Competency Framework for Interprofessional Comprehensive Geriatric Assessment

Draft

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Note: This competency document is provided in its current draft form for the purposes of evaluating applications to the Central East 2016/17 Geriatric Education Initiative. This work is part of an ongoing competency development process which is expected to conclude in 2017.

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Background

The impetus to develop a competency framework for interprofessional comprehensive geriatric assessment (CGA) was prompted by growth in specialized geriatric services (SGS) that resulted in a significant influx of new Interprofessional (IP) team members (e.g. in the Central East the addition of 59 new FTEs in a six month period). It was recognized that new members of the IP team entering the SGS practice environment had varying levels of geriatric expertise. The inconsistency in expertise was further complicated by both an absence of competencies against which to measure professional knowledge and skills, and the lack of a systematic way to identify learning gaps to support the development of clinicians newly entering the SGS practice environment.

Confounding this situation was a lack of clear understanding and agreement by the IP team on the meaning and required components of a CGA. Adding to this picture was a lack of undergraduate and post-graduate programming dedicated to the development of the skills of geriatric assessment in the IP team. These impressions were supported by a meta-summary conducted in 2015 of training needs assessments relevant to the care of older adults[1] that demonstrated gaps in knowledge about geriatrics among health professionals. Consequently, there was growing concern that the desired growth in capacity of SGS programs to deliver high quality interprofessional CGAs and interventions was being undermined because new members of the team did not possess the required competencies to conduct a CGA, and there was no systematic or standardized approach to develop those competencies.

In Fall 2014, an initial clinician panel, using clinical experience and evidence, identified an extensive list of domains and elements believed to be required for the delivery of an interprofessional CGA and associated interventions.

This work resulted in the identification of 63 initial domains and elements that were organized into a decision matrix with a 9-point scale. This decision matrix was circulated in 2015 to the membership of the Regional Geriatric Programs (RGP) of Ontario to reach consensus on the required domains of the interprofessional CGA. The initial domains were consolidated into thirteen broad assessment domains and complimentary elements. This new list of domains and elements was again reviewed by the RGPs of Ontario in February 2016. Additional feedback was incorporated and the final domain list was then endorsed by the RGPs of Ontario in June 2016. This final list of domains underpins the development of this competency framework (see pages 10 & 11).

[1] SIM-One (2015). Needs assessment meta-summary - Priority learning needs and practice challenges of healthcare providers supporting seniors aging at home. Retrieved from www.SIM-One.ca.

This work builds on prior work conducted by the RGPs of Ontario and draws upon the definition of SGS and CGA developed in May 2015[2]. The competency framework project is led by Seniors Care Network, the North East Specialized Geriatric Centre and the Regional Geriatric Program of Toronto, who oversee the project through a Joint CGA Task Group, in collaboration with the Regional Geriatric Programs of Ontario.

CGA – A Philosophy Statement

Comprehensive geriatric assessment and intervention (CGA) is the standard of care for specialized geriatric services for the frail elderly. A multidimensional process used to manage frail or vulnerable seniors, the CGA employs an interprofessional, patient-focused approach to comprehensive assessment and intervention across identified domains. The CGA is supported by a highly skilled interprofessional (IP) team that uses expert clinical judgment, technology and tools to gather, synthesize and interpret the information needed to understand the patient's story and biopsychosocial needs. The outcome of the CGA is an integrated clinical picture and practical interventions that address patient goals and enable function, independence, restorative potential and/or palliation. The team supports the patient and family to implement individualized recommendations, balancing risk and autonomy while supporting choice. [3]

The CGA can be initiated by any member of the IP team. This means that all IP team members function as geriatric assessors, sharing a common set of competencies that facilitate comprehensive assessment. Team members contribute additional information using the lens of profession-specific, geriatric knowledge and skills, and together the team creates a comprehensive plan of care in collaboration with the patient and their family. The integration of geriatric competencies blended with profession-specific, collaborative assessment and intervention, differentiates this practice from a multidisciplinary model.

