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, 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

Target

- Collect 5 observations of achievement
- A variety of case mix
- At least 2 different settings

Case presentation

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

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 service

Assessor

- Geriatrician

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 co-morbidities
- 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