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Recommended Curriculum Guidelines for Family Medicine Residents

Care of Older Adults

This document was endorsed by the American Academy of Family Physicians (AAFP).

Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME), www.acgme.org. The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skill set and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME website. Current AAFP Curriculum Guidelines may be found online at www.aafp.org/cg. These guidelines are periodically updated and endorsed by the AAFP, and in many instances, other specialty societies as indicated on each guideline.

Each residency program is responsible for its own curriculum. **This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.**

Preamble

The percentage and number of older adults in the population continues to increase in the United States and throughout the world. Older adults occupy a large number of acute care hospital beds, are the largest percentage of nursing home residents, and make more visits to physicians' offices than any other segment of the population. The acquisition of age-appropriate skills and knowledge in taking an older adult patient's history, performing a physical examination, making clinical and psychosocial diagnoses, and managing a patient's condition must be an integral part of residency training. As the U.S. health care system continues to evolve, we will need to develop better strategies for providing quality care to this complex segment of the population while framing care of older adults with attention to patient-specific goals of care and multimorbidity.

There are many subtle, yet significant, differences in the diagnosis and management of older adults when compared with younger patients. The philosophy of providing comprehensive, continuous care includes the belief that a patient's health in later years is vitally affected by lifestyle and health care patterns established earlier in life. Family physicians play a critical role in promoting health maintenance and optimizing chronic disease management as patients age. They also play an integral role in helping older adults maintain physical function and independence for as long as possible. Family medicine residents must gain skill in helping older adults develop appropriate goals of care and competence in developing patient-specific plans of care for older adults across care settings, including end-of-life care. This curriculum applies a comprehensive approach to the psychosocial and economic factors affecting aging patients and their families.

Competencies

At the completion of residency training, a family medicine resident should be able to:

- Perform comprehensive, standardized geriatric assessments and develop patient-specific treatment plans that incorporate the patient's goals of care, optimize function, and alleviate symptoms (Patient Care, Medical Knowledge)
- Optimize treatment plans based on knowledge of local geriatric care resources, including local, state, and federal agencies (Systems-based Practice, Practice-based Learning and Improvement)
- Lead coordination of care for older adults across ambulatory, inpatient, and institutional care settings and across health care providers, institutions, and governmental agencies (Systems-based Practice)

- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure the treatment plan is developed collaboratively and is clearly understood (Interpersonal and Communication Skills)
- Recognize practice limitations and seek consultation with other health care professionals when necessary to provide optimal care for older adults (Patient Care)

Attitudes

The resident should demonstrate attitudes that encompass:

- Awareness of the effects that attitudes and stereotypes related to aging, disability, acute/chronic pain, and death can have on the care of older adults
- Empathy and compassion for older adults and their families/caregivers when helping them cope with physical, functional, and/or cognitive decline and loss
- Promotion of the patient's dignity through self-care and self-determination
- Recognition of the importance of family, friends, home, and other social constructs in the overall lifestyle and health of patients
- Understanding of appropriate ages for the initiation and cessation of screening based on practice guidelines and be cognizant of the limitations of screening and treatment, which benefits the patient
- Awareness of the importance of a multidisciplinary and holistic approach to the enhancement of individualized, comprehensive care for older adults
- Accessibility to and accountability for patients and their families/caregivers
- Awareness of the need to consider resources and related limitations when developing patient-specific treatment plans for older adults
- Awareness of the benefits, limitations, and appropriate use of advance directives, living wills, durable powers of attorney, and where enacted by state statute, Medical Orders for Life-Sustaining Treatment
- Awareness of benefits, limitations, and appropriate use of formalized inpatient and/or outpatient hospice services
- Empathy when screening for depression, especially in older patients who are accustomed to a very independent lifestyle
- Compassion when screening for elder neglect or caregiver burnout, as many cases may be unintentional
- Accommodations for our veteran elderly population who may benefit from community resources, as well as mental health care services

Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. Normal physiologic changes that are associated with aging
    a. Diminished homeostatic abilities
    b. Altered metabolism and effects of drugs
    c. Physiology of aging in various organ systems
2. Normal psychological, social, and environmental changes of aging
    a. Reactions to common stressors, including retirement, bereavement, relocation, illness, and natural decline in physical and cognitive abilities
    b. Changes in family and socioeconomic parameters that affect health
3. Unique modes of presentation for care, including atypical presentations of specific diseases in older adult patients
4. Risk points and adverse outcomes in geriatric care, including:
    a. Polypharmacy, to include homeopathic and over-the-counter medications
    b. Transitions of care
    c. Non-recognition of treatable illness
    d. Iatrogenic illness
    e. Improper medication reconciliations
    f. Treatment that does not take goals of care into account
    g. Functional impairment, immobilization, and associated consequences
    h. Cognitive impairment and associated consequences
    i. Inappropriate institutionalization
    j. Unsupported family/caregivers
5. Promotion of health maintenance through patient- and age-appropriate screening and risk factor assessment
6. Promotion of health in older adults through exercise, nutrition, vaccinations, and behavioral or lifestyle counseling
7. Services available to promote rehabilitation or maintenance of physical independence of older adults, thus enhancing their ability to function in their existing family, home, and social environments
8. Community resources, including those used to help patients maintain independence

9. Indications for and benefits of the house call in the assessment and management of older adults

10. Characteristics of various types of housing alternatives and long-term care options available to the older adults, including independent living, personal care homes, assisted living, skilled nursing home care, and custodial nursing homes

11. Fiscal aspects of health care, with understanding of Medicare, Medicaid, housing, and long-term care funding

12. Recognition and management of elder abuse and neglect

13. Evaluation of the functional status of older adults

14. Evaluation of the cognitive status of older adults

15. Sexuality of older adults

16. Physical activity, leisure, hobbies, and exercise for older adults

17. Care of conditions that are common in older adults can impose significant burden or differ in presentation and/or management in older adults, such as:
    a. Sensory: hearing and vision loss, speech disorders, changes in taste, vestibular dysfunction, altered proprioception
    b. Respiratory: chronic obstructive pulmonary disease (COPD), pneumonia (infectious, aspiration, and silent micro-aspiration), bronchitis, upper respiratory infection, obstructive sleep apnea (OSA)
    c. Cardiovascular: hypertension, congestive heart failure, myocardial infarction, valvular heart disease, thromboembolism, temporal arteritis, cerebral vascular accident, transient ischemic attacks, syncope, postural hypotension, atrial fibrillation, and other arrhythmias
    d. Oral conditions: caries, periodontal disease, tooth loss, denture care, xerostomia, oral-pharyngeal cancers, oral-systemic linkages
    e. Gastrointestinal: dentition problems, dysphagia, gastroesophageal reflux, abdominal pain, constipation, fecal impaction
    f. Genitourinary: incontinence, urinary tract infections, asymptomatic bacteriuria, sexual dysfunction, prostate disease, pelvic prolapse
    g. Musculoskeletal: degenerative joint disease, osteopenia/osteoporosis, fractures, contractures, rheumatologic disease, podiatric problems, falls
    h. Neurological: pain, mild cognitive impairment, memory loss, delirium, dementia, altered mental status, dizziness, tremor, gait dysfunction, sleep disturbance
    i. Metabolic: dehydration, electrolyte imbalance, diabetes, hypothyroidism, medication-induced illness, malnutrition, anemia, hypothermia, malignancies, failure to thrive

j. Psychosocial: anxiety, depression, psychological effects of illness, alcoholism and other substance abuse, smoking, grief reactions, abuse (physical, financial, and psychological), gambling, end-of-life care

k. Dermatologic: xerosis, cutaneous neoplasms, environmental and traumatic lesions, including skin tears and pressure ulcers, wounds, and skin manifestations of systemic illness

l. Medication: pain management, Beers list, anticoagulation and novel oral anticoagulation (NOAC) management

m. Prevention and screening: United States Preventive Services Task Force (USPSTF) recommendations for prevention and screening for seniors

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer the following:

1. Basic elements of geriatric assessment, including the standardized methods for assessing physical, cognitive, emotional, and social functioning

2. Screening examinations for mental status, cognitive status, depression, and functional status, including activities of daily living (ADL) and instrumental activities of daily living (IADL)

3. Physical diagnosis, including:
   a. Mobility, gait, and balance assessments
   b. Recognition of normal and abnormal signs of aging
   c. Perioperative assessment and management
   d. Comprehensive history and mental status examination, utilizing all available sources of information
   e. Evaluation of the appropriate use of assistive devices (e.g., cane, walker, wheelchair, power chair)

4. Efficient and comprehensive physical examination in the following venues: office, hospital, home, and nursing home settings

5. Appropriate selection, performance, and interpretation of diagnostic procedures in older adults

6. Common office procedures for older adults

7. Comprehensive medication review and prescription of appropriate medications and dosages with consideration of age-related physiology, side effects in light of the patient's comorbidities, functional status, other medications, and drug-drug interactions

