**TO:**
**MARIANO LOPEZ, JR. MD**
President
Philippine College of Physicians, Inc.

Thru:

**BIEN MATAWARAN, MD**
Chair, Committee on Subspecialty Societies
Philippine College of Physicians, Inc.

**RE: PHILIPPINE COLLEGE OF GERIATRIC MEDICINE (PCGM) PLAN TO REQUEST FOR DUAL SUBSPECIALTY RECOGNITION FROM THE PHILIPPINE ACADEMY OF FAMILY PHYSCIANS (PAFP)**

## I. Introduction

The increasing Filipino elderly population in the next 30 years is a challenge to the healthcare needs of our country. The 2010 census-based population projections predict that in 2045, the Philippine population will be 142 million. The proportion of older persons is estimated at 7-9% *(Manila Bulletin, 2012)* or will be a good 10 to 12 million; with the females (55.8 per cent) outnumbering the males (44.2 per cent).

Health wise, chronic degenerative diseases will dominate mortality and morbidity indices. Therewill be a shift of treatment goals from cure to control, prevention, palliation, and quality of life improvement, requiring transitions in diagnostic indices, treatment foci, monitoring tools and outcomes. These paradigm shifts in health care calls for a unique set of competencies from the healthcare professional who can answer the above requirements. ***A subspecialist in geriatric medicine is trained to deliver this older person-centered care*** (*PCGM, 2011*) recognizing the latter's age-related physiologic changes, comorbid diseases, pharmacokinetics, functional decline, vulnerability and other unique health care needs.

A subspecialist in geriatric medicine practices the highest standards of professional elder care and behaves under a code of ethics that respects the rights, autonomy and dignity of the older Filipino, and champions her health and quality of life.

Aspiring geriatricians should be able to pass the subspecialty examination administered by the Philippine Subspecialty Board of Geriatric Medicine (PSBGM) before being called subspecialists. The multidisciplinary composition of the PSBGM (Appendix A) allows for a holistic and comprehensive diplomate examination for either internist or family physician who had geriatric medicine fellowship

training. Only board-certified internists or family physicians can complete the two (2) years of subspecialty training in hospitals/settings accredited by the PSBGM *(PCGM, 2011)*.

## II. History of The Philippine College Geriatric Medicine

The Philippine College of Geriatric Medicine (PCGM) is THE professional organization of subspecialists in Geriatric Medicine in the country, and the only professional organization in Geriatric Medicine recognized by the Philippine Medical Association (PMA). It was organized in 2011, as a subspecialty society of the Philippine College of Physicians (PCP).

Formed by an imperative of the PMA by virtue of the Philippine affiliation with the Medical Association of Southeast Asian Nations (PRC, 2015) and the Philippine Qualifications Framework (PQF) (Executive Order No.83), PCGM was organized in 2011 through the union of two (2) previous geriatric organizations: the Philippine College of Geriatrics and Gerontology, Inc. (PCGGI), an affiliate society of the Philippine Medical Association (PMA) and the Philippine Society of Geriatric Medicine (PSGM), the original component society of the PCP. Being recognized as a subspecialty society of the PCP, PCGM was launched during the 2011 PCP Convention, attended by Fellows of the PCGM, who were the multispecialty members—internists and family physicians-- of the two (2) previous societies who became Fellows by virtue of a grandfather's clause.

## III. Statement of the Problem:

The membership of PCGM can only grow by pursuing its vision of training, certifying, and credentialing geriatricians. Training regulation is through accreditation of different fellowship training programs that are established all over the country by the Philippine Subspecialty Board of Geriatric Medicine (PSBGM).

To date, PCGM has One Hundred Fifty Two (152) Members: active are one-hundred four (104). Of the active members, seventy-two (72) are internists, and thirty-four (34) are family physicians. With the present count of eight million Filipino older persons, the **active geriatrician: senior citizen ratio** is very far from the ideal. This ratio will continue to be a challenge to the health care of seniors in the coming years. The number of Fellowship Training Programs has to be improved, also, to respond to this challenge.