General Approach to CGA

A CGA is a foundational part of SGS clinical processes. A thorough picture of a patient's concerns and underlying health problems is needed to create the best possible plan to assist the individual to maintain/regain their function and independence. Such a thorough assessment can be lengthy and tiring for the older adult population. An initial assessment, if conducted in one encounter, may last as long as 2 to 4 hours, depending on the complexity of the patient's concerns. There are variations between approaches to assessment in clinical and home settings. In either setting, patients may not wish to or be able to engage in such a lengthy

[2] Regional Geriatric Programs of Ontario (2016, March). The RGPs of Ontario: Three frequently asked questions. Retrieved on October 26, 2016 from: http://rgps.on.ca/sites/default/files/RGPs%20FAQ%20-%20CGA%20and%20SGS%20Mar%206%202016_0.pdf

[3] Welsh et al, 2014

assessment in one encounter. Patients may also be less inclined to connect to resources or be reluctant to get help, and assessors need to be flexible in their approach.

The CGA includes an interview with the patient's caregiver, sometimes referred to as a "collateral historian". Patients are advised that a CGA includes discussion with their caregivers to help with the development of a fulsome plan. The information gathered from caregivers may include their observations and perceptions of the patient.

While is important that patients are assessed across all identified domains, teams have flexibility to work with patients and families to gather information in the manner most suitable for the individual. Clinicians must be confident that they have a clear understanding of the patient's condition in each domain. This distinction highlights the importance of clinical judgment, rather than routine, by-rote screening in conducting the CGA. **Knowing how, when and why to assess is equally as important as knowing *what* to assess.**

The approach to assessment includes the clinical review of thirteen core domains, and may include the use of tools and cueing questions to elicit information needed for clinical decision-making, diagnosis and the formulation of an accurate clinical impression. The selection of tools is determined by clinical judgment and may be influenced by the need for reference values to track change over time or signal the need for further assessment.

Domains of Assessment

Thirteen broad assessment domains are included in the CGA and minimum expectations for assessment are summarized. The table below explains how to read the domain list:

Domains (Screen/Scan level) **GREEN**	• Evaluate all areas • Minimum areas of assessment required to achieve a fulsome clinical picture of frailty • Ordered in logical order of screening, but non-linear in nature and sequencing of assessment depends on the interview and clinical approach

Selectively conduct further/deeper assessment as required as problems are identified in each domain

Elements **YELLOW**	• Selectively conduct further/deeper assessment as required as problems are identified • Use of additional in-depth interviewing, and/or validated tools as needed to further explore areas of concern

Domains and Elements

Intro	Medical/Surgical History	Medication	Social History	Mood/Mental Health	Cognition
Reason for referral What issues would you like to address? (Patient, family, caregiver) Access to Primary Care Provider	Past Medical History Chronic Disease Management Preventative Health Practices Communication Family history of relevant diseases (e.g. dementia – with age of onset)	Allergies Best Possible Medication History (BPMH) Adherence Packaging and administration	Gender/sexuality Culture/language/religion/place of birth Family Demographic (marital status, children) POA/SDM Advanced Care Directives Caregiver support/burden/social & community supports Current or Past Occupation Financial Resources Alcohol/smoking/rec. drugs (past and present) Abuse/neglect (i.e. Financial/Physical/ Emotional/Sexual) Hobbies and interests	Past/current issues with mood Depression Mental Health Anxiety Suicide Grief/Loss Stress Addictions Apathy	Subjective Cognitive Decline (SCD) MCI/Dementia Stage/Type Responsive Behaviours Delirium Risk (potential/theoretical vs. real/actual) Note 10 areas of risk: ☐ Driving ☐ Injury (Falls) ☐ Fire ☐ Malnutrition ☐ Wandering ☐ Medication non-adherence ☐ Self-poisoning ☐ Exposure (heat/cold) ☐ Weapons ☐ Abuse

