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Research Report

Geriatrician Roles and the Value of Geriatrics in an Evolving Healthcare System

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Executive Summary

I. *Introduction*

There are insufficient numbers of practicing geriatricians to meet current demand for their services, and the shortage is projected to worsen in the coming decades as the number of older Americans rapidly increases. Understanding how to best leverage geriatricians as members of an overall care team is critical.

This report is the second component of a two-stage project examining current and emerging roles of geriatricians as members of healthcare teams across different care settings. The first report, [The Roles and Value of Geriatricians in Healthcare Teams: A Landscape Analysis](#), provided a comprehensive analysis of the current landscape, derived from scholarly work assessing how geriatricians are integrated into healthcare teams and how care is delivered to the geriatric population in different types of healthcare delivery systems.

This study focuses on information solicited from leaders in geriatrics as to how different types of healthcare organizations utilize geriatricians and how geriatrician roles may evolve and new roles emerge as healthcare systems and organizations reorganize care in response to a changing environment.

II. *Methods*

Semi-structured qualitative interviews were conducted with field experts in geriatrics, including practicing geriatricians, academic researchers, clinician educators, healthcare philanthropists, and representatives from professional geriatric societies.

III. *Findings*

There were several common themes among key informants' descriptions of geriatrician roles: (1) Geriatrics should be seen as a set of principles that can inform all care provided to older adults, by all types of providers; (2) Geriatricians are engaged in direct patient care activities as primary care providers, serve in consultative and care management roles, are clinician educators, conduct academic and policy research, are engaged in practice model redesign and implementation,

and hold positions in many types of healthcare organizations at the director or executive level; (3) Healthcare organizations, conscious that geriatricians are a scarce resource, are increasingly focused on utilizing them in roles that amplify their expertise; and (4) Healthcare organizations are adapting to the emerging value-based payment environment, with its focus on interdisciplinary team-based care, and implementing care models designed to provide higher quality lower cost care to older adults, as compared with the procedure-based fee-for-service system.

IV. Conclusion

Interviews suggest that healthcare systems and organizations are reorganizing the delivery of geriatric care in ways that acknowledge the persistent shortage of geriatrician specialist physicians and seek to utilize this scarce resource to both amplify geriatricians' expertise and provide higher quality, lower cost care. Geriatricians continue to provide direct care to patients but increasingly do so as part of interdisciplinary teams, which facilitates integrated, comprehensive care.

While the role of academic clinician educator will always be necessary and fundamental, it is clear that for healthcare systems and organizations to embrace the concept of geriatrics as meta-discipline – not a niche specialty, but rather a set of principles that informs all care provided to older adults – a key role for geriatricians will be to educate non-geriatrician providers in geriatrics principles. As value-based care continues to incentivize the adoption of innovative geriatric care models, organizations will rely on geriatricians to lead efforts to implement them.

V. Policy Implications

The expectation that geriatricians will play a substantial leadership role in helping to transform the delivery of care to older adults raises questions about the content of fellowship training and need for other professional development opportunities. The experts interviewed suggested that fellowship programs could help prepare future leaders by incorporating experiences that allow fellows to deepen their knowledge of concepts such as population health, implementation science, healthcare financing, and practice model innovation. Programs should also offer mid-career professional development opportunities that utilize the executive MBA model to deliver content on these topics to practicing geriatricians and geriatrics fellowship-like content to non-geriatrician physicians. There is clear value in efforts to establish new billing codes within the fee-for-service system that reimburse for care activities geriatricians routinely provide, such as advance care planning, transitional care management, and chronic care management. The profession and policymakers should continue to advocate for expanding the number of geriatrics-relevant billing



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codes, as well as refining the performance measures used by the Centers for Medicare & Medicaid Services (CMS), as part of the Merit-based Incentive Payment System (MIPS), to determine upward (or downward) adjustments to a geriatrician's fee-for-service payment rates.

Geriatrician Roles and the Value of Geriatrics in an Evolving Healthcare System

This report is the second component of a two-stage project in which we examined current and emerging roles of geriatricians as members of healthcare teams across different care settings. The first report, [The Roles and Value of Geriatricians in Healthcare Teams: A Landscape Analysis](#), provided a comprehensive analysis of the current landscape, derived from scholarly work assessing how geriatricians are integrated into healthcare teams and how care is delivered to the geriatric population in different types of healthcare delivery systems. The landscape analysis was published in December 2017; this report adds new data from interviews with key stakeholders about the future of geriatricians in a complex, rapidly evolving healthcare system. The information contained in this report is summarized in an accompanying [Research Brief](#).

Background

The US healthcare system faces numerous challenges in meeting the needs of older adults.¹ These include increased longevity and the related burdens of chronic disease, cognitive decline, and physical frailty; the cost of care deriving from medical and pharmaceutical services, adapted housing, and ongoing support services; a reliance on family caregivers who may have increasingly limited ability to provide care; and the quality of care provided by healthcare professionals.

As specialists in the health and care of older adults, geriatricians play a central role in helping to address these challenges. However, there are not enough practicing geriatricians to meet current demand for their services, and the shortage is projected to worsen in the coming decades as the number of older Americans rapidly increases.² Data from the National Residency Matching Program indicate that just 213 of the 415 positions (50.8%) offered by geriatrics fellowship programs in 2019 were filled and that the share of filled positions has ranged from 44 to 50% over the past five years.³

Field experts interviewed for this study acknowledged that, despite decades of efforts to attract more physicians to the field, it is unlikely that the number of board-certified geriatricians will ever be sufficient to provide direct care to all who would benefit from their expertise. Many of the current workforce development initiatives and geriatric care models referenced in this report reflect this reality, in that they are focused more on finding ways to amplify geriatricians' expertise, rather than on increasing the number of geriatricians. This study focused on

soliciting information from leaders in the field as to how different types of healthcare organizations utilize geriatricians and how geriatrician roles may evolve and new roles emerge as healthcare systems and organizations reorganize care in response to a changing environment. Some familiar roles, such as medical director of a nursing home, are not discussed. In the context of describing professional roles for geriatricians, key informants also raised issues related to medical education and specialty training, professional development, healthcare finance and reimbursement, practice model redesign, and the development of geriatric expertise in the broader health professions workforce.

Methods

Semi-structured qualitative interviews were conducted with field experts in geriatrics, including practicing geriatricians, academic researchers, clinician educators, healthcare philanthropists, and representatives from professional geriatric societies.

Recruitment

Potential interviewees were first identified by the UCSF Health Workforce Research Center on Long-Term Care's Expert Advisory Group, and a snowball sampling method was used to identify additional subjects. Email invitations were sent to each potential participant (n=28) in waves starting in early March 2018. A second round of recruitment emails was sent 2 weeks following the initial email, and a third round was sent to non-responders another 2 weeks later. A total of 22 individuals responded with interest in the study, with another 4 individuals declining and 2 not responding, resulting in a total of 21 interviews conducted from March 19, 2018 through May 16, 2018.

