Overview

The Care of the Elderly Training Program has been officially recognized by the College of Family Physicians of Canada since 1989. It represents elective, supplementary training in care of the elderly of 6 or 12 months duration, available after the two-year core Family Medicine Residency. The McGill University program has existed since 1990 and is fully accredited by the CFPC and the CMQ.

The Department of Family Medicine and the Division of Geriatric Medicine jointly organize the content of our comprehensive Enhanced Skills Program in Care of the Elderly.

The Care of the Elderly Training Program provides in-depth training for Family Physicians seeking any or all of the following:

- to enhance their knowledge and skills in elder care;
- to enhance their knowledge and management skills of the special needs of the frail elderly;
- to act as resource persons in care of the elderly in the community, urban or rural;
- to pursue an academic career in geriatric medicine;
- to take on leadership roles including program development in settings such as Long-Term Care, Geriatric Assessment/Rehabilitation Units, or Home Care.

Program Objectives

Family Medicine Expert

1. Attain excellence in his/her chosen facet of caring for the elderly while maintaining competency in generalist medicine.
2. Perform a patient-centered clinical assessment and develop a management plan appropriate for the elderly.
3. Plan treatment and procedures appropriate for the elderly and the individual patient's goals of care.
4. Regularly assess medications in the care of the elderly to achieve appropriate prescribing.
5. Appropriately prescribe and deprescribe medications in the elderly. This includes
    a. Considering possibility of medication side-effects in new or ongoing symptoms.
    b. Stop medications that are no longer needed, may be harmful, or may interact with other medications
    c. Whenever possible, make a single change at a time
    d. Educate the patient and caregiver about each medication and the rationale for any change
    e. Select and prescribe a new medication for an elderly patient only after considering:
        i. The patient's goals and their overall prognosis

ii. The benefits
iii. The altered pharmacodynamics and pharmacokinetics in the elderly
iv. Drug interactions
v. The estimated risk-benefit of the treatment, as compared to other choices
vi. Adherence and appropriate medication delivery due to age-related changes

6. Establish plans for ongoing care and foster continuity of care throughout the life cycle.
7. Appreciate ageing as a stage in the normal life cycle and apply disease prevention strategies at middle age.
8. Facilitate continuous quality improvement and establish a practice environment that ensures the safety of the elderly.
9. Establish a practice environment that is inclusive to different cultures and patient perspectives.
10. Address the complex clinical needs of the elderly.

Communicator

1. Effectively communicate with the elderly and appropriately compensate for potential barriers specific to the elderly.
2. Effectively communicate with family members.
3. Obtain collateral history from caregivers and other health professionals.
4. Engage patients and families in developing care plans. When there is potential conflict between the patient, family or health team mediate to attempt resolution. Recognise situations when the involvement of others is required (Ex ethicist, lawyer).
5. Elicit and take into account patient and family perspectives and expectations.
6. Share health care information with patients and their families while maintaining patient autonomy and confidentiality.

Collaborator

1. Promote holistic, patient-centered care, using a team approach.
2. Maintain a positive working environment with team members.
3. Facilitate patient transitions and transfers through different care settings.

Leader

1. Work closely with other health care professionals and health care service administration to develop an integrated and coordinated care system for the elderly.
2. Facilitate the application of care of the elderly throughout the spectrum of community care, acute and sub-acute care, as well as institutional (ex. long-term care) settings.

3. Contribute to ongoing improvement in the health care of the elderly.
4. Utilise community resources in the care of the elderly.
5. Judiciously allocate health resources in the care of the elderly.

Health Advocate

1. Recognize elderly people as a vulnerable population and advocate for them within and beyond the clinical environment.
2. As a resource to the elderly, assess and respond to their needs by advocating with them for system-level change in a socially accountable manner.
3. Appropriately ensure patient autonomy in shared decision-making.

Scholar

1. Engage in ongoing learning in the care of the elderly.
2. Effectively teach and disseminate skills in care of the elderly to colleagues and trainees.
3. Apply the most recent evidence in care of the elderly to their own clinical practice and to their teaching.
4. Contribute to the creation and dissemination of knowledge relevant to care of the elderly.

Professional

1. Recognize and respond to societal needs in care of the elderly.
2. Maintain a commitment to patients through clinical excellence and high ethical standards.
3. Adhere to all professional and peer standards.
4. Remain committed to personal health through self awareness and reflective practice.

Priority Topics

In addition to the program objectives, trainees must achieve competency in the domain specific priority topics of the care of the elderly as listed by the College of Family Physicians of Canada. These topics are as follows:

1. Medical Conditions
2. Cognitive Impairment
3. Appropriate Prescribing
4. Falls and mobility issues
5. Teams
6. Communication
7. Frailty continuum/spectrum
8. Decision making and capacity
9. Family and informal care supports

10. Care across different settings
11. Organizing care using community resources
12. Advance care planning and goals of care
13. End -of-life care
14. Depression/anxiety
15. Delirium
16. Urinary incontinence
17. Driving issues
18. Pain

The full listing of the competencies for each priority topic can be found in Appendix I "Priority Topics and Key Features for the Assessment of Competence in Care of the Elderly." All priority topics may be encountered at any moment during training. Some learning experiences are more likely to encounter certain priority topics as outlined in Appendix II, "Priority Topics most likely to be addressed by rotation"

Rotations

The rotations done in the six and twelve months programs are outlined in Appendix III "Care of the Elderly Rotations Structure." Below is a brief description of each rotation.

Home Care

The trainee will participate in the evaluation and treatment of patients in the home care program. S/he will also learn about community resources, as well as the application process for placement in long term care institutions.

The trainee will be the primary care physician for a number of homebound patients. To facilitate continuity of care, the trainee will have approximately two half days per month for the duration of their training program to care for those patients. This will involve regular and emergency home visits as well as being available to respond to questions and problems which arise.

Out-patient Geriatric Clinic & Memory Clinics

The trainee will participate in multi-disciplinary outpatient geriatric assessment clinics, which respond to referrals coming from physicians in the community or in the hospital. Our residents have the opportunity to join any other specialty clinic according to their interests.

