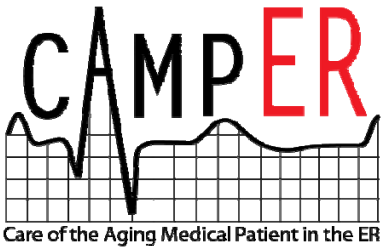

Curriculum Materials / Methods Overview / User's Guide

The University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine (UMDNJ-SOM) was awarded an Aging & Quality of Life grant by the Donald W. Reynolds Foundation to improve the quality of life for elderly Americans by preparing physicians to better care for this vulnerable age group. The emergency department, with its potential for iatrogenic events, challenging transitions of care, and increased mortality risk, is a crucial setting for treating older patients. "Current practicing ED physicians have not received extensive training in the special health care needs of older adults" and "efforts must be made to consider the special health and psychosocial needs unique to elderly in planning the emergency care system of the future."[1] This lack of training in geriatric content and competencies for emergency medicine has been recognized as a national problem and one which has yet to be fully addressed by the specialty.

A key initiative in UMDNJ-SOM's grant project is to enhance post-doctoral geriatric training in emergency medicine through the development of a geriatrics-specific curriculum for emergency medicine residents. The competency-based curriculum entitled, **Care of the Aging Medical Patient in the ER (CampER)**, was specifically designed to address the eight content domains and twenty-six geriatric competencies established as minimum training requirements in geriatrics for emergency medicine residents[2]. The CampER content is also aligned with the Accreditation Council for Graduate Medical Education (ACGME) / American Osteopathic Association core competencies. The curriculum content was developed collaboratively by faculty with expertise in geriatrics and emergency medicine, and designed by individuals with expertise in instructional design and evaluation.

The CampER Curriculum Development Team:

- Anita Chopra, MD, FACP, CMD (Director, New Jersey Institute for Successful Aging, Stratford, NJ)
- Victor Scali, DO, FACOEP-Dist (Co- Program Director, EM & EM/IM Residency Programs)
- Pam Basehore, EdD, MPH (Associate Director Education, New Jersey Institute for Successful Aging, Stratford, NJ)
- Patrick Chadd, M.Ed. (Manager, Academic Systems and Educational Technology, UMDNJ-SOM, Stratford, NJ)
- Abdul Elahi, MD, MPH (Assistant Professor of Medicine, New Jersey Institute for Successful Aging, Stratford, NJ)
- Susan Huff, BA (Postdoctoral Education Coordinator, New Jersey Institute for Successful Aging, Stratford, NJ)

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[1] Wilber ST, Gerson LW, Terrell KM, et al. Geriatric emergency medicine and the 2006 Institute of Medicine reports from the Committee on the Future of Emergency Care in the U.S. Health System. *Acad Emerg Med* 2006;13(12):1345-1351.

[2] Hogan TM, Losman ED, Carpenter CR, et al. Development of geriatric competencies for emergency medicine residents using an expert consensus process. *Acad Emerg Med* 2010;17(3):316-324.

- Sherry Pomerantz, PhD (Assistant Professor of Medicine, New Jersey Institute for Successful Aging, Stratford, NJ)
- Patrick Stewart, MBA (Supervisor, End User Services, Information Services and Technology, UMDNJ-SOM, Stratford, NJ)

Consultants:

- Paula Podrazik, MD (Project Role: Consultant on development of CampER curriculum and Virtual Patient) (Associate Professor, Donald W. Reynolds Department of Geriatrics, University of Arkansas Medical School, Little Rock, AR)
- Jorge Ruiz, MD, FACP (Project Role: Consultant on development of Virtual Patient) (Director at Laboratory of E-Learning and Multimedia Research [LEMUR], Miami, FL)

Section I: CampER Curriculum

The competency-based **CampER Curriculum** is developed as an instructor's manual and includes teaching lesson plans, case-based presentations with audience response questions, bedside teaching cards, and a virtual patient case. The content delivery is designed to promote learner interaction and application of learning in the classroom with reinforcement at the bedside. A detailed curriculum map is provided as a guide to the competencies addressed in each curricular element (refer to Section II. *CampER Curriculum Competency Map).*