Function	Falls	Sleep	Pain	Nutrition	Continence	Physical Assessment
Living Environment (Safety) Equipment/assistive devices Mobility/transfers/gait/balance ADLs IADLs Driving/transportation	History of falls/near falls Identification of modifiable risk factors Head injury	Changes in sleep patterns Sleep apnea	Chronic/Acute Non-Pharmacological treatments	Have you lost weight in the past 6 months without trying to lose this weight (and how much lost)? Have you been eating less than usual for more than a week? Hydration Swallowing	Bladder/Bowel	Vitals Orthostatic hypotension Vision Hearing Oral Health Neuro MSK Cardiovascular Respiratory Gastroenterology Foot Skin/nodes/ thyroid Labs/diagnostics

The Competency Framework

Purpose

To describe the knowledge, skills, attitudes and judgment required of a member of the interprofessional team for the performance of an accurate, culturally sensitive comprehensive geriatric assessment of older adults living with complex health conditions and frailty.

Note: This framework describes the practice expected of all members of the interprofessional team. Physicians and Nurse Practitioners required additional competencies specific to their roles that are not intended to be described by this work.

Overview

The interprofessional geriatric assessor is a regulated health professional[4] who uses core geriatric knowledge to guide a multidimensional comprehensive geriatric assessment (CGA). The competencies needed to enable an effective CGA are in addition to discipline specific competencies relevant to an individual's specific profession. This competency framework is not intended to replace practice competencies required by regulatory colleges, but to supplement/complement the practice of experienced clinicians who are now working in geriatrics.

The interprofessional geriatric assessor is expected to be proficient in all core geriatric assessor competencies and provide additional insights from their discipline specific knowledge about relevant clinical concerns, providing input into the assessment, planning, implementation and evaluation of care plans from both perspectives.

The interprofessional geriatric assessor works in collaboration with the interprofessional team and patients[5] to develop and implement plans of care and treatment plans.

[4] Geriatric Assessors may include Dietitians, Occupational Therapists, Pharmacists, Physiotherapists, Registered Nurses, Registered Practical Nurses and Social workers. Nurse Practitioners and Physicians (Geriatricians) also possess all competencies of the geriatric assessor and additional competencies related to their roles as diagnosticians and Most Responsible Providers (MRPs). Personal Support Workers may support the work of the Geriatric Assessor and contribute to the implementation of interventions and ongoing observations.
[5] Patients means the person receiving care and their family

Works Consulted

The following team-based competencies and behaviours practice statements reflect the expected practice of team-based interprofessional geriatric assessors. This list has been compiled following the review of existing competency documents including:

American Society of Consulting Pharmacists. (2015). Geriatric pharmacy curriculum guide. Retrieved from https://www.ascp.com/sites/default/files/CurriculumGuide_Final_2015B.pdf

Association for Gerontology in Higher Education (2014). Gerontology competencies for gerontology in undergraduate and graduate education. Retrieved from https://www.aghe.org/images/aghe/competencies/gerontology_competencies.pdf

Canadian Gerontological Nurses Association. (2010). Gerontological nursing competencies and standards of practice. Retrieved from http://www.cgna.net/uploads/CGNAStandardsOfPractice_English.pdf

Canadian Interprofessional Health Collaborative. (2010). A national interprofessional competency framework. Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

College of Occupational Therapists of Ontario. (2011). Essential competencies of practice for occupational therapists in Canada, 3rd edition. Retrieved from http://www.coto.org/resource/standards.asp

Council on Social Work Education Gero-Ed Centre. (2008). Advanced geri-social work practice. Retrieved from http://www.cswe.org/File.aspx?id=25501

National Association of Pharmacy Regulatory Authorities. (2009). Model standards of practice for Canadian pharmacists. Retrieved from http://napra.ca/Content_Files/Files/Model_Standards_of_Prac_for_Cdn_Pharm_March09_Final_b.pdf

National Initiative for the Care of the Elderly. (n.d.). Core interprofessional competencies for gerontology. Retrieved from http://www.nicenet.ca/files/NICE_Competencies.pdf

Royal College of Physicians and Surgeons. (2012). Objectives of training of the subspecialty of geriatric medicine. Retrieved from https://www.mcgill.ca/geriatrics/files/geriatrics/geriatrics_e_objectives.pdf

These competencies were consolidated, reviewed and edited. Several new statements reflecting the unique context of team-based specialized geriatrics were created by an expert working group that included:

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Practice Areas – Definitions

Following an exercise undertaken in August 2016 to confirm the domains of the CGA, the practice areas were re-envisioned by the Joint CGA Planning Team. Consensus was achieved on the following final practice areas and definitions.

