</td>
</tr>
<tr>
<td>4d</td>
<td>Prioritizes appropriately</td>
</tr>
<tr>
<td>4e</td>
<td>Employs conflict resolution</td>
</tr>
<tr>
<td>4f</td>
<td>Speaks up/persuades</td>
</tr>
<tr>
<td>5 Overall Teamwork</td>
<td></td>
</tr>
<tr>
<td>6 Overall Leadership</td>
<td></td>
</tr>
</tbody>
</table>

Any value of “1” or “0” require a narrative comment in the appropriate comment box.

0= expected but not observed
1= observed but poor
2= observed but marginal
3= observed and acceptable
4= observed and good
NA=not applicable
ABIM Teamwork Effectiveness Assessment Module (TEAM)

Overview
The TEAM is meant for use by an individual physician to gather and interpret feedback from their interprofessional “team” with whom they work to care for patients in the hospital. The teamwork assessment is designed for use by providers even in work settings that do not provide formal support or training for interprofessional teamwork.

The teamwork assessment is comprised of four parts/steps:
1. Identification of interprofessional team (see “criteria for identifying interprofessional team”)
2. Self-assessment (see “self-assessment questions”)
3. Assessment by team members (see “rater assessment of hospitalist”)
4. Guided reflection on results with team member(s) (see “guided debrief questions”)

1. Criteria for identifying interprofessional team
Instructions to user: Please use this worksheet to identify your team—the other healthcare professionals who will provide you with feedback. Please choose people with whom you spend a significant proportion of your time caring for patients, and whose work you have the ability to influence (i.e., people who rely on you for information, decisions, and/or opinions).

Requirements:
- You must select a minimum of 15 team members.
- You must select at least 1 nurse with a leadership role (e.g., a nurse manager).
- You may not select more than 5 physicians.

You may select:
- The care team on a specific unit or in a specific location (nurse managers, nurses, therapists, pharmacists, social workers, consulting physicians, etc.)
- The care team(s) with whom you work to care for one or more specific patients
- Care-team members from different units in which you work
- Other professionals within the hospital with whom you work regularly and who are qualified to assess your ability to work as part of a patient-care team, including specific individuals from:
  - Nursing managers
  - Bedside/floor nurses
  - Nurse practitioners
  - Therapists (e.g., physical, speech, respiratory, etc.)
  - Social workers
  - Case managers
  - Pharmacists
  - Physicians’ assistants
  - Housekeeping and administrative staff (if they are involved in patient care)
  - Other physicians with whom you co-manage patients, or consult re: patient care
You may not select:
- People who do not work at your current institution
- Residents or other physician trainees under your supervision
- Patients or patients’ family members

2. Self-assessment questions

Instructions to user: In all these questions, by "team" we mean the other care providers you work with to provide patient care, including nurses, nurse managers, therapists, social workers, pharmacists, etc., as well as other physicians (but not physician trainees such as residents or medical students).

Interprofessional teamwork behaviors (Never/rarely/sometimes/usually/always)
1. I check with the other non-physician health-care professionals involved in caring for my patients to make sure they have all the information they need from me to provide patient care.
2. I give my team all the information they need from me to assure a safe transition when a patient is transferred from another unit/facility to my unit.
3. I give my team all the information they need from me to assure a safe transition when a patient is transferred from my unit to another unit/facility, or discharged from the hospital.
4. I respond to other care providers' requests (for example, for information, new orders, etc.) without their having to remind me to do so.
5. I communicate respectfully with others on my team.
6. I communicate with my team about patients in a way that they can understand.
7. I address others on my team by name.
8. I make an effort to know others on my team as people.
9. I am sensitive to cultural differences within my team.
10. I make sure my team knows when there are urgent changes to a patient's plan of care.
11. I make sure my team knows the reason for any changes to a patient's plan of care.
12. I make sure my team knows who to contact, and how and when to contact them, if problems arise in a specific patient-care situation.
13. I proactively solicit and integrate input from my team regarding patients’ prognoses and the plans and limits of care.
14. I communicate effectively with my team about considerations regarding patients’ prognoses and the plans and limits of care.
15. I remain professional when dealing with difficult situations (for example, unexpected changes in a patient's status, unusual requests from a patient's family members, etc.).
16. I know the roles of the other health-care professionals on my team in providing patient care.
17. I ask for input about patient care from all the professionals (for example, nurses, therapists, social workers, etc.) involved with caring for that patient.
18. I only ask my teammates to do things that are within their scope of practice or professional expertise.
19. I acknowledge what others on my team contribute to caring for patients.
20. I encourage my teammates to use their expertise in the care of their patients.
21. I encourage my team to express any concerns they may have about a patient’s care.

ABIM TEAM
Benjamin Chesluk, PhD bchesluk@abim.org

Reynolds Foundation mtg., 8/4/14 213
22. I listen to the other members of my team when they have suggestions about a patient's care.
23. I respect unit and hospital rules and protocols around patient care.
24. I ask for help from other health-care professionals (nurses, therapists, social workers, etc.) when needed.
25. I give others on my team feedback about what they do well.
26. I give others on my team feedback about what they do that needs improvement.
27. I admit mistakes when I make them.
28. I ask for feedback from others on my team about my performance.
29. I accept feedback from others on my team about my performance.

General information (free text)
30. What do you do well to help your team members do their work?
31. What could you do better to help your team members do their work?

3. Rater assessment of physician

Interprofessional teamwork behaviors (Never/rarely/sometimes/usually/always)
1. This physician gives me all the information I need from him/her to provide patient care.
2. This physician gives me all the information I need from him/her to assure a safe transition when a patient is transferred from another unit/facility to my unit.
3. This physician gives me all the information I need from them to assure a safe transition when a patient is transferred from my unit to another unit/facility, or discharged from the hospital.
4. This physician responds to my requests (for example, for information, new orders, etc.) without my having to remind him/her to do so.
5. This physician communicates respectfully with me.
6. This physician communicates with me about patients in a way that I can understand.
7. This physician addresses me by name.
8. This physician makes an effort to know me as a person.
9. This physician is sensitive to cultural differences within the team of care providers.
10. This physician makes sure I know when there are urgent changes to a patient's plan of care.
11. This physician makes sure I know the reason for any changes to a patient's plan of care.
12. This physician makes sure I know who to contact, and how and when to contact them, if problems arise in a specific patient-care situation.
13. This physician proactively solicits and integrates information from me regarding patients' prognoses and the plans and limits of care.
14. This physician communicates effectively with me about considerations regarding patients' prognoses and the plans and limits of care.
15. This physician remains professional when dealing with difficult situations (for example, unexpected changes in a patient's status, unusual requests from a patient's family members, etc.).
16. This physician knows my role in providing patient care.
17. This physician asks for my input about patient care.
18. This physician only asks me to do things that are within my scope of practice or professional expertise.

ABIM TEAM
Benjamin Chesluk, PhD bchesluk@abim.org
19. This physician acknowledges what I contribute to caring for patients.
20. This physician encourages me to use my expertise in patient care.
21. This physician encourages me to express any concerns I may have about a patient's care.
22. This physician listens to me when I have suggestions about a patient’s care.
23. This physician respects unit and hospital rules and protocols around patient care.
24. This physician asks for help from me when needed.
25. This physician gives me feedback about what I do well.
26. This physician gives me feedback about what I do that needs improvement.
27. This physician admits mistakes when he/she makes them.
28. This physician asks for feedback from me about his/her performance.
29. This physician accepts feedback from me about his/her performance.

**General information (free text)**
30. What does this physician do well to help you do your work?
31. What could this physician do better to help you do your work?
32. Please provide any additional information that you think we should know about how this physician works with you and others on your interprofessional team.

---

**4. Guided debrief questions**

_Instructions to user:_ Please select at least one other person with whom to review and analyze your feedback report. You should select someone who works in the same hospital and is familiar with your work, but not someone who is directly responsible for managing you or evaluating your performance. You can select someone who is not a physician, and you can select more than one person.

