Increasing the quality and quantity of geriatric medicine training for family practice residents is a particular challenge for community-based programs. With support from the John A. Hartford Foundation of New York City, the American Academy of Family Physicians (AAFP) implemented in 1995 a multi-part project to improve the amount and quality of geriatric medicine education received by family practice residents. This report summarizes the initial results of the regional geriatric medicine curriculum retreats for residency directors. The goals of the retreats were to build recognition among the residency directors of the skills that future family physicians will require to be successful providers of primary care to older adults and to allow the residency directors to identify and develop solutions to barriers to improving geriatric medicine training for residents. Forty-six program directors participated in the three retreats between February 2000 and February 2001. The participants represented 52 programs and rural tracks in all geographic regions, small and large programs, and urban and rural settings. The program directors developed a consensus on the geriatric medicine knowledge, skills, and attitudes that should be expected of all family practice residency graduates; developed a list of basic, required educational resources for each family practice residency program; and proposed solutions to common obstacles to successful curriculum development.

(Fam Med 2003;35(1):24-9.)

Since 1900, the percentage of Americans over age 65 has more than tripled, increasing from 3.1 million (4.1% of the population) to 35.0 million (12.4% of the population) in 2000. By 2030, that number will increase to 70 million (20.6% of the population). The quality of medical services received by older Americans is greatly affected by the knowledge and skills of the primary care physicians who provide their medical care. In the United States, half of the ambulatory medical care for older adults is delivered by family physicians and internists. Physicians in these two specialties also provide the majority of hospital care and nearly all the nursing home care for the elderly. The National Ambulatory Medical Care Survey of 1997 documented that about 200 million office visits were made to family physicians, representing 25.5% of all ambulatory visits during that year, more than any other medical specialty. Twenty percent of these visits to family physicians were made by adults ages 65 and older.

The importance of geriatric medicine training for primary care medical residents has been studied. The 1993 Institute of Medicine (IOM) report, Strengthening Training in Geriatrics for Physicians, recommended substantially expanding geriatric medicine training in primary care residencies. An ambitious recommendation in this IOM report was to incorporate 6 months of geriatric medicine training into family practice and internal medicine residency programs by 1996 and to have a minimum of 9 months of training in these programs by 1999.

The special requirements for residency training in family practice also require geriatric medicine training, though not to the extent recommended by the IOM. The residency requirements are that:

Educational experience must be provided in the common and complex clinical problems of the older...
patient and must include the preventive aspects of health care, functional assessment, the physiological and psychological changes of senescence, the sociocultural parameters of the patient and his or her greater community, the nutritional and pathological (acute and chronic) entities of aging, and the effective utilization of all members of the health care team. There must be experience with the older adult patient in the hospital, the family practice center, a long-term care facility, and the home (effective July 2001).9

Increasing the quality and quantity of geriatric medicine training for family practice residents is a particular challenge for community-based programs. These programs have an average of only seven full-time equivalent (FTE) physician faculty, compared with 13 for programs based in medical schools.3 In addition, many of the community residency programs are the sole training program in their hospitals and do not have access to teaching faculty from other specialties.

With support from the John A. Hartford Foundation, the American Academy of Family Physicians (AAFP) implemented in 1995 a multi-part project to improve the amount and quality of geriatric medicine education received by family practice residents. The AAFP Residency Assistance Program/Hartford Geriatrics Initiative (RAP/HGI) project is targeted at faculty teaching geriatrics in community hospital-based family practice programs. The project objectives and components are listed in Table 1.

One of the three components of the RAP/HGI project is a geriatric medicine curriculum retreat for residency directors. (Description and implementation of the other two components, the RAP/HGI consultations and faculty development workshops, are not presented in this report.) The retreat format was based on the Hartford Foundation project, “Integrating Geriatrics Into the Subspecialties of Internal Medicine,” a project of the American Geriatrics Society (AGS). The AGS project is aimed at defining the basic knowledge, attitudes, and skills that every subspecialist must possess to care for older adults.

The goals of the retreats for family practice residency directors were to build recognition among the residency directors of the skills that future family physicians will require to be successful providers of primary care to older adults and to allow the residency directors to identify and develop solutions to barriers to improving geriatric medicine training for residents. The retreat is a multi-day, total-immersion experience to help “gerontologize” exemplary faculty from leading academic health centers. To date, more than 10 retreats, involving most of the subspecialties of internal medicine, have occurred.10 This paper describes the retreats held for family practice residency directors.

