

Training & Practice Update

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Academic Geriatric Programs in US Allopathic Medical Schools

Introduction

This update provides new information on the status of academic geriatric medicine programs in U.S. allopathic medical schools. The ADGAP Status of Geriatrics Workforce Study (formerly, The Longitudinal Study of Training and Practice in Geriatric Medicine) originally surveyed the directors of geriatric medicine academic programs (DGAPs) in 2001 and resurveyed the DGAPs again in 2005. A comparison of faculty and staff numbers, allocation of faculty and staff time, characteristics of academic leaders, budgets and sources of program revenues, and obstacles to successful program development are presented in this update.

Methods

DGAPs from each of the 125 U.S. allopathic medical schools accredited by the Liaison Committee on Medical Education (LCME) were surveyed in 2001 and 2005.

In 2001, the overall response rate for allopathic schools was 82% (103 out of 125 schools), and for 2005, 71% (89 out of 125 schools). While the medical schools that responded each year varied, 78 of the schools responded to both surveys. Data presented in this update include all schools that responded each year, even if they did not respond in both years. There were no differences between responders and nonresponders for each year of the survey with regards to the region of the country that the school was located and the number of students enrolled.

Results

In 2001, there were 3 departments of geriatric medicine, (Mt Sinai School of Medicine, New York, NY; University of Arkansas, Little Rock; and University of Oklahoma, Oklahoma City).¹ By 2005, 3 more departments were established (East Tennessee State University, Johnson City; Florida State University, Tallahassee; and the University of Hawaii, Honolulu). Most recently, Wright State University in Dayton, Ohio established a department of geriatrics. However, the most common geriatric academic unit structure remains a division or section within a division.

Academic Faculty and Staff

For all categories of academic faculty and staff, the mean full time equivalents (FTEs) either increased or remained the same from 2001 to 2005. The largest increases were seen in physician faculty, which went from a mean of 8.2 FTEs to 10.1 FTEs and other professional support staff, which increased to 3.3 FTEs from 0.9 FTEs. (Table 1)

In 2001 and 2005, faculty spent the greatest percentage of their time in clinical practice. However in 2005, the percent of time spent in medical student education increased to 10% from 5% in 2001. (Table 2)

Characteristics of Academic Leaders

The characteristics of DGAPs in allopathic schools in 2001 and 2005 are presented in Table 3. As compared to 2001, in 2005 DGAPs had spent more time in their current position and a higher percentage had been promoted to the professor level.

Table 1. Faculty and Staff in Allopathic Academic Geriatric Programs – 2001 and 2005 (Clinical Support Staff Not Included)

Mean, Median and Ranges in Full time Equivalents (FTEs)

| Categories | 2001 n=103/125 | | | 2005 n=89/125 | | |
|--|-------------------|--------|-------|------------------|--------|-------|
| | Mean | Median | Range | Mean | Median | Range |
| Physician faculty (MD, DO, or equivalent) | 8.2 | 6.5 | 0-42 | 10.1 | 9.1 | 0-40 |
| Geriatric Medicine and Geriatric Psychiatry First Year Fellows | 2.7 | 2.0 | 0-13 | 3.0 | 2.0 | 0-16 |
| Geriatric Medicine and Geriatric Psychiatry Fellows (second year and beyond) and MD Postdoctoral faculty | 1.0 | 0.0 | 0-7 | 1.0 | 0.0 | 0-7 |
| PhD Postdoctoral staff without faculty appointment | 1.0 | 0.0 | 0-20 | 1.2 | 0.0 | 0-14 |
| Research Faculty (Does not include MDs or faculty included in another category) | 2.8 | 1.0 | 0-43 | 3.7 | 1.0 | 0-57 |
| Physician Assistants | 0.3 | 0.0 | 0-4 | 0.4 | 0.0 | 0-8 |
| Nurse Practitioners | 2.1 | 1.0 | 0-15 | 2.1 | 1.0 | 0-11 |
| Clinical Nurse Specialists | 0.7 | 0.0 | 0-7 | 0.8 | 0.0 | 0-12 |
| Pharmacists | 0.3 | 0.0 | 0-4 | 0.6 | 0.0 | 0-6 |
| Social Workers | 1.1 | 1.0 | 0-6.2 | 1.5 | 1.0 | 0-10 |
| Other Professional Support Staff | 0.9 | 0.0 | 0-23 | 3.3 | 1.0 | 0-85 |

