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**The Road Ahead in Education:
The Milestones for Geriatric Psychiatry Subspecialty Training**

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The Road Ahead in Education: The Milestones for Geriatric Psychiatry Subspecialty Training

Background: The Accreditation Council of Graduate Medical Education Milestone Project is the next step in a series of changes revamping the system of graduate medical education. In 2013, the Accreditation Council of Graduate Medical Education (ACGME) completed the general psychiatry milestones. The ACGME then pursued creation of milestones for accredited psychiatric subspecialty fellowships. This article documents the work of the geriatric psychiatry subspecialty milestones work group. It reports the history and rationale supporting the milestones, the milestone development process, and the implications for geriatric psychiatry fellowship training.

Methods: In consultation with the American Association for Geriatric Psychiatry (AAGP), the American Board of Psychiatry and Neurology (ABPN), and the ACGME Psychiatry Residency Review Committee, the ACGME appointed a working group to create the geriatric psychiatry milestones using the general psychiatry milestones as a guide.

Conclusions: The geriatric psychiatry milestones are the result of an iterative process resulting in the definition of the characteristics vital to a fellowship-trained geriatric psychiatrist. It is premature to assess their effect on psychiatric training. The true impact of the milestones will be determined as each training director uses the milestones to reevaluate their program curriculum and the educational and clinical learning environment. The ACGME is currently collecting the information about the milestone performance of residents and fellows to further refine, and determine how the milestones can best be used to assist programs in improving training.

Introduction

Concerns regarding the nature and content of medical education in the United States are first recorded in 1904 when the American Medical Association (AMA) created the Council on Medical Education (CME) tasked with restructuring American medical education. The CME established two standards: defining minimum educational requirements for medical school admission as well as the basic content of and length of medical school training. The CME charged the Carnegie Foundation with investigating the state of medical education and distilling best practices to create uniform standards (1). Abraham Flexner was chosen to lead the project. His findings were published in a 1910 report (Figure 1) which led to the creation of unified model of medical education which involved both didactic learning and apprenticeship (2). Following this, AMA reviewed graduate medical education (GME) and established the “Essentials of Approved Residencies and Fellowships” in 1928. Residencies and fellowships were reviewed and accredited by their specialty boards. The first residency review committee was formed in 1946. By the 1970’s this model was insufficient, and the AMA, the American Board of Medical Specialties, American Hospital Association, the American Association of Medical Colleges and the Council of Medical Specialty Societies together created the Liaison Committee for Graduate Medical Education in 1972 and subsequently the Accreditation Council of Graduate Medical Education (ACGME) in 1981. By the late 1980s, stakeholder and public concern regarding safety resulted in the emergence of national medical quality/safety initiatives (1, 3).

The ACGME embraced this call for greater accountability (1). Rapid advances in medical knowledge led medical educators to worry that the education and apprenticeship system implemented at the beginning of the century had lost its efficacy and no longer prepared clinicians for the lifelong learning requirements of the 21st century (1). In response, The ACGME initiated the Outcomes Project for Graduate Medical Education in 1997 in a consensus-driven effort to shift graduate medical education from a focus on required clinical experiences and didactics, to measurable outcomes for programs and learners (1, 4, 5). The project aims were an improvement in program's evaluation of residents' progress in training, greater accountability of learners and teachers, curricula development and program accreditation (1). The Dreyfus model, originally developed for pilots' skill development and later effectively applied in nursing education, was employed (1, 6, 7, 8). This extensive process produced six domains of medical "competence" which became known as the Core Competencies, implemented in 2002(9).

Six competencies were identified for all of graduate medical training: medical knowledge (MK), patient care (PC), professionalism (PROF), interpersonal communication skills (ICS), practice-based learning (PBL), and systems-based practice (SBP) (9). Sub-domains featuring the skills and features inherent in each domain were added to build an explicit map of curricular and behavioral requirements (1).

Using the ACGME competencies, the psychiatric education community established general objectives (11, 12). Since then, little was published on evidence-based

educational techniques, and thus, there is a lack of objective metrics two decades after the start of the Outcomes Project (1). This article describes the history and rationale behind the milestones, the development process for the geriatric psychiatry (GP) milestones, and their implications for fellowship training.

History and Rationale for the Next Accreditation System

Measuring the educational outcomes of the competencies established in the Outcomes project formed the core of the next evolutionary step in restructuring medical education accreditation termed the Next Accreditation System (NAS) (8). The ACGME implemented the NAS in 2013.

The milestones are a key component of the ACGME's NAS core competency outcomes measures. Milestones are descriptors and targets for performance as a fellow moves from entry, through fellowship and to graduation (1). This developmental approach assesses residents' acquisition of key knowledge, skills and attributes for each competency at each level of training, thus building the foundation for competent unsupervised practice at the completion of formal training (11).

Milestone Development

The ACGME appointed working and advisory groups to develop milestones for each specialty. In 2013, psychiatry followed other specialties that had already developed and implemented milestones, thus benefiting from the knowledge gained from these earlier efforts(14). The working groups focused on writing milestones that were clear and specific to the specialty while providing program directors flexibility in their own

assessments of residents' achievements of the competencies. Each specialty group subdivided each of the 6 competencies into the specific knowledge, skills, and attitudes relevant to the specialty (15), while maintaining consistency in the structure and basic principles between specialties.

