SPECIAL ARTICLE

Retooling for an Aging America: Building the Healthcare Workforce

A white paper regarding implementation of recommendation 4.2 of this Institute of Medicine Report of April 14, 2008, that “All licensure, certification and maintenance of certification for healthcare professionals should include demonstration of competence in care of older adults as a criterion.”

Section for Enhancing Geriatric Understanding and Expertise Among Surgical and Medical Specialists (SEGUE), American Geriatrics Society

In Chicago, Illinois, on May 7, 2009, a group of 53 medical educators representing many U.S. certification boards, residency review committees, and medical societies met to review and approve a white paper intended to promote Recommendation 4.2 of the Institute of Medicine report of April 14, 2008, “Retooling for an Aging America: Building the Healthcare Workforce.” This recommendation is one of 14 and states: “All licensure, certification and maintenance of certification for healthcare professionals should include demonstration of competence in care of older adults as a criterion.” Background information given included the growing numbers of older adults, review of a 15-year initiative by a section of the American Geriatrics Society (AGS) to include geriatric education in all surgical and some related medical specialties, a recent announcement of 26 elder care competencies to be expected of graduating medical students from Association of American Medical Colleges (AAMC) affiliated schools, and the American Board of Medical Specialties (ABMS) approach to “Reinforcing Geriatric Competencies through Licensure and Certification Examinations.” Nine points involved in the implementation of this recommendation received discussion, and approaches to realization were presented. In conclusion, this white paper, which those listed as being in attendance approved, proposes that all ABMS member boards whose diplomates participate in the care of older adults select the floor competencies enumerated by the AAMC that apply to their specialty and add or subtract those completed during their trainees’ initial (intern) year and then define those needed in subsequent years of residency and ultimate practice. This would fulfill the requirements of Recommendation 4.2 above. J Am Geriatr Soc 59:1537–1539, 2011.

Key words: geriatrics; workforce; competency

A National Conference on Advancing Physician Competence in the Care of Older Adults convened by the American Geriatrics Society, the American Medical Association, and the Council of Medical Specialty Societies

In the next score of years, increasing numbers of older adults will present for evaluation and management at the offices of all physicians except pediatricians. (Nevertheless, pediatricians see children who older adults care for and so should be versed in assessment of their cognitive and physical ability to provide that care.) Multiple studies indicate that the knowledge of most physicians and surgeons regarding appropriate care for these individuals remains inadequate and that availability of trained geriatric specialists is marginal and indeed their numbers are decreasing (http://www.iom.edu/CMS/3809/40113/53452.aspx).

For many years, the Section for Enhancing Geriatric Understanding and Expertise Among Surgical and Medical Specialists (SEGUE) of the American Geriatrics Society (Appendix A) has been pursuing the goal of Recommendation 4.2. The approach of this group urges inclusion of geriatric knowledge in all surgical and related residency programs.

In addition, the Association of American Medical Colleges (AAMC) recently put forward a set of 26 competencies in the care of older adults that should be achieved as the senior student approaches Year 1 of residency.

Work is under way in other specialties such as internal, family, and emergency medicine on defining additional competencies that their residents should possess upon completion of residency.

The president and chief executive officer of the American Board of Medical Specialties (ABMS), as the oversight and coordinating body for all 26 certifying boards in the United States, announced as a part of a public trust initiative their “commitment towards designing and implementing a series of new programs that will strengthen [their] role as a Public Trust Agent.” Improvement of care of older adults fits this initiative (Appendix A).

PROPOSAL

Hence, it is proposed that all ABMS member boards whose diplomates participate in the care of older adults select the
floor competencies enumerated by the AAMC that apply to their specialty and add those completed during their trainees’ initial residency (e.g., internal medicine, general surgery). These two components constitute the base upon which they may add the additional competencies deemed necessary for appropriate care of older adults in their own population and then incorporated within Residency Review Committee requirements. These competencies should be demonstrated as candidates enter into and pass their board certification examinations and continued as they pursue their maintenance of certification. Similar and appropriate (but not duplicative) requirements should exist for physicians pursuing and maintaining state licensure.

IMPLEMENTATION

Each involved certifying or licensing body will evaluate its geriatric care needs with the goal of establishing the competencies (in addition to the AAMC and primary residency competencies) that must be fulfilled for minimum adequate care of older adults.

This process could be most efficiently conducted if the competencies were identified in a stepwise fashion (medical student, primary residency, specialty residency, fellowship) so that each could build on those preceding and thereby decrease duplication of effort.

Ideally, a technical assistance program could coordinate this effort; provide, when requested, existing curricula and guidelines along with experts in geriatrics in each discipline; and convene national consensus conferences that could assist in moving this process forward.

As is usual in the process of change by these certifying and licensing organizations, their decisions will be disseminated for discussion upward and downward to their governing bodies and constituencies. A final group of competencies will then be established as a criterion for accreditation of training programs and for training programs to attest to the qualifications of their trainees for eligibility for board certification. Again, initiation and institution will occur over years, with adequate duration for implementation and evaluation.

This process will require creation and distribution of additional necessary educational resources in geriatric knowledge and bases for its use. Although a number of grant-funded initiatives have created a curricular floor upon which to build, much remains to be done. National conferences to enhance this goal will be necessary.

It will also require appropriate and adequate duration for development of the faculty and continuing medical education facilities necessary to educate and evaluate the participants.

