

GUIDELINES FOR FELLOWSHIP TRAINING IN GERIATRICS

RECOMMENDATIONS FROM AMERICAN GERIATRICS SOCIETY

Geriatricians currently fill a variety of roles in clinical practice, health care organizations, community agencies, industry, and academics. Although a core set of attitudes, knowledge, and skills is necessary for all geriatricians to fill any of these roles, some roles require additional knowledge and skills and, hence, necessitate additional training in geriatrics and other disciplines. This document will describe suggestions for fellowship training in geriatrics with specific emphasis on the core set of attitudes, knowledge, and skills needed for an internist or family physician to be formally trained as a clinical geriatrician. This core training requires one year of clinical training and will satisfy training eligibility requirements for the Certificate of Added Qualifications in Geriatrics Medicine (CAQGM) offered by the American Board of Family Practice and the American Board of Internal Medicine. Thus, geriatricians who have completed this training and have attained their CAQGM would be recognized as experts in the clinical care of older persons. They may fill additional roles in health care organizations, community agencies, and academics.

Nevertheless, for geriatricians who plan to fill leadership and most educational positions, the single year of training will be insufficient. Additional training in health care administration, education, health policy, and other disciplines that focus on older persons and geriatrics will provide the additional knowledge and skills that will allow these geriatricians to rise in leadership roles. In most cases, this training for "Educator" or "Administrative" geriatricians will require an additional year (total of 2 years). A third track that some geriatricians will pursue is that of the "Researcher" geriatrician, which will require a minimum of two years beyond the clinical geriatrician year (total of 3 years or more). The need for at least two years beyond the clinical training is justified both by additional course work necessary for basic science, clinical, social sciences, or health services research and to allow fellows sufficient time to plan and complete a research project that will solidify the skills needed to conduct research and begin to establish a track record of research credibility.

It is anticipated that the vast majority of physicians who enter fellowship programs will become clinical geriatricians and only a minority will choose training for careers as educators, administrators, or researchers. Nevertheless, each of these roles is critical in providing optimal care for older persons. For example, without an adequate number of "educator" or "researcher" geriatricians, the academic base of

training of generalist physicians who will provide the majority of care for older persons¹ will crumble. Hence, it becomes a priority of the Health Care Financing Administration to maintain fellowship funding for each of these tracks, especially in light of the shortage of geriatrics faculty². Additional support (e.g., for advanced research training) should be supported by the National Institute on Aging, Bureau of Health Professions, or other Federal agencies.

The following sections describe the AGS recommendations for fellowship training. The requirements for one-year of clinical training are presented and then separate recommendations for educational and administrative track and research track training are presented. Some programs may spread the 12 months of clinical training over more than one academic year as part of an integrated multi-year program. Differences between Internal Medicine and Family Practice are included by parentheses and *italics* for Family Practice.

¹ Reuben DB, Zwanzinger J, Bradley TB, Fink A, Hirsch SH, Williams AP, Solomon DH, Beck JC. "How many physicians will be needed to provide medical care for older persons? Physicians manpower needs for the twenty-first century". *J Am Ger Soc* 1993; 41:444-453.

² Reuben DB, Bradley TB, Zwanzinger J, Fink A, Vivell S, Hirsch SH, Beck J. "The critical shortage of geriatrics faculty". *J Am Ger Soc* 1993; 41 560-569.

Guidelines for Clinical Geriatrics Fellowship Training in Internal Medicine (*Family Practice*)

(Proposed Program Requirements for Residency Education in Family Practice Geriatric Medicine. In addition to complying with the "Program Requirements for Residency Education in Family Practice Geriatric Medicine and Family Practice Sports Medicine," programs must also comply with the following requirements, which may in some cases exceed the common requirements.)

I. Educational Program

An educational program in geriatric medicine must be organized to provide a well supervised experience at a sufficient level for the resident to acquire the competence of a physician with added qualifications in the field. It shall be at minimum 12 months in duration.

The program must be conducted by an accredited residency program in Internal Medicine or Family Medicine. Residents in geriatric medicine must have satisfactorily completed an Accreditation Council for Graduate Medical Education-accredited residency in family practice or internal medicine.