What began as a document with a large number of subcompetencies was streamlined and simplified to become a document that combined several related subcompetencies into larger categories. Input from advisory committees, including the American Psychiatric Association (APA), American Board of Psychiatry and Neurology (ABPN), and the American Association of Directors of Psychiatry Residency Training (AADPRT), contributed to several drafts (15). The psychiatry milestones were implemented in July, 2014. Educational innovations resulted from the milestones development process, including new evaluation methods. Whereas most residencies previously used global evaluations, the presence of detailed subcompetencies defined by each specialty prompted a new approach. The milestone working group created sample evaluations matching specific rotations with specific sets of subcompetencies relevant to the rotation (available on the ACGME Psychiatry webpage) (17).

The Milestones also prompted innovation in the process of evaluation and feedback in training programs. Historically, evaluation, and feedback was primarily the domain of the training director. The ACGME mandated that evaluation and feedback expand into a group process. Residency training programs are required to create Clinical Competency Committees (CCCs) for the purpose of collectively reviewing data and assigning milestone levels to each individual at defined intervals throughout training. The psychiatry milestone working group identified the competencies of Patient

Care and Medical Knowledge as the most specialty-specific of the competencies and thus requiring the greatest customization for each specialty (14). The remaining competencies became known as “general competencies” reflecting greater commonality (16). The working group ultimately defined 22 subcompetencies that were further organized by developmentally related skills, knowledge, or attributes into 66 “threads” cutting across different levels of expertise (17). Threads identify developmental themes within subcompetencies. The process included opportunities for feedback and critique through several surveys of training directors and pilot testing (18). While the milestones have elicited criticism, it is premature to assess their effect on psychiatric training. As each training director uses the milestones to reevaluate the curriculum, as well as the educational and clinical environment of their program, it is anticipated that the milestones will demonstrate a significant impact (19).

The Subspecialty (GP) Milestones

With the specialty milestones completed and implemented, the ACGME’s addressed milestone development for subspecialty fellowship programs by first forming working and advisory groups for each subspecialty. The psychiatry subspecialties were: Addiction Psychiatry, Child and Adolescent Psychiatry, Forensic Psychiatry, Geriatric Psychiatry (GP), and Psychosomatic Medicine. For GP, the ACGME formed groups with input from the American Association for Geriatric Psychiatry (AAGP) and the ABPN. The members were geriatric psychiatry educators, including current and former fellowship directors, who worked in diverse clinical settings. Two of the members, who are also authors of this article, are members of the Psychiatry Residency

Review Committee (RRC) of the ACGME (IA and JC) and one member participated in the beta test of the psychiatry milestones (SS).

The subspecialty milestones are based on the model established in the general psychiatry milestones. Subspecialty committee chairs started by writing a draft of the four general competencies most common to all of the subspecialties. All of the psychiatry subspecialty working groups met in June, 2014, tasked with developing the Patient Care and Medical Knowledge competency milestones for their respective subspecialties. The GP working group then turned to the general competencies for psychiatric subspecialties; collaboratively editing the competencies and defining sub-competencies meaningful to geriatric psychiatry and appropriately flexible for use in diverse training programs and settings.

The major changes from the general psychiatry milestones occur in the Patient Care and Medical Knowledge milestones. The GP working group used core competencies developed by Lieff et al, in 2005 (20), as the framework for creating the Medical Knowledge competencies.

Rationale for the chosen core competencies and subcompetencies

The GP milestone working group reviewed the ACGME psychiatry milestones, the subspecialty competencies outlined by the AAGP and the ABPN, and identified themes common to each list and reflective of GP fellowship training programs. Table 1 provides

a comparison of approaches taken by the ACGME, the AAGP, and the ABPN in categorizing the medical knowledge competency for geriatric psychiatry. The GP working group then explored the appropriate level of detail for the milestones that would allow program directors the flexibility to customize their curriculum built upon individual program strengths and resources. The group considered the heterogeneity of GP fellowship training programs' clinical populations and settings as well as the constraints of a one year training period common to most fellowships. A robust discussion focused on the generation of milestones that were inclusive, limited in number and with neither an overly narrow focus nor too much detail.

The major changes from the general psychiatry milestones occur in the Patient Care and Medical Knowledge milestones. The working group summarized the Patient Care subcompetencies into 3 categories: Geriatric Psychiatric Evaluation and Differential Diagnosis, Geriatric Therapeutic Modalities, and Treatment Planning and Management. Patient Care milestones build upon residency milestones while adding specific milestones addressing the unique nature geriatric care. Each of these was further broken into 3 milestone threads on which the milestone progress for the fellows would be tracked. The Evaluation and Differential Diagnosis milestone threads emphasize interview skills modified to the patient's needs, functional and neurocognitive assessments, as well as collateral information from family and caregivers culminating in differential diagnoses which reflect the psychiatric, cognitive, and medical basis of illness. Therapeutic modalities milestone threads include somatic, psychotherapy, behavioral, and environmental interventions. Treatment planning and management

milestone threads reflect the collaborative interdisciplinary nature of geriatric care with attention to patient safety, self-determination, and decisional capacity.