Lectures:
The CampER curriculum consists of 12 case-based presentation modules. Each module consists of a lesson plan with learning objectives, references, a PowerPoint slide presentation, pre- and post-test questions, and a session rating form. Lecture-capture videos of the lectures that were presented at UMDNJ-SOM are available on a dedicated YouTube channel. To view the lectures, visit the YouTube channel at http://www.youtube.com/user/CampEmerRm. Lectures were presented by both geriatricians and emergency medicine physicians. The specific topics and presenters included are:

- Approach to the Geriatric Patient in the Emergency Department *(Victor J. Scali, DO FACOEP-Dist)*
- Clinical Implications of the Aging Process *(Anita Chopra, MD, FACP, CMD)*
- Saving Our Elderly Patients from Adverse Drug Effects *(Abdul Elahi, MD, MPH)*
- The Geriatric Patient with Altered Mental Status *(Anita Chopra, MD, FACP, CMD)*
- The Geropsychiatric Patient in the ED *(Stephen Scheinthal, DO, dFACN)*
- Ethical and Legal Issues *(Ricardo Perez, DO, JD)*
- Medical and Surgical Emergencies & Urgencies in the Aging Patient: Geriatric Cardiovascular Emergencies *(James A. Espinosa, MD, FACEP, FAAFP)*
- Medical and Surgical Emergencies & Urgencies in the Aging Patient: Geriatric Neurologic Emergencies *(Alan Lucerna, DO)*
- Medical and Surgical Emergencies & Urgencies in the Aging Patient: Acute Geriatric Abdomen *(Wayne Tamaska, DO, FACOI, FACOEP)*
- Trauma & Falls in the Elderly Patient *(Anthony DiPasquale, DO)*
- Infections in the Elderly *(Karen Greenberg, DO)*
- Acute and Chronic Pain Management of the Elderly Patient *(Henry R. Schuitema, DO, FACOEP)*

Bedside Trigger Cards:

Complementary materials include faculty teaching trigger cards, which can be used to facilitate bedside teaching and reinforce key presentation content.

- Altered Mental Status
- Falls
- Iatrogenesis
- Medication Management
- Pain Management in the Geriatric Patient
- Transitions of Care
- Trauma
- Value-Based Medicine / Prognostication

Virtual Patient Case

A virtual patient case delivered in a web-based or CD-ROM format was designed to allow residents the opportunity to apply their learning in a simulated environment. The case focuses on identifying delirium in a patient presenting to the emergency room with multiple co-morbidities through the application of a validated evaluation tool known as the Confusion Assessment Method (CAM).[3] The case evolves as residents interact with the content and make decisions in the management of their patient. Through a series of scored questions, residents have the opportunity to test their skill in the case.

[3] Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion: the Confusion Assessment Method. A new method for detection of delirium. *Ann Intern Med* 1990;113(12):941-948.

Section II: CampER Curriculum Competency Map

Emergency Medicine and ACGME/ AOA Competencies

Geriatric EM Competencies[2]	ACGME/ AOA Competencies	CampER Lecture Topic	Trigger Card Topic
Domain: Atypical Presentation of Disease			
1. Generate an age-specific differential diagnosis for elder patients presenting to the ED with general weakness, dizziness, falls, or altered mental status.	Medical Knowledge, Patient Care	▪ Approach to the Geriatric Patient ▪ Clinical Implications of the Aging Process ▪ Infections in the Elderly	
2. Generate a differential diagnosis recognizing that signs and symptoms such as pain and fever may be absent or less prominent in elders with acute coronary syndromes, acute abdomens, or infectious processes**.**	Medical Knowledge, Patient Care	▪ Approach to the Geriatric Patient ▪ Clinical Implications of the Aging Process ▪ Medical and Surgical Emergencies & Urgencies in the Aging Patient: o Geriatric Cardiovascular Emergencies; o Geriatric Neurologic Emergencies; o Acute Geriatric Abdomen ▪ Infections in the Elderly	Pain
3. Document consideration of adverse reactions to medications, including drug-drug and drug-disease interactions, as part of the initial differential diagnosis.	Practice-Based Learning & Improvement	▪ Approach to the Geriatric Patient; ▪ Saving Our Elderly Patients from Adverse Drug Effects	Medication Management
Domain: Trauma including fall			
4. In patients who have fallen, evaluate for precipitating causes of falls such as medications; alcohol use/abuse, gait or balance instability; medical illness and/or deterioration of medical condition.	Patient Care, Medical Knowledge	▪ Trauma & Falls in the Elderly Patient	Falls Trauma
5. Assess for gait instability in all ambulatory fallers; if present, ensure appropriate disposition and follow up including attempt to reach primary care provider.	Patient Care, Medical Knowledge	▪ Trauma & Falls in the Elderly Patient	Falls Trauma
6. Demonstrate ability to recognize patterns of trauma (physical/sexual, psychological, neglect/abandonment) that are consistent with elder abuse. Manage the abused patient in accordance with the rules of the state and institution.	Medical Knowledge, Patient Care, Professionalism		Trauma
7. Institute appropriate early monitoring and testing with the understanding that elders may present with muted signs and symptoms, (e.g., absent pain and neurologic changes) and are at risk for occult shock.	Medical Knowledge, Patient Care	▪ Trauma & Falls in the Elderly Patient	Falls Trauma Value-Based Medicine/Prognostication
Domain: Cognitive and Behavioral Disorders			
8. Assess whether an elder is able to give an accurate history, participate in determining the plan of care, and understand discharge instructions.	Patient Care, Interpersonal & Communication Skills	▪ Approach to the Geriatric Patient ▪ The Geriatric Patient with Altered Mental Status ▪ The Geropsychiatric Patient in the ED	Altered Mental Status