1. Who did you meet with to review your data?
2. Why did you choose this person / these people?
3. What did you learn from reviewing the data with them?
4. What practical next steps will you take to improve where needed?
# Team Performance Observation Tool

**Date:**

**Unit/Department:**

**Team:**

**Shift:**

**Rating Scale**

1 = Very Poor  
2 = Poor  
3 = Acceptable  
4 = Good  
5 = Excellent

<table>
<thead>
<tr>
<th>1. Team Structure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Assembles a team</td>
<td></td>
</tr>
<tr>
<td>b. Assigns or identifies team members' roles and responsibilities</td>
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<tr>
<td>c. Holds team members accountable</td>
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<tr>
<td>d. Includes patients and families as part of the team</td>
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<tr>
<td>Comments:</td>
<td>Overall Rating – Team Structure</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Communication</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Provides brief, clear, specific, and timely information to team members</td>
<td></td>
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<tr>
<td>b. Seeks information from all available sources</td>
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<tr>
<td>c. Uses check-backs to verify information that is communicated</td>
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</tr>
<tr>
<td>d. Uses SBAR, call-outs, and handoff techniques to communicate effectively with team members</td>
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</tr>
<tr>
<td>Comments:</td>
<td>Overall Rating – Communication</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Leadership</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Identifies team goals and vision</td>
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<tr>
<td>b. Uses resources efficiently to maximize team performance</td>
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<tr>
<td>c. Balances workload within the team</td>
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<tr>
<td>d. Delegates tasks or assignments, as appropriate</td>
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<tr>
<td>e. Conducts briefs, huddles, and debriefs</td>
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<tr>
<td>f. Role models teamwork behaviors</td>
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<tr>
<td>Comments:</td>
<td>Overall Rating – Leadership</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Situation Monitoring</th>
<th>Rating</th>
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<tbody>
<tr>
<td>a. Monitors the status of the patient</td>
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<tr>
<td>b. Monitors fellow team members to ensure safety and prevent errors</td>
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<tr>
<td>c. Monitors the environment for safety and availability of resources (e.g., equipment)</td>
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<tr>
<td>d. Monitors progress toward the goal and identifies changes that could alter the plan of care</td>
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<tr>
<td>e. Fosters communication to ensure that team members have a shared mental model</td>
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</tr>
<tr>
<td>Comments:</td>
<td>Overall Rating – Situation Monitoring</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Mutual Support</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Provides task-related support and assistance</td>
<td></td>
</tr>
<tr>
<td>b. Provides timely and constructive feedback to team members</td>
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</tr>
<tr>
<td>c. Effectively advocates for patient safety using the Assertive Statement, Two-Challenge Rule, or CUS</td>
<td></td>
</tr>
<tr>
<td>d. Uses the Two-Challenge Rule or DESC Script to resolve conflict</td>
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</tr>
<tr>
<td>Comments:</td>
<td>Overall Rating – Mutual Support</td>
</tr>
</tbody>
</table>

**TEAM PERFORMANCE RATING**
Attaining Your Career Goals in Geriatrics: Applying Best Practices to the Critical Appraisal of Educational Scholarship

CAREER WORKSHEET

Directions: Take a few minutes and make notes about your career focus in geriatrics. Organize using the Glassick’s Criteria with input from your facilitator/small group members. Identify 2 actionable items: 1 to complete at the Reynolds meeting and 1 within 1 week of your return home.

<table>
<thead>
<tr>
<th>GLASSICK’S CRITERIA</th>
<th>BRIEF NOTES – CONTINUE TO UPDATE DURING DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) CLEAR GOAL:</td>
<td>What is your career focus in geriatrics?</td>
</tr>
<tr>
<td>(2) ADEQUATE</td>
<td>What need to do to prepare (e.g., leadership</td>
</tr>
<tr>
<td>PREPARATION:</td>
<td>skills; educational research skills)</td>
</tr>
<tr>
<td>(3) APPROPRIATE</td>
<td>What will you do it? (e.g., take a course; read; join a writing group)</td>
</tr>
<tr>
<td>METHODS:</td>
<td></td>
</tr>
<tr>
<td>(4) SIGNIFICANT</td>
<td>How will you know you’re making progress (milestones) and when you’ve accomplished your goal?</td>
</tr>
<tr>
<td>RESULTS:</td>
<td></td>
</tr>
<tr>
<td>(5) EFFECTIVE</td>
<td>Who do you need to share your plan with?</td>
</tr>
<tr>
<td>PRESENTATION:</td>
<td></td>
</tr>
<tr>
<td>(6) REFLECTIVE</td>
<td>What else?</td>
</tr>
<tr>
<td>CRITIQUE:</td>
<td></td>
</tr>
</tbody>
</table>

**ACTIONABLE ITEM #1:** Complete prior to leaving Reynolds Meeting

**ACTIONABLE ITEM #2:** Complete within 2 weeks of your return home. [Encourage sharing with your local direct report or mentor]
ATTAINING YOUR CAREER GOALS IN GERIATRICS: APPLYING BEST PRACTICES TO THE CRITICAL APPRAISAL OF EDUCATIONAL SCHOLARSHIP

Timothy Farrell, MD, Deborah Simpson, PhD, Richard Besdine, MD, Edmund Duthie Jr, MD, Mark Supiano, MD, Cherie Brunker, MD, Manuel Eskildsen, MD, MPH, Kathryn Denson, MD, Katherine Anderson, MD, Shaida Talebreza MD,

2014 Annual Reynolds Grantee Meeting -- Las Vegas, NV
Goals

• To introduce best practices in educational product development and assessment
• To demonstrate the application of Glassick’s criteria to the evaluation of a scholarly portfolio
• To increase participants’ abilities to critically review their own ideas/scholarship
Workshop Agenda

• 10 min – Overview
  – Glassick’s criteria for scholarship
  – AAMC’s Toolbox for Evaluating Educators
• 15 min – Mock Promotion Committee (sm grps)
  – Assistant to Associate OR Associate to Full
• 5 min – Debrief
• 25 min – Individualized Small-Group Session
  – 1 faculty and 3 participants at each table
  – Jr & Sr Faculty “consultants”
• 5 min - Debrief
What We Know Nationally re: Education & Scholarship

- AAMC GEA Consensus Conference on Educational Scholarship
  - February 9-10, 2006
  - Reaffirm Educator Activity Categories
    1. Teaching
    2. Curriculum Development
    3. Advising and Mentoring
    4. Educational Leadership & Administration
    5. Learner Assessment

What We Know Nationally re: Education & Scholarship

• AAMC Task Force on Educator Evaluation: 2010-13
  – **The Charge:** To provide resources that will aid decision-makers in developing clear, consistent and efficient *evaluation* processes for faculty with a career focus in education
# Task Force on Educator Evaluation

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jonathan Amiel</td>
<td>Columbia University</td>
</tr>
<tr>
<td>Brian Mavis</td>
<td>Michigan State University</td>
</tr>
<tr>
<td>Suzanne Rose</td>
<td>University of Connecticut</td>
</tr>
<tr>
<td>Constance Baldwin</td>
<td>University of Rochester</td>
</tr>
<tr>
<td>Kathe Nelson</td>
<td>University of Alabama</td>
</tr>
<tr>
<td>Deb Simpson</td>
<td>Aurora Health Care [Medical College of Wisconsin]</td>
</tr>
<tr>
<td>Latha Chandran</td>
<td>SUNY Stony Brook</td>
</tr>
<tr>
<td>Lois Nora</td>
<td>President &amp; CEO of ABMS Commonwealth Medical College</td>
</tr>
<tr>
<td>Henry Strobel</td>
<td>University of Texas Medical School at Houston</td>
</tr>
<tr>
<td>Ruth-Marie E. Fincher</td>
<td>GHSU/Medical College of Georgia</td>
</tr>
<tr>
<td>Jamie Padmore</td>
<td>MedStar Health</td>
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<tr>
<td>Craig Timm</td>
<td>University of New Mexico</td>
</tr>
<tr>
<td>Nancy Lowitt</td>
<td>University of Maryland</td>
</tr>
<tr>
<td>Pat O’Sullivan</td>
<td>UCSF</td>
</tr>
<tr>
<td>Tom Viggiano</td>
<td>Mayo Medical School</td>
</tr>
</tbody>
</table>

Maryellen Gusic - Chair of the Task Force  
formerly IU now Chief Medical Education Offer at AAMC
What we know @ scholarship: “Glassick Criteria”