Profile of Interview Participants

Nearly three-quarters of the interview participants were trained geriatricians (n=15; 71.4%) (Table 1). Interviewees were either formerly or currently employed in the following organizations: the American Board of Internal Medicine, the American Geriatrics Society, Aurora Health Care, Blue Cross Blue Shield, CareSource, Centers for Medicare & Medicaid Services, the Donald W. Reynolds Foundation, Fallon Health, the John A. Hartford Foundation, Johns Hopkins University, the Institute for Healthcare Improvement, Iora Health, Mayo Clinic, Mount Sinai Health System, National Association of Area Agencies on Aging, Swedish Family Medicine in Seattle, University of Alabama Birmingham, University of Alberta, University of California, Los Angeles, University of California,

San Francisco, University of North Carolina Chapel Hill, University of Rochester, University of Texas Southwestern, University of Washington, University of Wisconsin School of Medicine and Public Health, the Veterans Health Administration, Wake Forest University, Warren Alpert Brown University Medical School, and Xavier University.

Table 1. Interview participants' occupations and types of organizations

Count	Type of Organization	Occupation
7	Academic	Geriatrician
5	Health System	Geriatrician
2	Insurer	Geriatrician
2	Academic	Researcher
2	Philanthropy	Program Director
1	Federal Institution	Geriatrician
1	Professional Society	Program Director
1	Federal Institution	Program Director

Many interviewees were past or current division chiefs or chairs of geriatrics at their organizations and identified themselves as clinician educators. Several were also fellowship program directors, some of whom were founders of these programs at their organizations and were responsible for managing geriatric education at all levels of education: undergraduate, residency, and fellowship. Geriatrician interviewees reported practicing in a variety of care settings: inpatient hospitals, post-acute facilities (nursing homes, memory-support assisted living, long-term care, acute care, rehabilitation), outpatient primary care clinics, house calls, home-based care and hospice, and in specific models of care including Acute Care for Elders (ACE) units and Programs of All-inclusive Care for the Elderly (PACE) programs. Many interviewees described their work as focused on the interplay between geriatric and palliative care, transitions of care and integrated care models, and age-friendly home- and community-based care models. Other interviewees focused their work on policy development and evaluation and quality improvement at federal institutions and insurers. Each interviewee had breadth and depth of knowledge about the history of geriatric care in the US and insight as to where the profession is heading.

Interviews and Analysis

Verbal consent to participate and record audio was obtained at the time of the interview. An interview guide was designed, covering ideal geriatrician roles, whether these roles differ by care setting or health system, and how to best

leverage geriatric expertise by drawing from the interviewee's own experience or in reference to an ideal system. The interviews were conducted by telephone and were of 32-58 minutes duration (46 minutes on average). Interviews were then transcribed verbatim and analyzed to identify common themes across all interviews using Dedoose Version 8.1.8 web application (SocioCultural Research Consultants, LLC, Los Angeles, CA). The Institutional Review Board (IRB) at the University of California, San Francisco reviewed the study and determined it did not require IRB oversight (#17-24000).

Key Findings

Geriatrician Roles

Key informants provided evidence that organizations are utilizing geriatricians in roles that track closely with prior research on this topic.^{4,5} Geriatricians are engaged in direct patient care activities as primary care providers, serve in consultative and care management roles, are clinician educators, conduct academic and policy research, are engaged in practice model redesign and implementation, and hold positions in many types of healthcare organizations at the director or executive level. Frequently, their professional positions combine several of these roles.

Interviewees were asked to consider the question of what is the “right” role for geriatricians, given their short supply. Interviewees consistently emphasized that the answer to this question was dependent on whose perspective is considered. Patients would likely prefer to have a geriatrician manage their primary care. However, from a health systems perspective, it is logical to have geriatricians in administrative leadership positions where they can champion geriatric care models and initiatives designed to create age-friendly health systems. From the individual geriatrician's perspective, the ideal role varies with personal preference. As one key informant said, *“The field is remarkably open to different pathways and different ways of thinking and different ways of being as a geriatrician. Everybody should be able to do what they want to do and make a strong contribution to the communities in which they live.”*

There were a few common themes among key informants' descriptions of geriatrician roles. One was that the broader healthcare system is slowly embracing the idea of geriatrics as a “meta-discipline” on both the delivery side and the education and training side. With the term meta-discipline, key informants conveyed that geriatrics should be seen as a set of principles that can inform all care provided to older adults, by all types of providers, rather than a niche specialty practiced only by a small number of highly trained experts. A second theme was the

growing awareness among healthcare organizations that the emerging value-based payment environment, with its focus on interdisciplinary team-based care, shows much promise for providing higher quality, lower cost care to older adults, as compared with the procedure-based fee-for-service system. This is especially true for the frail elderly who live with multiple chronic conditions. Finally, key informants suggested that healthcare organizations, conscious that geriatricians are a scarce resource, are increasingly focused on utilizing them in roles that amplify their expertise – as one individual put it, “*force multipliers.*”

Direct Patient Care Roles

Most geriatricians involved in direct patient care focus on comprehensive primary care services. Key informants described primary care roles for geriatricians that are shaped by the emergence of value-based payment models and their orientation toward comprehensive, coordinated, interdisciplinary team-based care. Most, but not all, of the primary care roles referenced were focused on patient populations that have complex care needs, but some served populations with a mixture of routine and complex care needs. For example, one key informant who represented an organization of primary care practice groups that partners with Medicare Advantage companies noted that her organization served a patient population that was “not the oldest and frailest.” However, for the range of Medicare enrollees served, the organization offers comprehensive primary care; as she described it: “*We have a team-based approach that includes physicians, nurse practitioners, integrated behavior health, so we have PhD-level clinical psychologists or licensed social workers. We also have health coaches, who operate as medical assistants in the clinic, but they also have a significant role in being sort of care navigators for patients and advocates to help people achieve what they want to achieve.*” The organization also has a care coordination component for services delivered outside of the primary practice setting (e.g., ED visits and hospital admissions).

She emphasized that the physicians in her organization have a smaller patient panel size compared with what is typically found in fee-for-service primary care practices and that the team-based structure allows the physician to focus on medical decision-making, building relationships with patients, and making sure the care plan is executed; in her words, clinicians can focus on “the things that doctors are really good at.” As a result, she felt that the quality of care provided was better in comparison with a conventional primary care practice. Many of the physicians working in these practices are not geriatricians, but she suggested the model of care within her organization may prove attractive to geriatricians (or other primary

care physicians who want to focus on older adult care) because it provides an opportunity to practice in ways they would “*find meaningful and rewarding.*”

The concept of a geriatrician as a “complexivist” has been described in the literature for more than a decade and reflects the idea that the oldest, frailest, and most medically complex patients are the ones who would most benefit from the care of a geriatrician specialist.⁶ Most key informants expressed the view that geriatricians engaged in direct patient care ought to be functioning as complexivists. One of the key informants representing a large, integrated health system affiliated with a medical school and geriatrics fellowship program commented, “*What we’ve embarked on over the past year is a re-thinking of the role for geriatric specialists, recognizing that the number of older adults who are living longer with more complex illness is increasing rapidly, while the number of geriatricians is not.*” Historically, geriatricians in his health system have been concentrated in small, ambulatory care practices “essentially doing primary care for people over the age of 65.” As the organization has transitioned to a clinically-integrated system and a value-based payment model, these geriatric primary care practices are being reorganized into interdisciplinary team practices focused on older patients with complex and/or serious illness. “*Our strategy is to focus on the 5 to 10% of our older patients with multiple morbidities and high caregiver-need, who are driving 50% of our healthcare costs.*”

Another key informant from the Veterans Health Administration (VA) described the VA system’s use of a specialized version of its patient-centered medical home model, the Patient Aligned Care Team (PACT). This care model utilizes geriatricians or providers with demonstrated geriatric expertise in the primary clinician role and focuses on the VA’s oldest, frailest, and most medically complex patients. Each physician works closely with a registered nurse care manager, a clinical associate who is a licensed practical/vocational nurse, and an administrative associate who is typically a medical assistant. The GeriPACT program expands the standard PACT care team to include a dedicated social worker and pharmacist, and it offers additional services to support aging in a community setting, including comprehensive geriatric and behavioral health assessments, advance care planning, and coordination of wrap-around community-based services.