Geriatric EM Competencies[2]	ACGME/ AOA Competencies	CampER Lecture Topic	Trigger Card Topic
9. Assess and document current mental status and any change from baseline in every elder with special attention to determining if delirium exists or has been superimposed on dementia.	Patient Care, Medical Knowledge	▪ The Geriatric Patient with Altered Mental Status	Altered Mental Status
10. Emergently evaluate and formulate an age-specific differential diagnosis for elders with new cognitive or behavioral impairment, including self neglect; initiate a diagnostic work-up to determine the etiology; and initiate treatment.	Patient Care, Medical Knowledge	▪ The Geriatric Patient with Altered Mental Status	Altered Mental Status
11. Assess and correct (if appropriate) causative factors in agitated elders such as untreated pain, hypoxia, hypoglycemia and use of irritating tethers (defined as monitor leads, blood pressure cuff, pulse oximetry, intravenous access, and Foley catheter), environmental factors (light, temperature), and disorientation.	Patient Care, Medical Knowledge	▪ The Geriatric Patient with Altered Mental Status	Altered Mental Status Iatrogenesis
Domain: Emergent Intervention Modifications			
12. Recommend therapy based on the actual benefit to risk ratio, including but not limited to acute myocardial infarction, stroke and sepsis, so that age alone does not exclude elders from any therapy.	Systems-Based Practice, Patient Care, Medical Knowledge	▪ Medical and Surgical Emergencies & Urgencies in the Aging Patient: o Geriatric Cardiovascular Emergencies; o Geriatric Neurologic Emergencies; o Acute Geriatric Abdomen	Iatrogenesis Value-Based Medicine/Prognostication
13. Identify and implement measures that protect elders from developing iatrogenic complications common to the ED including invasive bladder catheterization, spinal immobilization and central line placement.	Medical Knowledge, Patient Care, Practice-Based Learning & Improvement		Iatrogenesis
Domain: Medication Management			
14. Prescribe appropriate drugs and dosages considering the current medication, acute and chronic diagnoses, functional status, and knowledge of age related physiologic changes (renal function, central nervous system sensitivity).	Medical Knowledge, Patient Care	▪ Saving Our Elderly Patients from Adverse Drug Effects	Medication Management
15. Search for interactions and document reasons for use when prescribing drugs that present high risk either alone, or in drug-drug or drug-disease interactions (e.g., benzodiazepines, digoxin, insulin, NSAID's, opioids, and warfarin).	Practice-Based Learning & Improvement, Medical Knowledge	▪ Saving Our Elderly Patients from Adverse Drug Effects ▪ The Geropsychiatric Patient in the ED	Iatrogenesis Medication Management
16. Explain all newly prescribed drugs to elders and caregivers at discharge, assuring they understand how and why the drug should be taken, the possible side effects, and how and when the drug should be stopped.	Interpersonal & Communication Skills, Patient Care, Medical Knowledge	▪ Saving Our Elderly Patients from Adverse Drug Effects	Medication Management
Domain: Transitions of Care			
17. Document history obtained from skilled nursing or extended care facilities of the acute events necessitating ED transfer, including goals of visit, medical history, medications, allergies, cognitive and functional status, advance care plan, and responsible PCP.	Interpersonal & Communication Skills, Patient Care, Systems-Based Practice		Transitions of Care