CLEAR GOALS

Reflective Critique

Adequate Preparation

Effective Presentation

Appropriate Methods

Significant Results

## Kirkpatrick’s Model Frame

**Judgment About Significant Results**

<table>
<thead>
<tr>
<th>Assessment Level</th>
<th>Criteria in Toolbox</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Satisfaction/reaction</strong></td>
<td>Of participants/stakeholders</td>
</tr>
<tr>
<td>2. <strong>Learning</strong></td>
<td>Measures of knowledge, skills, attitudes, and/or behaviors</td>
</tr>
<tr>
<td>3. <strong>Application</strong></td>
<td>Desired performance demonstrated in other settings</td>
</tr>
<tr>
<td>4. <strong>Impact</strong></td>
<td>On education programs and processes within and/or outside institution</td>
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</table>

Outcome: The Toolbox for Evaluating Educators: Resources to Facilitate Performance Appraisal

Using the AAMC Toolbox for Evaluating Educators:
You be the Judge!
Professional Development Workshop for Promotion/Tenure Committee Members

Instructors’ Guide

List of Resources for Use in the Workshop
- Powerpoint presentation
- Sample Worksheet
- Institutional criteria for promotion and/or tenure for faculty whose career focus is in education
- Sample portfolios for a faculty member whose career focus is in education
- AAMC Toolbox for Evaluating Educators
  - Glossary
  - Executive Summary
  - User’s Guide
  - Indicators for Evaluation in Five Domains
  - Appendices
  - Reference List

Please note: the institutional criteria for promotion/tenure and the sample portfolios must be provided by the instructors of the workshop.
<table>
<thead>
<tr>
<th>Glassick’s Criteria</th>
<th>Broad Indicators (for Decision Makers)</th>
<th>Detailed Indicators (for Expert Reviewers and Consultants to Decision Makers)</th>
</tr>
</thead>
</table>
| Clear goals         | Learning objectives for the curriculum are:  
1. Stated clearly  
2. Specified to measure learners’ performance  
3. At appropriate level for targeted learners | Learning objectives are:  
1. Based on documented needs of learners  
2. Specific, measurable, achievable, realistic, and timely (SMART)  
3. In multiple learning domains (e.g., knowledge, skills, attitudes and/or behaviors) |
| Adequate preparation| Needs assessment done, if required  
- Congruence with institutional/program goals and integration with other components of the curriculum  
- Use of best practices and approaches from the literature, professional development activities and personal experience  
- Systematic approach to identify + acquire resources to implement the curriculum | Rationale for curriculum development is supported by identified gap, problem, and/or opportunity to improve  
- Curriculum targeted for the specific needs of learners  
- Curriculum design and evaluation is based on accepted frameworks \(^{49,51}\)  
- Material is presented at depth and breadth matched to learners’ needs  
- Material is up-to-date and evidence based  
- Review of literature and available resources influence curriculum development and evaluation  
- Tools/guidelines that accompany curriculum provide sufficient detail for other individuals or institutions to implement it  
- Resources needed for curriculum implementation are specified and available  
- Time allocation for the curriculum is appropriate  
- Stakeholder buy-in is obtained  
- Adequate preparation for use of technology |
## Glassick’s Criteria

### Broad Indicators (for decision makers)

- Teaching, learner assessment, and curriculum evaluation methods are aligned with curriculum objectives
- Methods are feasible, practical, ethical
- Innovative teaching and assessment methods are used and aligned with objectives

### Detailed Indicators (for expert reviewers and consultants to decision makers)

#### Instructional Methods

- Employs suitable range and variety of teaching strategies supported by learning theory, by best practices and/or by literature review
- Uses interactive approaches and promotes self-directed learning
- Uses methods that promote critical thinking and reasoning skills
- Provides evidence of innovation (e.g., novel strategies to promote learning and critical reasoning skills)
- Teaching methods include ways to monitor learners’ progress

If technology is used, it:

- Aids learning of the content
- Is easy to navigate
- Is interactive (e.g., teacher to learner, peer to peer, learner to content, learner to technology)

#### Curriculum Evaluation

- Is linked to learning objectives for curriculum
- Employs multiple data sources
- Incorporates assessment of instructional methods, teachers and learning

#### Learner Assessment

- Learner can obtain feedback re performance (formative + sum)
- Assessment of knowledge, skills, attitudes, + behaviors

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## Curriculum Development

### Glassick's Criteria

<table>
<thead>
<tr>
<th><strong>Significant Results</strong></th>
<th><strong>Broad Indicators</strong> (For Decision Makers)</th>
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<tr>
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<tr>
<td></td>
<td>Learning: Measures of knowledge, skills,</td>
<td>Rating of curriculum by learners and by faculty who teach components of the</td>
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<tr>
<td></td>
<td>attitudes, and/or behaviors</td>
<td>curriculum, peers or experts</td>
</tr>
<tr>
<td></td>
<td>Application: Desired performance</td>
<td>Comparison of learner ratings to ratings of other curricular components (internal,</td>
</tr>
<tr>
<td></td>
<td>demonstrated in other settings</td>
<td>external)</td>
</tr>
<tr>
<td></td>
<td>Impact: On education programs and</td>
<td><strong>Learning:</strong></td>
</tr>
<tr>
<td></td>
<td>processes within and/or outside</td>
<td>Evidence of learning based on measurable changes in knowledge, skills, attitudes,</td>
</tr>
<tr>
<td></td>
<td>institution</td>
<td>behaviors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comparison of learner performance to established benchmarks and/or to other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>learners' performance in previous years</td>
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<tr>
<td></td>
<td></td>
<td><strong>Application</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstration of learned skills/behaviors from curriculum in other settings or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>curricular components</td>
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<tr>
<td></td>
<td></td>
<td><strong>Impact</strong></td>
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<td></td>
<td></td>
<td>Positive evaluation by knowledgeable peers, educational leaders, curriculum</td>
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<td></td>
<td></td>
<td>committees</td>
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<td></td>
<td></td>
<td>Curriculum highly rated in accreditation review</td>
</tr>
<tr>
<td></td>
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<td>Recognition by internal/external awards or incentives</td>
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# Curriculum Development

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<tr>
<td></td>
<td></td>
<td>Comparison of learner performance to established benchmarks and/or to other learners’ performance in previous years</td>
</tr>
<tr>
<td>Effective presentation</td>
<td>Recognized as valuable by others (internally or externally) through: Peer review</td>
<td>Application Demonstration of learned skills/behaviors from curriculum in other settings or curricular components</td>
</tr>
<tr>
<td></td>
<td>Peer reviewed publications/presentations of curriculum</td>
<td>Impact Positive evaluation by knowledgeable peers, educational leaders, curriculum committees</td>
</tr>
<tr>
<td></td>
<td>Invitations to provide faculty development, conduct workshops or do presentations to help others with curriculum development locally, at other institutions, or in other regional, national or international settings</td>
<td>Curriculum highly rated in accreditation review Recognition by internal/external awards or incentives</td>
</tr>
</tbody>
</table>
### Glassick’s Criteria

<table>
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<th>Broad Indicators (for decision makers)</th>
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</thead>
<tbody>
<tr>
<td>Adequate Preparation</td>
<td>Recognized as valuable by others (internally or externally) through:</td>
<td>• Peer reviewed publications/presentations of curriculum</td>
</tr>
<tr>
<td>Adequate Preparation</td>
<td>1. Peer review</td>
<td>• Invitations to provide FD, conduct workshops or do presentations to help others w cur dev locally, at other institutions, or in other regional, national or international venues</td>
</tr>
<tr>
<td>Appropriate Methods</td>
<td>2. Dissemination (Presentations/publications) and/or</td>
<td>• Invitations to peer review curricula in other educational programs within or outside the institution</td>
</tr>
<tr>
<td>Appropriate Methods</td>
<td>3. Use by others</td>
<td>• Breadth of dissemination + adoption of curriculum’s teaching methods/materials, etc and/or guides and processes: local, regional, national, international</td>
</tr>
<tr>
<td>Significant Results</td>
<td>Reflection and evaluation results used for ongoing improvement</td>
<td>• Critical analysis of curriculum using all information from others and from self-assessment</td>
</tr>
<tr>
<td>Effective Presentation</td>
<td></td>
<td>• Evidence of ongoing improvement of curriculum based on critical analysis and reflection</td>
</tr>
</tbody>
</table>

#### Diagram

- **Impact**
- **Application**
- **Learning**
- **Satisfaction/Reaction**

**CLEAR GOALS**

- **Effective Presentation**
- **Reflective Critique**
- **Adequate Preparation**
- **Appropriate Methods**

**Significant Results**

**Scholarship Assessed**

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Using the AAMC Toolbox for Evaluating Educators: You be the Judge!

