Basic Standards

for Fellowship Training in

Geriatrics in Osteopathic Family Medicine

and Manipulative Treatment

American Osteopathic Association

and

American College of Osteopathic Family Physicians

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I. Introduction

A. Definition

1.1 Fellowship training programs in Geriatrics in Osteopathic Family Medicine and Manipulative Treatment are designed to provide osteopathic family physicians with advanced and concentrated training in the specialty of geriatrics.

II. Mission

2.1 Upon the successful completion of a fellowship in geriatrics, the physician will be prepared to provide comprehensive geriatric care and will be prepared for geriatric certification by the American Osteopathic Board of Family Physicians (AOBFP).

III. Educational Program Goals

The goal of geriatric fellowship training is to prepare fellows for competency in the following core areas:

3.1 Osteopathic Philosophy and Osteopathic Manipulative Medicine
   a. The integration of osteopathic principles into the daily practice of geriatrics.
   b. The appropriate application of OMM to geriatric patient management.

3.2 Medical Knowledge
   a. Maintain current knowledge of clinical medicine that reflects the majority of patient care issues present in geriatric settings.
   b. Maintain current knowledge of behavioral medicine that reflects the majority of patient care issues present in geriatric settings.

3.3 Patient Care
   a. Provide osteopathic geriatrics patient care service in ambulatory continuity, hospital, and extended care sites.
   b. Accurately gather essential information from all sources including patients, care givers, other professionals, electronic sources, and paper sources.

3.4 Interpersonal & Communication Skills
   a. Develop appropriate doctor-patient relationships in all geriatrics settings.
   b. Develop effective listening, written, verbal and electronic communication skills in professional interactions with patients, families and other health professionals.

3.5 Professionalism
   a. Demonstrate respect for patients and families and advocate for the primacy of patient’s welfare and autonomy.
   b. Adhere to ethical principles in the practice of geriatrics.
   c. Demonstrate awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, mental and physical disabilities.

3.6 Practice-Based Learning and Improvement
   a. Apply the principles of evidence-based medicine to geriatrics.
b. Participate in practice-based objective performance improvement projects in geriatrics settings.

3.7 Systems-Based Practice
   a. Effectively function within local and national health care delivery systems to provide high quality geriatrics services.
   b. Effectively function within a team to provide care to geriatrics populations.

IV. Institutional Requirements

A. Programmatic
4.1 The institution must have an organized department or section of Family Medicine.

B. Facilities
4.1 The primary training facilities shall be located in geographic proximity so as to allow for efficient functioning at the educational program.

4.2 Training in ambulatory geriatrics shall take place in a physician’s office, a multi-physician clinic and/or geriatrics centers, where medical care is delivered under supervision of the geriatrics program director.

4.3 Training in nursing home care shall take place in facilities that are licensed to provide skilled nursing care by state and federal authorities.

4.4 Training in inpatient geriatrics care must take place in an institution that is accredited by any CMS deemed accrediting body.

V. Program Requirements

A. Programmatic
5.1 The duration of geriatrics fellowship training will be twelve (12) months.

5.2 The program must have an organized schedule of didactic presentations on geriatrics topics. At a minimum this must include:
   a. Disorders of the aging renal system.
   b. The biology, psychology and physiology of aging.
   c. Pharmacology in the elderly.
   d. Comprehensive geriatrics assessment including cognitive, functional, and psychosocial evaluation.
   e. Preventive medicine, including proper nutrition, exercise prescription, counseling, immunizations and chemoprophylaxis.
   f. Physical medicine and rehabilitation, including complications to rehabilitation caused by illness.
   g. Health promotion and disease prevention, nutrition, exercise and health screening as it relates to the geriatrics patient.
   h. Mental health concerns including loss of a spouse, death and dying, depression, dependency, caregiver burden and sexuality in the elderly.

5.3 The program must have provide clinical training in the following areas as they pertain to the geriatrics patient:
a. Special problems common in the hospitalized elderly including iatrogenesis, immobility, polypharmacy and pressure ulcers.

b. Cardiovascular disorders with emphasis on degenerative diseases, dysrhythmias, congestive heart failure and peripheral vascular disease.

c. Neurologic disorders, including cerebrovascular disease, neurodegenerative disease, dementias and delirium.

d. Endocrine disorders, including diabetes mellitus and thyroid disorders.

e. The arthritides and osteoporotic disease.

f. Fracture management including hip, spinal and extremity fractures.

g. Pre-surgical evaluation and medical clearance.

h. Post-surgical rehabilitation and recovery.

i. Nutritional needs to include hyperalimentation and parenteral nutrition.

j. Infectious diseases of the elderly.

k. Malignant diseases.

l. Psychiatric and psychological needs and evaluation of the geriatrics patient.

m. The impact of health care cost or the elderly and public policy recommendations.

n. Geriatrics facility administration.

o. Ethics, advance directives and end-of-life decision-making skills.

5.4 Training must include the interdisciplinary approach to patient care:

a. Fellows must gain experience in collaboration with multiple professions such as physician assistants, nurse practitioners, nurses, social workers, physical, speech and occupational therapists, and others involved in the comprehensive care of elderly persons.

b. Training must include participation in interdisciplinary case management of nursing home patients.