Medical Knowledge Milestones were summarized into 3 subcompetencies:

Development through Later – life, Psychopathology including the presentation of psychiatric disorders in diverse older adult populations, and Treatment and Management. Each subcompetency was further broken into 3 milestone threads in which specific milestones were conceptually linked across the developmental levels as progress within a specific area of competency. Development through Later-life encourages a knowledge of developmental theories across all developmental domains in later-life development, knowledge of pathological and environmental influences on later-life, and knowledge of the impact of life events, functional change, and general medical health on later-life. The Psychopathology Milestones outline the expectation that fellows identify and treat psychiatric conditions in settings including inpatient, clinic, assisted living, long-term care, and community home care. Fellows are also expected to know how to assess risk, determine the level of care need for older adults, and interface with other clinical disciplines. Treatment and Management establishes subcompetencies for somatic therapies, and non-pharmacological therapies including behavioral interventions and psychotherapies within the context of the clinical setting of care.

After the Patient Care and Medical Knowledge subcompetencies were completed, the working group reviewed the 4 general competencies for psychiatric subspecialties and edited these more specifically for geriatric psychiatry. For **Systems Based Practice**, there are four subcompetencies. The first subcompetency of **Patient Safety and the**

Health care Team emphasizes that the Geriatric Psychiatrist should be adept in recognizing special patient or family circumstances that affect discharge planning, such as the patient admitted from home and assessed to be unsafe in the home and now requiring a transition to a more structured level of care. The Geriatric Psychiatrist will negotiate patient centered care among multiple care providers, participate in a team-based approach to quality improvement activities, and follow regulatory requirements. Fellows should progress to a leadership and/or patient advocate role, ensuring accurate transitions of care across systems and the continuum of care. The GP working group adopted the **Resource Management** Milestone subcompetency and added the expectation that the Geriatric Psychiatrist is aware of health care funding and regulations related to organization of health care services. **Community Based** subcompetency milestone threads were adapted to reflect the expectation that the Geriatric Psychiatrist will not only describe, but also make use of local health care delivery systems. Geriatric Psychiatrists will employ principles of evidence-based practice and patient and family-centered care in the management of chronically-ill patients. The GP group edited the Consultation Milestone subcompetency milestone threads to reflect the Geriatric Psychiatrist role as consultant and collaborator involved in activities specific to the older adult. The working group maintained the number and structure of the Practice Based Milestones. A Practice Based Quality Improvement subcompetency was not included in the Geriatric Psychiatry Fellowship Milestones due to the lack of any requirement for a formal quality improvement project during fellowship training, and this subcompetency is adequately addressed in general psychiatry training. The **Practice Based Learning and Improvement competency**, with its 2

subcompetencies, for Geriatric Psychiatry expands the role of teaching from that expected for the Psychiatry Resident. This reflects the important role of the Geriatric Psychiatrist in the development, organization and presentation of didactic presentations for early, mid-level and advanced learners. The GP working group maintained the 2 subcompetencies for **Professionalism**, adding the expectation that the Geriatric Psychiatrist recognizes and adapts an approach based on geriatric psychiatry-related issues of diversity and special needs populations, leads educational activities regarding ethical issues, and participates in the geriatric psychiatry professional community. The GP working group revised **Interpersonal and Communication Skill's 2** subcompetencies to place greater emphasis on the Geriatric Psychiatrist taking a leadership role in multidisciplinary care teams, and recognizing the differing philosophies within and between different disciplines while managing interdisciplinary team conflicts. The geriatric psychiatrist is also expected to sustain relationships with geriatric patients across systems of care during long-term follow-up. The Information Sharing and Record Keeping subcompetency was revised to emphasize the importance of demonstrating communication strategies insuring geriatric patient and family understanding regardless of limited communication or neurocognitive abilities, and/or sensory impairments as well as adhering to professional privacy regulations.

The summary of final competencies, with their 16 subcompetencies, and milestone threads are listed in Table 2. The GP working group faced challenges common to other subspecialty groups in choosing a range of milestone levels corresponding to what fellows could reasonably achieve within the limits of a 1 year program. The GP milestones reflect the same 4 subcompetency levels ranging from an entering (level 1)

to a graduate trainee (level 4) and including a fifth “aspirational” level to describe trainees exceeding expectations. Recognizing the heterogeneity of entering fellows, the working group included a “beginner level” (level 1) for fellows with limited GP experience while acknowledging that many residents enter their fellowship year at a level 2 or 3 for some subcompetencies (Table 2.). Level 5 describes a fellow operating at an advanced level, such as leadership role, and gives training directors the broadest possible developmental range.

Feedback and Modifying the Milestones

The ACGME reviewed the initial draft and offered critique which the GP working group incorporated into a revised document. The ACGME then sought feedback on the revised document from geriatric psychiatry fellowship directors. This feedback was collated and returned to the GP working group for review and incorporation. The final document contained 16 competencies and 41 threads.

Dissemination and Implementation

The final draft of the GP milestones were posted by the ACGME in October, 2014, with implementation in GP fellowship programs in July, 2015 (21).