**Format**
Evaluation Tool, Presentation, Reference

**Publication ID**
9313

**Version**
1

**Published**
January 18, 2013

**Description**
This workshop is designed to provide hands-on opportunities for members of promotions/tenure committees to apply the indicators in the AAMC Toolbox for Evaluating Educators to assess the performance of faculty members whose career focus is in education. The exercises in the workshop allow participants to use the indicators to reach summative decisions through a rigorous and consistent application of clear, yet flexible standards. The workshop can be adapted and the resources can be used for training/professional development sessions for other decision making committees/members (e.g., awards committees or selection committees for a Teaching Academy). The workshop ends with an exercise that allows the participants to explore how the evidence-based standards in the Toolbox can be integrated with existing institutional processes for the evaluation of the performance of educators.

**Citation**
Evaluating Educators Using a Novel Toolbox: Applying Rigorous Criteria Flexibly Across Institutions

Maryellen E. Gusic, MD, Constance D. Baldwin, PhD, Latha Chandran, MD, MPH, Suzanne Rose, MD, MSEd, Deborah Simpson, PhD, Henry W. Strobel, PhD, Craig Timm, MD, and Ruth Marie E. Fincher, MD

Abstract

Valuing faculty as educators is essential for medical schools to fulfill their unique mission of educating physicians. The 2006 Consensus Conference on Educational Scholarship, sponsored by the Association of American Medical Colleges (AAMC) Group on Educational Affairs, provided educators seeking academic promotion with a portfolio-based format for documenting activities in five domains, using evidence of quantity, quality, a scholarly approach, and educational scholarship. Yet, the lack of a rigorous, widely accepted system to assess educator portfolio submissions during the promotion and tenure process continues to impede the ability to fully value educators and educational scholars.

The AAMC Task Force on Educator Evaluation was formed in 2010 to establish consensus guidelines for use by those responsible for the rigorous evaluation of the educational contributions of faculty. The task force delineated the educational contributions currently valued by institutions and then fulfilled its charge by creating the Toolbox for Evaluating Educators, a resource which contains explicit evidence-based criteria to evaluate faculty in each of the five domains of educator activity. Adoption of such criteria is now the rate-limiting step in using a fair process to recognize educators through academic promotion. To inform institutional review and implementation of these criteria, this article describes the iterative, evidence- and stakeholder-based process to establish the criteria. The authors advocate institutional adoption of these criteria so that faculty seeking academic promotion as educators, like their researcher colleagues, can be judged and valued using established standards for the assessment of their work.

Acad Med. 2014;89:1006–1011
Workshop Agenda

✓ 10 min – Overview
  – Glassick’s criteria for scholarship
  – AAMC’s Toolbox for Evaluating Educators

• 15 min – Mock Promotion Com (sm grps)
  – Assistant to Associate OR Associate to Full

• 5 min – Debrief

• 25 min – Individualized Small-Group Session
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  – 1 faculty and 3 participants at each table
  – Jr & Sr Faculty “consultants”
  – Worksheet
• 5 min - Debrief
Directions: Take a few minutes and make notes about your career focus in geriatrics. Organize using the Glassick’s Criteria with input from your facilitator/small group members. Identify 2 actionable items: 1 to complete at the Reynolds meeting and 1 within 1 week of your return home.

<table>
<thead>
<tr>
<th>GLASSICK’S CRITERIA</th>
<th>BRIEF NOTES — CONTINUE TO UPDATE DURING DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) CLEAR GOAL: What is your career focus in geriatrics?</td>
<td></td>
</tr>
<tr>
<td>(2) ADEQUATE PREPARATION: What need to do to prepare (e.g., leadership skills; educational research skills)</td>
<td></td>
</tr>
<tr>
<td>(3) APPROPRIATE METHODS: What will you do it? (e.g., take a course; read; join a writing group)</td>
<td></td>
</tr>
<tr>
<td>(4) SIGNIFICANT RESULTS: How will you know you’re making progress (milestones) and when you’ve accomplished your goal?</td>
<td></td>
</tr>
<tr>
<td>(5) EFFECTIVE PRESENTATION: Who do you need to share your plan with?</td>
<td></td>
</tr>
<tr>
<td>(6) REFLECTIVE CRITIQUE: What else?</td>
<td></td>
</tr>
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**ACTIONABLE ITEM #1:** Complete prior to leaving Reynolds Meeting

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Evaluating Educators Using a Novel Toolbox: Applying Rigorous Criteria Flexibly Across Institutions

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The AAMC Task Force on Educator Evaluation was formed in 2010 to establish consensus guidelines for use by those responsible for the rigorous evaluation of the educational contributions of faculty. The task force delineated the educational contributions currently valued by institutions and then fulﬁlled its charge by creating the Toolbox for Evaluating Educators, a resource which contains explicit evidence-based criteria to evaluate faculty in each of the five domains of educator activity. Adoption of such criteria is now the rate-limiting step in using a fair process to recognize educators through academic promotion. To inform institutional review and implementation of these criteria, this article describes the iterative, evidence- and stakeholder-based process to establish the criteria. The authors advocate institutional adoption of these criteria so that faculty seeking academic promotion as educators, like their researcher colleagues, can be judged and valued using established standards for the assessment of their work.

Educating the next generation of physicians is the unique mission of medical schools, and education is the primary academic activity of many clinical and some basic science faculty. There has been progress toward recognition and promotion of educators based on the work of Boyer,1 who argued that academic institutions should redeﬁne scholarship to include the scholarship of teaching.2–7 However, many institutions lack deﬁned criteria for systematically evaluating the work of educators.5–7 The consensus report from the Conference on Educational Scholarship,4 organized by the Association of American Medical Colleges (AAMC) Group on Educational Affairs (GEA) in 2006, reinforced the work of educators across ﬁve domains—teaching, learner assessment, curriculum development, advising and mentoring, and educational leadership and administration—and gave examples of standard methods to document a scholarly approach and educational scholarship in a promotion portfolio. To further advance the medical education mission, we must implement an objective process with speciﬁc criteria for evaluating the performance of educators that can be used ﬂexibly by academic health centers. To meet this need, we introduce a new toolbox to help institutions make objective and criterion-based evaluations of faculty educators and support fair, rigorous decisions about educators’ contributions.

AAMC Task Force on Educator Evaluation

The AAMC Task Force on Educator Evaluation, in which all the authors have participated, was convened in 2010 to create an objective process for evaluating educators that can be used by institutions to support faculty whose careers focus on education. The task force includes 16 nationally recognized educational leaders who represent various AAMC constituencies, ranging from the Group on Faculty Affairs (GFA) and the GEA to the Council of Teaching Hospitals and Council of Deans. Task force members teach learners across the spectrum of medical education in various settings, and collectively provide expertise across the five domains of educator activity.

The task force was charged to establish consensus guidelines for use by those responsible for the rigorous evaluation of the educational contributions of faculty. To fulﬁll this charge, the task force met in person four times, and task-speciﬁc subgroups met by telephone over 100 times between 2010 and 2013. Subgroups planned and conducted a national survey of medical schools, created the Toolbox for Evaluating Educators, designed materials for regional and national presentations and feedback, submitted materials to MedEdPORTAL, and wrote this article. Products emerging from these activities were reviewed by the subgroups, and feedback was solicited widely through dialogue with national leaders from academic health centers and teaching hospitals and with attendees at regional and national AAMC meetings.
The task force’s principal product is the Toolbox for Evaluating Educators, which contains explicit criteria for objective evaluation of the educational contributions of faculty. The toolbox is the centerpiece of a set of professional development materials published on MedEdPORTAL, presented in workshop format to provide promotion and tenure committee members with hands-on opportunities to apply the performance indicators and discuss use in their specific setting.

The criteria-based evaluation tools enable rigorous and objective review of educators, but they must be adopted broadly if we are to see a change in the way educators are valued. In this article, we invite the community of academic medicine to incorporate these tools into established processes for recognition and reward. The AAMC Task Force accomplished its charge by following established criteria for the assessment of all forms of scholarship, as articulated by Glassick: clear goals, adequate preparation, appropriate methods, significant results, effective presentation, and reflective critique. Glassick’s framework not only outlines the approach to the work done by the task force but was also the structure used to develop the criteria contained in the toolbox. In this article, we describe clear goals and reflective critique for the project as a whole; the other four criteria are addressed separately for the two objectives delineated below.