Geriatric EM Competencies[2]	ACGME/ AOA Competencies	CampER Lecture Topic	Trigger Card Topic
18. Provide skilled nursing or extended care facilities and/or PCP with ED visit summary and plan of care, including follow-up when appropriate.	Interpersonal & Communication Skills, Professionalism, Systems-Based Practice, Patient Care		Transitions of Care
19. With recognition of unique vulnerabilities in elders, assess and document suitability for discharge, considering the ED diagnosis, including cognitive function, the ability in ambulatory patients to ambulate safely, availability of appropriate nutrition/social support, and the availability of access to appropriate follow-up therapies.	Patient Care, Medical Knowledge, Systems-Based Practice		Transitions of Care
20. Select and document the rationale for the most appropriate available disposition (home, extended care facility, hospital) with the least risk of the many complications commonly occurring in elders during inpatient hospitalizations.	Systems-Based Practice, Patient Care, Medical Knowledge		Transitions of Care Value-Based Medicine/Prognostication
Domain: Palliative Care			
21. Rapidly establish and document elder's goals of care for those with a serious or life threatening condition and manage accordingly.	Interpersonal & Communication Skills, Patient Care, Medical Knowledge	▪ The Geropsychiatric Patient in the ED	
22. Assess and provide ED management for pain and key non-pain symptoms based on the patient's goals of care**.**	Patient Care, Medical Knowledge	▪ Acute & Chronic Pain Management of the Elderly	Pain
23. Know how to access hospice care and how to manage elders in hospice care while in the ED.	Systems-Based Practice, Patient Care, Medical Knowledge	▪ Acute & Chronic Pain Management of the Elderly	Pain
Domain: Effect of Co-Morbid Conditions			
24. Assess and document the presence of co-morbid conditions (e.g., pressure ulcers, cognitive status, falls in the past year, ability to walk and transfer, renal function, and social support) and include them in your medical decision making and plan of care.	Patient Care, Medical Knowledge	▪ Trauma & Falls in the Elderly Patient	Falls Iatrogenesis Value-Based Medicine/Prognostication
25. Develop plans of care that anticipate and monitor for predictable complications in the patients' condition (e.g., gastrointestinal bleed causing ischemia).	Patient Care, Medical Knowledge, Practice-Based Learning & Improvement	▪ Trauma & Falls in the Elderly Patient	Falls Iatrogenesis Trauma
26. Communicate with patients with hearing/sight impairments, speech difficulties, aphasia and cognitive disorders (e.g., using family/friend, writing)	Interpersonal & Communication Skills, Patient Care, Medical Knowledge	▪ Approach to the Geriatric Patient ▪ The Geriatric Patient with Altered Mental Status ▪ Trauma & Falls in the Elderly Patient	Altered Mental Status Falls; Trauma

Section III: CampER - How to Use the Materials

The CampER curriculum is organized in topic modules. The series can be delivered in its entirety to create a focused geriatric unit within core residency lectures or individual modules can be selected and delivered to meet the specific needs of your program.

Each module includes a lesson plan, presentation slides, and a session evaluation form. The lesson plans include learning objectives and resources. As noted above, lecture-capture videos of the lectures that were presented at UMDNJ-SOM are available on a dedicated YouTube channel (http://www.youtube.com/user/CampEmerRm). These presentation recordings are provided to help aid the faculty in preparing to deliver the content. The recordings can also be used directly for instruction to residents.

Faculty teaching trigger cards are designed to reinforce presentation content at the bedside, however, they can also be used as a stand-alone product to facilitate teaching of residents in the emergency room setting.

The Virtual Patient is designed as a capstone simulation activity to the geriatric lecture series and can be used for formative feedback to the learner. However, the case can also be used as a stand-alone tool to engage residents in learning about the assessment and management of acute confusion in the emergency room.

All materials created for the CampER curriculum are included in the manual. The materials are also available on POGOe (Portal of Geriatric Online Education) and can be accessed by searching either by geriatric content areas or topics in "Teaching Geriatrics in the Emergency Department."

Part IV: CampER Evaluation

The Donald W. Reynolds Foundation grant required comprehensive evaluation of the newly developed CampER curriculum. The tools described below were developed both for assessing the learner and as part of the overall curriculum evaluation. The EM initiative was evaluated by assessing attitude, knowledge, and skills. Faculty members were also surveyed. The tools developed and or adapted for this evaluation are included in the Appendix.

