Retooling for an Aging America: Building the Health Care 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 health care professionals should include demonstration of competence in care of older adults as a criterion."[1]

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

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Summary
In Chicago, IL, on May 7, 2009, a group of 53 medical educators representing many United States Certification Boards, Residency Review Committees, and Medical Societies, met to review and approve a White Paper intended to promote Recommendation 4.2 of the IOM report of Apr. 14, 2008: "Retooling for an Aging America: Building the Health Care Workforce". This recommendation is one of 14 and states: "All licensure, certification and maintenance of certification for health care professionals should include demonstration of competence in care of older adults as a criterion". Background information given included the growing numbers of the elderly, 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, recent announcement of 26 elder care competencies to be expected of the graduating medical student from the 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 was approved by those listed as being in attendance, proposes that all ABMS Member Boards whose Diplomates participate in the care of the elderly patient 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 then fulfill the requirements of Recommendation 4.2 above.

Background:

1. In the next score of years increasing numbers of elderly will present for evaluation and management at the offices of all physicians except pediatricians.[Σ] Multiple studies indicate that most physicians' and surgeons' knowledge of 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).

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[1] IOM (Institute of Medicine), 2008 *Retooling for an Aging America: building the health care workforce.* Washington, DC: the National Academies Press.

[Σ] Pediatricians do see children who are cared for by older adults and so should be versed in assessment of their cognitive and physical ability to provide that care.

2. For many years, the Section on Surgical and Related Medical Specialties of the American Geriatrics Society (See 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.
3. In addition, the Association of American Medical Colleges recently put forward a set of 26 competencies in the care of the elderly that should be achieved as the senior student approaches year one of residency.[2] Currently 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.
4. The President and CEO of the American Board of Medical Specialties, as the oversight and coordinating body for all 26 Certifying Boards in the USA, announced as a part of a Public Trust Initiative their ….”Commitment towards designing and implementing a series of new programs that will strengthen (their) roll as a Public Trust Agent”. Improvement of care of the elderly fits this initiative (Appendix A).

Proposal:

Hence, we propose that all ABMS Member Boards whose Diplomates participate in the care of the elderly patient 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 comprise the base upon which they may add the additional competencies deemed necessary for appropriate care of elderly patients in their own population, and then placed into RRC 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 those physicians pursuing and maintaining State Licensure.

Implementation:

1. Each involved Certifying/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 their elderly patients.
2. This process could be most efficiently conducted if the competencies were identified in a stepwise fashion (medical student, primary residency, specialty residency or fellowship) so that each could build on those preceding and thereby decrease duplication of effort.
3. Ideally, a Technical Assistance Program could co-ordinate 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.
4. As is usual in the process of change by these Certifying/Licensing organizations, their decisions will be aired 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 acceptable duration for implementation and evaluation.
5. 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.

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[2] Leipzig R, Granville L, Simpson D, et. al. Keeping Granny Safe on July 1: A Consensus on Minimum Geriatrics Competencies for Graduating Medical Students. Acad Med. 2009; 84:604–610..

6. It will also require appropriate and adequate duration for development of the Faculty and/or CME facilities necessary to educate and evaluate the participants.
7. An ongoing part of development of each Specialty or Licensure program will require evaluation of effectiveness and usefulness.
8. Clearly, a project of this dimension will require funding in excess of that presently available to the participating bodies. Hence, accumulation of additional funding mechanisms must be a part of the overall plan. It is understood that, with the present financial state of our country, use of economical methods takes precedence.
9. 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 the elderly will occur.

Conclusion:

Achieving the goal of improving the care of the elderly in the USA will not occur without the integrated and forceful action of our multiple Medical Certifying/Licensing organizations. This proposal outlines our 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. To do nothing at this time, however, will leave us with a crisis in medical care for the elderly that will worsen with time. Addressing this need, and assuring 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[3] at a conference held in Chicago IL on May 7, 2009:

Allergy and Immunology
Carol Saltoun, MD
- The 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
- The American College of Emergency Physicians

Physical Medicine and Rehabilitation
Karen J. Kowalski, MD
- The American Board of Physical Medicine and Rehabilitation

Preventive Medicine
Denece O. Kesler, MD
- The American Board of Preventive Medicine

Psychiatry and Neurology
Rita Hargrave, MD
- The American Board of Psychiatry and Neurology

Psychiatry
James H. Scully, MD
- The American Psychiatric Association

[3] The opinions expressed in this white paper reflect the consensus of the attendees at a May 7th 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. NB: Conference attendees' affiliations are listed for identification purposes only.