Implications of the Milestones on Fellowship Programs and Recommendations

The GP milestones will improve the process of assessment and feedback during fellowship training by providing objective, standardized criteria for evaluation. In turn, this facilitates semi-annual feedback meetings and allows for a clear description of the fellow's progress as well as identifies deficiencies for remediation (21). In addition, the milestones will shape the evaluation of the fellow by the clinical competency committee (CCC) (22). The CCC will review fellow evaluations and identify the milestones achieved by each trainee at the midpoint and near the conclusion of the fellowship training year. Given this short training period, the CCC will have a significant role in identifying potential deficiencies and making corrective plans that will positively influence the fellow's training. The milestones will also encourage and improve the fellow's own self-assessment as they progress through training and career. Individual programs may also use the milestones to identify opportunities for program development or modification. All residencies and fellowships are expected to submit the milestones data on all of their residents and fellows. However, this data are not currently being used to evaluate the individual programs. Accreditation decisions are not based on the data submitted. The ACGME is collecting the data about the milestone performance in an effort to further refine the milestones and determine how they can best be used to assist programs in improving training. A future project could examination of training directors' perception of the utility of the Milestones in helping them to reevaluate their program curriculum and the educational and clinical learning environment.

We anticipate that the implementation of milestones will require new and innovative methods of fellow assessment (23). Unlike the general psychiatry milestone working

group which developed sample assessment instruments, the subspecialty working groups left each individual program to modify or create milestone evaluation tools (22). Even though each fellowship program is unique, the challenges for milestone assessment are not. GP fellowship program directors have a great deal to contribute through group development of standardized assessments which limit administrative burden and improve the quality of assessments.

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Figure 1.

Timeline of Milestone Development

1910 – Flexner Report
1928 – Essentials of Approved Residencies and Fellowships
1946 – First Residency Review Committee
1972 – Liaison Committee for Graduate Medical Education
1981 – ACGME Established
1997 – ACGME initiated the Outcomes Project
2001 – Outcomes Project implementation
2002 – Six general competencies to assess resident competence
2008 – Milestones Project started
2013 – Next Accreditation System is launched
2013 – Psychiatry Milestones developed
2014 – Psychiatry Milestones are in effect

A timeline of key events in the history of graduate medical education leading up to the milestones.

Table 1. Comparison of Approaches to Categorizing the Medical Knowledge Competency for Geriatric Psychiatry

Medical Knowledge	ACGME (20)	AAGP (19)	ABPN (24)
MK1--Development through Later-life	<p>A. Knowledge of developmental theories across all developmental domains in later-life development</p> <p>B. Knowledge of pathological and environmental influences on later-life</p> <p>C. Knowledge of the impact of life events, functional change, and general medical health on later-life⁶</p>	<p>Theories of aging, physiology, pharmacokinetics, ect, sexuality, neurological, medical & functional problems.</p> <p>Psychological development and adaptation</p>	<p>Theories of aging - biological, social, and psychological</p> <p>b. Age-related changes in organ systems, sensory systems, memory, and cognition</p> <p>c. Pharmacologic implications of biological changes</p> <p>d. Pharmacokinetics and pharmacodynamics e. Special considerations in the use of psychotropics in the elderly</p>

<p>MK2 – Psychopathology: Presentation of Psychiatric Disorders in Diverse Older Adult Populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)</p>	<p>A. Knowledge to identify and treat psychiatric conditions in a variety of treatment settings</p> <p>B. Knowledge to assess risk and determine level of care</p> <p>C. Knowledge regarding the interface of geriatric psychiatry and other clinical disciplines</p>	<p>Psychopathology, cultural and ethnic differences, minority groups, caregiver and family issues, institutionalization and impact on individuals and families</p>	<p>Cultural and ethnic differences and special problems of disadvantaged Geriatric minorities Caregiver and family issues (1) Epidemiology of late-life conditions (2) Clinical presentation of late-life conditions (3) Pathogenesis of late-life conditions (4) Diagnostic approach and differential diagnoses of late-life conditions (5) Suicidal and parasuicidal behavior 2. Psychopathology and geriatric presentations in regard to the following disorders: a. Mood disorders b. Anxiety disorders c. Adjustment disorders/ bereavement d. Delirium e. Dementia f. Psychotic disorders g. Substance-related disorders h. Mental disorders due to a general medical condition including acute and chronic physical illnesses as well as iatrogenesis i. Sleep disorders j. Sexual disorders 4. Sexuality in late life 5. Common neurologic disorders of the elderly, e.g., Parkinson's, stroke 6. Psychiatric disorders due to general medical conditions a. Complications of medical treatment for systemic disease b. Psychological factors affecting physical illness</p>
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MK3 – Treatment and Management	A. Somatic therapy		1. Recognize drug interactions, non-compliance, and psychiatric manifestations of iatrogenic influences, such as multiple or overmedication as well as strategies to correct these issues 2. Recognize indications for, side effects of, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging, including changes in pharmacokinetics and pharmacodynamics. 3. Apply appropriate indications for and use of electroconvulsive therapy appropriately in the elderly. 4. Frequency and management of side effects, polypharmacy and drug interactions in the elderly.
	B. Non-pharmacological therapies	Psychotherapeutic principles and practice, personality disorders, psychological and behavioral-therapeutic techniques, group and activity therapies.	1. Understand psychodynamics in relationship to developmental problems, conflict, and adjustment difficulties in the elderly that may complicate the clinical management and influence the doctor-patient relationship or treatment planning. 2. Use of nonpharmacologic approaches, with particular reference to applications and limitations of behavioral therapeutic strategies including physical restraints.
	C. Clinical settings of care	Practice related and policy and legal issues. Forensic, economic aspects of care. Title III	1. Role of geriatric psychiatrist in health care systems. 2. Elder abuse 3. Forensic issues 4. Current economic aspects of health care

