A Competency Framework for Interprofessional Comprehensive Geriatric Assessment

Final Report

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Introduction

According to the Regional Geriatric Programs (RGPs) of Ontario,

> *Comprehensive Geriatric Assessment (CGA) guides a multidimensional specialized geriatric team approach to care that determines a frail older person's biomedical, psychosocial, functional, and environmental needs, and initiates an appropriate treatment and follow-up plan… There is evidence demonstrating that CGA improves diagnostic accuracy, optimizes care plans, improves patient and system outcomes, and assists clinicians in identifying the need for treatment*[1]

The purpose of this competency framework is to describe detailed practice expectations of health professionals participating in the CGA. This Framework will help health professionals to adequately prepare themselves to deliver interprofessional comprehensive geriatric assessments and interventions and work effectively in a specialized geriatrics environment.

[1] RGP of Ontario (2016, p 1).

Background

This Framework draws on the definition of specialized geriatric services (SGS) and CGA developed by the RGPs of Ontario[2]. The Framework development was facilitated by Seniors Care Network, the North East Specialized Geriatric Centre, and the Regional Geriatric Program of Toronto, who oversaw the project through a Joint CGA Task Group, in collaboration with the RGPs of Ontario. The development of this Framework began with the Phase 1 Development Panel who conducted a review of existing relevant competency frameworks (see Appendix B) and undertook the iterative development of initial behavioural statements. A Phase 2 Expert Review Committee later focused on confirming the domains of the CGA (See Appendix A) laying the foundation for the revision of the initial behavioural statements. In Phase 3, A Provincial Expert Delphi Panel, a group of geriatric experts from a variety of health professional disciplines who were identified by their local RGP, completed three rounds of rigorous review, rating and revision, culminating in this final Framework. A list of all Expert Panel members is found at Appendix C.

Benefits to SGS Practice

The implications for practice resulting from this framework are expected to include: (1) improved quality of assessments; (2) improved goal-based care planning; (3) better tailoring of appropriate interventions; (4) appropriate follow-up and follow through; and (5) improved consistency in assessment practices across SGS providers. It is anticipated that this framework will support training needs assessment (TNA) approaches in SGS. This may include the critical appraisal of existing educational/training resources to identify most appropriate methods to support competency development across each domain, or the development of new strategies to support capacity development/education for practitioners related to interprofessional CGA.

[2] Ibid

Comprehensive Geriatric Assessment

A Philosophy Statement

CGA is the standard of care for specialized geriatric services for frail seniors[3]. The CGA is a multi-dimensional process used to manage care for frail seniors, and employs an interprofessional, patient-focused approach to comprehensive assessment and intervention[4,5]. The CGA is supported by a highly skilled interprofessional team that uses expert clinical judgment, evidence-informed practices, technology and tools, in order to gather, synthesize, and interpret information required to understand the patient's[6] story and biopsychosocial needs. The outcome of the CGA is an integrated clinical profile and an individualized care plan. The resulting care plan addresses patient goals, enables choice and includes practical interventions that support function, independence, restoration/rehabilitation and/or palliation. The team supports the patient and their identified support networks to implement their individualized care plans and interventions.

The CGA can be initiated by any member of the interprofessional team who has received appropriate training[7]. This means that all team members function as geriatric assessors, sharing a common set of competencies. Geriatric assessors are supported by an expert clinician whose scope includes diagnostic and prescriptive authority (e.g. geriatricians, non-specialist physicians or specialist nurse practitioners). 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. It is the combination of interprofessional geriatric assessment data, physical assessment findings, analysis and synthesis of the clinical profile and development of a collaborative plan of care and follow-up plans that constitutes a complete CGA.

Strengths of the interprofessional model in SGS include the leveraging of common geriatric competencies and profession-specific skills and knowledge. The integration of common geriatric competencies, profession-specific competencies, and collaborative competencies relevant to interprofessional practice, differentiates this practice model from multidisciplinary models of care.