8. Appropriate house calls and coordination of home care services

9. Development of problem lists in practical, clinical, functional, psychological, and social terms

10. Integration of factors in the patient's family life, home life, and general lifestyle in the diagnostic and therapeutic process

11. Establishment of appropriate priorities and limitations for investigation and treatment

12. Communication with the patient and/or caregivers about proposed investigation and treatment plans in a way that promotes understanding, adherence, and appropriate attitudes

13. Provision of counseling for patients about age-related psychological, social, and physical stressors, and normal life cycle changes, including aging and death

14. Coordination across disciplines of a range of services appropriate to the patient's needs and support systems

15. Participation with an interdisciplinary team in transitions of care to ensure that accurate data (e.g., acute events, medical history, medications, allergies, baseline cognitive and functional status, physical findings, advance care plan, responsible physician) are well documented; that the patient and/or family understand the plan of care; and that the follow-up plan is clearly outlined

16. Attendance to patient safety concerns (e.g., fall risk, hydration, nutrition, bladder and bowel function, skin integrity, inappropriate medications) in the assessment and management of older adults across care settings

17. Recognition of warning signs of potential elder abuse or misuse, differentiating the normal sequelae of aging from that of abuse; identifying the multiple facets of potential abuse and identification of appropriate resources for reporting, treatment, and protection of the elder.

18. In patients with life-limiting or advanced chronic illness, assessment for symptoms (e.g., pain, dyspnea, nausea, vomiting, fatigue, constipation) at regular intervals and institution of appropriate treatment based on goals of care

Implementation

This curriculum should be taught during both focused and longitudinal experiences throughout the residency program. Physicians who have demonstrated competence and compassion in caring for older adults and who have a positive attitude toward older adults should be available to act as role models to the residents and should be available to provide education and support to residents who are managing their own older adult patients. A multidisciplinary approach coordinated by the family physician is an appropriate method for structuring teaching experiences. Individual teaching, home

visits, reflective narratives, simulations, and small group discussion will help promote appropriate attitudes.

The resident should be responsible for caring for older adults across care settings and have opportunities to act as the team leader and patient advocate. Teams should include decision makers, caretakers, counselors, case managers, and family members. Each family medicine resident's panel of patients should allow for exposure to a variety of patients, including healthy, community-dwelling older adults; older adults suffering from chronic illness; acutely ill and/or hospitalized older adults; and patients at the end of life. This experience must include cognitive and functional assessments, disease prevention, health promotion, and management of older adults with multiple chronic diseases. The resident should be required to have experiences providing continuing care for older adult patients in the ambulatory setting, the home, the hospital, and in long-term care.

Resources

Tatum P, Talebreza S, Ross J. Geriatric assessment: an office-based approach. *Am Fam Physician*. 2018;97(12):776-784.

Wang Z, Dong B. Screening for cognitive impairment in geriatrics. *Clin Geriatr Med*. 2018;34(4):515-536.

Accreditation Council for Graduate Medical Education. American Board of Family Medicine. American Board of Internal Medicine. The Geriatric Medicine Milestone Project. https://acgme.org/Portals/0/PDFs/Milestones/GeriatricMedicineMilestones.pdf?ver=2015-11-06-120530-847

Quill TE, Periyakoil VS, Denney-Koelsch E, et al. *Primer of Palliative Care.* 7th ed. Glenview, Ill: American Academy of Hospice and Palliative Medicine; 2019.

Brangman S, Periyakoil VS, eds. *Doorway Thoughts: Cross-Cultural Health Care for Older Adults*. Volume 2; American Geriatrics Society; 2014.

Durso SC, Sullivan GM, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine*. 9th ed. New York, NY: American Geriatrics Society; 2016.

Reuben DB, Herr KA, Pacala JT, Pollock BG, Potter JF, Semla TP. *Geriatrics at Your Fingertips.*17th ed. Mechanicsburg, Pa: Fry Communications; 2015.

Ham RJ, Sloane PD. *Ham's Primary Care Geriatrics, A Case-Based Approach*. 6th Edition. Philadelphia, PA: Elsevier Saunders, 2014.

Website Resources

American Geriatrics Society. www.americangeriatrics.org/

Journal of the American Geriatric Society. onlinelibrary.wiley.com/journal/15325415

American Academy of Hospice and Palliative Medicine. aahpm.org/

American Association for Geriatric Psychiatry. www.aagponline.org/

British Geriatrics Society. www.bgs.org.uk/

The University of Iowa. Iowa Geriatric Education Center. igec.uiowa.edu/

National Institute on Aging. www.nia.nih.gov/health/elder-abuse

U.S. Preventive Services Task Force. www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations