What Is a Geriatrician? American Geriatrics Society and Association of Directors of Geriatric Academic Programs End-of-Training Entrustable Professional Activities for Geriatric Medicine

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Entrustable professional activities (EPAs) describe the core work that constitutes a discipline's specific expertise and provide the framework for faculty to perform meaningful assessment of geriatric fellows. This article describes the collaborative process of developing the end-of-training American Geriatrics Society (AGS) and Association of Directors of Geriatric Academic Programs (ADGAP) EPAs for Geriatric Medicine (AGS/ADGAP EPAs). The geriatrics EPAs describes a geriatrician's fundamental expertise and how geriatricians differ from general internists and family practitioners who care for older adults. **J Am Geriatr Soc 2014.**

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The definition and work of geriatricians in the United States has been the topic of several highly discussed and debated articles in the medical literature.[1–6] Whom do geriatricians care for? Do we see all older adults? Just the old-old[5] or the most complex?[1] How does the work of geriatricians differ from that of the general internist or family practitioner who also provides primary care to older adults?

Entrustable professional activities (EPAs) describe the core work that constitutes a discipline's specific expertise.[7] They are critical, observable, measurable tasks and responsibilities that practicing specialists can be trusted to perform proficiently, consistently, and unsupervised by the end of their training. EPAs provide the framework for faculty to perform meaningful assessment of trainees. Pediatrics, internal medicine, psychiatry, and family medicine are among the medical disciplines that have developed or are developing EPAs.[8–13] This article describes the collaborative process of developing the end-of-training American Geriatrics Society (AGS) and Association of Directors of Geriatric Academic Programs (ADGAP) EPAs for Geriatric Medicine (AGS/ADGAP EPAs).

END-OF-TRAINING GERIATRICS EPA DEVELOPMENT PROCESS

Competency-based medical education is becoming the standard to ensure that those who complete undergraduate and graduate medical education have the skills needed for their next level of practice, be it supervised or unsupervised.[14,15] Geriatric curricular milestones (CMs), previously known as competencies, have been identified for medical students[16] and for internal and family medicine residents.[17] Seventy-six CMs have been established for geriatric medicine fellows.[18] As part of developing the CMs, 635 geriatricians reviewed a set of proposed CMs; indicated whether they believed a graduating fellow must, should, or does not need to demonstrate competence in each; and were given the option to provide comments on all CMs. The responses and comments were reviewed in detail, and the CMs were revised in response, with subsequent review by leaders of the AGS and ADGAP. The boards of ADGAP and the AGS approved these CMs, which were used as a starting point for the development of AGS/ADGAP EPAs for geriatrics.

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Table 1. American Geriatrics Society and Association of Directors of Geriatric Academic Programs End-of-Training Geriatrics Entrustable Professional Activities (EPAs)

Geriatricians entering into practice, in and across all care settings (hospital, home, office, and long-term care and subacute rehabilitation facilities), are able to