Table 2. Summary of the Geriatric Psychiatry Milestones* (19)				
Level 1	Level 2	Level 3	Level 4	Level 5
Competency**: Patient Care (PC) Subcompetency***: PC1---Geriatric psychiatric evaluation and differential diagnosis: Gathers data using geriatric-specific interview skills, collateral information, functional assessments, neurocognitive assessment; organizes and summarizes findings and generates a differential diagnosis Threads****: Geriatric-specific interview skills, including use of collateral information and functional assessment as indicated, Neurocognitive assessment, Organization and summary of findings and generation of differential diagnosis				
Consistently obtains complete, accurate, and relevant general psychiatry history and mental status; describes the elements of functional assessment; describes elements of neurocognitive assessment	Obtains complete, accurate, and relevant geriatric psychiatry history and mental status; Usually obtains and documents functional assessment; Develops a basic differential diagnosis for common geriatric syndromes	Routinely identifies subtle and unusual findings in geriatric psychiatry history and mental status; Performs efficient functional assessment with flexibility appropriate to the clinical setting and workload demands; Performs the neurocognitive assessment and selects appropriate laboratory and imaging tests, and refers for neuropsychological testing as indicated; Develops a full differential diagnosis while avoiding premature conclusions	Skillfully obtains and synthesizes collateral information while preserving patient autonomy; Integrates functional assessment with other clinical data; Integrates findings from neurocognitive assessment with other clinical data; Synthesizes clinical data into a comprehensive, stratified differential diagnosis	Teaches and supervises other learners in the geriatric psychiatry evaluation and differential diagnosis

Subcompetency: PC2---Geriatric therapeutic modalities: Includes somatic and psychotherapies as well as behavioral and environmental interventions Threads: Somatic Therapies, Psychotherapies, Behavioral and Environmental Interventions				
Applies knowledge of the general principles of psychopharmacology; Establishes and maintains a therapeutic alliance and professional boundaries while providing psychotherapies to patients with uncomplicated problems	Applies knowledge of the geriatric psychopharmacology principles; Establishes and maintains a therapeutic alliance with older adults; Identifies behavioral and environmental factors that impact psychiatric presentations	Applies principles of geriatric psychopharmacology and treatment response in the selection and management of somatic therapies; Integrates the selected psychotherapy with other treatment modalities and other providers of care; Provides behavioral and environmental interventions when clinically appropriate	Titrates dosage and manages side effects of multiple medications based on principles of geriatric psychopharmacology in patients with significant medical comorbidities; Appropriately selects evidence-based somatic treatment options for patients whose symptoms are partially responsive or not responsive to treatment; Selects a psychotherapeutic modality and tailors the selected psychotherapy to the patient on the basis of an appropriate case formulation; Integrates behavioral and environmental setting intervention appropriately with other treatment modalities	Explains less common somatic treatment choices to patients/families in terms of proposed mechanisms of action; Integrates emerging studies of geriatric therapeutic modalities into clinical practice

Subcompetency:PC3---Treatment planning and management: Participates in the development, management and periodic review of inter-professional treatment plans; manages geriatric patient safety issues and evaluates and manages issues of self-determination and decisional capacity

Threads: Participates in the development, management, and periodic review of inter-professional treatment plans

Manages geriatric patient safety issues, Evaluates and manages issues re: self-determination and decisional capacity

Establishes treatment goals with the patient; Recognizes geriatric patient in crises or acute presentation; Recognizes issues of self-determination and decisional capacity in the general psychiatric patient	Identifies additional disciplines to address treatment goals specific to the needs of a geriatric patient; Manages geriatric patient crises with supervision; Recognizes issues of self-determination and decisional capacity in the geriatric psychiatric patient	Devises and modifies, as needed, individualized patient-centered treatment plans for common presentations; Manages most geriatric patient crises while recognizing the need for consultation and supervision for complicated or refractory cases; Routinely identifies and manages issues of patient self-determination and decisional capacity	Devises and modifies, as needed, individualized patient-centered treatment plans for complex presentations; Integrates multiple modalities and providers in a comprehensive approach; Consistently identifies and manages geriatric patient safety issues; Consistently and proactively identifies and manages issues of patient self-determination and decisional capacity	Supervises treatment planning of other trainees and multidisciplinary providers; Provides written report and/or oral testimony in a legal setting
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Medical Knowledge (MK)

Subcompetency: MK1---Development through later life: Knowledge of developmental theories across all developmental domains; pathological and environmental influences and the impact of life events, functional change and general medical health in later-life

Threads: Knowledge of developmental theories across all developmental domains in later-life development

Knowledge of pathological and environmental influences on later-life, Knowledge of the impact of life events, functional change, and general medical health on later-life