Other nationally disseminated models of geriatrician-led, interdisciplinary team-based primary care referenced by key informants included:

*Programs of All-inclusive Care for the Elderly (PACE)*⁷ – This model uses a geriatrician-led (or geriatrics-aware primary care physician-led) interdisciplinary team to provide coordinated, comprehensive healthcare and social services to

older, frail adults who are eligible for nursing home care. The goal of the PACE model is to allow participants to remain in the community as opposed to receiving care in the nursing home environment. Most of the patient population is dually-eligible for Medicaid and Medicare.

*Independence at Home*⁸ – This is a national demonstration project administered by the Centers for Medicare & Medicaid Services (CMS) that provides home-based primary care services to frail elderly adults who suffer from multiple chronic conditions. A geriatrician or geriatric nurse practitioner (or other geriatric-aware physician) leads care as part of an interdisciplinary team, most often including a physician assistant, pharmacist, and licensed clinical social worker.

Consultant Versus Co-management

Many geriatricians believe their longitudinal relationship with a patient is one of the most important sources of professional satisfaction. As one key informant commented, *“The actual ability to be there for people day in and day out, and together over time, is really where the meaning comes from.”* The conventional consultant role, in which geriatricians provide guidance to primary care providers in the care of older adults with complex needs, does not encourage this focus on relationship-centered care. Moreover, the effectiveness of a geriatrician’s counsel is potentially diminished because it may simply be ignored. As one key informant remarked, *“I used to run a geriatric consult service. I would see [other provider’s] patients one time and I would tell them what to do about dementia. Did they do it? I don’t know. How effective was it? I don’t know.”*

Key informants acknowledged the utility of geriatrician consultant roles as a means of extending geriatric expertise to patients cared for by non-geriatrician providers. They also emphasized that these roles are evolving as evidence of what makes the geriatric consult model effective accumulates and as the healthcare delivery system responds to new value-based care incentives. Key informants’ descriptions of the ways in which healthcare organizations are effectively utilizing geriatricians in consultant roles suggested two important characteristics. First, as with primary care provider roles, the geriatrician consultant role is commonly associated with an interdisciplinary care team. Second, there is more emphasis on formalizing the relationship between the geriatric consultation team and patients’ principal care providers (e.g., primary care physician, attending hospitalist, or other physician specialist). This can help accomplish two things: (1) effectively identifying patients who are likely to benefit from a geriatric assessment, and (2) increasing the likelihood of adherence to treatment recommendations. These characteristics are consistent with the Comprehensive Geriatric Assessment model, “defined as a

multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging.”⁹

In emphasizing intra-professional relationships, key informants acknowledged that a best practice geriatric consultation model would be, in essence, a co-management model. The nature of the relationship between the geriatric consult team and a patient’s principal provider is a defining feature of the co-management care model. With co-management, the consultant role is formally defined rather than based on presumption by either provider, and patient selection criteria are often explicit, automatically resulting in co-management. Perhaps most importantly, co-management affords the consulting provider a broad scope of practice, which means he or she can usually manage a patient’s care as necessary, ensuring adherence to treatment recommendations.

The co-management model is well-defined for the inpatient setting, most frequently deployed for geriatric patients undergoing surgery, although key informants indicated that the model is increasingly being adapted for other specialty practices including oncology and cardiology. One key informant described her institution’s use of a co-management model in which a team of a geriatrician and nurse practitioner collaborates with attending hospitalists to identify at-risk patients, conduct comprehensive geriatric assessments, develop care plans, coordinate with other hospital-based staff providing care (e.g., physical therapist, pharmacist, social worker), and provide discharge planning and outpatient care follow-up. The model has been developed into a curriculum for both geriatric medicine fellows and internal medicine residents. Another key informant noted that his institution uses a co-management model for post-acute care focused on care transitions, working with patients’ primary care providers.

Key informants also referenced examples of geriatric co-management being adopted for outpatient care practice. *“We are developing a co-management model for people in our primary care network,”* commented a key informant who represented an academic medical center and affiliated regional health system. She noted that the focus would be on the most complex patients. *“In some cases, maybe we take over their care completely, or maybe we just manage a syndrome. Maybe it’s dementia symptoms with agitation that they’re really struggling with. Or maybe we support the family. But that’s the next thing we want to build, a complex care model.”*

Many interviewees referenced the importance of leveraging telemedicine for geriatric care delivery, especially for patients living in rural communities. *“It’s hard for our patients who live far away to go to the clinic as often as they might need to, so, thinking about where geriatrics goes in the future, it has a lot to do with learning new systems of care like telemedicine to deliver consultative care to far off places,”* commented one key informant.

Many of the key informants acknowledged that efforts to develop and implement consulting or co-management care models are often based on established, nationally disseminated, interdisciplinary team-based models, including:

Acute Care for Elders Consult Team (ACE Team) model¹⁰ – This is an inpatient consultation service derived from the primary geriatrics unit (ACE unit) model of care. The ACE unit entails a dedicated hospital ward, which in some cases has been structurally modified to accommodate older patients and where a geriatrician-led (or geriatrics-aware physician-led) interdisciplinary team assumes primary care for the patient. The ACE Team consultation model operates without a dedicated ward and without assuming the patient’s primary care, but seeks to replicate the core elements of a primary care geriatrics unit, including comprehensive geriatric assessment, and more intensive discharge planning, rehabilitation, and patient education, compared with standard hospital care. In some hospitals, these teams are described as Mobile ACE units or Virtual ACE units.

ACE-tracker/e-Geriatrician¹¹ – This model of care seeks to extend core elements of the ACE unit model to inpatient settings that lack geriatric services. It relies on a software-based tool that compiles information from patients’ electronic medical records and is used by a dedicated, interdisciplinary team of non-geriatrician clinicians, in consultation with a remotely located geriatrician, to develop a care plan and coordinate treatment.

Geriatric Resources for Assessment and Care of Elders (GRACE)¹² – This is a model of home-based, primary care utilizing interdisciplinary teams to serve low-income seniors suffering from multiple chronic conditions. Geriatricians lead a consultative group of other healthcare professionals that provides support for each patient’s primary care provider team (nurse practitioner, licensed clinical social worker, and primary care physician) through the development of individualized care plans consistent with the patient’s healthcare goals and treatment recommendations for specific geriatric conditions.

