GERIATRIC FELLOWSHIP TRAINING MODULE: HOSPICE & PALLIATIVE CARE

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
Osteopathic Principles & Practice	1. Describe the integration of Osteopathic principles and philosophy into the care of older adults toward the end of life (EOL). 2. Describe the musculoskeletal changes that occur with normal and pathological aging. 3. Recognize the limitations necessary to consider when performing OMT on individuals at the EOL. 4. Perform individualized OMT to treat acute or chronic symptoms. 5. Utilize caring, compassionate, holistic, person-centered behavior with older adults and their families. 6. Role model caring for the "whole person" versus merely treating symptoms.	• SDPC • W/COM • CP • RC • IR • D	▪ Discuss the capacity of older adults to function across many domains – physical, functional, cognitive, emotional, social & spiritual. ▪ Describe the use of selection, optimization, and compensation that older adults use to adapt to life's challenges.	▪ Komara ▪ Ward ▪ Williams	• PRR • ORAL • SP • S/M • OSCE • 360° • JC PORTF
Medical Knowledge	1. Demonstrate knowledge of established and evolving biomedical, clinical,	• SDPC	▪ Define optimal aging.	▪ Billings & Block ▪ Brummel-Smith	• CSR

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	epidemiological, and social-behavioral sciences in Hospice and palliative care settings and facilities. 2. Utilize pharmacologic narcotic principles at the EOL for: • Assessment of pain, constipation, dyspnea • Titration of narcotics • Side effects • Prevention of side effects and adverse drug reactions (ADR) 3. Utilize evidence-based prognostication tools to determine prognosis in cancer and non-cancer illnesses. 4. Apply the Hospice Medicare benefit structure to patient care. 5. Utilize educational resources available in EOL care. 6. Utilize medical knowledge to teach others. 7. Incorporate clinical questions and cases for	• AGS-FT • CP • IR • D	▪ Compare/contrast optimal aging to successful aging. ▪ Describe the eight (8) determinants of health (Health Field Model). ▪ Recognize the unique individuality of older adults across cohorts and the continuum of care. ▪ Utilize exercises that promote optimal aging and improve balance and strength. ▪ List the primary	(2 articles) ▪ Fox ▪ GRS7: Chapter 2 – Biology of Aging ▪ GRS7: Chapter 16 – Hospital Care ▪ Hazzard ▪ Kane ▪ POGOe ▪ AGS – Pain (2 articles) ▪ EPEC ▪ OEPEC ▪ Cognitive Tools ▪ Prognostication Tools	• ORAL • MCQ • LOG • PORTF • JC

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	discussion and research. 8. Observe and participate in the role and responsibilities of the hospice or palliative care physician/provider.		biological activities/factors known to increase the chance of aging optimally (exercise, nutrition, sleep, avoidance of disease-causing agents, practicing preventive medicine, early treatment of disease and medical conditions, avoidance of iatrogenic complications).		
Patient Care	1. Provide person-centered care that is compassionate, appropriate, and effective for the treatment of the dying. 2. Obtain a patient history and perform a physical examination pertinent to	• SDPC • CP • IR • D	• Promote optimal nutrition. • Promote optimal cognitive health and function.	▪ POGOe - Drugs and Aging ▪ Beers ▪ Hazzard	• 360° • PRR • CSR • OSCE

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	the terminal diagnosis and level of comfort. 3. Demonstrate comfort and a compassionate demeanor when interacting with dying patients. 4. Assess and provide initial management of pain and key non-pain symptoms based on the patient's goals of care. 5. Evaluate medications for contribution to patient comfort while at the same time respecting the financial limitations of the hospice philosophy. 6. Order testing in a medically appropriate and fiscally responsible manner to affect patient comfort. 7. Assess, develop, and implement patient management plans for the dying patient including: • Loss of appetite • Weight loss • Edema • Dysphagia • Terminal congestion		• Recognize social support systems as a critical factor in patient outcomes. • Incorporate knowledge of the benefits of social engagement and interaction in patient treatment plans.	▪ Kane ▪ Lo ▪ Touro University, (2008, August). *Ethical, legal and health-care related behaviors*. – Dr. Carron ▪ GRS7: Chapters 4, 15, 32, 33	• S/M • PORTF

