| *MINIMUM GERIATRIC COMPETENCIES for Emergency Medicine Residents (DRAFT) 6/30/09* | |
|---|---|
| ***The graduating emergency medicine resident, in the context of a specific older patient scenario (real or simulated), must be able to:*** | |
| | |
| **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. |
| **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. |
| **3** | Document consideration of adverse reactions to medications, including drug-drug and drug-disease interactions, as part of the initial differential diagnosis. |
| **TRAUMA INCLUDING FALLS** | |
| **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. |
| **5** | Assess for gait instability in all ambulatory fallers; if present, ensure appropriate disposition and follow up including attempt to reach primary care provider. |
| **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. |
| **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. |
| **COGNITIVE AND BEHAVIORAL DISORDERS** | |
| **8** | Assess whether an elder is able to give an accurate history, participate in determining the plan of care, and understands discharge instructions. |
| **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. |
| **10** | Emergently evaluate and formulate an age-specific differential diagnosis for elders with new cognitive or behavioral impairment, including self neglect, and initiate a diagnostic work-up to determine the etiology, and initiate treatment. |
| **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 ox, IV and Foley), environmental factors (light, temperature), disorientation. |
| **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. |
| **13** | Identify and implement measures that protect elders from developing iatrogenic complications common to the Emergency Department including invasive bladder catheterization, spinal immobilization and central line placement. |

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| **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, CNS sensitivity). |
| **15** | Search for interactions and document reasons for use when prescribing drugs which present high risk either alone, or in drug-drug or drug-disease interactions (e.g. benzodiazapines, digoxin, insulin, NSAID's, opioids, and warfarin). |
| **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. |
| **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. |
| **18** | Provide skilled nursing or extended care facilities and/or PCP with ED visit summary and plan of care, including follow-up when appropriate. |
| **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. |
| **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. |
| **PAIN MANAGEMENT / PALLIATIVE CARE** | |
| **21** | Rapidly establish and document elder's goals of care for those with a serious or life threatening condition and manage accordingly |
| **22** | Assess and provide ED management for pain and key non pain symptoms based on the patient's goals of care. |
| **23** | Know how to access hospice care and how to manage elders in hospice care while in the ED. |
| **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. |
| **25** | Develop plans of care that anticipate and monitor for predictable complications in the patients' condition (e.g., GI bleed causing ischemia). |
| **26** | Communicate with patients with hearing/sight impairments, speech difficulties, aphasia and cognitive disorders (e.g. using family/friend, writing). |

# The Development of Geriatric Competencies for Emergency Medicine Residents – Enhancing Preparedness to Care for Older Emergency Department Patients

**OBJECTIVES:** A virtual tidal wave of older adults is straining the capacity of emergency departments (EDs) across the United States. Older patients can have complex clinical presentations and be resource intensive. Evidence indicates that emergency physicians fail to provide consistent high quality care for elder ED patients resulting in poor clinical outcomes. We propose The Geriatric Competencies for Emergency Medicine (EM) Residents, a set of minimum knowledge and skills that can feasibly be implemented in EM residency curricula to improve resident education for a population that will challenge them during the next twenty years.

**METHODS:** This inductive qualitative study used a multi-phase process to determine what the minimum geriatric skills should be for EM residents. Face validity and reliability were tested throughout the process.

**GUIDELINES FOR COMPETENCIES**

Each competency must be:

1. Specific to the appropriate care of geriatric ED patients, not simply good care for the entire ED population.
2. Behaviorally based and measurable to enable assessment
3. Within the purview of resident level actions and responsibilities.
4. Feasible within the structure of current residency programs.
5. A minimum standard that can be demonstrated by the completion of an EM residency program.

**RESULTS**: In Phase I, a snowball sample of participants (n=363) in a narrative inquiry process identified 12 domains and 300 potential competencies. In Phase II an expert panel[1] clustered the Phase I responses resulting in 8 domains and 72 competencies. Phase III reduced the competencies to 26. During Phase IV, the 8 domains and 26 competencies resulted in 100% face validity and reliability.

**CONCLUSIONS:** The *Geriatric Competencies for EM Residents* is a consensus document that defines the minimum set of knowledge and skills that Emergency Medicine residents need to ensure that they are able to care for our nation's rapidly growing and complex older patient population.

[1] Listed in Appendix

*APPENDIX*

## Emergency Medicine Geriatrics Competencies Expert Panel

Robert Anderson MD, University of Maryland
Louis Binder MD, MetroHealth Medical Center
Chris Carpenter MD, Washington University at St. Louis
Linda Emanuel MD, MPH, PhD, Northwestern's Feinberg School of Medicine
Lowell Gerson PhD, Northeastern Ohio Universities, College of Medicine
Lisa Granville MD Florida State University College of Medicine
Linda Herman MD, Resurrection Medical Center
Teresita Hogan MD, Resurrection Medical Center
Frederic Hustey MD, The Cleveland Clinic Foundation
Ula Hwang MD, MPH, Mount Sinai School of Medicine
Cheryl Irmiter PhD, LCSW, CADC, Aging and Community Health
David P John MD, Caritas Carney Hospital
Gloria Kuhn DO, PhD, Wayne State University School of Medicine
Rosanne Leipzig MD PhD, Mount Sinai School of Medicine
Eve Losman MD, University of Michigan
Amal Mattu MD, University of Maryland
Heather Prendergast MD, University of Illinois
Tammie E.Quest MD, Emory University School of Medicine
Lynne Richardson MD, Mount Sinai School of Medicine
Karen Sauvigné MA, Mount Sinai School of Medicine
Joanne G. Schwartzberg MD American Medical Association
Manish Shah MD MPH, University of Rochester School of Medicine and Dentistry
Rebecca Smith Coggins MD, Stanford University School of Medicine
Gary Strange MD, University of Illinois

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