The attitude survey described below was adapted from the UCLA Attitudes Survey[4] and was used with permission of its authors; other tools were created by the CampER Development Team. The tools are available as described below.

- Attitudes:
  - Evaluated using a modified version of the UCLA Attitudes Survey (available in Appendix as Attitudes & Self-Reported Confidence Survey)
    - Administered at the beginning of the PGY-1 year and again at the PGY-3, after the residents have been exposed to all 12 lectures

[4] Reuben DB, Lee M, Davis JW Jr, et al. Development and validation of a geriatrics attitudes scale for primary care residents. *J Am Geriatr Soc* 1998;46(11):1425-1430.

        - Comparison of residents in PGY-1 and 2 years later in PGY-3, to determine change in attitudes

- Knowledge Acquisition:
    - Knowledge acquisition is assessed by delivery of pre- and post-tests that include 3 questions related to each of the 12 CampER lecture topics
        - Pre-test delivered to all PGY-1 EM residents during their residency orientation
        - Post-test delivered to all PGY-3 EM residents near the end of their third year of training
        - Additional questions are delivered during each lecture using an audience response system to gain insight into overall knowledge of the topics

- Skills
    - Self-reported confidence (perceived skill) in treating elderly patients: Evaluated using 15 item questionnaire (available in Appendix as Attitudes/Confidence Survey)
        - Administered at the beginning of the PGY-1 year and again in PGY-3, after the residents have been exposed to all 12 lectures.
        - Comparison of residents as PGY-1 and 2 years later in PGY-3, to determine change in self-reported confidence
    - Virtual patient, developed in collaboration with the University of Miami: Evaluated using 10 items, testing the ability of users to recognize delirium
        - Administered to PGY-4 residents
        - Percent correct reported

- Faculty Surveys
    - Evaluated using survey related to self-report of impact of the CampER curriculum on management of older patients and on teaching (available in Appendix)
        - Administered once to EM Faculty
        - Summary of responses

- Session Evaluations
    - A brief survey instrument designed to evaluate whether learning objectives were met and the effectiveness of the presentation
        - Specific to each presentation and included within each module
        - Likert scale
        - Administered post-session to attendees

Appendix

1. Attitudes & Self-Reported Confidence Survey for PGY-1 and PGY-3 Residents

2. Faculty Survey

Attitudes/ Confidence EM Resident Survey (PGY-1, PGY-3)

First Name:

_____

Last Name:

_____

A Number

_____

Please indicate the degree to which you agree or disagree with each of the following statements. Remember, there are no right or wrong answers; the best response is the one that truly reflects YOUR personal opinion. Findings of this study will be reported only on a group basis. You will NOT be identified. "Old people" and "elderly patients" mentioned in the questions refer to persons aged 65 or older.

Most old people are pleasant to be with.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

The federal government should reallocate money from medicare to research on AIDS or pediatric diseases.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

If I have the choice, I would rather see the younger patients than elderly ones.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

It is society's responsibility to provide care for its elderly persons.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Medical care for old people uses up too much human and material resources.
( ) Strongly Disagree

( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

As people grow older, they become less organized and more confused.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neutral
( ) Somewhat Agree
( ) Strongly Agree

Elderly patients will tend to be more appreciative of the medical care I will provide than are younger patients.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Taking a medical history from elderly patients is frequently an ordeal.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

I will tend to pay more attention and have more sympathy towards my elderly patients than my younger patients.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Old people in general do not contribute much to society.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Treatment of chronically ill old patients is hopeless.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Old persons don't contribute their fair share towards paying for their health care.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

In general, old people act too slow for modern society.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

It is interesting listening to old people's accounts of their past experiences.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

An elderly patient does not live long enough to benefit from the investment of time spent in educating him/her in preventive measures.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

Elderly patients are not able to take care of their own needs and follow treatment plans.
( ) Strongly Disagree
( ) Somewhat Disagree
( ) Neither Agree Nor Disagree
( ) Somewhat Agree
( ) Strongly Agree

I can assess whether an older adult patient is able to give an accurate history.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can conduct a cognitive assessment of the elderly ED patient.*
( ) Not at all Confident
( )
( )