An ongoing part of development of each specialty or licensure program will require evaluation of effectiveness and usefulness.

A project of this dimension will require funding in excess of that presently available to the participating bodies, so accumulation of additional funding mechanisms must be a part of the overall plan. It is understood that, with the present financial state of the country, use of economical methods takes precedence.

This plan for implementation of one of the multiple proposals noted in the IOM report (above) should integrate and improve upon any additional actions proposed in the report. Cooperation and coordination with other organizations working to improve care of older adults will occur.

CONCLUSION

Achieving the goal of improving the care of older adults in the United States will not occur without the integrated and forceful action of the multiple medical certifying and licensing organizations. This proposal outlines the suggested approach to this goal, with the understanding that the many state and specialty medical boards may accept all, part, or none of these suggestions, but to do nothing at this time will leave a crisis in medical care for older adults that will worsen with time. Addressing this need, and ensuring that all medical professionals demonstrate specific competencies in their care of older adults, will result in better and safer quality care for our parents, grandparents, and eventually ourselves.

This white paper and its recommendations resulted from deliberations among the following physicians and healthcare professionals at a conference held in Chicago, Illinois, on May 7, 2009:

- Allergy and Immunology: Carol Saltoun, MD, American Academy of Allergy and Immunology; Dennis K. Ledford, MD, University of South Florida College of Medicine (also a member of the Allergy and Immunology Residency Review Committee)
- Anesthesiology: Arnold Berry, MD, American Society of Anesthesiologists (serving for the American Board of Anesthesiology)
- Emergency Medicine: Teresita Hogan, MD, American College of Emergency Physicians
- Family Medicine: Perry A. Pugno, MD, American Academy of Family Physicians; Anne Fabiny, MD, American Board of Family Medicine
- Geriatric Medicine: Rosanne Leipzig, MD, PhD, The American Board of Internal Medicine; John Burton, MD, Lisa Granville, MD, Jane Potter, MD, American Geriatrics Society
- Internal Medicine: F. Daniel Duffy, MD, Lorna A. Lynn, MD, American Board of Internal Medicine; Marie T. Brown, MD, American College of Physicians; Lynne Kirk, MD, University of Texas Southwestern Medical Center (also a member of the Internal Medicine Residency Review Committee)
- Medical Genetics: Mira Irons, MD, American College of Medical Genetics
- Obstetrics and Gynecology: Norman Gant, MD, Sterling B. Williams, MD, MS, American College of Obstetrics and Gynecologists
- Neurological Surgery: Dennis Spencer, MD, Yale University (also a member of the Neurological Surgery Residency Review Committee)
- Ophthalmology: Martha Farber, MD, American Board of Ophthalmology; Gwen K. Sterns, MD, Richard A. Zorab, American Academy of Ophthalmology
- Orthopedic Surgery: Kenneth Singer, MD, American Academy of Orthopaedic Surgery
- Otolaryngology: Kimberly Belaunde, David Nielsen, MD, Mark Wax, MD, American Academy of Otolaryngology—Head and Neck Surgery
Pathology: Bette K. DeMasters, MD, College of American Pathologists
Physical Medicine and Rehabilitation: Karen J. Kowalski, MD, American Board of Physical Medicine and Rehabilitation
Preventive Medicine: Denece O. Kesler, MD, American Board of Preventive Medicine
Psychiatry and Neurology: Rita Hargrave, MD, American Board of Psychiatry and Neurology
Psychiatry: James H. Scully, MD, American Psychiatric Association; Victor Reus, MD, University of California at San Francisco (Chair, Psychiatry Residency Review Committee, Accreditation Council for Graduate Medical Education and American Board of Psychiatry and Neurology)
Radiology: E. Stephen Amis, MD, Albert Einstein College of Medicine and Montefiore Medical Center (also Chair of the Diagnostic Radiology Residency Review Committee)
Surgery: Richard H. Bell Jr., MD, American Board of Surgery; Ronnie Ann Rosenthal, MD, American College of Surgeons
Thoracic Surgery: Robert M. Vanecko, MD, American Board of Thoracic Surgery
Urology: Michael Coburn, MD, Baylor College of Medicine (also Vice-Chair, Residency Review Committee for Urology); George W. Drach, MD, American Urological Association
Umbrella Organizations: Richard Hawkins, MD, American Board of Medical Specialties; Alejandro Aparicio, MD, Claudette Dalton, MD, Cheryl Irmiter, PhD, Saul Levin, MD, MPA, Kelly Towey, MEd, Joanne Schwartzberg, MD, Daniel H. Winship, MD, American Medical Association; M. Brownell Anderson, MEd, Association of American Medical Colleges; Norman Kahn, Jr, MD, David B. Reuben, MD, Council of Medical Specialty Societies; Peter J. Katsufrakis, MD, National Board of Medical Examiners
Additional Participants: Nancy E. Lundebjerg, MPA, American Geriatrics Society; Gavin W. Hougham, PhD, Christopher Langston, PhD, John A. Hartford Foundation
The opinions expressed in this white paper reflect the consensus of the attendees at a May 7, 2011, conference convened by the Council of Medical Specialty Societies, the American Medical Association, and the American Geriatrics Society and have not been formally endorsed by any organization. Conference attendees’ affiliations are listed for identification purposes only.

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REFERENCES