**Clear Goals**

In the research arena, well-accepted, standardized qualifications for academic advancement focus on peer-reviewed publications, national presentations of scientific work, and funded grants. Our goal is to enable promotion committees and other decision makers to reach objective, evidence-based decisions about the quality of educators’ performance, based on equally well-understood criteria. To achieve this goal, the task force focused on two objectives:

- **Objective 1:** To determine what educational contributions are valued by our institutions.
- **Objective 2:** To create guidelines for the structured evaluation of educational contributions, using a rigorous, evidence-based framework.

**Objective 1: To Determine What Educational Contributions Are Valued by Our Institutions**

**Adequate preparation**

To examine the current state of decision making regarding educator performance and advancement at medical schools nationwide, we obtained information using a national survey. Using an iterative, consensus-building process based on the existing literature, a task force subgroup identified educational activities that could be evaluated during the promotion process. In addition, during the development of the questionnaire, each person on the task force, as a representative of an AAMC constituent group, was asked to submit names of key members of their group to be invited to a stakeholder meeting held in November 2010, at the annual AAMC meeting; 14 of 31 invitees attended the meeting and provided feedback on the survey and on the project. Participants included directors of academies of medical educators, associate deans for medical education and faculty affairs, a chief academic officer of a teaching hospital, a dean, a director of education for a basic science department, the director of an international professional development program, and the editor of a peer-reviewed electronic publication. Twenty-eight educational activities that represent the five standard educator domains were identified for inclusion on the questionnaire.

**Appropriate methods**

The final survey (see Supplemental Digital Appendix 1, http://links.lww.com/ACADMED/A200) was electronically distributed using the AAMC’s Vovici Survey Platform to 117 primary representatives of the AAMC GFA at U.S. and Canadian medical schools. Recipients were asked to complete the survey or forward it to another person who was knowledgeable about the promotion process at their institution, thus ensuring reliable responses. Respondents first rated the importance of each activity in promotion and tenure decision making as it is practiced now at their institutions (1 = not important to 5 = very important) and then rated how important they thought these items should be ideally in decision making. Respondents also rated the importance of 10 types of evidence for evaluating the quality of an educator’s work (e.g., educational grants, peer ratings). Ratings over 3.5 were considered to be important. Additional items sought perspectives using five-point Likert scales to report whether educator tracks were valued at the respondent’s school (5 = strongly agree they are valued to 1 = strongly disagree) and the degree to which educators seeking academic advancement were successful (5 = highly successful to 1 = not successful at all). The survey site was open from March through August 2011. The institutional review board of the AAMC approved the survey and the plan for data analysis.

**Significant results and effective presentation**

Survey respondents included 77 of the 117 primary GFA representatives contacted, a 66% response rate. Most respondents were associate deans (31/77; 40%) and had an academic rank of professor (60/77; 78%); some held additional positions on institutional promotion committees, including chair (10/77; 13%) and member (18/77; 23%). In all, 71% (55/77) of respondents were at public medical schools, 19% (15/77) at private medical schools, and 9% (7/77) at teaching hospitals.

Overall, 77% (59/77) of respondents indicated that individuals at their institution could be promoted primarily on the basis of their achievements as an educator, and 71% (55/77) indicated that educators were eligible for tenure. Most institutions reported the existence of one (21/77) or two (22/77) educator tracks (27% and 29%, respectively). Slightly over 40% (31/77) of the institutions had a teaching academy or society for educators. The potential for successful promotion and tenure of faculty whose work focuses on education was judged by respondents to be moderate. Respondents indicated that faculty are “somewhat successful” in being promoted as educators (mean = 3.62; SD = 0.91, where 3 was a neutral response between not successful at all and highly successful), but they were neutral about the success of obtaining tenure primarily as an educator (mean = 3.06; SD = 1.08).

In response to questions about the importance of specific kinds of evidence in promotion and advancement determinations (e.g., grants, teaching hours, mentoring impact), nearly all types of evidence were rated as more...
important in the ideal than in the current environment (26 of 28 items). Eleven out of 28 items (39%) were rated over 3.5 for their current importance. The most highly rated were evidence of educational scholarship (mean = 4.3), quality of teaching (4.0), role as an educational leader (3.8), development of new/improved curricula (3.8), and leadership in regional/national educational organizations (3.7). Respondents believed that ideally, the most important evidence for "determining the quality of an educator's work" should be peer-reviewed scholarship, national recognition, adoption/adaptation by others,4,8 disseminated products that are available (producing peer-reviewed, publicly acknowledged scholarly products using the definition of scholarship proposed by Hutchings and Shulman11 and confirmed by the 2006 consensus conference; scholarship creates products that are peer reviewed and disseminated to allow their use or adaptation by others.4,8

Once the toolbox was built, we refined its structure and the criteria iteratively, using a scholarly approach: referring to the literature and accepted best practices and obtaining expert and end-user feedback from decision makers, mentors, and educators. Detailed feedback about the content and structure of the toolbox was obtained in oral and written formats in various contexts: the 2010 stakeholder meeting (described above), workshops at the four regional GEA conferences in March through May of 2011, a session at the August 2011 meeting of the AAMC's GFA, and workshops at the November 2011 and 2012 AAMC annual meetings. At each stage, the task force reviewed the feedback and incorporated changes to enhance the toolbox.

Significant results and effective presentation
The toolbox in its final form has been peer reviewed and is published on MedEdPORTAL,9 along with a user's guide and extensive resource list. The domain-specific evaluation criteria are presented in tables in three columns: Glassick's criteria; broad indicators of quality for use by promotion and tenure committees and other decision makers; and elaborated/detailed indicators for use by experts who provide decision-making bodies with assessments of a particular educator's record of performance, and by writers of letters of recommendation.

To illustrate this format, the table for the curriculum development domain (Table 1) provides criteria to evaluate an educator who designs, implements, and evaluates curricula. Evidence in his or her educator portfolio should demonstrate six criteria: a clear goal/purpose (e.g., curricula are based on documented needs of the targeted learners); adequate preparation (e.g., use of an accepted model and content that is up-to-date in the literature); appropriate methods (e.g., instruction aligned with learning objectives; use of interactive methods suitable for active learning); significant results (e.g., satisfaction by learners and faculty; positive learner outcomes); effective presentation of results for local review (e.g., by education committees) and external review (e.g., by accrediting organizations), so that others may use the curriculum and judge its value; and reflective practice (e.g., critical analysis of the curriculum based on experience with its use and careful evaluation by others).

The user's guide for the toolbox provides two principles for consideration: No one educator should be expected to have extensive activity in all five educator activity domains; and within each domain, no educator should be expected to provide evidence to satisfy every criterion. The toolbox's criteria lists are intentionally comprehensive: they can be applied to the work of a variety of health professions educators, and they are sufficiently flexible to facilitate incorporation with institutional benchmarks used in educator advancement decisions. Institutions must decide internally how many and which criteria should be met in order for an educator to meet institutional standards for advancement.

Objectives 1 and 2: Reflective Critique
Academic medical institutions are facing unprecedented challenges,18 including the regional realignment of health care systems, diminished economic resources, redefinition of institutional missions, increased use of accountability systems, and, in consequence, competing priorities for faculty. Simultaneously, educational programs are facing major revisions of national accreditation standards linked to outcome measurement,19–21 thereby creating a heightened need for talented and dedicated faculty with educational expertise. To ensure that our institutions are able to recruit, nurture, and retain the requisite educator faculty, viable career paths and clearly defined expectations and assessment criteria for academic advancement must exist to acknowledge and credit their work.22

The Toolboxes for Evaluating Educators’ addresses this need with comprehensive,
Table 1
Curriculum Development Domain, From a Toolbox for Evaluating Educators, Developed to Evaluate Faculty in Five Domains of Educator Activity