[3] Stuck et al. (1993).
[4] Welsh et al. (2014)
[5] Ramani et al. (2014)
[6] Throughout this document the term "patient" is used and is intended to mean patient and their identified support system (e.g. caregivers, family).
[7] Grant. (2016)

The Competency Framework

Purpose

The *Competency Framework for Interprofessional Comprehensive Geriatric Assessment* includes practice-specific behavioural statements describing the common and overlapping requisite knowledge, skills, values, and attitudes (i.e. competencies) that are the foundational elements of competence in interprofessional geriatric team-based practice[8]. Competence is demonstrated through the application of appropriate clinical judgments and actions in the context of care for older people living with frailty.

Health professionals performing an interprofessional CGA are regulated health professionals[9] who use core geriatric knowledge to guide a multidimensional CGA. The competencies needed to enable an effective CGA are in addition to discipline specific competencies relevant to an individual's specific profession. Further, some health professions require additional role-specific professional competencies (e.g. physicians, nurse practitioners, etc.), that are not intended to be described in this work.

This competency framework is not intended to replace practice competencies required by health professional regulatory colleges, but to supplement/complement the practice of experienced clinicians who are now working in geriatrics.

[8] Frank et al. (2010)

[9] Geriatric Assessors may include, but are not limited to: Dietitians, Occupational Therapists, Pharmacists, Physiotherapists, Registered Nurses, Registered Practical Nurses, Social Workers, Speech-Language Pathologists and others. 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.

Practice Areas and Behavioural Statements

1. CORE GERIATRIC KNOWLEDGE

Definition: *Demonstrate fundamental understanding of physiological and biopsychosocial mechanisms of the aging processes, age-related changes to functioning, and the impact of frailty.*

1.a) Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to geriatric clinical practice, including but not limited to:

- 1.a.i) Normal aging
- 1.a.ii) Frailty
- 1.a.iii) Atypical presentation of disease or medical conditions in the older adult
- 1.a.iv) Geriatric management of the older adult with multiple, complex medical conditions
- 1.a.v) Falls and mobility
- 1.a.vi) Immobility and its complications
- 1.a.vii) Cognitive function
- 1.a.viii) Mild cognitive impairment (MCI)
- 1.a.ix) Dementias including behavioral and psychological symptoms (BPSD)
- 1.a.x) Delirium
- 1.a.xi) Mood disorders and other psychiatric manifestations
- 1.a.xii) Pain management
- 1.a.xiii) Nutrition/Malnutrition
- 1.a.xiv) Bowel and bladder management
- 1.a.xv) Bone disorders
- 1.a.xvi) Metabolic disorders

1.b) 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).

1.c) Demonstrate knowledge of medications management, including but not limited to:

- 1.c.i) Complete a detailed Best Possible Medication History and perform medication reconciliation.
- 1.c.ii) Promote adherence to a prescribed drug regimen.
- 1.c.iii) Identify potentially inappropriate medications for an older adult patient.
- 1.c.iv) Recognize polypharmacy.

1.d) Demonstrate knowledge of currently accepted recommendations for primary and secondary prevention of common geriatric syndromes.

1.e) Demonstrate an awareness of the limitations of the scientific literature with regard to generalizability and applicability to a frail older population.

2. SCREENING, ASSESSMENT, AND RISK IDENTIFICATION

Definition: *Gather patient medical and social history and clinical data in sufficient depth to inform care planning and effective clinical decision making.*

2.a) Identify and explore issues to be addressed in a patient encounter including the patient's context and preferences.

2.b) Conduct an assessment within identified domains of the CGA using clinical acumen in conjunction with standardized, valid, reliable instruments as appropriate.

2.c) Recognize important clinical indicators to promote patient safety (e.g. signs and symptoms, laboratory tests, adverse effects).

2.d) Assess an older person with multiple physical, medical, cognitive/psychiatric, functional, and/or social problems.

2.e) Identify reliable sources of information to inform the patient history (e.g. Cumulative Patient Profile, involved family etc.).

2.f) 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.

2.g) Gather information about a patient's beliefs, concerns, expectations and illness experience.

2.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).

2.i) Recognize the significance of behavioural observations in dementia care.