Geriatric Day Hospital

The trainee is involved in the initial assessment and ongoing evaluation of the patients in the geriatric day hospital. The focus is on rehabilitation of the frail, community-based elderly; co-management of patients with primary-care physicians; and learning about community resources. A special focus of this rotation focuses is the dynamics of interdisciplinary team-work.

Geriatric Ward

The trainee is actively involved in the care and responsibility of patients on the ward, including the discharge planning process. Conducting daily rounds together with the staff physician, the trainee will be involved in the teaching of the family medicine residents and medical students rotating on the ward. Multidisciplinary management is emphasized.

Long Term Care

The trainee will jointly round with the attending physician in charge of a long-term care ward, and actively participate in patient care. The particular focus is on management of ethical issues, competency, and managing complex issues in a "care rather than cure" mode.

Consultation (ER &Ward)

As a member of a multi-disciplinary team, the trainee will be involved in the evaluation of geriatric patients referred from the emergency room, and from medical, surgical and psychiatric wards. The trainee will be involved in decisions concerning admission and discharge from the emergency room or hospital.

Geriatric Psychiatry

The trainee will participate in the evaluation of new problems and the ongoing treatment of patients, on both the geriatric psychiatry ward and the outpatient clinic or home setting

Scholarly Activity

Trainees in the twelve-month stream will have a month of protected time to devote to their scholarly project.

Electives

Clinical electives help the trainee achieve their particular goals in Care of the Elderly. Commonly chosen electives include palliative care, rheumatology, and neurology. Electives in teaching, research, and administration can be tailored to suit individual needs.

Rotation-Specific Objectives

In addition to the global program objectives, rotation-specific objectives have been developed for each of the learning experiences in the program.

Home Care

Family Medicine Expert

1. Assess the patient's home environment for possible health risks and develop a management plan tailored for the patient at home.

2. Appropriately modify investigations and assessments to minimize patient's preferences regarding displacement.

Communicator

1. Interview patients in their home setting while protecting confidentiality.

Collaborator

1. Maintain continuous communication with home care team to respond to patient needs between medical visits.
2. Collaborate with medical teams in assessing the patient outside of their home setting.

Leader

1. Develop systems to ensure continuity of care in a home environment.

Advocate

1. Advocate for resources to maintain patient autonomy and dignity at home.

Scholar

1. Appraise and apply relevant medical literature in home care to their practice.

Professional

1. Maintain professional boundaries during home visits.

Consults

Family Medicine Expert

1. Effectively evaluate and manage delirium.
2. Develop management plan that minimizes risk of iatrogenic complications.

Communicator

1. Obtain collateral history from family members and referring institutions.
1. Clearly communicate professional both written and verbal opinion with source of referral.

Collaborator

1. Obtain collateral history from family members and referring institutions.
2. Clearly communicate transfers of care with team members, family and community health care providers.

Leader

1. Manage consultation team to provide professional expertise in an appropriately timely manner.

Advocate

1. Advocate for systems change in inpatient care to favour positive outcomes in the elderly.

Scholar

1. Identify the learning needs of trainees and other health care professionals.
2. Deliver effective teaching to address those learning needs.
3. Provide effective feedback to learners on their progress towards learning goals.
4. Appraise and apply relevant medical literature in care of the elderly to their practice.

Professional

1. Effectively manage differing opinions between colleagues in a professional manner.

Long-Term Care and Rehabilitation

Family Medicine Expert

1. Adapt medical management appropriately to patient's goals of care and life expectancy in long term care.
2. Assess and manage common medical issues in long term care including wound care, advanced dementia and end of life care.

Communicator

1. Update patient and family on patient medical issues and treatment decisions on a regular basis.

Collaborator

1. Collaborate with allied health professionals as well as non-regulated staff (example: sitters, music therapists) in patient care.
2. Use community resources to facilitate re-engagement after hospital discharge

Leader

1. Judiciously use transfers to acute care settings.
2. Manage medical care while minimizing use of external resources.

Advocate

1. Advocate for appropriate resources for this marginalized patient population.

Scholar

1. Appraise and apply relevant medical literature in long term care to their practice.

Professional

1. Appreciate and respect standards of practice unique to long term care.

Geriatrics Clinics

Family Medicine Expert

1. Assess and manage common geriatric syndromes including falls, incontinence, frailty and cognitive impairment.
2. Consider the variety of potential causes of cognitive impairment and assess for all possible reversible causes.
3. In a patient at risk of falls: implement fall prevention strategies and appropriate use of gait aids. Discuss emergency alert systems.
4. Make use of standardized instruments in cognitive evaluations.
5. Make use of the INESSS guidelines in the assessment and management of dementia.
6. Assess for and manage caregiver burnout.

Communicator

1. Provide a written response to the referring primary care physicians with clear diagnostic and management plans.

Collaborator

1. Utilise and seek feedback from allied health professionals in evaluations.

Leader

1. Manage the appropriate use of the available clinic resources.

Advocate

1. Develop strategies to maintain patient autonomy in the community.

Scholar

1. Appraise and apply relevant medical literature in geriatric syndromes and cognition to their practice.

Geriatric Day Hospital

Family Medicine Expert

1. Assess and manage common geriatric syndromes including falls, incontinence, frailty and cognitive impairment.
2. Understand and assess the factors that can lead to driving impairment.

Communicator

1. Communicate with referring primary care physicians and family, especially with regards to ongoing management after completion of the day hospital program.

Collaborator

1. Collaborate with other health professionals on day hospital team.
2. Understand role of allied health professionals in establishing therapeutic goals of the program.

Leader

1. Allocates community resources for optimal patient care.

Advocate

1. Advocate for mechanisms to maintain autonomy in a community setting.
2. Identify adaptations to maximize patient function.

Scholar

1. Appraise and apply relevant medical literature in rehabilitation to their practice.

Professional

1. Understands the ethical implications of a driving assessment.

Geriatric Psychiatry

Family Medicine Expert

1. Appreciate how mental health problems present differently in the elderly.
2. Identify and manage depression in the elderly.
3. Appreciate the potential for overlap between cognitive and mood symptoms in the elderly.
4. Understand the determinants and spectrum of capacity and appropriately evaluate capacity.

Communicator

1. Adapts psychiatric interview for older adults.

Collaborator

1. Collaborates with community mental health workers.

Leader

1. Be familiar with community resources for elderly with mental health problems.

Advocate

1. Understand residual elements of capacity and insure patient participates in shared decision making.
2. Recognise sings of elder abuse and proactively evaluate for abuse.
3. Recognise high level of vulnerability of elderly with psychiatric disease and appropriately advocate for them.

Scholar

1. Appraise and apply relevant medical literature in geriatric psychiatry to their practice.

Professional

1. Understand the ethical and legal implications of a capacity assessment.
2. Respect patient confidentiality and autonomy while collaborating with care givers.

Geriatric Ward

Family Medicine Expert

1. Effectively evaluate elderly patients in the hospital setting.
2. Effectively evaluate and manage delirium.
3. Develop management plan that minimizes risk of iatrogenic complications.

Communicator

1. Obtain collateral history from family members and referring institutions.
2. Clearly communicate transfers of care with team members, family and community health care providers.

Collaborator

1. Collaborate with other health professionals during interdisciplinary rounds to develop management and discharge plans for patients.

Leader

1. Manage team of trainees of varying levels to effectively care for roster of hospitalised patients.

Advocate

1. Appropriately advocate for patients desires in discharge planning.

Scholar

1. Identify and facilitate the learning needs of trainees and other health professionals.
2. Deliver effective presentations to address those learning needs.
3. Provide effective feedback on progress of learning goals.
4. Appraise and apply relevant medical literature in care of the elderly in the acute hospital setting to their practice.

Professional

1. Effectively balance personal needs with professional expectations.

Scholarly Project

Family Medicine Expert

1. Utilise knowledge from scholarly project to improve patient care.

Communicator

1. Clearly presents project and findings to medical community.

Collaborator

1. Effectively collaborate with other professionals, including librarians, statisticians and research assistants, during scholarly project.

Leader

1. Shares knowledge from scholarly project with goal to improve systems of patient care.

Advocate

1. Assesses community needs when identifying scholarly question.

Scholar

1. Understand and apply scientific principles to scholarly inquiry.
2. Uses appropriate research methods to answer scholarly inquiry.

Professional

1. Considers how findings of scholarly inquiry could impact standards of practice.

Scholarly Activity

Each trainee is responsible for completing a scholarly project on a subject of their choosing, with a view to presentation at the annual McGill Research Day, or at other national/ international conferences.

Alternatively, the resident can elect to complete a literature search on a topic of choice/clinical case, with a view to publication in an appropriate journal, such as the Canadian Family Physician.

A new research course is in the process of being developed to aid our trainees with this process.

Trainees actively participate in a Care of the Elderly Trainee Seminar Series, often conjointly with fellows in the specialty Geriatric Medicine training program, held approximately once a month, depending on the number of trainees in the program at one time.

Trainees are often involved in teaching activities (sometimes to family medicine residents and students, and members of the multidisciplinary team). They may be invited to give talks to community audiences.

Evaluation Process

The evaluation process is the same as the process followed during the family medicine residency program. Daily field-notes are used to collect feedback. There is a mid-rotation evaluation during each period (informally with the supervisor of that rotation) and a final evaluation at the end of each period (via ONE-45 system).

Each trainee will be assigned an academic advisor to review their academic progress every three months throughout the training to set updated learning objectives and to allow for further mentoring when needed.

Appendix I:

Priority Topics and Key Features for the Assessment of Competence in Care of the Elderly

N.B. This document can also be accessed electronically from the College of Family Physicians website at:
https://www.cfpc.ca/uploadedFiles/Education/COE_KF_Final_ENG.pdf

Priority Topics and Key Features for the Assessment of Competence in Care of the Elderly

This collection of priority topics and key features for assessment was developed by the College of Family Physicians of Canada (CFPC) Working Group on the Assessment of Competence in Care of the Elderly from 2013 to 2016. It outlines what to assess to determine competence at the enhanced skills level, following the CFPC's traditional approach to developing priority topics, procedures, and their key features.

The goal of these priority topics and key features is to guide the assessment of competencies required for awarding Certificates of Added Competence (CAC), both for residents in enhanced skills programs and for practice-eligible candidates, and to inform curriculum and training development.

When using this document, it is critical to remember that the priority topics and key features listed are not meant to be an exhaustive scope of practice in care of the elderly, nor do they represent a checklist for the determination of competence. They represent a guide to focus the sampling of performance. When trainees consistently demonstrate most of the key features across a good sample of the priority topics, it can be inferred that they have competence in care of the elderly.

It is also important to bear in mind that, because there is a great overlap between crucial competencies that are required for different priority topics, the tendency was to avoid repetition and list key features selectively.

Successful candidates for a Certificate of Added Competence in Care of the Elderly are expected to have demonstrated core competence in family medicine, including the Six Essential Skills and Procedures.

The order of the appearance of the priority topics listed reflects the frequency in which the topics appeared in the validation survey.

Finally, this is a living document that will be regularly revisited and updated to ensure its relevance.

How the priority topics and key features were developed

The Working Group on the Assessment of Competence in Care of the Elderly (6 members) acted as the nominal group, generating an initial list of priority topics through an individual survey followed by group discussion and consensus. A survey to a larger group of family practitioners (212 recipients at a 19% response rate), representative of physicians from across the country, generated another independent list.

The lists of priority topics generated by the nominal group and the larger reference group were very similar, both in the topics named and the priorities assigned, with a strong positive correlation of 0.68. A final list of 18 priority topics was identified.

Key features were developed and finalized for all topics using the nominal group technique, which included four iterations of individual comments, discussions and consensus building.

How to use the priority topics and key features

It is important to note that materials in this booklet are intentionally selective and not comprehensive. It is most desirable and useful to assess what will best discriminate between competent and less competent individuals. Priority topics do not represent an extensive list of topics that should be covered in training, but rather a selective list of areas for assessment that can help teachers/assessors to infer overall competence in care of the elderly. Key features represent the critical or essential steps in the resolution of a clinical situation or problem, so the achievement of underlying competencies can be inferred. All key features refer to observable actions, not knowledge. They do not cover all necessary steps (e.g., history, physical examination, diagnosis, management), but only those that are critical and most likely to be missed.

As such, the priority topics and their features are not meant to be used in a checklist approach when assessing competence. They are best used for guiding assessment efforts (sampling, observation, reflection) over time to build a case for overall competence or the lack thereof. They may also be useful in the following situations:

For trainees:

- Use as a guide for self-reflection on competence and development of a learning plan, particularly prior to and during clinical experiences
- Use as a guide for soliciting feedback from teachers/assessors

For teachers/assessors:

- Compare and contrast materials in this document with your assessment strategies and adjust as necessary
- Use as a guide assessment of your trainees, including soliciting feedback, developing questions to ask trainees, and completing field notes
- Use as a guide to help develop learning plans for your trainees
- Use as a self reflection guide to assess your teaching

For programs:

- Use as assessment standards when making decisions about residents' successful completion of training
- Use as a guide to develop assessment strategies
- Use as a guide to plan curriculum that can adequately expose trainees to the priority topics and procedures

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Priority Topics

1. Medical conditions
2. Cognitive impairment

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3. Appropriate prescribing
4. Falls and mobility issues
5. Teams
6. Communication
7. Frailty continuum/spectrum
8. Decision making and capacity
9. Family and informal care supports
10. Care across different settings
11. Organizing care using community resources
12. Advance care planning and goals of care
13. End-of-life care
14. Depression/anxiety
15. Delirium
16. Urinary incontinence
17. Driving issues
18. Pain

Priority Topic 1: Medical conditions

1. When assessing an elderly patient:
    a) Consider special conditions that may require assistance or intervention to obtain a full and accurate history (e.g., hearing impairment, language barrier, cultural differences, speech difficulties, cognitive impairment)
    b) Obtain and integrate collateral information (with consent) when appropriate to aid in the patient's medical assessment
2. When assessing an elderly patient, consider atypical presentations of diseases in your differential diagnosis.
3. For an elderly patient, tailor preventive care as appropriate to age, functional status, and life expectancy (e.g., cancer and cholesterol screening, falls and fracture prevention).

4. When assessing and managing an elderly patient's medical condition, consider the contributions and impact of comorbidities, frailty, and functional status, as these can affect clinical outcomes, prognosis, longevity, and the patient's treatment choices and preferences.
5. For an elderly patient, recognize medical conditions (e.g., systolic hypertension/orthostatic hypotension, diabetes mellitus, atrial fibrillation, thyroid disorders) that need special attention or unique management.
6. When caring for an elderly patient with multiple comorbidities:
    a) Prioritize medical condition(s) that warrant more immediate assessment and management, being guided by patient goals
    b) Recognize that recommendations from disease-specific guidelines may not apply, and may increase the likelihood of issues such as excessive testing and polypharmacy
    c) Ensure that treatment of one condition does not worsen another
7. When caring for an elderly patient:
    a) Recognize that deterioration can occur rapidly
    b) Respond quickly to lessen the risk of long-term functional disability, morbidity, and mortality
8. For elderly patients with functional decline who have potential for improvement:
    a) Consider a rehabilitative approach
    b) Use community resources to facilitate the re-engagement of an elderly patient back into community life after hospitalization or in-patient rehabilitation

Priority Topic 2: Cognitive impairment

See also: **Dementia** under Evaluation Objectives in Family Medicine

1. For an elderly patient for whom there are concerns about memory problems, determine the level of cognitive impairment and the impact on function by:
    a) Using a structured history (e.g., neuro-behavioural symptoms, cognitive features, and impact on function)
    b) Including collateral sources (with consent)
2. For an elderly patient for whom there are concerns about memory problems, differentiate between normal aging, mild cognitive impairment, and dementia.
3. For an elderly patient for whom memory problems are recognized as normal aging:

a) Avoid over-investigation

b) Develop a follow-up plan with the patient

4. For an elderly patient with mild cognitive impairment (MCI), establish the level on the spectrum.
5. For an elderly patient presenting with behavioural changes or other subtle cues (e.g., uncertainty about recent events, changes in personal hygiene or medication compliance, concerns from family, dysphasia): a) Consider cognitive impairment in the differential diagnosis

   b) Assess using objective cognitive testing when appropriate
6. For an elderly patient presenting with worsening dementia, assess appropriately to rule out delirium and depression.
7. For an elderly patient presenting with cognitive or memory problems, rule out remediable factors (e.g., malnutrition, thyroid disease, vitamin B deficiency, progressive subdural, normal pressure hydrocephalus, other metabolic disorders).
8. For an elderly patient presenting with dementia, investigate selectively, according to accepted guidelines and the patient's context, to identify the type of dementia (i.e., Alzheimer, mixed, vascular, Lewy body, fronto-temporal, other).
9. When an elderly patient has an atypical presentation of dementia (e.g., younger, rapid progression, focal neurological manifestations, not responding or unexpected adverse reactions to treatment), a) Review the accuracy of the current working diagnosis

   b) Consider the merits of seeking a second opinion
10. For an elderly patient being followed for dementia, avoid unexpected decompensation or crisis by actively enquiring about:
    - Behaviours
    - Psychological or psychiatric symptoms
    - Issues of safety and risk (e.g., driving, abuse, wandering, cooking safety, occupational and social hazards)
11. For an elderly patient with a newly established diagnosis of dementia, share early and appropriately with caregivers and the patient the diagnosis and the management options to ensure:
    - Early advance planning
    - Use of appropriate pharmacological options for management (e.g., cognitive enhancers)
    - Social support for patients and family (e.g., Alzheimer's society, other community organizations)

12. For an elderly patient with progressing dementia, continue to actively engage the patient in a process of shared decision making, even as their capacity continues to decline.
13. For an elderly patient with dementia who develops behavioural changes:
    a) Inquire about the impact on the patient and the caregivers
    b) Rigorously assess (e.g., evolution of change, thorough history examination and chart review) the underlying causes of the changes
14. When managing an elderly patient with dementia and behavioural changes:
    a) Correct and/or treat any underlying causes
    b) Develop and implement a non-pharmacological plan of management with the caregivers and the resources in the community
    c) Use pharmacological treatment judiciously, reserving the use of antipsychotic medications for emergency situations and for those patients with distressing psychosis, severe physical aggression, or agitation who have not improved with non-pharmacological methods
    d) Consider gradual dose reduction of medications as soon as possible
15. For elderly patients with mild-to-moderate dementia:
    a) Consider treatment with a cholinesterase inhibitor for patients without contraindications (e.g., heart block, bradycardia, syncope, significant frailty)
    b) Develop a plan for follow-up to review effectiveness/outcomes and side effects of treatment to decide collaboratively with patient and caregivers whether to continue or discontinue the medication
16. For elderly patients with severe dementia:
    a) Make decisions to continue or stop cognitive enhancers after discussions with corroborating sources about past benefits, side effects, and goals of treatment
    b) If the decision is made to stop the medication(s), titrate with close monitoring for rapid or unexpected cognitive decline

Priority Topic 3: Appropriate prescribing

1. When caring for an elderly patient:
    a) Review adherence and update medication lists regularly, especially during transitions (e.g., a move to long-term care, or a diagnosis or progression of terminal illness), including non-prescription, over-thecounter medications, and natural health products in order to identify risks of interactions, side effects, inappropriate use, or treatments that are no longer indicated

b) Consider collaborating with a clinical pharmacist

2. When an elderly patient shows functional decline or non-specific symptoms, always consider and rule out the possible contribution of their medications to the situation.
3. When caring for an elderly patient, take a methodical approach to prescribing:
    - Stop medications that are no longer needed, may be harmful, or may interact with other beneficial prescribed medications
    - Whenever possible, make only one change at a time (e.g., medication for behavioural and psychological symptoms of dementia)
    - Educate the patient and caregiver about each medication and the rationale for any change
4. Select and prescribe a new medication for an elderly patient only after considering:
    - The patient's goals and their overall prognosis
    - The benefits (i.e., don't assume that harms are greater than benefits just because the patient is elderly)
    - The altered pharmacodynamics and pharmacokinetics of many drugs in elderly patients
    - Drug interactions
    - The estimated risk-benefit of the treatment, as compared to other choices
    - Adherence and appropriate medication delivery due to age-related changes (e.g., hand dexterity and strength, memory, swallowing)
5. For an elderly patient, consider age-related responses and react appropriately (e.g., changed pharmacodynamics, —start low, go slow)

Priority Topic 4: Falls and mobility issues

1. For the ongoing care of any elderly patient, periodically assess for unreported falls and the risk of falls, and discuss strategies for the prevention of falls.
2. For an elderly patient who is at a risk of falling or has fallen:
    a) Consider and inquire about possible predisposing and precipitating factors, and do not assume a single cause: obtain corroborative history (with consent), clarifying the circumstances of the fall (e.g., tripping, short loss of consciousness, presence of seizure)
    b) Perform an appropriate physical examination focusing on neurological, cardiovascular and musculoskeletal systems with a particular emphasis on assessing gait, but also ensuring the

assessment of other possible precipitants (e.g., pneumonia, urinary retention, urinary tract infection)

3. For an elderly patient who has had an acute fall, assess for the presence of injuries that are not obvious (e.g., fractured hip, C-spine, subdural hematoma), in addition to diagnosing and treating the specific cause(s) of the fall itself.
4. For an elderly patient who is at risk of falling, or has fallen, carefully review and use all medications judiciously (e.g., psychoactive, anti-hypertensive, Parkinsonian), optimizing doses or eliminating entirely, to minimize the risk of contributing to falls.
5. For an elderly patient who is at risk for falling, in addition to managing the primary cause(s) of the falls, plan the active reinforcement of capacities that are "working" and that may help the patient to avoid further falling (e.g., walking and balance aids, visual/hearing aids, balance or strengthening therapy, community resources, protection as necessary, home safety assessment).
6. For an elderly patient who has fallen or is at risk of falling, consider osteoporosis and fracture risk as part of falls risk assessment and treat appropriately.
7. For an elderly patient who is at risk of falling, consider the use of an appropriate gait aid, ensuring that it is the proper size, and is used appropriately.
8. For an elderly patient who is at a risk of falling, discuss strategies in the event of fall, including using an emergency alert system.
9. For an elderly patient:
    a) Inquire about and assess the fear of falls as it may have a large social impact
    b) Develop strategies to mitigate the likelihood of social isolation and loss of independence

Priority Topic 5: Teams

1. For elderly patients, use a team approach as appropriate (e.g., rehabilitation, falls assessment, discharge planning).
2. When caring for elderly patients with a team:
    a) Show respect for the other team members by encouraging safety and trust within the team
    b) Ensure effective shared goals and desired are outcomes supported by all team members
    c) Be prepared to assume various roles within the team (e.g., collaborator, leader)
3. When caring for elderly patients:
    a) Include the patient and family in the team discussions and conferences whenever practical
    b) Facilitate the patient's and the family's effective participation in decision making

Priority Topic 6: Communication

(see also Communication Skills for Family Medicine)

1. When communicating with elderly patients:
    a) Recognize the multiple and complex barriers to good communication (e.g., adequate time, pace, noise level, language, need for assistive devices, delirium, generational response)
    b) Use strategies to mitigate the barriers (e.g., optimize physical environment, use active listening, provide access to interpreter)
2. When communicating with elderly patients and their caregivers (e.g., family conference), ensure that the patient's voice is heard and respected.
3. Regarding elderly patients with cognitive impairment, continue to include them in clinical discussions when appropriate.
4. For situations of potential conflict (e.g., when an elderly patient's goals of care differ from the wishes of their children, when there are differences between the views of joint substitute decision makers (SDM), or between the family and the health providers)
    a) Mediate and attempt to resolve the conflict
    b) Recognize the situations when the involvement of others is required (e.g., family doctor, ethicist, spiritual advisor, lawyer)

Priority Topic 7: Frailty continuum/spectrum

1. For the ongoing care of any elderly patient:
    a) Regularly assess the degree of frailty considering their ability to function safely in their environment with their current social support (e.g., functional status and reserve; physiological characteristics such as gait speed, nutritional status, and weight loss; comorbidities)
    b) Share this information with the patient, encouraging and promoting activities that will help them maintain function
2. For frail elderly patients:
    a) Do not assume a loss of decision-making capacity
    b) Adapt the treatment and preventive care (e.g., do not over-treat just to follow generic guidelines, do not under-treat simply because of the patient's age)
3. For the ongoing care of a frail or elderly patient, regularly review all medications, with a focus on deprescribing, as polypharmacy and inattentive prescribing can worsen frailty.