The usual health problems of the elderly are multiple, with the biomedical problems interfacing with psychosocial. An older person can have simultaneously musculoskeletal problems, hearing and visual impairment, dental problems, osteoporosis, gait and balance disorders, depression, memory lapses, fractures, incontinence, etc. As they get older their health problems increase, making them more vulnerable. They are also poorer because their pensions are not enough for them *(Crisostomo, 2015)*. Appropriate care for the elderly entails a careful multidimensional assessment, including a home visit, in order to come up with realistic and person-centered, psychosocially-oriented treatment plans.

Enabling legislations were passed to prioritize care of the elderly. Encouraging, but daunting, in view of the lack of geriatricians in the country. Republic Act 9994, the Expanded Senior Citizens Act of 2010 (*Philippines, 2010*) requires all government hospitals to establish a geriatric ward. This entails the employment/utilization of a geriatric health team in a public inpatient setting to deliver the services. Republic Act 10645 (*Philhealth, 2014)* mandates the health insurance coverage of all Filipinos 60 years

old and above; this, together with theAquino Health Agenda of Universal Health Care for all (*DOH, 2010*) will be successful if there are clear mechanisms of how *additional geriatric syndromes, eg, hearing impairment, aspiratio*n *pneumonia, depression, etc.* will be covered for indigent and paying patients, in the inpatient and outpatient settings.

The utilization of geriatric health services is high, as an out-of-pocket expense. The per capita health expenditure for those 65 years and older are triple than those for persons under 50 years old. A study done by Racelis et al (2006) on the share of the 65 yrs old and above on health expenditure from the National Health Accounts showed that the elderly are "relatively heavy consumers of personal health care, and relatively light consumers of public health care". From out-of-pocket costs, the aged utilize heavily care provided by medical centers, hospitals, non-hospital health facilities and traditional care facilities; with marginal utilization of national health insurance. Regarded as a subspecialty, geriatricians are in tertiary hospitals, usually in private settings.

In the public health sector, primary health care of diabetes, hypertension, cancer and mental health are carried out by the health facilities at the local government units and municipal levels. Disease prevention, health promotion, lifestyle modification and long-term care for the elderly and disabled are also carried out by the local government units. Provincial and regional hospitals provide secondary and tertiary health services, including intensive care. Rehabilitative services are tertiary hospital or community-based. Palliative care is provided by a few tertiary hospitals (*DOH, 2012)*. To date there are still no geriatric wards in the above settings, but there is already an existing specialty hospital in geriatric medicine in Manila.

There is a lack of geriatrician-led long term care facilities and services in the country. From the study of the National Institute on Aging on dementia care services, there are no dementia-specific services/facilities in the country (*de la Vega & Cordero, 2014*). There are institutions for general elder care, some of which were never seen by a geriatrician, especially the public institutions. There are also private institutions visited by geriatricians, but only a few Filipinos can afford the cost of custodial care in a private setting.

In both the private and public settings, there is a need to train more internists and family physicians to become geriatricians, who will develop and deliver more geriatric health services in the country.

## IV. The Subspecialty of Geriatric Medicine

Board certified internists and family physicians, being primary care doctors with the potential to become medical subspecialists who care for adults, can play an essential role in the care of the growing number of older people in the country if adequately educated and trained to practice independently after a prescribed period. The complex needs of older patients often require a team of health care providers with aging related expertise to work together to assess the patient's physical and mental wellbeing and to coordinate care in a variety of settings—the patient's home, the physician's office, the hospital, and the nursing home. Geriatric care teams also work cooperatively with caregivers, such as family and friends, who play a crucial role in helping the older patient maintain health and independence. Older patients who receive specialized geriatric care tend to do better than those who receive usual care (O'Neill and Barry).

In one study, patients who received inpatient and outpatient care in geriatric units experienced large reductions in functional decline and improvements in mental health at no additional cost (Cohen, 2002).

The Competencies of the Subspecialist Geriatrician were formulated by the PSBGM to define the geriatrician and set her apart from the other subspecialists. Included in the competencies are the scope of practice, required knowledge base and skills, and appropriate attitude while practicing the following roles of care provider, manager, educator and researcher while moving across the different settings of care where the seniors are, namely, but not limited to: acute care, ambulatory, transitional and long-term care. See Appendix B.

For the longitudinal care of older patients, there is a notion that internists are hospitalists, and can take care of older persons admitted for acute health problems; internists can also be in ambulatory care. The family physicians are in community-based settings such as the older persons' homes, adult day care programs, senior citizens' centers giving lay forums, and in hospice and palliative care units. The geriatrician should be able to move smoothly between these settings to prepare the patients in transition.