Clinical experience must include opportunities to manage elderly patients with a wide variety of medical problems on an inpatient and outpatient basis. Residents must be given the opportunity to provide both primary care and consultation for patients in acute, ambulatory, community, and institutional-based long-term care settings in order to understand the interaction of natural aging and disease as well as the techniques of assessment, therapy, and management. Additionally, residents must be given the opportunity to care for persons who are generally healthy and require primarily preventive health-care measures.

The program should include an emphasis on the physiology of aging, the pathophysiology of disease that commonly occur in older persons, atypical presentations of illnesses, functional assessment, cognitive status and affective assessment, and concepts of treatment and management in the acute and long-term care setting, as well as in the community and in the home. Attention should be directed as well to the behavioral aspects of illness, socioeconomic factors, and ethical and legal considerations that may affect medical management.

II. FACULTY AND STAFF

A. Program Director

The program director must be fully committed to the program in order to devote sufficient time to the achievement of the educational goals and objectives. The program

director must be primarily based at the teaching center and must be certified in internal medicine or family practice and hold a Certificate of Added Qualifications in Geriatric Medicine or possess equivalent credentials. The program director must be based in a division or section of geriatrics, have considerable experience in geriatric medicine, and must be responsible for the entire program. The individual must have demonstrated interest in education and have a career commitment to academic geriatric medicine.

B. Other Faculty

In addition to the program director, each program must have at least two other faculty members with similar qualifications, who devote a substantial portion of professional time to the training program. For programs with more than two residents, there must be one additional faculty member with similar qualifications for each additional resident. Some of these faculty may be part-time in geriatric medicine or drawn wholly from collaborating programs. The faculty commitment must not attenuate the quality of the core residency training program. Because of the multidisciplinary nature of geriatric medicine, the program must have meaningful relationships with physical medicine and rehabilitation, neurology, and psychiatry. Appropriate relationships with other disciplines including but not limited to general surgery, orthopaedics, ophthalmology, otolaryngology, urology, gynecology, dentistry, pharmacy, audiology, physical and occupational therapy, and speech therapy should be maintained. Additionally, liaisons must be established with nursing, social work, and physician assistants, when available.

C. Geriatric Care Team

There must be a meaningful experience with interdisciplinary geriatric teams in acute care hospital, nursing home (including subacute and long-term care), home care, (*and the family practice center*) or other outpatient settings. Essential members include a geriatrician, a nurse, and a social worker. Additional members may be included in the team as appropriate including representatives from disciplines such as neurology, psychiatry, physical medicine and rehabilitation, physical, occupation and speech therapy, dentistry, pharmacy, psychology and pastoral care. Regular team conferences must be held.

III. FACILITIES/RESOURCES

A patient population adequate to meet the needs of the training program must be available in the facilities in which the educational experiences take place. Elderly patients of both sexes with a spectrum of chronic illness, at least some of whom have potential for rehabilitation, must be available. At all facilities utilized by the program, the resident must be

given opportunities to provide meaningful care. At each setting, certain activities are mandated and must be precepted by the appropriate clinician. The program must include the following:

A. Acute-Care Hospital

The acute-care hospital central to the geriatric medicine program must be an integral component of a teaching center. It must have the full range of services usually ascribed to an acute-care general hospital, including intensive care units, emergency room, operating rooms, diagnostic laboratory and imaging services, and pathology department.

B. Long-Term Care Institution

One or more long-term care institutions, such as a skilled nursing facility or chronic-care hospital, is a necessary component of the geriatric medicine program. Exposure to subacute care and rehabilitation care in the LTC setting is desirable. The total number of beds available must be sufficient to permit a comprehensive educational experience. The institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each must be consistent with those promulgated by the Joint Commission on the Accreditation of Healthcare Organizations.

C. Long-Term Noninstitutional Care

Noninstitutional care service (e.g. home care, day care, residential care or assisted living) is a major component of the geriatric medicine program. A home care program or home health care agency is a necessary resource to permit residents to learn to provide care for patients who are homebound but not institutionalized. Day care or day hospital, life care communities, and residential care facilities for the elderly are also desirable training sites.