<table>
<thead>
<tr>
<th>Glassick’s criteria</th>
<th>Broad indicators&lt;sup&gt;b&lt;/sup&gt; (for decision makers)</th>
<th>Detailed indicators&lt;sup&gt;b&lt;/sup&gt; (for expert reviewers and consultants to decision makers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear goals</td>
<td>Learning objectives for the curriculum are:</td>
<td>Learning objectives are:</td>
</tr>
<tr>
<td></td>
<td>• Stated clearly</td>
<td>• Based on documented needs of learners</td>
</tr>
<tr>
<td></td>
<td>• Specified to measure learners’ performance</td>
<td>• Specific, measurable, achievable, realistic, and timely (SMART)</td>
</tr>
<tr>
<td></td>
<td>• At appropriate level for targeted learners</td>
<td>• In multiple learning domains (e.g., knowledge, skills, attitudes, and/or behaviors)</td>
</tr>
<tr>
<td>Adequate preparation</td>
<td>• Needs assessment done, if required</td>
<td>• Rationale for curriculum development is supported by identified gap, problem, and/or opportunity to improve</td>
</tr>
<tr>
<td></td>
<td>• Congruence with institutional/program goals and integration with other components of the curriculum</td>
<td>• Curriculum targeted for the specific needs of learners</td>
</tr>
<tr>
<td></td>
<td>• Use of best practices and approaches from the literature, professional development activities, and personal experience</td>
<td>• Curriculum design and evaluation is based on accepted frameworks</td>
</tr>
<tr>
<td></td>
<td>• Systematic approach to identifying and acquiring resources needed to implement the curriculum</td>
<td>• Material is presented at depth and breadth matched to learners’ needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Material is up-to-date and evidence based</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review of literature and available resources influence curriculum development and evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tools/guidelines that accompany curriculum provide sufficient detail for other individuals or institutions to implement it</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Resources needed for curriculum implementation are specified and available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Time allocation for the curriculum is appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stakeholder buy-in is obtained</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adequate preparation for use of technology</td>
</tr>
<tr>
<td>Appropriate methods</td>
<td>• Teaching, learner assessment, and curriculum evaluation methods are aligned with curriculum objectives</td>
<td>Instructional methods:</td>
</tr>
<tr>
<td></td>
<td>• Methods are feasible, practical, and ethical</td>
<td>• Employ suitable range and variety of teaching strategies supported by learning theory, by best practices, and/or by literature review</td>
</tr>
<tr>
<td></td>
<td>• Innovative teaching and assessment methods are used and aligned with objectives</td>
<td>• Use interactive approaches and promotes self-directed learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use methods that promote critical thinking and reasoning skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provide evidence of innovation (e.g., novel strategies to promote learning and critical reasoning skills)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Include ways to monitor learners’ progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If technology is used, it:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Aids learning of the content</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is easy to navigate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is interactive (e.g., teacher to learner, peer to peer, learner to content, learner to technology)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Curriculum evaluation:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is linked to learning objectives for curriculum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Employs multiple data sources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Incorporates assessment of instructional methods, teachers, and learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learner assessment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allows learners to obtain feedback about performance (formative and summative)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assesses knowledge, skills, attitudes, and behaviors (as appropriate)</td>
</tr>
<tr>
<td>Significant results</td>
<td>• Satisfaction/reaction</td>
<td>Satisfaction/reaction:</td>
</tr>
<tr>
<td></td>
<td>• Learning: Measures of knowledge, skills, attitudes, and/or behaviors</td>
<td>• Rating of curriculum by learners and by faculty who teach components of the curriculum, by peers, or by experts</td>
</tr>
<tr>
<td></td>
<td>• Application: Desired performance demonstrated in other settings</td>
<td>• Comparison of learner ratings with ratings of other curricular components (internal, external)</td>
</tr>
<tr>
<td></td>
<td>• Impact: On education programs and processes within and/or outside institution</td>
<td>• Evidence of learning based on measurable changes in knowledge, skills, attitudes, and behaviors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comparison of learner performance with established benchmarks and/or with other learners’ performance in previous years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Application:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Demonstration of learned skills/behaviors from curriculum in other settings or curricular components</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Impact:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positive evaluation by knowledgeable peers, educational leaders, and curriculum committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Curriculum highly rated in accreditation review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognition by internal/external awards or incentives</td>
</tr>
</tbody>
</table>

(Table Continues)
Table 1 (Continued)

<table>
<thead>
<tr>
<th>Glassick’s criteria</th>
<th>Broad indicatorsb (for decision makers)</th>
<th>Detailed indicatorsb (for expert reviewers and consultants to decision makers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective presentation</td>
<td>Recognized as valuable by others (internally or externally) through: • Peer review • Dissemination (presentations/publications) and/or • Use by others</td>
<td>• Peer-reviewed publications/presentations of curriculum • Invitations to provide faculty development, conduct workshops, or do presentations to help others with curriculum development locally, at other institutions, or in other regional, national, or international venues • Invitations to peer review curricula in other educational programs within or outside the institution • Breadth of dissemination and adoption of curriculum’s teaching methods/materials, assessment methods/tools, evaluation methodology, and/or guides and processes: local, regional, national, international</td>
</tr>
<tr>
<td>Reflective critique</td>
<td>• Reflection and evaluation results used for ongoing improvement</td>
<td>• Critical analysis of curriculum using all information from others and from self-assessment • Evidence of ongoing improvement of curriculum based on critical analysis and reflection</td>
</tr>
</tbody>
</table>

Broad indicators are useful for summative judgments about the performance of a faculty member. Detailed indicators enable greater clarity and specificity and are useful for writers of recommendation letters and other expert reviewers who advise decision makers.

yet flexible, criteria for decision makers across diverse institutional contexts and value systems. Our criteria are rigorous and evidence based, paralleling the standards used to assess the scholarship of research faculty. The criteria are elaborate because of the need to recognize all of the critical domains of educator activity. In accord with stakeholder input, the toolbox does not contain metrics or weights to accompany the criteria for evaluation, to allow flexibility for academic institutions to apply their own value judgments. We provide no suggestions for how many domains should be reflected in an educator’s portfolio or the number of criteria that must be met for promotion to a specific rank. Such decision making remains the purview of each institution, informed by toolbox criteria.

One of the potential risks of developing evaluation criteria is that decision makers may use them for unintended purposes. For example, use of the criterion lists as checklists and measuring “percent of items accomplished” would be a misinterpretation of their purpose. Therefore, we recommend that institutions develop a rational and transparent process that addresses the number of domains in which activity is expected for each academic level, the relative weights of the different domains in decision-making processes, which and how many criteria define higher and lower levels of performance in each domain, and how to evaluate faculty who are in various tracks, or who contribute to multiple missions in a scholarly fashion. Institutions must also decide how faculty should document their educational accomplishments, and when to use educational experts to assist in the technical evaluation of this documentation.

We anticipate that our scholarly approach to the development of the toolbox will help to promote its acceptance by academic medical institutions. When used widely by both decision makers and consultants to decision makers, the criteria will give additional structure and credibility to the review processes for educators and will provide consistency in applying the standards. Sharing these criteria with faculty seeking promotion should enhance career planning and educator portfolio preparation. Faculty should submit a detailed portfolio with their activities categorized into the five domains, to facilitate assessment that is based on toolbox indicators.

The toolbox is intended primarily for assessment in the promotion process, but it can be used longitudinally throughout the educator’s academic career: at appointment and during new faculty orientation, during mentoring conversations, when expectations for new job roles are defined, and in annual performance reviews. Faculty must understand from the beginning what evidence they are expected to provide for promotion review, and what metrics will be used in decision making.

Future Directions

Continuing work of the task force includes teaching educators how to document the quality of their work and prepare their portfolio for promotion decisions, and consulting with institutional leaders and decision makers as they apply the toolbox criteria in their decision-making processes. In the long term, we plan a national follow-up project to assess the use of the toolbox and its impact on educators and their advancement and to track changes in institutional policies and processes. These outcomes will elucidate the impact of the toolbox on educator evaluation.

We are convinced that as more schools adopt practical and evidence-based criteria for evaluation of educators, faculty will strengthen their contributions to the educational mission. If your institution is not using specific guidelines to evaluate educators in their varied roles, we challenge you to use the toolbox in order to recognize excellence in your teaching faculty and advance your institutional vitality.
Acknowledgments: The authors wish to thank Jonathan Amiel, MD, Brian Mavis, PhD, Jaime Padmore, MA, Patricia O’Sullivan, PhD, and Thomas R. Viggiano, MD, who are the colleagues of the Association of American Medical Colleges (AAMC) Task Force on Educator Evaluation for their contributions to the development of the Toolbox for Evaluating Educators; Ms. Kelli Ramsey for her administrative assistance throughout the work of the task force; and M. Brownell Anderson, MEd, Katherine McOwen, MSED, and the steering committee of the AAMC Group on Educational Affairs for providing the charge to the task force and for their support of this work.

