Medicine
UNIVERSITY OF TORONTO | Geriatric Medicine

EPA COD#2

COD #2 Managing older adults with multiple co-morbidities across the spectrum of frailty

Key Features

- This EPA focuses on developing an individualized management plan, demonstrating knowledge of a wide variety of interacting medical conditions common in older adults, and projecting trajectory of illness and care needs.
- In addition to conducting a CGA, this EPA includes integrating the degree of frailty using a validated frailty assessment tool, performing advanced medication reviews, applying optimal prescribing and deprescribing practices, and recommending health promotion as applicable.
- This EPA may be observed across multiple clinical settings, including collaborative geriatric specialty services.

Assessment Plan:
Case discussions with supervisor.

- Case mix (select all that apply) hypertension; coronary artery disease; CHF; arrhythmia; stroke; diabetes; chronic kidney disease; anemia; Parkinson's Disease; movement disorders; COPD; pain; osteoporosis; gout; osteoarthritis; polymyalgia rheumatica; spinal stenosis; infections; thromboembolic disease; common rheumatological conditions; other
- Frailty: mild; moderate; severe
- Multiple co-morbidities: yes; no
- **Setting:** inpatient consult; geriatric unit; outpatient clinic; day hospital; geriatric oncology service; trauma service; hip fracture service; transcatheter aortic valve implantation (TAVI) service; pre-operative assessment service.

Target

Collect 5 observations of achievement.

- A variety of case mix
- At least 1 patient with moderate or severe frailty
- At least 2 different settings

Milestones in Elentra

- **ME 1.3 Apply a broad base and depth of knowledge in clinical and biomedical sciences to manage the breadth of patient presentations across the spectrum of frailty including multiple complex interacting comorbidities.**
- **ME 2.1 Iteratively establish priorities, considering the perspective of the patient and family as the patient's situation evolves.**
- **ME 2.2 Project the trajectory of illness and care needs**
- **ME 2.2 Integrate new findings and changing clinical circumstances into the assessment of the patient's clinical status.**
- **ME 2.2 Perform medication reviews.**
- **ME 2.4 Establish a patient-centred management plan informed by comprehensive geriatric assessment.**
- **ME 2.4** Develop, in collaboration with the patient and family, a plan to deal with clinical uncertainty**.**
- **ME 2.4 Integrate the results of a frailty assessment to develop a management plan that is safe, patient-centred, and considers the risks and benefits of all approaches.**
- **ME 3.3 Balance risk, effectiveness and priority of interventions in the presence of multiple co-morbidities.**
- **COM 3.1 Share information and explanations that are clear and accurate while checking for patient and family understanding.**
- **COM 3.1** Convey information related to the patient's health status, care, and needs in a timely, honest, and transparent manner.
- **COL 1.3 Engage in respectful shared decision-making with other physicians and/or health care professionals.**
- **HA 1.2 Incorporate disease prevention and health promotion into interactions with individual patients, as applicable.**