4. Whenever a frail elderly patient shows a sudden decline in function, do not assume it is a simple progression of the overall condition, but look for and rule out acute precipitating cause(s) (e.g., delirium, infection).
5. For a frail elderly patient with an acute illness associated with acute loss of function:
    a) Adopt an early and aggressive multi-faceted assessment and management plan (e.g., hydration, treatment of infection, medication review) to minimize loss of function
    b) Develop a rehabilitation plan to help the patient regain the previous level of functioning. (e.g., day hospital, home visits, interdisciplinary interventions)
    c) Consider re-establishing goals of care
6. For a frail elderly patient, whose condition and burden of illness are advancing, in spite of regular assessment, maintenance, and treatment, take the initiative to revisit the living situation, the goals of care, and advance planning with the patient and their caregivers.

Priority Topic 8: Decision making and capacity

1. When recommending a specific treatment to an elderly patient, establish their capacity to consent by assessing their understanding and appreciation of the choices and the possible consequences of each choice (e.g., by asking specific questions, getting collateral information, asking patients to paraphrase).
2. When assessing the capacity of an elderly patient:
    a) Do not assume that a patient who is at an advanced age or has dementia is incapable of making all treatment decisions
    b) Do not assume that incapacity to make one decision renders a patient incapable of all decisions
    c) Consider acute health conditions or circumstances that may temporarily affect capacity, or cause it to fluctuate
    d) Recognize that the greater the risk resulting from a particular decision, the greater capacity that is required
3. When an elderly patient makes a decision that appears to be unwise from the perspective of the health care team:
    a) Assess the patient's capacity
    b) Respect the capable patient's right to make choices you do not approve of (e.g., capable patients can decide to live at risk or leave hospital against medical advice)
4. When a substitute decision maker (SDM) is making decisions for an incapable patient:

a) Ensure an SDM (or joint SDMs) understands their role in making decisions that are consistent with the patient's known wishes and in their best interest

5. Advocate for the incapable patient if a SDM makes a decision that is not in keeping with the patient's known wishes or in their best interest (e.g., consult an expert in ethics, refer to appropriate review authorities)
6. When an elderly patient is found to be incapable, inform the patient and their substitute decision maker (SDM), in a caring and compassionate manner, of the finding and the possible options, including the right to appeal.

Note: Refer to topic 17 for driving issues.

Priority Topic 9: Family and informal care supports

1. When caring for an elderly patient:
   a) Assess the family/caregivers to gauge their level of stress and capacity (e.g., cognitive, physical, social) to provide the necessary care and support
   b) Be proactive to reduce the risk of caregiver exhaustion (e.g., provide education, training, and resources; work with other health care providers to optimize support at home; advocate for additional resources when required)
2. When assessing a change in condition or function, or a crisis in an elderly patient:
   a) Evaluate the contribution of their social and home environment to this change
3. Determine the need for immediate intervention, including a home visit to mitigate harm; direct (e.g., wandering leading to hypothermia) or indirect (e.g., move from home, hospitalization leading to functional loss)
4. In situations of caregiver stress, consider:
   - Risk of elder abuse of the patient
   - Risk for mistreatment of the caregiver

Priority Topic 10: Care across different settings

1. When caring for an elderly patient in different settings (e.g., in their home, in a community-based location, or preparing to return to the community from hospital), familiarize yourself with available community resources and use them when and where appropriate.
2. When seeing an elderly patient in the office, recognize they may not be doing as well in their home environment as they may appear to be in the office setting.
3. When caring for an elderly patient in any clinical setting, engage interdisciplinary team members to provide care.
4. When caring for an elderly patient, especially when transferring health care information (including patient's goals of care and updated medication records), ensure ongoing communication across settings with:
    - Formal and informal community support providers, including family members
    - Emergency department and hospital staff, as these are high-risk environments
5. When considering transferring an elderly patient to a different care setting, make plans that take into account the patient's goals of care and advance care wishes.

Priority Topic 11: Organizing care using community resources

1. When developing plans for support and care for an elderly patient, reach out proactively to integrate and engage community and other professional resources (e.g., case managers, social workers)
2. When using community resources for the care of an elderly patient, consider all available resources and match the patient's needs to the specific resources available, including privately and publicly funded services (e.g., Alzheimer society, government home care services).
3. For an elderly patient who is receiving care and support from community resources:
    a) Maintain an active, ongoing therapeutic relationship with the patient
    b) Ensure an effective exchange of information between all care providers

Priority Topic 36: Advance care planning and gals of care

1. When caring for an elderly patient, encourage them to discuss their goals and treatment preferences and, based on these, develop a plan that meets provincial/territorial legal requirements.