Describes the influence of psychosocial factors (gender, ethnic, economic) of general medical and neurological illness on personality development	Demonstrates basic knowledge of the major developmental theories across all developmental domains in later-life development; Identifies pathological and environmental factors that commonly occur in later-life and may impact later-life development; Describes common life events, functional change, and general medical conditions occurring in later-life	Describes the impact of pathological and environmental factors on later-life	Compares and contrasts the theories of later-life development; Analyzes and discusses the influence of pathological and environmental factors on later-life; Describes and evaluates the impact of life events, functional change, and general medical health on the expression of psychopathology in later-life	Incorporates new neuroscientific knowledge into understanding of later-life development
<p>Subcompetency:MK2---Psychopathology: Knowledge to identify and treat psychiatric conditions, assess risk and determine level of care and knowledge regarding the interface of geriatric psychiatry and other clinical disciplines in diverse older adult populations in a variety of treatment settings</p> <p>Threads: Knowledge to identify and treat psychiatric conditions in a variety of treatment settings, Knowledge to assess risk and determine level of care, Knowledge regarding the interface of geriatric psychiatry and other clinical disciplines</p>				

Demonstrates sufficient knowledge to identify and treat most psychiatric conditions throughout the life cycles and in a range of treatment settings' Displays knowledge of and the ability to weigh risk and protective factors for danger to self and/or others across the life cycle and the ability to determine the need for acute psychiatric hospitalization	Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in later-life; Displays knowledge of and the ability to weigh risk and protective factors for danger to self and/or others in older adults and the ability to determine the need for appropriate level of care; Describes the use of screening and evaluation tools to identify geriatric psychiatric conditions in the general medical patient population	Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in later-life and in a range of treatment settings; Recognizes the impact of functional and neurocognitive impairments on safety in older adults; Demonstrates knowledge sufficient to recognize medical conditions in geriatric psychiatry patients	Demonstrates sufficient knowledge to identify and treat atypical and complex psychiatric conditions in later-life and in a range of treatment settings; Consistently displays knowledge sufficient to determine the appropriate level of care for patients who are expressing or representing danger to self and/or others, or who are functionally or neurocognitively impaired; Consistently demonstrates knowledge sufficient to systematically screen for, evaluate, and diagnose complex clinical conditions in geriatric psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other clinical disciplines	Demonstrates knowledge sufficient to teach assessment of risk and determination of the appropriate level of care for geriatric patients who may represent danger to self and/or others; Demonstrates sufficient knowledge to identify and treat uncommon psychiatric conditions in geriatric patients with medical disorders; Demonstrates sufficient knowledge to identify uncommon medical conditions in geriatric patients with psychiatric disorders
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Subcompetency: MK3---Treatment and management: Somatic and non-pharmacological therapies and clinical settings of care Threads: Somatic therapy, Non-pharmacological therapies, Clinical settings of care				
Demonstrates an understanding of psychotropic and other somatic treatment modality selections based on current practice guidelines or treatment algorithms for common psychiatric disorders; Demonstrates an understanding of the basic principles, indications, contraindications, benefits, and risks of individual, couples, group,	Describes the principles of geriatric physiology and psycho-pharmacology; Describes the basic techniques of evidence-based individual psychotherapies in geriatric patients; Describes the applicable regulations for billing and reimbursement	Demonstrates an understanding of evidence-based psychotropic and other somatic treatment modality selections for common psychiatric disorders among geriatric patients; Describes principles of behavioral management and environmental interventions in various clinical care settings; Describes federal and state regulations regarding the care of geriatric psychiatric patients in different clinical care settings	Demonstrates a comprehensive understanding of the principles of geriatric physiology and psychopharmacology as they relate to the initiation, titration, and the side-effect management of somatic therapies; Critically appraises the evidence for efficacy of non-pharmacological therapies with and without concomitant pharmacotherapy; Describes how to seek out and integrate new information on the practice of geriatric psychiatry	Incorporates emerging studies and new theoretical developments of geriatric therapeutic modalities into knowledge base; Demonstrates sufficient knowledge of geriatric therapeutic modalities to teach others effectively
Competency: Systems-based practice (SBP) Subcompetency: SBP1---Patient safety and the health care team Threads: Medical errors and improvement activities, Communication and patient safety, Regulatory and educational activities related to patient safety				

Describes the common system causes for errors; Follows institutional safety policies, including reporting of problematic behaviors and processes, errors, and near misses; Actively participates in conferences focusing on systems-based	Describes systems and procedures that promote patient safety; Effectively and regularly utilizes all appropriate forms of communication to ensure accurate transitions of care and to optimize communication across systems and the continuum of care; Follows regulatory requirements related to reporting requirements	Recognizes special patient or family circumstances that will affect discharge planning; Negotiates patient-centered care among multiple care providers	Participates in a team-based approach to medical error analysis, including quality improvement projects; Takes a leadership role in ensuring accurate transitions of care and optimizing communication across systems and the continuum of care; Develops content for and facilitates a patient safety presentation or conference focusing on systems-based errors in patient care (e.g., a morbidity and mortality [M&M] conference, root cause analysis meeting)	Leads multidisciplinary teams (e.g., human factors engineers, social scientists) to address patient safety issues; Participates in quality management and patient safety activities within the health
Subcompetency: SBP2---Resource management: costs of care and resource management				