There are many common geriatric conditions that need specialist care in their acute states hence, a multi-disciplinary type of management would be the desired situation. The coordination of care, management of resources, and the continuity - from the well state to an ill state, from the acutely ill state to a chronically ill state, from an able state to a disabled one - is the responsibility of the geriatrician, and both internists and family physicians can be trained to do this.

As the coordinator and leader, the geriatrician can make use of the contributions of a multidisciplinary health care team to give psychosocial, behavioral and rehabilitative interventions (*Alliance, 2006)* in the acute care, ambulatory, transitional or long term care setting. This competency of working with community resources is also common to internists and family physicians.

Home visits are encouraged under laws governing care of the elderly (*Philippines, 2010*). Home visits strengthen the doctor-patient-family relationship through the judicious use of healthcare resources, and reduction of unnecessary referrals and hospitalizations. Home care, family meetings, family interventions and care of the terminally ill and the dying are also the usual "caring skills" of a geriatrician. This type of caring can also be handled by internists and family physicians.

V. Dual Recognition from Two (2) Specialty Divisions of the Philippine Medical Association

The recognition by PCP of PCGM as a subspecialty in 2011 paved the way for the career track in geriatric medicine for the internist. Since 2011, the PSBGM has certified already one (1) internist from the lone accredited fellowship training program.

But high quality care of the elderly need not be within the province of one specialty only. *In the United States, the American Board of Family Practice joined with the American Board of Internal Medicine in forming the Certificate of Added Qualifications in Geriatrics (Brummel-Smith, 2015).* This was done to certify both internist and family physician geriatricians in the USA .

In the same manner, a parallel track under the PAFP can be created, with the GM-graduate family physician also certified by a single Subspecialty Board of Geriatric Medicine. If the difference in specialties will be the basis of questioning the validity of board examinations, the multidisciplinary

composition of the Board Examiners (internists and family physicians) will balance this out (See Appendix A).

Accreditation of training programs from either Internal Medicine or Family Medicine Departments will also be the function of the single Subspecialty Board. A well laid out accreditation process can be thought of by the PSBGM. *In the USA, accreditation of fellowship training programs is carried out by the Accreditation Council for Graduate Medical Education (ACGME), and for Geriatric Medicine, programs are open to both Internal Medicine and Family Medicine programs. The ACGME Guidelines for Geriatric Programs clearly stipulates that the Program Directors should be certified as having "added qualifications in geriatrics" by the American Board of Internal Medicine and Family Practice (ACGME, 2014).*

The PCP recognition is already a response to the present challenge of lack of geriatricians and geriatric health services in the country. Laying down the rules and regulations for the geriatric medicine career track of the family physician will encourage family physicians to pursue further training. Through PAFP recognition, the PCGM will be able to respond further, because the PCP cannot accredit geriatric training programs developed in Family Medicine Departments. Likewise, the family physician geriatrician cannot be a PCP fellow (FPCP).

IV. Concluding Statements

1. While PCGM is already a component society of the PCP, *a second track recognized by the PAFP for family physicians interested in caring for senior citizens* will encourage the establishment of training programs under Family Medicine Departments in government and private hospital settings or in any setting of care.

2. The Competencies of the Subspecialist Geriatrician formulated by the PSBGM outlines the scope of practice, roles, knowledge base, attitude and skills of the geriatrician while moving into the different settings of care where the senior citizens are, and this will be the guide of all internal medicine and family medicine departments in developing their training programs.

3. The PSBGM, the certifying organization of geriatricians at present, is recognized by one (1) specialty division, the PCP. Recognition by another specialty division, the PAFP, is an all-inclusive move rather than a divisive one, to ensure the certification of geriatricians in all settings of care in the country wherever the senior citizens are. It is this all-inclusive move of parallel tracks that may answer the growing challenges in healthcare of a burgeoning population of Older Filipinos.

On behalf of the PCGM Board of Directors, yours sincerely.

Doris D. Camagay

**DORIS MARIEBEL D. CAMAGAY, MD, FPAFP, FPCGM**
President
Philippine College of Geriatric Medicine

17 June, 2015

References:


1. Manila Bulletin (2012). *NSO: Filipino Elderly Population Up.* Manila Bulletin.09.07.2012.https://ph.news.yahoo.com/nso-filipino-elderly-population-095602908.