### Table 1

**Project Objectives and Components**

**Project Objectives**
- To improve the amount and quality of geriatric medicine education received by family practice residents
- To identify and support faculty teaching geriatrics in smaller, community hospital-based family practice programs
- To invigorate the geriatric medicine education mandate within family practice

**Project Components**
- RAP/HGI on-site geriatric medicine curriculum consultations—1-day, flexible on-site consultations for family practice residency programs
- Regional and national geriatric medicine faculty development workshops for residency program faculty
- Regional geriatric medicine curriculum retreats for residency directors

**Methods**

The project team included the project director, a project administrator based in the AAFP Division of Medical Education, and two project advisors/program directors. The project team competitively selected 46 (approximately 15 per retreat) residency directors, representing residency programs from diverse geographic regions, to attend three 2-day regional retreats during 2000–2001. The retreats were arranged to occur at resort locations in the Southwest, Northeast, and Southeast. They were advertised through mailings from the AAFP to the program directors (eg, **Directors Newsletter**). The specific work objectives for the participants during the retreats are shown in Table 2.

The retreats were planned to develop consensus among the participants. Continuity was achieved by having project faculty attend each retreat. Participants in the first retreat worked on objectives one and two.

### Table 2

**Program Director Geriatric Education Retreat Work Objectives**

- To review existing curriculum content guides for geriatric medicine training in family practice residencies
- To develop a consensus regarding the necessary components of an effective geriatric medicine curriculum for family practice residency training
- To conduct an analysis of the educational strategies available to residency directors
- To conduct an analysis of the faculty identification and development strategies available to residency directors
- To develop solutions for overcoming barriers to implementing effective curricula
The subsequent retreat participants reviewed and modified previous work and then moved on to objectives three through five. Summaries of the retreat discussions were drafted. After each retreat, all current and previous retreat participants had the opportunity to review and comment on the draft products. All 46 program director participants reviewed the final products. Planned outcomes of the retreats included presentations by the project faculty on geriatric medicine training for family physicians at national family practice meetings, as well as the distribution of geriatric educational resource materials to all residency directors.

Results

Forty-six program directors participated in the three retreats between February 2000 and February 2001. The participants represented 52 programs and rural tracks in all geographic regions, in small and large programs, and in urban and rural settings (Appendix 1). The mean and median size of the programs represented was 18 residents in training. Seventy-five percent of the participants represented was 18 residents in training. Seventy-five percent of the participants represented programs based in community hospitals with medical school affiliation and/or medical school administration, 14% were based at a medical school, 9% were community based without medical school affiliation, and 2% were military based. Twenty-nine percent of the programs were in rural settings, 63% were in urban and suburban settings, and 8% were located in inner cities. Three national presentations by project faculty allowed for further review and comment on the project’s products (Table 3).

The program directors developed a consensus on the geriatric medicine knowledge, skills, and attitudes that should be expected of all family practice residency graduates (Table 4). For family practice residency programs to ensure that their residents achieve the educational objectives, retreat participants developed a list of basic, required educational resources for all family practice residency programs (Table 5).

A number of common obstacles confront busy program directors as they work to improve their geriatric medicine training. Many of these obstacles, and possible solutions, are specific to geriatrics. During each retreat, these obstacles were identified and possible solutions proposed (Table 6).

The retreat participants shared and discussed many innovative training ideas and best practices for teaching geriatric medicine. The participants also reviewed curriculum and faculty development resources. (Summaries of this work are available from the project administrator at the Education Division of the AAFP—ssinglet@aafp.org.)

### Table 3

<table>
<thead>
<tr>
<th>Retreat and Project Presentations</th>
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<tbody>
<tr>
<td><strong>February 2000</strong></td>
</tr>
<tr>
<td>Retreat &amp; Program Directors Workshop presentation</td>
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<tr>
<td><strong>June 2000</strong></td>
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<tr>
<td>Program Directors Workshop presentation</td>
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<tr>
<td><strong>September 2000</strong></td>
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<tr>
<td>Retreat</td>
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<tr>
<td><strong>February 2001</strong></td>
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<tr>
<td>Retreat</td>
</tr>
<tr>
<td><strong>April 2001</strong></td>
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<tr>
<td>Residency Assistance Program Workshop presentation</td>
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<tr>
<td><strong>June 2001</strong></td>
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<tr>
<td>Program Directors Workshop presentation</td>
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</tbody>
</table>