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	• Difficulty in breathing (DIB) • Debility 8. Identify the psychological, social, and spiritual needs of patients with advanced illness and include their family members. 9. Conduct advanced care planning. 10. Demonstrate competence in rendering care to the dying patient. 11. Explain aspects of the health care continuum and locations of hospice and palliative care services/facilities available.				
Interpersonal & Communication Skills	1. Demonstrate communication skills that are effective, therapeutic, and that result in the effective exchange of accurate and appropriate information while protecting the patient's rights (autonomy, confidentiality,	• SDPC • JC • RC • CP • IR • D	• Avoid use of ageist and stereotypical language when communicating with older adults.	• Buckman (3 resources) • CHAMP	• 360° • PS • OSCE • SP/M • CL • PORTF

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	privacy. 2. Present hospice and palliative care as a positive, hopeful, treatment option for a patient with advanced disease. 3. Incorporate the use of effective team principles when working with patients, their families, hospice physicians, and professional associates. 4. Utilize therapeutic and effective communication with patients, families, guardians across a broad range of socioeconomic, cultural, and religious backgrounds. 5. Communicate effectively with physicians, other health professionals, and health related agencies, across the healthcare continuum. 6. Participate in hospice				

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	and interdisciplinary team meetings and link patient needs to the appropriate team member. 7. Demonstrate effective use of communication strategies including: Listening Asking questions slowly when needed Allowing a pause for time for patient to answer if needed. 8. Establish the ability to manage difficult family issues/conflicts compassionately and effectively. 9. Present history and physical data in a clear and concise manner. 10. Maintain comprehensive, timely, and legible medical records all patients served during the Hospice/Palliative care rotation. 11. Return family calls in a timely manner while				

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	addressing patient/family concerns appropriately.				
Professionalism	1. Consistently demonstrate compassion, integrity, and respect for others. 2. Demonstrate responsiveness to patient welfare that supersedes self-interest. 3. Incorporate respect for patient privacy, autonomy, and the doctor-patient relationship in providing EOL care. 4. Demonstrate life-long learning abilities with participation in journal club and other didactic sessions. 5. Discuss the interaction between medical/healthcare and spiritual, cultural, ethnic, sexual, and racial factors. 6. Incorporate CMS guidelines on patient privacy issues. 7. Participate in diversity awareness opportunities.	• SDPC • Zemper • IR • CP • D			• 360° • PS • ORAL • CSR • PRR • CL • PORTF

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	8. Utilize cultural competence to work compassionately with patients and families of varied cultures. 9. Apply ethical principles to EOL care.				
Practice-Based Learning & Improvement	1. Demonstrate the ability to investigate and evaluate care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life long learning. 2. Identify strengths, deficiencies, and limits in one's knowledge and expertise. 3. Analyze personal practice utilizing quality improvement (QI) methods and implement practice improvement changes. 4. Utilize educational resources available in the EOL life care setting to assist in optimizing patient comfort.	• SDPC • AGS-FT • IR • D • SA	• Advocate for public education and public policy that can influence health promotion and wellness for older adults at a local, state, and national level.	• Hazzard • Kane	• JC • PRR • CSR • 360° • PS • PORTF • SCS Research Training & Evidence Based Modules (Zemper)

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	5. Evaluate an EOL case for a M&M conference to self-evaluate care provided. 6. Complete all assigned readings and activities recommended by the attending in a timely manner.				
Systems-Based Practice	1. Demonstrate an awareness of and responsiveness to the larger context of the health care delivery systems, as well as the ability to call effectively on other resources in the system to provide optimal health care. 2. Coordinate patient care within the health care system and work in teams to enhance patient safety and improve the quality of patient care. 3. Incorporate cost awareness and risk-benefit analysis in patient care. 4. Describe the role and function of a positive team member within the hospice or palliative care team. 5. Discuss the limitations of	• SDPC • AA • CP • CM • IR • D	• Become knowledgeable about community-based resources that promote optimal aging and refer/collaborate when appropriate for older adults discharging back to the community from the hospital	• How to use an ethics committee • Ethics components • Hazzard • Kane • JCAHO • HIPAA • E & M	• 360° • PS • MCQ • CL • PORTF

CORE COMPETENCY (AOA & ACGME)	OBJECTIVES *The geriatric fellow will:*	INSTRUCTIONAL STRATEGY	OPTIMAL AGING COMPONENT	CONTENT & RESOURCES	EVALUATION METHODS
	hospice and palliative care. 6. Incorporate correct E&M coding for hospice and palliative care services to maintain compliance with insurance regulations. 7. Discern what services are available to the hospice and palliative care patient. 8. Participate in advocacy activities that enhance the quality of patient care. 9. Incorporate the rules and regulations that guide hospice and palliative care.				