( )
( ) Very Confident

I can screen for delirium in the elderly ED patient.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can distinguish dementia from acute delirium in the elderly ED patient.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can identify and treat the etiology/s of delirium in elderly patients including medical, environmental and iatrogenic causes.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can conduct a functional assessment of an elderly patient in the ED based on ADLs and IADLs.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can identify the etiologies for falls for the elderly ED patient who presents with fall.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can assess pain in elderly patients including appropriate use of a pain scale.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can determine the risk vs. benefit of treatment for an elderly patient with an emergent condition requiring an acute procedural intervention.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can implement measures that protect older adult patients from developing iatrogenic complications in the ED due to bladder catheterizations, spinal immobilization and central line placement.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can prescribe appropriate drugs and dosages based on patient's current medications, medical diagnoses & knowledge of age-related pathophysiologic changes.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can assess whether an elderly patient can participate in determining his/her plan of care.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can assess whether an elderly patient can understand discharge instructions.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can manage a safe disposition of an elderly patient with appropriate follow up to home or alternate level of care.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

I can reconcile medication list and communicate on patient condition, discharge plan, and any test abnormalities to the elderly patient's PCP or covering physician.*
( ) Not at all Confident
( )
( )
( )
( ) Very Confident

Thank you for taking our survey. Your response is very important to us.

Emergency Medicine Faculty CampER Curriculum Survey

Name: _____

We have been developing the CampER curriculum, a Geriatric Emergency Medicine curriculum, to improve education through a grant from the Donald W. Reynolds Foundation. You may have attended some of the lectures and have been sent a DVD which included six of the lectures and three trigger cards (on Falls, Delirium, and Medication Management).

We would appreciate your responding to the following survey regarding the lectures on Geriatric topics in the ED that you heard presented or which were mailed to you along with bedside trigger cards.

Which of the Camp ER lectures have you had the opportunity to attend or review?*
[ ] Acute Abdomen
[ ] Clinical Implications of the Aging Process
[ ] Adverse Drug Effects
[ ] Ethical Legal Issues
[ ] Altered Mental Status
[ ] The Geropsychiatry Patient
[ ] Approach to the Geriatric Patient
[ ] Infections in the Elderly
[ ] Cardiovascular Emergencies
[ ] Pain Management
[ ] Cerebrovascular Emergencies
[ ] Trauma and Falls

Which trigger cards have you reviewed? (Check all that apply)*
[ ] Falls
[ ] Delirium
[ ] Medication Management

Which trigger cards have you found helpful in clinical practice? (Check all that apply)*
[ ] Falls
[ ] Delirium
[ ] Medication Management

How do you think implementation of the CampER curriculum has influenced your bedside teaching and clinical practice? Please answer the following questions:

How important are the topics with regard to the care of your geriatric patients in the ED?*
( ) Very important
( ) Important
( ) Moderately important
( ) A little important
( ) Not important

To what degree has your knowledge base in the application of geriatric medicine principles and practice to the ED setting improved?*
( ) A great deal
( ) Somewhat
( ) A small amount
( ) Not at all

To what degree has your management of older patients changed as a result of implementation of the CampER curriculum with regard to the following?*

	A great deal (more)	Somewhat (more)	A little (more)	Not at all (no change)
I recognize and treat delirium	( )	( )	( )	( )
I prescribe bladder catheterization only when there are appropriate indications	( )	( )	( )	( )
I have reduced the use of NSAID prescriptions in elderly patients discharged from the ED	( )	( )	( )	( )
I have increased my communication to PCPs of elderly patients discharged home	( )	( )	( )	( )
I am able to recognize atypical presentation of acute abdomen in an elderly patient who presents to the ED	( )	( )	( )	( )
I assess pain in elderly patients	( )	( )	( )	( )
I utilize the Get Up and Go Test when appropriate in evaluating ambulatory older patients presenting with falls	( )	( )	( )	( )

Please describe any other changes you have made:
_____

As a result of the implementation of the CampER curriculum, has your approach to resident clinical bedside teaching in the ED changed?*
( ) Yes
( ) No

If yes, in which of the following content areas has your teaching emphasis changed? Check all that are appropriate.

[ ] Atypical presentation of disease
[ ] Predisposition to iatrogenic injury
[ ] Age-related bias in evaluation and treatment
[ ] Medication management and adverse drug reactions (ADR's)
[ ] Impact of dementia, functional impairments, medical complexity, prognosis, and patient preferences in developing a care plan
[ ] Assessment of cognitive impairment
[ ] Discharge dispositions and transitions of care
[ ] Other

Thank You!
Thank you for taking our survey. Your response is very important to us.