D. Ambulatory Care Program

A substantial proportion of the resident's time during the 12 months of clinical training must be spent in ambulatory care settings. This must include at least 1/2 day per week spent in a continuity of care experience. This experience must be designed to render care in a geriatric clinic or family practice center to elderly patients who may require the services of multiple medical disciplines (including but not limited to neurology, gynecology, urology, psychiatry, podiatry, orthopaedics, dentistry, audiology, and ophthalmology) as well as nursing, social work, and nutrition, among other disciplines. The opportunity to render continuing care and to coordinate the implementation of recommendations from these medical specialties and disciplines is mandatory. In addition, ambulatory experiences in

relevant specialty and subspecialty clinics (e.g., geriatric psychiatry and neurology) and those that focus on geriatric syndromes (e.g., falls, incontinence, osteoporosis) are highly desirable.

E. Managed Care Experience

Capitated reimbursement of the health care of elderly persons is becoming an increasingly important method of reimbursement. It is highly desirable that residents obtain experience with caring for older persons enrolled in at-risk Medicare contract health plans.

F. Additional Educational Environment

Peer interaction is essential for residents. To achieve this goal, an accredited training program must be present in at least one relevant specialty other than internal medicine. Involvement in other health care and community agencies is desirable. There must be a formal affiliation agreement between each long-term care facility included in the program and the sponsoring institution, in which each institution must acknowledge its responsibility to provide a high quality of care, adequate resources, and administrative support for the educational mission. In addition, there must be a letter of agreement between each long-term care facility and office of the director of the geriatric medicine program that guarantees the director appropriate authority at the long-term care institution to carry out the training program.

IV. SPECIFIC PROGRAM CONTENT

All major dimensions of the curriculum should be structured educational experiences for which written goals and objectives, a specific methodology for teaching, and a method of evaluation exist. A written curriculum that describes the program comprehensively including sites, educational objectives for each component, topics to be covered in didactic sessions should be available to residents and faculty. The curriculum must ensure the opportunity for residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experience required of a physician in the care of the aged.

Didactic as well as clinical learning opportunities must be available to the resident. Conferences or seminars/workshops in geriatric medicine should be specifically designed for the resident to augment the clinical experiences. Journal club or other activities that foster interaction and develop skills in interpreting the medical literature are necessary.

As the residents progress through their training, they must have the opportunity to teach personnel such as nurses, allied health personnel, medical students, and residents. Appropriate supervision of the residents must be provided during all of their educational experiences.

The following components must be provided:

A. Geriatric Medicine Consultation Program

This program must be formally available in the ambulatory setting, the inpatient service, and/or emergency medicine in the acute-care hospital or at an ambulatory setting administered by the primary teaching institution.

B. Institutional Long-Term Care Experience

In the long-term care institutional setting each resident must have 12 months of continuing longitudinal clinical experience with an assigned panel of patients for whom the resident is the primary provider. Additional block time long-term care experience is encouraged. Emphasis during the longitudinal experience should be focused on (1) the approaches to diagnosis and treatment of the acutely and chronically ill frail elderly in a less technologically sophisticated environment than the acute-care hospital, (2) working within the limits of a decreased staff-patient ratio compared with acute-care hospitals, (3) a much greater awareness of and familiarity with subacute care physical medicine and rehabilitation, (4) the challenge of the clinical and ethical dilemmas produced by the illness of the very old, and (5) administrative aspects of long-term care.

C. Community Long-Term Care

Experience with home visits and hospice care must be included. The resident must be exposed to the organizational and administrative aspects of home health care. Continuity of care with an assigned panel of home or hospice care patients for whom the resident is the primary provider is essential.

D. Geriatric Psychiatry

Identifiable structured didactic and clinical experiences in geriatric psychiatry must be included in the program of each resident. Behavioral sciences such as psychology/social work and others must be included in the curriculum.