2.j) Assess an older person for their capacity to consent to treatment and make personal decisions.

2.k) Recognize and identify risk factors for and assess the presence of abuse/neglect (i.e. financial, physical, emotional, sexual).

2.l) Perform and/or interpret an environmental safety screen.

2.m) 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.

2.n) Identify and assess caregiver burden.

3. ANALYSIS AND INTERPRETATION

Definition: *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.*

3.a) Synthesize relevant information from multiple sources including perspectives of patients and families, colleagues, and other professionals.

3.b) Analyze and interpret results against age-appropriate and patient-specific norms.

3.c) Analyze and take appropriate action related to important clinical indicators (e.g. signs and symptoms, laboratory tests, adverse effects) to promote patient safety.

3.d) Evaluate the reason for change from baseline pre-morbidity to current functional status.

3.e) Evaluate the restorative potential of the older patient.

3.f) Demonstrate the ability to deal effectively and efficiently with clinical complexity by prioritizing problems.

4. CARE PLANNING AND INTERVENTION

Definition: *Demonstrate expertise in treatment, education, goal setting, future and advance planning. With patients and their identified support network, formulate comprehensive, collaborative care plans focused on optimization of function and quality of life. Demonstrate knowledge of community resources and appropriate referral sources and mechanisms to access them. Conduct iterative and ongoing review and revision of the care plan and adjust interventions and modify goals as needed.*

4.a) Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care.

4.b) Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of older patients.

4.c) Include interventions to alleviate caregiver burden in the care plan.

4.d) Apply evidence-informed interventions appropriate to a geriatric population.

4.e) Use information about behavioural observations to inform a patient centred goal-based care plan.

4.f) Develop care plans that include the use of preventive, adaptive and therapeutic interventions in collaboration with interprofessional team members.

4.g) Negotiate and construct timely care plans reflecting a patient's goals, beliefs, concerns and expectations in the context of their health trajectory.

4.h) Clearly synthesize the agreed interventions and responsibilities including follow-up actions.

4.i) Assure that individual responsibilities in a specific care plan are explicit and understood.

4.j) Check for patient and family understanding, ability and willingness to follow through with recommended interventions within recommended time frames.

4.k) Encourage participation in health promotion and disease prevention activities.

4.l) Promote safety while respecting patient autonomy in care planning decisions.

4.m) Propose a safety plan in response to abuse, in conjunction with clinical team and others (e.g. police).

4.n) Mediate situations of conflict between older adults and their family members in relation to care planning.

4.o) Conduct follow-up consultation(s) to evaluate the therapeutic effectiveness of care plans.

4.p) Assess acceptance, tolerance, safety, and adherence to the care plan.

4.q) Continue to refine interventions based on patient response and goal attainment.

4.r) 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.

4.s) Identify the role of specialized geriatric services in providing case management for the frail senior.

4.t) Identify and appropriately discharge patients whose specialized geriatric service goals have been met.

4.u) 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 advance care plan.

4.v) Support patients and their families to access timely and appropriate end-of-life care consistent with their belief systems.

5. INTERPROFESSIONAL PRACTICE

Definition: *Demonstrate and support interprofessional geriatric practice. Recognize and engage in inter-organizational collaboration through 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.a) Demonstrate both knowledge of critical concepts and the skills needed for the effective functioning in multidisciplinary/interprofessional clinical teams.

5.b) Identify and describe the role and expertise of members of the interprofessional team in the care of patients.

5.c) Demonstrate insight into limits of own expertise.

5.d) Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care.

5.e) Demonstrate the skills needed to address potential differences and misunderstandings between professionals.

5.f) Regularly reflect on dynamics and productivity of self and interprofessional team.

5.g) Cooperate with and show respect for all members of the interprofessional team by:

- 5.g.i) Making expertise available to others.
- 5.g.ii) Sharing relevant information.
- 5.g.iii) Contributing to identification of shared areas of concern and strategies and priorities for patient care to address those concerns.

5.h) Participate in defining team goals and objectives.