2. When caring for an elderly patient, find opportunities to introduce discussions about goals of care before the patient's capacity is reduced, especially when loss of capacity can be anticipated (e.g., very advanced age, malignancy, cognitive decline, multiple c-morbidities, Parkinson disease).
3. When initiating a discussion on goals of care with an elderly patient, ensure that:
    - It takes place in a manner that facilitates the patient's full understanding and participation in the process
    - The patient has the capacity to participate in any necessary decisions
4. When discussing goals of care with an elderly patient:
    a) Empathically provide frank and clear information about prognosis and reasonable therapeutic options
    b) Help the patient prioritize goals of care that reflect their values, preferences and concerns
5. When establishing goals of care with an elderly patient:
    a) Take the time necessary (i.e., multiple sessions may be required) to come to clear understanding and decisions, including time for reflection and reconsideration,
    b) Encourage full discussion with care partners and SDMs, should they need to take over decision making, so that they may act according to the patient's wishes and best interests
6. For an elderly patient experiencing significant change (e.g., new diagnosis, significant functional loss, social change, or transitions to new living or care setting), initiate a re-evaluation of the goals of care.
7. For an elderly patient who no longer has the capacity to decide:
    a) Do not equate previously-established goals of care with a specific consent to treatment
    b) Use the goals as a guide to help the SDM make decisions, particularly where they may conflict with their own values or preferences
8. For an elderly patient receiving different recommendations from multiple consulting physicians and other health care professionals, help the patient balance these options in relation to their own goals of care.
9. When receiving a request for a treatment of an elderly patient, that is unlikely to be of benefit or that you would not recommend:
    a) Listen carefully to try to fully understand the patient's perspective before presenting yours
    b) Attempt to find common ground for moving forward, while continuing to care for the patient

Priority Topic 38: End-of-life care

1. For an elderly patient with a severe or an end-stage condition:
    a) Recognize as early as possible that the end of life is or may be near
    b) Communicate this to the patient and family at the earliest appropriate moment
2. When communicating with an elderly patient who is approaching end of life, and their family, be empathic and patient-centred in order to facilitate a discussion about goals of care:
    - Consider and respect the cultural and personal perspectives of the patient and family, especially when they differ from yours
    - Be realistic without being negative and always be supportive, recognizing your own values and perspectives; do not impose them on the patient
3. When caring for an elderly patient who is at the end of life:
    a) Assess for symptoms that may be distressing and amenable to treatment
    b) Pay particular attention to non-verbal indicators of distress and collateral information in patients with a diminished capacity to communicate (e.g., decreased alertness, confusion, aphasia)
    c) Use validated assessment tools as appropriate
4. When caring for an elderly patient who is at the end of life:
    a) Review all medications with a view to continuing and adjusting those that contribute to the patient's well-being
    b) Reduce or discontinue medications that do not have current beneficial effects, or potential for benefit over the expected life of the patient, and may decrease the patient's well-being
5. When treating symptoms in an elderly patient who is at the end of life:
    a) Use a multi-faceted approach (e.g., pharmacological and non-pharmacological treatment, interdisciplinary approach) to achieve comfort
    b) Anticipate adverse effects and treat proactively
    c) Review and adjust the treatment according to the response and overall well-being
6. When an elderly patient, who is at the end of life, wishes to stay at home:
    a) Anticipate the support and resources that will be needed, including your own availability and participation
    b) Help the patient and caregivers develop plans to deal with all the situations that may arise, including caregivers' bereavement
7. For the elderly patient who has requested Medical Assistance in Dying (MAID):

a) Explore the meaning behind the request and consider the patient's capacity

b) Follow all relevant federal/provincial/territorial legislation and College policies as they apply to the patient

Priority Topic 14: Depression/anxiety

1. For an elderly patient with a presentation that is atypical for depression (e.g., fatigue, insomnia, anxiety, agitation, somatisation) look for and recognize depression.
2. For an elderly patient who is taking anti-depressant medications, clarify the original indication, reassess the effectiveness and need for ongoing therapy.
3. For an elderly patient who is depressed or anxious, assess to rule out underlying medical conditions or comorbidities that may be causative or contributing.
4. For elderly patients who may have dementia:
   a) Always consider depression and anxiety as a factor in the presentation
   b) Regularly look for depression/anxiety in any patient with existing dementia
5. When treating an elderly patient, who has depression:
   a) Use non-pharmacological strategies (e.g., mindfulness, cognitive behavioural therapy)
   b) Engage community resources effectively to provide therapy, support and socialisation for the patient and their caregivers
6. For an elderly patient who has depression always consider and assess for the risk of suicide.
7. For an elderly patient who has depression, look for psychotic features (e.g., paranoia, delusions, marked withdrawal).
8. When using pharmacotherapy to treat depression in an elderly patient:
   a) Select an agent with an activity profile and side effects that are appropriate to the patient's symptoms and comorbidities
   b) Introduce slowly, titrate, and adjust according to response and side effects
9. For an elderly patient who has depression and is not responding well to treatment:
   a) Review the diagnosis, particularly with respect to psychiatric and other co-morbidities
   b) Consider the need for consultation for more intensive therapy, such as electroconvulsive therapy and in-patient psychiatric care

Priority Topic 15: Delirium

1. For any elderly patient with discrete or fluctuating changes in attention or awareness:
    a) Consider the possibility of a diagnosis of delirium
    b) Act promptly to clarify the diagnosis
2. For an elderly patient with dementia presenting with confusion, change in arousal, or behavioural change:
    a) Do not assume that the change is progression of underlying dementia
    b) Assess to distinguish between delirium, dementia, and depression
3. For an elderly patient with decreased arousal, consider hypoactive delirium.
4. For an elderly patient with symptoms or signs suggesting delirium, look for underlying and contributing causes, and continue the assessment to ensure a comprehensive review of possibilities, keeping in mind that the cause of delirium is often multifactorial (e.g., infection, new medication, dehydration, metabolic disturbances).
5. For all elderly patients:
    a) Proactively identify situations in which delirium is more likely to occur (e.g., dementia, post-operative, acute infection)
    b) Take steps to prevent the onset of delirium (e.g., review of medications, hydration, orientation strategies)
6. When managing delirium in an elderly patient:
    a) Always include non-pharmacologic measures, such as physical touch, familiar faces, and orientation strategies in the treatment plan
    b) Keep in mind the high risk associated with the use of physical restraints (e.g., death, asphyxiation, increased agitation)
7. For an elderly patient with delirium, while continuing to diagnose and treat the underlying causes, only use a short-term antipsychotic if absolutely necessary for patient safety or distress, and reduce or stop the medication as soon as possible.
8. For an elderly patient with delirium, communicate the possible duration and outcomes of an episode of delirium with the patient and family, focussing on communicating uncertainty.