EPA	Overview	Observable Tasks (and Related Curricular Milestones[a])
1. Provide patient-centered care that optimizes function and/or well-being	Geriatricians provide comprehensive geriatric assessment and management, including health promotion and disease prevention, and work with patients, families, and caregivers and community resources to optimize a patient's independence	Perform and interpret a comprehensive geriatric assessment, and develop a comprehensive, patient-centered management plan. (1, 3, 10, 14, 15, 22, 24, 36, 37, 45, 46, 47) Know community resources and how to access them. (14, 15, 35, 36, 38, 41) Provide preventive health measures based on national standards and individualized to the patient's prognosis and preferences; document clinical reasoning when screening differs from standard recommendations. (19)
2. Prioritize and manage the care of older patients by integrating the patient's goals and values, comorbidities, and prognosis into the practice of evidence-based medicine	Geriatricians develop prioritized management plans for patients that take into account their prognosis, multiple chronic conditions, function, goals, and preferences and the strength and applicability of the medical evidence to older adults in general and to individual patients	Consider patient preferences, comorbidity, function, prognosis, age-related changes in physiology, pharmacology, treatment efficacy and response, and psychosocial concerns in designing plans of care and in considering other consultants' recommendations. (9, 10, 12, 16, 19, 20, 21, 22, 23, 24, 49) Develop and implement a prioritized management plan individualized to patient's current status and goals of care. (6, 14, 15, 16, 21, 22, 23, 26, 51) Use prognostic tools and guidelines that recognize comorbidity and function. (21, 26) Have in-depth knowledge of diseases and disease prevention common to geriatric medicine. (16, 17, 18, 19, 20) Critically review the medical literature for studies that are valid and applicable to the care of older adults. (20) Demonstrate the ability to prioritize care, in a time-efficient manner during patient encounters. (37) Document clinical reasoning when management differs from standard recommendations. (9, 19, 22)
3. Assist patients and families in clarifying goals of care and making care decisions	Geriatricians facilitate complex shared medical decision-making with patients and families by clearly communicating the patient's situation, prognosis, and options; eliciting preferences, values, and concerns; and skillfully leading the discussion (see EPA 9: facilitating a family meeting)	Use prognostic tools and guidelines that recognize comorbidity and function. (21, 26) Assess patients for capacity to make specific medical decisions and, if lacking, identify decision-maker. (5) Consider specific cultural and health literacy differences in communication styles or approach to illness. (1) Effectively educate patient and family regarding expectations, prognosis, follow-up plans based on anticipated expected course of disease, and barriers to health and recovery. (16, 40) Skillfully discuss and document care decisions, goals of care, and advance care planning with patients, families, and caregivers. (4, 24)
4. Prevent, diagnose, and manage geriatric syndromes	Geriatricians design and implement plans to prevent, diagnose, and treat geriatric syndromes (e.g., falls and dizziness; cognitive, affective, and behavioral disorders; pressure ulcers; sleep disorders; hearing and vision disorders; urinary incontinence; weight loss and nutritional concerns; constipation and fecal incontinence; elder abuse) in older persons in every setting of care	Have a high index of suspicion and regularly screen for geriatric syndromes and their risk factors. (11, 29, 36, 43, 45, 52, 53, 55, 56, 59, 63, 64, 66, 67, 68, 72, 74) Consider the possibility of multiple predisposing and precipitating etiologies for each syndrome. (43, 52, 53, 54, 58, 62, 66, 69, 72, 75, 76) Design and implement a setting of care appropriate plan that includes the patient/family/caregiver, appropriate involvement of other team members or specialists, and community or institutional resources. (29, 36, 44, 45, 47, 49, 53, 54, 57, 59, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76)
5. Provide comprehensive medication review to maximize benefit and minimize number of medications and adverse events	Geriatricians review all over-the-counter and prescribed medications to ensure there is a current indication and a target outcome, use the principles of	Perform comprehensive medication review and reconciliation to ensure continued indication, minimize duplications, maximize adherence and prevent iatrogenic events. (10, 29/42) Justify medication regimen based upon indications, age-related changes in pharmacokinetics and pharmacodynamics, common

(Continued)

Table 1 (Contd.)

Geriatricians entering into practice, in and across all care settings (hospital, home, office, and long-term care and subacute rehabilitation facilities), are able to

EPA	Overview	Observable Tasks (and Related Curricular Milestones[a])
	geriatric pharmacology to select medications and doses, and always consider medications as a possible contributor when patients present with new symptoms or geriatric syndromes	lists of medications to be avoided or used with caution in older adults, and consideration of benefits and risks, particularly when prescribing a newly released medication. (9, 10) When a patient presents with a new symptom or geriatric syndrome, investigate whether a medication(s) is contributing. (11) Individualize pain control using pharmacological and nonpharmacological strategies based on the etiology and chronicity of the patient's pain. (12) Prescribe pain medications with instructions and methods to prevent common complications. (13)
6. Provide palliative and end-of-life care for older adults	Geriatricians identify patients with serious illness who are likely to benefit from palliative or hospice care, including those with noncancer diagnoses (e.g., congestive heart failure, chronic obstructive pulmonary disease, dementia). They regularly re-assess goals of care, effectively treat most pain and nonpain symptoms, and refer to hospice or palliative medicine specialists as needed	Assess and provide care to patients at end of life; refer to hospice or palliative medicine specialist as needed. (1, 2, 3, 5, 6, 7, 23, 24, 26, 27, 28) Treat pain and nonpain symptoms to decrease suffering. (12, 13, 27, 28, 73) Regularly reassess goals of care to recognize patients likely to benefit from palliative or hospice care. (4, 21, 22, 26)
7. Coordinate health care and healthcare transitions for older adults with multiple chronic conditions and multiple providers	Geriatricians identify appropriate care settings that meet the needs of a patient and recognize when transition to a different setting is needed. They provide care for patients during these transitions in a manner that ensures continuity for the patient and works to optimize the care of that patient by future caregivers	Seek and incorporate input from patients' medical specialists, interprofessional team members, and the patient, family, and caregivers to optimize plan of care. (2, 24) Identify appropriate care settings that meet the needs of a patient and recognize when transition to a different venue is needed. (26, 30, 49-a, 51) Develop prioritized care plans appropriate to the care setting, including accessing site-specific resources. (14, 15, 35, 36, 38, 48, 51) Oversee medical care transitions across multiple delivery settings including ambulatory, subacute, acute, rehabilitation, long-term care, and hospice. (34, 16) Whenever transferring care, provide the next caregiver with an assessment of patient's medical conditions, cognition and function, reconciled medications, code status, goals of care discussions, pending study results, and follow-up needs. (10, 31)
8. Provide geriatrics consultation and comanagement	Geriatricians respond to requests for consultation or comanagement with explicit recommendations that reflect the patient's prognosis, multiple chronic conditions, function and goals, and provide guidance to providers and patients, families, and caregivers	Provide care with attention to age-related changes in physiology, function, treatment efficacy and response, medication management, and psychosocial issues. (25, 37) Perform preoperative assessments for older adults and document specific perioperative management recommendations to improve patient care and safety based on type of surgery and patient characteristics. (44) When appropriate, address goals of care with patient, family, and caregivers. (1, 4, 26) Synthesize, prioritize, and formulate recommendations that consider prognosis, comorbidity, and patient and family goals. (4, 21, 22, 23, 24, 28, 37) Communicate recommendations clearly with requestor or comanagement team and patient or family. (2, 3, 7)
9. Skillfully facilitate a family meeting	Geriatricians skillfully facilitate family meetings by providing a safe and culturally appropriate environment and when eliciting	Demonstrate advanced communication skills (language choice, cultural awareness, nonverbal behavior, response to emotion, conflict mediation) when eliciting patient and family values, goals, and preferences; when negotiating goals of treatment; and