5.i) Effectively collaborate with others, including primary health care providers and other partners:

- 5.i.i) To provide quality care.
- 5.i.ii) In research, education, program review or administrative responsibilities.
- 5.i.iii) To promote health and wellness in the community.

6. PROFESSIONAL PRACTICE

Definition: *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.*

6.a) Demonstrate compassionate and patient-centered care.

6.b) Facilitate older adults' active participation in all aspects of their own health care (e.g. access to information, right to self-determination, right to live at risk, access to information and privacy).

6.c) Respect and promote older adults' rights to dignity and self-determination.

6.d) Demonstrate leadership and accountability for providing follow-up on identified patient needs or directing follow-up as appropriate.

6.e) Discuss with the patient the ongoing responsibilities of the geriatric assessor, patient and other health care professionals.

6.f) Understand and apply the principles of capacity for decision making and informed consent.

6.g) Follow procedures for voluntary consent or proxy decision making (e.g. Substitute Decision Maker, Public Guardian and Trustee etc.) that arise from aging issues.

6.h) Obtain informed consent throughout assessment, care planning and interventions.

6.i) Evaluate the impact of family dynamics on patient's health, safety, and therapeutic goals.

6.j) Respect diversity and difference, including but not limited to the impact of gender, sexual identity, family dynamics, religion and cultural beliefs on decision-making.

6.k) Address challenging issues effectively, such as obtaining informed consent, sensitively discussing a diagnosis/prognosis, addressing emotional responses, confusion or misunderstanding.

6.l) Identify and appropriately respond to relevant ethical issues arising in the care of older adults.

6.m) Maintain the patient's health record as per organizational policy and legislated requirements.

6.n) 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.

6.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.

6.p) Evaluate self and demonstrate an understanding of the importance of and the process of continuing professional development.

- 6.p.i) Critically reflect on own practice.
- 6.p.ii) Assess own learning needs.
- 6.p.iii) Develop a plan to meet learning needs.
- 6.p.iv) Seek and evaluate learning opportunities to enhance practice.
- 6.p.v) Incorporate learning into practice.
- 6.p.vi) Act as a preceptor/mentor for interprofessional team and students.

Appendix A: Domains of Assessment

In Fall 2014, an initial clinician panel identified an extensive list of domains and elements believed to be required for the delivery of an interprofessional comprehensive geriatric assessment and associated interventions (CGA). This list was created based on clinical experience and current evidence. Through an iterative decision making process with provincial experts, the initial domains were then consolidated into thirteen broad assessment domains and constituent elements. This list of domains and elements was approved by the Regional Geriatric Programs (RGPs) of Ontario in June 2016. This final list of domains is included in this appendix and underpins the development of the *Competency Framework for Interprofessional Comprehensive Geriatric Assessment.*

The approach to CGA includes the clinical review of the following 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.

The thirteen broad assessment domains that have been endorsed by the RGPs of Ontario are described 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 accurately determine whether more detailed assessment is needed within the domain to develop a full clinical profile 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 concerns are identified • Use of additional in-depth interviewing and/or validated tools as needed to further explore areas of concern

Introduction	Medical/Surgical History	Medication	Social History	Falls	Function
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) Medication Adherence Packaging and Administration	Gender/ Sexuality Culture/lan-guage/religion/ place of birth Family Demographic (marital status, children) POA/SDM Advance Care Directives Caregiver Support/ Burden/Social & Community Supports Current or Past Occupation Financial Resources Alcohol/Smoking /Recreational drugs (past and present) Abuse/Neglect (i.e. Financial/ Physical/ Emot-ional/Sexual) Hobbies and interests	History of Falls/Near Falls Identification of Modifiable Risk Factors Head Injury Risk	Living Environment (Safety) Equipment/Assist-ive Devices Mobility/ Transfers/Gait/ Balance Activities of Daily Living (ADLs) Instrumental Activities of Daily Living (IADLs) Driving/ Transportation

