

MINIMUM GERIATRIC COMPETENCIES for IM-FM RESIDENTS (DRAFT 1.0) 6/1/09

The graduating IM or FM resident, in the context of a specific older patient scenario (real or simulated), must be able to:

MEDICATION MANAGEMENT

| | |
|---|--|
| 1 | Prescribe appropriate drugs and dosages considering: age-related changes in renal and hepatic function, body composition, and CNS sensitivity; common side effects in light of patient's comorbidities, functional status, and other medications; and drug-drug interactions. |
| 2 | When prescribing drugs which present high risk for adverse events and interactions (these medications include, but are not limited to, coumadin, NSAID's, opioids, digoxin, insulin, strongly anticholinergic drugs, and psychotropic drugs), discuss and document the rationale for their use, alternatives, and ways to decrease side effects. |
| 3 | Periodically review patient's medications (including meds prescribed by other physicians, OTC and CAM) with the patient and/or caregiver to assess adherence, eliminate ineffective, duplicate and unnecessary medications, and assure that all medically indicated pharmacotherapy is prescribed. |

COGNITIVE, AFFECTIVE, AND BEHAVIORAL HEALTH

| | |
|---|---|
| 4 | Appropriately administer and interpret the results of at least one validated screening tool for each of the following: delirium, dementia, depression, and substance abuse. |
| 5 | Recognize delirium as a medical urgency, promptly evaluate and treat underlying problem. |
| 6 | Evaluate and formulate a differential diagnosis and workup for patients with changes in affect, cognition, and behavior (agitation, psychosis, anxiety, apathy). |
| 7 | In patients with dementia and/or depression, initiate treatment and/or refer as appropriate. |

COMPLEX OR CHRONIC ILLNESS(ES) IN OLDER ADULTS

| | |
|----|--|
| 8 | Identify and assess barriers to communication such as hearing and/or sight impairments, speech difficulties, aphasia, limited health literacy, and cognitive disorders. When present, demonstrate ability to use adaptive equipment and alternative methods to communicate (e.g., with the aid of family/friend, caregiver). |
| 9 | Determine whether an older patient has sufficient capacity to give an accurate history, make decisions and participate in developing the plan of care. |
| 10 | In evaluating adults with undifferentiated illness, generate differential diagnoses that include diseases that often present atypically in older adults (e.g., acute coronary syndromes, the acute abdomen, urinary tract infection, and pneumonia). |
| 11 | Consider adverse reactions to medication in the differential diagnosis of new symptoms or geriatric syndromes (e.g., cognitive impairment, constipation, falls, incontinence). |
| 12 | Demonstrate understanding of the major age-related changes in physical and laboratory findings during diagnostic reasoning (e.g., S4 does not reflect CHF, pulse increase less common with orthostasis, pO2 declines with age, abdominal pain may be less severe). |
| 13 | Discuss and document advance care planning and goals of care with all patients with chronic or complex illness, and/or their surrogates. |
| 14 | Develop a treatment plan that incorporates the patient's and family's goals of care, preserves function, and relieves symptoms. |