Revised Practice Areas	Definition
1. Core Geriatric Knowledge	Demonstrate fundamental understanding of physiological and biopsychosocial mechanisms of the aging processes, age-related changes to functioning, and the impact of frailty.
2. Screening/Assessment/Risk Identification	Gather patient medical and social history and clinical data in sufficient depth to inform care planning and effective clinical decision making.
3. Analysis/Interpretation	Conduct accurate analysis of assessment findings and clinical information to develop a complete understanding of the patient's story. Integrate assessment findings within and across domains to formulate a cohesive clinical impression.
4. Interprofessional Practice	Recognize and engage in inter-organizational collaboration through deep understanding of the roles of internal and external team members, and demonstrate the ability to identify appropriate opportunities to refer to collaborating teams/individuals.
5. Care Planning and Intervention	Demonstrate expertise in treatment, education, goal setting, future and advanced planning through formulation of comprehensive, collaborative care plans focused on optimization of function and quality of life. Conduct iterative and ongoing review and revision of the care plan and adjust interventions as needed.
6. System navigation	Demonstrate knowledge of community resources and appropriate referral sources and mechanisms to access them.
7. Evaluation	Participate in the development and collection and analysis of outcome measures that evaluate quality, patient experience and cost effectiveness (i.e. Triple Aim framework)
8. Professional Practice	Demonstrate core values, behaviours and skills required to provide comprehensive, team based geriatric care. Demonstrate confidence in evaluating and maximizing own professional scope to optimize geriatric practice.

V Nov 24, 2016

Summary of Practice Areas and Behavioural Statements

Note: To rate these statements, please use the "Rating Tool – Practice Areas and Behavioural Statements"

Summary of Practice Areas and Behavioural Statements	
Practice Area	**Behavioural Statements**
1. Core Geriatric Knowledge	a) Recognize the significance of behavioural observations in dementia care. b) Demonstrate knowledge of currently accepted recommendations for primary and secondary prevention in older individuals. c) Demonstrate an awareness of the limitations of the scientific literature with regard to generalizability and applicability to a frail older population. d) Demonstrate skill in working with older adults with significant functional deficits and communication challenges (e.g. cognitive impairment, sensory impairment, behavioral problems or ethno-cultural pluralities). e) Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to geriatric clinical practice, including but not limited to: i. Normal aging ii. Physiology, biology and psychology of aging iii. Geriatric management of the older adult with multiple, complex medical conditions iv. Atypical presentation of disease or medical conditions in the elderly v. Frailty vi. Cognitive function vii. Delirium viii. Dementias including behavioral and psychological symptoms (BPSD) ix. Mild cognitive impairment (MCI) x. Falls and mobility xi. Bowel and bladder management xii. Pain management xiii. Immobility and its complications xiv. Nutrition/Malnutrition xv. End of life care xvi. Mood disorders and other psychiatric manifestations xvii. Bone and metabolic disorders f) Demonstrate knowledge of medications management, including but not limited to: i. Complete a detailed best possible medication history and perform medication reconciliation. ii. Promote adherence to a prescribed drug regimen iii. Identify potentially inappropriate meds for an elderly patient i. Recognize polypharmacy