Cognition	Mood/Mental Health	Sleep	Pain	Nutrition	Continence	Physical Assessment
Subjective Cognitive Decline (SCD) Mild Cognitive Impairment Dementia (stage and type) Responsive Behaviours Delirium history 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	Past/current issues with mood Depression Mental Health Anxiety Suicide Grief/Loss Stress Addictions Apathy	Changes in Sleep Patterns Sleep Apnea	Chronic/ Acute Non-Pharmaco-logical Treatments	Amount of Unintentional Weight Loss in the Past 6 Months Reduced Food Intake (how long?) Hydration Swallowing	Bladder/ Bowel	Vitals Orthostatic Hypotension Vision Hearing Oral Health Neurological Musculo-skeletal (MSK) Cardiovascular Respiratory Gastroenter-ology Foot Skin/Nodes/ Thyroid Labs/ Diagnostics

Appendix B: 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)[10]. 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

[10] With additional consultation provided by Dr. Birgit Pianosi, Chair of the Competency Task Force, AGHE, Associate Professor, Gerontology, Huntington University.

Appendix C: Expert Panels

These domains and elements of the CGA, and competencies were consolidated, reviewed and edited through several iterative review cycles.

PHASE 1: DEVELOPMENT PANEL

Preliminary domains and elements of the CGA and initial behavioural statements reflecting the unique context of team-based specialized geriatrics were created by an expert working group that included:

Carolee Awde-Sadler, Clinical Pharmacist,
Geriatric Assessment and Intervention Network (GAIN)

Melanie Briscoe, OT Reg. (Ont.)
Manager of Clinical Services, Northeast Specialized Geriatric Centre

Dee Craddock, RN, MN
Care Coordinator, Geriatric Assessment and Intervention Network (GAIN)

Debbie Daly RN(EC) MN, Nurse Practitioner
GAIN Regional Clinical Lead & GAIN Clinic Lead, The Scarborough and Rouge Hospital

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Research and Project Coordinator NESGC

Don Doell, MD, FRCPC
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Lynda Dus
Administrative Assistant, Geriatric Assessment and Intervention Network (GAIN)

Stacey Hawkins, MA, CPG
Director System Planning, Implementation and Evaluation, Seniors Care Network

Kelly Kay, MA (Leadership-Health Specialization)
Executive Director, Seniors Care Network

Lesley Krempulec, OT Reg. (Ont.)
Director, Geriatric Assessment and Intervention Network (GAIN) - CareFirst Seniors

Valerie Scarfone
Executive Director, Northeast Specialized Geriatric Centre

Shirin Vellani, RN(EC), NP(Adult), MN, BA, GNC(C)
Geriatric Assessment and Intervention Network (GAIN), SPLC

PHASE 2: REVIEW PANEL

Preliminary domains and elements of the CGA and initial behavioural statements were distributed to a group of expert reviewers who completed a decision matrix and provided input prior to launching the Provincial Expert Delphi Panel. The Phase 2 Review Panel Included:

Individual Reviewers

Michelle Acorn, RN(EC), NP(Adult), PhD
Lakeridge Health

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Sinai Health System

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Michael Bernard, RN(EC), NP(Adult)
Peterborough Family Health Team

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Executive Director, RGP of Toronto

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GAIN SPLC

Ken Wong, BScPT, MSc
Education Consultant, RGP of Toronto

Group Reviewers

- NPSTAT Program, Central East LHIN
- RGP of Eastern Ontario
- South West RGP (Parkwood Institute)

PHASE 3: PROVINCIAL EXPERT DELPHI PANEL

Revised behavioural statements were incorporated into a Delphi consensus process and underwent three rounds of review and revision by a group of expert reviewers from across Ontario. Panel members were identified and selected through the Regional Geriatric Programs of Ontario. This panel included:

Julia Borges, BSc
University of Waterloo

Jo-Anne Clarke, MD, FRCPC, Geriatrician
Clinical Lead, Northeast Specialized Geriatric Centre

Audrey Devitt
Waterloo-Wellington Geriatric Services System Coordinator
Canadian Mental Health Association AND St. Joseph's Health Centre Guelph

AnnMarie Dimillo, RN, BScN
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