Co-management with Orthopedic Surgeons – AGS CoCare: Ortho™¹³ is a nationally disseminated model of perioperative care for older patients requiring hip fracture surgery. Geriatricians (or geriatrics-aware hospitalists) work closely with orthopedic surgeons to identify risk factors for adverse events, implement needed protocols to minimize identified risks, and provide coordinated, continuous care throughout the hospital admission.

Educator for Geriatricians and Non-geriatricians

Being a clinician educator is a fundamental role for geriatricians, as they bear responsibility for training new geriatricians, developing and disseminating innovative geriatric care models, and leading efforts to integrate principles of geriatric medicine into undergraduate medical school curricula and residency training programs. Key informants focused on the importance of supporting junior academic faculty through the Geriatric Academic Career Award (GACA) program sponsored by the Health Resources and Services Administration (HRSA). GACA funding was suspended in 2015, and subsumed by a separate HRSA program. A new funding opportunity was recently announced, with awards projected to be made in fall 2019.¹⁴ According to key informants, the GACA program provides a critical source of funding for young geriatrician clinician educators that allows them to focus on research activities, develop new courses, and pursue related professional development opportunities. As one expert said, *“Support for faculty in academic medicine is driven by clinical revenue and that takes you away from teaching. GACA is critical because it directly supports geriatric education and developing geriatric educators - there is no other mechanism that does this so directly.”*

In addition to training new geriatricians, interviewees repeatedly emphasized the importance of geriatricians' engagement in service-based education of other clinicians, which was dubbed “little g” education. As one key informant said, *“You could argue that the biggest role for geriatricians is to make sure that all healthcare providers, particularly doctors, are skilled in primary care geriatrics.”* One informant described how his organization was beginning to place geriatricians within outpatient primary care and family medicine practices to serve as formal consultants on patient cases (*“to do acute, time-limited management for complicated geriatric syndromes”*) and also to be a resource for the primary care physicians to help them develop geriatric competence.

A key informant representing an organization of primary care practice groups that contracts with Medicare Advantage companies reported that geriatricians within her group take time to teach other clinicians *“how to be better in areas that they're*

weak, particularly, I would say, in the care of patients with dementia, and then palliative and end-of-life care.” She also noted that, in some of the practice groups, geriatricians are provided with dedicated time for service teaching of principles of geriatric care and mentoring of non-geriatrician primary care physicians. She added, *“I think as we grow, that might certainly be a model that we would adopt, letting the geriatric expert help us teach the regular primary care doctors;”* in effect, she anticipates adopting a model of in-service teaching to build the geriatric competence of all the organization’s providers.

Several key informants described their organization’s use of the TeleECHO™ (Extension for Community Health Outcomes) clinic model, which uses telehealth to provide geriatrics training and consultation to distant sites.¹⁵ Although TeleECHO™ clinics are frequently oriented toward serving rural communities, the model is well-suited to providing consultative care to any underserved community of patients, including those living in institutional settings. One of the components of the TeleECHO™ model that makes it so appealing in the context of geriatric care is its emphasis on training and educating non-specialist physicians. The model is being utilized not only to give community providers access to expert guidance with respect to diagnostic information, patient treatment plans, and goals of care, but also to have the expert team of consultants mentor community providers, improve their content knowledge, and encourage a longitudinal, co-management approach to patient care.

A key informant representing a major academic medical center indicated that her institution has been using the TeleECHO™ model to serve community-based, long-term care clinicians with patients that have behavioral health and dementia care needs. These clinicians participate in regularly scheduled sessions where they present challenging patient cases to an interdisciplinary team of consultants consisting of a geriatric psychiatrist, a geriatrician, a pharmacist, a social worker, and often a psychologist. The expert team guides a structured discussion of the case, provides feedback and recommendations for the care plan, and delivers a short didactic presentation intended to develop additional content knowledge. These sessions are open to any other primary care or long-term care clinicians interested in participating, and participants can earn continuing medical education credit at no cost. Originally, the initiative was funded through a HRSA Geriatric Workforce Enhancement Program (GWEP) grant, but its success led to it being adopted by the state’s Medicaid Design System Reform Incentive Payment (DSRIP) program, which will provide sustainable funding. The medical center has now expanded use of the TeleECHO™ model to other types of services, including palliative care.

The Geriatric Research Education and Clinical Center (GRECC) system within the VA has deployed a version of the TeleECHO™ model (GRECC Connect) to increase access to geriatric specialty care for patients in rural settings and provide education and support to their non-geriatrician providers.¹⁶ Several different modalities are used based on resources and service demand. These include geriatric telehealth clinics that provide video-based consultations for veterans at their local outpatient clinic; web-hosted “case-based conferences” that allow community providers to engage with interdisciplinary, expert geriatric teams on a range of clinical issues; virtual meetings (“telehuddles”) where primary care providers can have specific patient concerns addressed by a geriatric team; and electronic consultations where geriatricians make clinical referrals based on patient chart reviews. The direct care, video-based telehealth consultations initially focused on dementia care and related behavioral health issues but have since expanded to cover other geriatric ailments such as frailty, polypharmacy, and palliative care. The consulting teams are interdisciplinary and support the patient’s primary care team (PACT) by providing an assessment of patients’ medical histories, cognitive and physical assessments, support for care planning and goal setting, case management for care coordination, and assistance connecting to needed wrap-around services.

Leadership

Geriatricians have assumed leadership positions at all levels in organizations and institutions engaged in healthcare delivery and health professions education. Key informants stressed that geriatricians’ experience delivering different modes of care (i.e., acute, chronic, hospice, palliative) across varied delivery settings (e.g., hospital, outpatient clinic, nursing home, assisted living, in-home), and experience providing coordinated, comprehensive, interdisciplinary team-based care that often includes engagement of social and community services, gives them a rich system-oriented perspective. It is this breadth of experience, key informants suggested, that makes geriatricians well-suited for leadership roles, and many expressed the view that geriatricians can have the greatest impact on service delivery and educational reform from positions of leadership. *“My view is that if geriatrics is going to have any significant leverage in the health system writ large, it has to emerge as a leadership specialty,”* commented one expert, head of the division of geriatric medicine at an academic medical center.

Key informants generally focused on leadership roles for geriatricians in the context of emerging value-based care and alternative payment models. They also cited the availability of new billing codes for reimbursement of services commonly provided by geriatricians, which are creating opportunities to change the way healthcare

services for older adults are delivered. They emphasized that healthcare organizations look to geriatricians to lead efforts to implement new care models. Some of these efforts are modest in scope, while others are very ambitious.

One of the experts referenced her medical center's participation in Medicare's Bundled Payments for Care Improvement (BPCI) program, focusing on patients admitted for specific cardiac-related procedures. (Currently there are 37 specific clinical episodes eligible for BPCI.) The objective of the BPCI program is cost containment by providing incentives to improve care coordination and efficiency. Medicare provides a fixed payment for an entire episode of care, which is generally defined as a hospitalization and all of the included services delivered in the period that follows. (Episodes are defined as 30, 60, or 90 days in length.) If spending is less than the "bundle" of payment, the institution retains the savings. If spending is greater, the institution is responsible for covering the additional cost. Key informants consistently referenced the challenge of demonstrating the value of care geriatricians provide within a fee-for-service payment environment that otherwise obscures their contributions. In the case of bundled payments, a geriatrician in a position of leadership was able to demonstrate the financial value of geriatric medicine when integrated with other service lines, which drove down the cost of episodic care. The cost savings provide evidence to build the business case for supporting further initiatives to incorporate geriatrics into care models.