Recognizes disparities in health care at individual and community levels; Knows the relative costs of care (e.g., medication costs, diagnostic costs, level-of-care costs, procedure costs)	Coordinates patient access to community and system resources; Is aware of health care funding and regulations related to organization of health care services	Balances the best interests of the patient and family with the availability of resources; Uses all aspects of the Electronic Medical Record (EMR) and other resources to improve patient safety and quality of care	Practices cost-effective, high-value clinical care, using evidence-based tools and information technologies to support decision making	Designs measurement tools to monitor and provide feedback to providers/ teams on resource consumption to facilitate improvement; Advocates for improved access to and additional resources within systems of care
SBP3---Community-based Care: Community-based programs, self-help groups and recovery and rehabilitation Threads: Community-based programs, Self-help groups, Recovery and rehabilitation				
Describes, and makes use of, local health care delivery systems	Coordinates care with community services related to aging and care of older adults; Recognizes role and explains importance of self-help groups and community resource groups (e.g., family-based and disorder-specific support and advocacy groups)	Incorporates support and self-help groups, community agencies, and social networks in clinical care; Appropriately refers to rehabilitation, recovery programs, and/ or alternative residential settings	Uses principles of evidence-based practice and patient- and family-centered care in management of chronically-ill patients; Practices effectively in a rehabilitation, recovery-based program , and/ or alternative residential settings	Participates in the administration of community-based treatment programs; Participates in creating new community-based programs; Demonstrates capacity to provide medical-psychiatric leadership to community-based programs and groups
Subcompetency: SBP4---Consultation to non-psychiatric medical providers and non-medical systems and provides care as a consultant and collaborator in a variety of settings Threads: Provides care as a consultant and collaborator, Specific consultative activities				

Provides consultation to other medical services; Clarifies the consultation question	Assists primary treatment team in identifying unrecognized clinical care issues; Discusses methods for integrating mental health and medical care in geriatric treatment planning	Provides integrated care for geriatric psychiatric patients through collaboration with other physicians and advanced level practitioners; Identifies system issues in clinical care and provides recommendations	Manages complicated and challenging consultation requests; Leads a consultation team	Provides psychiatric consultations to larger systems
Competency: Practice-Based Learning and Improvement (PBLI) Subcompetency: PBL1--- Development and execution of lifelong learning through ongoing self-evaluation, including critical evaluation of research and clinical evidence Thread : Self-assessment and self-improvement, Incorporation of evidence into clinical practice				
Regularly seeks and incorporates feedback to improve performance; Identifies self-directed learning goals and periodically reviews them with supervisory guidance; Formulates a searchable question from a clinical question ¹¹	Demonstrates a balanced and accurate self-assessment of competence, using clinical outcomes to identify areas for continued improvement; Selects an appropriate, evidence-based information tool ¹² to meet self-identified learning goals; Critically appraises different types of research, including randomized controlled trials (RCTs), systematic reviews, meta-analyses, and practice guidelines	Demonstrates improvement in clinical practice based on ongoing self-assessment and evidence-based information; Independently searches for and discriminates evidence relevant to clinical practice problems	Identifies and meets self-directed learning goals with little external guidance; Demonstrates use of a system or process for keeping up with relevant changes in medicine ¹¹	Sustains practice of self-assessment and keeping up with relevant changes in medicine, and makes informed, evidence-based clinical decisions; Teaches others techniques to efficiently incorporate evidence gathering into clinical practice; Independently teaches appraisal of clinical evidence

Subcompetency: PBL2---Teaching: development as a teacher and demonstrates observable teaching skills

Threads: Development as a teacher, Observable teaching skills

Assumes a role in the clinical teaching of early, mid-level, and advanced learners; assists faculty members in providing supervision to these learners; Communicates goals and objectives for instruction of early, mid-level, and advanced learners	Participates in activities designed to develop and improve teaching skills; Evaluates and provides feedback to early, mid-level, and advanced learners	Gives informal and formal didactic presentations to groups (e.g., grand rounds, case conference, journal club); Organizes content and methods for individual instruction for early, mid-level, and advanced learners	Develops and gives geriatric psychiatry-specific presentations to groups; Effectively uses feedback on teaching to improve teaching methods and approaches	Educates broader professional community and/or public (e.g., presents at regional or national meeting); Organizes and develops curriculum materials
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Competency: Professionalism (PROF)Subcompetency: PROF1---Compassion, integrity, reflection, respect for others, sensitivity to diverse patient populations, adherence to ethical principles

Threads; Compassion, reflection, sensitivity to diversity, Ethics

Demonstrates capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity; Provides examples of the importance of attention to diversity in psychiatric evaluation and treatment; Recognizes ethical conflicts in practice and seeks supervision to manage them	Elicits beliefs, values, and diverse practices of patients and their families, and discusses their potential impact on geriatric patient care; Routinely displays sensitivity to diversity in geriatric psychiatric evaluation and treatment; Recognizes ethical issues in practice and is able to discuss, analyze, and manage these in common geriatric clinical situations	Develops a mutually-agreeable geriatric care plan in the context of conflicting physician and patient and/or family values and beliefs; Discusses own cultural background and beliefs and the ways in which these affect interactions with geriatric patients; Systematically analyzes and manages ethical issues, including those specific to geriatric psychiatry	Recognizes and adapts approach based on geriatric psychiatry-related issues of diversity and special needs populations; Leads educational activities and case discussions regarding ethical issues specific to both general psychiatry and the subspecialty; Adapts to evolving ethical standards (i.e., can manage conflicting ethical standards and values and apply these to practice)	Serves as a role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient populations; Identifies emerging ethical issues within sub-specialty practice and can discuss opposing viewpoints; Adapts to evolving ethical standards (i.e., can manage conflicting ethical standards and values and apply these to practice); Systematically analyses and manages ethical issues and complicated and challenging geriatric clinical situations
Subcompetency: PROF2---Accountability to self, patients, colleagues and the profession: Fatigue management, work balance, professional behavior and participation in professional community and ownership of patient care Threads: Fatigue management and work balance, Professional behavior and participation in professional community, Ownership of patient care				

