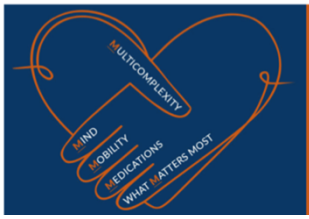
AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.



THE GERIATRICS 5Ms

Minimum Competencies in Geriatrics for Medical Students

The graduating medical student, in the context of a specific older adult patient scenario, must be able to demonstrate the following, in collaboration with an interprofessional team when appropriate:

MIND

1.	**Cognitive concerns:** In an older patient for whom there are concerns about cognition or mood, obtain a detailed history from the patient and/or caregiver as appropriate , perform a physical exam, and use validated screening tools to differentiate among normal aging, delirium, dementia, or depression.
2.	**Capacity:** Identify the abilities an older patient must demonstrate to determine capacity for making a medical decision.
3.	**Delirium diagnosis:** Identify delirium as a medical emergency and urgently initiate a diagnostic work-up for precipitating factors.
4.	**Agitation management:** In an agitated patient with delirium or dementia with behavioral symptoms, attempt to determine underlying causes, and identify treatment strategies that avoid pharmacological and physical restraints, unless the patient poses a risk to themselves or others.

MOBILITY

5.	**Functional assessment:** Perform and interpret a functional assessment in an older patient that includes basic and instrumental activities of daily living. Collaborate with appropriate interprofessional team members to optimize the patient's functional status.

6.	**Fall risk screening**: Screen older patients for fall and fracture risks, identify intrinsic and extrinsic risk factors, including environmental hazards and the improper use of assistive devices, and perform and interpret a gait and balance assessment using a validated screening tool.
7.	**Fall risk management**: In an older patient at increased risk of falls or fractures, collaborate with interprofessional team members, such as pharmacists, physical therapists, and occupational therapists, to develop a plan to mitigate fall risk.
 **MEDICATIONS**	
8.	**Medication reconciliation**: For each medication on an older patient's complete medication list (prescribed, over-the counter, supplements, vitamins, and herbals), accurately document the dose, frequency, and indication, and identify barriers to adherence, and collaborate with pharmacists when appropriate.
9.	**Geriatric pharmacology**: When reviewing or prescribing medications, justify drug selection and dosing based on how age-related physiologic changes may impact drug pharmacokinetics and pharmacodynamics.
10.	**Prescribing cascades**: In an older patient with new symptoms, review the medication list to determine if a medication adverse effect, drug-drug interaction, and/or drug-disease interaction may be contributing, and demonstrate how the treatment plan can be modified to avoid a prescribing cascade.
11.	**Deprescribing**: When evaluating an older patient's medication list, describe strategies for optimizing medication regimens, and deprescribing those medications which are potentially inappropriate, high risk, or lack a current indication.
 **MULTICOMPLEXITY**	
12.	**Health equity**: Identify how structural and social determinants of health, including systemic racism, ageism, and sexism, impact health outcomes and healthcare access for older adults and those who care for them, and take steps to overcome one's own biases when addressing issues of health equity.

13.	**Transitions of care**: Describe a transition of care plan for an older patient based on the level of care needed at discharge, functional status, and available community resources. Communicate care course, ongoing care needs, and an accurate and reconciled medication list to the receiving clinician.
14.	**Hazards of hospitalization**: Describe the hazards of hospitalization for an older patient, including loss of mobility, falls, malnutrition, delirium, pressure injuries, infection, potentially inappropriate medications, incontinence, procedural risks, and risks during transitions of care, and utilize strategies for prevention of these hazards.
15.	**Atypical presentations**: Demonstrate consideration of conditions that may present uniquely in older adults when constructing a differential diagnosis for an older patient with an acute concern. These conditions include infections, surgical emergencies, cardiac conditions and fluid and electrolyte abnormalities.
16.	**Aging physiology**: Identify changes of normal aging within each organ system and how these contribute to homeostenosis (the age-related narrowing of homeostatic reserve mechanisms) by impacting function, physiologic reserve, diagnosis and treatment.
17.	**Frailty**: Recognize the heterogeneity of aging by identifying an older patient's current status along the spectrum of fit to frail, using a validated screening tool.
18.	**Prognosis**: Use validated disease-specific or multimorbidity-based prognostic tools for estimating life expectancy in older adults and informing clinical decision making. Recognize the role of social and structural determinants of health in prognosis for older adults.
19.	**Individualized recommendations**: Demonstrate inclusion of prognostic information, frailty status and patient preference in recommendations for screening, diagnosis, treatment and end of life care.
20.	**Sensory impairment**: Screen for hearing, vision, and oral health concerns that may impact cognition, function, social isolation, and health outcomes. Collaborate with interprofessional team members, such as audiologists, optometrists, and dentists, to recommend appropriate assistive devices.
21.	**Pressure injuries**: Identify an older patient's risk for skin breakdown, routinely examine high risk pressure injury areas, and involve appropriate interprofessional team members, such as nurses and wound care specialists, to mitigate risk.

22.	**Urinary incontinence**: Screen for urinary incontinence, elicit precipitating factors, and identify which type of urinary incontinence is most likely.

MATTERS MOST

23.	**Communication**: For older patients who may have caregivers present, and particularly for those with cognitive, sensory, or functional impairment, use communication techniques to demonstrate cultural sensitivity and respect, including appropriate body language and thoughtful seating arrangements to avoid marginalization.
24.	**Psychosocial and spiritual needs**: Identify the psychological, social, and spiritual needs of an older patient and/or caregiver, recognize signs of caregiver stress, elder neglect, and elder abuse, and collaborate with interprofessional team members, such as social workers and chaplains, to identify appropriate resources.
25.	**Symptom assessment**: Assess non-pain and pain symptoms in an older patient, and collaborate with interprofessional team members, including those from nursing, pharmacy, and palliative care, to reduce suffering through non-pharmacologic and pharmacologic treatments, based on the patient's goals of care and safe prescribing principles.
26.	**Patient Priorities**: Elicit what matters most to an older adult, and work with the patient and team to honor these priorities.
27.	**Advance care planning**: Distinguish among healthcare proxies, advance directives, and life sustaining treatment orders, in the context of the laws of the state in which one is training.

American Geriatrics Society Minimum Competencies in Geriatrics for Medical Students

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The Minimum Competencies in Geriatrics for Medical Students are based on the Geriatric 5Ms[1] and adapted from the 2009 Geriatrics Competencies.[2] Project EDGE is a collaboration between the American Geriatrics Society, Harvard Medical School and the VA New England's Geriatric Research Education and Clinical Center conducting a national survey on the landscape of Geriatrics Education for Medical Students. The competencies were developed using a modified Delphia method including expert input, and a national survey of Geriatrics educators, and obtained IRB exemption from Harvard Medical School.

1. Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: a new way of communicating what we do. *J Am Geriatr Soc.* 2017;65(9):2115-2115.

2. Leipzig RM, Granville L, Simpson D, Anderson MB, Sauvigné K, Soriano RP. Keeping granny safe on July 1: a consensus on minimum geriatrics competencies for graduating medical students. *Acad Med.* 2009;84(5):604-610.