2. Screening/Assessment/Risk Identification	a) Recognize important clinical indicators (e.g. signs and symptoms, laboratory tests, adverse effects) to promote patient safety. b) Identify and explore issues to be addressed in a patient encounter including the patient's context and preferences. c) Assess an older person with multiple physical, medical, cognitive/psychiatric, functional, and/or social problems. d) Conduct an assessment within identified domains of the CGA using clinical acumen in conjunction with standardized, valid, reliable instruments as appropriate. e) Compile a history, drawing from reliable sources, that is relevant, clear, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis, treatment and/or management. f) Gather information about a patient's beliefs, concerns, expectations and illness experience. g) Identify reliable sources of information to inform the patient history (e.g. Cumulative Patient Profile, involved family etc.). h) Collect a collateral history; supporting details from a close source who knows the patient's daily routines and function accurately (e.g. family member or caregiver). i) Assess an older person for their capacity to consent to treatment and make personal decisions. j) Perform and interpret an environmental safety screen. k) Recognize and identify risk factors for and assess the presence of abuse/neglect (i.e. financial, physical, emotional, sexual). l) Identify specific patient vulnerabilities across the social determinants of health (e.g. lack of family support, lack of primary care, and chronic mental health issues, financial challenges etc.) that increase the risk the patient's needs will not be met. m) Identify and assess caregiver burden.
3. Analysis/Interpretation	a) Analyze and take appropriate action related to important clinical indicators (e.g., signs and symptoms, laboratory tests, adverse effects) to promote patient safety. b) Analyze outcomes against measurable therapeutic end points. c) Evaluate the reason for change from baseline pre-morbidity to current functional status. d) Evaluate the restorative potential of the older patient e) Demonstrate the ability to deal effectively and efficiently with clinical complexity by prioritizing problems f) Synthesize relevant information from multiple sources including perspectives of patients and families, colleagues, and other professionals.

4. Interprofessional Practice	a) Demonstrate both knowledge of critical concepts and the skills needed for the effective functioning in multidisciplinary/interprofessional clinical teams b) Help the team set goals and objectives and define tasks and roles of team members c) Provide leadership when appropriate and participate in determining how decisions are made d) Identify communication patterns and establish good working relationships, and evaluate and provide constructive feedback e) Identify and describe the training, role and expertise of members of the interprofessional team in the care of patients. f) Enter into interdependent relationships with other professions for the provision of quality care g) Actively communicate and collaborate with primary health care providers and other community partners h) Work with others to assess, plan, provide and review other tasks, such as research problems, educational work, program review or administrative responsibilities i) Demonstrate leadership in a health care team by managing self, engaging others, achieving results, building partnerships and championing change. j) Clearly describe own roles and responsibilities to other professionals within and outside the team k) Recognize and respect the diversity of roles, responsibilities and competencies of other professionals in relation to one's own l) Work with other health care professionals to promote health and wellness in the community. m) Demonstrate insight into own limits of expertise n) Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care o) Demonstrate a respectful attitude towards colleagues and members of an interprofessional team p) Work with other professionals to prevent conflicts q) Demonstrate an understanding of the problems that may occur in a interprofessional team r) Respect differences and address misunderstandings and limitations in other professionals s) Recognize one's own differences, misunderstanding and limitations that may contribute to interprofessional tension t) Reflect on interprofessional team function u) Demonstrate the skills needed to deal with challenging team dynamics

	v) Demonstrate and support interprofessional collaboration by (CIHC, 2010): i. Understanding the process of team development ii. Contributing to and upholding principles for working together that respect the ethical values of members iii. Effectively facilitating discussions and interactions among team members iv. Participating and being respectful of all members' participation in collaborative decision-making v. Regularly reflecting on own functioning with team learners/practitioners and patients/clients/families vi. Establishing and maintaining effective and healthy working relationships with learners/ practitioners, patients/clients, and families, whether or not a formalized team exists vii. Respecting team ethics, including confidentiality, resource allocation, and professionalism. w) Cooperate with and show respect for all members of the interprofessional team by. i. Making expertise available to others. ii. Sharing relevant information. iii. Contributing to identification of shared areas of concern and strategies and priorities for patient care to address those concerns. iv. Participating in integrated team decision making v. Supporting other professionals and accepting their support to optimize health outcomes.
5. Care Planning and Intervention	a) Apply evidence-informed interventions appropriate to a geriatric population. b) Assess acceptance, tolerance, safety, and adherence to the care plan. c) Conduct follow-up consultation(s) to evaluate the therapeutic effectiveness of care plans. d) Identify and appropriately discharge patients whose specialized geriatric service goals have been met. e) Use information about behavioural observations to inform a patient centred goal-based care plan. f) Propose a safety plan in response to abuse, in conjunction with clinical team and others (e.g. police). g) Mediate situations of conflict between older adults and their family members in relation to care planning. h) Balance client autonomy and safety decisions in care planning. i) Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of older patients.