Potential Methods/Strategies of Instruction

ACRONYMN	MEANING	EXPLANATION
AA	• Advocacy Activity	• Participate in Michigan DO Day on the Hill • Membership in professional organizations
AGS-FT	• American Geriatrics Society. (2012). *Geriatrics at your fingertips* (14th ed.). Mechanicsburg, PA: Fry Communications. • Retrieved from https://fulfillment.frycomm.com/ags/gayf/order_form.asp	• Provides accessible, concise information for healthcare professionals caring for older adults with complex, chronic diseases and disorders; current medication use; clinical guidelines; calculators; assessment instruments; algorithms
CC	• Care Conference	
CM	• Case Management	• Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services patients, and, in some instances, the family or close support network • CM can include: intake/history, needs assessment, developing plan of care, developing mutual goals, treatment plan implementation, service coordination, monitoring, follow-up, reassessment, case conferencing, crisis intervention, and case closure
CP	• Case Presentation (oral)	• The Oral Case Presentation is an art form that requires effort and repeated practice • The purpose is to concisely summarize the patient's presentation: (1) history, (2) physical examination, (3) laboratory results,

ACRONYMN	MEANING	EXPLANATION
		and (4) your understanding of these findings (clinical reasoning)
D	• Didactic Content	• A didactic method is a basic component of education • Related to the teaching-learning process it includes delivery of information, engaging the learner, and completion of a variety of activities that help to maintain the learned concepts • Lecture
GRSC	• Geriatric Review Syllabus Didactics	The geriatric fellow will participate in weekly didactics based on the Geriatrics Review Syllabus; held ____________________ (for example - Wednesday afternoons at 1600)
JC	• Journal Club	• Provides a forum for keeping abreast of new developments in a particular content area • Promotes engagement, interaction and scholarly dialogue • Approached in a systematic fashion with emphasis on key elements • Helps in development of oral and written presentation skills • Assists in mastery of critical appraisal
IC	• Independent Collaboration/Consultation	• Telephone conversations o Pharmacy, home care, Hospice, Office on Aging (local), home visit, Adult Protective Services
IDT	• Interdisciplinary Team Meetings	• An approach to patient care that includes a variety of professionals with knowledge/expertise in an aspect of person-

ACRONYMN	MEANING	EXPLANATION
		centered care that leads to quality care of individuals and their families; need to know the credentials, scope of practice, and function of each member of the health care team
ITC	• Interdisciplinary Team Conference	The geriatric fellow will participate in interdisciplinary team conferences for selected patients
IR	• Independent Reading	• **S**elected readings based on the fellow's needs are assigned by supervising attending physicians • Fellows are also referred to standard textbooks and are expected to independently research topics related to specific patient encounters
M	• Meetings	• Can include: o Administrative o Behavior management o CQI o Falls o Infection control o Weight loss o Wounds
RC	• Record Completion	• Patient medical record – written or electronic - maintained accurately, efficiently, and thoroughly according to acceptable standards for documentation
SA	• Scholarly Activity	• Professional activity • Conference attendance/presentation • Poster presentation

ACRONYMN	MEANING	EXPLANATION
		• Publication: journal, newsletter • Quality improvement (QI) project • Research
SDPC	• Supervised Direct Patient Care	• Forms the majority of the training experience, which includes: o Bedside Rounds (BR) o Morning Report (MR)
W/COM	Workshop	• Combination of demonstration, hands-on-experience/practice, reading • Provided by College of Osteopathic Medicine faculty • Held annually
Zemper	Modules developed for ___________________	• Research