Notifies team and enlists appropriate coverage for clinical and non-clinical responsibilities when fatigued or ill; Follows institutional policies for physician conduct and responsibility; Accepts the role as the patient's physician and takes responsibility (under supervision) for ensuring that the patient receives the best possible care	Identifies and manages situations in which maintaining personal, emotional, physical, and mental health is challenged, and seeks assistance when needed; Recognizes the importance of participating in the geriatric psychiatry professional community; Is recognized by self, patient, patient's family, and medical staff members as the patient's geriatric psychiatric provider	Knows how to take steps to address impairment in self and in colleagues; Prepares for obtaining and maintaining board certification in geriatric psychiatry; Displays increasing autonomy and leadership in taking responsibility for ensuring that geriatric psychiatry patients receive the best possible care	Prioritizes and balances conflicting interests of self, family, and others to optimize medical care and practice of profession; Participates in the geriatric psychiatry professional community (e.g., professional societies, patient advocacy groups, community service organizations); Serves as a role model in demonstrating responsibility for ensuring that geriatric psychiatry patients receive the best possible care	Develops physician wellness programs or interventions and/or participates as an active member on committees or in organizations that address physician wellness; Develops organizational policies, programs, or curricula for geriatric psychiatry professionalism
Competency: Interpersonal and Communication Skills (ICS) Subcompetency: ICS1---Relationship development and conflict management with patients, families, colleagues and members of the health care team: Self-assessment and self-improvement and incorporation of evidence into clinical practice Threads: Relationship with patients and families, Conflict management, Team-based care				

Develops therapeutic relationship with adult patients and their families in uncomplicated situations; Is aware of cultural diversity in communicating with people of different backgrounds; Recognizes communication conflicts in work relationships; Is able to collaborate with team members in patient care	Is respectful of cultural diversity in discussions and management suggestions with geriatric patients and their families; Develops working relationships across specialties and systems of care in uncomplicated situations; Negotiates and manages simple geriatric patient/family-related conflicts; Actively participates in team-based care; supports activities of other team members, and communicates their value to the geriatric patient and family	Develops therapeutic relationships in complicated situations; Sustains working relationships in the face of conflict; Takes a leadership role in a multidisciplinary care team; Recognizes differing philosophies within and between different disciplines in care provision	Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care; Sustains relationships across systems of care and with geriatric patients during long-term follow-up; Manages interdisciplinary team conflicts as team leader; Effectively leads multidisciplinary geriatric patient care and family meetings	Develops models/ approaches to managing difficult communications; Effectively mentors other health care providers in leadership, communication skills, and conflict management; Designs research or quality improvement project on the benefits of team-based care
<p>Subcompetency: ICS2---Information sharing and record keeping: Accurate and effective communication with the health care team and patients, maintaining professional boundaries in communication</p> <p>Threads; Accurate and effective communication with health care team, Effective communications with patients, Maintaining professional boundaries in communication</p>				

<p>Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care;</p> <p>Ensures that the written record (electronic medical record [EMR], personal health records [PHR]/patient portal, hand-offs, discharge summaries, etc.) are accurate and timely, with attention to preventing confusion and error, consistent with institutional policies;</p> <p>Organizes both written and oral information to be shared with patient, family, team, and others;</p> <p>Maintains appropriate boundaries in sharing information by electronic communication and in the use of social media;</p> <p>Adheres to professional regulations regarding HIPAA and Privacy Act</p>	<p>Uses easy-to-understand language in all phases of communication, including working with interpreters and geriatric patients;</p> <p>Consistently demonstrates communication strategies to ensure geriatric patient and family understanding;</p> <p>Demonstrates appropriate face-to-face interaction while using EMR</p>	<p>Demonstrates effective verbal communication with geriatric patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent;</p> <p>Demonstrates written communication with geriatric patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent;</p> <p>Consistently engages geriatric patients and families in shared decision making</p>	<p>Demonstrates communication with geriatric patients who have limited communication, neurocognitive abilities, and/or sensory impairments that is appropriate, efficient, concise, and pertinent ;</p> <p>Recruits appropriate assistance from external sources when cultural differences create barriers to geriatric patient care;</p> <p>Uses discretion and judgment in the inclusion of sensitive patient material in the medical record;</p> <p>Uses discretion and judgment in electronic communication with geriatric patients, families, and colleagues</p>	<p>Participates in the development of changes in rules, policies, and procedures related to communication technology;</p> <p>Engages in scholarly activity (e.g., teaching, research) regarding teamwork, conflict management, and privacy issues</p>
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***Milestones:** Specific behaviors, attributes or, developmental outcomes linked to competencies
****Competencies:** A set of skills that can be demonstrated progressively by fellows from the beginning of their education through graduation to unsupervised practice in their specialties, e.g., *Patient Care*
*****Subcompetencies:** More specific aspects of Competencies, e.g., *Psychiatric evaluation and differential diagnosis*
******Threads:** A type of activity, behavior, skill, or knowledge, typically consisting of two-to-four milestones extending across the 4 - 5 levels, e.g., *Geriatric interview skills..*