Geriatric Medicine Curriculum Consultations for Family Practice Residency Programs: American Academy of Family Physicians Residency Assistance Program/Hartford Geriatrics Initiative

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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 physician faculty. This report summarizes results of the Residency Assistance Program/Hartford Geriatric Initiative (RAP/HGI) geriatric medicine curriculum consultations for family practice (FP) residency programs conducted from 1996 to 2001. This project was developed as part of the RAP in family practice. Ten experienced FP educators were selected and trained as special consultants. Between 1996 and 2001, 39 FP residency programs participated in the 1- to 4-day RAP/HGI consultations. The programs were diverse in size and location. The consultations reached 308 family practice residency faculty members involved in training 807 residents. Program evaluations of the consultants were uniformly in the very good to excellent range, with a mean rating of 4.6 (5-point scale, with 5 indicating excellent). At the end of the initial consultation visit, the residency program faculty and the consultant developed short-term goals for geriatrics program development. Eighty-five percent (33/39) of the programs submitted their curriculum goals in writing. The mean number of goals per program was 4.8 (range = 3–11). Of the 33 programs with written goals, follow-up was documented for 29 programs. Seventy-nine percent of the programs' self-defined educational goals were met during the 6 to 12 months of follow-up (range 50–100%). Ten of the programs implemented all of their educational goals. The RAP/HGI project demonstrated that achievable geriatric medicine curriculum improvements could occur as part of an onsite consultation process. **J Am Geriatr Soc 51:858–862, 2003.**

Key words: family practice; residency training; geriatric medicine curriculum

The knowledge and skills of primary care physicians greatly affects the quality of medical services that older Americans receive.[1] In 1999, 21% of ambulatory visits to family physicians were from adults aged 65 and older.[2] Family physicians in 2020 can anticipate that at least 30% of their outpatient practices, 60% of their hospital practices, and 95% of their nursing home and home care practices will involve care of individuals aged 65 and older.[3]

The Accreditation Council of Graduate Medical Education special requirements for residency training in family practice (FP) specifically require geriatric medicine training.[4] Guidelines for implementing these requirements are available to program directors (PDs).[5–8] Increasing the quality and quantity of geriatric medicine training for FP residents is a particular challenge for community-based programs.[9] Community-based programs account for 84% of all FP residencies and have an average of only seven full-time-equivalent (FTE) physician faculty, compared with 13 for the programs based in medical schools.[10] In addition, many community residency programs are the sole training program in their hospitals and do not have access to teaching faculty from other residency programs.

In 1995, with support from the John A. Hartford Foundation of New York City, the American Academy of Family Physicians (AAFP) implemented a multipart project to improve the quantity and quality of geriatric medicine education received by FP residents. This project, AAFP Residency Assistance Program/Hartford Geriatrics Initiative (RAP/HGI), was targeted to faculty teaching geriatrics in community hospital–based FP residency programs.

This report summarizes results of the RAP/HGI geriatric medicine onsite curriculum consultations for FP residency programs conducted from 1996 to 2001. This

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project was developed as part of the RAP in FP. The RAP for FP began in 1975 with a grant from the W.K. Kellogg Foundation to promote the development of quality graduate medical education in family practice through provision of consultative services.[11]

METHODS

Project Administration

The RAP at the AAFP headquarters in Kansas City administered the geriatric medicine consultation program. A project administrator based at the AAFP (SS) and a project advisory board assisted the project director (GW) in directing the consultation program. The full resources of the AAFP's Division of Medical Education were available to the project team.

Consultant Recruitment and Training

Qualified FPs/geriatricians were invited to submit applications to serve as the geriatric medicine consultants. The project steering committee selected 10 experienced FP educators with fellowship training or similar experience in geriatric medicine.

The training for the consultants followed the traditional RAP training methodology.[12] With assistance from the RAP project staff, a special 2-day training experience was presented for the consultants when the project started in 1995. The AAFP RAP director (NK) led the training. The project director (GW) and a consulting faculty member, from the Stanford University School of Medicine Faculty Development Program, assisted with the training session. The training consisted of an orientation to the goals of the project and the RAP administrative process and emphasized the skills necessary to be an effective educational consultant. Follow-up 1-day debriefing and training sessions for the consultants were provided after project Years 1 and 2.

RAP/HGI Consultation

Promotion and Cost

The availability of RAP/HGI geriatric medicine consultations was promoted through regular AAFP publications and special communications to FP residency PDs and geriatric medicine curriculum leaders. In 1996 the standard RAP consultation fee was $2,000 per day; it is now $2,500 per day. This fee covered the cost of the consultants' travel expenses and honoraria and the RAP program's administrative costs, including preparation of a final report. With Hartford Foundation support, the RAP/HGI program subsidized the consultants' costs so that the program fee could be set at $250 per day from 1996 to 1999 and $500 per day from 2000 to 2001.