(Continued)

Table 1 (Contd.)

Geriatricians entering into practice, in and across all care settings (hospital, home, office, and long-term care and subacute rehabilitation facilities), are able to

EPA	Overview	Observable Tasks (and Related Curricular Milestones[a])
	patient and family values, goals, and preferences or negotiating goals of treatment, use advanced communication skills (e.g., jargon-free language, nonverbal behavior, response to emotion, conflict mediation)	when communicating with other healthcare providers. (1, 2, 3, 4, 6, 7, 23, 40) Assess and incorporate family and caregiver needs and limitations, including caregiver stress, into patients' management plans. (24, 34, 35) If appropriate, counsel patients, families, and caregivers about the range of options for palliative and end-of-life care, including pain management, artificial nutrition and hydration, and hospice care. (27, 40)
10. Collaborate and work effectively as a leader or member of an interprofessional healthcare team	Geriatricians lead and work within interprofessional healthcare teams in multiple settings of care to improve patient outcomes through coordination, collaboration, and mutual understanding. They recognize situations when team leadership should reside with other members of the interprofessional team	Allow team leadership to reside with the appropriate team member depending on the goal of a team meeting. (2, 50) Demonstrate respect for the members of the interprofessional healthcare team. (2, 31) Elicit team input and manage diverse beliefs and opinions, using these constructively in negotiating an optimal care plan. (2, 30) Provide and receive feedback constructively. (2)
11. Teach the principles of geriatrics care and aging-related healthcare issues to professionals, patients, families, healthcare providers, and others in the community	Geriatricians teach patients, physicians-in-training, other healthcare professionals, and lay audiences principles of geriatrics care; identify and adjust teaching messages based on the audience; and supervise trainees providing constructive feedback	Teach patients, physicians-in-training, and other healthcare professionals about the principles of geriatric care and the geriatric syndromes. (8, 40) Identify and adjust teaching messages and strategies to context, learners, and environment. (40) Respond to and answer learners' questions or comments. (40) Demonstrate ability to supervise trainees by assessing learner understanding and skill and then providing constructive feedback. (40) Provide appropriate balance between supervision and autonomy of trainees. (40)
12. Collaborate and work effectively in quality improvement and other systems-based initiatives to assure patient safety and improve outcomes for older adults	Geriatricians identify real and potential problems threatening older adults' safety and outcomes, notify the appropriate person or entity, and initiate or participate in system improvement efforts to improve care. They advocate to improve care and communication within complex systems such as the hospital and with other service care providers	Regularly look for systems-remediable problems when identifying deficiencies in patient care and identify improvement strategies. (29, 39, 41, 42) Participate in quality improvement efforts or a systems-based initiative to enhance the quality of care for older adults. (33, 38) Demonstrate understanding of a variety of metrics (quality indicators) used for evaluation of quality improvement or systems-based initiatives concerning care of older adults. (32, 50) Advocate for quality patient care and assist patient, family, and caregiver to navigate system complexities (e.g., facilitate communication between patient, family, and caregivers and service care providers such as home care, hospital administration). (6, 29, 30, 31, 32, 33, 37, 38, 39, 41, 50)

[a] Numbers in parentheses refer to the Geriatric Curricular Milestones (see companion article; or http://adgap.americangeriatrics.org/academic-resources/competencies/geriatric-fellowship-curriculum-milestones-December-2012 (accessed January 26, 2014); or http://www.pogoe.org/fellowcompetencies (accessed January 26, 2014)).