Potential Methods of Evaluation

ACRONYMN	MEANING	EXPLANATION
360°	• 360° Global Rating	• A comprehensive (but labor intensive) assessment using brief instruments with 3-4 Likert scale questions completed by nursing staff, attendings, peers and patients • Ideally, a minimum of 10 responses from each category of evaluator
CL	• Checklist	• Assessment items that are used to record whether intended behaviors were observed by an assessor • Typical checklist responses are dichotomous ("done" or "not done") but may use more categories (e.g. "done", "partially done", or "not done") • Rater training is critical so that each rater scores observed behaviors correctly and consistently
CSR	• Chart Stimulated Recall	• A standardized oral exam using examinees' patients' records • Allows the examiner to ask questions about clinical diagnosis and management based on actual patient records
GR	• Global Rating	• Rating scales that rate performance as an integrated whole • For example, "Overall this performance was: excellent, very good, good, marginal, unsatisfactory"
GS/DL	• Geriatric Syndrome/Disease Log	• Log of patients seen, focusing on syndromes/diseases treated • Used to assess range and volume of syndromes/diseases treated in comparison with required minimums
JC	• Journal Club	• Presentation to peers and faculty of critique of a research journal article • Can be evaluated using the SCS Journal Club Checklist, and added to portfolio
MCQ	• Multiple-choice question written examination	• Objective examination of factual knowledge • Easy to administer and score, but takes some effort to develop appropriate questions and distractors

ACRONYMN	MEANING	EXPLANATION
ORAL	• Standardized Oral Examination	• An oral examination comprised of specific questions given to all examinees and scored by examiners using previously agreed upon guidelines
OSCE	• Objective Structured Clinical Examination	• An assessment format that consists of a series of performance tests • Each test within an OSCE is called a "station" • Often uses simulations or models or standardized patients
P/CL	• Procedure or Case Logs	• Log of patients seen, focusing on cases treated and specific procedures performed • Used to assess range and volume of cases and procedures performed in comparison with required minimums
PORTF	• Portfolio	• In assessment, a collection of evidence (either electronic or hardcopy) of progression towards proficiency (e.g. in the core competencies) • Portfolios typically include both constructed components (selected by the program or faculty) and unconstructed components (selected by the learner)
PRR	• Patient Record Review	• Review of patient records to assess range and volume of cases seen and appropriateness of care provided by a fellow
PS	• Patient Survey	• Survey instrument directed at patients to assess satisfaction with care received • Normally a brief series of Likert scale questions, open-ended questions, or a combination of both
S/M	• Simulations and Models	• Simulations (mechanical devices) or models (human actors) for training or evaluation purposes • Focused on a specific medical problem or procedure
SP	• Standardized Patient	• Actors trained to play the roles of patients, portray specific cases, and rate performance of the learner • Often used in OSCE stations

Resources & References

ACRONYMN	REFERENCE / RESOURCE	INFORMATION
AGS-FT	• American Geriatrics Society. (2013). *Geriatrics at your fingertips* (15th ed.). Mechanicsburg, PA: Fry Communications. • Retrieved from https://fulfillment.frycomm.com/ags/gayf/order_form.asp	• Provides accessible, concise information for healthcare professionals caring for older adults with complex, chronic diseases and disorders; current medication use; clinical guidelines; calculators; assessment instruments; algorithms
AGS – Pain	• American Geriatrics Society Panel. (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society,* 57, 1331-1346. doi:10.1111/j.1532-5415.2009.02376.x Retrieved from http://www.americangeriatrics.org/files/documents/2009_Guideline.pdf • American Geriatrics Society Panel. (2002). The management of persistent pain in older persons. *Journal of the American Geriatrics Society*, 50, 5205-5224. Retrieved from http://www.americangeriatrics.org/files/documents/2002_persistent_pain_guideline.pdf	• In 2009, the AGS updated its guidance to clinicians around management of persistent pain with a specific focus on pharmacologic treatment • The Expert Panel determined that the sections of the 2002 Guideline dealing with Assessment and Non-Pharmacologic treatment did not need to be updated and are still relevant to today's clinicians
Beers	• American Geriatrics Society Panel. (2012). American geriatrics society updated Beers criteria for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society, 60*(4), 616-631. doi:10.1111/j.1532-5415.2012.03923.x • Retrieved from http://www.americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf	• Retrieved from http://www.americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf
Billings &	• Billings, J.A., & Block, S. (1997). Palliative care in undergraduate medical	