Residency Program Applications for Consultations

The project's consultation application process was the same as that for other RAP consultations.[12] The residency PD or geriatrics curriculum coordinator could request a RAP consultation. Consultation requests and reports are confidential between RAP staff and the PD. A two-page application was developed, which requested basic program information, the name of the geriatrics curriculum director, and the particular items or concerns the program wished the consultant to address during the onsite consultation. Program eligibility requirements included a stable, accredited program, support from the PD for the consultation, and substantive geriatrics curriculum concerns. Preference was given to programs located far from academic medical centers and those with limited access to trained geriatric medicine educators, although applications from community-based programs closely affiliated with medical schools were considered. PDs completed a specialized "geriatric medicine curriculum" presite visit-consultation questionnaire that provided the consultant with basic information about the program's curriculum. Consultants were assigned to visit programs outside their own region, consistent with the RAP's traditional approach.

Consultation Methodology

The consultations used a collaborative faculty model that included a 2-day initial consultation followed by two 1-day follow-up visits by the same consultant over the subsequent 6 to 12 months. A checklist was developed for the consultants' use to help them gather comprehensive data on the respective residency program's geriatric medicine curriculum. In addition to addressing specific curriculum development questions, the consultations were encouraged to develop a collaborative faculty role. The focus of the two follow-up visits was to evaluate progress toward defined residency curriculum goals, clinical teaching, and modeling, as well as curriculum and faculty development.

The initial 2-day consultation visits followed a standard format. Consultants arrived at the residency program site in the late afternoon and attended an informal dinner with key faculty. The following day (Day 1) was spent gathering data through interviews with faculty, administrators, and residents. The evening of Day 1 was left open for the consultant to plan the Day 2 schedule and begin drafting preliminary recommendations. Day 2 included finalizing the data collection process and assisting the residency faculty in developing a set of short-term (6–12 months) goals for enhancing their geriatric medicine curriculum. Day 2 concluded with an informal presentation to the program faculty, providing a preliminary assessment and recommendations.

At the end of the second project year, a survey was mailed to all community hospital FP residency PDs. Applications for consultations had decreased, and the project steering committee was seeking guidance from PDs on ways to modify the program to make it more attractive. As a result of the PD's input, consultation length in subsequent years was more flexible, 1 to 4 days, in one or two parts. Other aspects of the consultation process were unchanged.

Evaluation

The residency PD receiving the consultation evaluated each consultant, using a standard form developed by the RAP staff. This was a 14-question survey covering all aspects of the consultation visit, follow-up visits, and any phone contacts. The form used a 5-point scale, ranging from excellent to poor, to evaluate the consultants' performance. During follow-up visits and phone contacts, the consultants and project staff documented each program's achievement of specific curriculum goals. The consultants

met after project Years 1 and 2 and provided project staff with feedback on project strengths and weaknesses. At the end of the second project year, a survey was mailed to 400 community hospital-based PDs to assess barriers that might be preventing programs from applying for the consultations.

RESULTS

Each of the 10 consultants participated in the 2-day initial training and two 1-day follow-up training sessions during the project's first 3 years. Each consultant provided at least two full program consultations during the project period, with some of the consultants conducting as many as five consultations. Program evaluations of the consultants were uniformly in the very good to excellent range, with a mean rating of 4.6 (5-point scale, with 5 indicating excellent.) Representative positive comments included, "The consultant had an excellent knowledge of the general residency review committee (RRC) requirements for FP residency training," "The written report provided structure for achieving our curriculum goals," and "The summary presentation to our faculty was extremely valuable." Representative negative comments included, "The written report of the consultation came late," "The consultant's recommendations were not always realistic, e.g., hire a geriatrician," and "The consultant should spend less time describing what is being done elsewhere, and help us work with our available resources."

Between 1996 and 2001, the 39 FP residency programs participating in the RAP/HGI consultations were diverse in size and location. Twenty-one states were represented. The mean program size (number of residents) was 20 (range = 10–40). The mean number of full-time faculty in the residency programs was 7.9 (range = 2–26). The 39 consultations reached 308 FP residency faculty members involved in training 807 residents. Thirty of the programs had been established (and first enrolled residents) before 1990, and the remaining nine programs were more recently established. Four of the 39 programs were university-based or closely affiliated.

During the first year of the project, the RAP/HGI received 19 applications, and the project budget supported the selection of 10 sites. After the first year, the RAP/HGI was able to provide consultations to all applicants, as long as they met the basic eligibility requirements. Even with extensive promotion of the project and significant cost subsidy, fewer than 10% of all FP programs applied for a RAP/HGI consultation. As part of the application process, residency programs listed their self-identified needs for assistance with their geriatric medicine curricula (Table 1). The needs ranged from basic help with curriculum development to assistance with geriatric medicine faculty identification and recruitment.