Many of the key informants framed the implementation of innovative geriatric care models within the context of population health management, which signifies a comprehensive approach to managing the care of older patients. It entails the use of interdisciplinary teams (led by a geriatrician or other geriatric-aware provider) to deliver care at all levels of intensity, from wellness and prevention to complex and serious illness. It includes the development of processes that can be used to stratify risk among the patient population in order to target resources and build relationships with patients and families so that risk can be proactively monitored. It requires taking a systematic approach to coordinating care transitions between settings and providers and integrates behavioral health into the provision of care and management of patients' ongoing mental health needs. Population health management also involves engaging in data collection and analysis to identify clinical quality issues at the patient, practice, and system levels, all of which should be part of a deliberate performance improvement plan. Finally, a population health approach to geriatric care involves engaging with community-based entities outside of the clinical setting that can provide supportive resources aligned with the goals of such a comprehensive approach.

Several key informants discussed the Age-Friendly Health System initiative as an ambitious example of population-focused systemic reform of the organization and delivery of geriatric care. This initiative originated with the John A. Hartford Foundation and synthesizes best practices identified through the Foundation's decades-long investment in developing geriatric expertise and innovative models of geriatric care.¹⁷ The approach is composed of the core characteristics of existing geriatric care models and is designed to be implemented across all care settings. The program was developed by a working group that included representatives of the Hartford Foundation, the Institute for Healthcare Improvement, the American Hospital Association, selected geriatric field experts, and leadership from the five major US health systems selected to participate in the pilot program. The elements of clinical intervention are organized around four key concepts: mentation, mobility, medications, and what matters to patients, abbreviated as the "4 Ms." Within the 4 Ms conceptual framework there are a specific set of clinical interventions, presented in Table 2.

Table 2. Specific high-level interventions for the Age-Friendly Health System 4 M Model

Specific high-level interventions		
What matters	1	Know what matters: health outcome goals and care preferences for current and future care, including end of life
	2	Act on what matters for current and future care, including end of life
Medications	3	Implement standard process for age-friendly medication reconciliation
	4	De-prescribe and adjust doses to be age-friendly
Mobility	5	Implement an individualized mobility plan
	6	Create an environment that enables mobility
Mentation	7	Ensure adequate nutrition, hydration, sleep, and comfort
	8	Engage and orient to maximize independence
	9	Identify, treat, and manage dementia, delirium, and depression

Source: Reproduced from Mate et al. (2018).¹⁷

The Age-Friendly Health Systems model has now expanded to 73 different systems. The Hartford Foundation has affirmed a goal to have the model spread to 20% of US hospitals by the end of 2020.¹⁸ Implementing the model requires investments in

staff development to ensure competence in providing geriatric care; information systems designed to capture meaningful data that facilitate the measurement of patient outcomes; and protocols for effective care coordination among different providers and organizations, including family caregivers, and at different points of care delivery. Implementation fundamentally requires health systems to commit to better geriatric care as a core value and core competence. The scope and scale of transforming into an Age-Friendly Health System requires significant organizational leadership and geriatricians can be expected to play a central role.

Interviewees also noted the importance of geriatricians holding positions of leadership within institutions of academic medicine. One key informant, a nationally recognized geriatrician clinician-educator and geriatrics division chief at an academic medical center, noted that geriatricians *“having a seat at the table”* in academic settings can have innumerable positive spillover effects. She described an opportunity to develop a research institute focused on aging that would likely not have arisen had she not been in a position of influence within her organization. The research institute exists as a collaboration among different fields with aging expertise, not only from academic departments within the university but also from outside entities that are based in the region. Key informants noted that geriatricians in positions of leadership within academic medical institutions can improve the visibility of geriatrics and contribute to it being seen as a meta-discipline that concerns all fields of medicine. For example, if an undergraduate medical program’s curriculum committee includes a geriatrician, it is more likely that principles of geriatric medicine can be integrated into the curriculum in a lasting way.

Interwoven with expectations that geriatricians assuming leadership roles will drive systemic change were concerns regarding whether geriatricians have the skills needed to be effective as leaders and questions about how geriatricians can access experiences to develop those skills. Key informants emphasized the multiple layers of complexity inherent in the process of implementing new care models, including an organization’s culture and its capacity for change, the cost of implementation (including staffing resources), measurement of effectiveness and outcomes, and careful economic and sustainability evaluation. Geriatricians have the knowledge base and the clinical expertise, but several key informants suggested that what may be missing is a preparedness to manage change and all of its components. Said one expert with an established record of reforming geriatric service delivery across many types of organizations, *“I can’t tell you the number of phone calls I get from folks that say, ‘Hey, can you help me do this? Can you help me do that?’ And it’s more of they don’t even know where to begin to have the discussions, and they want to advance the care delivery model, they want to advance population health,*

but they don't have the skills and don't have the experience.” He added, “These are critical skills, how to present a value proposition, how to make the business case, how to negotiate, how to take a passionate desire to improve care for older adults and translate that into the language that will resonate and get you the resources that you need.”

Valuing Geriatric Care

Key informants also shared perspectives on issues including how geriatric care is valued, the education and training of new geriatricians, and reframing geriatrics as a meta-discipline.

Valuing Geriatrics Effectively

In most circumstances, healthcare providers in the US are reimbursed for services based on a fee-for-service payment model that rewards procedures and volume. This model is at odds with the type of care that geriatricians routinely provide: low-tech, high-touch, and oriented toward an overall reduction in use of services. The fact that geriatricians provide care insured through Medicare, which is still predominantly a fee-for-service system, means that geriatricians are at greater risk than other medical specialties for reimbursement at rates that are less than the cost of services. This is compounded by the fact that geriatricians frequently provide care for patients with complex medical histories, which means patient encounters are comparatively time-consuming.

Several key informants acknowledged the value of successful efforts to establish new billing codes within the fee-for-service system that reimburse for care activities geriatricians routinely provide, such as advance care planning, transitional care management, and chronic care management. They also expressed support for ongoing efforts to refine the performance measures used by Centers for Medicare & Medicaid Services (CMS), as part of the Merit-based Incentive Payment System (MIPS), to determine upward (or downward) adjustments to a geriatrician's fee-for-service payment rates. Although Medicare physician payments are transitioning to value-based models, the fee-for-service payment system still predominates.

Nonetheless, value-based payment models, which incentivize quality over quantity of care, are expanding within Medicare. Demonstrating the value that geriatricians add to the healthcare system is a persistent need; as one key informant commented, *“I was making the case that we needed more geriatricians, when one of the senior leaders in the office that funds residency and fellowship training told me ‘well, the problem is that you guys haven't proven that you add any value to*

the system.” Since passage of the Affordable Care Act, new payment models that function as alternatives to the fee-for-service payment system have proliferated. While it is beyond the scope of this report to describe these models in detail, they generally fall into three categories: performance-based models that offer bonus payments for demonstrated improvements in care quality and cost containment; bundled or episodic-based models that offer fixed, lump sum payments to manage all care related to a specific condition; and accountable care models that are mixed payment schemes, including both capitation and bonus payments. These alternative payment models apply to care delivered across all settings (e.g., inpatient, outpatient, long-term care, and home-based care).