ACRONYMN	REFERENCE / RESOURCE	INFORMATION
Block	education: Status report and future directions. *Journal of the American Medical Association, 278*(9), 733-738.	
Brummel-Smith	• Brummel-Smith, K. (2007a). Optimal aging, part I: Demographics and definitions. *Annals of Long-Term Care, 15*(11), 26-28. • Brummel-Smith, K. (2007b). Optimal aging, part II: Evidence-based practical steps to achieve it. *Annals of Long-Term Care, 15*(12), 32-40.	
Buckman	• Buckman, R. (1984). Breaking bad news: Why is it so difficult? *British Medical Journal, 288*(1), 597-9. • Buckman, R. (1992). *How to break bad news: A guide for health care professionals*. Baltimore, MD: The John Hopkins University Press. • Buckman, R. (2010). *Practical plans for difficult conversations in medicine: Strategies that work in breaking bad news*. Baltimore, MD: The John Hopkins University Press.	
CHAMP	• Retrieved from champ.bsd.uchicago.edu/	• Curriculum for the Hospitalized Aging Medical Patient, University of Chicago, Geriatrics website
E&M	• Evaluation and Management Services Billing Guide, March 2011 • Retrieved from http://www.medicarenhic.com/providers/pubs/Evaluation%20and%20Management%20Services%20Billing%20Guide.pdf	• Guide provides Medicare Part B Evaluation and Management Services billing information.

ACRONYMN	REFERENCE / RESOURCE	INFORMATION
EPEC	• Emmanuel, L.L., von Gunten, C.F., & Ferris, F.D. (1999). *The education for physicians on end-of-life care (EPEC) curriculum*. EPEC Project, The Robert Wood Johnson Foundation. Institute for Ethics at the American Medical Association. • Retrieved from http://www.ama-assn.org/ethic/epec/download/plenary_3.pdf	• Permission to produce for non-commercial, educational purposes with display of copyright and attribution is granted.
GRS7	• Pacala, J.T., & Sullivan, G.M. (Eds.). (2010). Geriatrics review syllabus: A core curriculum in geriatric medicine (7th ed.). New York City, NY: American Geriatrics Society.	
Fox	• Fox, E. (1997). Predominance of the curative model of medical care: A residual problem. *Journal of the American Medical Association, 278*(9), 761-763.	
Hazzard	• Halter, J., Ouslander, J., Tineetti, M,. Studenski, S., High, K., & Asthana, S. (2009). *Hazzard's geriatric medicine and gerontology* (6th ed.). New York, NY: McGraw Hill – Professional.	
HIPAA	• US Department of Health & Human Resources: The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) Privacy and Security Rules • The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") • Retrieved from http://www.hhs.gov/ocr/privacy/	• Establishes, for the first time, a set of national standards for the protection of certain health information • The Privacy Rule standards address the use and disclosure of individuals' health information - called "protected health information" by organizations subject to the Privacy Rule - called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health

ACRONYMN	REFERENCE / RESOURCE	INFORMATION
		information is used
JCAHO	• The Joint Commission on the Accreditation of Healthcare Organizations – or currently referred to as The Joint Commission **(TJC)** • Retrieved fromhttp://www.jointcommission.org/	• Sets standards for healthcare organizations and issues accreditation to organizations that meet those standards • Conducts periodic on-site surveys to verify that an accredited organization substantially complies with TJC standards and continuously makes efforts to improve the care and services it provides
Kane	• Kane, R., Ouslander, J., Abrass, I., & Resnick, B. (2008). *Essential of clinical geriatrics* (6th ed.). McGraw Hill – Professional. Maryland Heights, MO: Elsevier Mosby.	
Komara	• Komara, F. (2012). *Assessment and treatment of somatic dysfunction in the elderly*.	• Work in progress • Collaboration with COM/OMM • Product will be DVD
Lo	• Lo, B. (2009). *Resolving ethical dilemmas: A guide for clinicians* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.	
OEPEC	• Education for Osteopathic Physicians on End-of-Life Care • Retrieved from http://www.osteopathic.org/inside-aoa/development/quality/aoa-quality-initiatives/Documents/	• Osteopathic EPEC
POGOe	• Portal of Geriatric Online Education • Located at http://www.pogoe.org/	• POGOe is a free public repository of a growing collection of geriatric educational materials in various e-learning formats, including lectures, exercises, virtual patients, case-