After the initial consultation visit to a program, the consultants provided specific recommendations in written reports sent to the PD and the geriatric medicine faculty (Table 2). Consultants' recommendations emphasized the identification of geriatrics faculty (especially volunteer and other health professionals) already in the program's area, development of new training settings beyond the nursing home, and basic curriculum development.

At the end of the first consultation visit (or shortly thereafter), the residency program faculty and the consultant developed short-term goals for geriatrics program development. A list of selected short-term goals appears in Table 3. Eighty-five percent (33/39) of the programs submitted their curriculum goals in writing. The mean number of goals per program was 4.8 (range = 3–11). Of the 33 programs with written goals, follow-up was documented for 29 programs. Seventy-nine percent of the programs' self-defined educational goals were met during the 6 to 12 months of follow-up (range = 50–100%). Ten of the programs implemented all of their educational goals.

A case example illustrates the consultation process:

A residency program, with 10 residents per year and eight faculty members, based in a 350-bed Texas community hospital requested a consultation. Leadership of the program was in transition; a new PD had been recruited

Table 1. Residency Programs' Self-Identified Needs

Adequacy of the current geriatrics curriculum
Need for written curriculum
Strategies for nursing home and home care teaching
Methods to expose residents to well elderly
Strategies to adapt curriculum to managed Medicare
How to find faculty
How to improve teaching in the ambulatory setting
Content for lecture series
How to use other disciplines in teaching
Strategies to increase the census of geriatric patients
How to make the family practice center user-friendlier for older patients
Help with implementing geriatric assessment program in the family practice center
Restructure curriculum as a longitudinal experience with specific measurable outcomes
Help with establishing faculty development activities in geriatrics

Table 2. Consultant Recommendations (Listed in Order of Frequency of Recommendation)

Recruit new faculty
Provide faculty development
Use volunteer faculty
Use nursing and social work faculty
Place residents in new clinical settings
Increase the support from program director
Develop effective interdisciplinary geriatric team
Move curriculum beyond the nursing home
Increase geriatric medicine component of lecture series
Place curriculum in writing
Develop teaching contracts with nursing homes
Increase resident supervision in nursing home and home setting
Assign a faculty member to lead the geriatric medicine curriculum
Update the geriatric medicine texts in the family practice center library
Develop home care visits by identifying near by homebound elderly
Organize a home care "black" bag

Table 3. Residency Programs' Short-Term Goals

Faculty
Faculty recruitment—physician, nursing, social work, pharmacist
Appoint geriatric medicine curriculum coordinator
Recruit volunteer faculty
Increase faculty development on geriatric topics
Ensure that all faculty participate in nursing home and home care
Curriculum planning
Develop curriculum goals and objectives
Improve resident evaluation forms for the geriatrics curriculum
Nursing home experience
New nursing home or home care rotation
Expand and consolidate nursing home practice
Increase faculty supervision and teaching for residents at the nursing home
Other clinical experiences
Develop senior center rotation
Recruit additional older patients to the family practice center
Establish an outpatient geriatric assessment program in the family practice center
Develop geriatric psychiatry experience
Develop geriatric rehabilitation experience
Didactic teaching
Revise teaching conference topics
Develop reading list and resource library
Compile geriatric assessment instruments

but was not yet in place. The applicant requested assistance with the overall geriatric medicine curriculum, scheduling faculty, and the effect of change in the location of the family practice center (FPC).

During the initial 2-day visit, the consultant met with most of the faculty, many residents, the hospital president, and the directors of geriatrics training sites. The consultant identified the program's strengths as good faculty (two with a certificate of added qualification in geriatric medicine), FPC patient's panel with more than 25% aged 65 and older, excellent facilities, engaged consultant faculty in rehabilitation medicine and geriatric psychiatry, and an excellent library. Concerns noted by the consultant included uncertain leadership of the geriatrics curriculum, inadequate faculty time for planning and supervision of the geriatrics rotation, absence of learning objectives, no plan for integrating geriatric topics into existing lecture series, and a potential decrease in FPC older patients with the proposed move to a new location.

The consultant's recommendations included assigning at least 1.0 faculty FTE to geriatrics (including a 0.3 FTE curriculum coordinator), developing measurable learning objectives for the geriatrics curriculum, instituting a revised geriatric block rotation with a defined reading list, and developing a prioritized list of geriatric topics for the core lecture series.

The program faculty developed five short-term goals: recruit volunteer faculty to enhance a full-time FP position, improve faculty supervision of residents at their clinical training locations, develop curriculum goals and objectives, develop a required geriatric medicine reading list, and develop a new, required geriatric medicine project, including in-depth readings on a specific clinical topic. The faculty indicated the need for more FP faculty and the possible change in the FPC location as the most significant barriers to achieving their geriatrics curriculum goals.