### Discussion

Little is known about graduating family practice residents’ readiness for practice. In geriatric medicine, a “residency-practice mismatch” may exist: new physicians may not be adequately prepared to care for the many complex older adults they will see in their practices.11 A 1998 national survey of residents graduating from eight specialties at US academic health centers addressed this concern.12 A stratified, random sample of graduating residents was surveyed and 2,626 (65%) responded. The survey asked family practice graduating residents to assess their preparedness in several areas relevant to geriatric medicine. Less than half of family practice residents indicated that they were “very prepared” to manage the terminally ill, the chronically ill, or nursing home patients.

Bringing together 10% of the family practice program directors nationwide to spend a weekend focused on the challenge of improving geriatric medicine training for family practice residents provided an invaluable opportunity to address this issue. While this sample of program directors was likely biased toward an interest in geriatric medicine, the healthy discussion at each of the retreats revealed considerable differences among the participants. Some of the program directors attending the retreats were clearly advocates for geriatrics, but most were pragmatic leaders who need to balance many competing educational priorities.

Residency directors are crucial to the implementation of a successful geriatric medicine curriculum. Numerous competing curricular needs distract residency directors from their geriatrics curriculum, and it is essential that future strategies engage this important constituency. A recent national survey of family practice program directors found that the most significant barrier reported by program directors to improving their geriatric medicine training is the overcrowded curricula.
lum demands placed on the 36-month-long residencies. This complaint is not surprising given the breadth of family practice training and the expansion of Residency Review Committee (RRC) requirements. In the same survey, when residency directors were asked to rate the importance of several curricular areas to the training of the future successful family physician, pediatrics, geriatrics, and inpatient medicine were rated as the top three priorities.13

### Table 4

Prioritized Knowledge, Skills, and Attitudes: Competencies in Geriatric Medicine for Family Practice Residents

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Residents must demonstrate knowledge about established and evolving biomedical, clinical, and social aspects of geriatric medicine practice and the application of this knowledge to patient care. Topic areas of particular importance include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Normal aging physiology</td>
<td>2. Normal psychological, social, and environmental changes of aging</td>
</tr>
<tr>
<td>3. The tendency of the elderly to experience iatrogenic illness (eg, adverse effects from medications, institutionalization, diagnostic tests)</td>
<td>4. Principles of health maintenance, including wellness, nutrition, and exercise</td>
</tr>
<tr>
<td>5. Financial aspects of health care of the elderly, including regulations governing practice in the home and nursing home</td>
<td>6. Syndromes: dementia/delirium, depression, incontinence, falls/mobility/ balance, immobility, pressure ulcers, sensory impairment, elder abuse, polypharmacy, malnutrition</td>
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<tr>
<td>7. Management of diseases that occur more commonly in the older adult</td>
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<table>
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<tr>
<th>Skills</th>
<th>Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health of the older adult. Residents are expected to:</th>
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<tbody>
<tr>
<td>1. Perform the components of comprehensive geriatric assessment</td>
<td>2. Demonstrate competence and medical decision making, taking into account family/personal/cultural/spiritual values of the individual</td>
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<tr>
<td>3. Identify and work effectively with the older adult’s caregivers</td>
<td>4. Provide palliative care, pain management, and end-of-life care in the context of family and individual values</td>
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<tr>
<td>5. Develop the skills to manage patients in transition between settings, eg, between ambulatory/hospital settings and long-term care, including home care, nursing home</td>
<td>6. Develop the skills to provide continuity of care for older adults in the home, assisted living, nursing home, rehabilitation settings, and hospice</td>
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<tr>
<td>7. Understand Medicare regulations and demonstrate appropriate billing applying current E&amp;M (Evaluation and Management) coding</td>
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<tr>
<th>Attitudes</th>
<th>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Specifically, residents are expected to:</th>
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<tbody>
<tr>
<td>1. Demonstrate a commitment to maintaining and improving the older patient’s functional abilities and independence</td>
<td>2. Demonstrate sensitivity and responsiveness to the patient’s culture, age, gender, and disabilities</td>
</tr>
<tr>
<td>3. Demonstrate a commitment to ethical principles pertaining to the provision or withholding of clinical care</td>
<td>4. Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with older patients, their families, and professionals from varied disciplines</td>
</tr>
</tbody>
</table>