E. Curriculum

The training program must provide opportunities for the residents to develop clinical competence in the overall field of geriatric medicine. The curriculum of the program must exhibit, as a minimum, the following content and skill areas:

1. Current scientific knowledge of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, and epidemiology of sociodemographic characteristics and diseases of the aged.
2. Aspects of preventive medicine, including nutrition, oral health, exercise, and screening for and immunization and chemoprophylaxis against disease. Instruction about and experience with community resources dedicated to these activities should be included.
3. Geriatric assessment including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); the appropriate use of the history, physical and mental examination, and the laboratory.
4. Appropriate interdisciplinary coordination of the actions of multiple health professionals, including physicians, nurses, social workers, dietitians, and rehabilitation experts, in the assessment and implementation of treatment.
5. Topics of special interest to geriatric medicine, including but not limited to cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, malnutrition and functional impairment.
6. Diseases that are especially prominent in the elderly or that have different characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders.
7. Pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, overmedication, appropriate prescribing, and adherence.

8. Psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety.
9. The economic aspects of supporting services, including Title III of the Older Americans Act, Medicare, Medicaid, capitation and cost containment.
10. Ethical and legal issues especially pertinent to geriatric medicine, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, wills, and durable power of attorney for medical affairs.
11. General principles of geriatric rehabilitation, including those applicable to patients with orthopaedic, rheumatologic, cardiac, and neurologic impairments. These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, environmental modification, patient and family education, and psychosocial and recreational counseling.
12. Management of patients in long-term care settings, including respecting patient wishes for palliative care, knowledge of the administration, regulation, and financing of long-term institutions and the continuum from short- to long-term care.
13. A basic understanding of research design and research methodologies related to geriatric medicine, including critical evaluation of medical literature.
14. Peri-operative assessment and involvement in management.
15. Iatrogenic disorders and their prevention.
16. Communication skills with patients, families, professional colleagues, and community groups, including presenting case reports, literature searches, and research papers (when appropriate) to peers and lectures to lay audiences.
17. The pivotal role and needs of the family in caring for many elderly persons and the community resources (formal support systems) required to support both patient and family.
18. Cultural aspects of aging including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment, and use of an interpreter in clinical care. Issues of ethnicity in long-term care, patient education, and special issues relating to urban and rural older persons of various ethnic backgrounds should be covered.
19. Home care including the components of a home visit, accessing appropriate community resources to provide care in the home setting.
20. Hospice and palliative care including pain management, symptom relief, comfort care and end-of-life issues.

Guidelines for Second Year/Educational or Administrative Track

Although the purpose of training in these tracks is to develop non-clinical expertise, it will be necessary for the trainee to continue to provide patient care to maintain clinical skills. Fellows may play an increasing role in preceptorship of medical students or residents in addition to direct patient care. Much of the clinical care provided will occur in longitudinal care settings such as geriatrics clinics, nursing homes, and home care.

During the second year of advance geriatrics training, fellows may choose to focus exclusively on developing teaching and/or administrative skills. Potential mechanisms to accomplish these goals are listed below.

I. Clinical Teaching and Education

- a. Attendance at symposia, workshops, or lecture series on effective clinical teaching methods and clinical curriculum development.
- b. Review of the literature on effective clinical teaching strategies and integration of these strategies into a review article or presentation to peers.
- c. Demonstration of these skills by lecture, poster or research presentation of material in geriatric medicine or education.
- d. Skill development and demonstration of evaluation strategies.
- e. Exposure to and development of innovative teaching strategies, incorporating proper use of audio-visual materials.
- f. Participation in the planning of a teaching symposium or CME activity.
- g. Instruction in bedside clinical teaching.
- h. Scholarly review articles on clinical topics.
- i. Curriculum development on special clinical topics (example: osteoporosis, incontinence).

The above methods accomplished by inter- or intra- institution partnership with Masters level programs (such as Masters in Education) or curricula that include formal relevant course work (such as Schools of Public Health or Education). This coursework could be complemented with practical experiences such as proctored teaching experience in the medical schools or residency programs.

II. Administration

- a. Instruction in the financing of health care as it pertains to older adults (e.g., Medicare, Medicaid, managed care).
- b. Instruction in basic health care management course content focusing on the proposed following topics applicable to a variety of settings (e.g., academic, hospital, ambulatory, nursing facility and managed care sites) including:
 1. Developing leadership skills
 2. Team building
 3. Employee recruitment, interviewing and retention

4. Performance improvement
5. Providing feedback and holding critical conversations
6. Improving meeting effectiveness
7. Creating clinical outcome measures
8. Problem solving and prevention (individual and group)
9. Creating performance-based appraisals
10. Project management
11. Presentations to the business and health care community
12. Preparing and implementing a budget
13. Population and individual care management
14. Strategies for futile care prevention/advance directive strategies
15. Time management
16. Training in total quality improvement/management
17. Strategic plan development

- c. Demonstration of administrative competency by presentation, lecture or committee work.