During the first follow-up visit, 5 months after the initial consultation, the new PD was in place and was supportive of the effort to improve the geriatrics curriculum. The program's progress in achieving its goals included recruitment of volunteer faculty, improved resident supervision in the nursing home, written goals and objectives, development of a required reading list, and incorporation of the geriatric medicine project into the curriculum. The second follow-up visit occurred 3 months later; by which time the program's hospital had joined a new health system. This was viewed as a positive change.

The written evaluation of the consultant was positive (4.7/5). There were positive comments on the consultant's experience and knowledge of RRC requirements. In addition, the geriatrics coordinator stated that preparation for the consultation had motivated her to undertake a comprehensive curriculum review.

During the second year of the consultation project, there was a decrease in applications. A survey was sent to 400 community-based FP residency PDs in March 1997 to assess their awareness of the program and to obtain the PDs' guidance on how to modify the program to make it more appealing. One hundred seventy-four PDs responded, for a response rate of 43%. Despite extensive promotion of the project, one-third of respondents were not aware of the RAP/HGI consultations. The respondents strongly supported the core model of a RAP consultation focused directly on the geriatric medicine curriculum, with a family physician serving as the consultant. Almost two-thirds of respondents requested the option to contract for less than the full 4-day onsite consultation model. The majority preferred that consultations place more emphasis on faculty and curriculum development and less emphasis on assessing their current geriatric medicine curriculum. Thirty-eight percent of respondents viewed the subsidized fee of $250 per day as a barrier to requesting a consultation.

In response to this survey, starting with the 1998–99 program applicants, the project was revised to allow PDs to contract with RAP/HGI for a 1- to 2-day initial visit with or without follow-up visits. In addition, the consultants were advised to place more emphasis on addressing the programs' needs for faculty and curriculum development. Overall, for the 39 participating residency programs, the consultants spent 4 days onsite at 17 residency programs, 3 days onsite at four programs, 2 days onsite at six programs, and 1 day onsite at 12 programs.

During the consultant training and debriefing sessions at the end of project Years 1 and 2, the 10 consultants provided feedback on the consultation approach. In general, the consultants were pleased with their experiences and reported satisfaction in having helped residency programs achieve many of their curriculum goals. The expectation of expanding the consultant role to include a collaborative faculty role was challenging and was not often met. (The limited time visiting the program made this dual role difficult.) The most serious obstacle to successful consultations was the overall instability of some of the residency

programs. Programs with budget or faculty retention problems were not able to focus attention on improving their geriatric medicine curricula. A few of the consultations, after the initial onsite assessment, required a broader focus than just geriatric medicine, expanding into traditional, general RAP program visits.

DISCUSSION

The RAP/HGI consultation model demonstrated that FP residency programs would dedicate time and effort to improving their geriatric medicine curriculum. The numerous distractions associated with the multiple responsibilities of faculty in smaller FP training programs are a significant obstacle to improving specific aspects of the curriculum. Sending trained consultants to visit and assist residency programs is time-intensive and costly, but onsite consultations encourage program faculty to create the time to work on their geriatrics curriculum. Residency program curriculum development, especially in geriatric medicine with the need for community-based experiences, requires solutions specific to the individual program location. Skilled consultants, when visiting a program, can help residency programs develop practical curricula, using local resources.

The RAP/HGI project demonstrated that achievable geriatric medicine curriculum improvements could occur as part of an onsite consultation process. The consultants frequently identified the need for additional faculty time for geriatrics curriculum development. The recruitment of physician faculty with geriatrics experience and training remains a challenge for FP residency programs. Residency programs with unstable leadership or hospital support were least likely to develop and successfully implement curriculum goals.

Even though the RAP/HGI greatly expanded the number of RAP consultations focused on geriatric medicine, the demand for onsite consultations from FP residency programs was not strong. The competing demands on program directors to address many RRC curriculum areas (e.g., obstetrics, inpatient medicine, and pediatrics) limits programs' abilities to dedicate scarce time and energy to any particular topic area. The project was not funded to address outcomes beyond the consultation period, and long-term outcomes were not measured. The influence of the consultations and the curriculum changes on resident knowledge, skills, and attitudes was not assessed.

In summary, lessons learned from the 39 RAP/HGI consultations include:

Most community hospital FP residency programs have the resources to train family physicians to provide quality care to older adults.

Competing curriculum priorities can interfere with the development of effective geriatric medicine training.

Focused onsite consultations conducted by well-trained family physician/geriatricians can help program faculty develop and implement geriatric training.

Shorter, more-flexible onsite consultations are more acceptable than longer, highly structured visits.

In smaller programs, even experienced geriatric medicine faculty can become isolated. Ongoing faculty development is essential.

Residency program directors are crucial to the implementation of a successful geriatric medicine curriculum.

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