### Table 5

Required Resources for Geriatric Medicine Training for Family Practice Residents

<table>
<thead>
<tr>
<th>Administrative Leadership</th>
<th>The residency director is expected to provide the necessary curriculum, necessary curriculum time, moral support, and other resources for geriatric education.</th>
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<td></td>
<td>At least one faculty member must be assigned the responsibility for leading the geriatric medicine component of the curriculum. This faculty leader must have sufficient knowledge and experience in geriatric medicine, developed through earning an American Board of Family Practice/American Board of Internal Medicine certificate of added qualifications, completing fellowship training, or through equivalent experience. The curriculum leader should advocate for geriatrics training within the residency program and help to attract the necessary educational resources. The curriculum leader should also be responsible for engaging the entire residency faculty in the geriatric medicine educational process.</td>
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</table>

| Faculty Support | The entire core family physician faculty must demonstrate and teach the principles of excellent care for older adults. There should be evidence of scheduled updates in geriatrics as part of an ongoing faculty development program. Nurse practitioner/physician assistant faculty can be used to expand teaching resources. Community faculty based in nursing homes, home health, or hospice settings can be recruited to supplement the efforts of the core faculty. |

<table>
<thead>
<tr>
<th>Geriatric Training Sites</th>
<th>The residency program must be committed to provide comprehensive training experiences in geriatric care in a variety of practice sites.</th>
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<tbody>
<tr>
<td>1. Family practice center (FPC)—Resident experience with ambulatory older adults must be sufficient to teach prioritized competencies (a minimum of 10% of visits being with patients age 65 or older is recommended in FPC or other community sites).</td>
<td>2. Hospital inpatient service—Resident experience with older adults in the hospital must be sufficient to teach prioritized competencies (a minimum of 30% of the inpatient volume being with patients age 65 or older is recommended).</td>
</tr>
<tr>
<td>3. Nursing home/assisted living—Resident experience with older adults in long-term care institutions must be sufficient to teach prioritized competencies (a minimum of two continuity patients followed for 12–24 months is recommended).</td>
<td>4. Home and community-based care (eg, hospice, home health care, day care, family support groups)—Resident continuity experience with older adults in long-term care settings must be sufficient to teach prioritized competencies (a minimum of five home visits during training and experience with at least two older patients who are continuity patients over 12–24 months is recommended).</td>
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</table>

<table>
<thead>
<tr>
<th>Educational Resources</th>
<th>1. Library—There should be current geriatric medicine texts, journals, media (not &gt;5 years old), access to the World Wide Web, and patient education materials on geriatric topics.</th>
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<tbody>
<tr>
<td>2. FPC/home visit equipment—There should be an existing protocol and “black bag” for home visits, chart forms available to assess mental and physical functioning and promote health maintenance in the older adult, handicap access (entry, waiting room, bathroom), one power table (including the procedure room table), and a hearing handicap pocket amplifier.</td>
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</table>

Although the requirements for the geriatric medicine curriculum for family practice residents are described in the RRC and RAP guidelines for training, these brief documents provide program directors with limited direction. On the other hand, the recommended content
of the geriatric medicine curriculum as outlined in the AAFP/STFM Core Educational Guidelines on the “Care of Older Adults” and in numerous other published documents tend to be comprehensive, and their length made them difficult for the program directors to apply in all family practice training programs (Table 4).

The educational strategies for geriatric medicine training implemented by family practice residencies vary widely. This is to be expected since settings vary considerably. However, most community hospital and medical center family practice residency programs can develop the resources to train family physicians to provide quality care to older adults. The retreat participants felt that it was possible to define the resources required to develop an effective geriatric medicine curriculum for family practice residents that can be applied in all family practice training programs (Table 5).

In summary, a series of three geriatric medicine education retreats attracted a total of 46 family practice program director participants. The program directors demonstrated a comprehensive understanding of geriatric medicine and the training needs of future family physicians. Through a consensus process they developed expected competencies in geriatric medicine, educational resource requirements, and strategies for overcoming obstacles to curriculum development. The results of this project will be disseminated and represent a valuable resource to program directors and residency faculty in their efforts to further our discipline’s mission of training family practice residents to provide outstanding clinical care to older adults.

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REFERENCES


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**RAP/HGI—Residency Assistance Program/Hartford Geriatric Initiative**