The emphasis on quality and performance is complementary to geriatricians' patient-centered practice model. By design, these payment models encourage improvements in patient outcomes, such as improved functional status and reductions in harms related to care transitions, which can incentivize healthcare organizations and systems to adopt innovative geriatric care models. As one expert commented, *“These payment models have made dramatic changes in how health systems think. I mean, just the simple penalties that were put in place to discourage hospital readmissions, when that started, hospitals for the first time in my career were interested in what happens in nursing homes.”* The expectation is that this shift in how Medicare reimburses for care, favoring quality over quantity, will ultimately reduce the disparity in remuneration for geriatricians, who earn less than nearly every other physician specialty. As one key informant representing the VA noted, even with the system being capitated and over 50% of the patient population being older than age 65, *“Geriatricians in the VA actually are on the lowest salary tier, even lower than primary care. That sends a very clear message.”* Alternative payment models have the potential to improve the earnings gap for geriatricians, but it is not guaranteed.

The economics of geriatric care, however, is not the only factor that contributes to devaluation of geriatric medicine. Some key informants referenced a perception that the professional culture of medicine denigrates geriatrics. *“I’ve had [physician] colleagues tell me that geriatrics is medicine when it doesn’t matter,”* recounted one expert. Another explained how this attitude can infect medical students and residents, who may not have completely formed views about the value of different specialty fields of medicine. *“By and large, other physicians undervalue geriatricians because, currently, professional medicine is focused on acute care and disease. It’s the procedural-driven, medical subspecialists who make up the bulk of teaching and clinical faculty. If they themselves don’t see the merit in geriatric medicine, it’s easy*

to pass those attitudes on to trainees.” Key informants conceded that the cultural phenomenon of ageism also plays a role in geriatric medicine’s diminished standing relative to other fields.

The importance of medical students and residents being exposed to role model geriatricians was stressed by key informants. They noted that it is possible that an individual could complete medical school and residency and then go on to a fellowship without having had any significant interaction with a geriatrician. All of the key informants who are geriatric physicians described experiences with geriatrician role models as formative and highly influential in their decision to pursue geriatrics. This underscores the importance of deliberately exposing medical students and residents to practicing geriatricians not only for the impact of direct clinical experience, but also to gain some understanding of *how* geriatricians practice.

Several key informants pointed to the decision to reduce the length of geriatrics fellowship training from two years to a single year as contributing to the problem of geriatrics being held in low regard by medical students, residents, and other physician specialists. Said one expert, *“In creating a one-year fellowship, I think we made our specialty seem less of a specialty and more of a tack-on, an add-on, like people adding on a year of this or of that, rather than a specialty in its own right.”* Others noted that, historically, geriatric medicine, as a field, has failed to make a case for itself to hospitals and health systems. One key informant contrasted geriatrics with palliative medicine, noting, *“When palliative medicine got started back in the mid-nineties, there was a very strong focus on making the business case for why palliative medicine was essential, as well as creating jobs that would attract people to the field, and creating opportunities for positions of leadership. Geriatrics needs to do that.”* Another key informant pointed out that the ongoing development of a conceptual framework for serious illness care is garnering a lot of attention, but the concepts and even the language used by proponents are *“wholly geriatrics-pioneered, they just don’t use the term geriatrics.”* She added that it is important that the professional community of geriatricians emphasize this fact, that *“the key components of advanced illness care are principles of geriatric medicine.”*

Key informants stressed that there is a great need to develop champions for geriatric care across the healthcare delivery system and within academic medicine, to *“relentlessly make the case that geriatrics expertise makes a difference in patient care.”* Several key informants suggested that a large-scale public information campaign would raise public awareness of the value of expert geriatric care and the fact that there are too few geriatricians. As one expert commented,

“We expect that our children will have access to a pediatrician; why shouldn’t we expect that older adults who want to see a geriatrician be able to do so?”

Geriatrics as a Meta-discipline

A predominant theme of the interview findings was that the US healthcare system cannot rely on geriatricians alone to meet the need for geriatric care. To meet current and future demand for geriatricians, as one key informant said, *“We’d need to increase the number of new geriatricians being trained every year by a hundred-fold.”* Acknowledging that it is highly unlikely that the US will experience a significant increase in the number of board-certified geriatricians, key informants emphasized that there must be an expectation that every professional engaged in providing care to older adults possess knowledge of geriatric principles, including family caregivers, direct care aides/assistants, social workers, registered nurses, pharmacists, and non-geriatrician physicians. In this sense, geriatrics must become a meta-discipline.

The primary focus of key informants’ views on building a geriatrics-aware healthcare workforce was the recognition that other physicians typically function as the principal care providers of older adults. Interviewees emphasized opportunities to build awareness of the importance of geriatrics knowledge through undergraduate and post-graduate medical training, board certification (or re-certification) exams, and initiatives to encourage other fields of medicine to develop and adopt their own standards for high-quality geriatric care. Ongoing efforts to develop geriatric competence more broadly in the healthcare workforce were noted, including the Geriatric Workforce Enhancement Program (GWEP) and the VA’s Geriatric Scholars Program, which are discussed in greater detail below.

Key informants suggested that exposure to geriatric medicine during undergraduate medical education and post-graduate residency training is highly variable. There are examples of medical schools in which geriatric content is well integrated with the curriculum, but in other schools medical students may take a single course covering geriatric principles and don’t have access to any geriatrics-focused clinical experiences. Similarly, some institutions offer significant clinical experiences focused on geriatrics for residents in both primary care-related and specialty fields of medicine, while other institutions offer little if any geriatrics training.

Key informants recommended that strong measures be taken to ensure consistent exposure to principles of geriatric medicine at both undergraduate and post-graduate levels, and across disciplines. For example, one expert suggested that accreditation standards for medical schools could be revised to state that

undergraduate programs must require clerkships in geriatric medicine. Another key informant expressed the view that content in the American Board of Internal Medicine (ABIM) & American Board of Family Medicine (ABFM) certification exams should have a stronger orientation toward older adults; this interviewee recommended that standards should *“Ensure that the ABIM and ABFM exams have 50-75% of their content related to older adults. Right now it's not, the standard [point of reference] is the physiology of a 35-year-old. If you change the test, docs will learn it.”*

One expert pointed out that Medicare is the principal source of funding for graduate medical education (GME), and raised the possibility of reorienting policies that govern Medicare funding of GME to support geriatrics training. Medicare GME payments are distributed primarily to teaching hospitals and are defined by statutory formulas linked to Medicare patient volume. Key informants noted that GME funding is not tied to any accountability for population health needs, nor to quality of physician training. The funding structure includes no incentives to support training opportunities outside of the inpatient setting or to provide residents with clinical experiences other than those related to acute care. Some key informants viewed revision of Medicare GME funding policies as a way to foster the development and expansion of geriatrics-related experiences during residency training. *“What if Medicare said ‘we want X% of all GME dollars set aside for the education of all non-pediatric specialties in geriatric principles.’ That would immediately elevate the profile of every division of geriatric medicine in every center or hospital in the country,”* commented one expert whose career in geriatrics has included roles as a clinical care provider, medicine clerkship director, clinician educator, board member for various medicine-related professional associations, and health services researcher.