	j) Include interventions to alleviate caregiver burden in the care plan. k) Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care. l) Reinforce the importance of advance care planning and discuss with patients and families the implications of their illness to allow patients and their families to prepare a robust advanced care plan. m) Support patients and their families to access timely and appropriate end-of-life care consistent with their belief systems. n) Develop care plans that include the use of preventive, adaptive and therapeutic interventions in collaboration with interprofessional team members. o) Negotiate and construct timely care plans reflecting a patient's goals, beliefs, concerns and expectations in the context of their health trajectory. p) Clearly synthesize the agreed interventions and responsibilities including follow up actions. q) Assure that individual responsibilities in a specific care plan are explicit and understood. r) Check for patient and family understanding, ability and willingness to follow through with recommended interventions within recommended time frames. s) Continue to refine interventions based on patient response and goal attainment. t) Encourage participation in health promotion and disease prevention activities.
6. System navigation	a) Demonstrate the ability to promote integrated care of older patients, especially those with complex needs, and ease transitions across the variety of settings where they may receive services. b) Identify the role of specialized geriatric services in providing case management for the frail senior.
7. Evaluation	a) Contribute to the discovery of new knowledge and skills (e.g., participating in collaborative health related research). b) Contribute to the development, dissemination, and translation of new knowledge and geriatric practices.
8. Professional Practice	a) Demonstrate compassionate and patient-centered care b) Use strength-based approaches throughout assessment and treatment planning c) Discuss with the patient the ongoing responsibilities of the geriatric assessor, patient and other health care professionals. d) Assess and respect the patient's need for and right to intimacy. e) Understand and apply the principles of capacity for decision making and informed consent. f) Follow procedures for voluntary consent or proxy decision making (e.g.

	Substitute Decision Maker, Public Guardian and Trustee etc.) that arise from aging issues. g) Obtain informed consent in collaboration with patient and family throughout assessment, care planning and interventions. h) Evaluate the impact of family dynamics on client's health, safety, and therapeutic goals i) Respect diversity and difference, including but not limited to the impact of gender, sexual identity, family dynamics, religion and cultural beliefs on decision-making. j) Address challenging issues effectively, such as obtaining informed consent, sensitively delivering bad news, addressing anger, confusion and misunderstanding. k) Facilitate older adults' active participation in all aspects of their own health care (i.e. access to information, right to self-determination, right to live at risk, access to information and privacy). l) Maintain the patient's health record as per host organizational policy and legislated requirements m) Document and share within the circle of care, the patient goals, appropriate findings of patient assessment, recommendations made, responsibilities of involved parties and actions taken. n) Demonstrate leadership and accountability for providing follow-up on identified patient needs or directing follow-up as appropriate. o) Document communication with patient and health care professionals across the broad care team in the appropriate locations (e.g. patient record and/or care plan) including connections with inter and extra agency team members, telephone calls of a clinical nature etc. p) Champion non ageist approaches to care to eliminate ageism and stereotyping of the older adult, especially those with cognitive and functional limitations q) Identify and appropriately respond to relevant ethical issues arising in patient care r) Demonstrate the ability to identify specific age-associated ethical issues in clinical practice s) Respect and promote older adults' rights to dignity and self-determination t) Evaluate self and demonstrate an understanding of the importance of and the process of continuing professional development. i. Critically reflect on own practice ii. Assess own learning needs. iii. Develop a plan to meet learning needs. iv. Seek and evaluate learning opportunities to enhance practice. v. Incorporate learning into practice. vi. Act as a preceptor/mentor for IP team and students