| PALLIATIVE AND END OF LIFE CARE | |
|--|---|
| 15 | In patients with life limiting or severe chronic illness, assess pain and distressing non-pain symptoms (dyspnea, nausea, vomiting, fatigue) at regular intervals and institute appropriate treatment based on their goals of care. |
| 16 | In patients with life limiting or severe chronic illness, identify with the patient, family and care team when goals of care and management should transition to primarily comfort care. |
| HOSPITAL PATIENT SAFETY | |
| 17 | As part of the daily physical exam of all hospitalized older patients, assess and document whether delirium is present. |
| 18 | In hospitalized medical and surgical patients, evaluate - on admission and on a regular basis - for fall risk, immobility, pressure ulcers, adequacy of oral intake, pain, new urinary incontinence, constipation, and inappropriate medication prescribing, and institute appropriate corrective measures. |
| 19 | In hospitalized patients with an indwelling bladder catheter, discontinue or document indication for use. |
| 20 | Before using or renewing physical or chemical restraints on geriatric patients, assess for and treat reversible causes of agitation (e.g., use of irritating tethers [including monitor leads, blood pressure cuff, pulse oximeter, intravenous lines and in-dwelling bladder catheters], untreated pain, alcohol withdrawal, delirium, ambient noise). Consider alternatives to restraints such as additional staffing, environmental modifications, and presence of family members. |
| TRANSITIONS OF CARE | |
| 21 | In planning hospital discharge, work in conjunction with other health care providers (e.g., social work, case management, nursing, physical therapy) to recommend appropriate services based on: the clinical needs, personal values and social and financial resources of the patients and their families (e.g., symptom and functional goals in the context of prognosis, care directives, home circumstances and financial resources); and the patient's eligibility for community-based services (e.g., home health care, day care, assisted living, nursing home, rehabilitation, or hospice). |
| 22 | In transfers between the hospital and skilled nursing or extended care facilities, ensure that: for transfers to the hospital: the caretaking team has correct information on the acute events necessitating transfer, goals of transfer, medical history, medications, allergies, baseline cognitive and functional status, advance care plan and responsible PCP; and for transfers from the hospital: a written summary of hospital course be completed and transmitted to the patient and/or family caregivers as well as the receiving health care providers that accurately and concisely communicates evaluation and management, clinical status, discharge medications, current cognitive and functional status, advance directives, plan of care, scheduled or needed follow-up, and hospital physician contact information. |
| AMBULATORY CARE | |
| 23 | Yearly screen all ambulatory elders for falls or fear of falling. If positive, assess gait and balance instability, evaluate for potentially precipitating causes (medications, neuromuscular conditions, and medical illness), and implement interventions to decrease risk of falling. |
| 24 | Detect, evaluate and initiate management of bowel and bladder dysfunction in community dwelling older adults. |
| 25 | Identify older persons at high safety risk, including unsafe driving or elder abuse/neglect, and develop a plan for assessment or referral. |
| 26 | Individualize standard recommendations for screening tests and chemoprophylaxis in older patients based on life expectancy, functional status, patient preference and goals of care. |

**MINIMUM GERIATRICS COMPETENCIES FOR INTERNAL MEDICINE AND
FAMILY MEDICINE RESIDENTS
IM / FM Geriatrics Competencies Working Group¹**

Version 1.0 released May 6, 2009

In the fall of 2007 a group of geriatrics educators from General Internal Medicine, Family Medicine, and academic geriatrics designed a project to define minimum geriatrics competencies for Internal Medicine and Family Medicine residents. The project was designed to build on the success of a similar project to define competencies for medical students completed in the summer of 2007; and complement other ongoing curricular reform projects in Internal Medicine, the surgical specialties, and medical subspecialties. Previous residency geriatrics curricula have been developed within Family Medicine, the American Geriatrics Society, the Federated Council for Internal Medicine, and others; but are lengthy and have not been widely adopted by residencies.

The specific purposes of this project are to define geriatrics competencies for Internal Medicine and Family Medicine residents that: a) are unique to the care of older patients (i.e., not general competencies), b) are feasible within the structure of current residency programs, c) constitute a minimum but uniform expectation for all graduating residents, d) are behavioral and specific to enable assessment, and e) are approved and accepted by key stakeholder organizations and residency program directors.

Beginning in 2008, the 8-member working group obtained financial support for the project from the American Medical Association, the American Geriatrics Society, the American Board of Family Medicine Foundation, and the Society of General Internal Medicine. A multi-stage development process was implemented that included a literature review, creation and revision of initial competencies through small group meetings and a whole-group survey among over 100 field experts, detailed item review by 25 program directors and residency clinical educators recruited from key professional organizations, and final review for sensibility by 10 program directors. At each stage, the working group made revisions to incorporate new input and maintain consistency and compatibility within and among the competencies.

The outcome of this process is a set of 26 geriatrics competencies in 7 domains: Transitions of Care; Hospital Patient Safety; Cognitive, Affective, and Behavioral Health; Complex or Chronic Illnesses; Medication Management; Ambulatory Care; and Palliative and End of Life Care (Version 1.0 - attached).

Work is now underway to secure formal support of the competencies by professional and regulatory organizations, review and recommend methods to assess learners' mastery of the competencies, and coordinate their adoption with geriatrics competencies for medical student and other physician specialties.

¹ Listed in Appendix

APPENDIX

IM / FM Geriatrics Competencies Working Group

Brent Williams, MD, MPH - University of Michigan; SGIM Geriatrics Task Force
Gregg Warshaw, MD - University of Cincinnati
Annette Medina-Walpole, MD - University of Rochester; AGS Education Committee
Anne Fabiny, MD – Harvard Medical School
Joanne G. Schwartzberg, MD - American Medical Association
Nancy Lundjeberg - American Geriatrics Society
Karen Sauvigné, MA – Mount Sinai School of Medicine
Rosanne M. Leipzig, MD, PhD - Mount Sinai School of Medicine

Supported by grants from:

**American Board of Family Medicine Foundation
American Geriatrics Society
American Medical Association
Society of General Internal Medicine**