2. PCGM (2011). *By-Laws of the Philippine College of Geriatric Medicine* . Quezon City, Philippines: Philippine College of Geriatric Medicine.

3. PRC (2015 ). Accredited Professional Organization: Philippine Medical Association. http://www.prc.gov.ph/prb/default.aspx?id=28&content=166. Accessed 06.16.2015.

4. Executive Order No. 83, s.2012. http://www.gov.ph/2012/10/01/executive-order-no-83-s-2012/ . Accessed 06.16.2015.

5. Crisostomo, S (2015). Pinoys Living Longer, But in Poor Health. *Philstar Headlines.http://www.philstar.com/headlines/2015/03/01/1428816/pinoys-living-longer-poor-health*

6. Philippines, F. C. (2010). AN ACT GRANTING ADDITIONAL BENEFITS AND PRIVILEGES TO SENIOR CITIZENS, FURTHER AMENDING REPUBLIC ACT NO. 7432, AS AMENDED, OTHERWISE KNOWN AS "AN ACT TO MAXIMIZE THE CONTRIBUTION OF SENIOR CITIZENS TO NATION BUILDING, GRANT BENEFITS AND SPECIAL BENEFITS AND PRIVILEGES TO SENIOR CITIZENS". *Philippine Star* .

7. Philhealth Circular 033-2014 (2014). Implementing Guidelines for the Mandatory Philhealth Coverage of Senior Citizens Pursuant to RA 10645.

8. Department of Health (2010). Universal Health Care to Address Inequity in the Health System.http://www.doh.gov.ph/

9. DelaVega S & Cordero CP (2014). P419. Status of dementia care services and workforce in the Philippines. *European Geriatric Medicine.* Vol.5. S1.pp. 213-214.

10. Racelis, et al (2006). The National Health Accounts of the Philippines: Continuing Development and New Findings. *The Philippine Journal of Development.* Vol. 23 1-2. Pp.179-209.

11. Department of Health in Collaboration with World Health Organization (2012). Health Services Delivery Profile in the Philippines.

12. O'Neill and Barry. "Training Physicians in Geriatric Care: Responding to a Critical Need." *Public Policy and Aging Report*. Vol. 13. No 2. Pp. 17-21. http://www.agingsociety.org/agingsociety/pdf/trainging.pdf

13. Cohen, HJ et al (2002). "A Controlled Trial of Inpatient and Outpatient Geriatric Evaluation and Management," *New England Journal of Medicine 346*, no.12: 906-912.

14. Alliance, N. A. (2006, May). *Australian Association of Gerontology.* Retrieved November 15, 2011, from Australian Association of Gerontology: http://www.aag.asn.au/filelib/AHMAC_and_beyond.pdf

15. Brummel-Smith, K (2015). Family Physician Geriatricians Do Mostly Geriatric Care: Is this a Problem for our Specialty? *Journal of American Board of Family Medicine*. May-June 2015. Vol. 28. No. 3. Pp.311-313.

16. ACGME (2014). Accreditation Council for Graduate Medical Education Program Requirement for Graduate Medical Education in Geriatric Medicine (Internal Medicine and Family Medicine). ACGME.

**APPENDIX A**

THE PHILIPINE SUBSPECIALTY BOARD OF GERIATRIC MEDICINE
2011-2013

Alejandro P. Inocencio, MD, FPCP, FPCGM
Chair

Examiners:
Joel A. Abonado, MD, FPAFP, FPCGM
Doris Mariebel D. Camagay, MD, **FPAFP,** FPCGM
Rosanna M. Cortez, MD, FPCP, FPCGM
Irene Y. Maglonzo, MD, **FPAFP,** FPCGM
Eduardo Rommel A. Poblete, MD, FPCGM
Miguel A. Ramos, Jr. MD, FPCP, FPCGM

THE PHILIPINE SUBSPECIALTY BOARD OF GERIATRIC MEDICINE
2013-2015

Alejandro P. Inocencio, MD, FPCP, FPCGM
Chair

Examiners:
Joel A. Abonado, MD, FPAFP, FPCGM
Doris Mariebel D. Camagay, MD, **FPAFP,** FPCGM
Rosanna M. Cortez, MD, FPCP, FPCGM
Irene Y. Maglonzo, MD, **FPAFP,** FPCGM
Marc Evans M. Abat, MD, FPCP, FPCGM
Alvin Mojica, MD, PARM