Developing “geriatric champions” in other fields of medicine and among non-physician clinicians was noted by key informants as a challenge, but necessary to the cause of developing broad geriatric competence in the healthcare workforce. One expert described an initiative to increase awareness and build support for integrating geriatric principles into all clinical service lines at the academic medical center where she practices. *“We buy some portion of [an individual's] time and they become a geriatric champion for their area,”* through dissemination of research, an in-service education project, or a small clinical demonstration. She added, *“I do have people come to me and say ‘I just want you to come and help us take care of our patients,’ but that's not gonna work, we need champions, we need people who are willing to learn new principles. That's the only way we're going to change the model of care.”*

Key informants cited other examples of initiatives designed to develop geriatrics expertise in other fields of medicine, including:

Geriatric Emergency Department Collaborative – This is an initiative aimed at improving care provided to older adults in the emergency department setting. The collaborative has produced a set of standardized guidelines for Geriatric Emergency Department (GED) best practices, which create a template for staffing, equipment, education, policies and procedures, follow-up care, and performance improvement measures.¹⁹

*Geriatrics-for-Specialists Initiative*²⁰ – This initiative dates to the early 1990s and has focused on multiple objectives, among them improving the care that older adults receive from specialist physicians by increasing specialists' awareness of geriatric principles of medicine.

Key informants also referenced the HRSA-sponsored Geriatric Workforce Enhancement Program (GWEP) and the VA's Geriatric Scholars Program as examples of what should be done to broadly develop a healthcare workforce competent in providing geriatric care. As of June 2019, there were 44 GWEP participants representing a mix of health professions schools (medicine, nursing, social work, allied health) and healthcare facilities, spread across 29 states. The overall objectives of the GWEP include the integration of geriatrics with primary care; improved engagement of patients, family members, and caregivers in healthcare decision-making; development of care models that leverage community-based resources; and support for interdisciplinary education and training. By design, individual GWEP sites have program characteristics that reflect local training and education needs. The Geriatric Scholars Program is targeted to primary care physicians, nurse practitioners, physicians, clinical pharmacists, and behavioral health specialists practicing in rural outpatient clinic settings. It also focuses on integrating geriatric medicine with primary care practices through continuing education, practical clinical experiences, and coaching and mentoring.

Initiatives designed to disseminate principles of geriatric care and develop geriatric competence across the healthcare workforce were uniformly cited as a priority by key informants. The one caveat offered, however, was that these efforts should be carefully targeted toward reinforcing education and training needs specific to the practice of clinicians. As one key informant put it, *"You can teach somebody how to do a cognitive assessment, they can do it, but it may not persist because they don't use it often enough."* Another key informant noted how interdisciplinary team care has, for important reasons, become a touchstone in health professions education.

“It’s an area where medical schools, nursing schools, pharmacy schools and schools of social work, increasingly, have curricular requirements to teach interdisciplinary care, and how to participate in team-based care.” She continued, *“When you teach students a concept like team-based care, but then they don’t experience it in professional practice, then what you taught really has no impact, it gets unlearned.”*

Geriatrician Training

Key informants expressed the view that fellowship training programs are capable of adapting to an evolving healthcare delivery system that is creating new professional opportunities for geriatricians. Each fellowship program has its own character, enabling prospective students to select a program that matches their interests; as one key informant framed it, *“when we attract someone to the field, they come to like minds.”* Historically, some programs have attracted fellows whose focus is academic research, other programs have been oriented to training long-term care medical directors, and still others have produced mostly geriatrician clinician-educators. One expert noted that it is important to understand that the Accreditation Council for Graduate Medical Education (ACGME) requirements are written in a way that *“gives individual geriatrics fellowship programs a lot of flexibility to design a program that produces the sort of fellow that they want to see.”*

Key informants expressed two interrelated concerns regarding fellowship training. The principal concern was that geriatric medicine needs to become a leadership-oriented field and fellowship programs, in general, are not designed to provide the kind of content and experiential learning that would address this need. *“What are the skills that we need to be teaching, what are the experiences that fellows need to be getting, and how do we redesign our fellowship programs so that we are producing people who are going to be making system-level changes, rather than producing a generation of physicians who are going to be doing individual patient management?”* asked one expert. The secondary concern was that fellowship programs are, with few exceptions, only one year in length. As noted, several key informants described the decision to reduce the length of geriatrics fellowship training from two years to a single year as contributing to a devaluation of geriatrics. Moreover, most, though not all, key informants felt one year was not enough time to adequately prepare fellows beyond being a good clinician. One expert noted that there is a growing consciousness of the tension between the need for new modes of training and the time available to accommodate them: *“Fellowship programs are aware that it’s just not enough to do great clinical care. But it’s challenging to actually do leadership, to do education, to do clinical care, to*

do all of these different things within the 12-month fellowship. It's something that we are all struggling with; it's very much on the top of people's minds."

Some of the key informants acknowledged ongoing efforts to restructure the fellowship programs sponsored by their institutions: *"A couple of things our team has been thinking about are providing experiential learning within our health system's CMO's office and President's office, so that not only do fellows rotate on the traditional clinical care services, but they rotate through the administrative structure at the executive level,"* noted one expert. Another key informant stressed that fellowship programs need to improve the primary care clinical experiences trainees have access to, *"Unfortunately, we educate our physicians in residency clinics, which are not designed as efficient, high-functioning clinic systems. So I think it's incumbent on educators to try to get their physicians-in-training into some high functioning clinics to see how things actually work, to see what nurses do, what health coaches do, and that there are things a behavioral health specialist can do so that they don't have to."*

Key informants were attentive to the need for geriatricians to develop non-clinical skills to maximize their expertise. They emphasized knowledge of population health management, implementation science, change management, community relations, healthcare financing and payment models, practice model innovation, and health systems innovation. A few experts felt that these topics and related skills – including negotiation and bargaining, persuasion, and diplomacy – could be effectively integrated within the one-year fellowship structure, but most felt that this kind of content should be reserved for a second or third year of fellowship training.

Several key informants acknowledged that this kind of content could be organized as a mid-career opportunity, with programs oriented toward preparing individuals for leadership roles in healthcare administration, health systems design, or policy-making. An advantage of receiving this kind of education mid-career, as opposed to it being part of post-residency fellowship training, is that an individual would have experience in practice and exposure to systems-level issues and would, presumably, find the experience more meaningful. The learner also would be more likely to be in a position, professionally, to take action. Said one expert, *"It's always good to have some experience under your belt before you start thinking about bigger picture items."*

However, key informants emphasized that mid-career training would need to be organized in a way that acknowledges the challenges associated with maintaining a professional practice while in training. It would be unrealistic to expect an individual

who has an established medical practice, may have substantial debt incurred while in medical school, and may have a family to support, to suspend employment to compete a geriatrics fellowship. One of the ideas raised by the interviewees was to establish a model of formal geriatrics training based on the executive MBA experience, where individuals would spend some number of weekends in training, over the course of a year or two, but maintain their professional practice. This model could be effective both to provide physicians and other clinicians with basic geriatrics training similar to a conventional geriatric fellowship, and to offer leadership training, population health management, and other relevant knowledge to experienced clinicians.