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Disclaimers: The Toolbox for Evaluating Educators has been published as a component of professional development materials published on MedEdPORTAL.

Previous presentations: The Toolbox for Evaluating Educators has been presented in regional and national meetings of the Association of American Medical Colleges’ Groups on Educational and Faculty Affairs.

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References
7 Thomas PA, Diener-West M, Canto MI, Martin DR, Post WS, Streiff MB. Results of an academic promotion and career path survey of faculty at the Johns Hopkins University School of Medicine. Acad Med. 2004;79:258–264.
Practice Redesign

David B. Reuben, MD
Archstone Professor of Geriatrics
David Geffen School of Medicine at UCLA
What we will cover

• Assignment
• Donabedian categorization
• The Chronic Care Model
• The ACOVE-2 practice redesign model
• Co-management
• Emerging approaches
• Exercise
• Best practices
Assignment

• During the next 35 minutes think of a practice redesign pilot project you might propose
Practice Redesign

• Aims to improve quality and/or increase efficiency by:
  – Fixing a problem or inefficiency in patient care
  – Using different people or people differently
  – Exploiting technology
A Model for Improving Chronic Illness Care

Community Resources and Policies
- Self-Management Support

Health System Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes
ACOVE-2 Quality Improvement Model

- Case finding
- Delegation of data collection
- Structured visit notes to guide appropriate care processes
- Physician and patient education
- Linkage to community resources

# Practice Redesign Interventions based on the ACOVE-2 Model

<table>
<thead>
<tr>
<th>Study</th>
<th>Conditions</th>
<th>Groups</th>
<th>Delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOVE-2</td>
<td>Falls, UI, Dem</td>
<td>2 PCP</td>
<td>Minimal</td>
</tr>
<tr>
<td>ACOVEprime</td>
<td>Falls, UI</td>
<td>5 PCP</td>
<td>Minimal-Moderate</td>
</tr>
<tr>
<td>Alz Assoc</td>
<td>Dem</td>
<td>2 PCP</td>
<td>Moderate</td>
</tr>
<tr>
<td>JAHF NP</td>
<td>Falls, UI, Dem, Dep, HF</td>
<td>1 Ger</td>
<td>High</td>
</tr>
<tr>
<td>UniHealth NP</td>
<td>Falls, UI, Dem, Dep</td>
<td>2 PCP</td>
<td>High</td>
</tr>
</tbody>
</table>
## Effects on Quality of Care by Condition in ACOVE-2 Intervention

<table>
<thead>
<tr>
<th>Condition</th>
<th>Usual Care</th>
<th>ACOVE-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>22-32%</td>
<td>37-71%</td>
</tr>
<tr>
<td>Falls</td>
<td>23-40%</td>
<td>44-79%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>17-37%</td>
<td>37-64%</td>
</tr>
<tr>
<td>Dementia</td>
<td>38-44%</td>
<td>43-60%</td>
</tr>
<tr>
<td>Depression</td>
<td>28-61%</td>
<td>51-63%</td>
</tr>
</tbody>
</table>

In each, significant differences between UC and ACOVE for overall, falls and UI; variable significance for depression and dementia.
Co-management

• Two or more health care providers jointly managing the patient’s medical care to achieve the best quality and outcomes
• Many models, most focus on specific conditions (e.g., cancer, dementia) or on multiple conditions and coordination of care (e.g., Guided Care)
Co-management

• Who?
  – Physician specialist-physician generalist (e.g., oncologist-general internist)
  – Other health profession-physician generalist (e.g., depression clinical specialist-primary care physician)
Co-management

• What?
  – Assessment
  – Developing care plan
  – Recommendations
  – Orders
  – Monitoring
  – Revising care plan
Co-management

• Why?
  – Evidence base: general
    • Decreases in HbA1c, systolic and diastolic BP, total and LDL cholesterol (Shaw RJ, 2014)
  – Evidence base: falls

ACOVE-3 Quality of Care for Falls

<table>
<thead>
<tr>
<th>Study</th>
<th>Physician alone</th>
<th>Co-management with nurse practitioner</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ganz 2010</td>
<td>17%</td>
<td>44%</td>
<td>.002</td>
</tr>
<tr>
<td>Reuben 2013</td>
<td>32%</td>
<td>78%</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
Co-management

• Challenges
  – Defining scope of responsibility
    • Range of clinical problems
    • Falls Care Manager versus primary care physician
    • Order writing
    • Acute clinical problems
  – Communication
    • With primary care physician
    • With other health providers (e.g., specialists, therapists)
New Practice Redesign Efforts

• Improving communication
  – Sight lines and co-location
  – Huddles and team meetings

• Redefining roles of staff
  – Enhanced rooming/prepping the chart
  – Standing orders/prescription renewals
  – Scribes and order entry
  – Inbox management
  – Health coaching and care coordination
Physician Partners (P²)

• A Physician Partner is a novel position at UCLA whose role is to
  – navigate the electronic health record
  – document a patient encounter
  – expedite patient care immediately prior to, during, and after the office visit
Roles of P²s: During the visit

• Look up patient records, recent results, consults, drug interactions
• Queue medication changes, lab orders, and referrals as verbally instructed by physician.
• Input patient instructions, follow-up, level of service, and charge capture
Roles of P²: end of the visit

- Provide summary of the patient encounter and physician instructions
- Reviews how to contact the office and how to obtain help after hours
- If applicable, communicates pending MA/LVN orders to be completed
- Directs patient to checkout or the lab
Roles of P²: After the visit

• Completes H&P, progress or consult note and routes to physician for review and closure of the encounter

• Facilitates electronic communication with other providers or office staff
Results: timed office visits

<table>
<thead>
<tr>
<th></th>
<th>MD Time (Minutes) Spent with Patient</th>
<th>P²</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatrics</td>
<td>Control (N=90) 22.0</td>
<td>P² (N=93) 18.0</td>
<td>0.0002</td>
</tr>
<tr>
<td>GIM</td>
<td>Control (N=71) 11.0</td>
<td>P² (N=90)  9.0</td>
<td>0.0014</td>
</tr>
</tbody>
</table>
Median physician time (minutes) spent per 240 minute (4-hour) scheduled session - cView

<table>
<thead>
<tr>
<th>Geriatrician time in minutes</th>
<th>Control</th>
<th>P²</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD Preparation Prior to Session *</td>
<td>30</td>
<td>15</td>
<td>0.002</td>
</tr>
<tr>
<td>MD time spent in examining room†</td>
<td>248</td>
<td>216</td>
<td>0.014</td>
</tr>
<tr>
<td>MD wrap-up post session *</td>
<td>90</td>
<td>15</td>
<td>0.012</td>
</tr>
<tr>
<td>Total estimated physician time/session</td>
<td>368</td>
<td>246</td>
<td></td>
</tr>
</tbody>
</table>
Median physician time (minutes) spent per 240 minute (4-hour) scheduled session - cView

<table>
<thead>
<tr>
<th>GIM time in minutes</th>
<th>Control</th>
<th>P²</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD Preparation Prior to Session *</td>
<td>20</td>
<td>5</td>
<td>0.004</td>
</tr>
<tr>
<td>MD time spent in examining room†</td>
<td>192</td>
<td>160</td>
<td>0.145</td>
</tr>
<tr>
<td>MD wrap-up post session *</td>
<td>28</td>
<td>0</td>
<td>0.005</td>
</tr>
<tr>
<td>Total estimated physician time/session</td>
<td>240</td>
<td>165</td>
<td></td>
</tr>
</tbody>
</table>
Exercise

• Identify your practice redesign project: 5 min
• Present the project to the person on your right (your boss): 5 min
• Questions from your boss: 2-3 min
• Switch roles: 7-8 min
Best practices

• Who would like to present her or his practice redesign project?
Think different.
NAS, CLER and Enhancing Geriatrics Education

Lynne M. Kirk, MD, MACP

With thanks to Eric Holmboe and Kevin Weiss of the ACGME
Disclaimer

Dr. Kirk is a Director of the Accreditation Council for Graduate Medical Education (ACGME)
Goals

• Describe the ACGME Next Accreditation System (NAS)
• Describe the Clinical Learning Environment Review (CLER)
• Describe where we have come in geriatrics
• Describe where we might go in the future
“We improve healthcare by assessing and advancing the quality of resident physician education through accreditation”

ACGME Mission Statement
A Brief History of NAS

• 1999 – The ACGME and American Board of Medical Specialties (ABMS) establish the six core competencies
  • Designed to shift emphasis from process-oriented to outcomes-oriented standards in physician education
  • ACGME “Outcome Project”
• 2002 – Public and political pressure on the GME community to produce physicians capable of cost-conscious, patient-centered care begins to increase
• 2009 – The ACGME, ABMS boards, specialty colleges/academies, residency program directors, and residents begin to define the “Milestones”
A Brief History

• 2012 – Alpha test sites begin to implement Milestones at the individual program level
• 2013 – Phase I programs implement Milestones
• 2014 – All programs are under the Next Accreditation System (NAS) and must implement Milestones
Why Is a New System Needed?