THE PHILIPINE SUBSPECIALTY BOARD OF GERIATRIC MEDICINE
2015-2017

Alejandro P. Inocencio, MD, FPCP, FPCGM
Chair

Examiners:
Marc Evans M. Abat, MD, FPCP, FPCGM
Ma. Tricia G. Bautista, MD, **FPAFP**, FPCGM
Rosanna M. Cortez, MD, FPCP, FPCGM
Manuel V. Del Moro, MD, FPCP, FPCGM
Alvin Mojica, MD, PARM
Cheridine Oro-Josef, MD, **FPAFP,** FPCGM

APPENDIX B

**COMPETENCIES OF A SUBSPECIALIST-GERIATRICIAN**
**The Philippine Subspecialty Board of Geriatric Medicine**

The subspecialist geriatrician is a medical doctor who is specially trained to meet the unique healthcare needs of older adults. Illnesses, diseases and medications may affect older people differently than younger adults and older patients often have multiple health problems and take multiple medications. Geriatricians prevent, manage and develop care plans that address the special health problems of the elderly.

Geriatricians are diplomates or fellows in internal medicine who have completed the additional training necessary to become subspecialists in Geriatric Medicine. Diplomates in family practice may also qualify with similar credentials. Geriatricians often work as part of a team with other healthcare providers, including nurses, pharmacists and physical therapists — who may also have advanced training and hold special certifications in geriatrics.

The competencies of a geriatrician will be described using the framework of settings of care and the roles of a subspecialist. The same will be classified under the educational outcomes of attitude, skills and knowledge. The geriatrician may practice the subspecialty in the settings of acute care, ambulatory care, long-term care and in transitions between and among the above. S/he may assume one or more of the following roles: as healthcare provider, manager, communicator-educator and researcher.

| **ACUTE CARE** | **Attitude** | **Skills** | **Knowledge** |
|---|---|---|---|
| CARE PROVIDER | • act as a care provider with self-confidence<br>• prioritize patient safety<br>• use a holistic approach which focuses on the person rather than the disease<br>• be a team player | • assess acute illness in the older person to triage to urgencies and emergencies<br>• perform CGA on inpatients (medical, special sensory, cognitive, psychosocial and functional status)<br>• assess and manage elderly with multiple medical problems<br>• assess and manage geriatric syndromes (delirium, constipation, falls and fracture, pain) in the acute care setting<br>• manage urgent and emergency medical conditions in the older person<br>• effectively facilitate a | • discuss basic concepts of biology and physiology of aging<br>• recognize atypical presentation of acute illness<br>• distinguish urgent and emergency medical conditions in the older person<br>• recognize risk factors for poor outcomes<br>• in the presence of new symptom or geriatric syndrome, identify drug adverse events, drug-to-drug and drug-to-disease interactions<br>• discuss appropriate |

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| | | family conference<br>• effectively manage medications in polypharmacy | and optimal drug prescribing for older patients<br>• apply evidence-based approach to medical management |
| MANAGER | • protect the rights of the patient, family and carers<br>• prioritize patient safety in decision-making<br>• utilize multidisciplinary approach<br>• ensure quality standards in service provision<br>• practice efficient time management | • assess capacity for decision-making, health care proxy<br>• manage psychosocial aspects of care<br>• regularly participate in quality improvement programs<br>• reduce iatrogenic events by implementing patient-specific and system-wide strategies to prevent falls, pressure sores, restraints, DVT and functional decline<br>• manage and allocate financial resources appropriately | • apply relevant legislation based on the Expanded Senior Citizens Act, Universal Health Care, etc<br>• apply principles of continuous quality improvement |
| EDUCATOR | • give importance to patient's participation in acute care | • educate other specialists and paramedical community on when to refer to a geriatrician<br>• communicate bad news – prognosticate<br>• use strategies to enhance oral and written communication in difficult patients<br>• counsel on options in palliative and end-of-life care<br>• conduct bereavement counseling for terminal illness and death | • outline the course & prognosis of acute illness |
| RESEARCHER | • demonstrate receptive attitude towards change<br>• utilize the ethical principles in | • appraise and apply geriatric research findings to clinical care<br>• design and conduct | • discuss demographic trends and implications for health and social services |