Table 2. Allocation of Allopathic Faculty and Staff Time in Full Time Equivalents (Median Percent and Range)

| Area | 2001 n=103/125 | 2005 n=89/125 |
|---|-------------------|------------------|
| Medical Student education in geriatrics | 5 (0-75) | 10 (0-75) |
| Residency education in geriatrics | 10 (0-60) | 10 (2-80) |
| Fellowship training in geriatrics | 10 (0-65) | 10 (0-45) |
| Continuing education in geriatrics | 5 (0-25) | 3 (0-20) |
| Clinical practice in geriatrics | 38 (0-85) | 39 (5-75) |
| Research/Scholarship in geriatrics | 15 (0-80) | 15 (0-65) |
| Administration | Not asked | 10 (0-20) |
| Other | 0 (0-85) | 0 (0-30) |

| Characteristics of DGAPs | 2001 n=103/125 | 2005 n=89/125 |
|--|--------------------------|-------------------------|
| Number of Years Academic Leader (Mean \pm SD) | 7.5 (\pm 6) | 9 (\pm 7) |
| DGAPs Academic Rank (percent) | | |
| Professor | 53% | 68% |
| Associate Professor | 33% | 19% |
| Assistant Professor | 12% | 11% |
| Other | 2% | 1% |
| % DGAP with CAQ without fellowship training | 37% | 40% |
| % DGAP with CAQ with fellowship training | 44% | 44% |
| % DGAPs without a CAQ | 19% | 16% |
| % DGAPs reporting to Dean | 33% | 28% |
| % DGAPs reporting to Chair of Dept. of Internal Medicine | 68% | 69% |
| % DGAPs reporting to Chair of Dept. of Family Medicine | 12% | 11% |
| % DGAPs reporting to Chair of Dept. of Psychiatry | 0% | 1% |
| % DGAPs with other reporting relationship | 20% | 17% |

Note: DGAPs can have more than one reporting relationship.

Program Revenue

Table 4 lists the sources of program revenue for allopathic schools. Programs continue to report diverse sources of revenue. Since 2001, there is a trend for programs to report a higher percentage of program

revenue from clinical practice and other sources. Institutional and hospital support, research and educational grants also remain important.

| CATEGORY | 2001 n=103/125 | 2005 n=89/125 |
|---|--------------------------|-------------------------|
| College of Medicine required geriatrics support | 10% (\pm 22) | 12% (\pm 22) |
| College of Medicine-discretionary geriatrics support | 8% (\pm 15) | 11.5% (\pm 15) |
| Direct hospital support | 10% (\pm 15) | 14% (\pm 20) |
| Income from endowments | 5% (\pm 12) | 7% (\pm 9) |
| Clinical Practice | 26% (\pm 25) | 32% (\pm 25) |
| Veterans Health Administration independent of the College of Medicine support and excluding research support | 13% (\pm 23) | N/A |
| Veterans Health Administration independent of the College of Medicine and including GRECC educational support | N/A | 13% (\pm 21) |
| Veterans Health Administration independent of the College of Medicine and including GRECC research support | N/A | 4% (\pm 9) |
| Research grants and contracts, direct and indirect | 17% (\pm 22) | 18% (\pm 18) |
| Educational grants and contracts, direct and indirect | 9% (\pm 17) | 13% (\pm 17) |
| Other | 0.4% (\pm 3) | 14% (\pm 31) |

Tables 5 and 6 present program budgets and reserve dollars. Among responding programs in 2005, 72% reported annual budgets of \$500,000 or more as compared

to 61% reporting such budget levels in 2001. In 2005, 62% of programs reported financial reserves of \$125,000 or less.

| Table 5. Geriatrics Annual Budgets in Allopathic Schools in 2001 and 2005 (Percent) | | |
|--|--------------------------|-------------------------|
| Budget Categories | 2001 n=103/125 | 2005 n=89/125 |
| <=\$500,000 | 39% | 28% |
| \$500,001-\$2,000,000 | 28% | 37% |
| \$2,000,001 - >\$10,000,000 | 33% | 35% |

| Table 6. Geriatrics Programs Reserve Dollars in Allopathic Schools in 2001 and 2005 (Percent) | | |
|--|--------------------------|-------------------------|
| Budget Categories | 2001 n=103/125 | 2005 n=89/125 |
| No reserve dollars | 43% | 38% |
| <=\$125,000 | 27% | 24% |
| \$125,001 - \$1,000,000 | 25% | 21% |
| >\$1,000,001 | 5% | 16% |
| Due to rounding, percents may not equal 100. | | |