• The old process-based system was “one size fits all”
• We need to standardize outcomes while simultaneously allowing programs to individualize education
• Good programs must be free to innovate
• We need to shift from a “catch them being bad” to “reward them for being good” accreditation paradigm
The NAS in a Nutshell

• A Continuous Accreditation Model based on key screening parameters
  • Annual program data (resident/faculty information, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
  • Aggregate board pass rate
  • Resident clinical experience
  • Resident survey and faculty survey (latter is new)
• 10 year Self Study and Self Study Site Visit
• Semi-annual resident Milestone evaluations
• Clinical Learning Environment Review (CLER) Visits

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## 10 Year Self Study Visits

<table>
<thead>
<tr>
<th><strong>Old Accreditation System</strong></th>
<th><strong>Next Accreditation System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Site visits every 5 years (or less)</td>
<td>Scheduled site visits every 10 years</td>
</tr>
<tr>
<td>Programs evaluated by RRC in conjunction with site visits</td>
<td>Program data evaluated annually by the RRC</td>
</tr>
<tr>
<td>Large printed Program Information File (PIF)</td>
<td>No PIF; data transmitted electronically to ACGME annually</td>
</tr>
<tr>
<td>Periodic evaluation</td>
<td>Longitudinal evaluation</td>
</tr>
<tr>
<td>Process oriented (provide appropriate documentation)</td>
<td>Performance oriented (evaluate performance against goals)</td>
</tr>
<tr>
<td>Future goals not addressed</td>
<td>Help programs establish goals for the future</td>
</tr>
</tbody>
</table>

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Accreditation Categories

• Initial Accreditation (new programs)
• Initial Accreditation with Warning
• Continued Accreditation
• Continued Accreditation with Warning
• Probationary Accreditation
• Withhold/Withdrawal of Accreditation
Milestones
• Observable developmental steps from Novice to Expert/Master (based on Dreyfus model)

• Organized under the six domains of clinical competency
  • Set aspirational goals of excellence (Level 5)
  • Provide a blueprint for resident development across the continuum of medical education

• Development committees were anchored by members of each specialty including board members, program directors, RRC members, national specialty organization leadership, and residents – with ACGME support

• General competencies were translated into specialty-specific competencies
Competency Development Model

Time, Practice, Experience

Dreyfus SE and Dreyfus HL. 1980
Carraccio CL et al. Acad Med 2008;83:761-7
The NAS Milestone Assessment System

Assessments within Program (examples):
• Direct observations
  • Audit and performance data
• Multi-source FB
  • Simulation
  • IT Exam

Judgment and Synthesis: CCCommittee

Milestones and EPAs as Guiding Framework and Blueprint

Residents

Institution and Program

Faculty, PDs and others

ACGME RRCs

Unit of Analysis: Program

Milestone Reporting

Residents

Assessments within Program (examples):
• Direct observations
  • Audit and performance data
• Multi-source FB
  • Simulation
  • IT Exam

Judgment and Synthesis: CCCommittee

Milestones and EPAs as Guiding Framework and Blueprint

Faculty, PDs and others

Institution and Program

Residents
Shared Mental Model Challenge

* From TeamSTEPPS/AHRQ
Entrustable Professional Activities

- EPAs represent the routine *professional*-life activities of physicians based on their specialty and subspecialty.
- The concept of “entrustable” means:
  - “a practitioner has demonstrated the necessary knowledge, skills and attitudes to be trusted to perform this activity [unsupervised].”¹

EPA # 9. Skillfully facilitate a family meeting.

- Geriatricians skillfully facilitate family meetings by providing a safe and culturally appropriate environment, and when eliciting patient/family values, goals, and preferences, or negotiating goals of treatment, utilizing advanced communication skills (e.g., jargon-free language, nonverbal behavior, response to emotion, conflict mediation).
  - Demonstrate advanced communication skills (language choice, cultural awareness, nonverbal behavior, response to emotion, conflict mediation) when eliciting patient and family values, goals, and preferences; when negotiating goals of treatment; and when communicating with other healthcare providers. (1, 2, 3, 4, 6, 7, 23, 40)
  - Assess and incorporate family and caregiver needs and limitations, including caregiver stress, into patients’ management plans. (24, 34, 35)
  - If appropriate, counsel patients, families, and caregivers about the range of options for palliative and end-of-life care, including pain management, artificial nutrition and hydration, and hospice care. (27, 40)
Competencies, Milestones and EPAs
Clinical Learning Environment Review (CLER) Visits
An Institutional Assessment

- All programs within an institution evaluated simultaneously
- CLER is NOT tied to program or institutional accreditation
- Six areas of focus:
  - Resident engagement/participation in patient safety programs
  - Resident engagement/participation in QI programs
  - Establishment and oversight of institutional supervision policies
  - Effectiveness of institutional oversight of transitions of care
  - Effectiveness of duty hours and fatigue mitigation policies
  - Activities addressing the professionalism of the educational environment
- Formative, non-punitive learning process for institutions and the ACGME
CLER Feedback

• Site visitors conduct “walk arounds” accompanied by resident hosts/escorts designed to facilitate contact with nursing and support staff and patients (eventually)

• Meetings held with:
  • DIO, GMEC Chair, CEO, CMO, CNO
  • CPS/CQO
  • Core faculty
  • Program directors
  • Residents

• Answer questions honestly if approached by CLER visitors

• No “gotchas”, and no stealth accreditation impact
In Summary

• A focus on outcomes benefits everyone (patients, programs, and trainees)
• The NAS should permit innovation while ensuring that graduating residents can provide effective, independent patient care
• CLER adds an institutional dimension that focuses on establishing a humanistic educational environment
In Summary

• The Milestones are not perfect - they will require revision as programs gain experience using them
• The Milestones are not absolute benchmarks that determine if and when trainees graduate
• The Milestones should lead to better understanding of what is expected of trainees (and when it is expected) and improve the feedback trainees receive
Where are We in Geriatrics?

• For Fellows:
  • Competencies (Curriculum Milestones) Defined (JAGS, 2014)
  • EPAs developed (JAGS, 2014)
  • Reporting Milestones developed
  • CCCs formed and reporting milestones (12/31/14)

• For Residents:
  • Geriatric competencies for IM, FM (JGME, 2010)
  • Milestones reported 6/14 for IM, 12/14 for FM

• For Students:
  • Geriatric competencies (2009)
  • EPAs from AAMC (11/13)
Where Can we Go in Geriatrics?

- Implement and refine EPAs/milestones for fellows.
- Develop assessment of milestones for geriatrics and other rotations in our own residency programs and possibly nationally.
- Develop milestones and assessments for geriatrics competencies for students.
How Reynolds Has Helped

• Facilitated (at these meetings) development of geriatric fellow competencies/curricular milestones, and EPAs (assisted by Hartford).

• Made all of us highly integrated, visible and credible in the geriatrics education of medical students and residents and IPE at our institutions, regionally, and nationally.
IOM report on GME (7/29/14)

- Maintain Medicare/Medicaid GME support ($15B)
- Build GME Financing and Policy Infrastructure
  - Office of GME Policy in HHS responsible for Medicare GME financing
  - GME Center in CMS
- Two funds for GME
  - Operations Fund-support positions
  - Transformation Fund-develop and evaluate innovative GME
- Modernize GME payment system
  - Per-resident amount to institutions sponsoring GME
- Require similar accountability and transparency for Medicaid GME funds
Conclusion

• We’ve accomplished a lot in geriatrics education at all levels of the education continuum.

• Our strengths include high value care, shared decision making, focus on quality and safety, achieving good outcomes for older patients, and interprofessional collaboration.

• These are just the outcomes CMS is looking for in funding GME.

• We need to continue to innovate, document what we accomplish, and share it with the education and policy communities.