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| | research | basic science researches, clinical trials, health services research, clinical epidemiology and other types of clinical investigation that will further the science of aging and healthcare for the older person | • apply outcome measures in continuous quality improvement<br>• apply basic knowledge on research protocol development , conduct of research and research writing<br>• apply basic knowledge of evidence-based medicine |

| **AMBULATORY CARE** | **Attitude** | **Skills** | **Knowledge** |
|---|---|---|---|
| CARE PROVIDER | • Practice respect for older persons, and their wish for autonomy<br>• Seek out and consider the observation and opinions of family and other concerned individuals in evaluating older persons<br>• Provide compassionate care while establishing personal and professional boundaries with patients and families/caregivers<br>• Must comply with the existing Code of Ethics of the medical profession | • Perform and interpret an outpatient geriatric assessment<br>• Diagnose and manage acute and chronic illnesses in the outpatient setting<br>• Assess and manage common geriatric syndromes in the outpatient setting: dementia, depression, fall, delirium, incontinence, constipation, malnutrition, pressure ulcer, sleep disorder, hearing and vision disorder, and pain<br>• Manage psychosocial aspects of the care of older adults including interpersonal and | • Justify medication regimen and duration based upon:<br>a) age-related changes in pharmacokinetics and pharmacodynamics ;<br>b) maximizing medication adherence<br>c) common lists of medications that should be avoided or used with caution in older adults<br>d) knowledge of drug interactions<br>• Formulate a wellness (primary, secondary and tertiary prevention) plan for older persons |

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| | | family relationships, living situations, adjustment disorders, bereavement and anxiety<br>• Assess caregiver needs and burden<br>• Implement and monitor wellness plans for the elderly | |
| MANAGER | • Foster the development of positive attitudes about the importance of a multidisciplinary approach to caring for older persons, including appropriate respect for other health professionals and paraprofessionals and their roles in the provision of services | • Coordinate rehabilitation with the multidisciplinary team if needed<br>• Identify patient and family/caregiver needs and refer to appropriate local community resources<br>• Regularly participate in continuous quality improvement programs | • Apply principles of health care administration (planning, organizing, staffing, implementation, monitoring and evaluation ) in practice management<br>• Apply principles of continuous quality improvement |
| EDUCATOR | • Demonstrate empathy and compassion to relatives and caregivers<br>• Advocate for older adults' rights and benefits within healthcare systems and settings | • Communicate effectively with patient and family with regards to the nature of the illness, course, prognosis and treatment options<br>• Use strategies to enhance clinician-patient oral and written communication in patients in difficult patients<br>• Facilitate effectively a family/caregiver meeting | • Apply the principles of creative teaching when conducting health education |

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| | | • Conduct lay forums on healthy aging, and other geriatric conditions as the need arises<br>• Educate the medical and paramedical community on when to refer to a geriatrician | |
| RESEARCHER | • Utilize the ethical principles in research | • To design and conduct basic science researches, clinical trials, health services research, clinical epidemiology and other types of clinical investigation that will further the science of aging and healthcare for the older person<br>• Critically appraise current evidence on geriatric research | • Apply basic knowledge on research protocol development , conduct of research and research writing<br>• Apply basic knowledge on evidence-based medicine |

| **LONG-TERM CARE** | **Attitude** | **Skills** | **Knowledge** |
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| CARE PROVIDER | • Practice respect for older persons, and their wish for autonomy<br>• Seek out and consider the observation and opinions of family and other concerned individuals in evaluating older persons<br>• Provide compassionate while establishing | • Perform and interpret geriatric assessment and triage patient to the appropriate level of care<br>• Diagnose and manage acute and chronic illnesses in the long-term care setting<br>• Assess and manage common geriatric syndromes in the long-term care setting: dementia, | • Justify medication regimen and duration based upon:<br>a) age-related changes in pharmacokinetics and pharmacodynamics ;<br>b) maximizing medication adherence<br>c) common lists of medications that should be avoided or used with |