ACRONYMN	REFERENCE / RESOURCE	INFORMATION
		based discussions, simulations, as well as links to other resources • New products are added continuously
Ward	• Ward, R.C. (Ed.). (2003). *American osteopathic association: Foundations for osteopathic medicine* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.	
Williams	• Williams, S. (n.d.). Geriatric osteopathic structural examination: GET-IT (Geriatric Education & Training in Texas). Reynolds Foundation Grant. Retrieved from www.hsc.unt.edu/geriatrics	
Zemper	• American College of Sports Medicine, *Exercise is Medicine* • Retrieved from http://acsm.org/	• The American College of Sports Medicine advances and integrates scientific research to provide educational and practical applications of exercise science and sports medicine.

Instruments, Scales & Tools

ACRONYMN	REFERENCE	INFORMATION
COGNITION		
Executive Dysfunction	• Kennedy, G.J. (2012). Brief evaluation of executive dysfunction: An essential refinement in the assessment of cognitive impairment. The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_d3.pdf	• Executive functioning = te ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior • Higher-level cognitive skills used to control and coordinate other cognitive processes
Mini-Cog	• Doerflinger, D.M.C. (2013). Mental status assessment of older adults: The mini-cog. The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_3.pdf	• Simple screening tool, takes 3 minutes to administer
MMSE	• Mini-Mental Status Examination	• Screens for cognitive impairment in 15 minutes or less • Copyrighted; pay for administration
MoCA	• Montreal Cognitive Assessment • Retrieved from http://www.mocatest.org/ • Doerflinger, D.M.C. (2012). Mental status assessment in older adults: Montreal cognitive assessment: MoCA version 7.1 (original version). The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_3_2.pdf	• Screening test designed to assist in detection of mild cognitive impairment • Permission to use located at web site • Test, instructions, normative data, references, available in many languages

ACRONYMN	REFERENCE	INFORMATION
SLUMS	• Saint Louis University Mental Status (SLUMS) Examination • Retrieved from http://aging.slu.edu/uploads/pdf/SLUMS%20w%20citation%20032707.pdf • Tariq, S.H., Tumosa, N., Chibnall, J.T., Perry III, H.M., Morley, J.E. (2006). The Saint Louis University mental status (SLUMS) examination for detecting mild cognitive impairment and dementia is more sensitive than the mini-mental status examination (MMSE): A pilot study. *American Journal of Geriatric Psychiatry*, 4, 900 – 910.	• An alternative screening test to the MMSE; effective for diagnosing very early Alzheimer's symptoms • 11 items; measures several aspects of cognition; scores range from 0 – 30 with scores of 27-30 considered normal in a person with a high school education; scores between 21 – 26 suggest mild neurocognitive disorder; scores between 0 – 20 indicate dementia
	END OF LIFE	
Hospice Card	• Eligibility Card • Retrieved from http://geriatrics.uthscsa.edu/tools/Hospice_elegibility_card__Ross_and_Sanchez_Reilly_2008.pdf	• Includes information on eligibility criteria; PPS; FAST; terminal condition criteria
	FUNCTION	
ADL or Katz ADL	• Katz Index of Independence in Activities of Daily Living (ADL) • Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, *10*(1), 20-30. • Shelkey, M., & Wallace, M. (2012). Katz index of independence in activities of daily living. The Hartford Institute for Geriatric Nursing. Retrieved from	• Assesses functional status as a measurement of the patient's ability to perform ADLs independently • Bathing, dressing, toileting, transferring, continence, feeding