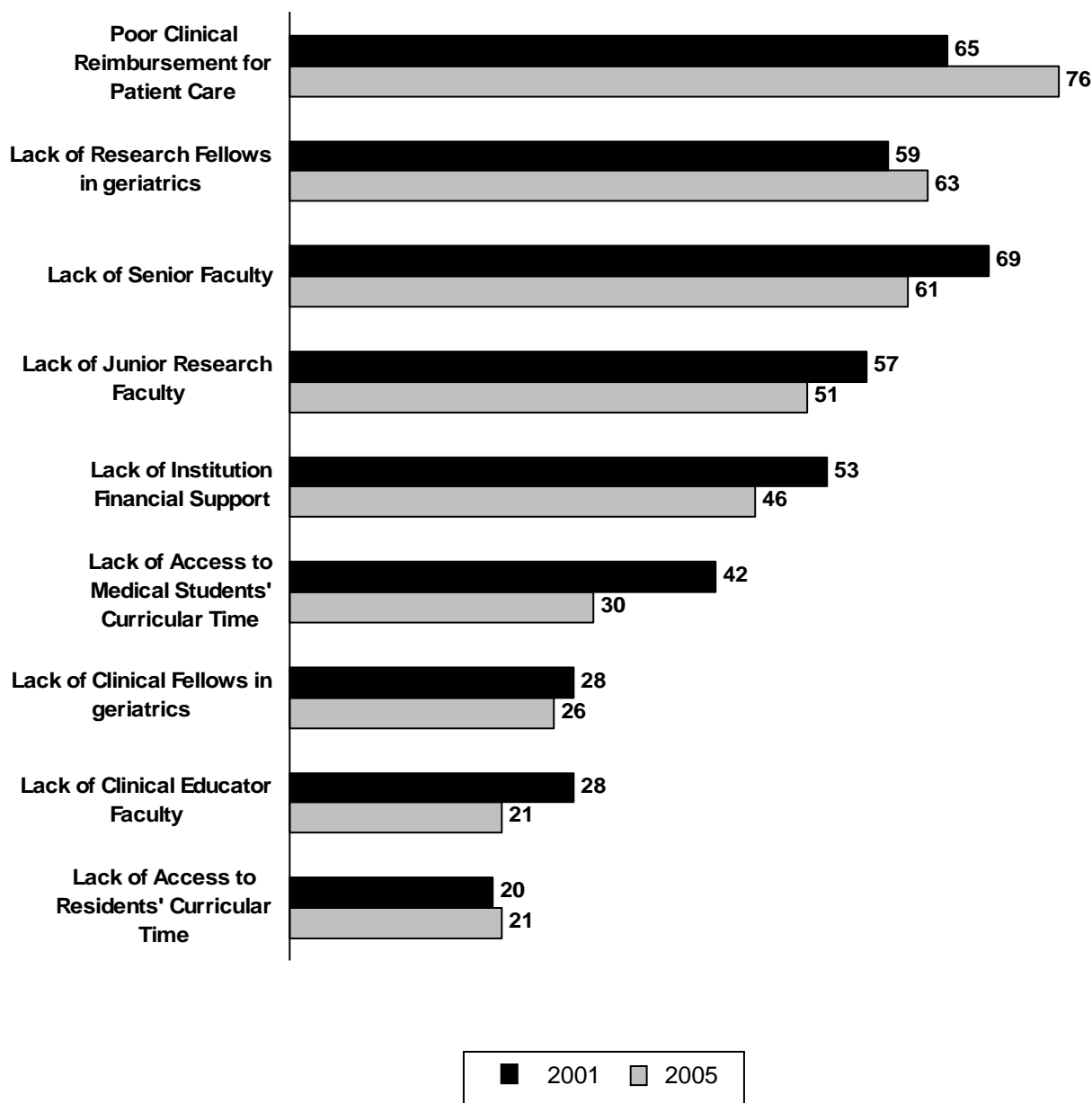
Obstacles

Figure 1 depicts the obstacles DGAPs encountered in implementing an academic geriatric program in allopathic schools in 2001 and 2005. Poor clinical reimbursement, limited number of research fellows,

a continued need for faculty, and inadequate institutional financial support remain the chief obstacles encountered by DGAPs.

Figure 1

Obstacles to Achieving Goals of Geriatric Programs as reported by DGAPS in Allopathic Schools in 2001 & 2005



Respondents were asked to rate each item on a scale of 1-5, where 1=never an obstacle and 5=major obstacle. Data presented are the percent of DGAPs that rated each item either 4 (almost always an obstacle) or 5 (major obstacle).