Family Medicine
Perry A. Pugno, MD
– American Academy of Family Physicians

Anne Fabiny, MD
– The 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
– The American Geriatrics Society

Internal Medicine
F. Daniel Duffy, MD
Lorna A. Lynn, MD
– The American Board of Internal Medicine

Marie T. Brown, MD
– The 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
– The American College of Medical Genetics

Obstetrics and Gynecology
Norman Gant, MD
– The American Board of Obstetrics and Gynecology

Sterling B. Williams, MD, MS
– The American College of Obstetrics and Gynecologists

Psychiatry (cont'd)
Victor Reus, MD
– The University of California, San Francisco (Chair, Psychiatry RRC, ACGME and American Board of Psychiatry and Neurology)

Radiology
E. Stephen Amis, MD
– The Albert Einstein College of Medicine and Montefiore Medical Center (Also Chair of the Diagnostic Radiology Residency Review Committee)

Surgery
Richard H. Bell Jr., MD
– The American Board of Surgery

Ronnie Ann Rosenthal, MD
– The American College of Surgeons

Thoracic Surgery
Robert M. Vanecko, MD
– The 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
– The American Urological Association

Umbrella Organizations
Richard Hawkins, MD
– The 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
– The American Medical Association

Neurological Surgery
Dennis Spencer, MD
- Yale University (Also a member of the Neurological Surgery Residency Review Committee)

Ophthalmology
Martha Farber, MD
- The American Board of Ophthalmology

Gwen K. Sterns, MD
Richard A. Zorab
- The American Academy of Ophthalmology

Orthopaedic Surgery
Kenneth Singer, MD
- The American Academy of Orthopaedic Surgery

Otolaryngology
Kimberly Belaunde
David Nielsen, MD
Mark Wax, MD
- The American Academy of Otolaryngology - Head and Neck

Pathology
Bette K. DeMasters, MD
- College of American Pathologists

Umbrella Organizations (cont'd)
M Brownell Anderson, M.Ed
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- 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
- The American Geriatrics Society

Gavin W. Hougham, PhD
Christopher Langston, PhD
- The John A. Hartford Foundation

Appendix A

American Board of Medical Specialties

The American Board of Medical Specialties (ABMS), a not-for-profit organization, assists 24 approved medical specialty boards in the development and implementation of standards in the ongoing evaluation and certification of physician specialists. The ABMS, believes that higher standards underlying physician certification and Maintenance of Certification (MOC) means better care for patients.

American Geriatrics Society

The American Geriatrics Society (AGS) is a not-for-profit organization of over 6,700 health professionals devoted to improving the health, independence and quality of life of all older people. The Society provides leadership to healthcare professionals, policy makers and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. The mission of the AGS is to improve the health, independence and quality of life of all older people. The AGS is the organizational home for the Geriatrics-for-Specialists Initiative (GSI), a ten-specialty collaboration with a focus on improving care of older adults.

The GSI aims to: 1) improve the amount and quality of geriatrics education received by surgical and related medical specialist trainees; 2) identify and support specialty faculty in promoting geriatrics training and research within their own disciplines; 3) assist professional certifying bodies and professional societies in improving the ability of their constituencies to care for older patients; and 4) enhance the geriatrics knowledge and expertise of practicing surgeons and medical specialists through continuing medical education, Maintenance of Certification programs, and quality measures that help to improve the care that they provide to frail older adults.

American Medical Association

The mission of the American Medical Association (AMA) is to promote the art and science of medicine and the betterment of public health. AMA's vision is to be an essential part of the professional life of every physician. It helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues.

Council of Medical Specialty Societies

The mission of the Council of Medical Specialty Societies (CMSS) is to provide a respected and influential voice for medical specialty societies and their members by working with the societies and other medical organizations to formulate, articulate and promote adoption of policies that will improve the United States' healthcare system and health of the public. CMSS fosters, promotes, supports, augments, develops and encourages: (1) improved quality of medical care for all patients; (2) improved standards and systems of delivery of patient care; (3) effective programs for continuing and graduate medical education; (4) studied responses to medical and health policy issues; (5) communication among specialty organizations concerned with the principal disciplines of medicine; and (6)ethical practice and professionalism in medicine.