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| | personal and professional boundaries with patients and families/caregivers<br>• Must comply with the existing Code of Ethics of the medical profession | depression, fall, delirium, incontinence, constipation, malnutrition, pressure ulcer, sleep disorder, hearing and vision disorder and pain<br>• Perform home visits, demonstrate modification of the physical exam for the home setting<br>• Assess physical safety of the environment<br>• Assess caregiver needs and burden<br>• Skillfully discuss and document goals of care and advance care planning with elderly individuals and/or their families/caregivers across the spectrum of health and illness<br>• Manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement and anxiety<br>• Regularly re-assess goals of care to recognize patients likely to benefit from palliative and/or hospice care, including those with non-cancer diagnoses (eg. | caution in older adults<br>d) knowledge on drug interactions<br>• Formulate a wellness (primary, secondary and tertiary prevention) plan for older persons<br>• Recognize indications for and availability of durable medical equipment |

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| | | CHF, COPD, Dementia) | |
| MANAGER | • Foster the development of positive attitudes about the importance of a multidisciplinary approach to caring for older persons, including appropriate respect for other health professionals and paraprofessionals and their roles in the provision of services | • Coordinate rehabilitation with the multidisciplinary team if needed<br>• Refer patients to appropriate home health and support services to maximize ability to remain in their homes and provide durable medical equipment<br>• Effective coordination of transfer of care to receiving unit or area<br>• Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship<br>• Regularly participate in continuous quality improvement programs | • Describe the role of a long-term care medical director , and the multidisciplinary care team<br>• Apply principles of health care administration (planning, organizing, staffing, implementation, monitoring and evaluation )in a long term care facility<br>• Discuss the principles, standard regulation and requirements of a long-term care facility<br>• Apply principles of continuous quality improvement |
| EDUCATOR | • Demonstrate empathy and compassion to relatives and caregivers<br>• Advocate for older adults' rights and benefits within healthcare systems and settings | • Counsel patients and families/caregivers about the range of options for palliative and end of life care<br>• Use strategies to enhance clinician-patient oral and written | • Apply the principles of creative teaching when conducting health education |

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| | | communication in patients with hearing, vision, or cognitive impairment<br>• Facilitate effectively a family/caregiver meeting<br>• Conduct lay forums on healthy aging, and other geriatric conditions as the need arises<br>• Educate the medical and paramedical community on when to refer their patient to long-term care | |
| RESEARCHER | • Utilize the ethical principles in research, eg, Ethical Guidelines in Geriatric Research by the DOST | • To do or conduct researches on topics of interest concerning older persons in the outpatient setting<br>• Critically appraise current evidence on geriatric research | • Apply basic knowledge on research protocol development , conduct of research and research writing<br>• Apply basic knowledge on evidence-based medicine |

| **TRANSITIONAL CARE** | **Attitude** | **Skills** | **Knowledge** |
|---|---|---|---|
| CARE PROVIDER | • be a team player<br>• prioritize patient safety | • formulate and implement a discharge plan<br>• triage patient to appropriate level of care<br>• provide team leadership<br>• effectively manage medications in polypharmacy | • discuss risk factors for complicated care transitions<br>• recognize indications for and availability of durable medical equipment<br>• apply evidence-based approach to medical management |
| MANAGER | • protect the rights of the patient, family | • effective coordination of | • discuss roles and rights of carers |

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| | and carers | transfer of care to receiving unit or area<br>• liaison with primary & social services to facilitate transfer of care | • discuss roles of geriatrician and multidisciplinary team in discharge planning<br>• discuss structure & regulations on residential facility<br>• identify financial support available to patient & carers<br>• discuss end-of-life care issues in care transitions<br>• identify agencies & resources involved in community care |
| EDUCATOR | • advise/clarify guardianship issues<br>• underscore importance of social support | • prepare family and caregiver for transitions<br>• empower patients consider patient preferences in treatment goal-setting | • assess suitability for different levels of care with ease<br>• discuss and apply legislation on intermediate care |
| RESEARCHER | • demonstrate receptive attitude towards change<br>• utilize the ethical principles in research | • appraise and apply geriatric research findings to clinical care<br>• design and conduct basic science researches, clinical trials, health services research, clinical epidemiology and other types of clinical investigation that will further the science of aging and healthcare for the older person<br>• demonstrate good presentation skills | • discuss demographic trends and implications for health and social services<br>• apply outcome measures in continuous quality improvement<br>• apply basic knowledge on research protocol development , conduct of research and research writing<br>• apply basic knowledge of evidence-based medicine |