Conclusions

Departments of geriatric medicine in allopathic schools remain rare. Although four more departments were established in allopathic schools since 2001, most of the largest programs remain organized as divisions or centers. It is encouraging to document that the mean and median number of FTE physician faculty in geriatric programs have increased since 2001. There continues to be significant variability in size of faculties among medical schools.

The increasing proportion of faculty and staff time spent in medical student education since 2001 may be the result of the investments made by the John A. Hartford Foundation/ Association of American Medical Colleges medical student initiative and the Donald W. Reynolds Foundation Geriatrics training sites. Nonetheless, the one category that accounts for the largest portion of geriatric program faculty and staff's effort remains clinical practice. There continues to be significant variability in allocation of faculty and staff effort among medical schools.

In 2005, more than half of the academic leaders of geriatric medicine programs either had not been fellowship trained or did not have a CAQ. Most of these senior leaders will be retiring during the next decade, emphasizing the need for leadership development within academic geriatric medicine.

In 2005, nearly one third of mean revenue for geriatric programs derived from clinical practice, emphasizing the importance of Medicare reimbursement to program financial stability. VHA support remains important at

many programs. Thirteen percent of program support in 2005 came from educational grants and contracts. This increased by 4% since 2001, partly the result of the \$20 million dollar investment by the Reynolds Foundation in geriatrics training. The pending loss (academic year 2006-2007) of federal support for Geriatric Education Centers, Geriatric Medicine and Dentistry fellowship programs, and Geriatric Academic Career Clinical Educator Awards will directly impact this category of support.

The variation in the scope of academic geriatric programs is reflected in the reported size of their annual budgets. In 2005, more than one fourth of responding programs reported annual budgets of under \$500,000. Program vulnerability to cuts in federal research, education, and clinical support is reflected in the large number of programs with small financial reserves.

In 2005, as compared to 2001, program leaders were less likely to rank obstacles to program success as major challenges. This is an encouraging trend and is consistent with the ongoing public and private investment in geriatric medicine faculty development.

In summary, since 2001, academic geriatric medicine programs in allopathic medical schools have demonstrated the ability to develop diverse sources of revenue and expand faculty size. Continuing challenges include dependence on Medicare for clinical revenue, recent loss of funding from the Bureau of Health Professions, cutbacks at the NIH, and the need to develop the next generation of academic leaders.

References

¹Warshaw GA, Bragg EJ, Shaul RW, and Lindsell CJ. Academic Geriatric Programs in US Allopathic and Osteopathic Medical Schools. *JAMA*. 2002;288:2313-2319.

The Status of Geriatric Workforce Study National Oversight Panel

M . Brownell Anderson
Association of American Medical Colleges

Robert F. Avant, MD
American Board of Family Medicine

Linda H. Barondess
American Geriatrics Society

Robin A. Barr, PhD
National Institute on Aging

Marie A. Bernard, MD
*University of Oklahoma College of
Medicine*

James F. Burris, M.D.
Veterans Health Administration

John Burton, MD
Johns Hopkins Geriatrics Center

Thomas Cavalieri, DO
*American Association of Colleges of
Osteopathic Medicine*

Joseph Cheong, MD
American Association for Geriatric Psychiatry

Louis J. Grosso, MEd
American Board of Internal Medicine

William J. Hall, MD
University of Rochester

William R. Hazzard, MD
University of Washington

Gavin W. Hougham, PhD
John A. Hartford Foundation

Seth Landefeld, MD
University of California, San Francisco

Stephanie Lederman
American Federation for Aging Research

Rosanne Leipzig, MD, PhD
Mount Sinai School of Medicine

David B. Reuben, MD
University of California, Los Angeles

Judith Salerno, MD
National Institute on Aging

Joanne Schwartzberg, MD
American Medical Association

Philip Sloane, MD, MPH
University of North Carolina

Rani Snyder
Donald W. Reynolds Foundation

Joan Weiss, PhD, RN
Bureau of Health Professions

Editors: Elizabeth Bragg, PhD, RN and Gregg Warshaw, MD



Association of Directors of Geriatric Academic Programs
(ADGAP)

The Empire State Building
350 Fifth Avenue, Suite 801
New York, NY 10118

If you would like to be placed on our mailing list to receive the Updates automatically,
please write or e-mail Elizabeth Bragg at the following address:

Institute for the Study of Health

University of Cincinnati
3202 Eden Avenue, French East, Suite 275
PO Box 670840
Cincinnati, OH 45267-0840
Phone: 513-558-8792
Fax: 513-558-2744
Email: Elizabeth.Bragg@uc.edu
www.adgapstudy.uc.edu

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