The above requirements could be accomplished in partnership with Masters level programs in Public Health Administration or Business and could be complemented by practical experiences. Examples of these would include an apprenticeship in medical directorship in a skilled nursing facility, large group practice or Health Maintenance Organization. Trainees could additionally be involved in committees such as ethics, quality improvement, development of clinical pathways, development of training curricula, externships with community agency directors (e.g., the local chapter of the Alzheimer's Association or Council on Aging) would also be a source of this training. Linkage with the Certified Medical Directors Program under the American Medical Directors Association is an additional resource.

Guidelines for Second and Subsequent Years/Research Track

The second and third years of fellowship for geriatricians who plan research careers will be devoted to learning relevant methods and gaining experience with techniques sufficient to assume faculty or industry roles as researchers. Fellows should maintain clinical skills as geriatricians (e.g., by providing longitudinal care or a panel of patients or through clinical rotations) but these experiences should constitute a small minority of the trainees time.

- a. Research training may focus on basic science, clinical medicine, social sciences, clinical epidemiology, ethics or health services delivery. Each requires a sustained mentorship in addition to basic instruction and a substantial commitment of time. Mentors of fellows should have substantial research experience and record of funding. Many fellows will pursue advanced degrees, especially master's degrees in public health for those pursuing clinical, clinical epidemiology, or health services research careers. Some, including those planning basic science research careers will enroll in doctoral programs. The duration of fellowship

training for trainees who plan research careers will require a minimum of two years beyond clinical training but may require additional years depending upon the fellow's specific interest. Instruction in research should include formal coursework that addresses the following topics:

b.

1. Study design
2. Basic Biostatistics/Computer skills
3. Critical review of the literature
4. Research methods
5. Data collection
6. Data analysis
7. Abstract and paper preparation
8. Grant writing
9. Project management
10. Oral and written presentation of scientific data
11. Ethic aspect of research

The depth of training for each topic will vary by the specific research area of the trainee.

By the completion of research training, the fellow is expected to have acquired the skills necessary for continued research and have submitted manuscripts for publication as first author and at least one grant.

Author: AGS Education Committee

Contributors to this document:

David B. Reuben, MD (Corresponding author)

Director for Geriatrics and Division Chief
Multi-Campus Program in Geriatrics and Gerontology

UCLA School of Medicine
10945 LeConte Avenue, Suite 2339
Los Angeles, CA 90095-1687
ph (310) 825-8253
fx (310) 794-2199

Sharon A. Brangman, MD, AGSF
Assistant Professor of Medicine/Geriatrics

SUNY Health Sciences Center at Syracuse

Sally Brooks, MD, AGSF
Director, Section of Geriatric Medicine
The Christ Hospital

G. Paul Eleazer, MD
Director, Division of Geriatrics
University of South Carolina School of Medicine
Director, James F. Byrnes Center for Geriatric Medicine, Education and Research

Evelyn Granieri, MD
Assistant Professor of Medicine
University of Pittsburgh School of Medicine
Division of Geriatric Medicine

George T. Grossberg, MD
Samuel W. Fordyce Professor & Chairman, Department of Psychiatry
St. Louis University School of Medicine

Dennis Jahnigen, MD, AGSF
Director, Center on Aging
Goodstein Professor of Geriatric Medicine
Head, Division of Geriatric Medicine
Department of Medicine
University of Colorado Health Science Center

Adrienne Mims, MD, MPH
Chief, Prevention Health Promotion & Research
Kaiser Permanente

Thomas Mulligan, MD

Daniel Osterweil, MD

Barbara L. Thompson, MD
Professor and Chair
Department of Family Medicine
The University of Texas Medical Branch

Approved by AGS Board of Directors, November 1997. First published by The Journal of the American Geriatrics Society (JAGS), V46:1473-1477, 1998. American Geriatrics Society, The Empire State Building, 350 Fifth Avenue, Suite 801, New York, NY 10118.