ACRONYMN	REFERENCE	INFORMATION
	http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf	
HARP	• The Hospital Admission Risk Profile (HARP) • Sager, M.A., Rudberg, M.A., Jalaluddin, M., Franke, T., Inouye, S.K., Landefeld, C.S., Siebens, H., & Winograd, C.H. (1996). Hospital admission risk profile (HARP): Identifying older patients at risk for functional decline following acute medical illness and hospitalization. *Journal of the American Geriatrics Society*, *44*(3), 251-257; Appendix pp. 1-2. • Graf, C. (2008). The hospital admission risk profile (HARP). The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_24.pdf	• The HARP is a simple instrument that can be used to identify geriatric patients at risk of functional decline following hospitalization • Can be used to identify patients who might benefit from comprehensive discharge planning, specialized geriatric care, and experimental interventions designed to prevent/reduce the development of disability in hospitalized older populations
IADL or Lawton IADL	• Lawton Instrumental Activities of Daily Living (IADL) Scale • Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist, 9*(3), 179-186. • Graf, C. (2013). The Lawton instrumental activities of daily living (IADL) scale. The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_23.pdf	• Assess independent living skills • Ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medication, ability to handle finances
MOOD		
CAM	• Confusion Assessment Method • Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A., & Horwitz, R.	• The CAM includes 2 parts: o Part 1 is an assessment instrument that screens for

ACRONYMN	REFERENCE	INFORMATION
	(1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine, 113*(12), 941-948. • Waszynski, C.M. (2012). The confusion assessment method (CAM). The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_13.pdf	overall cognitive impairment o Part 2 includes those 4 features that have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment
CSDD	• Cornell Scale for Depression in Dementia • Alexopolous, G.S., Abrams, R.C., Young, R.C., & Shamoian, C.A. (1998). Cornell scale for depression in dementia. *Biological Psychiatry*, 23, 271-284. • Retrieved from http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf	• The CSDD is a screening tool consisting of 19 questions within 5 categories (mood related signs, behavioral disturbance, physical signs, cyclic functions & ideational disturbance) • Based on a 3 point score (0-2) where 2 is severe • Not diagnostic
GDS - SF	• Geriatric Depression Scale – Short Form • Greenberg, S.A. (2012). *The geriatric depression scale (GDS)*. The Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf	• The GDS Short Form consists of 15 questions • Questions from the Long Form GDS having the highest correlation with depressive symptoms in validation studies were selected for the short version • Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively • The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued Takes about 5 to 7 minutes to complete

ACRONYMN	REFERENCE	INFORMATION
PHQ-9	• Patient Health Questionnaire – 9 for Depression • Retrieved from http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf	• The PHQ-9 is a 9 question scale that asks about how often a cluster of symptoms that defines depression are experienced. • Questions based on 9 diagnostic criteria for major depressive disorder in the 4th edition of the DSM-IV
PAIN		
PROGNOSTICATION		
FAST	• Functional Assessment Staging Tool or Scale • Reisberg, B. (1988). Functional assessment staging (FAST). *Psychopharmacology Bulletin*, 24, 653-659. • Retrieved from http://geriatrics.uthscsa.edu/tools/FAST.pdf	• Functional scale designed to evaluate patients at moderate to severe stages of dementia • In the majority of cases, information is collected from a knowledgeable resource other than the patient
Karnofsky	• The Karnofsky Performance Scale Index • Crooks, V., Waller, S., Smith, T., & Hahn, T.J. (1991). The use of the Karnofsky Performance Scale in determining outcomes and risk in geriatric	• Classifies patients related to their functional status (impairment; • Can be utilized to compare effectiveness of therapies and to assess the prognosis in individual patients

ACRONYMN	REFERENCE	INFORMATION
	outpatients. *Journal of Gerontology, 46*,(4), M139-M144.	• The lower the Karnofsky score, the lower survival for most serious illnesses
PPS	• Palliative Performance Scale • Anderson, F., Downing, G.M., & Hill, J. (1996). Palliative performance scale (PPS): A new tool. *Journal of Palliative Care, 12*(1), 5-11. • Retrieved from http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_125.htm	• Used as a prognostic tool to predict survival • Uses 5 observer-rated domains correlated to the Karnofsky Scale • Reliable/valid tool • Correlates with actual survival & median survival time for cancer patients

Copyright © 2013. Michigan State University, College of Osteopathic Medicine, Family & Community Medicine, Division of Geriatrics. All rights reserved.
The Geriatric Fellowship (GF) Curriculum was developed through funds from the Bureau of Health Professions, Health Resources, and Services Administration (HRSA). Grant # D54HP23284.
If you would like permission to use any portion of this material, please contact Director and Principal Investigator, Carol L. Monson, DO at carol.monson@hc.msu.edu.