Key informants cited the following examples of mid-career training programs that have relevance to geriatrics:

*Practice Change Leaders for Aging and Health*²¹ – This is a 15-month long program designed to develop leadership skills by completing a project aimed at improving care for older adults, with the mentorship of Senior Leaders (many of whom are geriatricians). This program is more than a decade old and covers four core topic areas: enhanced primary care, accountable care organizations, transitional care and hospital readmission reduction, and programs for dually-eligible beneficiaries. Practice Change Leaders attend our national meetings/seminars throughout the program. The program is administered through a national program office based in the Division of Health Care Policy and Research at the University of Colorado Anschutz Medical Campus. The program is jointly supported by the Atlantic Philanthropies and the John A. Hartford Foundation.

*Emerging Leaders in Aging Program*²² – This is a one-year program focused on developing leadership skills in the areas of clinical care, research, policy, and education within the context of improving care for older adults. Fifteen scholars are selected through a competitive national process. Scholars' projects require finding a current and pressing need at their organizations and identifying and implementing the goals, action steps, and evaluation strategies needed to address the need and related challenges. There are two in-person meetings, individualized coaching and mentoring, and videoconference meetings. The program is jointly sponsored by Tideswell, the American Geriatric Society, and the American Directors of Geriatric Academic Programs and has been active since 2015.

Conclusion

One of the predominant themes of the interviews conducted for this study was that healthcare systems and organizations are reorganizing the delivery of geriatric care

in ways that acknowledge the persistent shortage of geriatrician specialist physicians and seek to utilize this scarce resource to amplify geriatricians' expertise. Geriatricians continue to provide direct care to patients but increasingly do so as part of interdisciplinary teams, which facilitates integrated, comprehensive care. Where appropriate, care is coordinated with community-based agencies that offer supportive services. The setting for care delivered by geriatricians is increasingly likely to be community-based, particularly for the frail elderly living with multiple chronic conditions, and to employ technologies associated with telemedicine. The role for geriatricians providing consultative care is likely to shift toward a co-management model, where the relationship between the geriatrician and another provider is formally defined and expectations regarding the geriatrician's scope of practice is explicit rather than presumed.

While the role of academic clinician educator will always be necessary and fundamental, it is clear that for healthcare systems and organizations to embrace the concept of geriatrics as a meta-discipline – not a niche specialty, but rather a set of principles that informs all care provided to older adults – a key role for geriatricians will be to educate non-geriatrician providers in geriatrics principles. Geriatricians' breadth of experience with different modes of care delivered across different settings and expertise in providing coordinated, comprehensive, interdisciplinary team-based care also gives them a perspective well-suited to organizational leadership. As value-based care continues to incentivize the adoption of innovative geriatric care models, organizations will rely on geriatricians to lead efforts to implement them. Geriatricians' leadership roles within academic medical institutions are critical too, as they can facilitate needed change within the professional culture of medicine, leading to broader recognition of the value of geriatrics.

The expectation that geriatricians will play a substantial leadership role in helping to transform the delivery of care to older adults raises questions about the content of fellowship training and need for other professional development opportunities. Key informants suggested that fellowship programs could help prepare future leaders by incorporating experiences that allow fellows to deepen their knowledge of concepts such as population health, implementation science, healthcare financing, and practice model innovation. This content could be organized as a specialty track occurring in a second year of fellowship training, although it would also be suitable for a mid-career professional development program. Academic geriatricians are in particular need of such knowledge, as they will play a primary role in developing new curricular materials and in organizing opportunities for experiential learning.

In this context, many of the key informants viewed the recent reinstatement of the Geriatric Academic Career Award (GACA) program as critically important.

Numerous initiatives over the past several decades have focused on improving the care of older adults, often directed at building geriatric competence in the health professions workforce. These efforts continue today, represented by programs such as the Geriatric Workforce Enhancement Program (GWEP), Geriatric Scholars Program, and the Age-Friendly Health System initiative. As these efforts evolve, and as the healthcare system responds to incentives to adopt new geriatric care models, health services and policy researchers will need to evaluate their effectiveness and disseminate findings.

Recommendations

Some recommendations can be derived from the key informant interviews conducted for this study.

General

The Health Resources and Services Administration (HRSA), Centers for Medicare & Medicaid Services (CMS), and Veterans Health Administration (VA) all make investments in initiatives designed to build geriatric competence in the health professions workforce and improve healthcare for older adults. These three agencies should explore the development of a mechanism that facilitates information sharing and encourages collaboration and complementary programming related to geriatric care.

Research

Numerous innovative geriatric care models targeting different delivery settings and population needs are being implemented across healthcare systems. The health services research agenda should prioritize evaluating these models, not only for their effect on patient outcomes and cost of care, but also to understand the specific roles and responsibilities of geriatricians as well as issues of scalability.

Education and Training

Exposure to principles of geriatric medicine during undergraduate medical education, both didactically and clinically, is inconsistent. Liaison Committee on Medical Education (LCME) accreditation standards for medical schools should be revised to require specific commitments to providing students with geriatrics-focused clerkship experiences.

Similarly, physicians in residency are not uniformly exposed to structured clinical geriatrics experiences. Policies that govern Medicare funding should be revised to set aside monies for the purpose of developing and maintaining required geriatrics-focused training for all non-pediatric specialties.

Within geriatrics fellowship programs, funding should be increased to support a second fellowship year curriculum focused on systems and organizational management, population health, and implementation science. These programs should also offer stand-alone, mid-career professional development programs based on the executive MBA model that deliver content on these topics to practicing geriatricians. Mid-career executive MBA-style programs should also be available to offer geriatrics fellowship-like content to non-geriatrician physicians.

Continued support and advancement of geriatrics education relies upon well-qualified faculty. Thus, support to junior faculty in departments of geriatrics at academic medical institutions through the Geriatric Academic Career Award (GACA) program should be maintained.

Licensing and Board Certification

The United States Medical Licensing Examinations (USMLE) should be reviewed to determine the extent of geriatrics-focused content for all non-pediatric medical specialties. If needed, the exams should be revised to incorporate material that tests knowledge of geriatric medicine. In addition, the certification exams administered by the American Board of Internal Medicine (ABIM) and American Board of Family Medicine (ABFM) should be reviewed to determine the extent of geriatrics-focused content. If needed, the exams should be revised to incorporate patient histories that test knowledge of geriatric medicine.

Professional Practice

Healthcare delivery organizations can play a central role in ensuring that clinicians have geriatrics knowledge and patients have access to geriatrics experts. Financial incentives and regulations can accelerate this; for example, regulations for governance of accountable care organizations could be revised to require inclusion of a geriatrician serving in a position that is able to influence clinical practice. In addition, organizations can incorporate technologies related to telemedicine to deliver community-based primary and specialty geriatric care, in particular to underserved populations.



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Related Resources

[Link to landscape analysis.](#)

[Link to policy brief.](#)

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