Geriatric Medicine Fellowship Program Aims
(Updates April 27, 2015)

The University of Wisconsin-Madison Geriatric Medicine Fellowship aims are to:

- Equip fellows with the professional behaviors, attitudes, knowledge and skills necessary to be a competent and compassionate geriatricians who employ strategies for life-long learning
- Prepare our trainees to practice team-based care in health systems that are constantly evolving and changing
- Engage in a process of regular programmatic review, innovation and performance improvement for the fellowship program to meet learner needs and accomplish regulatory requirements

Geriatricians entering into practice, in and across all care settings (hospital, home, office, and long term care and subacute rehabilitation facilities), are able to:

1. **Provide patient centered care that optimizes function and/or well-being.**
   Geriatricians provide comprehensive geriatric assessment and management, including health promotion and disease prevention, and work with patients/families/caregivers and community resources to maximize a patient’s independence.

2. **Prioritize and manage the care of older patients by integrating the patient’s goals and values, comorbidities and prognosis into the practice of evidence-based medicine.**
   Geriatricians develop prioritized management plans for patients that take into account their prognosis, multiple chronic conditions, function, goals and preferences, and the strength and applicability of the medical evidence to older adults in general and to individual patients.

3. **Assist patients and families in clarifying goals of care and making care decisions.**
   Geriatricians discuss and revisit goals of care and advance care planning in a skillful and culturally sensitive way taking into consideration issues of decisional capacity, patient/family care preferences and changes in status.

4. **Prevent, diagnose and manage geriatrics syndromes.**
   Geriatricians design and implement plans to prevent, diagnose, and treat geriatrics syndromes (i.e., falls and dizziness; cognitive, affective, and behavioral disorders; pressure ulcers; sleep disorders; hearing and vision disorders; urinary incontinence; weight loss and nutritional issues; constipation and fecal incontinence; elder abuse) in older persons in every setting of care.

5. **Provide comprehensive medication review to maximize benefit and minimize number of medications and adverse events.**
   Geriatricians review all over the counter and prescribed medications to assure there is a current indication and a target outcome, use the principles of geriatric pharmacology to select medications and doses, and always consider medications as a possible contributor when patients present with new symptoms or geriatric syndromes.

6. **Provide palliative and end-of-life care for older adults.**
   Geriatricians identify patients with serious illness who are likely to benefit from palliative and/or hospice care, including those with non-cancer diagnoses (e.g., congestive heart failure, chronic obstructive pulmonary disease, dementia). They regularly re-assess goals of care, effectively treat most pain and non-pain symptoms, and refer to hospice or palliative medicine specialists as needed.

7. **Coordinate healthcare and healthcare transitions for older adults with multiple chronic conditions and multiple providers.**
   Geriatricians identify appropriate care settings that meet the needs of a given patient and recognize when transition to a different setting is needed. They provide care for patients during transitions in care settings in a manner that ensures continuity for the patient and works to optimize the care of that patient by future caregivers.
8. Provide geriatrics consultation and co-management.
   Geriatricians respond to requests for consultation or co-management with explicit recommendations that reflect the patient's prognosis, multiple chronic conditions, function and goals, and provide guidance to providers and patients/families/caregivers.

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, utilize advanced communication skills (e.g., jargon-free language, nonverbal behavior, response to emotion, conflict mediation).

10. Collaborate and work effectively as a leader or member of an interprofessional health care team.
    Geriatricians lead and work within interprofessional health care teams in multiple settings of care to improve patient outcomes through coordination, collaboration and mutual understanding. They recognize situations when team leadership should reside with other members of the interprofessional team.

11. Teach the principles of geriatrics care and aging-related health care issues to professionals, patients, families, health care providers and others in the community.
    Geriatricians teach patients, physicians-in-training, other healthcare professionals and lay audiences principles of geriatrics care, identify and adjust teaching messages based on the audience, and supervise trainees providing constructive feedback.

12. Collaborate and work effectively in quality improvement and other systems-based initiatives to assure patient safety and improve outcomes for older adults.
    Geriatricians identify real and potential issues threatening older patients' safety and outcomes, notify the appropriate person/entity, and initiate or participate in system improvement efforts to improve care. They advocate to improve care and communication within complex systems such as the hospital and with other service care providers.

13. Engage in life-long learning and effective career planning that emphasizes life balance, career satisfaction and well being.
    Geriatricians need to engage in careers that provide fulfilment and that promote emotional and physical well-being to ensure a sustainable work life that can serve as a positive model for trainees and peers.

Fellows learn to provide geriatric care in a number of different settings as both a primary care geriatrician and a consultant. The fellowship is organized with a year-long longitudinal training that includes regular didactic offerings include weekly Geriatric Journal Club, Weekly Fellows' Core Lecture, weekly Gero-psychiatry Colloquium and monthly Geriatric Grand Rounds. Specifically, fellows complete three one-month rotations on our Acute Care for Elders Team. There are two eight-week blocks dedicated to our numerous geriatric specialty clinics and VA Geriatrics consult team. A six-week block spent on a Nursing Home Rotation spending time at Capital Lakes Teaching Nursing Home. A four week Community Care rotation exposes fellows to transitions of care, adult daycare, home care and quality improvement activities. A six-week block rotation is dedicated to Hospice and palliative care, nursing home administration/rehabilitation, and the remaining one month is spent on elective time respectively.

Fellows provide primary care within a half-day per week geriatric clinic at the University and half-day in the VA Geriatric Evaluation and Management Continuity Clinic over the twelve months. The VA clinic has a unique and well-developed staffing model that incorporates combined geriatric medicine and geriatric psychiatry oversight. Fellows are assigned a nursing home staff mentor and follow nursing home patients at area nursing homes throughout the year. Fellows participate in a year-long structured performance improvement activity.