Beginning with a subset of the geriatricians who created the CMs, an AGS/ADGAP geriatrics EPAs working group was formed to develop a set of EPAs that represent the essence of the critical activities of geriatricians enumerated in the CMs. The working group drafted an initial list of EPAs and used an iterative process to garner input from geriatrician clinician–educators. Initial input came from more than 225 attendees from 48 allopathic and two osteopathic medical schools at the 2011 and 2012 Annual Reynolds Grantees Meeting. In 2011, a plenary session at the meeting was devoted to competency-based medical education and EPAs, after which participants worked in small groups to review and comment on the draft EPAs. Over the next 8 months, the working group considered and incorporated these and other comments into a revised draft of the EPAs and then met in person in July 2012. At the 2012 Reynolds Grantees Meeting, participants broke into small groups to review the updated draft EPAs. Each group was also assigned one EPA and asked to describe the tasks a

trainee would need to perform to demonstrate competence in that EPA. In January 2013, the working group incorporated these comments and posted a draft list of 11 EPAs on the AGS e-mail list seeking a final round of comments. All comments were reviewed and considered, and on April 15, 2013, the AGS and ADGAP boards approved the final list of 12 geriatrics EPAs and posted them on their websites. An expanded working group then developed overviews to describe each EPA from the observable tasks identified at the 2012 Reynolds meeting and identified the CMs that, when observed, provide data on a trainee's entrustability.

The 12 EPAs for geriatrics, along with an overview and a description of the tasks that should be observed to determine that a physician can be entrusted to perform each EPA without supervision, are shown in Table 1. The CMs matched to each task are noted in parentheses.

DISCUSSION

The AGS/ADGAP end-of-training EPAs highlight the activities that are the core of a geriatrician's practice. They encompass all of the geriatric CMs and all settings of geriatric care. The EPAs define the "product" of a geriatric fellowship (a physician prepared to care for older adults across all settings); once in practice, individual geriatricians may choose to concentrate on specific EPAs or settings. EPAs also will allow program directors to assess their fellows' competence.

Beginning in July 2014, as part of the Accreditation Council for Graduate Medical Education (ACGME) Next Accreditation System (NAS), geriatrics fellowship directors will be required to review biannually each fellow's performance and chart his or her progress toward readiness for independent practice on each of the 23 American Board of Internal Medicine (ABIM) Subspecialty Reporting Milestones. (The American Board of Family Medicine and the ABIM have agreed to use these reporting milestones for geriatric fellowship programs.) These 23 reporting milestones are based on the ACGME six core competencies (patient care, medical knowledge, systems-based practice, practice-based learning and improvement, professionalism, and interpersonal and communication skills) and describe the "qualities of professionals."[7] They provide a framework to guide curricular focus and to help meet accountability to the public in exchange for the privilege of professional self-regulation. They are, by design, context free so that all internal medicine (IM) subspecialties can use them. The EPAs and their associated CMs provide the context for the IM subspecialty reporting milestones, allowing geriatrics fellowship directors to assess each fellow's progress and to make an entrustment decision (whether the trainee can perform the activity without supervision). Each CM provides a window on competence for one of the tasks that makes up the EPA. Because each EPA comprises multiple CMs and reporting milestones, entrustment indicates competence in multiple domains. It is not expected that fellows will be assessed in all CMs for an EPA.

The geriatrics EPAs describe a geriatrician's expertise and how geriatricians differ from internists and family practitioners who care for older adults. The EPAs emphasize the complexity of geriatric care and the greater likelihood of adverse events in those who are old, frail, or have multiple chronic conditions. Such complexity in turn requires prioritizing care with the individual and family and recognizing that the evidence is often insufficient and the individual's life expectancy uncertain. The EPAs recognize the need for fellows to become skilled communicators with patients, other physicians, and the healthcare team. They underscore that geriatrics is truly personalized and individualized medicine that recognizes good quality of life as one of the most important outcomes for patients. Because there will never be enough geriatricians to care for all older adults, the EPAs require that geriatricians be effective teachers and participate in developing safe systems of care for older adults.

The AGS/ADGAP EPAs and narratives presented here encompass the essence of all 76 CMs. They provide a shared mental model that defines the expertise of a geriatrician and add to the field's ability to meet the challenge of the 2014 ACGME NAS.

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