Priority Topic 16: Urinary incontinence

1. When providing ongoing care for any elderly patient:
    a) Periodically ask, in a sensitive manner, about the presence or absence of urinary incontinence
    b) Specifically assess the impact it may have on the patient's daily life and functioning
2. For an elderly patient with a complaint of urinary incontinence, explore whether medical/functional issues (e.g., such as constipation, poor mobility, pain or bathroom apraxia, medications) may play a contributing role.
3. For an elderly patient with a complaint of new onset urinary incontinence, use a systematic approach to establishing as exact an etiological diagnosis as possible.
4. For an elderly patient, treat urinary incontinence according to the etiological subtypes identified, (e.g., use lifestyle, behaviour modifications, physiotherapy, pessaries, surgical intervention).
5. When treating an elderly patient for incontinence, use pharmacotherapy judiciously, by balancing potential side effects and benefits.

Priority Topic 17: Driving issues

1. When caring for an elderly patient, explore whether:
    - The individual is driving
    - There might be health-related driving risks
2. For an elderly patient with a progressive disease (e.g., Parkinson disease, dementia) who continues to drive:
    a) Introduce an early discussion about driving issues, well before it is a problem that needs to be dealt with (not if but when)
    b) Help the patient adjust and plan appropriately
    c) Reassess regularly
3. When assessing an elderly patient's capacity to drive, look for and address potentially remedial factors that may affect this capacity (e.g., depression and anxiety, prescription and non-prescription drugs, alcohol, acute illness, poor driving habits, visual impairments).
4. When an elderly patient's capacity to drive is not clear, after obtaining consent, get corroborating information from multiple sources (e.g., family input, accident history, functional impairments, fitness-todrive assessments) before deciding to report this concern to the appropriate authority.
5. For an elderly patient at high risk of losing their driving privileges:
    a) Use a patient-centred approach to understand the full impact this may have on their life

b) Proactively develop suitable alternative strategies

c) Provide support throughout the adjustment period

6. For an elderly patient with cognitive impairment:

   a) Recognize that the presence of moderate or severe dementia is a contraindication to driving

   b) Recognize that the presence of mild cognitive impairment or mild dementia is not necessarily a contraindication to driving

   c) Perform a thorough assessment, if the decision is ambiguous, including an on-road assessment if required

7. When an assessment has demonstrated that an elderly patient is no longer medically fit to drive:

   a) Communicate this clearly to the patient and family

   b) Counsel them on the immediate or short-term implications for driving

   c) Follow the provincial legislation regarding the duty to report

Priority Topic 18: Pain

1. When determining the etiology of pain in the elderly, account for the greater burden of chronic and complex conditions, both physical and emotional, that may contribute to the perception of pain.

2. When assessing the impact of pain on an elderly person, look holistically for impact and common vulnerabilities (e.g., renal dysfunction, delirium risk, elder abuse) because pain and its pharmacological management can lead rapidly to further disability, vulnerability, and loss of independence.

3. For elderly patients who have a limited ability to express themselves (e.g., cognitive decline, decreased awareness, affective disorder), assess pain by looking for indicators such as discrete physical signs and behaviours, and by obtaining collateral information from others.

4. When using scales and other indicators to serially assess pain in elderly patients, ensure that your assessment accounts for patient specific factors (e.g., meaning of the pain, candidness in the face of authority, cognition, memory loss).

5. When treating an elderly patient, who has pain, use non-pharmacological measures whenever possible (e.g., exercise and stretching, physical modalities and therapy, mindfulness or cognitive behaviour therapy).

6. When selecting a pharmacological treatment for an elderly patient's pain, consider the possible impact of underlying comorbidities or risks (e.g., frailty, decreased renal function, altered sensorium or cognitive function, risk for addiction).

7. When providing pharmacological treatment for elderly patients' pain, integrate principles of prescribing for the elderly (e.g., start low, go slow, watch for interactions, use least effective dose) with a proactive approach to mitigating side effects because of the complex vulnerability often found in this age group.

Appendix II:

Priority Topics most likely to be addressed by rotation

	Home Care	Geriatrics Clinic	Memory Clinic	Day Hospital	Long Term Care / Rehab	Geriatric Psychiatry	Geriatrics Ward	Consults
Medical Conditions	X	X	X	X	X		X	X
Cognitive impairment	X	X	X	X	X	X	X	X
Appropriate Prescribing	X	X	X	X	X	X	X	X
Falls and Mobility Issues	X	X		X	X		X	X
Teams	X	X	X	X	X		X	X
Communication	X	X	X	X	X	X	X	X
Frailty Continuum/ spectrum	X	X		X	X		X	X
Decision making and capacity	X	X	X	X		X	X	
Family and informal care supports	X		X	X		X	X	
Care across different settings	X	X		X				
Community Resources	X	X	X	X				
Advance Care Planning and goals of care	X	X			X		X	X
End-of-life care	X				X		X	
Depression/ anxiety	X	X			X	X	X	
Delirium					X	X	X	X
Urinary Incontinence	X	X						
Driving Issues	X	X	X	X				
Pain	X	X		X	X		X	X

Note that the listed priority topics per rotation are not exclusive. All priority topics may be encountered in each rotation.

Appendix III:

Care of the Elderly Program Structure

Rotation	12 months (13 periods)	6 months (6 periods)
Geriatric Day Hospital	X	X
Long Term Care	X	X
Geriatric Psychiatry	X	X
Geriatrics Ward	X	X
Geriatrics Clinics	X	X
Elective #1	X	X
Research	X	
Geriatric Consults	X	
Clinics #2	X	
Elevtive #2	X	
Elective #3	X	
Elective #4	X	
Elective #5	X	

Longitudinal Schedules

- Identical for both six and twelve-month streams
- 0.5 day per week of longitudinal family medicine clinic
- 0.5 day per week of geriatrics clinics divided between:
    - Geriatrics Assessment Clinic (1 per period)
    - Memory Clinic (1 per period)
    - Home Care (2 per period)

Appendix IV:

Program Benchmarks

Please refer to the program benchmarks in the acompanying file

Appendix IV:

References

1. Outils / activités Alzheimer. Institut National d'excellence en santé et en services sociaux du Québec. https://www.inesss.qc.ca/en/outils-cliniques/outils-cliniques/outils-par-thematiques/outils/alzheimer.html