B. Continuity of Care Training

5.1 The fellow must receive continuity patient training at an ambulatory continuity site, an inpatient facility, a nursing home facility and in the patient’s home.

Ambulatory Continuity

5.2 Each fellow must be assigned a panel of patients at the geriatrics ambulatory continuity site. The fellow will be responsible for the management of these patients, for the majority of the year of fellowship.

Inpatient Medicine

5.3 Each fellow must receive training in the inpatient care of geriatrics patients. At a minimum this must include:

a. Participation in an integrated geriatrics service that includes medical and surgical services with cooperative involvement of all other related departments of the institution.

b. Management of geriatrics acute and chronic illness.
c. Management of geriatric patients with other health care professionals.
d. Coordination of care.
e. Management of transfer of care to and from the patient’s residence.
f. Production of comprehensive medical records.
g. Utilization management and discharge planning.

Nursing Home
5.4 Each fellow must receive training in the care of geriatrics patients in nursing home settings. At a minimum this must include:
   a. Evaluation of new patients and completion of requirements for admission.
b. Adherence to regulatory requirements governing nursing home care.
c. Participation in interdisciplinary team meetings and discharge planning when appropriate.
d. Completion of discharge duties and arrangement for appropriate follow-up.

Home Care
5.5 Training for home care services must be offered. At a minimum this must include:
   a. Referrals to appropriate home nursing or hospice care services.
b. Completion of appropriate admission and follow-up paperwork.
c. Home care visits.
d. Identification and utilization of community resources for care of elderly patients at home.

C. Osteopathic Manipulative Medicine
5.1 The program must train fellows in the clinical application of osteopathic manipulative medicine to geriatrics patients. At a minimum this must include:
   a. Training in outpatient and inpatient settings.
b. Documentation of OMM in the medical record.
c. Coding and reimbursement.

VI. Faculty and Responsibilities
A. Program Director
6.1 Each program must have a single program director that is compensated by the institution.

B. Qualifications
6.1 In addition to meeting all Program Director requirements stipulated in the AOA Basic Documents, the Program Director must meet the following qualifications:
   a. Must be actively engaged in the care of geriatrics patients.
b. Must be certified by the AOA through the American Osteopathic Board of Family Physicians (AOBFP) and hold a current CAQ in geriatrics medicine through the AOBFP.
c. Must be approved by the Committee on Education and Evaluation of the ACOFP.
C. Responsibilities

6.1 The Program Director must have sole responsibility and authority for the educational content and conduct of the fellowship. The Program Director’s authority in directing the fellowship must be defined in the program documents of the institution.

6.2 In addition to meeting all Program Director requirements stipulated in the AOA Basic Documents, the Program Director responsibilities shall include:
   a. The design and implementation of the geriatrics curriculum described in these standards.
   b. Selection and evaluation of program faculty.

VII. Fellow Requirements

7.1 Applicants for the Geriatrics fellowship program must be:
   a. A graduate of an AOA accredited family medicine residency program, or
   b. An American Osteopathic Board of Family Physicians (AOBFP) certified practicing family physician.

VIII. Evaluation

A. Evaluation of the Fellows

8.1 The program shall maintain a permanent record of formative and summative evaluations for each fellow.

8.2 Each fellow will be required to keep a portfolio. The portfolio shall include at least the following:
   a. Procedures performed.
   b. Procedural competency documentation.
   c. Semi-annual evaluations.
   d. Final summative evaluation.

B. Formative Evaluation

8.1 At the completion of each rotation the fellow must be evaluated by the appropriate faculty. These evaluations shall be signed by the responsible faculty, the fellow and the Program Director.

8.2 There must be semi-annual written evaluations of the knowledge and competencies of each fellow. These evaluations shall be signed by the fellow and by the Program Director.

C. Summative Evaluation

8.1 The Program Director is responsible for a final summative evaluation of each fellow who completes the program. This evaluation must include a review of the fellow’s competencies at the completion of training and shall verify that the fellow has demonstrated sufficient professional ability to practice geriatrics competently and independently.

8.2 In cases of early termination of a resident’s program, the Program Director shall provide the fellow with written documentation regarding which rotations, if any, were completed satisfactorily.
   a. The AOA Postdoctoral Training Division and the ACOFP shall be notified of the early termination.
D. Evaluation of Faculty

8.1 All geriatric teaching faculty must be evaluated annually. This shall include evaluation of teaching ability, clinical knowledge, and communication skills. The evaluation shall include a mechanism for anonymous input by the fellows.

E. Evaluation of Program

8.1 At the completion of each rotation, the resident shall evaluate the educational quality of the rotation. These evaluations shall be reviewed by the Program Director.

8.2 The Program Director shall prepare an annual written program review. This shall note the program’s compliance or non-compliance with these standards and shall be reviewed by the institution’s graduate medical education committee. This review may be waived during a year in which the institution completes a formal internal review.

F. Evaluation of Patient Care

8.1 There must be a mechanism to formally evaluate the care provided by the fellows and faculty in both inpatient and outpatient settings. There should be evidence that this information is used to improve education and patient care.